

**Maternal and Child  
Health Services Title V  
Block Grant**

**Georgia**

**FY 2018 Application/  
FY 2016 Annual Report**

Created on 7/5/2017  
at 2:53 PM

# Table of Contents

<b>I. General Requirements</b>	<b>4</b>
I.A. Letter of Transmittal	4
I.B. Face Sheet	5
I.C. Assurances and Certifications	5
I.D. Table of Contents	5
I.E. Application/Annual Report Executive Summary	6
<b>II. Components of the Application/Annual Report</b>	<b>10</b>
II.A. Overview of the State	10
II.B. Five Year Needs Assessment Summary and Updates	19
FY 2018 Application/FY 2016 Annual Report Update	19
FY 2017 Application/FY 2015 Annual Report Update	22
Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)	26
II.C. State Selected Priorities	49
II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures	55
II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures	59
II.F. Five Year State Action Plan	62
II.F.1 State Action Plan and Strategies by MCH Population Domain	62
<i>Women/Maternal Health</i>	62
<i>Perinatal/Infant Health</i>	76
<i>Child Health</i>	102
<i>Adolescent Health</i>	127
<i>Children with Special Health Care Needs</i>	137
<i>Cross-Cutting/Life Course</i>	151
<i>Other Programmatic Activities</i>	163
II.F.2 MCH Workforce Development and Capacity	164
II.F.3. Family Consumer Partnership	166
II.F.4. Health Reform	171
II.F.5. Emerging Issues	172
II.F.6. Public Input	175
II.F.7. Technical Assistance	176
<b>III. Budget Narrative</b>	<b>177</b>
III.A. Expenditures	179
III.B. Budget	180

<b>IV. Title V-Medicaid IAA/MOU</b>	<b>182</b>
<b>V. Supporting Documents</b>	<b>183</b>
<b>VI. Appendix</b>	<b>184</b>
Form 2 MCH Budget/Expenditure Details	185
Form 3a Budget and Expenditure Details by Types of Individuals Served	193
Form 3b Budget and Expenditure Details by Types of Services	195
Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated	198
Form 5a Unduplicated Count of Individuals Served under Title V	202
Form 5b Total Recipient Count of Individuals Served by Title V	204
Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX	206
Form 7 State MCH Toll-Free Telephone Line and Other Appropriate Methods Data	209
Form 8 State MCH and CSHCN Directors Contact Information	211
Form 9 List of MCH Priority Needs	214
Form 9 State Priorities-Needs Assessment Year - Application Year 2016	215
Form 10a National Outcome Measures (NOMs)	217
Form 10a National Performance Measures (NPMs)	258
Form 10a State Performance Measures (SPMs)	268
Form 10a Evidence-Based or –Informed Strategy Measures (ESMs)	272
Form 10b State Performance Measure (SPM) Detail Sheets	291
Form 10b State Outcome Measure (SOM) Detail Sheets	295
Form 10c Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets	296
Form 11 Other State Data	315
State Action Plan Table	316
Abbreviated State Action Plan Table	317

## I. General Requirements

### I.A. Letter of Transmittal



Brenda Fitzgerald, MD, Commissioner | Nathan Deal, Governor

2 Peachtree Street NW, 15th Floor  
Atlanta, Georgia 30303-3142  
dph.ga.gov

July 15, 2017

Michael Spencer, LGSW, MSW  
Public Health Analyst / Project Officer Region IV  
Division of State and Community Health  
HRSA / Maternal and Child Health Bureau  
5600 Fishers Lane, MC 18N-104B  
Rockville, MD 20857

**Grantee Name:** Georgia Department of Public Health  
**Grant Name:** Maternal and Child Health Services Title V Block Grant  
**Grant Number:** B04MC30606  
**Reference:** Notification of Submittal

Dear Mr. Spencer,

This is a letter of transmittal informing you that a grant application requesting funding for the FY 2018 Maternal and Child Health Services Title V Block Grant has been submitted from the Georgia Department of Public Health.

For any questions related to the grant, please contact Johanna Pringle, Title V Director. Ms. Pringle can be reached at 404-656-4782 or [Johanna.Pringle@dph.ga.gov](mailto:Johanna.Pringle@dph.ga.gov).

Sincerely,

Johanna Pringle  
Title V Director  
Georgia Department of Public Health

Dionne Denson  
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 C of the 2015 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 "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published January 2015; expires December 31, 2017.

## **I.E. Application/Annual Report Executive Summary**

The Georgia Department of Public Health (DPH) Maternal and Child Health Section (MCH) administers the Maternal and Child Health Services Title V Block Grant. As Georgia's lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective, DPH provides and assures access to quality MCH services for mothers and children; provide and promote family-centered, community-based, coordinated systems of care for Children and Youth with Special Health Care Needs (CYSHCN) and their families; and facilitate the development of community-based systems of care for the MCH and CYSHCN populations. The 2018 Application/2016 Annual Report provides an overview of MCH's recent successes and achievements, as well as a summary of the Five-Year Needs Assessment and 2016- 2017 update to that assessment. The needs assessment resulted in a new set of priority needs and a five-year plan with objectives and strategies designed to meet those needs.

### **Annual Report Highlights**

MCH achieved several successes in the annual reporting year. Although not comprehensive, the following list provides several highlights of work that were accomplished:

- As of September 2016, 13% of women in the age range 15-44 years served in the public health clinics use a LARC compared to 11.1% in the previous year. The percentage of teens who use a LARC, as of August 2016, went up to 7.6% from the previous year 5.1%.
- The Women's Health Program developed a 5-STAR advisory board comprised of a "Baby-Friendly" hospital, public health district representative, WIC representative, and provider and increased active enrollment in the program from 12 to 37 of the total 79 birthing centers statewide.
- All Georgia birthing hospitals are participating in the Georgia Safe to Sleep Campaign, on how to implement a hospital-based safe to sleep program.
- The Autism and Developmental Disabilities team trained over 40 Division of Family and Children Services (DFCS) caseworkers and 105 parents on developmental monitoring.
- CDC awarded grant to DPH Chronic Disease section; the oral health program selected one chronic disease risk factor (tobacco use) and worked with chronic disease staff to develop and implement a pilot project targeting young women at high risk of tobacco use during pregnancy.
- Children Medical Services collaborated with the Care Management Organization (CMO) Amerigroup Georgia Families 360 to ensure better coordination of services for children and youth in foster care in the adoption process and under the care of juvenile justice.
- Georgia legislature passed House Bill 436, HIV/Syphilis Pregnancy Screening Act of 2015, to eliminate the requirement of counseling prior to testing pregnant women for HIV and syphilis and allow for refusal of testing during the 1st and 3rd trimester of pregnancy.
- Georgia legislature passed Senate Bill (SB) 12, allowing dental hygienist to practice under "general supervision" at approved dental facilities of the Department of Public Health, Boards of Health, or the Department of Corrections. SB 12 also allows dental hygienist working within the stated parameters to bill Medicaid for reimbursable services.

### **Needs Assessment Summary**

In accordance with the guidance requiring states to conduct a needs assessment every five years, Georgia conducted a comprehensive needs assessment that included a thorough review of all available quantitative data sources and collection of qualitative data among members of the community and key leaders in MCH. After reviewing the data collected, the MCH program and epidemiology staff identified a set of needs. Stakeholders were then given the opportunity to review the findings and assist MCH in prioritizing the identified needs. Throughout the entire process, stakeholders were able to give input into the selection of priorities and development of strategies to address priority needs through a survey, participation in stakeholder meetings and an ongoing public comment period. A SWON (Strength, Weakness, Opportunity, Need) analysis was used to determine program capacity and ensure that the Title V program had sufficient capacity and authority to properly address the need.

Ten priority needs were identified: prevent maternal mortality, increase access to family planning services, prevent infant mortality, promote developmental screenings among children, promote physical activity among children, prevent suicide among adolescents, improve systems of care for children and youth with special health care needs, increase access to specialty care for CYSHCN, decrease maternal substance use and promote oral health among all populations.

### **National Performance Measures**

Eight national performance measures (NPM) were selected to address the priority needs. The table below shows Georgia's current annual indicator for each of these measures and the national average if possible. These data will continue to be updated throughout the reporting cycle to assess the impact of programmatic approaches and refine activities based on

noted trends.

National Performance Measure	Data Source	Year Available	Georgia
Percent of women with a past year preventive medical visit	Behavioral Risk Factor Surveillance System	2015	67.7%
Percent of very low birth weight infants born in a Level III facility with a Neonatal Intensive Care Unit (NICU)	Vital Records	2016	79%
A. Percent of infants who are ever breastfed	National Immunization Survey	A. 2013	A. 69.2%
B. Percent of infants breastfed exclusively through 6 months		B. 2013	B. 25.4%
Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool	National Survey of Children's Health	2011/12	40.8%
Percent of children ages 6 through 11 who are physically active at least 60 minutes per day	National Survey of Children's Health	2011/12	35.9%
Percent of adolescents, 12 through 17, who are bullied or who bully others	A. National Survey of Children's Health	A. 2011/12	A. 16.4%
	B. Youth Risk Behavior Surveillance System	B. 2013	B. 25.1%
Percent of adolescents with special health care needs who receive services necessary to make transitions to adult health care	National Survey of Children with Special Health Care Needs	2009/10	33.9%
A. Percent of women who had a dental visit during pregnancy	A. Pregnancy Risk Assessment Monitoring System B. National Survey of Children's Health	A. 2013	A. 29.3%
B. Percent of children, ages 1 through 17, who had a preventive dental visit in the past year		B. 2011/12	B. 75.9%

### State Performance Measures

Four state performance measures (SPM) were also selected to address the priority needs. The table below shows Georgia's current annual indicator for each of these measures. These data will continue to be updated throughout the reporting cycle to assess the impact of programmatic approaches and refine activities based on noted trends.

State Performance Measure	Data Source	Year Available	Georgia
Percent of women (ages 15-44) served in the Georgia Family Planning Program who use long-acting reversible contraceptives (LARC)	Georgia Family Planning Program Clinic Data	2016	16.6%
Rate of CYSHCN that have seen a specialty provider within the last 12 months at the Children's Medical Services (CMS) Program Telehealth Clinic	Georgia's CMS Program Data, Kids Count	2016	1.5 per 100,000
Rate of congenital syphilis	State Electronic Notifiable Disease Surveillance Syndrome (SendSS)	2016	17 per 100,000
Rate of neonatal abstinence syndrome among infants born in a Georgia birthing hospital	Hospital Discharge Data and SendSS	2016	6.1 per 1,000

### State Action Plan Summary

Through the five year needs assessment ten priority needs were identified: prevent maternal mortality, increase access to family planning services, prevent infant mortality, reduce maternal substance use, promote developmental screenings among children, promote physical activity among children, prevent suicide among adolescents, improve systems of care for children and youth with special health care needs, increase access to specialty care for CYSHCN, and promote oral health among all populations. Twelve performance measures, national and state, will address the priority needs identified.

A summary of the state action plan is as follows:

Georgia's MCH action plan includes a variety of strategies, evidence-based and evidence-informed, that address the 10 priority needs. Health promotion/communication campaigns will be used to gain improvements in all performance measures, national and state. The health promotion/communication strategies are designed to increase awareness or promote behavior change among the MCH population, their families and/or providers working with women and children. Promoting oral health, safe-sleep, well-women visits and developmental screening will include marketing positive behavior directly and indirectly with the MCH population. Health promotion strategies range from supporting legislation and assuring policy adherence to supporting physician-patient counseling.

MCH will also use other strategies that include; system building between partners who deliver service to the MCH population and policy development. Partnerships with MCH stakeholders is instrumental in realizing outcome goals and is also incorporated in all action plans for national and state performance measures. In such, MCH will be building new partnerships, identifying new MCH stakeholders and redefining the collective impact goals of existing partnerships in the upcoming years. For example, the Safe Sleep Coordinator will be working with first respondents and faith-based organizations to expand the safe sleep initiative.

The MCH Section recognized the need to redirect the strategic focus to address adolescent suicide and maternal mortality. Reducing bullying and increasing well-woman visits are both long term strategies to addressing adolescent suicide and maternal mortality. Due to growing concerns MCH will develop strategies to directly improve maternal mortality rates and adolescent suicide rates.

### Ongoing Needs Assessment

#### 2017 Ongoing Needs Assessment

The Title V ongoing needs assessment process provides an opportunity for MCH to redefine priorities based on the most current data available and strategically plan to address those needs.

During the reporting year, MCH assessed the public health impact of birth injuries and the feasibility of creating a surveillance system for birth injuries. Findings indicate that significant birth injuries can result in death, nerve palsy and deformations; all of which may have lifelong impacts for the affected infant and their family. Although impactful, literature shows that many of the factors contributing to the injury are either unavoidable or unpredictable. Monitoring occurrences of birth injuries as part of the 5-Year Title V Needs Assessment is reasonable to identify any changes that can be shared with physician organizations and hospital partners.

## II. Components of the Application/Annual Report

### II.A. Overview of the State

The Georgia Department of Public Health (DPH) is the lead state agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective. The Title V Director and Maternal and Child Health (MCH) Staff use a multifaceted strategic plan to identify and address the challenges and needs of Georgia's MCH population.

Georgia is a diverse state with a growing population, robust political landscape, and slow growing health care environment. The distinct health care environments in rural Georgia and the urban metropolitan are a unique challenge for the Title V 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. 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 Brasstown Bald, 4,784 feet; the lowest point is sea level. Georgia is ranked 24<sup>th</sup> in terms of land size and is the largest state geographically east of the Mississippi River.

#### Urban and Rural Counties

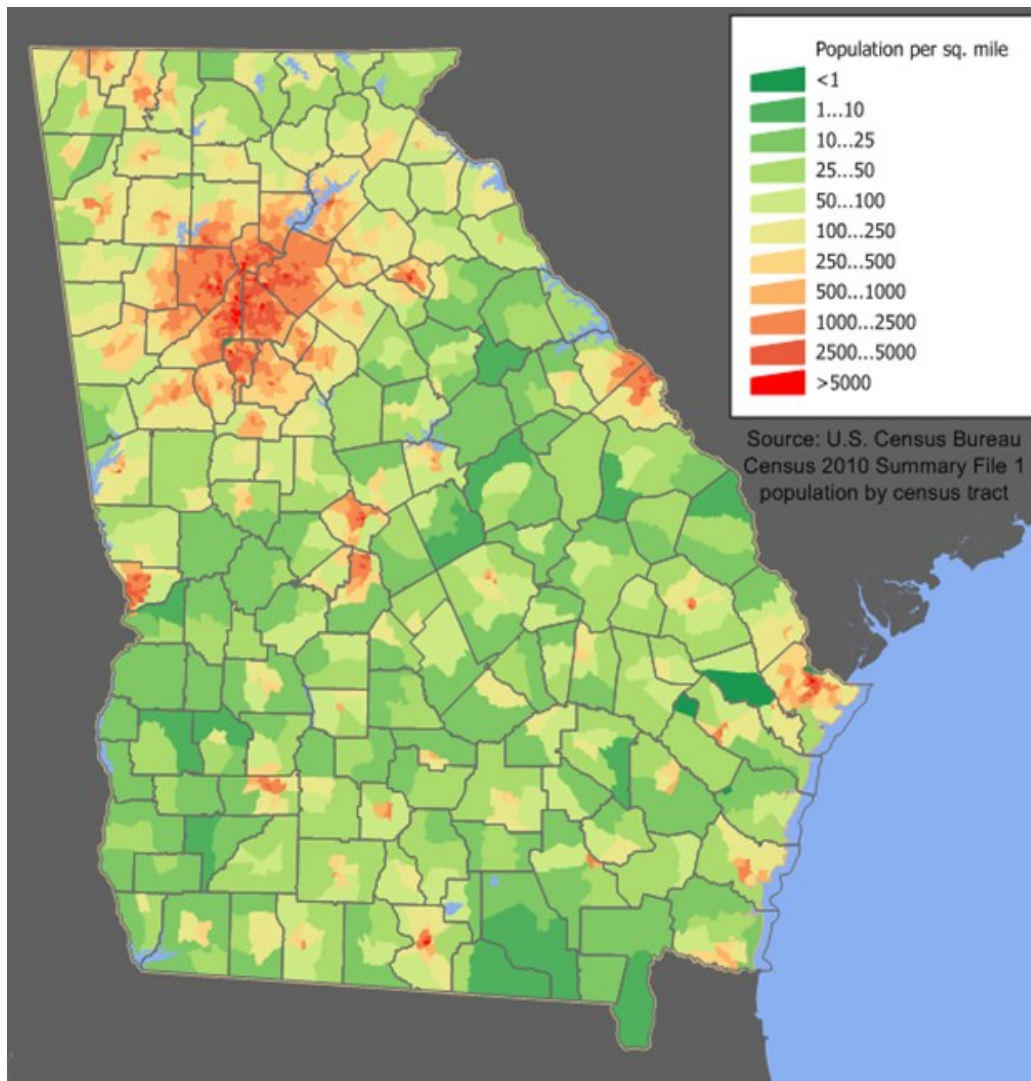
Of Georgia's 159 counties, there are urban and rural ones located throughout the state. The Census Bureau defines two types of urban areas: urbanized areas of 50,000 people or more, and urban clusters between 2,500 people and 50,000 people. All other counties are considered rural. In Georgia, 108 counties are designated as rural. There are 20 smaller cities and urban areas with populations above 50,000. The majority of the state's rural counties are located in the southern half of the state.

According to the 2010 census (most recent census available), there are 15 Metropolitan Statistical Areas in Georgia<sup>4</sup>: 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.

The increasing population and migration trends are resulting in certain rural areas that are experiencing growth in both economics and population while other rural areas are experiencing a decline. 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. Telemedicine and other innovative strategies alleviate disparities in access to health care 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 2: Urbanized areas in Georgia



## Population

As of 2016, Georgia had an estimated population of 10.3 million people.<sup>18</sup> It is ranked the 8<sup>th</sup> largest state with respect to population based on 2015 estimates.<sup>17</sup> Georgia is the 14<sup>th</sup> fastest growing state in the nation, with a 6.4% increase from 2010 to 2016<sup>17</sup>, and is 4<sup>th</sup> highest among states with the largest numeric population increase.<sup>17</sup> It is estimated that Georgia's population will increase to 11.3 million by 2020.<sup>10</sup> 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 capital, is the economic, cultural and demographic center of Georgia. It is the largest city in the state, with 460,000 people living in the city in 2015 and approximately 5.7 million living in the Atlanta Metropolitan Statistical Area. The population grew an estimation of 10.4% from 2010 to 2015, and is expected to continue to do so. Over 6% of residents are under 5, 19.4% are under 18 and 9.8% are over 65. The city also has a high percentage of minorities, with 54% of residents identifying as Black or African American, 38% as White, 5% as Hispanic and 3% as Asian. Hispanics are the largest growing minority, with Asians following as a close second. Poverty is rampant in Atlanta, with 1 in 4 Atlanta residents living below the federal poverty line as of 2011-2015, compared to 17% of the overall Georgia population.<sup>18</sup>



## Race/Ethnicity

The racial distribution has shifted slightly from 2000 to 2010, although the majority of Georgians are still White or Black. The percentage of Georgians who are White decreased from 65.1% in 2000 to 59.7% in 2010. However, an increase was seen in the percentage who are Black. In 2010, 30.5% of Georgians were Black. The number of Hispanics in Georgia doubled between 2000 and 2010. 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, education and human services.

**Table 1.** Georgia's Population by Race/Ethnicity, 2000 and 2010

<b>Georgia Population Estimates</b>				
	<b>2000 Census</b>		<b>2010 Census</b>	
<b><u>Population Characteristic</u></b>	<b>Number</b>	<b>Percent</b>	<b>Number</b>	<b>Percent</b>
<b>Total Population</b>	8,186,453	-----	9,687,653	-----
<b><u>Race/Ethnicity</u></b>				
<b>White</b>	5,327,281	65.1	5,787,440	<b>59.7</b>
<b>Black or African American</b>	2,349,542	28.7	2,950,435	<b>30.5</b>
<b>American Indian and Alaska Native</b>	21,737	0.3	32,151	<b>0.3</b>
<b>Asian</b>	173,170	2.1	314,467	<b>3.2</b>
<b>Native Hawaiian and Other Pacific Islander</b>	4,246	0.1	6,799	<b>0.1</b>
<b>Some other race</b>	196,289	2.8	388,872	<b>4.0</b>
<b>Two or more races</b>	114,188	1.4	207,489	<b>2.1</b>
<b>Hispanic or Latino (of any race)</b>	435,227	5.3	853,689	<b>8.8</b>

## Age and Gender

Georgia is a young state, with 25.7% of the population under 18 years of age, 38.2% between 18 and 44 years, 25.4% between 45 and 64 years and 10.7% over age 65.<sup>15</sup> Georgia is ranked 4<sup>th</sup> highest for the percentage of the population under age 18. The median age in the state is 35.3.<sup>15</sup> According to 2009-2013 estimates, 6.9% of Georgia's population is under 5 years old.<sup>19</sup>

## 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. The estimated percentage of immigration has stayed stable from 2010-2015. In 2015, it was estimated that 9.8% of the total population in Georgia are foreign-born. However, there has been an increase in naturalized citizens from 33.8% in 2010 to 40% in 2015.<sup>19</sup> Twenty-one percent of children under the age of 18 are foreign-born or reside with at least one foreign-born parent.<sup>20</sup> The parent's region of origin can be broken up into 61% from Latin American, 20% from Asia, 10% from Africa, and 6% from Europe.<sup>20</sup> In 2011-2015, an estimated 90% of children in immigrant families are U.S. citizens.



As of 2015, 40.6% of foreign-born residents identify as White, 17.1% identify as Black or African American and 25.8% as Asian.<sup>19</sup> Of all racial categories 41.6% identify as Hispanic or of Latin origin.<sup>19</sup> Over 46% are between ages 25 and 44.<sup>19</sup> Nearly 8% of foreign born residents were enrolled in college from 2010-2014.<sup>19</sup> In 2014, 46.3% of foreign-born residents fell below 200 percent of the poverty level.<sup>19</sup>

From 2000 to 2009, the Department of Homeland Security estimates that the number of unauthorized immigrants in Georgia increased by 115%, ranking Georgia as 6<sup>th</sup> among states with the largest number of undocumented immigrants. However, data from 2009-2012 show a major decline in the number of undocumented immigrants in Georgia. Georgia was one of 14 states nationwide to have a significant decrease in the number of undocumented immigrants from 425,000 to 400,000. This decrease may be the result of immigration laws enacted in Georgia in 2011.<sup>14</sup>

### **Language Proficiency**

Over 13% of Georgia residents speak a language other than English.<sup>19</sup> Of the other languages spoken, Spanish is the most commonly spoken language at approximately 8%. Both other Indo-European languages, Asian and Pacific Island languages, account for approximately 2.5%, and the remaining 1% of residents speaks another language. Of those that speak a language other than English, 43.2% speak English less than very well.<sup>19</sup> These factors can have interesting implications on the services offered to residents and may necessitate investment in interpretation and culturally competent approaches to health care delivery.

### **Family Household Type**

Household structures in Georgia are very similar to what is seen across the rest of the United States. In 2010, 47.8% of Georgia households were composed of a husband and wife, with 21.1% of these households having children under the age of 18. Female headed households comprised of 15.8% of the population and 8.9% of these households contained children under the age of 18; 4.9% were male family households with 2.2% having children under the age of 18. Finally, 25.4% of households were one-person households, with 7.5% being 65 or older. The average household size was 2.6 and the average family size was 3.2.<sup>16</sup>

### **Educational Attainment**

Public schools are the primary source of education in Georgia. In 2015, 63.8% of children attended a public nursery school and/or preschool while 36.2% attended a private nursery school and/or preschool. In 2015, 90.8% of students in Kindergarten to 12<sup>th</sup> grade were in public school and 9.2% were in private school.<sup>19</sup>

In the 2014 cohort, the high school graduation rate was 72.6 among all students. It was 36.5 for students with a disability, 79.7 among Whites, 64.0 among Hispanics and 65.3 among Blacks.<sup>8</sup>

More than 85% of Georgia residents over the age of 25 have a high school diploma, and 28.8% have a bachelor's degree or higher. The residents of Atlanta have slightly higher graduation rates. In Atlanta, 89% of people over the age of 25 are high school graduates and nearly 48% have a bachelor's degree or higher.<sup>18, 2</sup>

### **Income**

Georgia's per capita income was below the national average from 2009 to 2014 with a per capita income of \$25,427 relative to the U.S. average of \$28,555; at the same time, the state's poverty level was above the national average.<sup>18</sup> While median Georgia household incomes (\$49,620 in 2015) have not recovered to 2008 levels (\$55,027), the trend appears to be reversing with the largest increase from 2013 to 2014 (\$1,513).<sup>19</sup>

**Table 2.** Median Household Income in Georgia and the US, 2008-2014

Year	Georgia	United States
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. In 2015, 18.4% of Georgians were living below the poverty line, compared with 15.5% for the U.S. overall. Over eight percent were below 50% of the federal poverty level (FPL) and 23.6% were living at less than 125% of the FPL. About 1 in 4 children in Georgia under the age of 18 are in poverty as of 2013 an increase from 2009 where 1 in 5 children under the age of 18 were in poverty. Poverty disproportionately affects race and ethnicity in Georgia. The poverty status of Georgians living below the FPL based on race and ethnicity in 2015 was 13.5% of White, 26.7% of African-Americans, 26.2% American Indian and Alaska Native, 13.7% of Asians, 31.0% Native Hawaiian and Other Pacific Island, and 30.4% of Hispanics.<sup>19</sup>

### Employment

In March 2017 Georgia's unemployment rate was 5.1% ranking it 43<sup>rd</sup> in the United States. The lowest unemployment rate is 2.6% in Colorado. High unemployment rates may have serious implications on the burden of public health and the available resources for public and social services.

### Homelessness

The homelessness rate in Georgia has decreased 19% from the year 2013 to 2015. In 2013, 8,450 individuals were unsheltered and 8,497 were in transitional or emergency housing, compared to 5,803 unsheltered and 7,987 in transitional or emergency housing in 2015.<sup>7</sup> The majority of the state's homeless population was African American (65%), followed by White (31%). Approximately 64% of the homeless population was men. Of the homeless population, about 12% of are veterans, 16% have a disability and 18% are under age 18.<sup>7</sup>

### Insurance Status

Eight percent of Georgia's children are uninsured, making it the state with the 5<sup>th</sup> highest rate of uninsured children. Fourteen percent of the total state's population is uninsured, ranking it 2<sup>nd</sup> highest in the nation.<sup>11</sup> Minorities such as Blacks and Hispanics have a significantly higher rate of being un-insured and underinsured compared to their White counterparts. 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.

### 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 2017 Georgia will not expand. In 2016, analysts estimated that 1.17 million Georgia residents that were currently uninsured will obtain coverage by 2019. Approximately 511,826 Georgians acquired health insurance through the marketplace at the end of 2016 open enrollment.<sup>3</sup>

Georgia DPH and MCH Programs will continue to adapt to the changing health care landscape to promote the health of women and children.

## Emerging Issues

Georgia is one of the largest and fastest growing states in the nation, yet residents experience more poverty and unemployment than what is seen nationally. Although economists anticipated that Georgia's economy would catch up with the nation's recovery by mid-year 2011<sup>1</sup>, this was not the case. Economic recovery in Georgia yielded an increase in state revenue for the 2016 budget and 2017 budget.

Although state revenue increased in the 2018 fiscal year, the Department of Community Health faced a budget decline. The 2018 budget directs \$2.57 billion to the Department of Community Health, not including money for agencies attached for administrative purposes – which is a \$85.7 million decline from the 2017 budget. The budget decline is mostly due to an increased rate for federal matching funds in the Medicare program. Approximately 95% of the general fund is spent on health care services for Medicaid and PeachCare patients. The 2018 budget is also relying on the renewal of the Georgia hospital provider fee, or Medicaid assessment, when it expires on June 30, 2017. The extension of the fee will bring \$311 million in the fiscal year and 10 percent of the state contribution to the Medicaid and PeachCare programs.<sup>5</sup>

The 2018 fiscal year budget proposal increased the funding for Georgia public school students to \$9.4 billion. This money will fund a 2 percent salary increase for authorized teachers. However, this budget is \$166 million less than the calculated amount needed for the school systems.<sup>6</sup> According to the U.S. Census Bureau, Georgia ranks 38<sup>th</sup> in per-student funding for K-12 education.<sup>5</sup> Georgia ranks 4<sup>th</sup> in the nation for the highest percentage of public school students who are living in poverty as measured by their participation in the federal free and reduced lunch program.<sup>5</sup>

Georgia has received an extension of their Planning for Healthy Babies (P4HB) program, which is a Section 1115 Family Planning Demonstration Waiver that extends Medicaid eligibility coverage to women between the ages of 18 and 44 whose incomes are up to 200% of the FPL.

Nearly three-fourths of childhood deaths are due to unintentional injuries, most related to car accidents. Recent efforts have been made to improve awareness of car seat safety. Georgia supports the American Academy of Pediatrics (AAP) recommendation to have children remain in rear facing car seats up to two years of age and requires use of a booster seat for children until 8 years old or 57 inches. While this is making a positive impact on the lives of younger children in Georgia, more work needs to be done to protect the lives of preteens and teens traveling in cars in Georgia.

## Title V Priorities

In light of the geographic, demographic and political landscape in Georgia, this is a critical time for the Title V program set priorities. The process used by the Title V Director and MCH Staff for determining the needs and priorities of the program is multifactorial. Primarily, the five-year assessment is used to evaluate priorities. However, efforts are made to align priorities with ongoing needs assessment efforts, priorities of the Governor and Commissioner and Executive Leadership 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.

DPH developed a new strategic plan to carry the agency through 2019. Although the strategic plan is not comprehensive of all priorities within the agency, it does highlight the areas that will receive specific programmatic emphasis throughout the next three years. The strategic plan includes the following goals and objectives:

**GOAL 1: Prevent disease, injury, and disability.** Provide population-based programs and preventive services to prevent disease, injury, and disability by advocating for and promoting health, leading change in health policies and systems, and enabling healthy choices.

Objective 1.1: Childhood Obesity

Objective 1.2: Asthma

Objective 1.3: Infant Mortality

Objective 1.4: Cardio Metabolic Syndrome

Objective 1.5: Early Brain Development

**GOAL 2. Promote health and wellbeing.** Increase access to care throughout the State of Georgia and educate the public, practitioners, and government to promote health and wellbeing by collecting, analyzing and reporting health data, tracking disease and health determinants and applying science and epidemiological principles to support decisions.

Objective 2.1: Healthcare Access/Primary Care

Objective 2.2: Infrastructure support and improvement to promote health and wellbeing

**GOAL 3: Prepare for and respond to disasters.** Insure efficient, effective and quality Public Health infrastructure to prepare for and respond to emergencies to safeguard the health and wellbeing of Georgians by conducting surveillance, inspect for environmental hazards, epidemiological investigations and providing support for district operations.

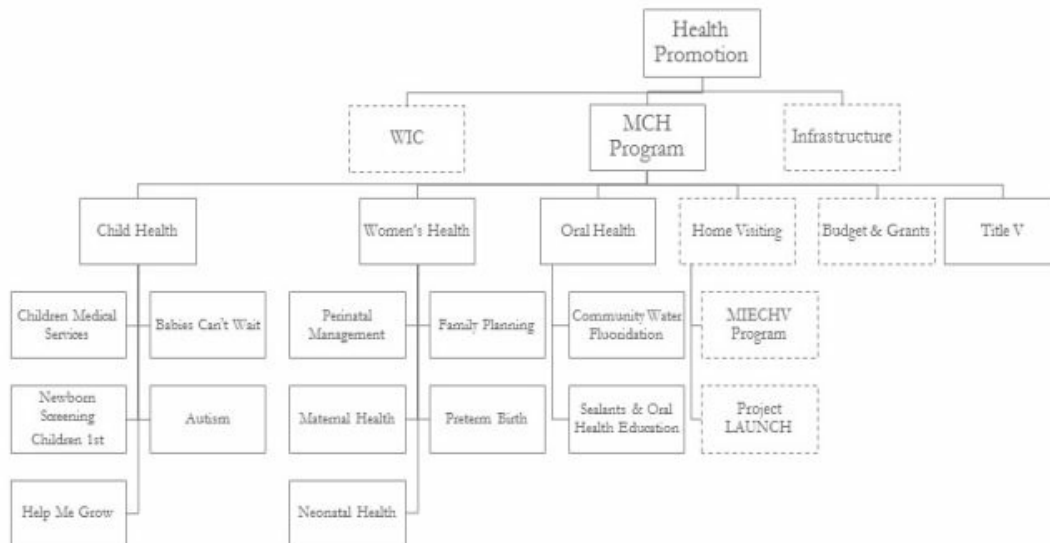
Objective 3.1: Infrastructure support and improvement to prepare for and respond to disasters

The initiatives outlined in the State Action Plan Chart to prevent infant mortality align with the strategies to meet Objective 1.3 of the DPH Strategic Plan.

### **Organizational Changes**

The Maternal and Child Health Section has had two reorganizations since 2015 in an effort to align programs and services with Good to Great principles and efforts to achieve a healthy Georgia. The MCH Section is now programmatically led by six Directors: Title V Director, Home Visiting Director, Women's Health Director and the Child Health Director (Image 1). Each Director reports directly to the Division of Health Promotion Director. The organization elevates the operation of programs and services for women and children to a higher level within the agency.

**Image 1.** The Maternal and Child Health Section Organization Chart



## MCH Leadership Staff

There are approximately 45 FTEs working on behalf of the Title V program in Georgia. The MCH leadership staff is comprised of the following individuals:

Lara Jacobson, MD is the Division Director for Health Promotion. Dr. Jacobson is a board-certified pediatrician and has served as a health care director in the non-profit sector, an Epidemic Intelligence Service (EIS) officer and epidemiologist at the Centers for Disease Control and Prevention (CDC). Dr. Jacobson is a published author of scientific journal articles on infectious diseases and public health interventions.

Johanna Pringle, MPH is the Title V Director. She has over 10 years of experience in Maternal and Child Health Programs. Ms. Pringle was awarded the 2016 Region IV Young MCH Professional Award and has served as an Oak Ridge Institute for Science and Education Fellow with CDC. She serves as the Project Director for Title V and is responsible for the five-year and on-going needs assessment. Ms. Pringle also provides technical support and guidance for the development of evidence-based and informed strategies.

Ruben D. Brambila, MPH is the Director of Child Health. He has over 15 years of leadership and outreach experience, specifically focused on children, adolescents and families. Mr. Brambila is responsible for overseeing child health related programs and initiatives, including Babies Can't Wait, Children's Medical Services, Autism/Developmental Disabilities, Child Health Screening, and Help Me Grow.

Sharifa Peart, MPH is the interim Director for Children and Youth with Special Health Care Needs (CYSHCN) and the Children Medical Services Manager. Ms. Peart has been with the DPH Maternal and Child Health Section since 2012 and has experience in health care transition, telemedicine expansion, care coordination, physician engagement, family satisfaction, and child health referral systems. She provides ongoing support in Title V strategic planning and reporting activities. Prior to her work with MCH, Ms. Peart directed the statewide hearing services program administered through a community based organization.

Diane Durrence, MPH, MSN, APRN is the Director of Women's Health. She has over 25 years of public health experience in clinical services and program management. Ms. Durrence oversees Family Planning, Women's

Health and Perinatal Health and directs key MCH section initiatives for DPH.

Jeanine Galloway, MPH is the Director of Home Visiting. She has over ten years of experience managing community-based programs and services and implementing evidence-based programs. Ms. Galloway oversees the MCH Home Visiting Program that includes Project LAUNCH and the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program.

Carol Smith, RDH, MSHA is the Director of the Oral Health. Ms. Smith received her MSHA from Georgia State University and is a registered dental hygienist. She has been in her current role for 5 years with previous experience in clinical practice. Ms. Smith oversees Oral Health program initiatives, including community water fluoridation and school sealant programs.

## II.B. Five Year Needs Assessment Summary and Updates

### FY 2018 Application/FY 2016 Annual Report Update

#### On-Going Needs Assessment: Birth Injury

The Georgia Department of Public Health (DPH) Title V Program received a request/public comment from a parent whose infant experienced a significant birth injury resulting in paralysis of an arm. The parent's comment included a request to identify the significance of birth injuries and the feasibility of creating a surveillance system for birth injuries.

DPH routinely collects birth injury data through the electronic birth certificate. The Title V Program used this data to identify the magnitude of birth injuries in Georgia and a literature search to identify the preventability of birth injuries. This information was used to determine whether public health surveillance for birth injuries was warranted. Two Master of Public Health students from the University of Georgia and Emory University worked with the Title V Program to conduct the investigation.

#### Introduction

Birth injuries, also known as birth traumas result from a physical injury a baby incurs during its' delivery.<sup>32</sup> According to the Centers of Disease Control and Prevention (CDC) in 2014, the rate of infant mortality was 5.82 deaths per 1,000 live births. Birth injuries are a cause of infant death and account for approximately 5% of all infant mortalities in the United States in 2016.<sup>27</sup> Georgia alone had a total of 1,023 infant deaths in 2015, but specific data on causes related to birth injuries are unknown.

The purpose of this study is to determine the magnitude of birth injuries and the preventability of birth injuries in the state of Georgia to identify potential preventive measures as well as additional support options for families.

#### Methods

Georgia birth data abstracted from electronic birth certificates were used to identify birth injury occurrences from years 2008 to 2015. The total number of births from years 2008-2015 were pulled from the Online Analytical Statistical Information System (OASIS). To examine the magnitude of birth injuries in Georgia, the prevalence of birth injuries was calculated out of all births in Georgia for years 2008 to 2015. The incidence of birth injuries across the years 2008 and 2015 were also compared to observe trends in birth injuries over time. Demographic information from the mother such as maternal race, ethnicity, age, education, and insurance type were examined for trends related to social demographics. Information related to the birth such as prenatal care and place of birth was also examined. Results obtained from analysis using Georgia's birth data, in addition to conclusions made in previous literature, were used to determine the overall significance of birth injuries.

#### Results

The period prevalence for birth injuries from 2008-2015 is 43.37 per 100,000 births. Approximately 58 birth injuries were reported annually from years 2008 to 2015. Of all births resulting in a birth injury, the mean maternal age was 27 years of age (median = 26) and more frequent among women with some college degree or higher. Almost all birth injuries occur within a hospital, 99.12%.

According to existing literature, there are a variety of factors that may result in birth injuries such as fetal macrosomia, mode of delivery, and maternal characteristics.<sup>21, 23, 24, 26, 28, 30</sup> Some of the most common injuries cause nerve palsy (brachial, phrenic, peripheral), skeletal fractures, shoulder dystocia, and deformations.<sup>21, 23, 24, 25, 26, 28, 30, 31</sup> Although various studies have identified potential risk factors that cause birth injuries, many have noted that most risk factors are unavoidable and unpredictable.<sup>22, 29, 33</sup>

Characteristic	% (n)	Mean	Median
Mother's Race			
White	66.96 (304)		
Black	25.33 (115)		

Table 1. Demographic information of mothers with births resulting in a birth injury (n=454) from 2008-2015, Georgia, USA.

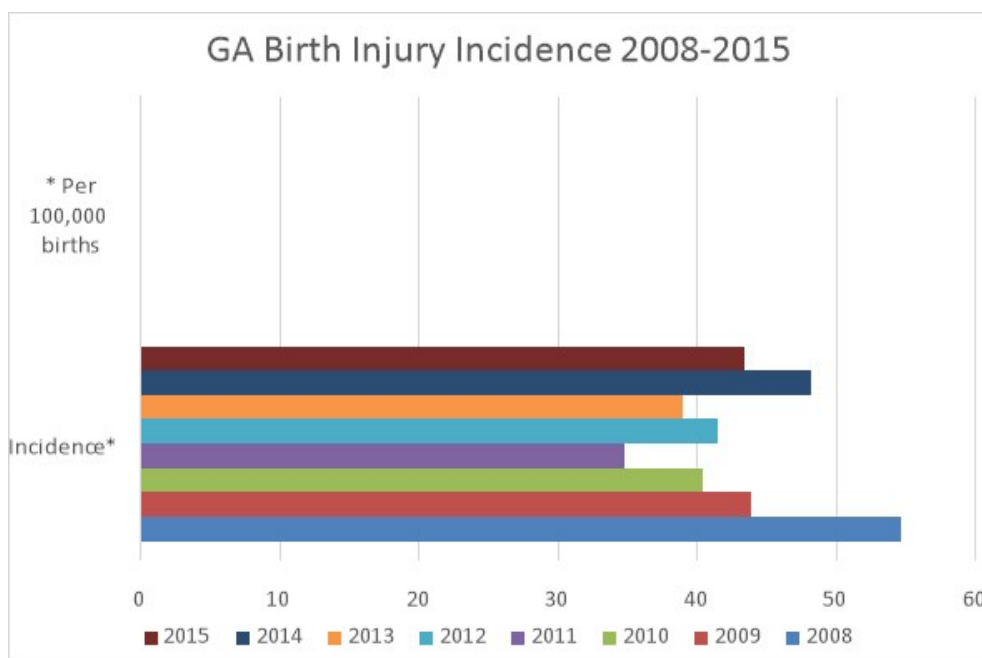
Asian	2.20 (10)		
Multiracial	3.74 (17)		
Mother's Ethnicity			
Hispanic	12.56 (57)		
Non-Hispanic	85.02 (386)		
Mother's Age		27.18±6.41	26
Mother's Education			
8th Grade or Less	3.52 (16)		
9 <sup>th</sup> -12 <sup>th</sup> Grade No Diploma	13.00 (59)		
High School Graduate or GED Obtained	29.74 (135)		
Some College or Higher	48.90 (222)		
Unknown	4.85 (22)		
Mother's Tobacco Use			
Yes	9.91 (45)		
No	90.09 (409)		
Insurance Type			
Medicaid Managed Care	1.98 (9)		
Blue Cross/Blue Shield	.22 (1)		
Tricare	4.85 (22)		
Medicaid	41.41 (188)		
Commercial Insurance	28.41 (129)		
Other Government Assistance	1.76 (8)		
Other	9.25 (42)		
Self Pay	4.85 (22)		
Unknown	7.27 (33)		
Birth Out of Hospital			
Yes	.66 (3)		
No	99.34 (451)		
Place of Birth			
Hospital	99.12 (450)		
Free Standing Birth Center	.22 (1)		
Residence (intended)	.22 (1)		
Residence (unintended)	.44 (2)		
Mother's First Birth			
Yes	43.61 (198)		
No	53.30 (242)		
Unknown	11.10 (5)		
Not Applicable	1.98 (9)		
Number of Prenatal Care Visits (of mothers who had at least one prenatal care visit)		11.83±5.55	12

Table 2. Incidence of birth injuries per year (n=466) from 2008-2015, Georgia, USA.



	2008	2009	2010	2011	2012	2013	2014	2015	Total
Birth Injuries	80	62	54	46	54	50	63	57	466
Total Births	146,464	141,332	133,668	132,239	130,112	128,511	130,776	131,333	1,074,435
Incidence*	54.62	43.87	40.40	34.79	41.50	38.91	48.17	43.40	43.37

\* Per 100,000 births



### Limitations

Due to limitations in obtaining the full birth data, variables related to demographic and hospital information in the analysis were restricted to births that resulted in a birth injury and could not be compared against births that did not result in a birth injury. To gain more substantial qualitative information relating to birth injury outcomes and impacts, interviews with healthcare professionals or other means to identify outcomes and impacts should be conducted.

### Conclusions

Significant birth injuries can result in death, nerve palsy and deformations. All of which may have lifelong impacts for the affected infant and their family. Although impactful, literature shows that many of the factors contributing to the injury are either unavoidable or unpredictable. Monitoring occurrences of significant birth injuries as part of the 5-Year Title V Needs Assessment is reasonable to identify any changes that can be shared with physician organizations and hospital partners.

## FY 2017 Application/FY 2015 Annual Report Update

The 2015 Needs Assessment identified suicide among adolescents 12 to 17 as a priority need. In 2013, 25.1% of Georgia's high school students reported either being bullied or bullying others, an increase from 2011. Almost twice as many 9<sup>th</sup> grade students reported that they were involved in bullying than those in the 12<sup>th</sup> grade (30.8% and 17.2% respectively). With suicide rates being 1.4 in those ages 10-14, 5.1 in those 15-17 and 8.2 in those 18-19, the MCH Section explored the relationship between suicide and bullying and the landscape of bullying prevention programs in Georgia. An examination of youth suicide and bullying in Georgia was conducted by analyzing the most current information available. Emory University Rollins School of Public Health students researched the evidence-based strategies for bullying prevention in Georgia.

The following reports were used for the Ongoing Needs Assessment:

- Georgia Child Fatality Report
- Evidence for Bullying Prevention in Georgia
- *Sexual Identity, Sex of Sexual Contacts, and Health-Related Behaviors Among Students in Grades 9-12—United States and Selected Sites, 2015*

### Findings from 2015 Needs Assessment

#### Suicide

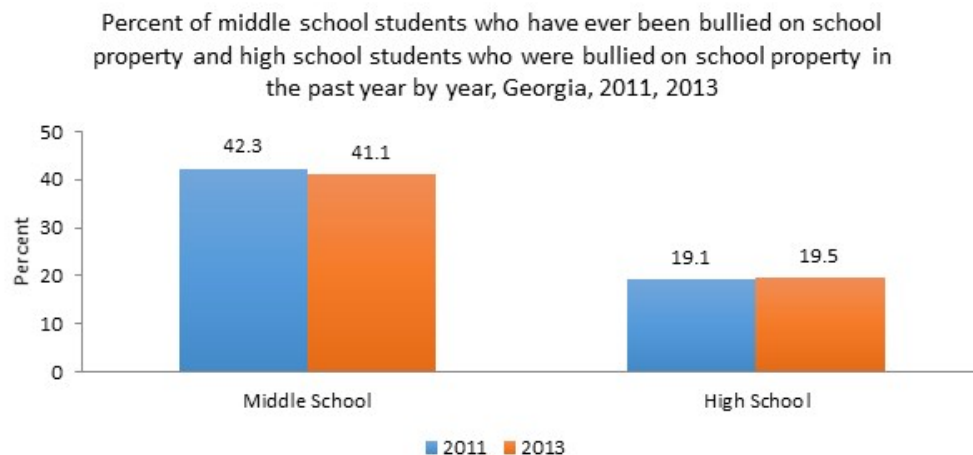
The adolescent suicide death rate increased from 3.2 in 2012 to 5.1 in 2013. From 2009-2013, the rate was 1.4 in those ages 10-14, 5.1 in those 15-17 and 8.2 in those 18-19. The rate was approximately twice as high among Non-Hispanic Whites (5.3) compared to Non-Hispanic Blacks (2.6) and Hispanics (2.7).

#### Bullying

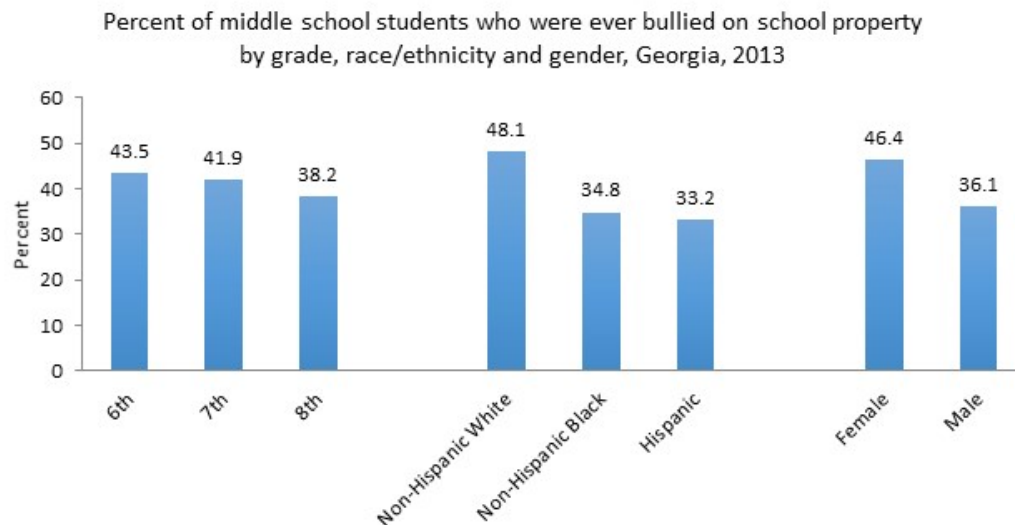
Just over 40 percent of Georgia's middle school students reported having ever been bullied on school property in 2011 and 2013. Among high school students during the same years, just over 19 percent were bullied on school property during the past year.

The percentage of middle school students who had ever been bullied on school property was similar across all grade levels in 2013. More non-Hispanic White adolescents reported experiencing bullying than non-Hispanic Blacks or Hispanics. Females (46.4 percent) reported being bullied on school property more often than males (36.1 percent).

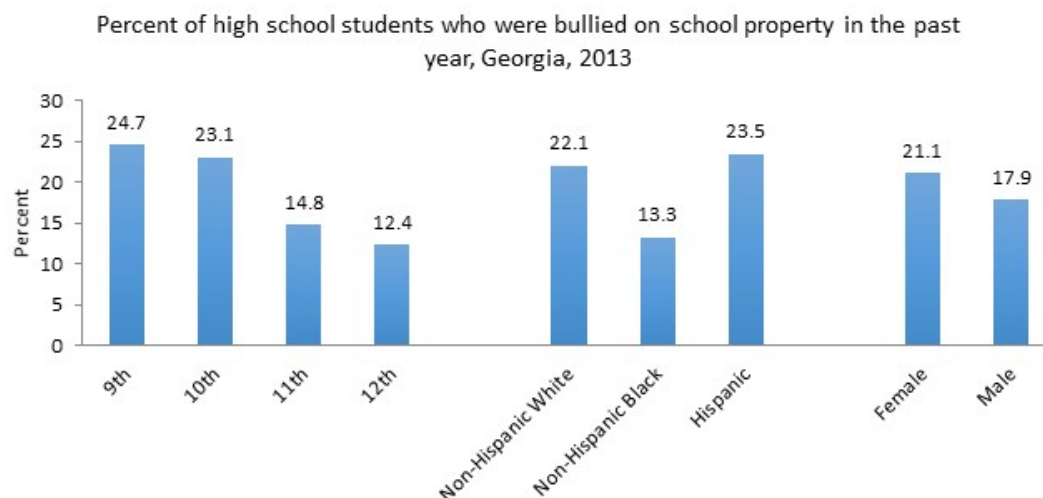
Bullying on school property during the past year was more prevalent among high school students in 9<sup>th</sup> and 10<sup>th</sup> grade (24.7 percent and 23.1 percent) compared to those in 11<sup>th</sup> and 12<sup>th</sup> grade (14.8 percent and 12.4 percent). Non-Hispanic Whites and Hispanics were bullied on school property in the past year over 1.5 times more than their non-Hispanic Black counterparts. Slightly more females reported experiencing bullying in the past year compared to males.



Source: YRBS



Source: YRBS



Source: YRBS

#### Victims and Bullies

In 2013, 25.1 percent of Georgia's high school students reported either being bullied or bullying others. Almost twice as many 9<sup>th</sup> grade students reported that they were involved in bullying than those in the 12<sup>th</sup> grade (30.8 percent and 17.2 percent respectively). Racial differences were seen as well. Hispanic and non-Hispanic White students (27.4 percent and 29.0 percent) reported experiencing far more bullying than their non-Hispanic Black (17.3 percent) counterparts. Females experienced bullying more often than did males (27.8 percent compared to 22.2 percent).

#### **Findings from 2016 Ongoing Needs Assessment**

##### Suicide-Georgia Child Fatality Report

Georgia's Child Fatality Review Program (GCFR) was established in 1990 by statute (Section 19-15-1 et seq.). CFR is an independent program currently administered out of the Georgia Bureau of Investigation (GBI). Local CFR committees review all injury, sleep-related, and unexpected/suspicious deaths to children who are less than 18 years old. Local committees submit their reviews using the National CDR Case Reporting System; the state Panel reviews selected case reports that have been completed by the local committees.

GCFR compiles the findings from the review and generates an annual report. The GCFR Annual Report 2014, was used to gather additional information regarding suicides among youth 12 to 17.

In almost half of the youth suicides, local CFR committees reported that the child talked about suicide at some point prior to the death. Suicide warning signs include anxiety, withdrawal from friends and family, uncontrolled anger, severe mood changes, substance use, and feeling like there's no sense of purpose. Additionally, risk factors for youth may include feelings of hopelessness and/or sadness for at least two weeks.

In 2014, 28 suicides were reviewed, marking a decrease from 40 in 2013. Suicide remains the fifth leading cause of death for Georgia's children. Teens ages 15 to 17 are at greatest risk for suicide. Suicide among males reduced from 35 in 2013 to 18 in 2014. However, suicide among females increased from 5 in 2013 to 10 in 2014.

Of the reported risk factors for reviewed suicide deaths (28), five deaths were associated with a bullied victim and three were associated with sexual orientation.

The GCFR Report acknowledges HB 198, to require 3 annual suicide prevention education training for certificated school system personnel, as an opportunity for prevention.

### Strengths

The data indicate a reduction in suicides from 2013 to 2014 but an increase in suicides among females. The GCFR Report identified that more than half of the teens that committed suicide talked about suicide before committing the act.

### Areas of Opportunity

HB 198 is an opportunity for DPH and the Department of Education (DOE) to partner on suicide/bullying prevention within schools.

### Bullying- Evidence for Bullying Prevention in Georgia

Emory University Rollins School of Public Health reviewed Georgia specific data on bullying and suicide to identify high-risk population sub-groups and geographic locations where intervention strategies could be targeted. To identify high-risk groups, Emory students used vital statistics from DPH's Online Analytical Statistical Information System (OASIS), Georgia's Child Fatality Review Report, Youth Risk Behavior Surveillance System (YRBSS) and the National Survey of Children's Health (NSCH).

From 2009-2013 19.3% of youth committing suicide were disabled. Of the population sub-groups youth with disabilities may disproportionately be affected by suicide and bullying-related suicide. Although this is a finding to explore further, authors state the finding cannot describe exact risk. From 2005-2014 one public health district, Cobb-Douglas, had a higher than expected number of suicides.

### Strengths

The data indicate a sub-group and geographic location at higher risk for suicide.

### Areas of Opportunity

Disabled youth and youth living in the Cobb-Douglas Public Health District were identified as being at greater risk of bullying. MCH will be able to target intervention strategies to reach these population groups.

### High Risk Groups – MMWR

Kann et al. used the Youth Risk Behavior Surveillance System (YRBSS) 2015 results to summarize results for 118 health-related behaviors by sexual identity and sex of sexual contacts. The YRBSS monitors six categories of priority health-related behaviors among youth and young adults including suicidal ideation, suicide attempts, bullying and perceptions on the safety of the environment.

When looking at students that were electronically bullied 15.5% of all students reported being electronically bullied.<sup>19</sup> Of the 15.5% of students reporting being electronically bullied, 14.2% are classified as heterosexual students, 28% gay, lesbian and bisexual; and 22.5% were "not sure" in their sexual identity classification.<sup>19</sup> According to Kann et al., the prevalence of electronic bullying was higher among gay, lesbian, and bisexual students and not sure students than heterosexual students.<sup>19</sup> This was also true when looking at males and females separately. Female students were also more prevalent than males students regardless of sexual classification.<sup>19</sup> Nationwide, 20.2% of all students reported being bullied on school property.<sup>19</sup> As with electronic bullying, the prevalence of having been bullied on school property was higher among gay, lesbian, and bisexual students than heterosexual students and not sure students.<sup>19</sup>

When looking at the safety of students, gay, lesbian, and bisexual students had higher prevalence for carrying a weapon on school property, being threatened or injured with a weapon on school property, and not going to school because of safety concerns.<sup>19</sup> When looking at violence, gay, lesbian, and bisexual students had higher prevalence for physical dating violence, and sexual dating violence.<sup>19</sup>

Lastly, when looking at seriously considered attempting suicide gay, lesbian, and bisexual students had higher prevalence.<sup>19</sup> Results for

seriously considered attempting suicide were similar to bullying results in which were higher among gay, lesbian, and bisexual students among female and male groups; and higher among females regardless of sexual classification.<sup>19</sup>

#### Strengths

The data clearly identify female adolescents and adolescents who identify as gay, lesbian, or bisexual, or have reported having sex or sexual contact with the same sex have higher risk for all behavioral risk factors associated with bullying, safety, violence and suicide.

#### Areas of Opportunity

MCH and the Adolescent and Youth School Health Section will be able to use these data to encourage school participation in the “whole school” sexual bullying prevention program; Step Up Step In.

## **Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)**

### **II.B.1. Process**

#### **Goals, Framework and Methodology Guiding Needs Assessment Process**

Georgia's Title V Needs Assessment was conducted by the Maternal and Child Health (MCH) Office of Epidemiology within the Georgia Department of Public Health. 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 focus of MCH Epidemiology is to promote and improve the health and well-being of women, children and families by building data capacity at the state and local levels to effectively use information for public health actions.

The Needs Assessment Workgroup (NAW) was established to complete Georgia's 2015 Title V Needs Assessment. The group, under the leadership of the Title V Director and Manager, consisted of directors and managers from all MCH programs. Monthly meetings were held beginning in April 2014. Although the NAW was charged with primary responsibility for planning and completing Needs Assessment activities, meetings were often held with all program staff by population domain (described below) to incorporate input from all Title V staff. An independent contractor was used to provide consultative services, analyze data, facilitate meetings and produce deliverables for the Needs Assessment.

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/life-course. Key steps for the needs assessment process are outlined in Figure 1.

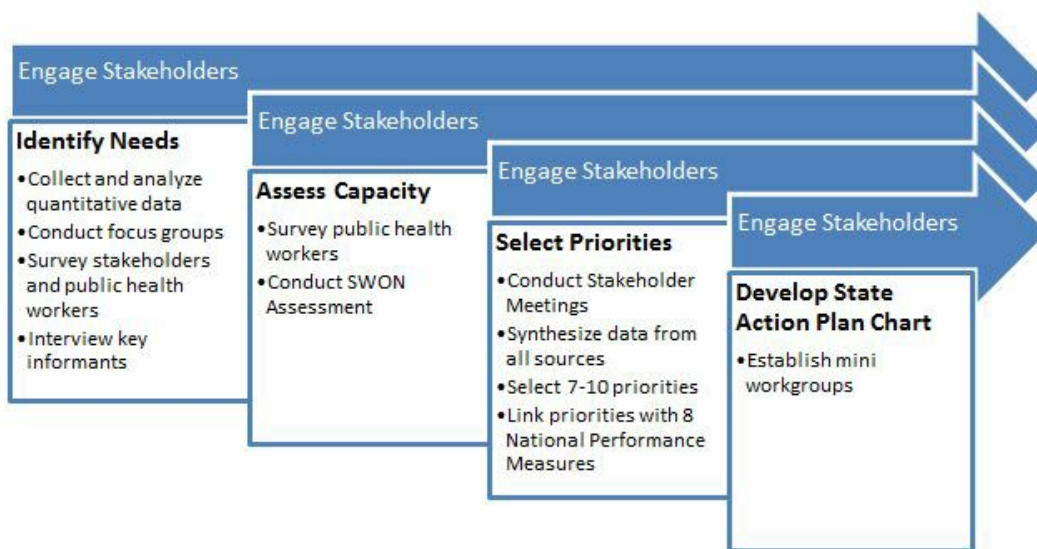


Figure 1. Georgia Title V Needs Assessment Process

## Quantitative Methods

A thorough examination of the health status of women and children in Georgia 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. Due to a lack of current data regarding CYSHCN, projection analysis was applied to the 2009/10 National Survey of Children with Special Health Care Needs results. The following data sources were used:

- Behavioral Risk Factor Surveillance System
- Babies Can't Wait Program
- Children's Medical Services Program
- Current Population Survey
- Early Hearing Detection and Intervention Program
- Family Planning Program
- Georgia Comprehensive Cancer Registry
- Hospital Discharge Data
- HIV Surveillance Program
- Metro Atlanta Developmental Disabilities Surveillance Program
- National Immunization Survey
- National Survey of Children's Health
- National Survey of Children with Special Health Care Needs
- National Vital Statistics System
- Online Analytical Statistical Information System
- Pregnancy Risk Assessment Monitoring System
- State Inpatient Databases
- State Vital Records
- STD Surveillance Program
- Youth Risk Behavior Surveillance System
- Youth Tobacco Survey

- Water Fluoridation Reporting System

## Focus Groups

Qualitative data were gathered from each of Georgia's 18 public health districts to gain insight into the needs of MCH populations and areas to improve the delivery of public health services. Data were collected through focus groups in 16 districts and through key informant interviews in 2 districts (East Metro and DeKalb). Focus groups were attempted in both East Metro and DeKalb, but due to low participation, key informant interviews were used as a culturally appropriate method of gaining insight into the Hispanic community. The focus groups were on three topics: perinatal health, school readiness and CYSHCN. The topics were chosen to cover the three legislatively-defined MCH populations. School readiness was chosen as the topic for child health due to the lack of quantitative data available.

Table 1. Needs Assessment Focus Groups by Location and Topic

Perinatal Health	School Readiness	CYSHCN
Rome	Waycross	Cobb Douglas
Fulton	Valdosta	Augusta
East Metro	Macon	Columbus
Dublin	Dalton	Gainesville
Albany	LaGrange	Clayton
Athens		Savannah
DeKalb		

Stakeholders and community members were engaged through focus groups, a survey, key informant interviews, priority selection and an ongoing public comment period. Focus groups were not only conducted among community members, they were conducted by community members experienced in focus group facilitation. A survey was conducted to identify needs and 492 responses were received. Snowball sampling, where participants are asked to disseminate the survey, was used to obtain a high number of responses. Key informant interviews were conducted among six leaders in their respective fields. Stakeholders had the opportunity to review the analysis, comment on areas covered and recommend priorities. Although the results from their prioritization were used as a recommendation, their opinions and capacity were given the highest weight when determining priorities. Sections of the Needs Assessment were posted upon completion for public input from March 2015 to July 2015.

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

MCH program and epidemiology staff reviewed all 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 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 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 occurred during two meetings. Meetings were held in Atlanta and Valdosta to encourage the participation of stakeholders in both North and South Georgia. A total of 100 stakeholders representing 38 organizations attended. Following 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 provided key activities and strategies within each area of need to inform the development of the State Action Plan Chart.

The individual rating tools were analyzed across the two meetings 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 survey rankings were reviewed to assess consistency and confirm an area of need. Needs were then aligned with a NPM when possible (displayed in Table 2).

Table 2. Linkage between Priority Needs and National Performance Measures

<b>Population Domain</b>	<b>Priority Need</b>	<b>National Performance Measure(s)</b>
Maternal/Women's Health	Prevent maternal mortality	Well-woman visit
	Increase access to family planning services	None
Perinatal Health	Prevent infant mortality	Breastfeeding Perinatal regionalization
Child Health	Promote developmental screenings among children	Developmental screening
	Promote physical activity among children	Physical activity
Adolescent Health	Prevent suicide among adolescents	Bullying
Children and Youth with Special Health Care Needs	Improve systems of care for CYSHCN	Transition
Cross-Cutting	Promote oral health among all populations	Oral health

The State Action Plan Chart was developed by mini-work groups for each domain consisting of staff in MCH Programs, Epidemiology and Strategy. Strategies were identified based on suggestions from the stakeholder meetings, focus group findings and a review of the evidence base for each NPM.

## **II.B.2. Findings**

The following summary provides an overview of the quantitative findings related to the identified priority needs and NPMs and qualitative findings from focus groups and key informant interviews. Each domain includes a summary of strengths and needs relative to the identified priority needs and national priority areas. A more comprehensive discussion of strengths and needs from all findings are provided in the full Needs Assessment report (available at [www.dph.ga.gov/titlev](http://www.dph.ga.gov/titlev)). Figures and citations for the data presented below are located in the Supporting Documents.

### **II.B.2.a. MCH Population Needs**

#### **Maternal/Women's Health**

### Maternal Mortality

The maternal mortality ratio (number of pregnancy-related deaths per 100,000 live births) increased from 11.5 (n=16) in 2004 to 43.6 (n=56) in 2013 (Figure 1). Georgia recently implemented a Maternal Mortality Review Committee to review all maternal deaths. Different inclusion criteria are used for this committee and the data should not be compared to the findings identified from cases identified by ICD codes. The committee identified 25 pregnancy-related and 60 pregnancy-associated cases in 2012 (Figure 2). Of the deaths that were related to pregnancy, 17 of the women were Black, 6 were White, 1 was Hispanic and 1 was unknown (Figure 3). The most common cause of death among pregnancy-related cases was hemorrhage. Hypertension, cardiac conditions and embolism were common causes as well, highlighting the importance of preconception health.

### Preventive Visit

Although there was an overall decline in the percentage of women receiving a preventive medical visit between 2009 and 2013 in Georgia (73.9% compared to 68.1%), the percentage remained above the national average in all years examined (Figure 4). Over 78% of non-Hispanic Black women reported having seen a provider, while only 60.7% of Hispanic women attended such a visit. The percentage of women receiving a preventive visit was higher among women with a higher educational attainment (Figure 5).

### Family Planning

The percentage of births that were not planned in Georgia increased from 52.6% in 2009 to 54.8% in 2011 (Figure 6). The percentage of unplanned births was 29.4% among mothers over the age of 35 and 82.3% among mothers less than 20 years of age. Non-Hispanic Black women reported a higher percentage of unplanned births (73.4%) than Hispanics (57.9%) and non-Hispanic Whites (42.6%) (Figure 7).

### Low-Risk Cesarean Deliveries

The prevalence of low-risk cesarean deliveries in Georgia remained relatively stable from 2009 to 2013, with only a slight increase from 27.8% in 2009 to 28.7% in 2013 (Figure 8). Differences are seen by maternal age and education level. Specifically, 58% more women over 35 years of age had a cesarean section compared to women less than 20 years of age in 2013. More college graduates had low-risk cesarean sections than women with less than a high school diploma (31.6% compared to 23.7%) (Figure 9).

Table 3. Maternal/Women's Health Qualitative Findings

Focus Groups: Perinatal Health	
Individual-Level Factors	<ul style="list-style-type: none"> <li>• Incorrect/inconsistent use of contraception</li> <li>• Limited or no preparation for a healthy pregnancy</li> <li>• Misunderstanding about birth spacing recommendations</li> <li>• Preference for private vs. public services</li> </ul>
Structural-Level Factors	<ul style="list-style-type: none"> <li>• Long wait times for appointments</li> <li>• Lack of transportation</li> </ul>
Key Informant Interviews	
Priority Needs	<ul style="list-style-type: none"> <li>• Promote preventive medical visits</li> <li>• Increase breastfeeding initiation and duration</li> <li>• Prevent maternal mortality</li> <li>• Prevent infant mortality</li> <li>• Reduce primary and repeat teen births</li> <li>• Prevent sexually transmitted infections</li> </ul>
Individual-Level Factors	<ul style="list-style-type: none"> <li>• Little awareness on the importance of preconception health</li> </ul>
Structural-Level Factors	<ul style="list-style-type: none"> <li>• Lack of insurance between pregnancies</li> <li>• Lack of facilities/clinics for prenatal care</li> <li>• Lack of access to mental health care</li> <li>• Reimbursement systems need to be updated</li> <li>• Programs providing birth control for low-income women between pregnancies are not well marketed</li> <li>• Shortages of Maternal and Fetal Medicine and Obstetric providers, especially in rural areas</li> <li>• Labor and Delivery Unit closures</li> </ul>

#### Strengths and Needs

The data indicate areas where sub-groups of Georgia's population are achieving acceptable outcomes. The percentage of women receiving a preventive visit in Georgia is higher than the national average. In Georgia, the percentage is highest

among non-Hispanic Blacks and women with higher educational attainment. Younger women in Georgia undergo cesarean deliveries for a low-risk birth less often than older women.

There is a need to reduce the maternal mortality ratio in Georgia. Not only has the statistic been increasing, there are differences among racial/ethnic groups. Additionally, the percentage of women who reported visiting a medical provider in the past year declined from 2009 to 2013. Efforts should be made to ensure that this percentage does not decrease further. Efforts reduce low-risk cesarean sections should be targeted to women over age 30 and with higher educational attainment.

#### Programmatic Efforts to be Continued

- The Maternal Mortality Review Committee has provided the state with important findings on the prevalence and causes of maternal mortality

#### Areas of Opportunity

- Continue to refine policies for the Maternal Mortality Review Committee and implement data to action activities
- Promote well-woman visits and pre- or interconception care
- Promote family planning services available through the health department

### **Perinatal Health**

#### Infant Mortality

The infant mortality rate was 7.2 in 2013 (Figure 10). A significant effort to decrease infant mortality is recognized by DPH Executive leadership and MCH leadership to ensure Georgia achieves the HP 2020 objective of 6.0. Disparities exist by race, with the rate of death for non-Hispanic Black infants being twice that of non-Hispanic Whites (Figure 11).

#### Perinatal Regionalization

The percentage of very low birth weight infants (VLBW) delivered at a Level III facility has steadily increased in Georgia. In 2008, 74.8% of infants were born in a Level III facility compared to 78.5% in 2012 (Figure 12). Georgia has six perinatal regions. Each region consists of a Regional Perinatal Center, Level III, Level II, and Level I facilities. The Atlanta perinatal region had the highest percentage (80.8%) of very low birth weight infants born at the appropriate level of care. The Augusta (62.3%) and Savannah (66.1%) perinatal regions had the lowest percentages of VLBW infants born in a level III facility (Figure 13).

#### Breastfeeding Initiation

The percentage of infants ever breastfed in Georgia increased from 64.8% in 2007 to 70.3% in 2011. However, the percentage in Georgia was lower than the national average (79.2%) in 2011 (Figure 14). The HP 2020 objective for the percentage of infants ever breastfed is 81.9%. As of 2011, an increase of over 16% is needed in Georgia to meet the objective by 2020. Mothers 30 years of age or more reported initiating breastfeeding (76.6%) more often than mothers between the ages of 20 and 29 (61.0%). When stratified by race/ethnicity, 61.2% of non-Hispanic Black mothers reported ever breastfeeding their infant compared to 72.6% of non-Hispanic White mothers and 78.4% of Hispanic mothers. The percentage was higher among mothers with higher educational attainment: 87.8% in those with a college degree, 74.4% in those with some college education and 65.8% in those with only a high school degree (Figure 15).

### Breastfeeding Exclusivity

There was an overall increase in the percentage of infants exclusively breastfed at six months in Georgia from 2007 to 2011, despite a decrease in 2010. In 2011, 14.5% of infants were exclusively breastfed at six months, less than the national average (18.8%) and HP 2020 target (25.5%) (Figure 16). The percentage of infants exclusively breastfed was higher among mothers with a college education (19.7%) than mothers with less than a high school degree (4.2%). Additionally, a higher percentage of women over 30 years of age were breastfeeding exclusively at six months compared to women less than 30 years of age (14.2% and 8.0% respectively) (Figure 17).

### Safe Sleep

Healthy People 2020's safe sleep objective is to increase the percentage of infants sleeping on their backs to 75.9%. In 2011, Georgia was more than twenty percentage points lower than this objective at only 53.1% (Figure 18). During the same year, the national average was 74.3%. Disparities exist regarding maternal age and race/ethnicity. A lower percentage of younger mothers less than 20 years of age put their infants on their back to sleep (37.0%) compared to mothers over 35 years of age (55.7%). Additionally, non-Hispanic White mothers placed their infant to sleep on the back most often, with over 61% compared to non-Hispanic Black (43.0%) mothers. The percentage of infants placed to sleep on their back was 1.7 times higher among mothers who graduated college compared to mothers with less than a high school degree. None of the groups examined meet or exceed the HP 2020 target (Figure 19).

Table 4. Perinatal Health Qualitative Findings

Focus Groups: Perinatal Health	
Individual-Level	<ul style="list-style-type: none"><li>• Familiarity with provider encourages care-seeking behavior</li><li>• Lack of knowledge on available parenting classes and resources</li></ul>
Structural-Level	<ul style="list-style-type: none"><li>• Support systems encourage breastfeeding</li><li>• Lack of transportation</li></ul>
Key Informant Interviews	
Priority Needs	<ul style="list-style-type: none"><li>• Improve the perinatal regionalization system</li><li>• Promote safe sleep environments</li><li>• Promote breastfeeding, especially for high-risk infants</li></ul>
Individual-Level	<ul style="list-style-type: none"><li>• Lack of awareness on the benefits of breastfeeding</li></ul>
Structural-Level	<ul style="list-style-type: none"><li>• Lack of public transportation</li><li>• Lack of access to specialized care in rural areas</li><li>• Insurance reimbursement prevents transfer of high-risk neonates to appropriate hospital</li><li>• Lack of a donor breast milk program in the state</li></ul>

### Strengths and Needs

Certain population sub-groups in Georgia are meeting or exceeding national standards. The infant mortality rate among White and Hispanic infants is below the Healthy People 2020 objective. Mothers with high educational attainment are initiating breastfeeding and maintaining breastfeeding exclusivity at acceptable rates.

There is a clear need to improve safe sleep in Georgia. The population as a whole and examined strata are failing to achieve national standards for the percent of infants placed to sleep on their back. Breastfeeding initiation and exclusivity

should be promoted among younger mothers and those with lower educational attainment. There is also a need to reduce the disparities in Georgia's perinatal regions, and ensure that all very low birth weight infants throughout the state are receiving care at the most appropriate facility. Addressing all three of these needs will help ensure the infant mortality rate does not increase further.

#### 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 March of Dimes banner program has been successful in reducing early elective deliveries
- The Safe to Sleep campaign continues to be promoted to change community norms regarding safe sleep environments

#### Areas of Opportunity

- The Georgia Perinatal Quality Collaborative (GaPQC) has just begun and there is opportunity to implement new quality improvement activities
- There is opportunity to ensure that the defined levels of neonatal care are being implemented in birthing hospitals throughout the state
- The Business Case for Breastfeeding can be promoted to employers throughout the state

### **Child Health**

#### Developmental Screening

In 2011/12, 30.8% of children in the US were screened for developmental, behavioral and social delays while 40.8% of children were screened in Georgia in 2011/12. In 2007, 22.7% of Georgia's children received a developmental screen. The percentage increased 79.0% from 2007 to 2011/12 (Figure 20). A higher percentage of non-Hispanic Black children (45.4%) receive a developmental screening than non-Hispanic Whites and Hispanics (36.1% and 34.1%). Additionally, more children in Georgia using public insurance receive a developmental screening compared to children using private insurance (44.9% and 38.2% respectively) (Figure 21).

#### Non-Fatal Injury

The rate of hospitalizations due to non-fatal injury among children was 162.1 in 2008. In 2012, the rate decreased to 134.2 (Figure 22). The rate in 2012 was highest among children under 1 year of age (244.61). It was 162.7 among children 1 to 4 years of age and 91.2 among children 5 to 9 years of age. More non-Hispanic White children experienced hospitalization due to injury (84.5) compared to their Non-Hispanic Black (74.8) and Hispanic (28.3) counterparts. A higher rate was seen among males compared to females (Figure 23).

#### Physical Activity

There was no notable shift in the overall percentage of children performing physical activity 20 minutes daily between 2007 and 2011/12 both nationally and in Georgia. During 2011/12, more children aged 6 to 11 performed physical activity

than those 12 to 17 years of age (35.9% compared to 24.8%). However, the 2011/12 estimate for children in Georgia aged 6 to 11 decreased from 39.2% in 2007 and became very similar to the national estimate of 35.6% for this age group (Figure 24). The most notable disparity is between genders, with 36.3% of males performing physical activity for 20 minutes daily compared to 24.4% of females (Figure 25).

Table 5. Child Health Qualitative Findings

<b>Focus Groups: School Readiness</b>	
<b>Individual-Level</b>	<ul style="list-style-type: none"> <li>• Lack of cultural competency among teachers</li> <li>• Lack of parental knowledge surrounding nutrition</li> <li>• Lack of knowledge about school readiness services</li> <li>• Parental involvement at home is key to success in school</li> </ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"> <li>• Middle class is ineligible for services</li> <li>• Transportation to schools of choice is not available</li> <li>• Long waiting times at the health department</li> <li>• Mandated screenings are difficult to finance</li> <li>• Fruits and vegetables are provided through WIC</li> </ul>
<b>Key Informant Interviews</b>	
<b>Priority Needs</b>	<ul style="list-style-type: none"> <li>• Promote physical activity</li> </ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"> <li>• Lack of pediatricians in rural areas</li> </ul>

#### Strengths and Needs

A major decline has been seen in the rate of hospitalizations due to non-fatal injury among children. Georgia has seen an increase in the percentage of children screened for developmental delays and is exceeding the national standards.

Despite the successes seen around developmental screenings, less than half of Georgia's children receive this screening. Additionally, there are disparities in Georgia related to race and insurance status that are not present at the national level. Obesity levels in Georgia are higher than the national average, and disparities exist due to income levels. Although Georgia's physical activity data are comparable to the US, a concerted effort is needed to ensure that females are performing physical activity and that children ages 6 to 11 continue to perform physical activity into adolescence.

#### Programmatic Efforts to be Continued

- Georgia SHAPE has successfully promoted physical activity in elementary and middle schools throughout the state
- The Child Occupant Safety Project distributes car seats to prevent injury and death due to motor vehicle crashes

#### Areas of Opportunity

- Developmental screenings are successfully conducted within public health programs, but there is opportunity to increase this reach and promote screenings for children not using the public health system

#### **Adolescent Health**

##### Suicide

The adolescent suicide death rate increased from 3.2 in 2012 to 5.1 in 2013 (Figure 26). From 2009-2013, the rate was

1.4 in those ages 10-14, 5.1 in those 15-17 and 8.2 in those 18-19. The rate was approximately twice as high among Non-Hispanic Whites (5.3) compared to Non-Hispanic Blacks (2.6) and Hispanics (2.7) (Figure 27).

### Bullying

In 2013, 25.1% of Georgia's high school students reported either being bullied or bullying others compared to 24.8% in 2011. Almost twice as many 9<sup>th</sup> grade students reported that they were involved in bullying than those in the 12<sup>th</sup> grade (30.8% and 17.2% respectively). Racial disparities exist as well. Hispanic and non-Hispanic White students (27.4% and 29.0%) reported experiencing far more bullying than their non-Hispanic Black (17.3%) counterparts. Females experienced bullying more often than did males (27.8% compared to 22.2%) (Figure 28).

### Physical Activity

When it comes to the percentage of high school students who are physically active every day of the week, Georgia is both lower than the national average (27.1%) for 2013 and below the HP 2020 target for adolescents (31.6%). There has been an overall decline in the percentage of high school students who are physically active every day of the week since 2007. In 2013, 24.7% of students performed 60 minutes of physical activity per day (Figure 29). Students in grades 9 through 11 reported more physical activity than 12th grade students. Male students are the only group in Georgia currently achieving the HP 2020 objective and reported two times the physical activity as their female counterparts (34.5% compared to 15.1%) (Figure 30).

### Non-Fatal Injury

The rate of hospitalization due to non-fatal injury among adolescents decreased from 2008 to 2012. In 2008, the rate was 260.8, but it decreased to 191.0 in 2012 (Figure 31). As adolescents age, they experience more hospitalizations. Adolescents ages 10 to 14 had a non-fatal injury hospitalization rate of 110.7 in 2012, compared to 271.7 among adolescents 15 to 19 years of age. The disparity due to gender is more pronounced among adolescents than children, with a rate of 240.4 among males and 139.2 among females. The rate was 177.7 among non-Hispanic Whites, 129.7 among non-Hispanic Blacks and 79.5 among Hispanics (Figure 32).

### Preventive Visits

In 2007, the percentage of adolescents 12 to 17 years who saw a doctor, nurse or other health care provider for preventive care was 82.9% (Figure 33). This percentage decreased to 77.0% in 2011/12, falling below the national average of 81.7% in 2011/12. Although the national average declined from 2007 to 2012 as well (84.2% to 81.7%), the decline was more pronounced among Georgia's adolescents. Adolescents in rural locations reported far fewer (59.5%) preventive visits than those living in a Metropolitan Statistical Area (MSA) non-central city (83.8%). Of all the groups examined, the only category exceeding the national average for 2011/12 is adolescents living in MSAs that are non-central cities (Figure 34).

Table 6. Adolescent Health Qualitative Findings



## Key Informant Interviews

<b>Priority Needs</b>	<ul style="list-style-type: none"><li>• Promote physical activity</li><li>• Prevent bullying</li><li>• Promote sexual and reproductive health</li></ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"><li>• Lack of teen clinics</li><li>• Providers need to provide teen-friendly services</li></ul>

### Strengths and Needs

Georgia has seen success in reducing hospitalizations due to non-fatal injury. The rate has decreased over the previous five years. 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 performing recommended amounts of physical activity and receiving well-visits remain low.

### Programmatic Efforts to be Continued

- Family planning clinics will continue to provide services to adolescents

### Areas of Opportunity

- Public health family planning clinics can implement teen-friendly approaches to providing services
- There is an opportunity to initiate bullying prevention initiatives at the state level

## Children and Youth with Special Health Care Needs (CYSHCN)

### Transition to Adulthood

The percentage of CYSHCN receiving services needed to transition to adulthood in Georgia was less than the national average in 2009/10 (33.9% compared to 40.0%) (Figure 35). Non-Hispanic White children (43.6%) received these services more often than their non-Hispanic Black (21.7%) counterparts. Most notably, half of CYSHCN on private insurance only received these services, while 17.8% on public insurance only did (Figure 36).

### Medical Home

In 2009/10, 45.7% of Georgia's CYSHCN received care within a medical home compared to 43.0% nationally (Figure 37). Georgia exceeds the national average for non-Hispanic White and non-Hispanic Black children, as well as those with only private insurance. However, a disparity exists between non-Hispanic Black and non-Hispanic White CYSHCN (38.4% and 53.8% respectively). There is a disparity at the national level due to insurance status, however this gap is more pronounced in Georgia. Of CYSHCN with private insurance only, 59.7% received care within a medical home compared to 31.5% on public insurance only (Figure 38).

Table 7. CYSHCN Qualitative Findings

Focus Groups: CYSHCN	
Individual-Level	<ul style="list-style-type: none"> <li>• Lack of knowledge about services</li> <li>• Poor communication between parents and providers</li> <li>• Lack of knowledge about medical home</li> <li>• Families are responsible for care coordination</li> <li>• Concerns over transition to adulthood</li> </ul>
Structural-Level	<ul style="list-style-type: none"> <li>• Lack of a centralized resource center</li> <li>• Lack of providers/specialists in rural areas</li> <li>• Eligibility restrictions</li> <li>• Lack of safe recreational places</li> <li>• Long wait times for appointments</li> <li>• Transportation</li> <li>• Lack of employment opportunities for CYSHCN and resources to aid with transition</li> </ul>
Key Informant Interviews	
Priority Needs	<ul style="list-style-type: none"> <li>• Increase access to medical homes</li> <li>• Increase access to primary and subspecialty care</li> </ul>
Structural-Level	<ul style="list-style-type: none"> <li>• No pediatric specialists</li> <li>• Lack of centralized body that serves as an information clearinghouse for CSYHCN</li> <li>• Challenges transitioning CYSHCN to comprehensive adult medical homes</li> </ul>

#### Strengths and Needs

Georgia exceeded national averages for CYSHCN receiving services within a medical home in 2009/10. However, the overall percentage is lower than desired and there are racial/ethnic and economic disparities that should be addressed. An effort to ensure that more CYSHCN are receiving the services needed to transition to adulthood is needed. Georgia's CYSHCN fall below the national average and experience larger gaps than what is seen at the national level.

#### Programmatic Efforts to be Continued

- Parents as Partners has successfully helped parents navigate the health care system for their children

#### Areas of Opportunity

- There is opportunity to increase services available for CYSHCN within CMS as they transition to adulthood and promote transition clinics throughout the state

#### **Cross-Cutting**

##### Smoking during Pregnancy

From 2009 to 2013, the percentage of mothers who smoked during the last three months of pregnancy decreased from 8.5% in 2009 to 6.2% in 2011 (Figure 39). The percentage of non-Hispanic White mothers (11.9%) who smoked during pregnancy was almost twice as high as the percentage among non-Hispanic Blacks. More mothers with less than a high school diploma reported smoking during the last three months of pregnancy (15.4%) than all other educational levels (Figure 40).

### Second Hand Smoke Exposure

In Georgia, 24.9% of children ages 0 to 17 years live in homes where someone smokes. This is similar to the national average of 24.1% in 2011/12. When stratified by race/ethnicity, 14.4% of Hispanic children live in a home where someone smokes compared to 22.2% of non-Hispanic Black and 29.6% of non-Hispanic White children (Figure 41).

### Dental Visits during Pregnancy

Although 38.0% of women overall reported having their teeth cleaned during pregnancy, only 29.4% of mothers less than 20 years old saw a dentist or dental hygienist during pregnancy compared to 47.2% of women over 35 years of age. Far more non-Hispanic White women (46.4%) report receiving a dental cleaning than their non-Hispanic Black and Hispanic (33.9% and 19.6%) counterparts (Figure 42).

### Childhood Dental Visits

Within Georgia, the most sizable ethnic disparity for childhood dental visits was in Hispanic children ages 1 to 17 years old in 2011/12. Only 69.6% of Hispanic children had one or more preventive dental care visits (check-ups and cleanings) compared to 73.9% of Hispanic children nationally and 77.5% of non-Hispanic White children in Georgia (Figure 43).

### Health Insurance

More than 70% of all children are adequately insured in every age category, both in Georgia and in the US. The highest percentage of adequate insurance coverage was among very young children (0 to 5 years old). While Georgia reported adequate coverage higher than the national average in 2007, as of 2011/2012 Georgia's children experienced loss of adequate insurance coverage across each age category and has fallen behind the nation for all age groups with the exception of 12 to 17 year olds. When stratified by income, 80.2% of children 0 to 17 years old in the 0 to 99% FPL category were adequately insured in Georgia compared to only 70.5% of children who lived in households where the income lies between 100 to 199% FPL. Hispanic children had higher adequate insurance coverage (82.9%) compared to non-Hispanic White children (75.7%) (Figure 44).

## Key Informant Interviews

<b>Priority Needs</b>	<ul style="list-style-type: none"><li>• Improve the oral health of adolescents</li><li>• Promote perinatal oral health</li><li>• Reduce early childhood caries</li><li>• Reduce racial disparities in prevalence of gingivitis and periodontal disease</li><li>• Reduce caries among Hispanics</li></ul>
<b>Individual-Level</b>	<ul style="list-style-type: none"><li>• Parents are unaware that children should see a dentist before the age of one</li><li>• Smoking and poor nutrition are impacting oral health</li></ul>
<b>Structural-Level</b>	<ul style="list-style-type: none"><li>• Reimbursement for dental care for special needs population is low</li><li>• Limited number of Medicaid providers</li><li>• Limited number of caregivers capable for taking care of oral health for CYSHCN</li><li>• Dentist shortages</li><li>• Uninsured clients cannot pay for care</li></ul>

## Strengths and Needs

Georgia has shown improvements regarding tobacco use. The percentage of children exposed to second hand smoke has decreased from 29.8% in 2003 to 24.9% in 2011/12. Additionally, the percentage of women smoking during pregnancy in Georgia remained below the national average of 8.4% in 2013.

Several needs should be noted. From 2007 to 2011/12, the percentage of children receiving a preventive dental visit declined. There are disparities among the women who received a dental visit during pregnancy in terms of age, race/ethnicity and education that should be addressed. Most notably, 46.4% of non-Hispanic White women received a teeth cleaning during pregnancy, while only 19.6% of Hispanic women did. Adequate health insurance coverage is another area of need. Between 2007 and 2011/12, Georgia saw a decrease in the number of children adequately insured and fell below the national average. Economic and racial disparities exist and need to be addressed.

## Programmatic Efforts to be Continued

- The Oral Health program has achieved high rates of community water fluoridation

## Areas of Opportunity

- There is opportunity to develop an oral health resource database for CYSHCN to increase preventive visits in this population

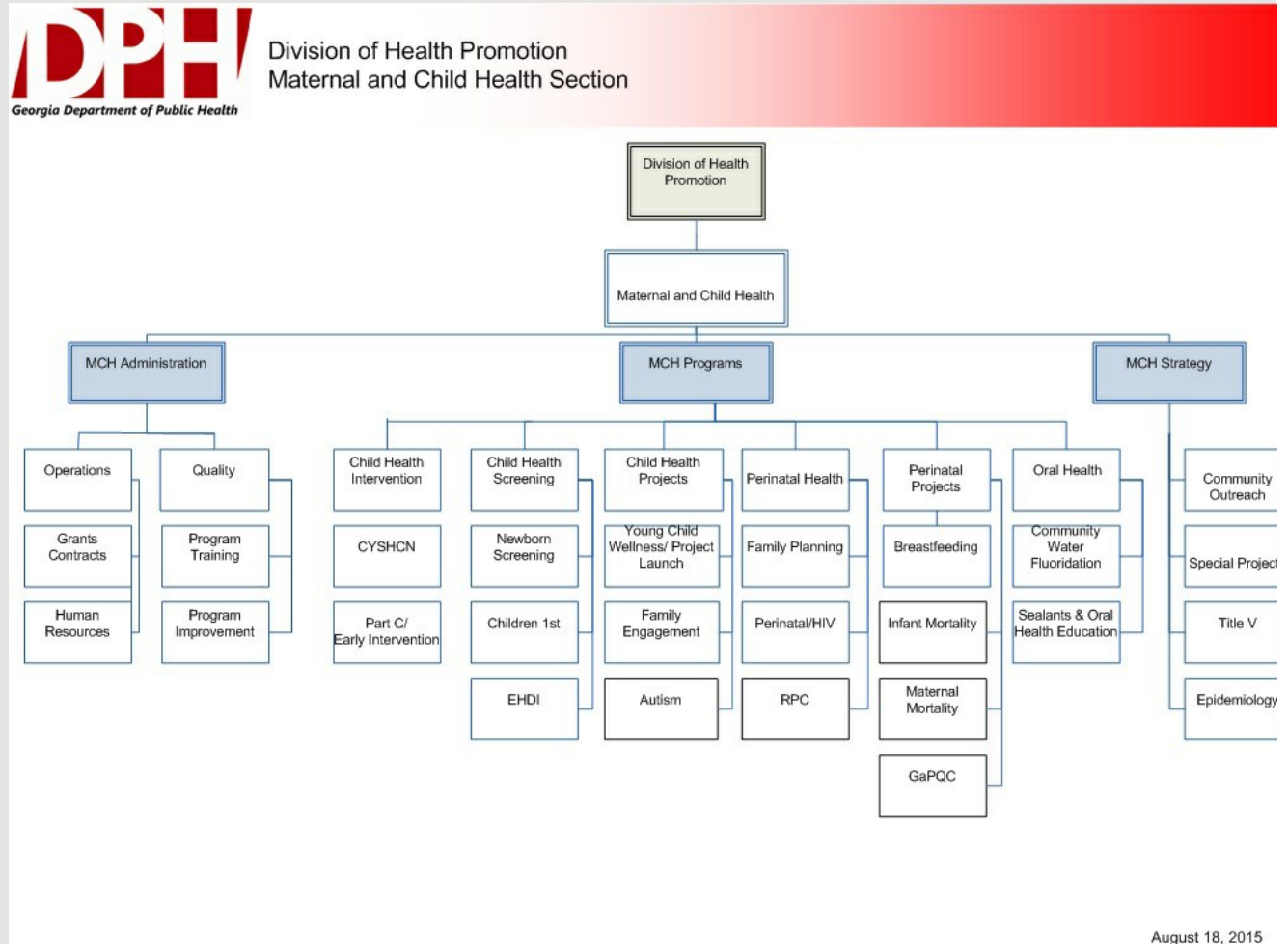
## II.B.2.b Title V Program Capacity

### II.B.2.b.i. Organizational Structure

The Department of Public Health is the lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a public health perspective. The agency's Commissioner reports directly to the Governor.

The Maternal and Child Health Section (MCH), located within the Division of Health Promotion, has primary responsibility for administration of the Title V Block Grant. The MCH Director serves as the Title V Director. In 2014, MCH began a restructure to provide better coordination across programs. The restructure is expected to be completed by December 2015. There are three Offices within MCH: Office of Programs, Office of Strategy and Office of Administration. The Office of Programs

includes the Perinatal Health Program, Perinatal Health Projects, Child Health Screening, Child Health Intervention (CYSHCN programs), Child Health Projects and Oral Health. The CYSHCN programs, Children's Medical Services and Babies Can't Wait, are both under the administration of the CYSHCN Director and Title V Director. The Office of Strategy is responsible for MCH Epidemiology, Community Outreach, Special Projects and activities to support the Title V application. The Office of Administration is responsible for Operations and Quality.



August 18, 2015

Title V provides funding to Injury Prevention, located in Health Protection, and Georgia SHAPE, located in the Chronic Disease Prevention Section. The following list provides a description of all 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 3 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 focused, 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 low income households.

Early Hearing Detection and Intervention (EHDI) screens infants for hearing loss in the birthing hospital and links them to appropriate interventions.

Family Planning improves the health of women and infants by enabling families to plan and space pregnancies and preventing unplanned pregnancy.

Georgia SHAPE improves the health of children and adolescents by providing opportunity and assistance around physical activity and nutrition.

Injury Prevention provides general support to local coalitions in helping promote safe and injury free life styles and behaviors.

MCH Epidemiology (MCH EPI) supports data collection and analysis for all MCH programs and administers 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 28 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 access comprehensive perinatal health care services appropriate to meet their individual needs and supports outreach efforts at six Regional Perinatal Centers. Perinatal health also addresses infant mortality, maternal mortality and breastfeeding.

#### **II.B.2.b.ii. Agency Capacity**

MCH currently has the capacity (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.

#### **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 through a partnership with the Chronic Disease Prevention Section. MCH actively supports the Maternal

Mortality Review Committee (MMRC) and will engage in various initiatives to promote maternal health, including the March of Dimes (MoD) Banner program to prevent early elective deliveries. MCH has epidemiology staff to support programmatic efforts. Data sources used are PRAMS, Vital Records, BRFSS and Family Planning program data. MCH also houses the data for the MMRC and identifies cases for review.

MCH has active partnerships with hospitals, private practice physicians, academic institutions, cancer and HIV screening agencies, the Chronic Disease Prevention Section, Healthy Mothers, Healthy Babies (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. MCH also provides financial support towards the Baby LUV program and other pilot projects that target high-risk pregnancies. Title V supports epidemiology staff to collect and analyze data on perinatal health. The primary data sources used are Vital Records and PRAMS.

MCH has active partnerships with the Regional Perinatal Centers, birthing facilities, private practice physicians, MoD, Association of State and Territorial Health Officials (ASTHO), GOGS, WIC, Worksite Wellness and (HMHB).

### **Child Health**

MCH promotes child health through promoting developmental screenings among children, preventing injury and promoting physical activity. 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 aims to prevent motor vehicle accident deaths among children. MCH works with the Chronic Disease Prevention Section to promote physical activity and nutrition in early care settings and schools through Georgia SHAPE. Title V supports the work of COSP and Georgia SHAPE, however they rely on additional funding sources as well. DPH also supports an Asthma Control Program in the Chronic Disease Prevention Section that addresses four areas of focusing which include: Environment, Family Support, Health Care Delivery System and Schools and Childcare Settings. MCH has a Child Health Epidemiologist to support data collection efforts. MCH utilizes the State Electronic Notifiable Disease Surveillance System (SendSS) and Babies Information and Billing System (BIBS) to assess developmental screening data.

To ensure a 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 institutions, GA Chapter of the American Academy of Pediatrics (GA-AAP), GA Academy of Family Physicians (GA-AFP), Marcus Autism and Emory Autism Center.

### **Adolescent Health**

DPH's Adolescent and School Health (ASH) unit sits within the Chronic Disease Prevention Section. ASH promotes adolescent health through programs targeting youth tobacco prevention, sexual violence prevention, teen pregnancy prevention and positive youth development. Data support for adolescent health is led by the Epidemiology Section.

There is currently no program dedicated to adolescent health within MCH, which provides a new opportunity for partnerships with other sections of DPH. MCH will partner with the Injury Prevention Program, Chronic Disease Prevention Section, the

Office of Nursing, the Epidemiology Section and the Department of Education to collectively address adolescent health.

## **CYSHCN**

MCH supports several programs to provide services to Georgia's CYSHCN. Children First acts as the point of entry 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. MCH has a data system that only captures youth enrolled in the CMS program at the public health district-level and does not have the data system to capture individual-level data. DPH is currently in the process to improve DPH data systems; however, this is a department initiative and will take approximately 5 years to complete.

To ensure a comprehensive system of services among CYSHCN, MCH has active partnerships with hospitals, private practice physicians, academic institutions, GA-AAP, GA-AFP, medical community members, Children's Healthcare of Atlanta (CHOA) and Parent to Parent.

## **Oral Health**

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 3<sup>rd</sup> Grade and Head Start Basic Screening Surveys. The Oral Health program does not have an Oral Health Epidemiologist; however, recruitment efforts are in progress to identify a qualified candidate.

To ensure a comprehensive oral health system of services, MCH has active partnerships with WIC, private practices, dental hygiene programs, academic institutions, middle schools, Oral Health Coalition and CDC.

## **II.B.2.b.iii. MCH Workforce Development and Capacity**

### **MCH Leadership Staff**

There are approximately 45 FTEs working on behalf of the Title V program in Georgia. The MCH leadership staff is comprised of the following individuals:

Seema Csukas, MD, PhD is the Maternal and Child Health Director. Dr. Csukas received her medical and doctorate degrees from Medical College of Georgia at Georgia Regents University. She is responsible for overseeing the Maternal and Child Health Section.

Tiffany Fowles, DrPH, MSPH is the Deputy Director of MCH Strategy and Epidemiology. Dr. Fowles received her doctorate degree from University of Georgia and MSPH degree from Tulane University School of Public Health and Tropical Medicine. She oversees MCH Epidemiology, Community Outreach, Title V Block grant, Special Projects and Operations.

Valeria Newton-Lamb, MHSA is the Deputy Director of Administration. She has over 20 years of experience in health care administration and managing large scale, complex operations for private and publicly funded organizations. Ms. Newton-Lamb is responsible for overseeing quality assurance and operations.



Donna Johnson is the Director of Child Health Intervention. She has over 12 years of experience working with children with special health care needs. Ms. Johnson is responsible for overseeing all child health intervention related programs and initiatives, including Babies Can't Wait and Children Medical Services.

Jeannine Galloway, MPH is the Director of Child Health Projects. She received her MPH from Mercer University School of Medicine and a Bachelor of Science from Spelman College. She has over eight years of experience implementing evidence-based programs. Ms. Galloway oversees Project LAUNCH and the Georgia Autism Initiative.

Johanna Pringle, MPH is the Director of Child Health Screening. Ms. Pringle received her MPH from the University of Florida and has 5 years of experience working in the Newborn Screening program. She oversees Newborn Screening, Children First and EHDI.

Patricia McAfee, DNPc, MSN, RN is the Director of Perinatal Health Programs. Ms. McAfee has 19 years of experience in direct patient care and 12 years of nursing practice management, including time as the Director of Women's and Infants Services. She oversees all activities related to perinatal health and family planning.

Renee Johnson, MPA is the Director of Perinatal Health Projects. Ms. Johnson has a bachelor's degree in Human Services and a master's degree in Public Administration from Kennesaw State University. She has over 10 years of leadership and administrative experience in project development, management and implementation with organizations in the public, private and nonprofit sectors.

Carol Smith, RDH, MSHA is the Director of the Oral Health. Ms. Smith received her MSHA from Georgia State University and is a registered dental hygienist. She has been in her current role for 5 years with previous experience in clinical practice. Ms. Smith oversees Oral Health program initiatives, including community water fluoridation and school sealant programs.

Two parents of CYSHCN, Sherry Richardson and Donna Johnson, are employed by the Title V program.

### **Strengths and Needs of Workforce**

The majority of the state Title V staff has been in MCH for fewer than 5 years. Over 15.0% have served for 10 years, 20.5% for 5-9 years and 64.0% for less than 5 years.

A survey was disseminated to state, district and local DPH employees providing MCH services to assess the strengths and needs of the workforce. Results indicate that training efforts should be targeted toward the following public health competencies: leadership and systems thinking, public health sciences, financial planning and management skills and community dimensions of practice.

### **Cultural Competency**

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. A bilingual interviewer is on PRAMS staff to ensure sufficient response rates from the Hispanic population. Focus groups and key informant interviews were conducted among Spanish speaking families for Title V and CMS.

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. Specifically, NBS works with community groups to address strategies specific to needs of the sickle cell community. Injury Prevention goes to where the members of the minority groups are, such as temples, churches or local businesses in an effort to establish community ties.

In all MCH programs, services and/or educational materials are provided in English and Spanish. The Oral Health program has bilingual staff that will provide outreach education targeted to Hispanic children. Oral Health also participates in the Georgia Alliance for Health Literacy to offer health literacy resources. Georgia SHAPE travels to diverse populations to educate on various physical activity and nutrition efforts. BCW and NBS hire bilingual service coordinators to assist in coordinating services in their native language. 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. Injury Prevention addresses cultural competency through partnering with the state Refugee Health Program and its case managers to address cultures and languages, such as Nepalese, Somali, Congolese, and Iraqi.

#### **II.B.2.c. Partnerships, Collaboration, and Coordination**

Georgia maintains partnerships to build the capacity of MCH services in the state.

MCHB investments: Georgia receives MCHB investments through Maternal, Infant and Early Childhood Home Visiting, Healthy Start, and Leadership Education in Neurodevelopmental and Related Disorders Training Program. The Title V program partners with all these programs. State Systems Development Initiative and D70 are MCHB investments provided directly to MCH.

Other federal investments: MCH receives other federal investments through Oral Disease Prevention, PRAMS and Early Hearing Detection and Intervention. MCH partners with Substance Abuse and Mental Health Services Administration grants, Personal Responsibility Education Program, Women, Infants and Children, and Head Start.

Other HRSA programs: District coordinators partner with Federally Qualified Health Centers.

State and local MCH programs: The state Title V program coordinates regularly with district and local health departments to implement activities within all programs.

Other programs within the State Department of Health: MCH partners with several other sections in DPH. MCH partners with Adolescent and School Health, Chronic Disease Prevention, Immunizations, Vital Records and Office of Health Indicators and Planning, Injury Prevention, Tobacco Cessation, HIV and STD Prevention, Environmental Health and Epidemiology. Partnerships with Adolescent and School Health and Injury Prevention are critical to addressing identified priority needs.

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 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, Valdosta State University and Georgia Regents University.

Others: MCH has a contractual relationship with six regional perinatal centers (RPC) to meet the needs of the perinatal regionalization system. The Georgia Obstetrical and Gynecological Society (GOGS) is contracted to administer the Maternal Mortality Review Committee. Relationships with Children's Health Care of Atlanta and Georgia Regents 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. MCH participates in three Collaborative Improvement and Innovation Networks (CoIIN): Safe Sleep, Social Determinants of Health and Perinatal Regionalization.

## **Family/Consumer Partnerships**

### Nature and Substance

MCH programs primarily engage families and consumers through parent organizations. BCW has contracted with Parent to Parent of Georgia to provide a central directory of resources for families and as a support mechanism for the program. BCW also has State and Local Interagency Coordinating Councils (SICCs and LICCs) in which 20% of members are required to be families. The Newborn Screening and Genetics Advisory Committee is composed of parent representative organizations, Parent to Parent of Georgia and Save Babies through Screening Foundation. Hands and Voices and the Sickle Cell Foundation of Georgia will be included. Other parent groups such as PKU Alliance and Kids Heart have participated in the development of policy or programs. Hands and Voices also currently serves on the EHDI stakeholder group. They assist with developing materials and advocacy for children with hearing impairment. Georgia Family Connection Partnership is Georgia SHAPE's main partner that speaks from the familial perspective. The Oral Health program has invited parents to attend the Georgia Oral Health Summit and they also partner with Voices for Georgia's Children. CMS supports the Family Engagement Specialist position within MCH. Family representatives served on three CMS Program Improvement workgroups. CMS partners with Easter Seals of West Georgia and Parent to Parent of Georgia.

### Diversity

A diverse group of families were engaged in Block Grant activities. Parents of CYSHCN and several community members attended the stakeholder meetings. These participants primarily had formal knowledge of MCH issues. The focus groups conducted for the needs assessment included parents from every public health district and various racial groups. Focus groups were conducted in Spanish for Hispanic families.

### Number engaged, degree of engagement, compensation, and training on core competencies

We estimate the following numbers of parents have been engaged within the past year at the state level: 20 in BCW, 40 in Georgia SHAPE, 5 in Newborn Screening, 10 in EHDI and 6 in CMS. BCW and CMS district coordinators provide an annual average of 500 opportunities for families to engage in local community activities such as health fairs, disability specific training, etc. Average yearly participation of both families and professionals for these events reaches approximately 10,000.

Only family/consumer partnerships in CYSHCN receive compensation, although other programs are looking to expand this service. Families that participate in the SICC are compensated for their travel expenses to attend meetings including child care if requested. Families are compensated if they provide clerical support for their LICC. The CMS Family Engagement Specialist receives salary and benefits. Parent Partners are paid hourly.

MCH is currently planning curriculum for families. Family Leadership Training, Public Health 101 and MCH 101 will be the first trainings conducted. Trainings on Title V and cultural competency will also be included.

#### Evidence and range of issues being addressed through the family/consumer partnership

Family/consumer partners primarily provide insight into the types of needs they are facing, and how they can best be addressed by the programs. Through participation in advisory councils, they impact all activities. In the CMS Parents as Partners project, parents are providing emotional support, linkages to community resources, transition to adult health care education and assistance with navigating the health care and special education systems. Families have been engaged with Child Health Screening in the last year on the addition of Critical Congenital Heart Disease Screening and Severe Combined Immunodeficiency, and expanding coverage for medical foods.

#### Impact of family/consumer partnership on programs and policies

Family/consumer partnerships have impacted programs and policies in several ways. They directly participate in planning through advisory councils. However, there are indirect impacts as well. A survey of program managers and directors showed that established family/consumer partnerships have enabled them to better understand what is relevant to the populations they are serving and the types of family issues involved. The CMS Family Engagement Specialist supports all child health programming with policy development, trainings and quality improvement.

#### Description of the state's efforts to build and strengthen family consumer partnerships for all MCH populations

Families are recruited through a variety of methods, including those who use the services, pediatricians, schools, workshops, health fairs, word of mouth, non-profit agencies and committees. Georgia SHAPE will work with afterschool programs to recruit families this year. It is intended that several of the families that were engaged for the needs assessment will continue to be engaged throughout the reporting cycle.

Trainings are currently being developed for families of CYSHCN to empower them to provide input on policies and program activities, as well as Block Grant activities.

Program managers were surveyed to determine their perceptions pertaining to the importance of family/consumer partnerships and the barriers they face. Although all respondents expressed the input they receive is crucial to effective program planning, they identified several barriers to engaging families and consumers, including the additional pressure to deliver more than is feasible, lack of father participation, keeping families involved, constraints of time and meeting location and having an ongoing funding source. These results will be used to engage with programs on how to best engage families and consumers throughout all programs.

## II.C. State Selected Priorities

No.	Priority Need
1	Prevent maternal mortality
2	Improve access to family planning services
3	Prevent infant mortality
4	Promote developmental screenings among children
5	Promote physical activity among children
6	Reduce suicide among adolescents
7	Improve systems of care for children and youth with special health care needs
8	Promote oral health among all populations
9	Decrease maternal substance use
10	Improve access to specialty care for CSHCN

## Priority Need Selection Process

Priority needs are defined as a gap between the observed and desired health status of the population that can reasonably be addressed by the Title V program in which stakeholders have demonstrated strong interest in or support for. In order to select priorities out of all needs identified through the needs assessment, stakeholders were asked to rate the top needs identified by MCH staff at the stakeholder meetings. Results from the meetings were treated as a recommendation and the ultimate selection of priority needs were determined by MCH leadership to ensure the selected needs were best aligned with the resources and reach of the Title V program. In determining final priorities, primary weight was given to the stakeholder meeting results; but findings from the quantitative analysis, focus groups, key informant interviews, surveys, public comment period and the capacity assessment were considered to ensure that the topic was identified as a need through multiple sources. Most NPMs were considered as priority needs at the stakeholder meetings. In most instances, the NPMs further informed the selection of the priority need they impact, and when appropriate, the NPM became a priority need.

## Needs Strongly Considered

Table 1 presents the results from the stakeholder meetings. Participants rated each need from 1-5 based on six criteria: seriousness of the issue, health equity, economic impact, trend, magnitude of the problem and importance. Weights were applied to the criteria as follows: 3 for seriousness of the issue, 3 for health equity, 2 for economic impact, 1 for trend, 2 for magnitude and 1 for importance. The criteria and the weights applied were chosen by the Needs Assessment Workgroup. Ratings for each criterion were averaged, multiplied by their weight, and added together to determine the final rating score for each priority need.

Table 1. Priority Need Rating

Rank	Potential Need Rated by Stakeholders	Rating	Status
1	Reduce the number of infants born with a low or very low birth weight	63.4	Addressed by preventing maternal mortality, infant mortality and increasing access to family planning services
2	Decrease the maternal mortality ratio	62.6	Selected as a priority need
3	Increase physical activity among children	60.9	Selected as a priority need and NPM
4	Increase access to specialty care for CYSHCN	60.4	Selected as a priority need and SPM
5	Reduce the number of infants born preterm	59.8	Addressed by preventing maternal mortality, infant mortality and increasing access to family planning services
6	Decrease deaths related to motor vehicle accidents for children 0-19	59.3	Not selected: Programmatic efforts to prevent childhood deaths are in place in DPH and MCH has a low capacity to address the need
7	Reduce substance abuse during pregnancy	59.2	Selected as priority need and SPM
8	Increase the percentage of VLBW infants born in a Level III facility	59.0	Selected as an NPM
9	Reduce suicidal ideation, planning and attempts	58.7	Selected as a priority need
10	Decrease adverse childhood experiences among children	58.1	Not selected: MCH has low program capacity to properly address the need
11	Decrease the percent of mothers smoking during pregnancy	58.0	Not selected: Although strongly considered as a priority need, percentages have been declining and there is a program outside of MCH to address this need. Tobacco cessation messages will be incorporated into oral health promotion
12	Decrease the percent of children, including those with special health care needs, exposed to second hand smoke at home	57.4	Not selected: Although strongly considered as a priority need, percentages have been declining and there is a program outside of MCH to address this need. Tobacco cessation messages will be incorporated into oral health promotion

13	Increase physical activity among adolescents	57.2	Not selected: There is low program capacity to address this need and resources were targeted to focus on physical activity among children in order to develop healthy behaviors at a young age
14	Decrease tobacco use among adolescents	56.7	Not selected: Although strongly considered as a priority need, there is a program outside of MCH to address this need. Tobacco cessation messages will be incorporated into oral health promotion
15	Reduce unplanned teen pregnancies	55.6	Addressed through increasing access to family planning services overall
16	Increase the number of women receiving well-woman visits	55.1	Selected as an NPM
17	Reduce the percent of adolescents who are bullied or who bully others	55.0	Selected as an NPM
18	Increase the percent of CYSHCN who received services necessary to make transitions to adult health care	54.6	Selected as an NPM
19	Increase the number of pregnancies that are planned	54.6	Selected as a priority need and SPM
20	Increase the percent of children and youth, including those with special health care needs, receiving a preventive dental visit	54.3	Selected as a priority need
21	Increase the proportion of women receiving prenatal care in the first trimester	54.2	Not selected: Community support for this need was lower than well-woman visits, which promote health before women enter pregnancy.
22	Increase the percent of CYSHCN having a medical home	54.1	Addressed by improving systems of care for CYSHCN
23	Decrease non-fatal injury among children	54.0	Not selected due to higher community support for other needs
24	Increase the number of CYSHCN that receive care coordination services	53.6	Addressed by improving systems of care for CYSHCN
25	Increase the percent of women receiving a dental visit during pregnancy	52.7	Selected as an NPM
26	Increase the percentage of children receiving a developmental screening	51.8	Selected as a priority need and NPM
27	Increase the number of infants placed to sleep on their back	51.6	Addressed through prevent infant mortality
28	Increase the percent of adolescents receiving a well-visit	50.7	Not selected due to higher community support for other needs
29	Increase the proportion of women receiving postpartum care	50.0	Not selected due to higher community support for other needs
30	Decrease cesarean sections among low-risk first births	49.3	Not selected due to higher community support for other needs
31	Increase the percent of families and emergency responders that feel prepared to assist CYSHCN during an emergency	49.0	Not selected due to higher community support for other needs
32	Reduce non-fatal injury among adolescents	48.1	Not selected due to higher community support for other needs

33	Increase the number of infants who are breastfed	46.1	Selected as an NPM
34	Increase the number of people drinking fluoridated water	41.4	Addressed through improving oral health among all populations

The following priorities were selected:

#### **Prevent maternal mortality**

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. Promoting well-woman visits, a related NPM, was the highest rated NPM in this domain at both the stakeholder meetings and through a survey completed by stakeholders.

#### **Promote physical activity among children**

Given the prevalence of obesity and low percentages of children performing recommended amounts of physical activity, promoting physical activity was selected as a state priority. Physical activity was the highest ranked priority in the child health domain.

#### **Increase access to specialty care for CYSHCN**

With majority of Georgia being rural and most pediatric specialty providers located in Atlanta's metropolitan and Augusta, access to specialty care for CYSHCN is a systemic issue that can be addressed by Title V. Access to specialty care for CYSHCN was ranked 4th among the list of 34 needs. This priority is unique to Georgia's health care environment and directly impacts the health and educational outcomes for CYSHCN. Thus will be addressed as a state performance measure.

#### **Reduce substance abuse during pregnancies**

Due to the rise in prescriptive opioid use, Georgia, like many other states, has seen an increase in neonatal abstinence syndrome (NAS). The increase of NAS and heroin use has garnered the attention of DPH's stakeholders and Georgia's politicians. This priority was rated 7<sup>th</sup> among the list of 34 needs and will be addressed through a state performance measure.

#### **Prevent infant mortality**

Preventing infant mortality is a clear need that came out of the needs assessment. Quantitative analysis showed that Georgia's infant mortality rate was 7.2 in 2013. Strong racial disparities are present and should be addressed to achieve health equity. Although preventing infant mortality was not independently rated at the stakeholder meetings, factors impacting infant mortality were considered. Low birth weight and preterm deliveries were among the highest ranked needs, displaying strong community support to address the overarching issue of infant mortality. Although breastfeeding, perinatal regionalization and safe sleep received lower ratings, quantitative analysis revealed that Georgia needs to make significant improvements to be comparable to national averages and achieve Healthy People 2020 goals. Strong community support to address breastfeeding was displayed throughout the public input period.

#### **Prevent suicide among adolescents**

Preventing suicide was identified as the priority need through quantitative data and by stakeholders. The suicide death rate among adolescents was 1.5 times higher in 2013 compared to 2012. Reducing suicide was chosen because it was rated highest in the adolescent health domain and in the top 10 overall. There was also strong support at the stakeholder meetings to reduce bullying, an associated NPM that can lead to depression, suicide ideation and possibly suicide attempts.

#### **Improve oral health among all populations**

Both quantitative and qualitative data examined support the selection for improving oral health as a priority need. Disparities were noted in women receiving dental care during pregnancy and an overall decline in the percentage of children receiving a dental visit. A particular lack of access to oral health services for CYSHCN was identified through key informant interviews. Throughout the needs assessment, strong community support for this need was demonstrated through the public input period.

#### **Promote developmental screenings among children**

Despite the percentage of children receiving developmental screens being higher among Georgia's children than nationwide, racial and insurance disparities are present in Georgia that do not exist at the national level. Less than half of Georgia's children are screened for developmental and social delays. Due to the benefits of early detection, there is room for improvement. This priority was rated fairly low by stakeholders, however through surveys and public input, a high level of community support was shown to support this need.

#### **Improve systems of care for CYSHCN**



Data examined during the needs assessment identified several areas where the system of care for CYSHCN should be improved. Therefore, this priority need was phrased to reflect the need to improve the overarching system that families engage with. Themes from qualitative data revealed that families are not aware of existing services, provide their own care coordination, serve as their own medical home, lack access to specialty providers and do not feel that their child is prepared to transition to adulthood.

### **Increase access to family planning services**

Unplanned pregnancies, lack of knowledge around birth spacing, and lack of preparation for healthy pregnancies were major themes identified during the perinatal health focus groups. Data showing 54.8% of births in 2011 were unplanned corroborate these findings. Key informants recommended family planning efforts to reduce adverse birth outcomes. Family planning was rated second highest within the maternal/women's health domain in the stakeholder meetings.

### **Priority Need Comparison**

The current priority needs were identified through a new vision and framework and are therefore not a direct continuation of priority needs from the previous reporting cycle. However, several similarities between the two sets of priority needs should be noted. Table 2 presents a comparison of these similarities and differences between priority needs for 2011-2015 and 2016-2020.

Table 2. Priority Need Comparison, 2011-2015 and 2016-2020

<b>2016-2020</b>	<b>2011-2015</b>
Prevent maternal mortality	No similar need
Increase access to family planning services	Reduce repeat adolescent pregnancy
Prevent infant mortality	Decrease infant mortality and injury
Promote physical activity	Decrease obesity among children and adolescents
Promote developmental screening	Increase developmental screening for children in need
Prevent suicide among adolescents	No similar need
Improve systems of care for CYSHCN	Increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs
Promote oral health among all populations	No similar need
Increase access to specialty care for CYSHCN	No similar need
Reduce substance abuse during pregnancies	No similar need
No similar need	Reduce motor vehicle crash mortality among children ages 15-17 years
No similar need	Improve maternal and child health surveillance and evaluation infrastructure
No similar need	Improve childhood nutrition
No similar need	Increase awareness of the need for preconception health care among women of childbearing age

Promoting planned pregnancies was identified as a key priority in both assessments, although it was expanded to promote family planning across all ages in 2016-2020. Given the overall infant mortality rate for the state and the racial, income, and geographic disparities, preventing infant mortality was identified as a priority in both assessments. Decreasing obesity among children (2011-2015) is related to increasing physical activity (2016-2020), which promotes overall health and wellness while reducing obesity. An increase in developmental screening has remained a priority for the state. Although there have been some improvements, efforts from 2016-2020 will target all children, not just those in need. Preventing maternal mortality, preventing suicide among adolescents, preventing substance abuse during pregnancy, increasing access to specialty care for CYSHCN and promoting oral health among all populations are priority needs for 2016-2020 that are not related to needs identified for the 2011-2015 reporting cycle.



## **II.D. Linkage of State Selected Priorities with National Performance and Outcome Measures**

- NPM 1 - Percent of women with a past year preventive medical visit
- NPM 3 - Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
- NPM 4 - A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
- NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
- NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day
- NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
- NPM 12 - Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
- NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

## Linkage Between Priority Needs and National Performance Measures

Eight national performance measures were selected based on their ability to impact priority needs and related outcome measures. The selected NPMs and their corresponding priority are displayed in Table 3. Increasing access to family planning services, maternal substance abuse and access to specialty care do not have an associated NPM and will be addressed by an SPM.

**Table 3.** Linkage between Priority Needs and National Performance Measures

Domain	Priority Need	National Performance Measure
Maternal/Women's Health	Prevent maternal mortality	Well-woman visit
Maternal/Women's Health	Increase access to family planning services	None
Perinatal Health	Prevent infant mortality	Perinatal regionalization Breastfeeding
Child Health	Promote developmental screenings among children	Developmental screening
Child Health	Promote physical activity among children	Physical activity
Adolescent Health	Prevent suicide among adolescents	Bullying
CYSHCN	Improve systems of care for CYSHCN	Transition
Cross-Cutting	Promote oral health among all populations	Oral health

### NPM 01: Well-woman visit (Percent of women with a past year preventive medical visit)

*Priority Need: Prevent maternal mortality*

Promoting well-woman visits was chosen to prevent maternal mortality. Findings from the Maternal Mortality Review Committee revealed that poor health status and the presence of chronic conditions prior to entering pregnancy were the primary contributors to maternal death in Georgia. Additionally, 48.5% of women are obese entering pregnancy. It is essential that Georgia ensures women are healthy prior to entering pregnancy through promoting well-woman visits among women of reproductive age. In 2013, the percentage of women in Georgia who received a preventive medical visit within the last year was nearly 69%. Although the overall percentage is higher than the national average, disparities by race/ethnicity and education were seen, with more women with higher educational attainment and non-Hispanic Black women visiting a provider for a comprehensive medical exam. Counseling and screening services provided at well-woman visits are essential to promoting pre-conception and inter-conception care for women. Not only do well-woman visits promote the overall health of women through the life-course, perinatal health is impacted by preventing low birth weight and preterm births. Although these outcomes do not directly relate to the priority need, these are important measures to address in Georgia, and it should be noted that by promoting well-woman visits these outcomes are expected to improve as well.

### NPM 03: Perinatal regionalization (Percent of very low birth weight (VLBW) infants born in a hospital with a Level

### **III+ Neonatal Intensive Care Unit (NICU))**

*Priority Need: Prevent infant mortality*

Perinatal regionalization was selected to address infant mortality. VLBW is a common cause of infant mortality. Although these births should be prevented, it is essential to put systems in place to ensure that appropriate care is given to these infants when VLBW births do occur. Due to the high percentages of infants born preterm and at low birth weight in the state, it is imperative to identify these infants early and ensure that they receive care to prevent mortality among these infants. Infants born in a facility with a NICU and with staffing that can accommodate their needs gives them a higher likelihood of survival and reduces infant mortality. There is room to improve the perinatal regionalization system in Georgia and promote the delivery of infants in a facility that provides the most appropriate level of care for their level of risk. Racial and regional disparities indicate that there is room to improve the system.

### **NPM 04: Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)**

*Priority Need: Prevent infant mortality*

Breastfeeding was selected due to its protective factor against sleep-related deaths and ability to prevent morbidity among infants, particularly those who are born preterm or with low birth weight. While there is currently a high percentage of infants born preterm and with low birth weight in Georgia, promoting breastfeeding will improve outcomes among these infants. Georgia is clearly lower than the national averages in terms of initiation and duration. Promoting breastfeeding will provide benefits across the life-course including preventing infant mortality and morbidity, preventing childhood obesity and promoting school readiness.

### **NPM 06: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)**

*Priority Need: Promote developmental screenings among children*

The NPM for developmental screening directly relates to Georgia's priority need to promote developmental screenings among children. Georgia has had clear success in exceeding national standards for children that are screened for developmental, social and emotional delays. Despite the success, fewer than half of Georgia's children are screened. Georgia will continue to focus on this measure to reduce disparities and promote it among all children, not just those receiving services from DPH. Increasing developmental screenings is intended to promote early identification of children that have social and emotional delays and linkage to services during critical periods of the child's development.

### **NPM 08: Physical activity (Percent of children ages 6 through 11 who are physically active at least 60 minutes per day)**

*Priority Need: Promote physical activity among children*

The national performance measure for physical activity is identical to the identified priority need for promoting physical activity among children. A low percentage of children in Georgia are performing recommended amounts of physical activity. Disparities are present by income, race/ethnicity, and gender. It is essential to address this performance measure in order to impact overweight and obesity among children. It is intended that by promoting positive behaviors early in life, they will continue into adolescence and adulthood to prevent obesity and the prevalence of chronic disease in the population.

Promoting physical activity promotes the overall health of children, even in the absence of chronic diseases.

**NPM 09: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)**

*Priority Need: Prevent suicide among adolescents*

Bullying was chosen as the national performance measure that most directly impacts the priority need to prevent suicide among adolescents. Bullying can lead to depression and suicide ideation and possibly suicide attempts. Victims of bullying often become bullies themselves engaged in a negative cycle. Approximately 1 in 4 adolescents in the state either experience bullying or bully others. The prevalence of bullying is higher among middle school students than high school students, and particularly seen in the Hispanic population. Not only does addressing bullying prevent suicide, but it also promotes overall health by preventing feelings of depression and associated behavior, including violence. Electronic bullying is an area that should be examined throughout the five-year reporting cycle as well, as social media usage continues to increase among adolescents. Data examined in the needs assessment showed that Georgia's adolescents frequently engage in violent behavior and weapon-carrying.

**NPM 12: Transition (Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care)**

*Priority Need: Improve systems of care for CYSHCN*

Improving transitions to adulthood is intended to address the priority need of improving the overall system of care for CYSHCN by linking them from their source of pediatric care to an adult medical home. It is essential that families receive services to assist as they transition out of state CYSHCN programs. The issue is of increasing significance as children with special health care needs are increasingly living into adulthood. It is also intended to promote their lifestyles by teaching them needed self-help skills as they transition, and teaching them to engage in independence and employment when possible. Fewer youth in Georgia are receiving the services needed to successfully transition compared to the nation as a whole. Addressing both health and health care will impact the overall health status of Georgians.

**NPM 13: Oral health (A. Percent of women who had a dental visit during pregnancy and B. Percent of children, ages 1 through 17, who had a preventive dental visit in the past year)**

*Priority Need: Promote oral health among all populations*

The oral health NPM was selected to promote oral health among all populations. The oral health measure not only promotes access to oral health services among pregnant women, but also ensures that infants and children are more likely to receive oral health care. The NPM addresses access to oral health care for all children, including those with special health care needs. Ensuring access to oral health services for children not only prevents decayed teeth and cavities, but also promotes positive attitudes toward oral health and teaches children important oral hygiene behaviors to practice into adolescence and adulthood. It is essential to ensure that oral health remains a topic of focus in Georgia, as it is vital to ensuring that Georgians achieve an excellent health status overall.

## **II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures**

- SPM 1 - 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%.
- SPM 2 - 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.
- SPM 3 - By 2020, decrease the rate of congenital syphilis from 13 (infants per 100,000 live births) to 11.7.
- SPM 4 - By 2020, decrease the rate of infants diagnosed with Neonatal Abstinence Syndrome (NAS) from 3.2 (per 1,000 live births) to 2.0.

## Linkage of Priority Needs and State Performance Measures

Four state performance measures were selected based on their ability to impact priority needs and related outcome measures. The selected SPMs and their corresponding priority are displayed in Table 4.

Table 4. Linkage between Priority Needs and State Performance Measures

Domain	Priority Need	State Performance Measure
Women's/Maternal Health	Increase access to family planning	Increase access to family planning
Perinatal Health	Maternal substance abuse	Decrease neonatal abstinence syndrome
Perinatal Health	Prevent infant mortality	Decrease congenital syphilis
CYSHCN	Improve access to specialty care	Improve access to specialty care for CYSHCN

### SPM 01: Improve access to family planning

*Priority Need: Improve access to family planning*

Improve access to family planning was selected as a priority need and state performance measure. Unplanned pregnancies (54.8% in 2011), lack of knowledge around birth spacing, and lack of preparation for healthy pregnancies were major themes identified during the perinatal health focus groups. Also, family planning was rated second highest within the maternal/women health domain in the stakeholder meetings. Data shows that the percentage of mothers who had recently given birth and reported using contraception at the time of conception was approximately 50 percent from 2009-2011. The percent of Georgia women ages 25 to 34 and teens who reported using contraception at conception were 60 percent and 47.6 percent, respectively. Thus, there is a need to improve access to family planning services, particularly long-acting reversible contraceptives (LARCS) to impact maternal health as well as perinatal outcomes.

### SPM 02: Improve access to specialty care for CYSHCN

*Priority Need: Improve access to specialty care for CYSHCN*

Improve access to specialty care was selected as a priority need and state performance measure. CYSHCN population lack access to needed health care services. In 2001, 19.0 percent of Georgia's families of CYSHCN reported having an unmet need for one of the 14 services, including specialty care. In 2009-2010, the percentage increased to 25.3 percent. During that time period, Georgia's percentage remained slightly higher than the national average. The projected prevalence in 2011-2012 is 20.0 percent. Additionally, the projected prevalence of unmet needs among CYSHCN who are uninsured is more than twice that of CYSHCN with either public or private health insurance. With majority of Georgia being rural and most pediatric specialty providers located in Atlanta's metropolitan and Augusta, access to specialty care for CYSHCN is a systemic issue that can be addressed by Title V. Access to specialty care for CYSHCN was ranked 4 among the list of 34 needs. This priority is unique to Georgia's health care environment and directly impacts the health and educational outcomes for CYSHCN.

### SPM 03: Decrease congenital syphilis

*Priority Need: Infant mortality*

Decreasing congenital syphilis was selected as a state performance measure to address priority need infant mortality. Congenital syphilis can cause miscarriage, stillbirth, failure to thrive, deformed bones, meningitis, and nerve problems leading to blindness or deafness. In 2014, Georgia ranked 12<sup>th</sup> in the U.S. for congenital syphilis rates (13 cases per 100,000 live births). From 2010-2015, Georgia had no less than 11 cases in a given year and 20 U.S. states had no cases reported. Congenital syphilis is considered by the Centers for Disease Control and Prevention (CDC) as a winnable battle.



#### **SPM 04: Decrease neonatal abstinence syndrome**

##### *Priority Need: Maternal substance use*

Decrease neonatal abstinence syndrome was selected as a state performance measure to address priority need maternal substance use. Due to the rise in prescriptive opioid use, Georgia, like many other states, has seen an increase in neonatal abstinence syndrome (NAS). Maternal substance use was ranked 7<sup>th</sup> among the list of 34 needs by MCH stakeholders. The rate of infants born with neonatal abstinence syndrome increased in Georgia and the US from 2008 to 2012. However, the rate was consistently two to three times higher in the US than Georgia throughout the same time period. In Georgia, the rate of infants born with neonatal abstinence syndrome was 5.2 among non-Hispanic Whites in 2012. The rate was far lower among non-Hispanic Blacks (1.1) and Hispanics (1.6). Differences were seen by insurance status in 2012 as well. The rate was only 1.1 among those with private insurance, but was 4.8 among those insured by Medicaid.

## **II.F. Five Year State Action Plan**

### **II.F.1 State Action Plan and Strategies by MCH Population Domain**

The following narrative provides activities, accomplishments, challenges and revisions over the past year for the previously national and state performance measures as well as plans for the future based on newly identified priority needs and selected national performance measures. The narrative is organized by the six federally-recognized population domains with corresponding NPMs and SPMs. The following areas are reported:

- Accomplishments: October 1, 2015 to September 30, 2016
- Current Activities: October 1, 2016 to September 30, 2017
- Plans for Upcoming Year: October 1, 2018 to September 30, 2019

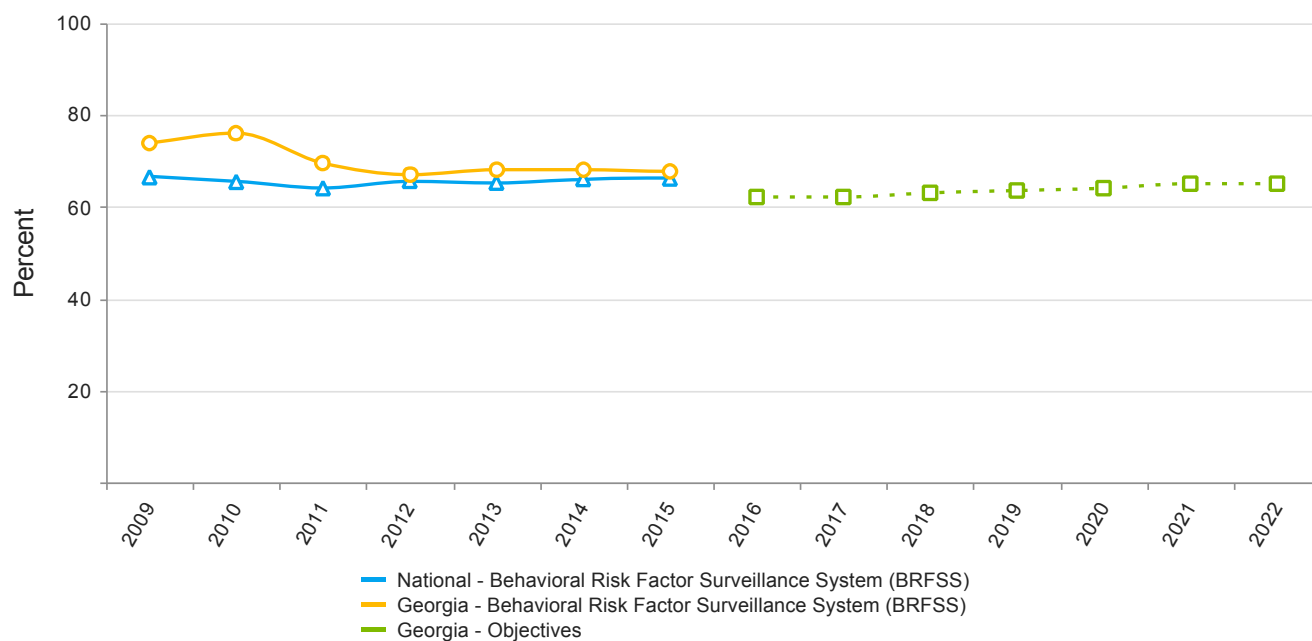
#### **Women/Maternal Health**

##### **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-2014	180.4	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2011_2015	46.2	NPM 1
NOM 4.1 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2015	9.5 %	NPM 1
NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)	NVSS-2015	1.8 %	NPM 1
NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)	NVSS-2015	7.7 %	NPM 1
NOM 5.1 - Percent of preterm births (<37 weeks)	NVSS-2015	10.8 %	NPM 1
NOM 5.2 - Percent of early preterm births (<34 weeks)	NVSS-2015	3.2 %	NPM 1
NOM 5.3 - Percent of late preterm births (34-36 weeks)	NVSS-2015	7.5 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2015	26.8 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2014	7.2	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	7.5	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	5.0	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.5	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	287.1	NPM 1

## National Performance Measures

**NPM 1 - Percent of women with a past year preventive medical visit**  
**Baseline Indicators and Annual Objectives**



### Federally Available Data

#### Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2016
Annual Objective	62.1
Annual Indicator	67.7
Numerator	1,258,025
Denominator	1,857,538
Data Source	BRFSS
Data Source Year	2015

### Annual Objectives

	2017	2018	2019	2020	2021	2022
Annual Objective	62.1	63.0	63.5	64.0	65.0	65.0

## Evidence-Based or –Informed Strategy Measures

### ESM 1.1 - 1.1.1. Number of public health districts with the Every Woman video in circulation

Measure Status:	Inactive - This measure is being deleted due to unforeseen barriers in implementing.
-----------------	--

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	GFPP Data
Data Source Year	SFY 2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	5.0	10.0	15.0	18.0	0.0

**ESM 1.2 - 1.2.1. Number of staff that have been trained on preconception health appraisals**

<b>Measure Status:</b>	<b>Inactive - This measure was deleted due to a change in the strategy.</b>
------------------------	---

State Provided Data	
	2016
Annual Objective	
Annual Indicator	97
Numerator	
Denominator	
Data Source	GFPP
Data Source Year	SFY 2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	60.0	70.0	80.0	90.0	100.0

**ESM 1.3 - 1.3. Number of focus groups across the state that assess barriers to well-woman visits**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	Title V On-Going Needs Assessment
Data Source Year	2017
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	5.0	10.0	15.0	18.0	0.0

**ESM 1.4 - 1.4. Proportion of birthing hospitals that implement Alliance for Innovation on Maternal Health Bundles**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	25.0	30.0	50.0	60.0	75.0

## State Performance Measures

**SPM 1 - 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%.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	16.6
Numerator	9,714
Denominator	58,434
Data Source	GFPP
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	11.0	12.0	13.0	14.0	15.0	17.0



## State Action Plan Table

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

#### Priority Need

Prevent maternal mortality

#### NPM

Percent of women with a past year preventive medical visit

#### Objectives

1.1. By 2020, develop a partnership to launch at least one targeted educational campaign or referral source to promote preventative healthcare.

1.2. By 2020, collaborate with the Georgia Perinatal Quality Collaborative (GaPQC) to implement Alliance for Innovation on Maternal Health (AIM) Bundles on Hemorrhage in 75% of birthing hospitals.

#### Strategies

1.1.a. Leverage existing partners to provide education to healthcare providers through in-person trainings, webinars and messaging campaigns for medical providers, health districts, community organizations and other women's health stakeholders to promote preventative healthcare.

1.2.a. In collaboration with GaPQC, disseminate Maternal Mortality Review Committee findings to Georgia birthing hospitals and market AIM Bundles.

1.2.b. In collaboration with GaPQC, use quality improvement strategies to implement AIM bundles.

1.2.c. In collaboration with GaPQC, develop and utilize a central database to collectively evaluate outcomes.

#### ESMs

#### Status

ESM 1.1 - 1.1.1. Number of public health districts with the Every Woman video in circulation Inactive

ESM 1.2 - 1.2.1. Number of staff that have been trained on preconception health appraisals Inactive

ESM 1.3 - 1.3. Number of focus groups across the state that assess barriers to well-woman visits Active

ESM 1.4 - 1.4. Proportion of birthing hospitals that implement Alliance for Innovation on Maternal Health Bundles 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 4.1 - Percent of low birth weight deliveries (<2,500 grams)

---

NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)

---

NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)

---

NOM 5.1 - Percent of preterm births (<37 weeks)

---

NOM 5.2 - Percent of early preterm births (<34 weeks)

---

NOM 5.3 - Percent of late preterm births (34-36 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

---

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

### Priority Need

Improve access to family planning services

### SPM

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%.

### Objectives

2.1. By 2020, increase the number of unduplicated patients in family planning clinics by 5%

2.2. By 2020, increase the percentage of teens (under age 19) served in Georgia Family Planning Program (GFPP) who use long-acting reversible contraceptive (LARC)

2.3. By 2020 increase the percentage of women (ages 15-44) served in family planning clinics who use long-acting reversible contraception (LARC) from 11% to 15%

### Strategies

2.2.a. Provide counseling to 75% of teens served with GFPP

2.3.a. Guide 85% of GFPP clients through creating a Reproductive Life Plan

2.3.b. Increase inventory of LARCs in GFPP clinics

2.1.a. Develop and disseminate a marketing campaign to increase awareness of the GFPP

## Women/Maternal Health - Plan for the Application Year



### Plan for the Coming Year: Oct 2017 – Sep 2018

*Priority Needs: Prevent maternal mortality*

#### NPMs: Well-Woman Visits

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 will revise its state action plan to focus on strategies that reduce maternal mortality. Under the direction of Health Promotions Division Director, Lara Jacobson, MD, the MCH section developed a simple visual to link strategies to common primary drivers (primary causes of maternal mortality). The diagram is being used by MCH staff, Department leaders and MCH partners to communicate the primary drivers and all of the efforts to reduce maternal death in Georgia.

Table 1: Georgia's Maternal Mortality Primary Drivers' Diagram

Aims	
Reduce Preventable Maternal Mortality in the State of Georgia	
	
Primary Drivers	
Medical Management: Hemorrhage, Hypertension, Embolism	Maternal Health and Birth Spacing
	
Interventions	
Risk-Appropriate Care	PCM Program
MMRC (to gain understanding of statewide drivers)	Birth Spacing (LARC's and other contraceptives)
AIM Bundles- Hemorrhage, Hypertension, Cardiomyopathy	P4HB

#### Medical Management of Hemorrhage, Hypertension, and Embolism

##### *Perinatal Regionalization*

In the coming year, the Women's Health Program intends to develop and implement targeted marketing strategies to increase awareness of the RPCs with the goal of increasing utilization and promote the use of PLAT, in Level I and Level II birthing hospitals in the southernmost region of the state, to quickly identify women presenting with preterm labor and initiate risk appropriate care (Numerator= # of Level I and Level II hospitals with PLAT; denominator = total # of Level I and II birthing hospitals south of Atlanta).

##### *Alliance for Innovation on Maternal Health (AIM) Bundles*

According to the American Congress of Obstetricians and Gynecologist (ACOG), AIM is a national alliance to promote consistent and safe maternity care to reduce maternal mortality by 1,000 and severe morbidity by 100,000 instances over the course of four years. The purpose of the AIM program is to equip, empower and embolden every state, perinatal quality collaborative, hospital network/system, birth facility and maternity care provider in the U.S to significantly reduce severe maternal morbidity and maternal mortality through proven implementation of consistent maternity care practices that are outlined in maternal safety bundles (action systems).

Maternal safety bundles represent best practices for maternity care and are developed and endorsed by national multidisciplinary organizations.

These maternal safety bundles include action measures for:

- Obstetrical Hemorrhage
- Severe Hypertension/Preeclampsia
- Prevention of Venous Thromboembolism
- Reduction of Low Risk Primary Cesarean Births/Support for Intended Vaginal Birth
- Reduction of Peripartum Racial Disparities
- Postpartum care access and standards

In the coming year, DPH, the Georgia Perinatal Quality Collaborative (GaPQC), and, the Georgia Obstetrical and Gynecological Society (GOGS) will partner to adopt maternal safety bundles as a focus for GaPQC. In the coming year, DPH and GaPQC will also increase participation in the perinatal quality collaborative, and create a data system.

#### *Maternal Mortality Review Committee (MMRC)*

In the coming year, the MMRC will continue to review cases and publish an updated report with appropriate recommendations.

#### *Maternal Health and Birth Spacing*

##### *Perinatal Case Management (PCM)*

In the coming year, the Women's Health Program will target three counties among the six cluster highly rated infant mortality counties without a PCM program for expansion. The Women's Health Program will also assess the potential impact of PCM Programs on infant mortality. Training and education to the current PCM programs will continue.

##### *Planning for Healthy Babies (P4HB)*

P4HB is a family planning demonstration waiver program issued by the Georgia Department of Community Health (DCH) to assist the Department 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 maybe eligible under the expansion policy to receive family planning services, Inter-pregnancy Care (IPC), Case Management, and/or Resource Mother. The program is intended to bridge health care for underinsured and uninsured women of high need.

Women ages 18-44 who meet the monthly family-income are eligible for family planning services, and IPC which includes primary care, substance abuse treatment, case management, limited dental services, and prescription drugs to treat chronic disease. Women who previously gave birth to a VLBW and do not receive Medicaid or are losing Medicaid are eligible for IPC. In addition, women who do not receive Medicaid and did not have a VLBW are eligible for family planning services.

In the coming year, the Women's Health Program will collaborate with DCH and other partners to increase enrollment into P4HB.

##### *Maternal and Child Health Information and Resource Center*

In the coming year, 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 IPC of P4HB, hypertension, heart disease, obesity, and diabetes.

##### *Family Planning*

In the coming year, the Family Planning Program will continue to work with Stakeholders to increase access to family planning by leveraging partnerships, providing training and technical assistance.

## Women/Maternal Health - Annual Report

### Reporting Year Oct 2015-Sept 2016

*Priority Need: Prevent maternal mortality*

#### NPM 3: Well-woman visits

##### *Maternal Mortality Review Committee (MMRC)*

During the reporting year, the MMRC reviewed and completed 2013 cases. In addition to reviewing cases, Georgia was one of four states selected by the Centers for Disease Control and Prevention (CDC) to participate in a pregnancy checkbox quality assurance pilot project in 2016. The goals of the project are to address the timely correction to deaths incorrectly identified as pregnancy-associated death (false-positive), evaluate the impact of the errors and offer potential solutions. In collaboration with the Vital Records Office, Maternal and Child Health Epidemiology designed a quality assurance process based on the Maternal Mortality Review Committee processes and protocol. Beginning in January 2016 and continuing monthly throughout the year, Maternal and Child Health Epidemiology staff contacted via multimodes of communication the certifiers of 95 maternal deaths that were identified by the pregnancy checkbox on the death certificate only (did not link to a birth or fetal death certificate).

*Priority Need: Increase access to family planning services*

#### SPM 1: Family Planning

The Georgia Department of Public Health's Family Planning Program provides leadership, guidance and resources to Georgia's 18 Health Districts in the development and provision of resources that increase the access of family planning services to Georgia's women.

DPH's Family Planning Program offers comprehensive health care services designed to provide women with support to plan the birth of their children, reduce unintended pregnancies, determine effective birth control methods and improve the wellbeing of families statewide. Family planning services are available in all 18 health districts, which support 159 counties.

Since the loss of Title X in 2014 and the challenging reorganization that occurred as a result, the family planning program has made tremendous strides in ensuring that family planning services to include LARCs are accessible to all of Georgia's women of reproductive age.

In 2015 there were a number of initiatives that were launched in the family planning program to support sustainability and encourage utilization.

These initiatives include:

1. Additional funding to increase access to LARCs. The family planning program received an additional \$650,000 to promote access to LARCs. This funding was utilized to purchase LARC pharmaceuticals that would otherwise be purchased from previously allocated funding, allowing clinics to increase inventory of drugs that year. Also, this funding was utilized to hire an additional 11 advance practice nurses (APRN) who are placed strategically in areas of need in the State to provide LARC services.
2. Providing contraceptive methods to women in need (at or below 200% FPL) based on a sliding fee system. Patients unable to pay are not denied services
3. Clinics are able to collect fees as appropriate via self-pay and third party billing to support sustainability efforts
4. The family planning program collaborated with the University Of California San Francisco - Bixby Reproductive Training Center to train over 130 clinicians and staff members about LARCs. All staff who attended were taught how to advocate and counsel patients about implants and IUDs, also, APRNs and doctors who attended were trained on inserting and removing the devices
5. A number of districts across the State launched marketing campaigns that targeted women of reproductive age and informed them about the availability of family planning services and LARCs
6. Nurse clinical protocols were also revised allowing patients to receive contraceptives on the same day without the need for annual exams, blood tests or other routine check-ups unless indicated and where indicated a quick start method can be prescribed. The clinical updates removed the need for additional patient appointments to receive contraception which historically resulted in loss to follow-up and in some cases follow-up when it's too late and the patient is pregnant. Also, contraceptive counselling is required so that they patients may make informed choices about contraception

Collectively, these initiatives have resulted in an increase in the number of insertions among women served in the public

health clinics from 2,213(FY2014) to 4,475(FY2015). Also, the program has made positive strides in strategic performance measures for example as of September 2016, 13% of women in the age range 15-44 years served in the public health clinics use a LARC compared to the baseline 11.1% in the previous year (goal is 15% by 2019). Another performance measure is to increase the number of teens (under age 19) who use a LARC. The percentage of teens who use a LARC, as of August 2016, went up to 7.6% from the previous year 5.1%. And as of September 2016, there were a total of 78 APRNs working in family planning within our public health clinics.

## **Current Year Oct 2016-Sept 2017**

*Priority Need: Prevent maternal mortality*

### NPM 3: Well-woman visits

#### *Maternal Mortality Review Committee (MMRC)*

The 2016 pregnancy checkbox quality assurance pilot project review closed May 3, 2017. The preliminary findings are 55 (58%) of the 95 maternal deaths identified by the pregnancy checkbox on the death certificate only and the status of pregnancy was unable to be confirmed for 27 (28%) of the deaths. The pilot project will be continued in 2017.

#### *Well-Woman Focus Groups*

In the current year, the MCH section worked with interns to understand the barriers women experience when trying to access a preventive health care visit. Interns identified through existing literature and the Well-Woman Project conducted by CityMatCH, UIC School of Public Health and City/County Health Departments that women experience a variety of barriers when accessing preventive health care that cannot be easily addressed. Georgia specific focus groups are needed to identify strategies to overcome barriers.

*Priority Need: Increase access to family planning services*

### SPM 1: Family Planning

In the current year, Family Planning received an additional \$651,000 in state funding to support the availability of LARCs. The funds were used to purchase additional pharmaceuticals and hire contract APRN staff to support the districts in making family planning more accessible to women. The additional funding helps to offset other costs that would be incurred through the regular funding stream available to districts.

Family Planning staff partnered with the Adolescent Health and Youth Development staff to provide training on best practices when serving our teen population. Family Planning staff are also working with the University of California San Francisco Bixby Reproductive Health Center to provide LARC training to clinic staff.

Family Planning staff began planning a marketing campaign intended to be launched in late 2017. The marketing campaign aims to increase awareness of family planning options and services to women across the state.

## 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-2014	7.2	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2014	7.5	NPM 3
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2014	5.0	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2014	2.5	NPM 4
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2014	287.1	NPM 3
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2014	123.0	NPM 4



## 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)

#### Baseline Indicators and Annual Objectives

FAD for this measure is not available for the State.

State Provided Data	
	2016
Annual Objective	81.8
Annual Indicator	79
Numerator	1,898
Denominator	2,402
Data Source	Vital Records
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	81.0	82.0	83.0	84.0	85.0

## Evidence-Based or –Informed Strategy Measures

### ESM 3.1 - 3.5.1. Percentage of birthing hospitals that are in compliance with neonatal level of care requirements

Measure Status:	Inactive - This measure is being deleted due to the reliability of the data source.
-----------------	---

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	79
Data Source	Women Health Program
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	0.0	40.0	60.0	65.0	65.0

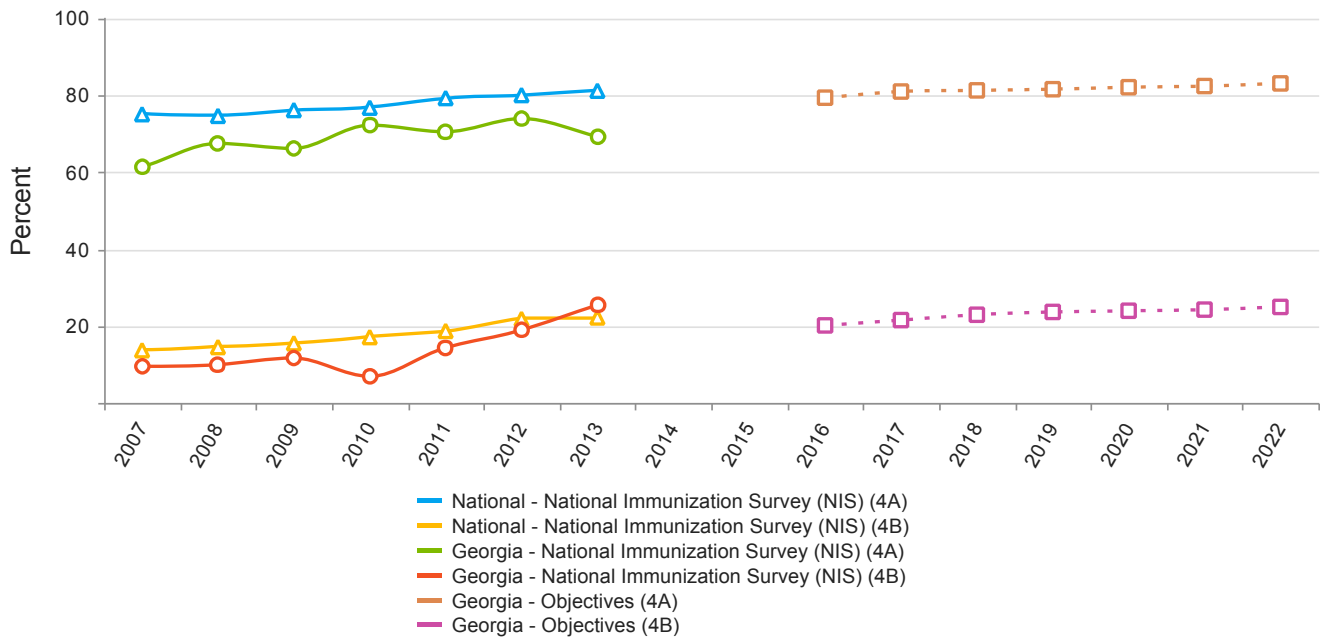
### ESM 3.2 - 3.6.1. Proportion of Regional Perinatal Centers that receive a process evaluation

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	6.0	6.0	6.0	6.0	6.0	6.0

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

**Baseline Indicators and Annual Objectives**



**NPM 4 - A) Percent of infants who are ever breastfed**

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	79.3
Annual Indicator	69.2
Numerator	80,818
Denominator	116,817
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.9	81.2	81.5	82.0	82.3	83.0

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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	20.2
Annual Indicator	25.4
Numerator	29,130
Denominator	114,622
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	21.6	23.0	23.7	24.0	24.3	25.0

## Evidence-Based or –Informed Strategy Measures

### 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
Annual Objective	
Annual Indicator	39
Numerator	
Denominator	
Data Source	Womens Health Program Data
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	10.0	20.0	30.0	40.0	40.0

#### ESM 4.2 - 3.1.2 Number of Train-the-Trainer workshops conducted

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

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	Womens Health Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	3.0	4.0	5.0	6.0	6.0

## State Performance Measures

**SPM 1 - 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%.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	16.6
Numerator	9,714
Denominator	58,434
Data Source	GFPP
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	11.0	12.0	13.0	14.0	15.0	17.0

**SPM 3 - By 2020, decrease the rate of congenital syphilis from 13 (infants per 100,000 live births) to 11.7.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	17
Numerator	21
Denominator	123,292
Data Source	Projected Data from OASIS and SendSS, Births and C
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	13.0	12.7	12.4	12.0	11.7	11.7



**SPM 4 - By 2020, decrease the rate of infants diagnosed with Neonatal Abstinence Syndrome (NAS) from 3.2 (per 1,000 live births) to 2.0.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	6.1
Numerator	735
Denominator	120,577
Data Source	Hospital Discharge Data, Vital Records
Data Source Year	2015
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	4.0	3.9	3.8	3.5	3.1	2.0

## State Action Plan Table

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

#### Priority Need

Prevent infant mortality

#### NPM

A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months

#### Objectives

3.1. By 2020, increase the number of birthing hospitals participating in the Georgia 5-STAR Hospital Initiative to 40

3.2. By 2020, develop a partnership with WIC to conduct 1 training per year for public health workers on breastfeeding

3.4. By 2020, 25% of birthing hospitals will have policies and education that adhere to the American Academy of Pediatrics (AAP) safe sleep guidelines

## Strategies

- 3.1.a. Recruit and train hospitals on the Georgia 5-STAR Hospital Initiative and the 10 Steps to successful breastfeeding.
- 3.1.b. Provide Train-the-Trainer opportunities for staff of hospitals participating in the Georgia 5-STAR Hospital Initiative.
- 3.1.c. Recognize hospitals for participating in and completing steps in the Georgia 5-STAR Hospital Initiative.
- 3.1.d. Work with community partners such as Georgia Academy of Pediatrics (GA-AAP), Georgia OB/GYN Society (GOGS), and other community partners to educate and train physicians, nurses, and other direct care providers on the importance of breastfeeding for mothers and babies
- 3.2.a. Continue to provide an education series to increase the breastfeeding knowledge base of public health employees throughout the state, including topics such as promoting the importance of breastfeeding, providing lactation support for working mothers, and other topics to support breastfeeding initiation and exclusivity at 6 months
- 3.2.b. Conduct a minimum of 4 VICS trainings annually for public health staff on topics developed through the breastfeeding education series
- 3.4.a. Recruit birthing hospitals by providing staff with a step by step guide on implementing a Safe to Sleep Program
- 3.4.b. Provide in-person trainings to hospitals participating in the program
- 3.4.c. Provide participating hospitals with education resources for staff and caregivers on the safe infant sleep recommendations
- 3.4.d. Collect pre and post crib audits and policy statements from participating hospitals
- 3.4.e. Recognize hospitals for implementing a Safe to Sleep Program and policy

## ESMs

## Status

- |   |        |
|---|--------|
| ESM 4.1 - 3.1.1 Number of birthing hospitals that participate in the 5-STAR Hospital Initiative | Active |
| ESM 4.2 - 3.1.2 Number of Train-the-Trainer workshops conducted                                 | Active |

## NOMs

- 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 2

### Priority Need

Prevent infant mortality

### NPM

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

### Objectives

3.5. By 2020, increase the percentage of birthing hospitals that have been educated on the requirements for neonatal level of care from 0 to 75%.

3.6. By 2020, increase the number of Regional Perinatal Centers (RPC) that have received at least one annual process evaluation

### Strategies

3.5.1. Collaborate with the Department of Community Health and RPCs to promote the use of RPCs among Level I and Level II care hospitals

3.6.1. Conduct at least one annual process evaluation to determine RPC compliance with level III care at each RPC

### ESMs

### Status

ESM 3.1 - 3.5.1. Percentage of birthing hospitals that are in compliance with neonatal level of care requirements

Inactive

ESM 3.2 - 3.6.1. Proportion of Regional Perinatal Centers that receive a process evaluation

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 3

### Priority Need

Decrease maternal substance use

### SPM

By 2020, decrease the rate of infants diagnosed with Neonatal Abstinence Syndrome (NAS) from 3.2 (per 1,000 live births) to 2.0.

### Objectives

4.1. By 2020, decrease the discharge rate of resident live births diagnosed as having neonatal abstinence syndrome (NAS) from 3.2 (per 1,000 live births) to 2.0

### Strategies

4.1.a. Educate health care providers (physicians, nurses) about NAS; includes educational classes for nurses, presentations to physicians & other health care providers who may come in contact with neonates

4.1.b. Educate pregnant women on the effects of unhealthy substance use

4.1.c. Establish a media campaign to increase community awareness of NAS

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

### Priority Need

Prevent infant mortality

### SPM

By 2020, decrease the rate of congenital syphilis from 13 (infants per 100,000 live births) to 11.7.

### Objectives

5.1. By 2020, decrease the rate of infants born w/congenital syphilis from 13.0 (per 100,000 live births) to 11.7

### Strategies

5.1.a. Ensure GC/CT/Syphilis/HIV are a part of routine screenings for women and men at targeted locations

5.1.b. Identify pregnancy status of all females identified as a new syphilis case

5.1.c. Ensure pregnant females with syphilis are adequately treated at least 30 days prior to delivery

5.1.d. Ensure disease investigation is conducted on all females ages 15-44 diagnosed with early syphilis

5.1.e. Education providers and the general public on the new law regarding 1st and 3rd trimester testing for syphilis and HIV (HB436)

## Perinatal/Infant Health - Plan for the Application Year

### Plan for the Coming Year: Oct 2017 – Sep 2018



*Priority Needs: Prevent infant mortality and Reduce maternal substance use*

NPMs: Breastfeeding and Perinatal Regionalization

SPMs: Congenital Syphilis and Neonatal Abstinence Syndrome (NAS)

Infant mortality is a priority for Georgia's Department of Public Health and many of MCH's stakeholders and partners. As a priority for many agencies and partners, it became important for Maternal and Child Health (MCH) staff to unify partners and create synergy around strategies to reduce infant mortality. Under the direction of Health Promotions Division Director, Lara Jacobson, MD, the MCH section developed a simple visual to link strategies to common primary drivers (primary causes of infant mortality). The diagram is being used by MCH staff, Department leaders and MCH partners to communicate the primary drivers and all of the efforts to reduce infant death in Georgia. Title V National Performance Measures are bolded on the Infant Mortality Primary Drivers' Diagram (Table 1).

Table 1: Georgia's Infant Mortality Primary Drivers' Diagram

Aims				
Reduce Preventable Infant Mortality in the State of Georgia				
				
Primary Drivers				
Maternal Factors	Birth Defects	Preterm Births	Neonatal Care	1 <sup>st</sup> Year of Life
				
Interventions				
PCM	Newborn Screening (genetic/CCHD)	Birth Spacing (LARCs and other contraceptives)	<b>Risk-appropriate care (RPC's, PLAT)</b>	Safe Sleep Program (Hospitals, EMS education)
<b>Well women (P4HB, HTN, obesity, BCCP)</b>	Zika Prevention	Centering Pregnancy (Baby Luv and PHP)	Banked breast milk (Reduces NEC)	<b>Breast Feeding (5-star, WIC peer counseling)</b>
Home Visiting	Birth Defect Monitoring	Dental care for pregnant women	Antenatal steroids	Immunizations
Maternal Nutrition (WIC)		Promotion of 17p		Injury Prevention
Maternal substance use (tobacco, drug abuse)				<b>NAS</b>



In the upcoming year, the MCH section plans to work with partners to improve and expand strategies on the primary drivers' diagram. An evaluation team has been identified to assist with evaluating strategies.

### Maternal Factors

#### *Perinatal Case Management (PCM)*

In the coming year, the Women's Health Program will target three counties among the six cluster highly rated infant mortality counties without a PCM program for expansion. The Women's Health Program will also assess the potential impact of PCM Programs on infant mortality. Training and education to the current PCM programs will continue.

#### *Planning for Healthy Babies (P4HB)*

P4HB is a family planning demonstration waiver program issued by the Georgia Department of Community Health (DCH) to assist the Department 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 maybe eligible under the expansion policy to receive family planning services, Inter-pregnancy Care (IPC), Case Management, and/or Resource Mother. The program is intended to bridge health care for underinsured and uninsured women of high need.

Women ages 18-44 who meet the monthly family-income are eligible for family planning services, and IPC which includes primary care, substance abuse treatment, case management, limited dental services, and prescription drugs to treat chronic disease. Women who previously gave birth to a VLBW and do not receive Medicaid or are losing Medicaid are eligible for IPC. In addition, women who do not receive Medicaid and did not have a VLBW are eligible for family planning services.

In the coming year, the Women's Health Program will collaborate with DCH and other partners to increase enrollment into P4HB.

#### *Maternal and Child Health Information and Resource Center*

In the coming year, 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 IPC of P4HB, hypertension, heart disease, obesity, and diabetes.

#### *Home Visiting*

A major service strategy within Department of Public Health (DPH) is the Maternal, Infant and Early Childhood Home Visiting Grant Program (MIECHV) initiative. The Maternal, Infant, and Early Childhood Home Visiting 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 is committed to implementing comprehensive, community-based maternal and early childhood system to include evidence-based home visiting (EBHV) programs, in twelve counties receiving MIECHV Program Formula funds.

The performance measures focus on the following critical areas: Pre-term Birth, Breastfeeding, Depression Screening, Well-child visits, Post-Partum Care, Safe Sleep, Child Injury , Child Maltreatment, Parent-child Interaction, Early Language and Literacy, Developmental Screenings, Behavioral Concerns, Intimate Partner Violence, Primary Caregiver education, Continuity of Insurance Coverage, Completed Depression Referrals, Completed Developmental Referrals, and Intimate Partner Violence Referrals.

To continue implementing Home Visiting and assist in the development of updated community plans, the Home Visiting Program will:

1. Explore the sustainability and expansion of EBHV programs;
2. Support sites to improve benchmark measures;
3. Maintain EBHV models (Head Start Home-Based Option, Healthy Families Georgia, Nurse Family Partnership and/or Parents as Teachers) in the at-risk communities selected for this program by September 30, 2018;
4. Maintain model fidelity for the EBHV models and work with other technical assistance (TA) providers by September 30, 2018;
5. Provide and coordinate EBHV model core training and subject matter expertise for dealing with serious family concerns such as maternal depression, domestic violence, substance abuse, and mental illness by September 30, 2018;
6. Assist program staff with data collection, data entry, and data reporting, meeting contract requirements, and

- working through quality improvement interests by September 30, 2018;
7. Provide training and technical assistance to counties in implementation of evidence-based home visiting models by September 30, 2018.

### Birth Defects

#### *Newborn Screening*

Georgia state legislature passed a bill to provide a pathway for parents to request Krabbe screening. In the coming year, the Newborn Screening Program will identify and implement the pathway for selective Krabbe screening and review Advisory Committee on Heritable Disorders in Newborns and Children (ACHDNC) recommended disorders, Pompe Disease, Mucopolysaccharidosis Type 1 (MPS 1), and X-linked Adrenoleukodystrophy (X-linked ALD).

#### *Zika Prevention*

The MCH section will continue to support the Zika Prevention Team in the preparation for zika response and prevention of perinatal zika infection.

### Preterm Births

#### *CenteringPregnancy*

The Women's Health Program submitted a March of Dimes Centering Pregnancy Proposal for \$45,000 for three years to provide education and training on the use of evidence-based group prenatal care models to public health providers and collaborative partners. In addition to training and education, the Women's Health Program will continue to support local public health districts in providing *CenteringPregnancy* options to at risk communities.

#### *Promotion of 17 alpha-hydroxyprogesterone caproate (17p)*

In the coming year, the Women's Health Program will partner with the Georgia Obstetrical and Gynecological Society (GOGS) to promote the use of 17p. Pregnant women who are carrying one fetus and have had a previous spontaneous premature birth before benefit from early and routine 17p injections. The widespread use of 17p is unknown but has potential for reducing Georgia's preterm birth rate.

### Neonatal Care

#### *Perinatal Regionalization*

In the coming year, the Women's Health Program intends to develop and implement targeted marketing strategies to increase awareness of the RPCs with the goal of increasing utilization and promote the use of PLAT, in Level I and Level II birthing hospitals in the southernmost region of the state, to quickly identify women presenting with preterm labor and initiate risk appropriate care (Numerator= # of Level I and Level II hospitals with PLAT; denominator = total # of Level I and II birthing hospitals south of Atlanta).

### 1<sup>st</sup> Year of Life

#### *Safe Sleep*

In the coming year, the Georgia Safe to Sleep Campaign's Hospital Initiative will continue to work with the participating birthing hospitals to meet all of the goals of the program. Recognition of hospitals who complete all aspects of the program will continue on a quarterly basis. Training and education will continue as needed and requested from hospital staff. The hospital program process evaluation will be completed by Oct. 2017 and work will begin to disseminate the information at conferences and, to other professionals and stakeholders. The program coordinator will also provide trainings to other professionals up to and including, home visitors, local health departments/WIC offices, first responders, social workers, and Doulas. Information on infant crying, shaken baby syndrome and, grief resources will also be provided. Additionally, the program coordinator is also assisting the Georgia Bureau of Investigation (GBI) in revitalizing the GA Safe Infant Sleep Coalition in order to pilot new ideas such as, a play yard donation program and a faith-based initiative.

### *Breastfeeding*

In the coming year, the Women's Health Program continues to support the 5-STAR hospital initiative in which the Department of Public Health (DPH) supports hospitals through completing the 10 steps to achieving Baby-Friendly designation. After completion, hospitals are able to pursue the Baby-Friendly designation if they so choose. DPH and the Georgia Hospital Association (GHA) will continue to recognize hospitals with a star for every two of the Ten Steps to Successful Breastfeeding that is implemented.

In addition to the 5-STAR Hospital Initiative, the Women's Health Program will also partner with the Georgia Chapter of American Academy of Pediatrics (GAAAP) to provide EPIC (Educating Physicians & Practices in their Communities) Programs; free peer-to-peer educational programs for Georgia's physicians, nurses, and office staff. Education is presented in the practice by a physician-led team of trained professionals. Participating physicians are offered CME credit hours and participating nurses received CEU contact hours. The EPIC Breastfeeding Program is also offered to physicians in hospitals and residency programs. The Program also provides information on evidence-based standards of how to encourage, promote and support breastfeeding. As well as information on how to access lactation and support services in the community and free resources for patient education.

### *Neonatal Abstinence Syndrome (NAS)*

In the coming year, the Women's Health Program plans to continue making improvements in hospital reporting, publish an inaugural report on NAS in Georgia, create additional resources (pamphlets, education/training, and web resources) for providers and the general public.

### *Congenital Syphilis*

In the coming year, the Sexually Transmitted Diseases (STD) Section will continue to promote 1<sup>st</sup> and 3<sup>rd</sup> trimester testing for HIV and syphilis, as well as improve the quality of data for congenital syphilis, and identify, confirm and treat patients with confirmed syphilis.

**Perinatal/Infant Health - Annual Report**  
**Reporting Year Oct 2015-Sept 2016**

*Priority Need: Prevent infant mortality*

NPM 3: Perinatal Regionalization

According to the Association of State and Territorial Health Officials (ASTHO), perinatal regionalization is a strategy to improve maternal and perinatal outcomes by establishing a network that supports patient transfers and increases the accessibility of perinatal specialty care. Perinatal regional systems assign hospitals a risk-appropriate level and support high-risk infants being born in facilities with higher levels of care. The Georgia Regional Perinatal Centers (RPC) are facilities selected by DPH to serve six geographical regions across the state to provide at minimum, subspecialty (Level III) services; which support the births of high-risk women and high-risk infants.

The RPCs provide comprehensive perinatal health services for pregnant women and neonates of all risk categories; consultation and/or medical transport for patients requiring subspecialty perinatal care; as well as outreach and educational support for regional hospitals. RPCs are integral to risk-appropriate care and as such contribute to the improvement of perinatal outcomes.

During the reporting year, the Women's Health Program within the Maternal and Child Health (MCH) Section piloted the use of the March of Dimes Prenatal Labor Assessment Toolkit (PLAT); an evidence-based tool used to standardize the assessment of preterm labor to facilitate prompt interventions to improve birth outcomes. PLAT guidelines allow medical professionals to make a determination on the diagnosis of preterm labor within 4 hours. Reducing the timeframe to determine whether a woman is in labor provides the medical professional with time to intervene accordingly; whether that is admission or transportation of the pregnant woman to a level III RPC. Five of 79 birthing hospitals with varying perinatal levels (levels I- III) participated in the PLAT pilot. Results from the pilot showed that after PLAT implementation all of the clinical indicators of care improved, and the average disposition time decreased by an hour to an average of 3.08 hours.

In addition to piloting PLAT, the RPCs collaboratively worked together to create a common data set with standardized definitions. Doing so allowed them to use common language to compare processes and outcomes across the system and assess collective goals.

NPM 4: Breastfeeding

The Georgia 5-STAR initiative was implemented to encourage hospitals to take steps toward becoming breastfeeding friendly and achieving the "Baby-Friendly" designation. Georgia 5-STAR recognizes hospitals with a star for every two of the Ten Steps to Successful Breastfeeding that is implemented. The Women's Health Program provides training and technical assistance to hospitals participating in Georgia 5-STAR.

During the reporting year, the Women's Health Program hired a full-time Project Director and Breastfeeding Coordinator to support the Georgia 5-STAR program and other breastfeeding initiatives. During this time, the Women's Health Program developed a 5-STAR advisory board (comprised of a "Baby-Friendly" hospital, public health district representative, WIC representative, and provider), created a comprehensive application and review process, and increased active enrollment in the program from 12 to 37 of the total 79 birthing centers statewide.

During the reporting year, the Women's Health Program provided quarterly DPH led workshops and Train-the-Trainer workshops to encourage new hospitals to join the Georgia 5-STAR program. Workshops provide an overview of the Ten Steps to Baby Friendly, the requirements for program participation and completion, and best practices and tools to train other staff and providers.

The Women's Health Program also partnered with the American Academy of Pediatrics – Georgia Chapter (GA-AAP) to provide the Educating Physicians in the Community (EPIC) breastfeeding training to providers statewide.

SPM 3: Congenital Syphilis

During the reporting year, the Sexually Transmitted Diseases (STD) Section promoted House Bill 436, the *Georgia HIV/Syphilis Pregnancy Screening Act* of 2015, to eliminate the requirement of counseling prior to testing pregnant women for HIV and syphilis and allow for refusal of testing during the 1<sup>st</sup> and 3<sup>rd</sup> trimester of pregnancy. The STD section collaborated with the Georgia Obstetrical and Gynecological Society to promote prenatal testing during the 1<sup>st</sup> and 3<sup>rd</sup> trimester.

## Other Programs

### *Newborn Screening*

The Georgia Public Health Lab (GPHL) and the Newborn Screening (NBS) Program routinely collaborate on the development of policies, procedures, budget, data exchange, quality assurance, program evaluation and education. The NBS Program within the MCH section provides training and education that supports the newborn screening system and follow-up services for all presumptive and diagnosed cases; in addition to coordinating the Georgia Newborn Screening and Genetics Advisory Committee (NBSAC).

Emory University, Augusta University, and Children's Healthcare of Atlanta are contracted to conduct follow-up of abnormal results. Each contractor utilizes a database to track newborns through diagnosis. The follow-up process utilizes protocols that have at least 12 steps to locating families and providers. The NBS Follow-up Coordinators completed Children 1<sup>st</sup> referrals on all diagnosed cases. These referrals are made to assess the newborn's eligibility for IDEA Part C Babies Can't Wait or Children's Medical Services. During the reporting year, contractors followed up on 5778 abnormal cases. Special formula and low-protein modified foods are provided to all children and young adults, particularly pregnant women with eligible metabolic disorders.

The program provides information on newborn screening to each parent in hospitals, doctor's offices and health departments prior to having a metabolic, critical congenital heart disease (CCHD) and hearing screen completed. NBS also trained and educated health care providers on NBS, specimen collection and NBS policies.

Each hospital has electronic access to their lab specimen reports in the state's database State Electronic Notifiable Disease Surveillance System (SendSS). The reports display a list of unsatisfactory blood spot screens and the cause of the unsatisfactory determination. The report also provides statistical measures of the hospital's comparative performance to other hospitals in the state. This report is used to monitor hospital performance and identify lab specimens needing to be repeated. Furthermore, the State NBS Clinical Coordinator provides technical assistance related to NBS specimen collection and submission to the Georgia Public Health Laboratory, to hospitals and birthing facilities through telephonic consultations and in-person visits.

MCH Epidemiology continues to analyze data on newborn screening results and link with electronic birth certificates in SendSS. The automatic patient matching rate increased by 4% during this time period due to improvements to the matching algorithm.

The Georgia Newborn Screening and Genetics Advisory Committee meets twice a year to discuss progress and issues relevant to the newborn screening community.

### *Perinatal Case Management*

Perinatal Case Management (PCM) is a voluntary program available to pregnant women who receive Medicaid services. PCM aims to improve perinatal outcomes by providing pregnant women with a case manager who identifies needs and resources. Perinatal case managers capture women who have received a positive pregnancy test in a health department and is placed on presumptive eligibility Medicaid. Perinatal case managers provide them with a list for Obstetricians, CMO's (Care Management Organization; such as Wellcare, Amerigroup, Peach State and Care Source), WIC services, and access to medical, nutritional, social, psychosocial, educational and other services. The perinatal case manager will assist the woman in locating Medicaid and community providers and making the necessary connections to the service needs identified in their individual plans. PCM helps expectant mothers achieve the best outcomes through linking her with resources unique to her needs. The expectant mother leaves with the knowledge of how to take care of her needs and her unborn babies' needs. PCM case managers are located in 88 of 159 local health departments across Georgia.

The DPH Strategic Plan (1.3.6) includes an objective to increase the number of local health departments providing PCM services to 104 by 2019. During the reporting year, the Women's Health Program assessed the feasibility of implementing PCM within local health departments that did not have a PCM program, developed standard operating procedures, and developed PCM training for case managers.

### *CenteringPregnancy*

The Georgia Department of Public Health partners with the *CenteringGeorgia* Coalition, March of Dimes of Georgia, public health districts and other stakeholders to promote group prenatal care, known as *CenteringPregnancy*. *CenteringPregnancy* brings together groups of 8-12 women of the same gestational ages to receive enhanced prenatal care in a group setting. Providing prenatal care in this way allows moms and providers to get to know each other on a much deeper and meaningful level in order to reduce health disparities. Members of the group form lasting friendships and are connected in ways not

possible in traditional prenatal care models.

Centering group prenatal care follows the recommended schedule of 10 prenatal visits, but each visit is 90 minutes to two hours long - giving women 10x more time with their provider. Moms engage in their care by taking their own weight and blood pressure and recording their own health data. They also have their own private time with their provider for a physical exam.

Women of different ages, races, and socio-economic backgrounds that are grouped together benefit from their differences and the shared common experience of pregnancy, birth, and family care. Many continue to receive family centered well-child care through the first two years with the *CenteringParenting* program.

MCH worked with the *CenteringGeorgia* coalition, Emory Rollins School of Public Health, and the Georgia State Health Policy Center to collect and analyze data from established *CenteringPregnancy* sites. MCH also participated in the Social Determinants of Health (SDOH) Collaborative Improvement and Innovation Network (CollIN) with the aim of promoting the *CenteringPregnancy* model of prenatal care to reduce health disparities for pregnant women throughout the state. During the reporting year, MCH and the *CenteringGeorgia* coalition (co-led by March of Dimes and United Way of Greater Atlanta) bridged discussions between Medicaid and the managed care organizations to explore funding for the centering model, including providing enhanced reimbursements for prenatal care providers.

#### *Safe Sleep*

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.

The Georgia Safe to Sleep campaign provides tools and resources that strengthen policy, provide consistent education, and change infant sleep environments to achieve four primary objectives:

- 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
- Disseminate accurate and consistent messages that empower families to make informed decisions about infant sleep
- Increase access to resources that support behaviors that protect infants from sleep-related deaths

As part of the Hospital Initiative, all participating birthing hospitals pledge to educate their staff as well as new parents and caregivers on proper infant sleeping practices, model safe infant sleep while infant is in the hospital and create policies on safe infant sleep following the American Academy Pediatrics recommendations. The hospitals were also provided several educational support resources for new parents. These included a supply of "This Side Up" infant gowns, "Sleep Baby Safe & Snug" board books for all families to take home and also, a supply of travel bassinets for our most at-risk families. Hospitals were also provided with various training resources for staff, assistance with crib audits, and mentoring on the safe infant sleep recommendations.

The Hospital Initiative has participation from all 79 birthing hospitals throughout the State of Georgia. As of October 2015, no hospitals were participating. In January 2016, recruitment of birthing hospitals began and by the official launch of the initiative in May 2016, all 79 birthing hospitals had pledged to participate.

As of September 2016:

- 100% of birthing hospitals had been recruited and provided a step by step guide, developed by the Georgia Safe to Sleep Campaign, on how to implement a hospital-based safe to sleep program. Goal achieved
- 100% of birthing hospitals received various educational resources for both staff and parents/caregivers. Goal achieved
- 5 out of 79 (6%) birthing hospitals had updated safe to sleep policies implemented
- 15 out of 79 (19%) birthing hospitals had submitted crib audits

No hospital were recognized for completing the program since all hospitals were still in process of implementation.

#### *Priority Need: Prevent maternal substance use*

##### SPM 4: Neonatal Abstinence Syndrome

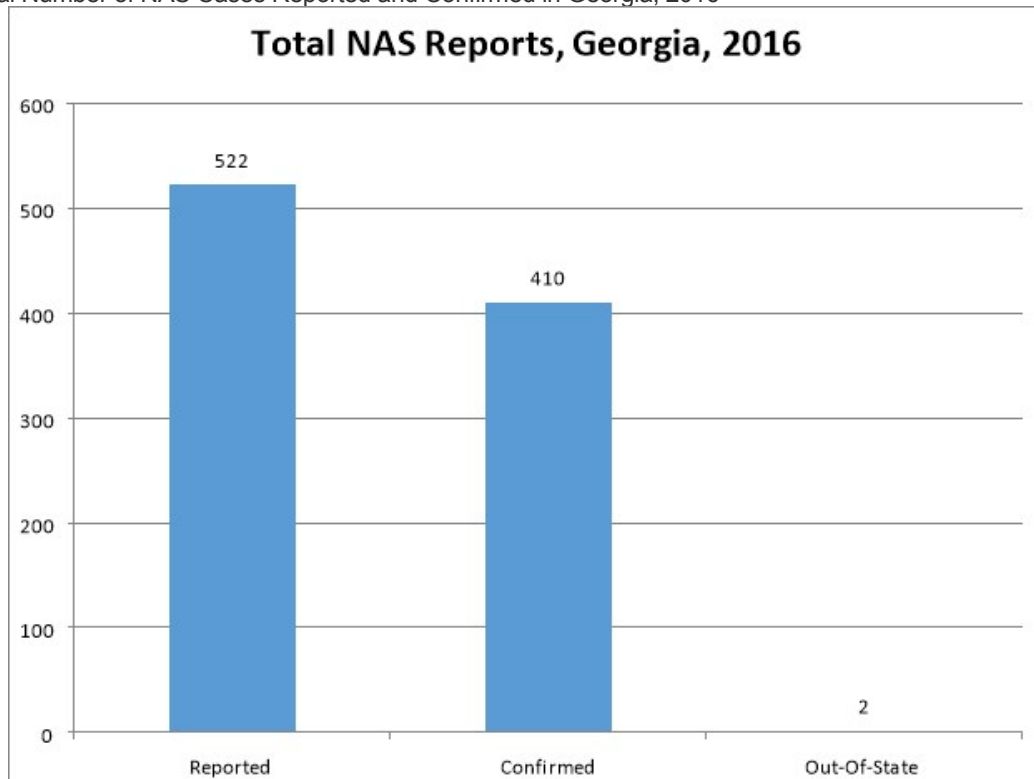
On January 1, 2016 Neonatal Abstinence Syndrome (NAS) was made a notifiable condition in Georgia. During the reporting



year, the Women's Health Program and Epidemiology Section have worked together to educate hospitals about the new requirements, monitor the progress of reporting, and assess the current status of NAS in Georgia. Georgia's NAS Surveillance system is a blend between a passive and active system. Case data is passively gathered through cases reported to the State Electronic Notifiable Disease Surveillance System (SendSS) and hospital discharge data. Cases are then verified by the NAS Coordinator by reviewing case variables, assigning a disposition and possibly verifying report information or requesting additional information. 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.

Between January 1<sup>st</sup> to December 31<sup>st</sup> of 2016 hospitals reported 522 cases of which 410 were confirmed as NAS cases (Graph 1).

Graph 1: Total Number of NAS Cases Reported and Confirmed in Georgia, 2016



Of the cases reported the most common substance found in positive drug screens is cannabis. Other opiates including, codeine, morphine, methadone, meperidine, propoxyphene, and other unspecified opiates are the second most commonly found substance.

During the reporting year, the Georgia Regional Perinatal Center educators educated clinicians and clinical professionals across the state on Neonatal Abstinence Syndrome and maternal substance use and misuse.

### Current Year Oct 2016-Sept 2017

*Priority Need: Prevent infant mortality*

#### NPM 3: Perinatal Regionalization

In the current year, the Perinatal Manager collaborated with hospitals and other community partners to expand PLAT and to make systemic changes to Georgia's perinatal system. Highlights of work completed this year include:

1. An additional five hospitals have implemented PLAT as their standard of care.
2. The creation of a specialized workgroup designed to revitalize the system of perinatal care in Georgia to include service delivery, data collection efforts and quality improvement initiatives.
3. The revision of the RPC Contract with DPH.
4. Increased communication with data, education and budget/financial personnel from each RPC to foster increased

collaboration and provide technical assistance in adherence to Contract guidelines.

#### NPM 4: Breastfeeding

In the current year, MCH hosted a 5-STAR Train-the-Trainer event in December 2016, and a 5-STAR overview workshop in March 2017. Future trainings are scheduled for June and September 2017. Additionally, MCH is planning to have a one-day statewide 5-STAR summit to celebrate the success of the program, recognize hospitals for their participation, and encourage enrollment from new birthing centers throughout the state.

MCH is also working to develop a comprehensive marketing strategy to promote Georgia 5-STAR statewide not only to hospitals and providers, but to expectant mothers also.

#### SPM 3: Congenital Syphilis

In the current year, the STD section continued to improve the quality of syphilis data by hiring an identified team member to focus on improving the accuracy and completeness of congenital syphilis data. In addition to improving data quality the STD section continued to promote 1<sup>st</sup> and 3<sup>rd</sup> trimester testing and identify, confirm and treat confirmed syphilis cases.

#### Other Programs

##### *Newborn Screening*

In the reporting year, the Newborn Screening (NBS) Program continuously assessed aspects of the NBS system and worked through improvements as well as, continued to educate parents and providers on NBS. The program generated a new hospital report to share key performance indicators related to newly added conditions, hearing and critical congenital heart disease (CCHD). Reports are generated on a monthly basis and accumulates over time.

Due to a lag in real-time data entry of hearing and CCHD screening results, the NBS Program hired a temporary FTE to manually enter the CCHD and Hearing data daily until the laboratory information system software upgrade is completed. The NBS program is currently working to reduce the number of unsatisfactory blood spots (unsats) as well. By identifying hospitals who submit unsats, notifying those submitters of their specimen collection performance and conducting site visits to offer technical assistance and training we are helping submitters improve specimen collection techniques. Webinars are also offered periodically for support.

As a result, the statewide unsatisfactory specimen rates for Q4 2016 was 3.59% and Q1 2017 was 3.22%. Our largest submitter, Northside Hospital (approx. 1500 births/month) had a rate of 0.76% for Q4 of 2016 and 0.53% for Q1 of 2017.

The program continues to provide education and resources to families and healthcare providers. A revised NBS brochure was created and distributed to birth hospitals and local health departments to educate parents and providers.

Pre-and post-natal screening education is given to families and healthcare providers including the importance of addressing positive results. Materials, such as the revised NBS brochure, are also distributed to parents in the hospitals, doctor's offices and health departments, prior to having a metabolic, critical congenital heart disease and/or hearing screen completed.

Information is disseminated via multiple communication methods, including the DPH website, newsletter articles, conferences, webinars and other training/professional development opportunities.

Through partnerships with our follow-up programs, such as Emory University, Augusta University and Children's Healthcare of Atlanta (CHOA), information and resources are provided to healthcare professionals and families of those who have confirmed disorders.

Provider education is completed in a variety of ways. The Georgia NBS Program contracts with professional organizations such as the Georgia Chapter of the American Academy of Pediatrics (AAP) to educate providers. In conjunction with Ga-AAP, the Early Hearing Detection and Intervention (EHDI) program and Augusta University gave webinars on 3/16/2017 and 5/25/2017, respectively, to educate providers on NBS practices. Telephone consultations and on-site in-services with birthing hospitals continue.

##### *Perinatal Case Management*

In the current year, MCH PCM staff continue to visit local health departments to explore opportunities to implement new PCM programs. State staff also continue to develop PCM SOPs, which will be used to train district perinatal case managers.



MCH PCM staff are also working with a HR contractor to develop a PCM curriculum to deliver to district perinatal case managers. PCM curriculum assessments will also be provided to district staff.

Some of the assessment, feasibility and quality improvement projects MCH PCM staff have begun include:

- Developing a table to compare percentage of Presumptive Eligibility (PE) Medicaid and PCM done in the 6 cluster county health departments with increased infant mortality rate
- Analyzing PCM enrollment by comparing district reported numbers with the numbers from DCH's Medicaid monthly reports
- Implementing a reporting tool for tracking PE/PCM numbers within the district for monthly submission
- Conducting QA/QI reviews on PCM Care Plan
- Conducting QA/QI reviews on Reproductive Life Plan (RLP)
- Collaborating with CMO's, Medicaid Partnership and District in relationship building

#### *CenteringPregnancy*

In Feb. 2017, MCH applied for funding from the March of Dimes to begin offering Centering training to public health providers throughout the state, beginning the expansion of Centering within Georgia's public health districts. If awarded funding, training for providers will start next quarter.

#### *Safe Sleep*

In the current year, all 79 birthing hospitals throughout the State of Georgia are participating in the Safe Sleep Hospital Initiative. Hospitals continue to develop and implement their programs. DPH continues recognition of hospitals that complete all aspects of the program (staff education, crib audits, policy and patient education) and will continue to on a quarterly basis.

To date:

- 24 hospitals (30.4%) have completed all portions of the safe to sleep hospital program and received recognition on February 2017
- 54 hospitals (69%) have provided data on crib audits
- 40 hospitals (51%) have provided their updated policies on safe infant sleep
- 79 hospitals (100%) participated in an in-person process evaluation visit
- 79 hospitals (100%) have provided education to their staff on safe infant sleep recommendations
- 79 hospitals (100%) distributed to families with recently born infants materials on safe infant sleep including the hospital "this side up" gown, safe sleep book and other materials

#### *Priority Need: Prevent maternal substance use*

##### SPM 4: Neonatal Abstinence Syndrome

In the reporting year, Women's Health Program staff continued to partner with the Epidemiology section to improve NAS reporting and education.

## Child Health

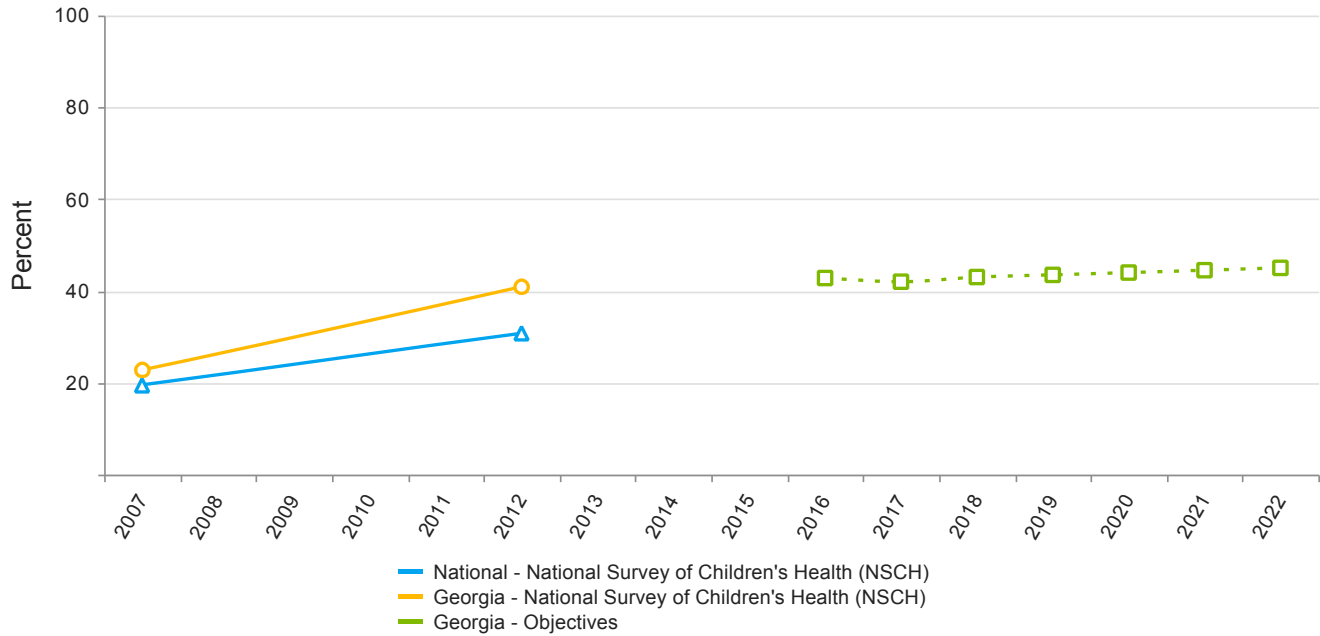
### Linked National Outcome Measures

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	NPM 6
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	85.3 %	NPM 6 NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	NSCH-2011_2012	35.0 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	WIC-2014	28.2 %	NPM 8
NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)	YRBSS-2013	29.8 %	NPM 8

## National Performance Measures

### NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

#### Baseline Indicators and Annual Objectives



#### Federally Available Data

##### Data Source: National Survey of Children's Health (NSCH)

	2016
Annual Objective	42.8
Annual Indicator	40.8
Numerator	257,898
Denominator	632,599
Data Source	NSCH
Data Source Year	2011_2012

#### Annual Objectives

	2017	2018	2019	2020	2021	2022
Annual Objective	42.0	43.0	43.5	44.0	44.5	45.0

## Evidence-Based or –Informed Strategy Measures

### ESM 6.1 - 6.1.1. Percentage of public health districts using at least two developmental screening methods regularly

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

State Provided Data	
	2016
Annual Objective	
Annual Indicator	44.4
Numerator	8
Denominator	18
Data Source	Children 1st Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	40.0	60.0	80.0	100.0	100.0

**ESM 6.2 - 6.1.2. Number of partners reporting utilization of developmental screening tools**

<b>Measure Status:</b>	<b>Inactive - This measure is being deleted due to the challenges in assessing utilization of developmental screening tools among partners</b>
------------------------	--

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Children 1st Program Data
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	5.0	10.0	15.0	20.0	23.0

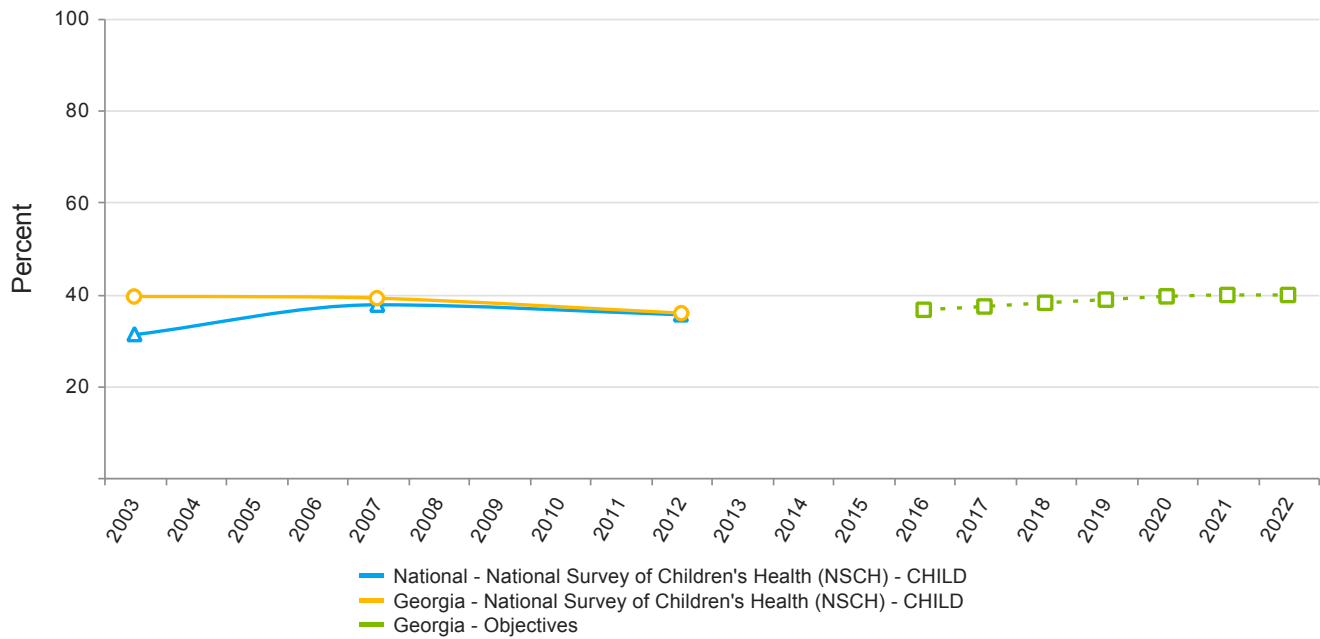
**ESM 6.3 - 6.2.1. Number of formal training opportunities on developmental screening conducted in each public health district health districts each year**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	9
Numerator	
Denominator	
Data Source	Children 1st Program Data
Data Source Year	FFY 2017
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	2.0	14.0	26.0	30.0	36.0	38.0

**NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day**  
**Baseline Indicators and Annual Objectives**



**NPM 8 - Child Health**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2016
Annual Objective	36.6
Annual Indicator	35.9
Numerator	309,751
Denominator	863,401
Data Source	NSCH-CHILD
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	37.3	38.1	38.8	39.5	39.8	39.8

**Evidence-Based or –Informed Strategy Measures****ESM 8.1 - 7.1.1. Average HFZ measure (aerobic capacity) among students in grades 4-12**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	50.1
Numerator	379,706
Denominator	757,811
Data Source	DOE Fitnessgram
Data Source Year	2016-2017
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	56.0	57.0	58.0	59.0	60.0	61.0



## State Action Plan Table

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

#### Priority Need

Promote developmental screenings among children

#### NPM

Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool

#### Objectives

- 6.1. By 2020, increase the number of partner agencies who are trained on developmental screening tools in the 18 public health districts from 0 to 20
- 6.2. By 2020, increase the number of early childhood providers in the 18 public health districts, from 0 to 20, who disseminate educational resources about developmental milestones and developmental screening to families.

#### Strategies

- 6.1.a. Convene a work group to recommend new, innovative, and effective screening methods (ie. phone, web-based, telephonic)
- 6.1.b. Identify two new partners per district who are able to administer developmental screens
- 6.1.c. Use a Train the Trainer model to train newly identified partners in each district on developmental screening tools
- 6.2.a. Partner with the Georgia American Academy of Pediatricians to disseminate educational resources to pediatric providers
- 6.2.b. Train public health district staff on developmental milestones and counseling skills to encourage parents to receive a formal developmental screen
- 6.2.c. Collaborate with early childhood stakeholders to disseminate Learn The Signs. Act Early, information to parents, to increase awareness of developmental milestones
- 6.2.d. Implement an evidence-informed child health information and referral system, to promote population developmental screening and referral for at-risk children
- 6.2.e. Collaborate with the Department of Family and Children Services, Women's Infants and Toddler, and Part C to disseminate information and provide training on monitoring developmental milestones.

ESMs	Status
ESM 6.1 - 6.1.1. Percentage of public health districts using at least two developmental screening methods regularly	Active
ESM 6.2 - 6.1.2. Number of partners reporting utilization of developmental screening tools	Inactive
ESM 6.3 - 6.2.1. Number of formal training opportunities on developmental screening conducted in each public health district health districts each year	Active

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

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

### Priority Need

Promote physical activity among children

### NPM

Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day

### Objectives

- 7.1. By 2020, improve Aerobic Capacity (AC) HFZ measure for students in grades 4-12 by 1% each year for 4 years.
- 7.2. By 2020, increase the number of Quality Rated Early Care and Learning Centers that are Shape awarded by 100%
- 7.3. By 2020, increase Georgia's student population assessed via Fitnessgram assessment
- 7.4. By 2020, improve the Body Mass Index (BMI) HFZ measure for students in grades 1-12 by 1% each year for 4 years.
- 7.5 By 2019, ensure 63% of males and 49% of females are inside the HFZ measure for AC
- 7.6 By 2019, 64% of Georgia's Students will fall inside the HFZ for BMI

## Strategies

7.1.a. Implement and build sustainability for the Power Up for 30 (PU30) program that trains elementary school educators how to incorporate an extra 30 minutes of physical activity into the day (in addition to quality physical education class)

7.1.b. Pilot a Middle School PU30 program in at least 5 middle schools

7.1.c. Pilot a Pre-service teacher certificate program that trains educators to incorporate physical activity into the school day

7.1.d. Train at least 300 after school providers with PU30 program to incorporate physical activity into after school programs

7.1.e. Award at least 50 schools through the Georgia Shape Grantee program to increase physical activity and healthy nutrition efforts at the school level with mini grants and expert technical assistance

7.2.a. Collaborate with Department of Early Care and Learning (DECAL) to award at least 75 additional early learning centers that adhere to the 14 Quality Rated Nutrition and Physical Activity assessment items, whereby receiving the Quality Rated Georgia Shape recognition award

7.2.b. Collaborate with DECAL to train at least 50 early learning centers with the Growing Fit Kit curriculum, whereby guiding centers to create physical activity and healthy nutrition policy at the local level

7.3.a. Collaborate with Department of Education to increase the number of students that receive the Fitnessgram assessment through physical educator teacher training, afterschool provider training, and in-service teacher training(s)

7.4.a. All strategies listed above are in place to support this measure

## ESMs

## Status

ESM 8.1 - 7.1.1. Average HFZ measure (aerobic capacity) among students in grades 4-12

Active

## NOMs

NOM 19 - Percent of children in excellent or very good health

NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)

## **Child Health - Plan for the Application Year**

### **Plan for the Application Year**

*Priority Need: Promote developmental screenings among children*

#### NPM 6: Developmental screening for children

Developmental screening was identified as a priority need for Georgia in 2015. This priority need will be addressed through promoting developmental screenings, and increasing opportunities for developmental screening (state action plan 6.1-6.2).

Children 1<sup>st</sup> (C1<sup>st</sup>), the single point of entry for at risk children, connects children and their families with public health programs and services, and other prevention based programs and services. Children 1<sup>st</sup> aims to identify all children birth to five who are at risk for poor health and development. C1<sup>st</sup> is available in every county in Georgia and its system includes partnerships with Department of Community Health (DCH), Department of Education (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. The five core functions of Children 1st are as follows: (1) Identification of all births in Georgia; (2) Screening of all births and referrals of children up to age five; (3) Assessment of children and families at risk for poor health and developmental outcomes; (4) Referral/linkage of children and families with risk conditions to early intervention programs and appropriate community resources; and (5) Monitoring of individual children who are not eligible for early intervention programs. Developmental screening is a primary tool utilized by C1<sup>st</sup> to identify children who, without early intervention, are at risk for poor developmental outcomes.

In the coming year, C1<sup>st</sup> will be exploring strategies to reach larger audiences of professionals with educational videos about developmental screening and the services offered through the Department of Public Health. These videos could also be marketed to professionals within Georgia's birthing hospitals and those conducting child birthing classes and other stakeholders reaching parents and children.

In addition to spreading the message of developmental screening and the public health services, Children 1<sup>st</sup> is developing a plan to assess the feasibility of offering the Ages and Stages Questionnaires through a web based platform.

Newborn hearing screening is screening for hearing loss. All babies should be screened for hearing loss before 1 month of age. The screening is typically done before the baby leaves the birthing facility.

*Priority Need: Promote physical activity among children*

#### **NPM 8: Physical Activity for children and adolescents**

Georgia Shape is a network of partners, agencies and athletic teams; including the Atlanta Falcons and the Atlanta Braves, the Georgia Department of Public Health, and the Georgia Department of Education, all committed to improving the health of Georgia's young people by offering assistance and opportunity to achieve a greater level of overall fitness.

Georgia Shape begins with a basic, benchmark measurement of fitness among our students called fitnessgram. The fitnessgram tool used for Shape's annual standardized fitness assessment evaluates five different parts of health-related fitness, including aerobic capacity, muscular strength, muscular endurance, flexibility and body composition using objective criteria. It also generates reports providing valuable individual, school, and state-level data to empower parents, schools, and the community to best access the current health needs for children in Georgia. The report is delivered confidentially to families and aggregate results are reported to create a true "snapshot" and highlight areas for improvement.

In the coming year, Georgia Shape will continue to work with partners (currently have 120) to decrease childhood BMI measures while increasing childhood aerobic capacity measures and physical activity levels.

#### Other Programs

##### *Early Hearing Detection and Intervention (EHDI)*

For the application year, the EHDI program plans to train a larger group of early hearing specialists on the updated Early Hearing Orientation Specialist (EHOS) protocol in October of 2017. The program also plans to renew contracts with Georgia PINES (Parent Infant Network for Educational Services) and the Auditory Verbal Center, Inc. and will continue to

engage parents and stakeholders in on-going evaluation and improvement of the EHDI program. The standard operating procedure manual for the EHDI program will be revised and distributed. The program will also evaluate, improve, and expand the tele-audiology capabilities in the state to serve more of Georgia's rural counties. The EHDI program will encourage new and innovative quality improvement projects within the districts to continue to reduce the rate of loss to follow up and improve timeliness of diagnosis and referral to early intervention. Findings from these projects will help to shape the ever-improving process used by the program to serve the children of Georgia.

#### *100 Babies Project*

Georgia's 100 Babies Project is a shared project between Georgia Department of Public Health (DPH), Georgia Pathway to Language and Literacy and Georgia Department of Education (DOE). The goal of the 100 Babies Project is that by 2020 all children in Georgia who are deaf and hard of hearing (D/HH) have a Birth to Literacy Plan. The Birth to Literacy Plan will include everything that must happen to be reading on grade level by third grade regardless language (spoken or American Sign Language).

In the application year, 100 Babies Project will continue to enroll new families into the 100 Babies Project, and to monitor early intervention enrollment and language assessments, there are plans to expand on the projects mentioned above. After reviewing qualitative and quantitative data from the pilot Early Hearing Operations Specialist (EHOS) group, the rest of the specialists in the state will be trained in the new visit format, and the results will be evaluated to determine what impact has been made in the time to early intervention enrollment and parent satisfaction. Also, the reporting portal that is currently being used by Audiologists will be expanded to Early Interventionists to document enrollment data and language assessments.

#### *Maternal, Infant, and Early Childhood Home Visiting (MIECHV)*

MIECHV is a key strategy in improving outcomes for children. In the coming year, MIECHV will continue to support child health screening and intervention programs as well as strengthen and expand the existing home visiting programs.

#### *Project LAUNCH (Linking Actions for Unmet Needs in Children's Health)*

In September 2014, the Georgia Department of Public Health (DPH) was awarded Project LAUNCH, Linking Actions for Unmet Needs in Children's Health. This five-year federal initiative from the Substance Abuse and Mental Health Administration, aligns with DPH's goals by helping to ensure the social, emotional, and behavioral health among children birth to age eight and to promote safe, supportive and nurturing families. Project LAUNCH Georgia is currently being piloted in Muscogee County and will allow for collaborative efforts among child serving agencies at the state and local level to increase screening, assessment and referrals to increase early identification of mental, behavioral and/or developmental concerns in young children.

In the application year, Project Launch plans to:

- Explore the use of telemedicine to address local needs and create points of access for children and families.
- Integrate mental, behavioral, and developmental screening into primary care practices for children ages 0-8.
- Increase the capacity of providers in Muscogee County who serve young children in providing integrated and comprehensive behavioral health services to all children using culturally relevant and evidenced based prevention methods.
- Build capacity and skill set in early childhood mental, behavioral and developmental health providers in Muscogee County.

#### *Help Me Grow (HMG)*

In the coming year, HMG-GA staff will work closely with the support and technical assistance from the National Center to conclude the workgroup's preliminary efforts in the areas of the four main components; centralized telephone access, community and family outreach, child health care provider outreach, and data collection and evaluation. As a result of ongoing collaboration and readiness assessment responses among the various workgroups, National will devise the initial/working/final drafts of the strategic plan for the installation and implementation of *Help Me Grow*. The plan is expected to include site-specific recommendations documenting a realistic, sequenced pathway, with proposed timeline, to full HMG replication. A process evaluation is expected to be conducted by HMG National, along with post-survey. DPH will continue to replicate the QI process across the next third of the districts, until the final third of the districts is completed. Finally, Help Me Grow National will provide a sustainability plan, in addition to technical assistance and support throughout the contract end date, set to be March 2018.

### *Immunizations*

DPH's Georgia Immunization Program (GIP) seeks to increase immunization rates for all Georgians and decrease the incidence of vaccine-preventable diseases.

Vaccine-preventable disease levels are at or near record lows. Even though most infants and toddlers have received all recommended vaccines by age 2, many under-immunized children remain, leaving the potential for outbreaks of disease. Many adolescents and adults are under-immunized as well, missing opportunities to protect themselves against diseases such as Hepatitis B, influenza, and pneumococcal disease.

GIP will continue to educate medical providers through partnerships and collaborations about the importance of protecting their patient population from vaccine preventable diseases, utilizing the recommended Advisory Committee for Immunization Practices (ACIP) immunization schedule. This activity has a specific target population of immunizing physicians with a pediatric patient population.

GIP will also continue to educate medical providers and laboratories about the importance of disease reporting, with a specific target population of prenatal care providers in an effort to increase the number of hepatitis B virus (HBV)-positive pregnant women identified in birth cohort 2017 by 3%, over the total from birth cohort 2016.

## Child Health - Annual Report

### Reporting Year Oct 2015-Sept 2016

*Priority Need: Promote developmental screenings among children*

#### NPM 6: Developmental screening for children

There are several agencies that support the development, health and well-being of children in the state of Georgia; not limited to: the Department of Public Health (DPH), Department of Community Health (DCH), Department of Education (DOE), Department of Early Care and Learning (DECAL), and the Division of Family and Children Services (DFCS). Each agency supports developmental screening as a key indicator for healthy well children. DPH administers a population-based screening and referral system known as the front-door for early intervention for children.

Children 1<sup>st</sup> (C1<sup>st</sup>), the single point of entry for at risk children, connects children and their families with public health programs and services, and other prevention based programs and services. Children 1<sup>st</sup> aims to identify all children birth to five who are at risk for poor health and development. C1<sup>st</sup> is available in every county in Georgia and its system includes partnerships with DCH, DOE, DECAL, DFCS, primary care and specialty physicians, and DPH home visiting programs. The five core functions of Children 1st are as follows: (1) Identification of all births in Georgia; (2) Screening of all births and referrals of children up to age five; (3) Assessment of children and families at risk for poor health and developmental outcomes; (4) Referral/linkage of children and families with risk conditions to early intervention programs and appropriate community resources; and (5) Monitoring of individual children who are not eligible for early intervention programs.

Developmental screening is a primary tool utilized by Children 1<sup>st</sup> to identify children who, without early intervention, are at risk for poor developmental outcomes.

The MCH section recognizes the importance of parental developmental monitoring and developmental screening. The Title V state action plan includes strategies to promote parental developmental monitoring and developmental screening. During the reporting year, C1<sup>st</sup> promoted developmental screening by distributing over 1,500 pieces of literature at Back-to-School events and community health fairs between July and August 2016. The Autism and Developmental Disabilities program, within the MCH section distributed the Learn the Signs. Act Early materials to the Babies Can't Wait (BCW) program and to the Women, Infants and Children (WIC) program in six public health districts. BCW Service Coordinators, who work closely with families of children with developmental delay, are encouraged to use those materials to promote consistent use of developmental monitoring tools for parents of children enrolling in BCW. WIC will use the materials to encourage developmental monitoring and referral to early intervention programs if needed.

Between July 2015 and June 2016, The Autism and Developmental Disabilities team, within the MCH section, trained over 40 DFCS caseworkers and 105 parents on developmental monitoring. The Early Detection of Developmental Delays & Disabilities training covered strategies for identifying developmental delay, resources to address suspected developmental delay and tools to help monitor development. Providers received developmental milestone materials, including Learn the Signs. Act Early milestone booklet and brochure/tracker.

In July of 2016, four DPH staff representing Babies Can't Wait (BCW), C1<sup>st</sup>, and Children's Medical Services (CMS) programs attended an Ages and Stages Questionnaire – 3 (ASQ:3) and ASQ, Social and Emotional – 2 (ASQ:SE2) training organized by Project Launch. In addition, to state staff, district representatives from six public health districts including Macon, Valdosta, Cobb/Douglass, Rome, Albany and Columbus attended the training which utilized the train the trainer model. Additional partners who represented Columbus Regional Pediatrics, Childcare Resources and Referral of Southwest Georgia, Early Head Start, and Head Start attended the training as well. This training helped springboard more than thirteen (13) trainings on developmental screenings between July 2016 and September 2016. Over 90 participants representing various district and county health department staff around the state attended these trainings.

The MCH section partners with the Georgia Chapter of the American Academy of Pediatrics (GA AAP) to promote developmental screening in private practice and increase referrals to early intervention programs within public health. During the reporting year, GA AAP coordinated a Bright Futures Quality Improvement cohort of 11 pediatric practices that worked on strategies to adhere to the periodicity schedule for 9 and 24 months' visits. The periodicity schedule is a schedule of screenings and assessments recommended at each well-child visit from infancy through adolescence. This schedule recommends general developmental screening at 9 months of age and autism specific screening at 24 months of age. As a result of the cohort, developmental screening was done 98% of the time and autism specific screening at 24 months was done at an average of 96% of the time during the last five cycles of the quality improvement programs. Children who screened with concerns received follow-up assessments and intervention services 100% of the time.

*Priority Need: Promote physical activity among children*



#### NPM 8: Physical Activity for children and adolescents

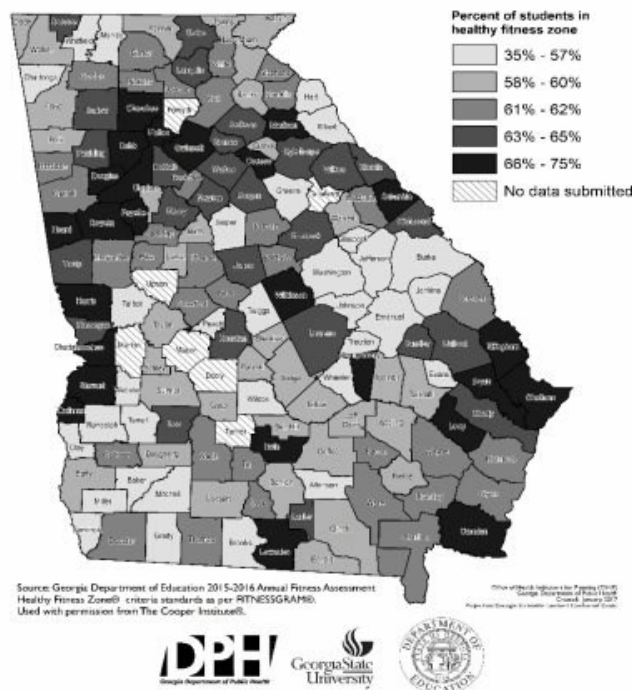
Georgia Shape is the Governor's statewide, multi-agency and multi-dimensional initiative that brings together governmental, philanthropic, academic and business communities to address childhood (0-18) obesity in Georgia. The overall goal of the initiative is to improve the health of young people in Georgia by offering assistance, and the opportunity to achieve a greater level of overall fitness while decreasing childhood obesity measures.

Beginning in 2012, Georgia Shape started collecting data from over one million public school students via the Fitnessgram\* fitness assessment. The results were alarming, over 41% of students were outside the Healthy Fitness Zone (HFZ) for Body Mass index (or at an unhealthy weight). Recent data suggest we are improving at the state (or population) level. Data from the 2015-2016 school year show that currently 39.7% of males and 39.8% of females were outside the HFZ for BMI (Figure1).

The improvements in BMI are possibly due to the integrative relationship DPH built with the Georgia Department of Education (DOE), HealthMPowers (a technical assistance non-profit organization), and the Cooper Institute.

Figure 1: Geographical distribution of students in healthy fitness zones by county from 2015-2016

#### **Students in Healthy Fitness Zone by Georgia County, 2015-2016 Georgia Department of Education, Annual Fitness Assessment**



Power Up for 30 (PU30) is a statewide program that trains educators to effectively integrate 30 minutes of daily physical activity for every student throughout the school day in addition to strengthening physical education. This program provides training, technical assistance, resources, and ideas for additional physical activity before, during, and after school in a way that adapts to each school's needs. Pilot data suggest that this program significantly improved Aerobic Capacity and BMI measures across one school year.

In 2015-2016 Georgia Shape continued our elementary school training and trained approximately 50 more schools, making our total elementary schools engaged to 881 schools. In addition, Georgia Shape has expanded the program to middle schools and began working with 7 pilot PU30 middle schools.

Georgia Shape's program staff also continued the PU30 out of school time training and trained 208 afterschool providers through our ongoing partnership with HealthMPowers and the Department of Family and Child Services.

Program staff worked closely with the University of West Georgia to create a pre-service PU30 teacher training certificate

program. This program allows pre-service early childhood educators and pre-service physical educators to learn how to increase physical activity levels in their future classrooms, as well as how to teach peer teachers how to implement. This provides Georgia with motivated young teachers increasing physical activity levels in their classrooms and schools, while also providing the students with additional experience on their resumes. This certificate program shows up on their actual college transcripts as well.

The Georgia Shape Grantee program is a technical assistance based program that provides schools (elementary, middle and high) with expert technical assistance and advisement in planning and implementing wellness policy and programming to their school in a way that fits their wants and needs. In 2015-2016 we awarded 26 schools with mini-grants and TA. We also evaluated past grantees and found that almost 90% of the schools were able to sustain efforts after funding ended.

In 2015-2016 Georgia Shape partnered with Children's Healthcare of Atlanta to train approximately 1,000 school cafeteria staff how to effectively re-design cafeterias and communicate with students how to make healthier choices. This work is based off of the Smarter Lunchroom Initiative out of Cornell University. To date we have trained over 3,300 school lunchroom staff.

Georgia Shape staff continued efforts to recognize groups that are excelling in child health and wellness efforts. In 2015-2016 we awarded 217 K-12 schools for excelling in physical activity best practices through our Governor's Shape Award.

DPH's Georgia Shape Early Care Environment (ECE) recognition grew by about 35 centers, now totaling 111 ECE's statewide that excel in physical activity and nutrition best practices. This is through our partnership with the Quality Rated program (and assessment) at the Georgia Department of Early Care and Learning.

Farm to School efforts also grew in the 2015-2016 school year. The program's Golden Radish Recognition was awarded to 30 school districts for excelling in Farm to School efforts. This program is a partnership through the Departments of Agriculture, Education and the Governor's office, as well as Georgia Organics (a technical assistance provider).

## Other Programs

### *Brain Trust for Babies*

The DPH has convened a public-private partnership called the Brain Trust for Babies—a multi-disciplinary statewide collaborative with a special emphasis on early brain development and language acquisition in children ages 0-3. Members of the partnership include the Georgia Department of Public Health, the Georgia Department of Education, the Marcus Autism Center, Children's Healthcare of Atlanta, Emory University, the Georgia Hospital Association, the Georgia Department of Early Care and Learning, and the Atlanta Speech School, the Georgia Department of Community Health, the American Academy of Pediatrics Georgia Chapter, the Georgia Early Education Alliance for Ready Students, the Georgia Department of Family and Children Services, La Amistad, Voices for Georgia's Children, the Georgia Family Connection Partnership, and Morehouse School of Medicine. One program supported by the Brain Trust is Talk With Me Baby. Talk With Me Baby 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 intends to identify at least three high-impact workforces that support new and expectant families with the goal of reaching and training at least 1,000 professionals by 2020.

Other goals of the Brain Trust: Ensure that all children who are deaf or hard of hearing are on a path to 3 grade reading by ensuring screening of hearing loss by 1 month, diagnosis by 3 months, and appropriate intervention by 6 months. Achieve breakthrough outcomes for all children by building the self-regulation skills, executive functions and social-emotional health of the adults who care for them. Ensure that children in Georgia are screened for Autism and Developmental Delays by 36 months and connected to appropriate intervention.

### *Early Hearing Detection and Intervention (EHDI)-Newborn Screening*

The Georgia Newborn Screening (NBS) Program is a six-part preventive health care system designed to identify and provide early treatment for 31 selected inherited disorders that otherwise would cause significant morbidity or death. 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. Includes consideration of adding other tests to the system as indicated by appropriate research and scientific evidence.

The Georgia Newborn Screening Program ensures that every newborn in Georgia is screened for 31 heritable disorders for prompt identification and treatment.

The program is responsible for the following:

1. Administration of the newborn screening system, including the oversight of follow-up programs.
2. Monitoring and evaluating newborn screening practices.
3. Managing electronic data surveillance and tracking system, including maintenance of long term results.
4. Facilitating communication between practitioners, birth hospitals, the laboratory personnel, and the follow-up teams.
5. Providing ongoing education for practitioners.
6. Reporting results to state and federal officials and to the public.

Newborn hearing screening, known as the Early Hearing Detection and Intervention Program (EHDI), is a multi-partner screening and intervention system for hearing loss. Along with the Newborn Metabolic Screening Program and Children 1st, the EHDI Program maintains and supports a comprehensive, coordinated, statewide screening and referral system. EHDI includes screening for hearing loss in the birthing hospital; referral of those who do not pass the hospital screening for rescreening; for newborns who do not pass the rescreening referral for diagnostic audiological evaluation; and, linkage to appropriate intervention for those babies diagnosed with hearing loss. Technical assistance and training about implementing and maintaining a quality newborn hearing screening program is provided to hospitals, primary care physicians, audiologists, early interventionists, and public health staff.

The most crucial period for language development is the first year of life. Without newborn screening, hearing loss is typically not identified until two years of age. Screening for 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, communication, educational and reading potential to be maximized.

During the reporting year, the EHDI program completed a systematic evaluation on early intervention services for Deaf and hard of hearing (DHH) children in Georgia; evaluation outcomes will assist in developing quality improvement strategies related to referral to and enrollment in early intervention. The program began collecting data during a quality improvement project focused on text messaging for non-responsive families in three health districts. Findings suggest families are more responsive and likely to follow up after receiving a text message. The findings from the project were presented at the National EHDI Conference and the EHDI program plans to incorporate texting into the standard follow-up protocol for all families. Additionally, the EHDI Program Coordinator presented with parent leaders at the 2016 national EHDI conference in San Diego, California on improving strategies for reaching unresponsive families. During this period, a pilot study of “drop-by” visits was initiated, and on-going data collection was completed to evaluate the effectiveness of unannounced home visits for families. The EHDI program continues to work on a long term follow up study and evaluation (100 Babies Project), which looks at long-term language outcomes of D/HH children in Georgia.

#### *100 Babies Project*

The 100 Babies project is a collaborative effort between the Department of Public Health, the Department of Education, and Georgia Pathway to Language and Literacy. This long-term evaluation project works to ensure that all babies born after January 1, 2014 who are identified with permanent hearing loss, bilateral or unilateral, have a birth-to-literacy plan. After a child enrolls in the evaluation, the Department of Public Health gathers audiological information, access to and enrollment in early intervention, on-going language assessments and family survey information. This data helps to inform partner organizations and stakeholders of strengths and challenges within the state in order to get all of Georgia’s children reading well by third grade.

An evaluation conducted with data gathered for babies born after January 1, 2014 identified factors that influence language development of D/HH children identified through newborn screening, including maternal and social factors, age of intervention, intensity of intervention and home language. Results from the evaluation are being used to develop and implement strategies so that newborns and infants identified as D/HH do not fall behind their hearing peers.

DPH collects the following from birth through third grade:

- Audiological information (hearing aids, cochlear implant, etc.)
- Access and enrollment of intervention services

- Language assessments
- Family survey (collected annually)

#### *Vision Screening*

The Child Health Screening Unit in cooperation with the Board of Education provide and monitor vision screening training for children three years of age and older. All vision screening staff within local health departments require certification prior to screening children and recertification occurring every two years. The recertification process includes a didactic online training with required successful completion of a post-test as well as and completion of vision screening procedures validation form by a current screener. All children are required to have vision screening completed, documented on Georgia state form 3300 and presented to school prior to entering the first grade. During the reporting year, the Child Health Screening Unit began providing support for certifying health department screeners.

#### *Help Me Grow*

*Help Me Grow* is a unique, comprehensive, and integrated statewide system designed to address the need for early identification of children at risk for developmental and/or behavioral problems, and then linkage to developmental and behavioral services and supports for children and their families. Engaging over 25 states and 50 different regions across the nation, *Help Me Grow* has achieved national attention for its integration of four essential components within its model: a centralized access point, child health provider and family/community outreach, data collection and data analysis. The MCH section has signed up to adapt the *Help Me Grow* framework into Georgia's existing early identification and referral system, Children 1<sup>st</sup>.

Late 2015, the state of Georgia expressed interest and initiated engagement with the *Help Me Grow* National Partnership (Connecticut Children's Medical Center) to support the eventual implementation of the *Help Me Grow* model. Georgia became one of 25 *Help Me Grow* Affiliate states. With strong support from DPH Executive Leadership, a group of stakeholders – representing different early childhood sectors – engaged in a comprehensive site visit with the *Help Me Grow* National Partnership. This site visit helped identify the current state of Georgia's early care network system, existing opportunities for successful program implementation, and stakeholder readiness for collective impact. This site visit informed recommendations for state implementation of the *Help Me Grow* model in Georgia (via *HMG Site Visit Report*).

#### *Maternal, Infant, and Early Childhood Home Visiting (MIECHV)*

Georgia continues its commitment to implement comprehensive, community-based maternal and early childhood system to include evidence-based home visiting (EBHV) programs, in twelve counties receiving MIECHV Program Formula funds. Since 2010, Georgia has formalized a comprehensive, high quality, community-based maternal and early childhood system, called Great Start Georgia (GSG), 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 evidence-based home visiting (EBHV) in improving outcomes for maternal/child health, home and child safety, school readiness, family safety, family economic self-sufficiency, referrals and linkages to community resources. A major service strategy within Georgia's Department of Public Health (DPH) is the Maternal, Infant and Early Childhood Home Visiting Grant Program (MIECHV) initiative. The MIECHV 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.

At risk is defined as premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school dropouts; substance abuse; unemployment; child maltreatment; military families; or living below federal poverty limit.

Evidenced-Based Home Visiting (EBHV) offers support and comprehensive services to at-risk families through home visits and group socialization experiences. At-risk pregnant women, children age birth to five and their families are linked to resources and opportunities to improve well-being. 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).

During the reporting year:

- 70% of New Mothers Initiated Breastfeeding
- 71% of New Mothers completed a Postpartum visit
- 94% of Home Visits included Safety Information
- 99.6% of Children had no Verified reports of maltreatment
- 83% of Mothers were screened for depression
- 94% of Home Visits included Brain Building Activities
- 91% of Mothers were screened for intimate partner violence

*Project Launch Georgia (Linking Actions for Unmet Needs in Children's Health)*

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services awarded the Georgia Department of Public Health and Georgia Department of Behavioral Health and Developmental Disabilities funding in fiscal year 2014 to support the implementation of Project LAUNCH in Georgia. The purpose of Project LAUNCH Georgia is to ensure the social, emotional, and behavioral health of children, birth to age eight, and to promote safe, supportive, and nurturing families residing in Muscogee County. Project LAUNCH Georgia is a 5-year collaborative effort focused around five core goals as developed by stakeholders through a strategic planning process. The goals are to:

1. [Increase screening, assessment and referral for families with children 0-8 identified as having developmental, mental and/or behavioral health concerns to services, supports and community resources.](#)
2. [Provide training to the early childhood workforce and parents on social and emotional development for children ages 0-8.](#)
3. [Build common infrastructure to address social emotional needs for children 0-8 on the local and state levels through increased collaboration and coordination of services.](#)
4. [Integrate mental, behavioral, and developmental screening into primary care practices for children ages 0-8.](#)
5. Increase the capacity of providers in Muscogee County who serve young children in providing integrated and comprehensive behavioral health services to all children using culturally relevant and evidenced based prevention methods.

During the reporting year, Project Launch:

- Worked with Children's 1<sup>st</sup> (Georgia's central intake program for child health) to create an up-to-date provider's list by calling and visiting providers in the county.
- Recruited new Young Child Wellness Council (YCWC) members to increase community outreach and buy in to the screening and assessment process such as: new parents, Open Door Community Home, Troy State University, Reaching Milestones, Victim Witness Program, The Housing Authority, Fort Valley University, Bethany Foster Services, Ameri-Group, Well Care, Disability Service Center, Rita Young – Parent Engagement Specialist, The Family Center. Columbus Technical College, Columbus State University-Continuing Education, Growing Room, Goodwill Industries of the Southern Rivers.
- Provided ASQ-SE training to Project LAUNCH local staff, as well as, local physician's offices, Fort Valley State University, Child Care Resource and Referral Staff, Early Head Start, Head Start, and Department of Public Health staff. With this training these community agencies are able to train the teachers at childcare centers and local Head Start Centers, expanding the capacity for screening in this area. Physicians have one specific person that completes screenings and referrals in their offices. Interpreters are hired to assist with the screenings for Spanish-speaking families.
- In phase 1 of the marketing roll out, MCH developed a provider toolkit that housed all the Project LAUNCH materials in one easy access box while providing consultation on how and when to use the Project LAUNCH services. These Project LAUNCH Georgia marketing tool kits have been distributed to many physicians and community agencies serving families with children age 0-8.
- Collaborated with the Georgia Chapter American Academy of Pediatrics to assist with the implementation of integrating behavioral care into primary settings. Mental Health providers were contacted by phone, and face- to-face for collaboration of behavioral health services to coordinate services that fit the Project LAUNCH population.
- Presented at the Department of Behavioral Health and Developmental Disabilities (DBHDD) Office of Behavioral Health Prevention Conference as a mental health promotion session.
- Attended Health Living Columbus Event –The mission of this organization is to empower citizens to improve their quality of life through healthy living activities. We promoted the Parent Resource Fair and program. Connections were also made with Hike with Me Baby and Stroller Moms; which are two prominent parenting groups in the Muscogee County area.
- Presented at the DBHDD sponsored Systems of Care Conference
- Presented at the Public Health Summit, sharing our collaboration with the Department of Public Health, DBHDD, and the local Muscogee County Community Service Board – New Horizons.
- Funded a new Project launch home visitor position. The Home Visitor will be utilized to provide evidence-based home visiting to families in Muscogee County, specifically to parents who are identified as being at-risk due to



substance abuse or mental illness. The Home Visitor will provide emotional support, parenting education and guidance, and linkage to community resources.

- Collaborated with the Community Service Board to increase community collaboration in Muscogee County. This includes a Memorandum of Agreement with Muscogee County School District which is currently in progress.
- Completed a two-day training with Georgetown University on Early Childhood Mental Health Consultation. During this training, fifty-nine (59) participants attended from the local community, and the training evaluations were positive and indicated a need to provide this training again in the future.
- Hosted Parent Cafés, and added Parents to Project Launch's Local Young Child Wellness Council.
- Hosted a Parent Resource Fair, which provided community resource vendors, and an evidence-based parent training webinar for all participants. The vendors included Childcare Network, New Horizons Behavioral Health, Child Care Resource and Referral, University of Georgia-Great Start Georgia Healthy Families, Autism Hope Center, Well Care, Reaching Milestones, Columbus State University-ACTIVATE, Columbus State University -Continuing Education, Babies Can't Wait, Talk with Me Baby, Columbus Technical College, Women, Infant, Children, and the GA Department of Maternal Health.

### *Immunizations*

The Georgia Immunization Program (GIP) oversees Georgia's Vaccines for Children Program (VFC), and federally funded program that ensures access to all ACIP vaccines for VFC-eligible children 0-18 years of age. Through this program, vaccines are federally purchased and distributed to enrolled Georgia provider locations for administration to their eligible patients. Vaccines are provided at no cost to enrolled VFC providers. This increases access and significantly reduces cost as a barrier to ensuring adequate immunization coverage and vaccine preventable disease protection for this vulnerable population.

Activity 1: Promotion of childhood immunization through stakeholders and key partnerships.

The Immunization program through collaboration with the GA Chapter of the American Academy of Pediatrics (GAAAP) promotes Healthcare Provider Immunization education. During this reporting period, AAP a total of 1,717 attendees through immunization AAP conference presentations (5), immunization educational webinars on immunization topics (3) for their membership, and completed 144 peer-to-peer physician immunization trainings with a total of 1,717 attendees through their Educating Physicians in the Community (EPIC) program. The GAAAP Immunization Coordinator attends quarterly PH Immunization Coordinators meetings.

Activity 2: Increase the number of identified and tracked infants exposed to HBV at birth to ensure completion of the HepB vaccine series and post-vaccination serologic testing through a targeted educational campaign.

The Georgia Perinatal Hepatitis B Prevention Program (PHBPP) case managed 314 hepatitis B virus (HBV)-exposed infants during years 2015-2016. In birth cohort 2015, 226 infants completed the hepatitis B vaccine series, postvaccination serologic testing (PVST) and developed adequate antibody protecting them against HBV; four infants completed the Hepatitis B (HepB) vaccine series, PVST, but did not develop adequate antibody against HBV and required additional HepB doses. No infants born in birth cohort 2015 were found to be infected with HBV.

### *Child Occupant Safety Program*

The mission of the Georgia Department of Public Health (DPH) is to protect the lives of all Georgians. 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, conducts monthly education classes to train caregivers on proper use and installation of child safety seats. After participating in the classroom education, caregivers are provided an appropriate child safety seat (either a convertible or a booster). The caregivers then demonstrate proper installation technique before leaving the event. This education and distribution program is known as the Mini-Grant program. In 2016, 144 counties either directly participated in or were covered by the Mini-Grant program. The Mini-Grant provided 2,584 monthly classes, trained 7,529 caregivers, and distributed 4,608 seats during FFY16.

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 63 children and 49 seats were distributed with 13

cases carried over to FFY17 for completion. To better assist with requests and to help manage expectations, COSP staff developed a flow chart for use by Children's Medical Services and other field referrers.

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 IP staff. In 2016, IPP staff received 29 Teddy Bear Sticker forms and replaced 27 seats.

Other trainings and presentations offered by IPP staff in FFY16 include:

- "You have the Power in Your Pen" – 14 classes, training 208 law enforcement officers
- Child Passenger Safety Technician course – 10 classes, training 171 people
- CPST recertification class for current CPSTs – 5 classes with 87 attendees
- "Transporting Children with Special Health Care Needs Training" – 2 classes with 40 attendees
- Keeping Kids Safe – 7 hospital group trainings with 235 nurses trained

Building on our minority outreach efforts, the mini-grant training presentation and all training materials were translated with narration in Spanish provided. Training was provided to Telamon staff and staff at Lutheran Services of Georgia in Savannah. Spanish-language training was provided to caregivers through Telamon in Tattnall County, through the Latin American Association in partnership with the Georgia Traffic Injury Prevention Institute and Safe Kids Gwinnett County, and three (3) individual classes for caregivers in Coffee County.

## **Current Year Oct 2016-Sept**

*Priority Need: Promote developmental screenings among children*

### NPM 6: Developmental screening for children

Children 1<sup>st</sup> continues to encourage the broadening of screening methods throughout local public health districts. Through three quarters, nearly 45% (8) of Children 1<sup>st</sup> coordinators have employed multiple developmental screening methods. In total, 84% of all developmental screens were administered in-person, 10% were telephonic, 3% were administered via mailing and 3% were administered via e-mail.

Children 1<sup>st</sup> has disseminated more than 5,000 pieces of literature or educational resources about developmental milestones and screenings since January 2017. Children 1<sup>st</sup> Coordinators distributed information to other DPH programs such as WIC, hospitals, head start programs and during presentations to local state agencies. In total, more than 20 organizations throughout the state received developmental screening resources from Children 1<sup>st</sup>.

Between October and December 2016, Children 1<sup>st</sup> Coordinators organized and facilitated thirteen (20) train-the trainer workshops covering developmental screening and how to make a referral to public health; approximately 90 participants attended these trainings. Most of the trainings were organized for local county and district health department staff, the Department of Family and Children Services (DFCS) staff, Head Start programs and physician's offices.

Between January 2017 and April 2017, Children 1<sup>st</sup> held four (4) formal trainings on developmental screenings. Each training was held in Albany, GA and a total of 25 participants attended.

*Priority Need: Promote physical activity among children*

### NPM 8: Physical Activity for children and adolescents

In the current year, Georgia Shape continues to work toward increasing participation in all the programs mentioned above, as well as creating "booster" session trainings as refreshers for participants that have completed trainings in the past, but are in need of additional training. We are also working to increase physical activity measures for female adolescent populations through private funding in afterschool settings.

## Other Programs

### Early Hearing Detection and Intervention Program

The EHDI Program adopted the use of text messaging as a part of the existing follow-up process across the state and

developed a standard protocol for all districts. Additionally, the EHDI program purchased a desktop texting program to improve efficiency and ease of texting families so that all districts are able to implement a texting strategy during the follow-up process, regardless of their phone plan. This platform was live in December 2016 and the program continues to see an 80% follow up rate for families texted. The quality improvement project that focused on “drop-by” visits also showed a 84% success rate for completed follow-up screens and documentation in two districts, and the information was presented at the 2017 National EHDI Conference in Atlanta, Georgia. The electronic database that the EHDI program uses was also updated with a provider “portal” to improve the timeliness and ease of diagnostic reporting from providers. Additionally, the program is pilot testing an automatic referral from the database to Georgia PINES, one of the non-Part C Early Intervention providers in the state. This referral will be emailed immediately after a provider reports an initial diagnosis of permanent hearing loss into the system and will reduce the time from diagnosis to intervention referral. The EHDI program is working towards piloting a tele-Audiology clinic in collaboration with Children’s Healthcare of Atlanta, and the LEND program with a target start date in May or June of 2017. The on-site clinic will be in Waycross. The EHDI Program will also begin to pilot learning communities in Georgia to improve provider knowledge of EHDI, and the effectiveness of follow-up care in the medical home. The EHDI program is also funding Georgia Hands & Voices, a parent organization, to provide advocacy support and training to families through a program called ASTra. Additionally, the program intends to fund the Deaf Mentor program within the Department of Education to provide American Sign Language education to more families in the state. The EHDI program continues work on a long term follow up study and evaluation, which is looking at outcomes of D/HH children in Georgia. The project will follow kids through third grade to evaluate reading and language ability, and the current outcomes of the evaluation will be presented at the National EHDI conference by the EHDI Program Coordinator in February 2017. This year, the EHDI program pulled together a workgroup with the aim of using quality improvement measures to improve the Early Hearing Orientation Specialist (EHOS) visit. Programmatic updates that emerged as a result of the quality improvement process were piloted in April with a small cohort of early hearing specialists.

#### *100 Babies Project*

In the current year, the EHDI program has worked to remove barriers to timely identification, reduce referral time into intervention, and promote the importance of intervention for all D/HH children. An article related to the 100 Babies project was published in the newsletter to Georgia Family Physicians, distributed to 2,800 members. The 100 Babies manager has also participated in a workgroup whose goal is to improve the Early Hearing Orientation (EHO) visit—the initial visit a family receives after their child has been identified with a permanent hearing loss. The workgroup (comprised of parents, members of Georgia Hands & Voices, Georgia PINES, and Georgia Pathway) have made changes to the EHO visit to simplify information given to families, focus more on language development and its link to literacy, as well as the urgency of early intervention. A small group of specialists who conduct EHO visits were trained and are currently piloting the new visit format. Additionally, to reduce the time from diagnosis to intervention, two projects have been tested using the program’s online database. The first is a reporting portal for audiologists to use in order to improve the number of results reported in less than 7 days. The second is an electronic referral sent to Georgia PINES after a permanent hearing loss is documented in the database. The efforts will help to identify families in need of services sooner, and begin the referral process immediately to reduce the time between identification and the start of services.

#### *Help Me Grow*

Building off identified recommendations, staff worked with the DPH Commissioner, DPH Executive Leadership, and Health Directors from each of the 18 public health districts in the state to finalize the overall approach leading to implementation of this model. After incorporating necessary changes based on final feedback, the MCH section engaged the services of a consultant with experience in process mapping and quality assessment/improvement.

Within this first phase of implementation of the *Help Me Grow* model, it was decided that efforts to implement a systems approach needed to begin with individuals directly engaged with intake, referrals, and related activities on a regular basis. Additionally, to provide ongoing engagement in meeting program goals, the MCH section hired a dedicated and full-time program manager to lead implementation efforts. With a good infrastructure in place, the MCH section has begun a series of voluntary process analysis/mapping sessions with employees from local District Sites who interface directly with local residents on early childhood services, referrals, intake, and related activities. Although the initial goal focused on engaging at least 3 of the 18 district sites in Phase 1, DPH was excited to identify the commitment and excitement of 6 (DeKalb, LaGrange, Columbus, Macon, Gwinnett, and Cobb-Douglas) sites thereby representing a third of all public health districts in the state. To date, all six districts have been involved in the three (3) of four (4) Process Analysis sessions. The fourth session is scheduled for June 20<sup>th</sup>, with plans to conclude with quality improvement (QI) recommendations to provide back to the districts and guide the next steps in strategic planning. Concurrently, Child Health staff has been meeting with various MCH programs to both educate and identify strategies for program collaboration, data alignment, and overall efficiency in providing local residents with a comprehensive menu of services.

Over the next coming months, the MCH section will be working closely with the *Help Me Grow National Partnership* on providing tailored technical assistance that builds on additional insights received from process analysis sessions. Technical



assistance to the state of Georgia will inform Phase II of the process which focuses on Planning, Installation, and Implementation. Throughout the months of July and August, DPH staff will continue working across Districts supporting “easy wins” identified in the process analysis session, continue engagement with *Help Me Grow National* to support the development of strategic workgroups as part of the model approach (begins Phase II activities), continue participation in site visits across the districts and with other Help Me Grow affiliate states, and engage broader DPH, external statewide agencies and parent/community partners.

#### *Maternal, Infant, and Early Child Home Visiting (MIECHV)*

In recent months, the U.S. Departments of Education (ED) and Health and Human Services (HHS) set a vision for stronger partnerships, collaboration, and coordination between awardees of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and the Individuals with Disabilities Education Act, Part C Program (IDEA Part C Program). These two entities in Georgia will now be in one Department making effective collaboration and coordination across MIECHV and the IDEA Part C Program. The hope is to create a high-quality system of services and supports for infants and toddlers with disabilities and their families.

Home visiting *also intends to* assure, on a voluntary basis, effective coordination and delivery of critical health, development, early learning, child abuse and neglect prevention, and family support services to at-risk children and families through home visiting programs.

During last year’s activities, Governor Deal requested the transfer of the home visiting program from Georgia’s Department of Human Services to DPH. The emerging challenge related to enrolling and retaining immigrant families is being initially addressed via distribution across Georgia’s home visiting networks listserv of a newsletter containing information about resources for immigrant families obtained from federal agency and community organizations.

#### *Project Launch Georgia (Linking Actions for Unmet Needs in Children’s Health)*

During the current year, Project Launch:

- Increased collaborations with local physicians and mental health providers by inviting them to the Local Young Child Wellness Meeting and other community events.
- Attended health fairs and meetings to promote the Project LAUNCH initiative utilizing our new marketing materials.
- Continued to partner with Children’s Healthcare of Atlanta (CHOA) to offer training webinars on social emotional development and trauma focused training and Strengthening Families through Knowledge of Child Development on Train-the-Trainer and parent trainings.
- Through partnerships with New Horizons Community Service Board and Project AWARE; Project LAUNCH collaborated with the school system to screen all children in Pre-K and any child referred through age 8.
- Conducted a Children’s Healthcare of Atlanta Training: Trauma Focused – Cognitive Based Therapy, Train the Trainer and coaching for the identified providers.
- Continued outreach to local physicians to increase their knowledge of developmental screenings.
- Provided training to the Healthy Families Georgia home visitor that includes the Project LAUNCH training modules and include the home visitor in future YCWC meetings.
- Enhanced Home Visiting Training will focus on intensive trauma informed reflective skills training.
- Begin consulting with daycare providers to meet unmet needs. We will partner with Childcare Resource and Referral to integrate into additional daycare centers.

#### *Immunizations*

Currently, childhood immunizations are promoted through collaboration with GAAAP, which promotes Healthcare Provider Immunization education. The AAP Immunization Coordinator attends quarterly PH Immunization Coordinators meeting. In order to recognize National Infant Immunization Week a media toolkit was revised using best practices and feedback, collected from providers, the Immunization Program contract with marketing firm, Golin. The revised toolkit will be distributed to Public Information Officers in Georgia’s 18 public health districts.

GIP works to educate medical providers and laboratories about the importance of disease reporting, with a specific target population of prenatal care providers in an effort to increase the number of HBV-positive pregnant women identified in birth cohort 2016.

#### *Child Occupancy Safety Project*

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 (TBS) placed on the child safety seats that are distributed.

Child passenger safety trainings to internal and external stakeholders continue. Staff is working to develop online, modular trainings and has been utilizing non-traditional methods to conduct outreach with agencies, utilizing platforms like Zoom, Skype, and FreeConferenceCall.com. Special Needs training has been upgraded. Two staff members has been approved as instructor's for the Riley's Automotive Program "Safe Travel for All Children: Transporting Children with Special Health Care Needs", increasing the training from 8-hours to 16-hours. This training is approved by Safe Kids Worldwide and appears as a special designation on the student's Child Passenger Safety Technician profile. The staff members are the only approved instructors for this program in the state.

COSP has also expanded the training capacity for EMS providers. The Program Manager is now an instructor for Riley's "Improving Occupant Protection for Non-Critical Pediatric Patients in Ambulances: A Training Curriculum for EMS Personnel". This training empowers EMS providers to select the appropriate transport mode and equipment for pediatric patients.

Training for law enforcement officers expanded into a train-the-trainer program to assist with increasing capacity statewide. Additionally, an updated curriculum for mandate classes was produced, approved by the Georgia Public Safety Training Center, and distributed statewide to the training academies.

For FFY16, COSP was not able to provide car seats to the Mini-Grant agencies for the full grant period. Funds for car seats were exhausted by August 2016. Because of the shortage, minority outreach distribution was impacted. Local agencies could not request seats for both English and Spanish language classes and most opted to support English language classes. It is once again anticipated that funding for car seats will not stretch through to the end of the grant period.

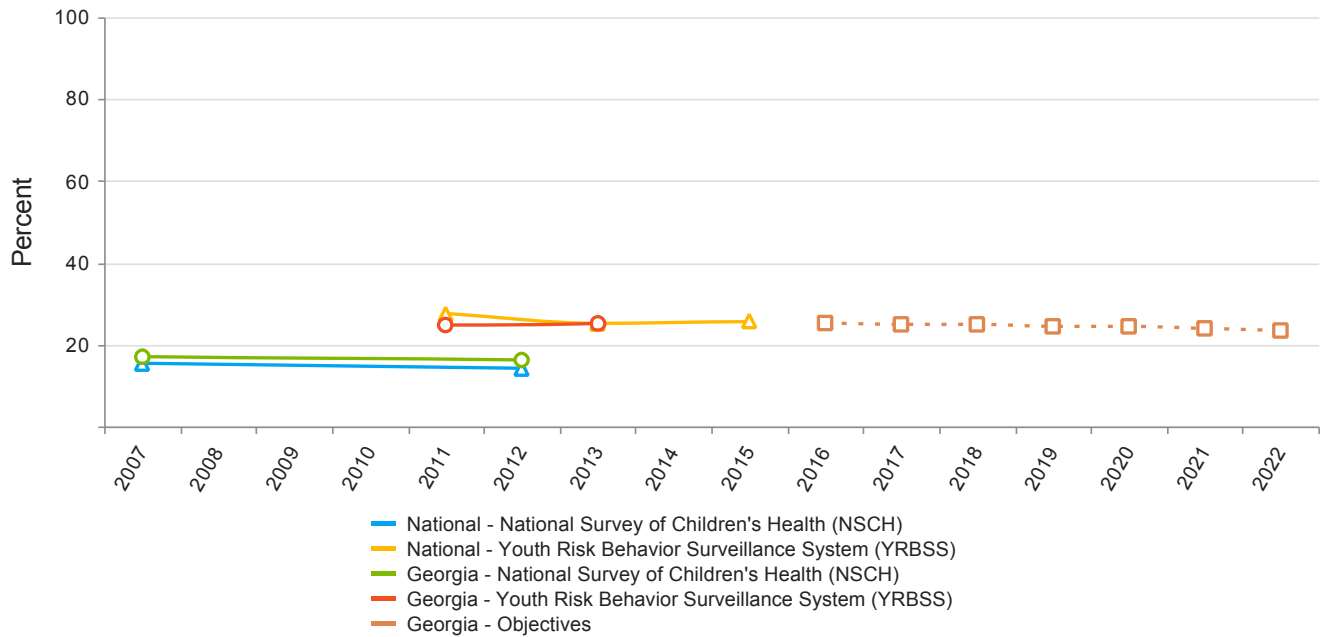
## Adolescent Health

### 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-2015	36.5	NPM 9
NOM 16.3 - Adolescent suicide rate, ages 15 through 19 per 100,000	NVSS-2013_2015	7.9	NPM 9

## National Performance Measures

### NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others Baseline Indicators and Annual Objectives



Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	25.3
Annual Indicator	16.4
Numerator	129,553
Denominator	790,591
Data Source	NSCH
Data Source Year	2011_2012

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	25.3
Annual Indicator	25.1
Numerator	110,846
Denominator	442,284
Data Source	YRBSS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	25.0	24.5	24.5	24.0	23.5

## Evidence-Based or –Informed Strategy Measures

### ESM 9.1 - 8.1.1. Communication plan to promote awareness of bullying and bullying prevention among youth

Measure Status:	Inactive - This measure has been deleted due to unforeseen barriers
-----------------	---

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Adolescent Health Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective						

**ESM 9.2 - 8.2.1. Number of schools participating in whole school bullying prevention initiatives**

<b>Measure Status:</b>	<b>Inactive - This measure is being deleted due to a change in strategy</b>
------------------------	---

State Provided Data	
	2016
Annual Objective	
Annual Indicator	15
Numerator	
Denominator	
Data Source	Adolescent Health and Youth Development Program
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	1.0	3.0	3.0	3.0	3.0

**ESM 9.3 - 8.1.2. Developed at least one evidence-based strategy for suicide revention**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective						

## State Action Plan Table

### State Action Plan Table (Georgia) - Adolescent Health - Entry 1

#### Priority Need

Reduce suicide among adolescents

#### NPM

Percent of adolescents, ages 12 through 17, who are bullied or who bully others

#### Objectives

8.1. By 2020, develop a partnership with suicide prevention experts to identify strategies to reduce the rate of suicides.

#### Strategies

8.1.a. Collaborate with the Injury Prevention Program to identify partners and evidence-based strategies.

8.1.b. In partnership with suicide prevention experts implement prevention strategies to targeted communities with high rates of adolescent and youth suicide.

#### ESMs

#### Status

ESM 9.1 - 8.1.1. Communication plan to promote awareness of bullying and bullying prevention among youth

Inactive

ESM 9.2 - 8.2.1. Number of schools participating in whole school bullying prevention initiatives

Inactive

ESM 9.3 - 8.1.2. Developed at least one evidence-based strategy for suicide prevention

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



## Adolescent Health - Plan for the Application Year

### Plan for Coming Year

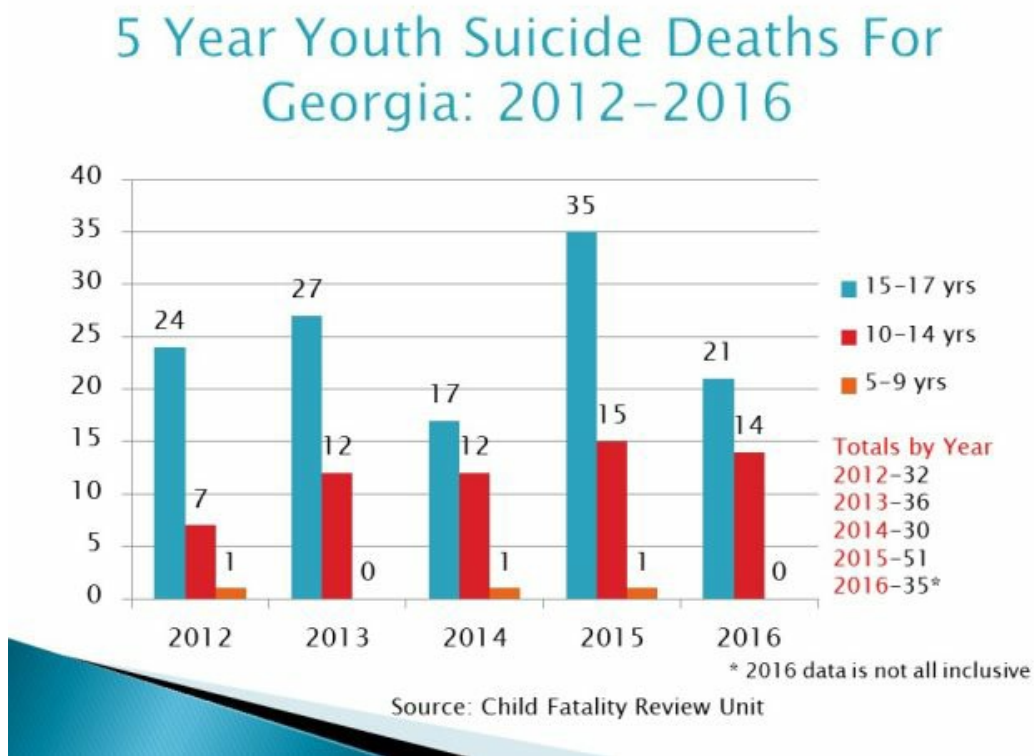
*Priority Need: Adolescent Suicide*

#### NPM 9: Bullying

Adolescent suicide was identified as a priority need for Georgia in 2015 with a strategic focus on adolescent bullying. Due to increasing concerns over youth suicide, the Title V Program will revise its state action plan to focus on strategies that reduce adolescent suicide.

Georgia's Child Fatality Review is conducted by the Georgia Bureau of Investigation (GBI) who released updated youth suicide data on May 17, 2017. Youth suicides increased in 2015 and will presumably maintain the increase in 2017 (Table 1). GBI reports that 18 children have reportedly taken their lives from January 2017 through May 2017.

Table1: Five Year Suicide Deaths for Georgia 2012-2016



# Youth Suicide Data for Georgia: 2017

	5 to 9	10 to 14	15 to 17	Total
White Male	0	1	8	9
White Female	0	0	3	3
African-American Male	0	1	1	2
African-American Female	0	1	0	1
Hispanic Male	1	0	1	2
Hispanic Female	0	0	0	0
Asian Female	0	0	1	1
Total	1	3	14	18

	5 to 9	10 to 14	15 to 17	Total
Gunshots	1	2	7	10
Hangings	0	1	5	6
Overdose	0	1	1	2
Total	1	4	13	18

Source: GBI Child Fatality Review Unit



The Georgia Department of Public Health will partner with the Georgia Child Fatality Review (GBI), Georgia Department of Education, and the Division of Family and Children Services to develop and support strategies to prevent youth suicide.

## Other Programs

### *Adolescent Health and Youth Development Program*

In the upcoming year, AHYD will provide Adolescent and Young Adult Centered Care (AYACC) training for public health family planning clinics. DPH's family planning clinics serve youth under 19. The AYACC training will help family planning providers tailor their organization and services to meet the needs of youth and adolescents. Each clinic will be designated an AYACC award once all recommended steps have been completed. Adolescent health will develop a referral list of AYACC family planning clinics for teens. In addition to AHYD activities ASH will continue with implementing new SUSI schools beginning August 2018.

## Adolescent Health - Annual Report

### Reporting Year Oct 2015-Sept 2016

*Priority Need: Reducing suicide among adolescents*

#### NPM 9: Bullying

The 2015 Title V Needs Assessment identified suicide as a priority need among the adolescent health population. This need was linked to National Performance Measure 9, Bullying. Georgia's Adolescent and School Health (ASH) Unit supports youth, schools, and parents in creating opportunities to be healthy and learn lifelong health habits in youth development, healthy behaviors, teen pregnancy prevention, sexual violence prevention, and bullying prevention.

Through the experiences of the Injury Prevention Program, Sexually Transmitted Diseases (STD) Program and Adolescent Health and Youth Development Program, MCH explored the possible relationship between sexual bullying and suicide during the reporting year. The 2016 On-going Needs Assessment identified potential relationships for all adolescents and specifically for adolescents that identify as Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ).

The Sexual Violence Prevention Program (SVPP) within the ASH Unit administers the Step Up Step In (SUSI) campaign which is an awareness campaign that targets middle and high school students to reduce sexual violence and bullying associated with sexual identity, gender and sexual acts. Sexual bullying behavior includes sexual activity unwanted touching, name calling (sexual identity), sexual rumors, sexting, and more. SVPP has successfully implemented SUSI in approximately 30 schools throughout Georgia from 2015 to 2016. Students, educators, staff, and administrators participate in a pledge to keep their school safe from sexual bullying and to hold each other to this standard. Activities and Incentives include poster contests, poetry slams, pep rallies, parades, creating PSA's, lunch and learns and more.

During the reporting year the Title V Manager, ASH Deputy Director, STD Senior Manager, and Injury Prevention Director met to discuss possible strategies to address suicide, bullying and particularly sexual bullying. The ASH Unit expanded its reach to Georgia schools by 3 schools and hired a State Adolescent Health and Youth Development (AHYD) Coordinator.

#### Program: AHYD

The Adolescent Health and Youth Development Program targets youth ages 10-24 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 peers. 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.

Approximately 50 middle schools participated in "Leadership through Life Skills" which allowed students to strengthen their life skills and act as peer counselors. Adolescents also participated in and designed activities around Red Ribbon Week, "Let's Talk Month" and World AIDS Day. Through the second quarter, 17 professional trainings and technical assistant activities have taken place. Activities included Adolescent and Youth Adult Centered Training workshops, Teen Outreach Program, among many others. During this period 27 public awareness and community education events occurred. Topics included were teen pregnancy prevention, effectively communicating with youth, World AIDS Day, and a program entitled "Choosing Health Activities and Methods to Promote Safety". About 275 youth participated in AHYD programs recognized by the Office of Adolescent Health including "Reducing the Risk", "Making a Difference", and "Making Proud Choices". Nine health districts have received funding for the 2017 fiscal year to implement a teen pregnancy prevention program either Making a Difference or Making Proud Choices for you ages 10-19. They will introduce a new program of four new sessions for Family Life and Sexual Health.

## Current Year Oct 2016-Sept 2017

*Priority Need: Reducing suicide among adolescents*

#### NPM 9: Bullying

#### **State Action Plan Progress:**

In the current year, the Title V Manager and ASH Unit met to discuss anti-bullying campaigns and expanding the whole-school anti-bullying program SUSI. These strategies along with creating a website are components of the Title V State

## Action Plan.

The ASH team supported five health districts Northwest, Coastal, East Metro, Clayton, and West Central to partner with 11 schools for the fall 2016 school year. Each school conducts a pledge drive for students, educators, staff, and administrators who pledge to keep their school safe from sexual bullying and to hold each other to this standard. Other activities include poster contests, poetry slams, student assemblies, parades, creating PSAs, lunch and learns and a variety of incentives for participants.

The ASH team was able to add two additional health districts to the SUSI program and prepare for the fall 2017 school year. Local schools submitted applications to one of the five health districts in March 2017. Seven health districts (Coastal, Cobb, Northwest, DeKalb, East Metro, South, and West Central) will partner with 15 schools to implement SUSI. Including the upcoming 2017 Fall semester, SVPP will have successfully implemented SUSI in 32 schools throughout Georgia.

## Other Programs

### *Adolescent Health and Youth Development Program*

The Adolescent Health and Youth Development (AHYD) youth development coordinators worked successfully with our youth to develop and strengthen their leadership and life skills through 32 activities.

A few of these include:

- Positive Social Norm messages
- Safe Sober Prom Campaign - #WhatIDidInstead
- STIs and Safer Sex
- Dating Violence Awareness
- Project One80 - a mental health initiative designed to encourage: 1) personal development, 2) life skills development, 3) positive behavior change, 4) building trusting relationships, 5) support system evaluation and 6) character development
- "Reality U" - financial literacy education

AHYD is diligent in identifying capacity building opportunities for the district staff as well as the communities they serve.

During the current year AHYD provided 23 professional training and technical assistance opportunities. A highlight from the opportunities offered include:

- Adolescent and Young Adult Centered Training "Clinical Best Practices" workshop.
- "How to Address Child Abuse"- The event was well attended with over 400 Head Start professionals from 13 counties.
- Gwinnett Rockdale Newton Health District sponsored three workshops. 1) Partnership Against Domestic Violence, "The 4<sup>th</sup> R"- The 4<sup>th</sup> R is an interactive classroom curriculum for ninth-grade students, that aims to reduce youth dating violence by addressing youth violence, bullying, unsafe sexual behavior and substance abuse; 2) Five Ways to a Healthy Lifestyle Workshops aimed at 10<sup>th</sup> thru 12<sup>th</sup> grade students; 3) A "Healthy Relationship" seminar; approximately 700 students participated in the three workshops.
- FLASH (Family Life and Sexual Health) for health educators, youth workers, teachers, and after school workers at the North Central Health District.
- Technical assistance to public middle/high school to implement evidence based sex education curricula as a standard practice in classes.

During the current year AHYD conducted 39 public awareness and community education events. Some of those include:

- HPV education at a Mother-Daughter HPV Dinner
- February National Teen Dating Violence Awareness and Prevention Month (200 participants)
- "Teen Dating Violence Community Awareness" event (100 participants)
- A Teen Maze (250 participants)

Youth in areas with high rates of teen pregnancy, HIV/STDs and school dropout were strategically targeted to receive evidence-based teen pregnancy prevention programs. The programs included: "Reducing the Risk," "Making A Difference," and "Making Proud Choices." Over 400 youth from targeted counties participated in the programs.

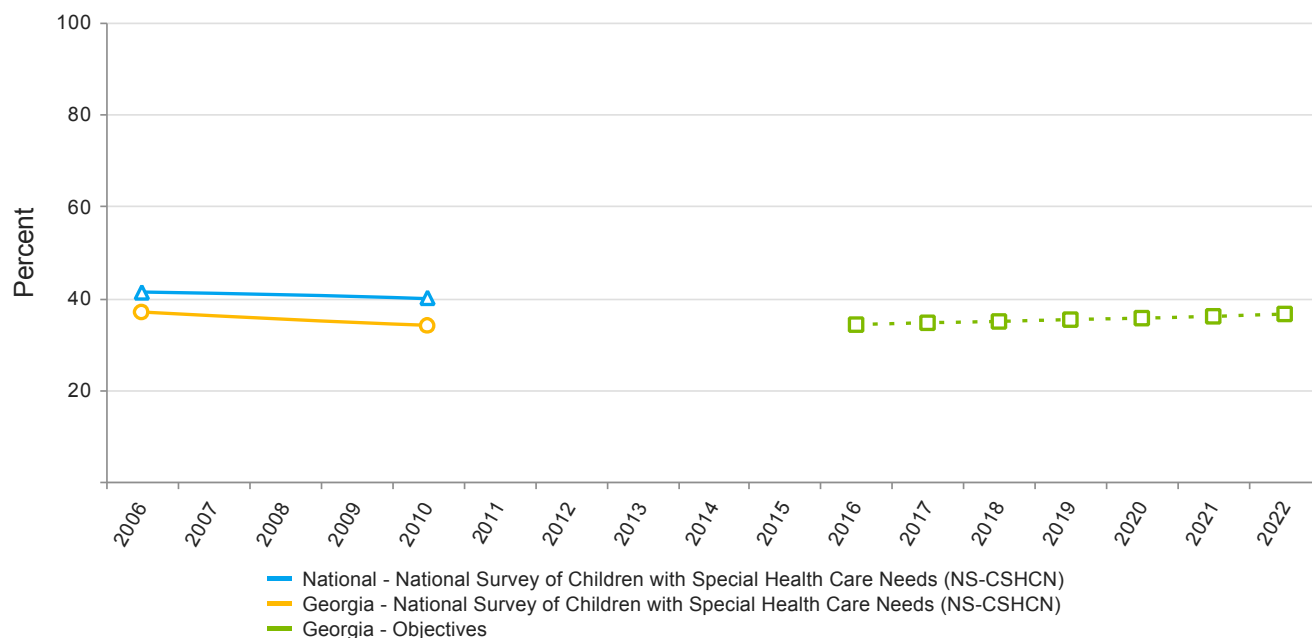
## Children with Special Health Care Needs

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system	NS-CSHCN-2009_2010	17.4 %	NPM 12
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	85.3 %	NPM 12

## National Performance Measures

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



Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	34.2
Annual Indicator	33.9
Numerator	48,646
Denominator	143,452
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	34.6	34.9	35.3	35.6	36.0	36.5

## Evidence-Based or –Informed Strategy Measures

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

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

State Provided Data	
	2016
Annual Objective	
Annual Indicator	250
Numerator	
Denominator	
Data Source	Children Medical Services
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	200.0	250.0	325.0	350.0	375.0	500.0

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	15.0	25.0	35.0	40.0	40.0



## State Performance Measures

**SPM 2 - 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.**

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

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1.5
Numerator	704
Denominator	477,000
Data Source	CMS Program Data and Kids Count
Data Source Year	SFY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.3	1.5	1.7	1.9	2.0	2.0

## State Action Plan Table

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

#### Priority Need

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

#### NPM

Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care

#### Objectives

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

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

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

## Strategies

- 9.1.a. Develop health care transition materials for stakeholders, youth and families
- 9.1.b. Develop a Health Care Transition Resource Portal
- 9.1.c. Provide health care transition presentations to community stakeholders
- 9.1.d. Establish and maintain community partnerships to facilitate the distribution of health care transition resources and materials
- 9.1.e. Provide 20 health care transition planning workshops for families and youth
- 9.2.a. Provide an online continuing education module on the six core elements of health care transition targeting a minimum of 10% of public health nurse workforce
- 9.2.b. Provide continuing education opportunities on the six core elements of health care transition for medical and nursing students, pediatric and adult providers
- 9.2.c. Provide an annual stakeholder meeting with continuing medical education credit for pediatric and adult providers to discuss evidence based practices, medical home and transition and coordination of care across pediatric and adult systems
- 9.3.a. Establish an advisory group to include youth, families, and providers to support practice improvement efforts for health care transition
- 9.3.b. Incorporate the use of transition readiness assessments and planning tools within the 18 district Children's Medical Services (CMS) programs
- 9.3.c. Assess family and youth satisfaction of the health care transition services and supports upon transitioning out of the program
- 9.3.d. Partner with pediatric and adult medical providers to provide guidance and support in the development and implementation of a health care transition policy within their practice

## ESMs

## Status

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

## NOMs

- NOM 17.2 - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system
- NOM 19 - Percent of children in excellent or very good health

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

### Priority Need

Improve access to specialty care for CSHCN

### SPM

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.

### Objectives

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

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

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

### Strategies

10.1.a. Provide comprehensive telehealth information to providers

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

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

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

10.2.c. Expand the telemedicine provider network

10.2.d. Establish a telehealth stakeholder workgroup for CSHCN

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

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

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

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

## Children with Special Health Care Needs - Plan for the Application Year

### Plans for Coming Year

#### *Priority Need: Improve Systems of Care for CYSHCN*

##### NPM 12: Transition to adult care for all children

Improving system of care for CYSHCN is a priority need that will be addressed by using outreach and awareness activities on health care transition, increasing training and educational opportunities for health care professionals, and implementing transitional protocols within public and private practice settings to standardize the care for youth and young adults. Efforts for next year will focus on streamlining and evaluating the transition planning process for young adults enrolled into the Children Medical Services (CMS) program and using evidence-based transition readiness and planning tools. CMS will continue to provide guidance, support and training opportunities to pediatric providers in establishing transition policies. As well as to engage with existing DPH partners to assist with reaching adult providers, nursing students and academic institutions so that we may emphasize the importance of health care transition.

##### SPM 02: Improve access to specialty care for CSHCN

In the coming year, CMS continues to expand clinical services throughout Georgia and to enhance telemedicine services by collaborating with medical partners, community stakeholders and families. Efforts for next year will include continued engagement with the GaLEND and Center of Excellence in MCH Education, Science, and Practice at Emory Rollins School of Public Health programs to ensure children and youth with special health care needs have access to a comprehensive and accessible system of care. With the recent approval of Medicaid reimbursement for speech therapy services via telemedicine, the CMS program will partner with the Part C Early Intervention, Babies Can't Wait, program to explore tele-interventions for infant's birth to three years of age. The CMS program will also work with the MCH evaluation team and Telehealth Department to strengthen mechanisms to monitor access to and satisfaction of specialty care services.

##### *Babies Can't Wait (BCW)*

In the coming year, the Babies Can't Wait Program will continue to serve children birth to three with developmental delay and category 1 chronic conditions. BCW continues to focus on improving provider service to enrolled children and will offer a variety of training opportunities. BCW will partner with a variety of professional associations such as the Physical Therapy Association of Georgia to of continuing education credits for BCW offered training. In the coming year, BCW will also review and revise Georgia's category 1 list. This list currently includes microcephaly, hydromicrocephaly, and micrencephalon; all zika related conditions. BCW will determine if "confirmed zika infection" or other zika related conditions should be added to the category 1 list.

##### *Autism*

In the upcoming year, The Autism Initiative will continue to expand Georgia's capacity for early diagnosis by training a new cohort of licensed psychologist to administer the ADOS–2 diagnostic instrument. The goal is to have trained 90 licensed psychologists across Georgia and decrease families wait time in receiving a comprehensive evaluation. In collaboration with The Emory Autism Center (EAC), the Autism Initiative will pilot the use of Autism Specialty Clinics by making a request for applications to existing Georgia Autism Assessment Collaborative (GAAC) professionals. To improve access to care for children and youth with ASD, the Autism Initiative and EAC will develop a supervision and training program for professionals seeking to obtain Board Certified Behavioral Analysis (BCBA) credentials. While enrolled in the BCBA Training and Supervision Program, trainees will provide low-to-no cost behavioral intervention services to 200-260 children with ASD.

The Georgia Autism Initiative will continue to focus on The *Autism Navigator* will be modified to address skills related to early identification and screening in a 7 hour, self-paced, web-based course. The Autism Initiative will target a broader range of professionals to include Children First Coordinators and Home Visitors. At least 5 health districts will be identified to establish *Autism Navigator* learning communities with tiered training mechanisms for reinforcement of workforce development. The Autism Initiative plans of offer autism specific screening to children enrolled in the Part C Early Intervention program, Babies Can't Wait, at the 18 month and 24 month intervals recommended by the American Academy of Pediatrics.

## **Children with Special Health Care Needs - Annual Report**

### **Reporting Year Oct 2015-Sept 2016**

*Priority Need: Improve Systems of Care for CYSHCN*

#### NPM 12: Transition to adult care for all children

Health Care Transition is a National Performance Measure for the State of Georgia. The goal is to increase the percentage of youth and young adults that successfully transition to adult health care services from 33.9% to 39% during the next five years. Health care professionals, youth and families each have essential roles to play in improving a youth or young adult's transition from pediatric to adult health care. Positive transitions begin when youth and families are prepared for change and when pediatricians and adult primary care professionals have access to tools and concrete methods to address barriers and improve care for youth and young adults. The areas of focus include:

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

The focus of the Children and Youth with Special Healthcare Needs' (CYSHCN) program, Children's Medical Services (CMS), is to provide program development, leadership, guidance, and resources to Georgia's 18 Health Districts in the development and provision of a comprehensive, integrated, and coordinated system of services for children and youth with special needs, birth to age 21 and their families. Georgia's CMS Program is the leading program to support the transition of CYSHCN into the adult health care system.

#### *Children's Medical Services*

The Children Medical Services (CMS) Program partners with the community, health care providers, and local resources to coordinate the care for CYSHCN and their families, and strengthen health care transition services. Children and youth (ages 0-20) with eligible chronic medical conditions, and family income less than 247% of the federal poverty level are served by CMS.

Continuity in medical care for CYSHCN is critical to achieving optimal outcomes for these children and preventing death. CMS serves as the payer of last resort for health care and medical expenses for families that do not qualify for the State's Medicaid, SCHIP, or, are without insurance during the time of 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 support such as transportation and support groups with other families. Helping CYSHCN and their families feel confident about managing their health care needs and navigating through complex social issues is a very important goal for CMS.

CMS Care Coordinators assess 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. For special cases, CMS Care Coordinators requests additional assistance from the Georgia Department of Community Health that administers the Medicaid and SCHIP Programs. In State Fiscal Year (SFY) 16 (June 2015-July 2016); 9,329 children and youth received care coordination services from the CMS program.

During the reporting year, CMS collaborated with the Care Management Organization (CMO), Amerigroup Georgia Families 360, program to ensure better coordination of services for children and youth in foster care, in the adoption process and under the care of juvenile justice. The Association of Maternal and Child Health Programs' (AMCHP) Strengthening Your System of Care for CYSHCN Action Learning Collaborative accepted Georgia's application to focus on this collaborative work with Amerigroup.

The MCH Section partners with Parent to Parent of Georgia (P2P) to implement the Parent Partner Project. Parent 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 Parent Partners are paid as part-time employees of P2P and support local district child health programs and private pediatric physician practices. Parent Partners provide information & resources, emotional support, and coordinate free training opportunities for parents served at their site.

Since the initiation of the program, there have been a six (6) Parent Partners trained and supporting families with children and youth with special health care needs. Parent Partners have served 1,400 families and coordinated 142 Parent Matches. Parent Matches is a P2P service, in which a parent of a child with a special health care need or disability is matched with a Supporting Parent with similar situation and challenges. The Supporting Parent is knowledgeable and able to provide one-on-one emotional support and guidance.

The most frequent requests for assistance that come from parents include; community resources, early childhood services, education, parent and family support, and healthcare. The Parent Partners have coordinated 20 trainings for parents and professionals in the community. P2P also maintains the Statewide Central Directory database funded by the MCH Section. The Directory allows users to search for information and referral resources or families of children ages birth to twenty-six (26) with developmental delays, disabilities and chronic health care conditions.

The CMS program provides and/or arranges for comprehensive physical evaluations, diagnostic tests, inpatient/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. For youth ages 16 and older, the program staff guides and coordinates the transition process from pediatric to adult health care. Pediatric specialty care clinics for children and youth living in rural counties in Georgia are offered where pediatric medical specialist's services are limited. In SFY16, 97% of children and youth enrolled were linked to a primary health care provider.

Approximately 1,027 CMS program participants, ages 16 and older, and their families received transition planning, support and education by care coordinators to facilitate successful healthcare transition in SFY 2016. The care coordinator's role in the transition process is one of planner, facilitator and support to the adolescent and family. The coordinator assists with transitioning the youth from pediatric care to physicians trained in adult medicine, ensuring that families and youth understand the health care systems available and learn to navigate services for adults with disability.

#### *Transition Projects*

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

The CMS program partnered with the Adult Disability Medical Home (ADMH) to implement a quality improvement initiative named "Step Up to Health Care Transition" to enhance transition services for patients 12 years of age and older with intellectual and developmental disabilities. Step Up to Health Care Transition uses the Six Core Elements of Health Care Transition as a framework. ADMH is housed within a family physician practice and transition clinics are supported by several disciplines, which includes: a dietician, behavioral analyst, clinical social worker, and family/patient advocate. Three transition clinics are conducted per month, with 5-7 patients seen at each clinic.

ADMH's Medical Directors serve as Physician Champions for health care transition and are asked to support many of the activities coordinated by the CMS program, which includes educating health care providers via webinars and conference lectures.

Dr. Leila Jerome Clay, Director of Sickle Cell Disease Transition with Augusta University, continues to serve as a Physician Champion for the CMS program by participating in conference lectures and providing direct services to patients (13 to 18 years of age) transitioning from pediatric to adult hematology care. Patients are seen in clinic in Augusta, as well as, in outreach clinics in Dublin, Valdosta, and Waycross. An annual "Stomp Out Sickle Cell" 5K Run/Walk hosted by the Comprehensive Sickle Cell Program and Sickle Cell Transition Program, attracts more than 150 community members annually, and provides support for transition related patient activities.

Health care transition training opportunities are made available for health care professionals and community stakeholders.

Eighty-three public health nursing staff received continuing education credits for the online "Health Care Transition for Adolescents and Young Adults" training offered by Got Transition. Also, the CMS program utilized telehealth technology and hosted the live broadcast of the 17<sup>th</sup> Annual Chronic Illness and Disability Conference: Transition from Pediatric to Adult-based Care for public health district staff and community partners. Seventy-two participants received continuing education credits. In partnership with the Georgia Chapter of American Academy of Pediatrics and Georgia Academy of Family Physicians lecture presentations on health care transition are offered during their annual and summer conferences.

CMS partners with the Coaching and Comprehensive Health Supports (COACHES) Program, a federally-funded pilot project that seeks to improve the health and transition outcomes for youth aging out of foster care in Georgia, to increase client knowledge and skills related to health care navigation. The COACHES Program is delivered through a public-private partnership between Families First and Amerigroup Georgia (an HMO that manages health services for youth in foster care) and the Georgia Department of Family and Children Services. COACHES employs the DPH *Taking Charge of My Health Care* booklet as a tool to support client education on healthcare navigation. Approximately 70, youth in foster care ages 17-21, who participate in the voluntary COACHES Program have received the booklet as a part of their coaching skills plan tools. Additionally, COACHES uses the material to train staff who provide one-on-one health and social services coaching services to clients, to assist program Coaches in offering strategies to the youth that they serve, impacting approximately 100 youth.

Based on a survey of program clients across 10 priority areas youth are increasing their skill in navigating health services for themselves. Data show that youth are making their own medical appointments, accessing their Amerigroup Care Coordinators for assistance and, accessing reproductive health care through their Amerigroup funded insurance. Finally, COACHES participants are showing reductions in healthcare spending related to in-patient behavioral health hospitalizations.

#### *Community Outreach*

MCH Section Child Health Programs within local public health departments host or participate in a variety of outreach events to build relationships with community partners, increase the number of referrals for child health programs, and inform clients of community resources. Some of the events include the SoopaFitt Health Expo and Street Festival in the LaGrange district providing medical screenings, flu shots, kid's workshops and Bounce House for kids. In the Clayton district, program staff participated in International Day hosted by the local Head Start program. The event provided medical screenings and children had the opportunity to dress up in costumes and take part in a parade. Nurses in the CMS program may also provide Asthma Education to school nurses and the Valdosta district hosts an annual SUPERPUFF Community Asthma Day Camp where asthma self-management education is provided via fun games (Asthma Monopoly, Asthma Jeopardy, Trigger Pictionary and Bronchial Tube Relay).

#### SPM 02: Improve access to specialty care for CYSNCN

The Children's Medical Services (CMS) Program partners with community, health care providers, and local resources to coordinate the care for CYSHCN and their families. To ensure that children and youth served in rural communities receive appropriate and needed specialty medical services, CMS offers specialty clinics in nine (9) local district programs, which include telemedicine services. CMS coordinates with more than thirty specialty providers for clinical services. During a twelve- month period, approximately 350 clinics are offered, 96 of those provided via telemedicine, and 3,800 children and youth served. Specialty clinics offered include:

- Endocrinology
- Nephrology
- Cardiology
- Chronic Lung
- Genetics
- Hematology
- Orthopedic
- Hearing
- Neurology
- Cystic Fibrosis

#### Other Programs

##### *Early Intervention Services*

Babies Can't Wait (BCW), also known as Part C, is an early intervention service to provide a coordinated, comprehensive and integrated system of service for infants and toddlers with special needs, birth to age 3, and their families. This program provides early identification and screening of children with developmental delays and chronic health conditions by using a multidisciplinary evaluation and assessment in order to determine the scope of services needed. BCW will then coordinate services to assist the family in developing a plan to improve the developmental potential of infants and toddlers with these health conditions.

Early intervention also allows for support and resources to be built to assist family members and caretakers to enhance children's learning and development throughout everyday learning opportunities.

BCW has served Georgia's children and families since 1987. According to Part C of the Individuals with Disability Education Act Amendment of 1997, early intervention services must be provided in natural environments, including home and community settings in which children without disabilities participate.

##### *Georgia Autism Initiative*

Autism Spectrum Disorder (ASD) is a developmental disability that can cause significant social, communication, and behavioral challenges. ASD affects 1 in 64 children in Georgia. According to the National Center on Birth Defects and



Developmental Disabilities, Georgia children can be diagnosed as early as 2 years old and on average of 3 years and 9 months old.

DPH aims to help children and families with ASD and other related disorder through projects within the DPH Autism Initiative. The goal is to improve early identification, screening, diagnosis, early intervention and family support for Georgia children suspected of having, or diagnosed with ASD. For one of the projects, Georgia DPH partnered with Emory Autism Center to review, pilot the use of, and modify existing transition materials for individuals with ASD, caregivers/parents and healthcare providers. Based on the review of the materials and staff experience in working with adolescents with ASD and their families, supplemental materials were created to enhance ASD specificity.

## **Current Year Oct 2016-2017**

### NPM 12: Transition to Adult Care for All Children

The CMS program continues to engage various partners to improve the successful transition for youth and young adults from pediatric to adult care. In partnership with the Georgia Chapter of the American Academy of Pediatrics, the *Transitioning Adolescents with Special Needs from Pediatrics to Adult Primary Care Conference* was held in March, 2017. This conference was designed to help family physicians, internists, OB/GYNs, pediatricians and clinical healthcare professionals to address issues surrounding transitioning youth with special health care needs from pediatric to adult care. Continuing medical education credits were provided with twenty-six (26) participants in attendance. How to prepare a Transition of Care Policy for your practice was the theme of the seminar with practical applications from Health Care Transition Physician Champions, hospital systems, health plans and private providers. The CMS program continues to also partner with the Georgia Academy of Family Physicians to support health care transition activities, which include lecture presentation at their Fall and Summer meetings as well as live webinars. Both medical societies have updated their websites to include health care transition information, resources and links to the Got Transition website.

### SPM: Improve access to specialty care for CYSNCH

In the current year, CMS continues to expand clinical services to other areas of Georgia and enhance telemedicine services by leveraging existing partnerships with the medical community. During SFY15, there were only two (2) local district (Waycross and Valdosta) programs that offered telemedicine services for neurology, nephrology, pulmonology and endocrinology. In coordination with the Department's Telehealth team, the CMS program expanded telemedicine services to five (5) local district (Valdosta, Albany, Athens, Columbus, and Waycross) programs for patients needing sickle cell and genetic care. Additional efforts to support neurology and endocrinology for telemedicine services are underway, as well as the installation of equipment to support a telemedicine clinic in the Gainesville health district

CMS continues to research the best ways to allocate specialty care and telemedicine resources to expand their services and improve access to care for CYSNCH. Thus, the CMS program partnered with the HRSA-sponsored Center of Excellence in MCH Education, Science, and Practice at Emory Rollins School of Public Health to establish a model to support the program in collecting and analyzing data that leads to improvements in the overall quality, access and continuity of care for children and youth with special health care needs. Core themes in the model include understanding the following:

1. Prevalence of disease in target population
2. Geographic access from patients to medical services
3. Financial access to medical services
4. Access to quality medical services

The model specifically looked at Critical Congenital Heart Defects (CCHD), and provided preliminary data that cardiology services are most needed in two (2) local districts (Dublin and Waycross) based upon the travel burden of children with CCHD (Age 0-20).

To assist with educating families about telemedicine as an option for care, the CMS program partnered with the Georgia Leadership Education in Neurodevelopmental Disabilities (GaLEND) Program and Early Hearing Detection and Intervention (EDHI) Program to help with developing strategies on structuring a family-centered and culturally-competent tele-audiology clinic for children with hearing loss. The GaLEND cohort interviewed key stakeholders, reviewed communication and evaluation materials and provided recommendations for the tele-audiology clinic flow and follow-up care.

## Other Programs

### *Early Intervention Services*

In the current year, the BCW program completed the Annual Performance Reporting (APR) and submitted it to OSEP February 2017.

The five State Systemic Improvement Plan (SSIP) districts identified two Master Cadres who were trained in the Pyramid model – Family Coaching and PIWI. These Master Cadres have worked side by side with our partners at Georgia State University to roll out the PIWI training to all non-licensed providers within their districts. As of June 2017, Gwinnett had one training left to complete and Coastal had four trainings. During the reporting year, the BCW program began working on the Family Coaching training, that will be rolled out to the same group of Providers through webinars or face to face trainings.

BCW also assessed the Strengths, Weakness, Opportunities and Threats (SWOT analysis) of the program. The SWOT analysis was conducted by a staff in 27 “hotspot” locations. Results will help BCW managers identify areas of improvement.

The BCW Program is also working closely with Parent 2 Parent and the Parent as Partners program. BCW recently implemented a parent satisfaction assessment survey and began collecting survey results.

#### *Georgia Autism Initiative*

In the current year, the Autism Initiative continues to expand Georgia’s capacity for early diagnosis by training psychologists to administer the Autism Diagnostic Observation Schedule, Second Edition (ADOS–2) which is considered the gold standard for a diagnostic assessment used during a comprehensive evaluation of a person suspected of having an autism spectrum disorder (ASD). To date, 52 licensed professionals have participated in 32 hours of hands-on training in the ADOS-2. Psychologists were targeted because they are the professionals most likely to diagnosis ASD in children; yet only about 10% of them use “gold standard” diagnostic instruments in their assessments.

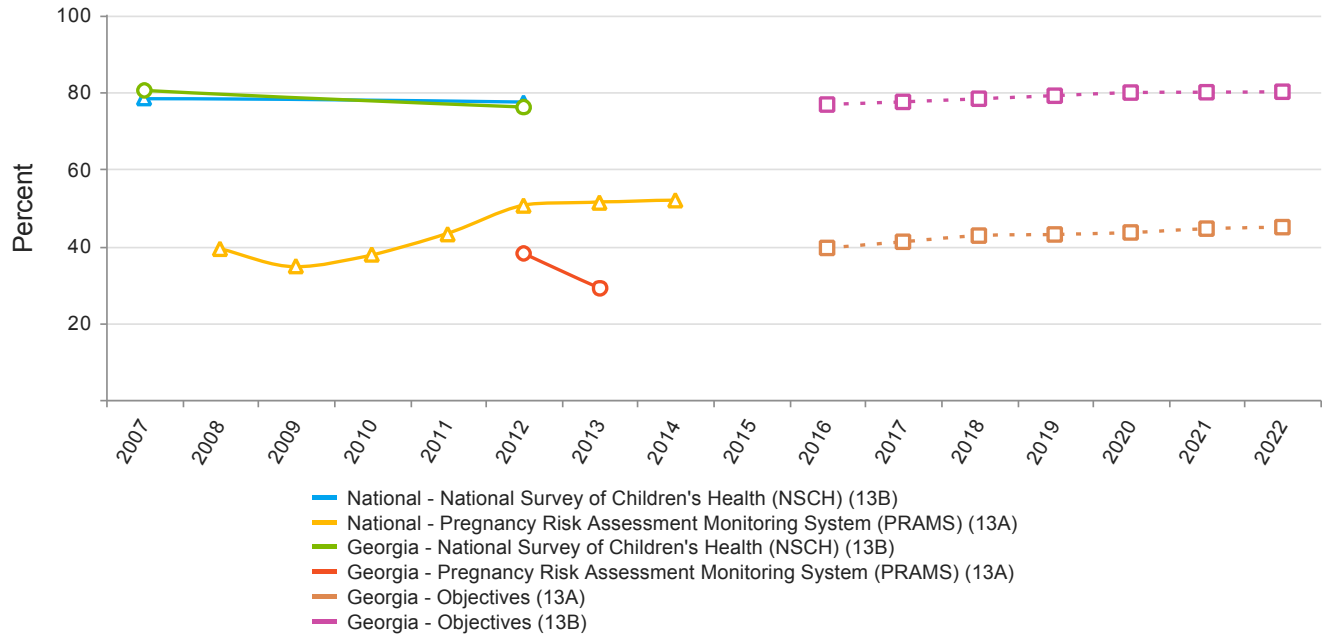
The Georgia Department of Public Health Autism Initiative collaborates with The Marcus Autism Center (MAC) to improve capacity for early identification of social, communication and behavioral challenges related to ASD and early intervention using evidence-based intervention practices. To date, 127 Early Intervention professionals, across 14 out of the 18 health districts, have received training on the *Autism Navigator*, a web-based course with 5 units and 30 hours of instruction, that uses interactive media to teach evidence-based strategies.

**Cross-Cutting/Life Course****Linked National Outcome Measures**

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months	NSCH-2011_2012	18.6 %	NPM 13
NOM 19 - Percent of children in excellent or very good health	NSCH-2011_2012	85.3 %	NPM 13

## National Performance Measures

### NPM 13 - A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year Baseline Indicators and Annual Objectives



### NPM 13 - A) Percent of women who had a dental visit during pregnancy

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	39.5
Annual Indicator	29.3
Numerator	18,443
Denominator	63,060
Data Source	PRAMS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	41.1	42.7	43.0	43.5	44.5	44.9

**NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	76.7
Annual Indicator	75.9
Numerator	1,773,709
Denominator	2,337,183
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	77.4	78.2	79.0	79.8	79.9	80.0

**Evidence-Based or –Informed Strategy Measures****ESM 13.1 - 11.1.1. Number of comprehensive webinars/presentations offered**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Oral Health Program Data
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	4.0	8.0	12.0	16.0	20.0	20.0

**ESM 13.2 - 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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	15
Numerator	
Denominator	
Data Source	Oral Health Program Data
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	5.0	10.0	20.0	30.0	40.0	40.0

## State Action Plan Table

### State Action Plan Table (Georgia) - Cross-Cutting/Life Course - Entry 1

#### Priority Need

Promote oral health among all populations

#### NPM

A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year

#### Objectives

11.1. By 2020, develop a collaborative partnership working with women's health partners and the Chronic Disease Section to promote perinatal oral health

11.2. By 2020, develop an oral health resource database for CYSHCN

11.3. By 2020, increase the education and promotion activities regarding oral health among low-income Hispanic mothers and children from 0 to 8

#### Strategies

11.1.a. Partner with public health districts, private practices, dental hygiene programs (the Augusta University, Dental College of Georgia) to promote perinatal oral health screenings

11.1.b. Offer comprehensive educational webinars/presentations

11.2.a Educate public health district oral health staff on special considerations and treatment needs for special needs patients

11.2.b. Determine data sources and begin collecting data to develop a special needs dental access database with location of practices serving special needs children and adults/special services offered, such as general anesthesia, orthodontics, insurance accepted and other specialties

11.3.a. Improve the Oral Health Education Initiative program to include culturally competent messages for low-income Hispanic children and adolescents



ESMs	Status
ESM 13.1 - 11.1.1. Number of comprehensive webinars/presentations offered	Active
ESM 13.2 - 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	Active

NOMs
NOM 14 - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months
NOM 19 - Percent of children in excellent or very good health

## **Cross-Cutting/Life Course - Plan for the Application Year**

### **Plan for the Coming Year: Oct 2017 – Sep 2018**

Oral health across all MCH populations is a priority for the MCH section and a strategic focus to improving health outcomes for infants and young children.

In the coming year, the Oral Health Program will support four districts to train and educate providers on the health outcomes for pregnant women with poor oral healthcare and tobacco use, and process for using the tobacco quit-line. The Oral Health Program will also educate public health district oral health staff on the special considerations and treatment needs for special needs patients. Education and training on caring for special needs will be condition specific and include evidence-informed practices. Education and training for school-based programs that include all children will continue.

In the coming year, the Fluoridation Specialist will provide 4 – 6 training classes for Georgia water plant operators in conjunction with Georgia Rural Water Association. Routine fluoride advisory meetings will be held in June, September, and December. There will also be coalition and coordinator meetings held in the summer of the upcoming year.

In the 2017-2018 school year, the Oral Health Program plans to open a school-based sealant pilot program in Forsyth County. The Oral Health Program will also work with the Fulton county school district to improve collaboration between public health oral health programs and Fulton county schools. The collaboration will help schools and the Fulton County Oral Health Program identify student eligibility, school specific responsibilities, program responsibilities, estimated costs, and liability for both the program and schools.

## Cross-Cutting/Life Course - Annual Report

### Reporting Year Oct 2015-Sept 2016

*Priority Need: Promote oral health among all populations*

#### NPM 13: Oral Health

Promoting oral health among all populations was determined as a priority need through the 2015 Title V Needs Assessment. The Title V Maternal and Child Health 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. The Oral Health Program focuses on preventing disease and actively engaging partners in private practice (dental and medical), schools, public health, Women, Infants, and Children Food and Nutrition Services Program (WIC), college and university dental and dental hygiene programs, Head Start, and other areas to support prevention education and services.

During the reporting year the Oral Health Program made several accomplishments in their routine program initiatives. Some of those highlights include:

- School-linked Fluoride Programs for high-risk children – Providing approximately 12,000 school-aged children with fluoride treatments.
- Dental Sealants – Placing more than 14,000 sealants on the permanent molars of Georgia's children.
- Dental Health Education – Teaching more than 90,000 school-aged children the importance of proper brushing, flossing, and good nutrition for good dental health.
- Community Water Fluoridation – As of December 2014, over 96% of Georgia's population using public water systems have access to fluoridated water; saving Georgians \$38 in future dental expenditures for each \$1 invested in fluoridation.

#### *Community Water Fluoridation*

The Community Water Fluoridation Program (CWF) in Georgia 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 (GRWA) to monitor and train water plant operators on 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, EPD, Department of Public Health (DPH), DNR, GDA, and GDHA. The committee guides the development of policies and advises on the daily operations of the CWF program. Currently, almost 97% of Georgia residents on community water system enjoy the benefits of fluoridated water. 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 Fluoridation Program. No major changes have occurred in this program this year.

#### *Children*

Georgia legislature passed Senate Bill (SB) 12 allowing dental hygienist to practice under "general supervision" at approved dental facilities of the Department of Public Health, Boards of Health, or the Department of Corrections. SB 12 also allows dental hygienist working within the stated parameters to bill Medicaid for reimbursable services. Public health will be able to directly expand preventive oral health services to underserved, children and families. The Oral Health Program has already begun expansion and expansion plans. A clinic in Houston, GA staffed with a dental hygienist opened in January of 2017. The Oral Health Program intends to also expand school-based programs in LaGrange, GA and is mapping underserved areas to determine new locations where dental hygienist could close the gap in access to preventive oral health care.

A presentation was offered twice during the Region IV Head Start Association meeting in Atlanta on the importance of preventing oral disease and community water fluoridation. In addition, the Oral Health Program completed two presentations during an 8-state meeting in Atlanta for Head Start Directors and Educators on pregnancy and infant

oral health.

In addition, the state staff worked with the Georgia Institute of Technology industrial modeling team on access to services. The university has access to county Medicaid oral health data and they are using the data to determine needs, dentist access, barriers to services and assisting our oral health team in most efficient and effective preventive services for those with the most need. This effort will support our ongoing needs assessment for the oral health priority need. Now we have access to this data and dental hygienists in DPH can be reimbursed for preventive services without direct supervision of a dentist therefore, we can expand our reach to the disparate communities the Georgia Tech team has indicated with the biggest access problems.

### *Pregnant Women*

Through partnerships with districts, private practice, education at dental hygiene programs, and in partnership with the Augusta University College of Dental Medicine, the Oral Health Program promoted perinatal oral health screenings, education on caring for pregnant women's oral care needs, guidance on infant oral health home care and pregnancy dental visits.

The MCH section contracts with the Georgia Academy of Family Physicians (GAFF) to promote medical guidelines and health education that improve health outcomes for women and children. The education contract with GAFF resulted in four oral health articles for the Georgia Academy of Family Physicians newsletter. These articles are available to over 2300 members and medical students. In addition to the articles, a face-to-face training on oral health, risk factors, and fluoride varnish was offered on March 5, 2016 at a conclave board meeting. Attendees indicated an intention incorporate fluoride varnish education into their routine visits.

During the reporting year, the Centers for Disease Control and Prevention (CDC) released a funding opportunity announcement to strengthen the partnership between oral health programs and chronic disease programs and develop a collaborative health promotion project. CDC's FOA aims to address common risk factors shared between oral health and chronic diseases; such as tobacco use and obesity. The Oral Health Program collaborated with DPH's Chronic Disease Section to co-author and administer a grant application. Through this project, DPH's oral health program selected one chronic disease risk factor (tobacco use) and worked with chronic disease staff to develop and implement a pilot project targeting young women at high risk of tobacco use during pregnancy.

The grant was awarded to and administered by the Chronic Disease Section who hired a project manager and partnership facilitator to guide the development of the collaboration.

## **Current Activities: Oct 2016 – Sep 2017**

*Priority Need: Promote oral health among all populations*

### NPM 13: Oral Health

The Oral Health Program continues its work to promote preventive oral health among Georgia's underserved populations.

### *Children*

As of October 2016, the district staff partnering with dental hygiene programs will reach more than 20 low-income elementary schools across Georgia and place more than 3,000 sealants on more than 2,000 vulnerable children. In June 2017, the Oral Health Program will be partnering with two dental hygiene programs to place sealants on children in Moultrie, GA.

In January 2017, the sealant coordinator targeted Spanish speaking families for oral health education at Hightower Elementary School where approximately 90% of the students are Hispanic and 94% of the students are eligible for the free and reduced lunch.

In May 2017, the Oral Health Program participated in a book fair for parents and students at Norcross Elementary; a school where according to Department of Education 90% of the students use Spanish as their home language and 86% are eligible for free and reduced lunch.

In January of 2017, GAFF published another encouraging family physicians to include the oral health assessment in routine visits and promote fluoride varnish for among children. In May 2017, GAFF aired a webinar on fluoride varnish. The webinar was recorded and will be available for family practice offices.

All eighteen public health district oral health staff continue to work with local Head Start Programs to promote oral health education, preventive fluoride treatments, and referrals for treatment. The Oral Health Program "Brush-Up" newsletters are distributed quarterly to DPH district staff to share with Head Start programs.

#### *Children and Youth with Special Health Care Needs*

The Oral Health Program and Children's Medical Services Program partnered to identify dental offices serving children and youth with special health care needs and create a web-based referral resource (database). Within the current year, the Oral Health Program determined and defined data variables. The database will house information on dental practices offering services to clients with special needs, the form of insurance they accept, whether they are general family practice or a pediatric practice, if they offer general anesthesia, and where they are located. The Georgia Academy of Pediatric Dentistry provided a list of member dentists who treat special needs children. To date data has been collected on providers in six counties.

#### *Pregnant Women*

Within the current year, the Oral Health Program and Maternal, Infant and Early Child Home Visitation Program (MIECHV) began a partnership to promote oral health among children and pregnant women. Home visiting nurses will receive a toolkit and training on oral health screening for pregnant women.

MIECHV contractors, the University of Georgia, will include the toolkit and educational plan into the Home Visitation newsletter.

Within the current year, Oral Health Program staff, Chronic Disease staff, and a staff member of Perinatal Health met routinely over the course of several months to learn how to collaborate with one another, define the common agenda, determine the projects vision, mission, goals and objectives, and develop a provider toolkit.

The Georgia Oral Health Coalition and the Georgia Dental Hygienists Association are professional groups that have been targeted to disseminate the tobacco cessation dental provider toolkit. The Oral Health Program presented the oral health chronic disease collaboration to the Georgia Oral Health Coalition and will continue to disseminate information during the regular scheduled meetings. Continuing education credits for learning more about using the DPH Quit-line are offered to the dental health professionals.

Local Oral Health Program staff continue to promote oral health provider training to WIC staff. WIC staff can also receive training online through a recorded webinar. In addition to training WIC staff, local Oral Health Providers began training public health colleagues on condition specific care for CYSHCN.

#### *Teledentistry*

The Georgia Department of Public Health champions the use of telehealth to serve Georgia's rural communities. In recent years, the public health telehealth system began expanding to include teledentistry. DPH's teledentistry program at the Waycross Public Health District has been gaining national attention and was recently published in the Oral Health Workforce Research Center's Report; *Case Studies of Six Teledentistry Programs: Strategies to*

*Increase Access to General and Specialty Dental Services*, December 2016. Georgia currently has two teledentistry programs in Waycross and Dublin that both successfully reach rural clients; women and children.

**Other Programmatic Activities**

No other programmatic activities to report

## II.F.2 MCH Workforce Development and Capacity

Under the leadership of Commissioner Brenda Fitzgerald, the Georgia Department of Public Health initiated a journey to ensure the agency would be prepared to accomplish its mission to prevent disease, injury and disability; promote health and well-being; and prepare for and respond to disasters. This journey has included implementing Jim Collins' Good to Great concepts and pursuing accreditation with the National Public Health Accreditation Board (PHAB). In an effort to accomplish the aforementioned goals the MCH workforce participated in several surveys and organizational restructures.

In 2015, a survey was distributed to MCH staff at the state, district and local level to determine their perceptions of workforce development needs and their experience in public health. Survey results allowed the Title V Director to determine areas where training and workforce development support were needed. Majority of the respondents stated they received public health education (skills training) via on-the-job training and just over 20% of respondents had worked in their jobs for 10 years or less. Respondents were also given multiple responses and asked to select the topics they were trained in when they started working with DPH. The three lowest responses were budget development, fundraising/grant writing, and epidemiology/data analysis.

During the reporting year and current year, the MCH workforce were able to seek skill based and content specific training and education through a variety of sources: Title V funded training, DPH HR supported training, HRSA funded Public Health Training Centers, and Conferences. In addition to professional development, DPH has been intentionally changing the culture of the agency through encouraging and facilitating continuous quality improvement (QI) and evidence informed decision making. Each a key component of the Jim Collins' Good to Great principles and PHAB accreditation.

### QI Staff Assessment Survey

In the current year, DPH issued another survey assessing their knowledge and use of QI practices. Survey results showed that approximately 81.1% of MCH employees were able to define quality improvement and 64.8% reported participating in organized improvement activities in the past three years. More than half the respondents (51.3%) agreed or strongly agreed that programs in DPH are constantly looking for ways to improve, and, the quality of many of the programs and services are routinely monitored. However, less than 5% of employees received formal training on QI frameworks. Approximately 32.4% of respondents have previously used the Plan Do Study Act framework. Even without formal training, the majority of the respondents have had some experience using QI tools. The top three highly known QI tools are brainstorming, flow charts, and story boards. The least known QI tools are kaizen event, forcefield analysis, and pareto chart.

Experience using QI Tools	
Brainstorming	94.6%
Process Map/Flow Chart	67.6%
Story Board	51.4%
Check Sheet	51.4%
Logic Model	35.1%
Fish Bone/ Cause and Effect Diagram	24.3%
Five Whys	24.3%
Gantt Chart	21.6%
Control Chart	18.9%
Histogram	16.2%
Scatter Diagram	16.2%
Run Chart	8.1%
Pareto Chart	5.4%
Forcefield Analysis	2.7%
Kaizen Event/ Rapid Process Improvement	2.7%



## **MCH Conference**

The MCH Section held its first *Maternal and Child Health Conference* from April 30, 2017 to May 2, 2017 in Athens, Georgia. The theme of the conference was "Building a Healthy Georgia, One Family at a Time". The MCH Conference invited public health employees from all over Georgia to participate in a three day face-to-face meeting. The goals of the conference were to build cross program synergy among Child Health, Women's Health and STD; train on policies, protocols, federal requirements and new and improved processes; highlight district successes, and best practices; and set new goals to move from Good to Great. There were 373 total conference attendees. The conference was divided into three primary tracks including child health, STD, and women's health. Within those tracks topics included program updates, oral health and family planning, opioid abuse, early signs of autism, HIV prevention and surveillance, and many more. Surveys were distributed after each session and were also available on the event app. Survey results showed that the majority of attendees were satisfied with their sessions with many of them rating it excellent. Attendees also reported that the sessions were very organized, session time lengths were about right, and the staff members were extremely friendly and very helpful. Those who attended the STD sessions were most likely to recommend the sessions to a friend. Overall, the conference provided many informative sessions on a variety of MCH topics and yielded positive feedback from attendees.

## **Leadership/Management Training**

The Un-Bossy Boss is a strategic learning tool which uses 12 powerful questions to make any individual into a great manager. This book is designed to build strong managers whose teams will therefore be highly productive, effective and motivated. Managers are encouraged to build interactive relationships with their employees that invites everyone on the team to build creative solutions. The MCH managers and employees participated in an instructor led Un-Bossy Boss training that consisted of real-life scenarios. Each lesson was followed by a worksheet for self-reflection on their current management skills and how these skills may be improved.

## **Plan for the Coming Year**

DPH will continue to implement the elements of Good to Great, foster a learning environment and culture of quality, and pursue PHAB accreditation. The Title V Director plans to continue to support the Department's efforts to build a workforce capable of accomplishing the mission of public health as well as meet the mission of the Title V Maternal and Child Health Services Block Grant. In the upcoming year, employee development will focus on each of the spheres defined by DPH HR as; organizational, core (PH competencies), leadership, and job specific/professional.

### II.F.3. Family Consumer Partnership

The Georgia Maternal and Child Health Section (MCH) recognizes the value that family and consumer partnerships add to developing strategies that meet the needs of the populations they are intended to address. While there are several existing family/consumer partnerships engaged in local and state public health, the MCH section set a goal with the MCH Transformation 3.0 to expand family consumer partnership.

MCH engages families and consumers on both the state and local levels. At the state level, MCH has two full time family engagement staff; a family engagement specialist, which works directly with the CYSHCN programs, and a family engagement leader, which provides guidance and technical assistance to all MCH programs, including CYSHCN. MCH also brings together families, community partners and stakeholders at every opportunity to facilitate partnership.

At the state level, MCH programs engage families and community partners in strategic planning, program development, quality improvement initiatives, block grant development and review, workforce development, training, and as members of advisory councils. MCH hosts the following committees and councils for which families, family organizations and community partners are encouraged to participate.

*Newborn Screening Advisory Council (NBSAC)* – The purpose of the NBSAC is to provide advice to the Georgia DPH regarding its statewide system for newborn screening and genetics. The NBSAC must include at least two parent/consumer representatives, and at least one representative from a community-based organization.

*The Early Hearing Detection and Intervention (EHD) Advisory Group* is a sub-committee of the Newborn Screening Advisory Council. Members meet quarterly to discuss the program's current quality improvement initiatives. The group consists of parents, adults who are deaf or hard of hearing, program staff, Early Intervention providers, healthcare providers, Audiologists and representatives from state agencies and non-profit community organizations. Additionally, each district EHD follow-up coordinator is tasked with hosting a local stakeholder meeting twice a year, with a similar goal of providing updates to and seeking guidance from the communities they serve.

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

*Georgia Oral Health Coalition (GOHC)* - The mission of the GOHC is to increase access to dental care, prevent and reduce dental caries, periodontal disease, oral-facial trauma, and tobacco use, and detect oral cancer in early stages and reduce its incidence thus, improving oral health and quality of life for all Georgians.

*Project LAUNCH* cohosts a state level council meeting alongside Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), and, also hosts a local Young Child Wellness Council (YCWC) meeting in Columbus, GA. Project LAUNCH is guided by a council whose mission is to improve coordination and collaboration across the systems that serve young children and their families. Long-lasting improvements to the collaboration and partnership system for birth to age 8 will increase access to screening, assessment and referrals to appropriate services that meet the social and emotional needs of children. This will in turn improve the well-being of families in Muscogee County which is the ultimate goal.

MCH also partners with medical societies, colleges and universities, community partners, other state agencies, and DPH's eighteen (18) local health districts to support family leaders and consumers on the local level.

#### State Level Partnerships

State/Federal/National Partners	Georgia 18 Health Districts Georgia Department of Education (DOE) Georgia Department of Community Health (Medicaid) Georgia Department of Juvenile Justice (DJJ) Georgia Department of Early Care and Learning (DECAL) GA Department of Family and Children Services (DFCS) Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) Georgia Parent Infant Network for Educational Services (PINES) – DOE Hearing/Vision
---------------------------------	---

	Georgia Bureau of Investigations Center for Disease Control (CDC) National Perinatal Information Center Association of Public Health Laboratories/New Steps Association of Maternal and Child Health Programs (AMCHP) Family Voices (National Center on Family and Professional Partnerships) Help Me Grow National Center State Commission on Family Violence
Community-based Partners	Arthur M. Blank Family Foundation Auditory Verbal Center Atlanta Speech School Atlanta Area School for the Deaf Bates Associates Emory Autism Center Get Georgia Reading Campaign Georgia March of Dimes Georgia Hands and Voices Georgia Pathway Georgia Family Connections Partnership Georgia Early Education Alliance for Ready Students (GEEARS) Georgia Rural Water Association Georgia American Academy of Pediatrics Georgia Academy of Family Physicians Georgia Hospital Association Georgia Dental Hygienists' Association Georgia Dental Hygiene Educators' Association Georgia Dental Society Georgia Leadership Academy Georgia Obstetrical and Gynecological Society (GOGS) Georgia Public Health Association Georgia Voices for Children Healthy Mothers, Healthy Babies Hemophilia of Georgia Marcus Autism Center Mental Health America of Georgia Parent to Parent of Georgia, Inc. Safe Kids Georgia Saving Babies through Screening Foundation Sickle Cell Foundation of Georgia Southeastern NBS and Genetics Collaborative United Way of Greater Atlanta
Hospitals/Healthcare Systems	Emory Navicent Health Memorial Health WellCare (CMO) Amerigroup (CMO) Peach State (CMO) Care Source (CMO) Grady Memorial Health System Morehouse Healthcare Midtown Medical Center Phoebe Putney Memorial Georgia Regents University Children's Healthcare of Atlanta (CHOA) Memorial University Medical Center
Colleges/University Systems	Emory University Augusta University Morehouse College University of Georgia Georgia State University

*Reporting Year Oct 2015-Sep 2016*

In 2015, the MCH Section set a goal to increase family and consumer partnership throughout all MCH population domains. Family and consumer partnership was defined as a system of service providers, families, consumers and leaders in public health who come together to set and collaborate on common goals and solve problems that affect them.

*Current Year Oct 2016-Sep 2017*

A major strategy to move MCH along the continuum of family engagement was to share the responsibility for family consumer partnership amongst each MCH program, the Title V Unit and MCH administration. Family consumer partnership now permeates throughout MCH. In the reporting year, the following family consumer partnership activities were accomplished by MCH programs/units:

Early Intervention Programs: Babies Can't Wait (BCW) and Children Medical Services (CMS) dually funded parent partners at local health districts and private provider sites. Parent Partners provide peer-to-peer support to families of CYSHCN, and provide family resources to CMS local staff. This partnership was accomplished through a partnership with Parent to Parent of Georgia, Inc., who serves as Georgia's Early Intervention Central Directory, Family to Family Health Information Center (F2F), and Parent Training and Information Center (PTI). Through this partnership, families of CYSHCN are provided community-based resources and support.

CMS partners with Parent to Parent of Georgia to conduct youth transition trainings, host a youth transition Facebook page, and with Children's Healthcare of Atlanta (CHOA) and Augusta University to support transition activities for youth affected by Sickle Cell.

BCW continues to support State and Local family leaders serving on its Interagency Coordinating Councils (SICC/LICC). BCW reimburses family leaders serving on its state and local councils, as well as any families that attend its quarterly council meetings. State and Local Family Leaders were an integral part of completing BCW's State Systemic Improvement Plan (SSIP). SSIP is an Office of Special Education Programs (OSEP) Results-driven Accountability Framework (RDA).

Newborn Screening (NBS) continues to support family leaders that serve on MCH's Newborn Screening and Genetics Advisory Committee (NBSAC). NBS also partnered with the Sickle Cell Foundation of Georgia to hire Community Partners to provide community-based resources and support to families living with Sickle Cell Anemia.

Early Hearing Detection and Intervention (EHDI) Georgia's EHDI program includes family engagement to best serve families whose children are identified as deaf or hard of hearing (D/HH). This is particularly important in helping families connect and enroll as early as possible into an intervention program.

EHDI partners with the Georgia Hands & Voices chapter to provide the Advocacy, Support, and Training (ASTra) program for parents and professionals to build their capacity to advocate for children and families in their community. EHDI also collaborates with the Georgia Hands & Voices Guide by Your Side initiative—a program in which parent mentors help provide support to parents of children identified as D/HH. This initiative is particularly important to EHDI, as parent guides often encourage and motivate other parents to enroll their children into early intervention (EI) services as soon as possible. In addition to these collaborative relationships, EHDI includes parents in training and programmatic decision-making. Parents are invited to state and district-level stakeholder meetings, and parents are encouraged to participate national EHDI conferences as attendees and as co-presenters alongside MCH staff.

EHDI developed a new partnership with DOE's Georgia PINES program to support their Deaf Mentor curriculum: a free, home-based service designed to help mentor, support, and teach families American Sign Language (ASL) and Deaf Culture. The EHDI program will also plan and facilitate learning communities in the state, with guidance from MCHB. These learning communities will include parents as a part of the core group, and will help to provide guidance to the program on best practices in service coordination and EI enrollment.

Maternal, Infant, and Early Childhood Home Visiting (MIECHV) began a Continuous Quality Improvement (CQI) project

which focuses on family engagement. The mission of Georgia's Home Visiting CQI plan is to facilitate the provision of high quality, evidence-based family support services to Georgia's at-risk families and children, prenatally and to age 5. The specific focus of Georgia's FY17 plan is to enhance family engagement in home visiting by testing improvements in enrollment, dosage, and retention of families.

**MIECHV CQI Goals:**

- Goal 1: Increase the number of families who remain active in home visiting for longer than three months
- Goal 2: Increase the number of expected home visits received by families enrolled in home visiting
- Goal 3: Increase the number of families who receive a first home visit within 14 days of referral to HV
- Goal 4: Increase the number of families who remain active in HV for greater than one month

Project LAUNCH partners with P2PGA to fund a Parent Partner to assist families with community-based resources and support in Columbus, GA. Project LAUNCH also partnered with an individual family organization to conduct six Parent Cafés at which approximately sixty (60) parents were in attendance. Project LAUNCH also held a virtual café on Facebook, one at a family center, and one at a local Columbus, GA barber shop. The Project LAUNCH Parent Partner also works closely with Early Head Start and the Boys and Girls Club of Columbus to host community events for families.

**Project LAUNCH Goals:**

- Goal 1: Identify parent leaders
- Goal 2: Encourage Local Young Child Wellness Council involvement
- Goal 3: Promote strengthening families (protective factors) and developmental milestone moments (Learn the Signs. Act Early).

Title V Family Engagement Specialist collaborates on activities that support family consumer partnerships and community partnerships for all programs within the MCH Section. Staff work to ensure that all MCH partners have information, resources and the support necessary to address the needs of the MCH population, including CYSHCN.

In the reporting year, MCH's Senior Manager of Planning and Partnerships (DPP) edited the MCH website to make it more family-friendly. The DPP also created a Family Portal for families to have quick access to resources and support. MCH's Family Portal received 5,315 hits to its webpage in FFY 2017. The DPP also worked with each program to insure written and media materials were family-friendly. In the reporting year, a vast amount of MCH marketing and promotional materials were distributed statewide at conferences, health fairs, and other public events.

MCH programmatic materials designed and distributed statewide include: NBS trifolds and booklets, BCW Family Cost Participation Guide, BCW transition trifolds, Neonatal Abstinence Syndrome (NAS) trifolds, CMS Youth Transition Guides, CMS Parent Transition Guides, CMS Transition Workbooks, and ZIKA Pregnancy Prevention Kits (10,000+).

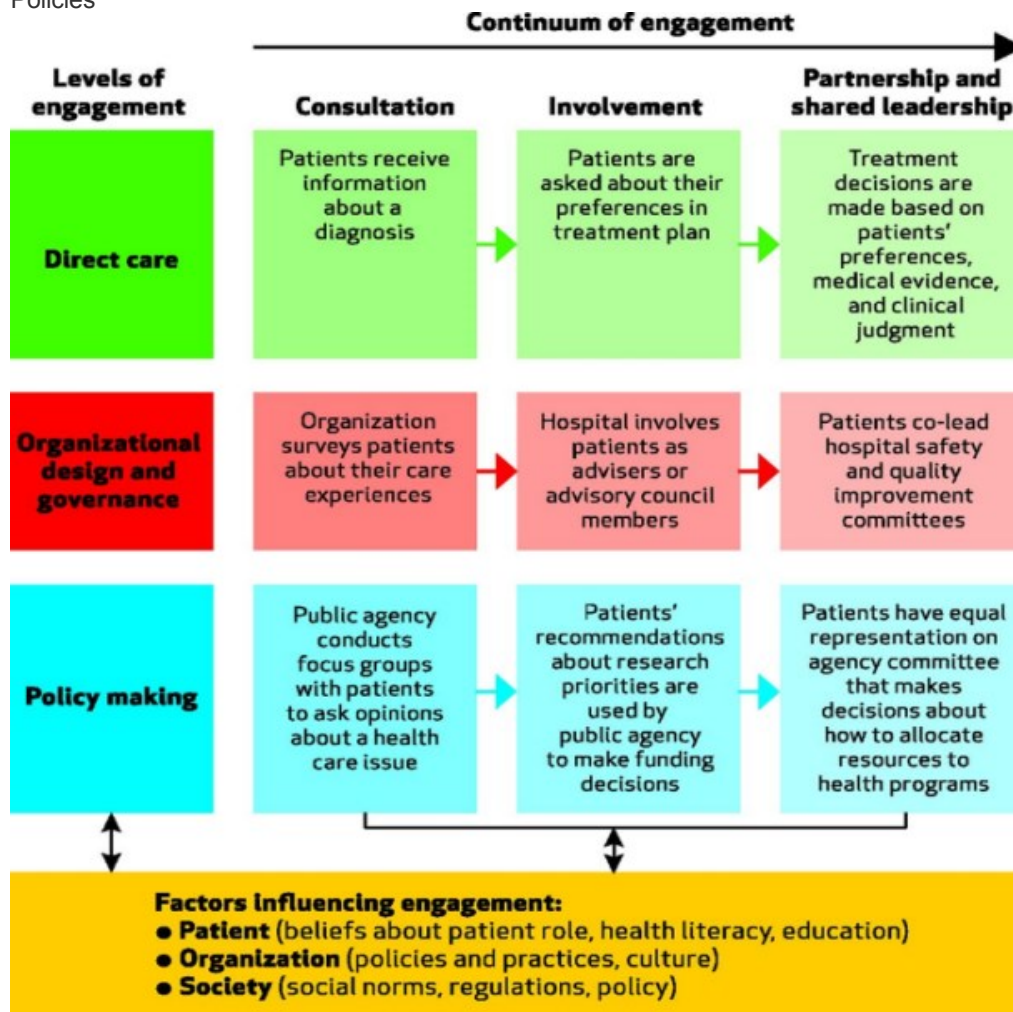
The Title V Unit partnered with Dr. Carol Hogue, PhD, MPH with Emory University's Rollin School of Public Health to conduct a MCH Foundations Training for state and local staff, family leaders and community-based partners. Family leaders representing each Title V health domain attended the training.

**Plan for the Coming Year Oct 2017-Sep 2018**

As MCH moves toward incorporating family participation in all of its programs, MCH staff and leadership intentionally work to support program managers as they take a major role in ensuring families become and remain an integral part of program activities.

The MCH section will complete a gap analysis of the family consumer partnership activities and use "*Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies*", (Carman, K et.al. 2012) as its model (Figure 1) for the gap analysis. The model seeks to create a pathway toward better-quality health care, more-efficient care, and improved population health. The model presents the forms patient/family engagement can take, ranging from consultation to partnership. It then depicts the levels at which engagement can occur across the health care system, from the direct care setting to incorporating patient/family engagement into organizational design, governance, and policymaking.

Figure 1: Patient and Family Engagement: A Framework For Understanding the Elements and Developing Interventions and Policies



#### **II.F.4. Health Reform**

HB 943 continues to be in effect. The Title V MCH Block Grant Program is providing gap-filling health care services to MCH populations that do not have coverage for health care services, particularly for children and youth with special health care needs. Children's Medical Services (CMS) is the Title V CYSHCN program. For families that do not qualify for Georgia's Medicaid and SCHIP programs, CMS will serve as the payor of last resort for all health care and medical expenses.



## II.F.5. Emerging Issues

Within the last three years, since the 2015 Title V Needs Assessment, both Zika and the Opioid Epidemic have emerged as issues warranting response by the Georgia Department of Public Health (DPH).

The emergence of the Zika outbreak in central/south America, the Caribbean and local transmission in Florida and Texas has led to extensive preparations in Georgia for a potential outbreak. As the first mosquito-borne infection to cause serious birth defects and poor pregnancy outcomes with sexual transmission, infectious disease epidemiologist, environmentalist, maternal and child health staff, and agency leaders are preparing for potential outbreak in Georgia and its potential to impact Georgia's newborns. Therefore, Zika has emerged as a state priority being led by the State Epidemiologist. The top priority in Georgia's Zika response is to protect pregnant women and their fetuses. DPH has established five key actions in the response plan: 1) human surveillance, 2) laboratory testing, 3) mosquito surveillance/control, 4) promote prevention and control strategies, and 5) expand outreach and communication.

In December of 2015, DPH Epidemiologists began preparing for the Zika response. Guidance documents created for the 2014 Chikungunya response were updated for Zika and disseminated to district epidemiologists. Surveillance for Zika began in January 2016 when DPH Epidemiology received the first call inquiring about testing for Zika in a pair of travelers.

DPH Epidemiology worked with the State Electronic Notifiable Disease Surveillance System (SendSS) developers to create secure documentation and a centralized system for the response. The Zika Active Monitoring System (ZAMS) hold detailed records on all patients tested for Zika in Georgia both through public health and through commercial labs. DPH Epidemiologists worked with commercial labs to ensure receipt of all Zika results, both positive and negative, which are documented within the system. Each patient record includes demographics, pregnancy information, contact information for providers, travel history, clinical presentation, special circumstances, and laboratory results. Additionally, forms for the US Zika Pregnancy Registry and US Zika Birth Defects Registry have been integrated into the system and can be found in the individual records of pregnant patients in ZAMS. ZAMS access is shared between state and district epidemiologists allowing for real-time and secure sharing of information related to the response. In addition to these functions, the system also has the ability for files to be uploaded to an individual's record, this allows users to add reports of mosquito surveillance done at a patient's home or laboratory submission forms that may be needed in the future. ZAMS has recently been updated to allow limited access for Environmental Health partners which allows them to see information for patients requiring mosquito surveillance/EH follow-up but also maintaining patient protections.

DPH Epidemiology utilized funds from the ELC and Zika Birth Defects grants to hire a US Zika Pregnancy Registry (ZPR) Coordinator and a Zika Birth Defects (BD) Epidemiologist. These epidemiologists work under the Zika Epidemiology Team Lead and manage the state's participation in these national registries. The US ZPR Coordinator follows any woman with evidence of Zika infection throughout pregnancy and then completes case reports on the infant at 0, 2, 6, and 12 months of age. The Zika DB Epidemiologist follows infants born with Zika-related birth defects. This includes using data from ZAMS on women identified during pregnancy, but also includes utilization of data streams available to identify infants with birth defects of interest outside of ZAMS and tracing back to see if a Zika exposure occurred.

Since January 2016, a small team of epidemiologists at DPH have triaged over 2,600 clinical inquiries related to testing for Zika and over 6,300 general inquiries about Zika (a total of almost 9,000 calls). These epidemiologists have facilitated testing for over 1800 persons at the Georgia Public Health Lab (>75% of which have been pregnant women). DPH Epidemiologists use these calls as an opportunity to educate providers and the general public on travel recommendations for pregnant women or women planning to become pregnant and to share information on mosquito-borne and sexual transmission risks and recommendations. Zika surveillance efforts in DPH epidemiology have identified 118 travel associated cases of Zika in Georgia citizens. Thirteen women have been included in the US Zika Pregnancy Registry. Two live-born infants have been identified with birth defects and one pregnancy loss has occurred in a woman infected with Zika during pregnancy.

Maternal and Child Health (MCH) staff have supported efforts to prepare for Zika by supplying over 1000 Zika pregnancy prevention kits (condoms, Zika education, DEET wipe and lubrication) to the public health districts in order to assist with local outreach and education. MCH staff also participate on our weekly statewide coordination calls and disseminate Zika-related material to external partners like the OB-GYN Society and Georgia chapter of ACOG. MCH has also prepared to respond to an increasing number of children with Zika related disorders by pulling out four Zika related disorders on Child Health Referral Forms. Doing so makes it easier for physicians to recognize the conditions qualify for early intervention services through child health programs.

Another emerging issue impacting the health of the maternal and child health population is opioid misuse and overdose. Georgia, like many other states, is seeing a rise in opioid misuse, overdose and neonatal abstinence syndrome. This issue emerged during the 2015 Title V five-year needs assessment focus groups and resulted in identifying substance use during pregnancy as a priority need to address neonatal abstinence syndrome. Opioid misuse and overdose has emerged as an



issue for Georgia's legislators and general public.

For the last 50 years motor vehicle crashes (MVC) have been a leading cause of death, particularly among Georgians 1-44. In 2014 drug overdose deaths (1223) eclipsed MVC fatalities (1104) as a leading cause of death in Georgia (Figure 1), following the national trend. As stated in the needs assessment summary and the priority need selection sections, the rise in opioid use and misuse (abuse) is consistent with the rise in deaths (Figure 2) and infants born with neonatal abstinence syndrome.

Figure 1: Deaths from Drug Overdoses and Motor Vehicle Crashes, Georgia Residents, 1999-2015

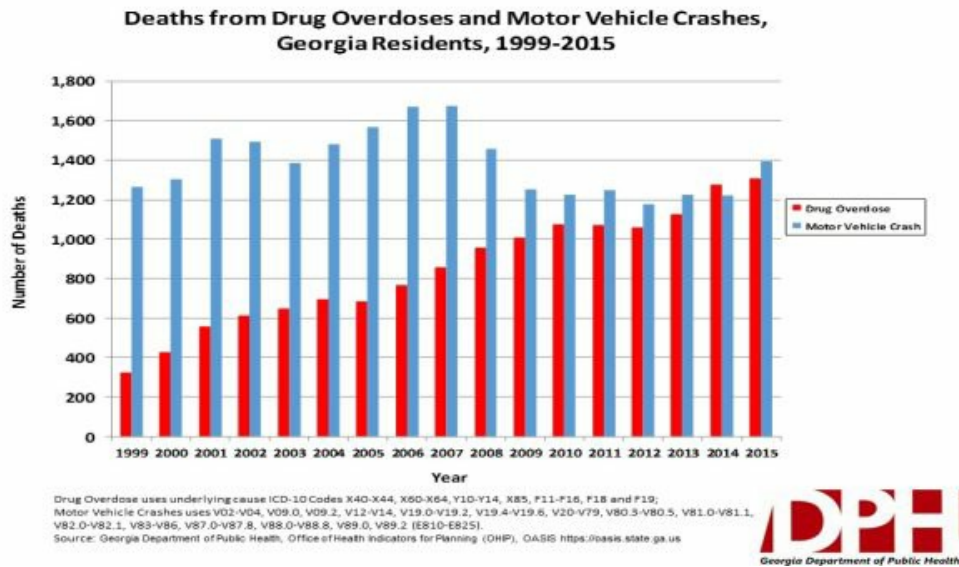
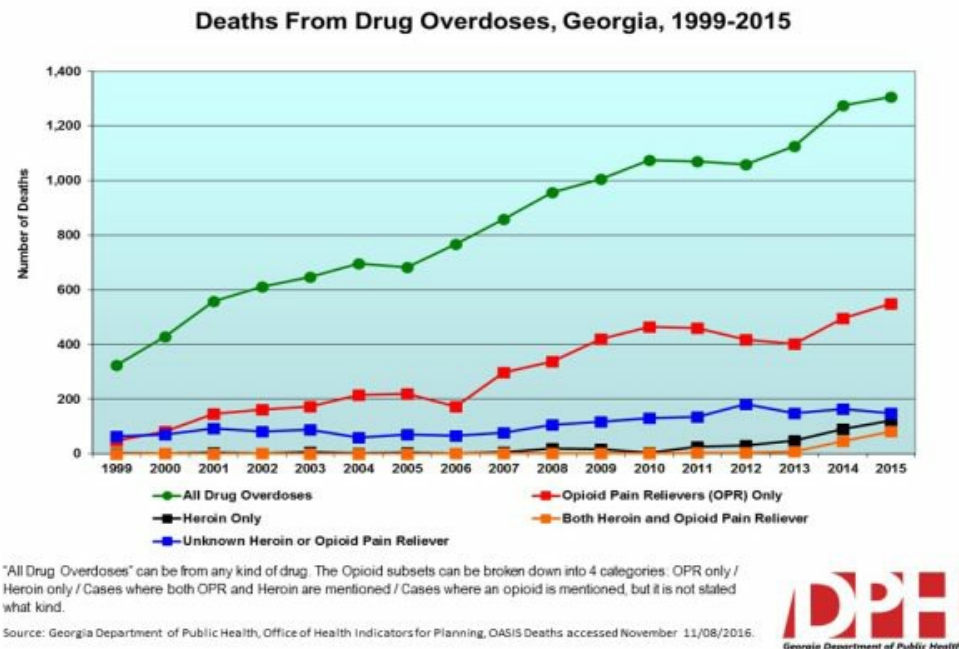


Figure 2: Deaths from Drug Overdoses, Georgia, 1999-2015



The number of women misusing opioids during pregnancy is increasing in Georgia. Increasing the risk for maternal obstetric complications associated with opioid use including pre-term birth, placental abruption and death. Neonatal complications include Neonatal Abstinence Syndrome (NAS), preterm delivery, growth restriction, low birth weight, and death. NAS is a

collection of symptoms infants experience as they withdraw from opioids. Symptoms include inconsolability, gastrointestinal system problems, autonomic and metabolic problems. In January 2016, NAS became a reportable condition in Georgia to monitor the spread of babies born with withdrawal to maternal opioid use.

DPH staff with the impetus and support of Commissioner Dr. Brenda Fitzgerald, partnered with Commissioner Frank Berry at the Georgia Department of Behavioral Health and Developmental Disabilities to convene stakeholders and formulate a strategic plan to address opioid misuse. Stakeholders were identified through a collaborative effort of DPH and DBHDD.

Now led by DPH's Opioid Czar, DPH is implementing Screening, Brief intervention and Referral to Treatment (SBIRT), a recommended framework which encompasses primary, secondary and tertiary prevention measures to decrease substance use. The goal of this proposed project is to decrease opioid use among pregnant women to improve maternal and neonatal outcomes. The program strategies and objectives are to provide health education to public health providers to increase provider's knowledge of and ability to conduct Screening, Brief Intervention, and Referral to Treatment (SBIRT); establish new and strengthen existing collaborations with internal and external partners to convene working group to develop state policies in Georgia; and develop and disseminate health education/health communication resources and materials to increase awareness and understanding of opioid use and adverse effects maternal and fetal outcomes.

#### **II.F.6. Public Input**

Public input was obtained by soliciting comment from partners and parents across the state. The 2018 Application and 2016 Annual Report, and population domain narratives were posted on the Georgia Title V website. Comment was received via email and anonymously through survey monkey. Survey monkey captured likert responses to pointed questions, as well as, open ended responses. Announcements on how and where to make comment were sent to partners, stakeholders, community members, and District Health Directors.

Public comment will continuously be solicited throughout the application year.

Below are the comments received thus far:

#### **II.F.7. Technical Assistance**

The Maternal and Child Health Section plans to request technical assistance from Emory University's Center of Excellence in MCH, Science and Practice (Emory) to develop evidence-informed training that will support the completion and accuracy of fetal-death certificates. Emory will identify the factors impacting the completion of fetal-death certificates among Georgia birthing facilities, develop an appropriate training for hospital staff, and test the efficacy of that training.

### III. Budget Narrative

	2014		2015	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$15,882,994	\$15,634,663	\$16,438,560	\$16,611,128
<b>Unobligated Balance</b>	\$0	\$0	\$0	\$0
<b>State Funds</b>	\$126,369,205	\$87,873,596	\$92,757,286	\$91,825,080
<b>Local Funds</b>	\$0	\$0	\$0	\$0
<b>Other Funds</b>	\$150,133,658	\$154,313,381	\$157,349,758	\$141,371,383
<b>Program Funds</b>	\$18,316,838	\$7,652,922	\$3,771,854	\$9,133,504
<b>SubTotal</b>	\$310,702,695	\$265,474,562	\$270,317,458	\$258,941,095
<b>Other Federal Funds</b>	\$306,402,197		\$275,603,567	\$27,954,952
<b>Total</b>	\$617,104,892	\$265,474,562	\$545,921,025	\$286,896,047

Due to limitations in TVIS this year, States are not able to report their FY14 Other Federal Funds Expended on Form 2, Line 9. States are encouraged to provide this information in a field note on Form 2.

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$16,611,128	\$16,838,159	\$17,267,095	
<b>Unobligated Balance</b>	\$0	\$0	\$0	
<b>State Funds</b>	\$98,513,369	\$96,689,064	\$114,351,317	
<b>Local Funds</b>	\$0	\$0	\$0	
<b>Other Funds</b>	\$132,713,617	\$141,206,672	\$147,350,720	
<b>Program Funds</b>	\$7,652,922	\$8,319,821	\$9,133,503	
<b>SubTotal</b>	\$255,491,036	\$263,053,716	\$288,102,635	
<b>Other Federal Funds</b>	\$25,324,930	\$25,570,889	\$33,098,697	
<b>Total</b>	\$536,307,002	\$288,624,605	\$321,201,332	

	2018	
	Budgeted	Expended
Federal Allocation	\$16,966,578	
Unobligated Balance	\$0	
State Funds	\$97,717,662	
Local Funds	\$0	
Other Funds	\$167,447,415	
Program Funds	\$8,425,409	
SubTotal	\$290,557,064	
Other Federal Funds	\$34,857,870	
Total	\$325,414,934	

### **III.A. Expenditures**

#### **FFY 16 Annual Report Expenditures**

State and Federal funds are allocated based on priority needs 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 Department of Public Health's budget process, recommendations are made for funding levels for services to women and children.

The State required match on our FFY 2016 MCHBG budget of \$16,838,159 is \$12,628,619. The financial report in the Financial Services Division of Georgia Department of Public Health (GADPH), reflects the match is \$12,628,619. Georgia's maintenance of effort (MOE) level is \$36,079,622. Our current MOE level is \$37,452,696 for the FFY 2016 grant as of January 31, 2017.

### III.B. Budget

#### FY18 Application Budget

The Department of Public Health has a system of accountability to monitor the allocation and expenditures of funds provided to local health districts. The department utilizes the computer program, Uniform Accounting System (UAS), where the local health districts' administrative personnel input budget (funds that are allocated by programs such as Children with Special Health Care Needs) and expenditures. The MCH Section and Department of Public Health staff (Audit's), when necessary, monitor programs quarterly and provide technical assistance where needed.

The FFY 2018 Budget for the Federal-State Title V Block Grant Partnership Subtotal \$290,557,064. Of this amount, \$16,966,578 are the Title V funds. The remaining amounts represent State Funds totaling \$97,717,662, Other Funds totaling \$167,447,415, Program Income totaling \$8,425,409 and Georgia's Maintenance of Effort (MOE) Amount \$36,079,622.

The total Federal-State Block Grant Partnership for FFY 2018 includes approximately \$8,425,409 in Program Income. This income is derived from Medicaid earnings, Private Insurance, Health Check earnings and Client Self Pay, for services provided to Pregnant and Postpartum Women, Preventive and Primary Care for Children and Reproductive Health Services to Women (See Form 2 line 6).

Other Federal Funds that support Maternal and Child Health (MCH) activities in Georgia are estimated at \$34,857,870. This represents a variety of Federal Programs including Temporary Assistance for Needy Families (TANF), Early Hearing Detection Initiative (EHDI), Preventive Health and Health Services Block Grant (PHHSBG), Maternal, Infant, and Early Childhood Home Visiting Program Formula, Maternal, Infant, and Early Childhood Home Visiting Program Innovation, Oral Disease Prevention Program, Project LAUNCH, and Early Identification and Intervention Infants and Toddlers. This brings the grand total for the State MCH Budget \$325,414,984 (See Form 2 line 11).

For FFY 2018, \$32,999,459 is budgeted for Direct Services, \$50,724,750 for Enabling Services, and \$189,866,277 for Public Health Services and Systems (See Form 3B Non-Federal).

Of the Title V Federal Allocation request (\$16,966,578), \$8,277,193 or 48.79% is earmarked for Preventive and Primary Care for Children (See Form 2 1A, 1B, and 1C).

**Pregnant Women:** Title V is used in this area for Perinatal 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. 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.

**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 1st Program population-based system in the State of Georgia, designed to serve as an entry point into all public health services for children, birth – 5 years old.

**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.

Approximately \$7,502,765 or 44.22% is earmarked for Children with Special Health Care Needs.



**Children with Special Health Care Needs (CSHCN):** Supports Genetic/Sickle and Children Medical Services provide care coordination and other needed medical/health services for eligible children and their families,

There is 6.99% or \$1,186,620 earmarked for Title V Administrative Costs, used to support positions and administration. These positions provide data, quality assurance, technical assistance, policy, planning, and operational services that support and enhance the State's MCH System. These percentages are in keeping with the 30/30 required by Title V.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [DPH 2016027 Title V and XIX EXECUTED.pdf](#)

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [2018 References.pdf](#)

Supporting Document #02 - [2017 MCH BG Glossary of terms - Acronym List.pdf](#)

## VI. Appendix

This page is intentionally left blank.

**Form 2**  
**MCH Budget/Expenditure Details**

State: Georgia

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 16,966,578	
A. Preventive and Primary Care for Children	\$ 8,277,193	(48.7%)
B. Children with Special Health Care Needs	\$ 7,502,765	(44.2%)
C. Title V Administrative Costs	\$ 1,186,620	(7%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 97,717,662	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 167,447,415	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 8,425,409	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 273,590,486	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 36,079,622		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 290,557,064	
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)	\$ 34,857,870	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 325,414,934	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 14,234,013
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 9,153,768
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 400,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 310,599
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	\$ 246,842
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	\$ 783,941
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program Innovation	\$ 2,000,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program Formula	\$ 7,478,707

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 16,611,128		\$ 16,838,159	
A. Preventive and Primary Care for Children	\$ 6,211,948	(37.4%)	\$ 6,583,871	(39.1%)
B. Children with Special Health Care Needs	\$ 8,838,889	(53.2%)	\$ 8,726,687	(51.8%)
C. Title V Administrative Costs	\$ 1,560,290	(9.4%)	\$ 1,527,601	(9.1%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 98,513,369		\$ 96,689,064	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 132,713,617		\$ 141,206,672	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 7,652,922		\$ 8,319,821	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 238,879,908		\$ 246,215,557	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 36,079,622				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 255,491,036		\$ 263,053,716	
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)	\$ 50,649,860		\$ 25,570,889	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 280,815,966		\$ 288,624,605	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 9,153,768	\$ 9,102,526
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 136,464	\$ 136,464
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 145,248	\$ 145,248
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 450,000	\$ 317,303
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374	\$ 92,410
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 230,715
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	\$ 799,177	\$ 1,255,799
US Department of Education > Office of Special Education Programs > Early Identification and Intervention Infants/Toddlers	\$ 13,856,300	\$ 13,856,300
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 9,153,768	\$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 136,464	\$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 145,248	\$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 450,000	\$ 0



OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374	\$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 0
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	\$ 799,177	\$ 0
US Department of Education > Office of Special Education Programs > Early Identification and Intervention Infants/Toddlers	\$ 13,856,300	\$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > D70	\$ 128,000	\$ 123,525
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > GA OH Prevention Pro	\$ 310,599	\$ 310,599
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > D70	\$ 128,000	\$ 0
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > GA OH Prevention Pro	\$ 310,599	\$ 0

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, A. Preventive and Primary Care for Children</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	In Form 2 Line 1A equals Pregnant Women, Infants<1 and Children 1-22.
2.	<b>Field Name:</b>	<b>1.FEDERAL ALLOCATION</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	In FFY 16 received an increase for Federal Allocation Funding.
3.	<b>Field Name:</b>	<b>Federal Allocation, A. Preventive and Primary Care for Children:</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	In Form 2 Line 1A equals to Pregnant Women, Infants<1, Children 1-22 years and All Others.
4.	<b>Field Name:</b>	<b>5. OTHER FUNDS</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Form 2: Field Name: Other Funds VFC expended amount for FFY 16 increased.
5.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Administration for Children &amp; Families (ACF) &gt; Temporary Assistance for Needy Families (TANF)</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	Duplicated Amount

6.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Centers for Disease Control and Prevention (CDC) &gt; Early Hearing Detection and Intervention (EHDI) State Programs</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> Duplicated Amount	
7.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Centers for Disease Control and Prevention (CDC) &gt; Pregnancy Risk Assessment Monitoring System (PRAMS)</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> Duplicated Amount	
8.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Centers for Disease Control and Prevention (CDC) &gt; Preventive Health and Health Services Block Grant</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> Duplicated Amount	
9.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Health Resources and Services Administration (HRSA) &gt; State Systems Development Initiative (SSDI)</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> Duplicated Amount	
10.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Health Resources and Services Administration (HRSA) &gt; Universal Newborn Hearing Screening and Intervention</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> Duplicated Amount	

11.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Substance Abuse and Mental Health Services Administration &gt; Project LAUNCH</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> Number Duplicated	
12.	<b>Field Name:</b>	<b>Other Federal Funds, US Department of Education &gt; Office of Special Education Programs &gt; Early Identification and Intervention Infants/Toddlers</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> Duplicated Amount	
13.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Health Resources and Services Administration (HRSA) &gt; D70</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> Duplicated Amount	
14.	<b>Field Name:</b>	<b>Other Federal Funds, Department of Health and Human Services (DHHS) &gt; Centers for Disease Control and Prevention (CDC) &gt; GA OH Prevention Pro</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b> Duplicated Amount	

**Data Alerts: None**

**Form 3a**  
**Budget and Expenditure Details by Types of Individuals Served**  
**State: Georgia**

**I. TYPES OF INDIVIDUALS SERVED**

<b>IA. Federal MCH Block Grant</b>	<b>FY18 Application Budgeted</b>	<b>FY16 Annual Report Expended</b>
1. Pregnant Women	\$ 1,940,061	\$ 1,528,467
2. Infants < 1 year	\$ 1,204,476	\$ 430,252
3. Children 1-22 years	\$ 5,132,656	\$ 4,411,085
4. CSHCN	\$ 7,502,765	\$ 8,726,687
5. All Others	\$ 0	\$ 214,067
Federal Total of Individuals Served	\$ 15,779,958	\$ 15,310,558

<b>IB. Non Federal MCH Block Grant</b>	<b>FY18 Application Budgeted</b>	<b>FY16 Annual Report Expended</b>
1. Pregnant Women	\$ 14,847,588	\$ 14,854,473
2. Infants < 1 year	\$ 101,281,254	\$ 89,699,374
3. Children 1-22 years	\$ 125,666,488	\$ 111,739,154
4. CSHCN	\$ 20,550,935	\$ 20,393,647
5. All Others	\$ 2,818,812	\$ 1,209,088
Non Federal Total of Individuals Served	\$ 265,165,077	\$ 237,895,736
Federal State MCH Block Grant Partnership Total	\$ 280,945,035	\$ 253,206,294

**Form Notes for Form 3a:**

None

**Field Level Notes for Form 3a:**

1.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1-22 years</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	In Form 2 1A equals to Pregnant Women, Infants<1 and Children 1-22 Years.
2.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 4. CSHCN</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Application Budgeted</b>
	<b>Field Note:</b>	In Form 2 1A equals to Children with Special Health Care Needs (CSHCN).
3.	<b>Field Name:</b>	<b>IA. Federal MCH Block Grant, 3. Children 1-22 years</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	In Form 2 Line 1A equals to Pregnant Women, Infants<1, Children 1-22 Years and All Others.
4.	<b>Field Name:</b>	<b>IB. Non Federal MCH Block Grant, 2. Infant &lt; 1 Year</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	VFC expended amount increased in FFY 16.
5.	<b>Field Name:</b>	<b>IB. Non Federal MCH Block Grant, 3. Children 1-22 years</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	VFC expended amount increased in FFY 16.

**Form 3b**  
**Budget and Expenditure Details by Types of Services**  
**State: Georgia**

**II. TYPES OF SERVICES**

<b>IIA. Federal MCH Block Grant</b>	<b>FY18 Application Budgeted</b>	<b>FY16 Annual Report Expended</b>
1. Direct Services	\$ 1,778,635	\$ 2,537,362
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 508,083	\$ 152,929
B. Preventive and Primary Care Services for Children	\$ 575,521	\$ 285,870
C. Services for CSHCN	\$ 695,031	\$ 2,098,563
2. Enabling Services	\$ 9,487,060	\$ 7,263,225
3. Public Health Services and Systems	\$ 5,700,883	\$ 7,037,572
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		\$ 426,832
Physician/Office Services		\$ 52,107
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 93,140
Dental Care (Does Not Include Orthodontic Services)		\$ 585,870
Durable Medical Equipment and Supplies		\$ 412,441
Laboratory Services		\$ 56,787
Other		
Various Programs and Services		\$ 910,185
Direct Services Line 4 Expended Total		\$ 2,537,362
<b>Federal Total</b>	<b>\$ 16,966,578</b>	<b>\$ 16,838,159</b>

IIB. Non-Federal MCH Block Grant	FY18 Application Budgeted	FY16 Annual Report Expended
1. Direct Services	\$ 32,999,459	\$ 39,468,986
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 22,256,954	\$ 28,860,952
B. Preventive and Primary Care Services for Children	\$ 4,460,634	\$ 3,011,716
C. Services for CSHCN	\$ 6,281,871	\$ 7,596,318
2. Enabling Services	\$ 50,724,750	\$ 42,239,828
3. Public Health Services and Systems	\$ 189,866,277	\$ 164,506,743
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		\$ 521,021
Physician/Office Services		\$ 72,450
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 135,051
Dental Care (Does Not Include Orthodontic Services)		\$ 2,053,620
Durable Medical Equipment and Supplies		\$ 611,121
Laboratory Services		\$ 89,821
Other		
Various Programs and Services		\$ 35,985,902
Direct Services Line 4 Expended Total		\$ 39,468,986
<b>Non-Federal Total</b>	\$ 273,590,486	\$ 246,215,557



**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

None

**Form 4**  
**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**  
**State: Georgia**

**Total Births by Occurrence: 129,069**

**1. Core RUSP Conditions**

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Core RUSP Conditions	112,470 (87.1%)	7,420	320	320 (100.0%)

Program Name(s)				
Propionic acidemia	Methylmalonic acidemia (methylmalonyl-CoA mutase)	Methylmalonic acidemia (cobalamin disorders)	Isovaleric acidemia	3-Methylcrotonyl-CoA carboxylase deficiency
3-Hydroxy-3-methylglutaric aciduria	Holocarboxylase synthase deficiency	β-Ketothiolase deficiency	Glutaric acidemia type I	Carnitine uptake defect/carnitine transport defect
Medium-chain acyl-CoA dehydrogenase deficiency	Very long-chain acyl-CoA dehydrogenase deficiency	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Trifunctional protein deficiency	Argininosuccinic aciduria
Citrullinemia, type I	Maple syrup urine disease	Homocystinuria	Classic phenylketonuria	Tyrosinemia, type I
Primary congenital hypothyroidism	Congenital adrenal hyperplasia	S,S disease (Sickle cell anemia)	S, β-thalassemia	S,C disease
Biotinidase deficiency	Critical congenital heart disease	Cystic fibrosis	Hearing loss	Severe combined immunodeficiencies
Classic galactosemia	Mucopolysaccharidosis, type I			

## 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	120,768 (93.6%)	6,914	210	201 (95.7%)

## 3. Screening Programs for Older Children & Women

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Developmental Screens	9,132	3,762	2,169	2,139

## 4. Long-Term Follow-Up

Beginning January 1, 2014, all babies with confirmed hearing loss were provided an informed consent form to allow the DPH to track the child through 3rd grade. In collaboration with the Department of Education, DPH collects information on the intervention program, health status, and conducts in-home language assessments for families not participating in an intervention program.

Beginning July 2016, DPH worked collaboratively with Emory University to develop long-term follow up for all babies confirmed with a metabolic disease from birth to 5 years of age. Retrospective data will be collected through survey and chart abstraction beginning September 2017.

The NBS Advisory Committee instituted a long-term follow-up workgroup on 3/17/2017 to guide the development of standardized long-term follow-up for NBS in the state of Georgia. The aim of the workgroup is to develop a statewide system to track the outcomes of babies with conditions diagnosed through newborn screening to at least age 5

**Form Notes for Form 4:**

None

**Field Level Notes for Form 4:**

1.	<b>Field Name:</b>	<b>Total Births by Occurrence</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Total Births by Occurrence Notes</b>
	<b>Field Note:</b>	This is a preliminary number
2.	<b>Field Name:</b>	<b>Core RUSP Conditions - Receiving At Lease One Screen</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>
	<b>Field Note:</b>	Column A is determined using an algorithm that matches newborn screens to vital records. The automatic match was 87% and 13% required manual matching. Manual matching is not complete for this reporting year. The Georgia Public Health Laboratory tested around 130,000 blood samples in the reporting year.
3.	<b>Field Name:</b>	<b>Core RUSP Conditions - Positive Screen</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>
	<b>Field Note:</b>	Presumptive positive screens may vary annually due to adjustments to screening technique, algorithm and cut off values. The screening percentage rate increased due to the number of military births that were removed from the denominator and the count of initial unique screens were used in the numerator.
4.	<b>Field Name:</b>	<b>Core RUSP Conditions - Confirmed Cases</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>
	<b>Field Note:</b>	Confirmed cases are provided through the Emory Follow-up Program and State Electronic Notifiable Disease Surveillance System (SendSS). This report was prepared on April 11th, 2017 and does not include cases still pending confirmation. Thus, it might be a possible that later on some numbers would be added in confirmatory cases due to delayed/late diagnosis.
5.	<b>Field Name:</b>	<b>Hearing - Receiving At Lease One Screen</b>

	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	An aggregate hospital generated report is used to verify screening rate.
6.	<b>Field Name:</b>	<b>Hearing - Confirmed Cases</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	Summary Report from SendSS was pulled on April 15th, 2017. These numbers are subjected to change due to late/delayed diagnosis, follow-up timeline, missed cases etc.
7.	<b>Field Name:</b>	<b>Hearing - Referred For Treatment</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Other Newborn</b>
	<b>Field Note:</b>	Summary Report from SendSS was pulled on April 15th, 2017. These numbers are subjected to change due to late/delayed diagnosis, follow-up timeline, missed cases etc.

**Data Alerts: None**

**Form 5a**  
**Unduplicated Count of Individuals Served under Title V**  
**State: Georgia**

**Reporting Year 2016**

		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	142	0.0	55.0	6.0	35.0	4.0
2. Infants < 1 Year of Age	130,198	42.0	51.0	0.0	1.0	6.0
3. Children 1 to 22 Years of Age	1,044,716	63.0	8.0	0.0	27.0	2.0
4. Children with Special Health Care Needs	9,329	77.0	4.0	8.0	10.0	1.0
5. Others	335	0.0	0.0	0.0	18.0	82.0
Total	1,184,720					

**Form Notes for Form 5a:**

None

**Field Level Notes for Form 5a:**

1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	Data Sources: Family Planning Program Data and Oral Health Program Data
2.	<b>Field Name:</b>	<b>Infants Less Than One YearTotal Served</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	Data Sources: Newborn Screening Genetics Program Data, Immunization Program Data, and Oral Health Program Data
3.	<b>Field Name:</b>	<b>Children 1 to 22 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	Data Sources: Newborn Screening and Genetics Program Data, Immunizations Program Data, Oral Health Program Data and Family Planning Program Data
4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	Data Source: Children's Medical Services Program Data
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	Data Source: Newborn Screening Genetics Program Data
6.	<b>Field Name:</b>	<b>Total_TotalServed</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	Form 5A data were pulled from Title V MCH Programs with individual data and the Immunizations Program. Data were retrieved from different databases or programmatic reports from local public health districts and contractors. Data represent individuals receiving at least one direct or enabling service from selected programs within a year (SFY, FFY or CY).

**Form 5b**  
**Total Recipient Count of Individuals Served by Title V**  
**State: Georgia**

**Reporting Year 2016**

Types Of Individuals Served	Total Served
1. Pregnant Women	3,792
2. Infants < 1 Year of Age	845,561
3. Children 1 to 22 Years of Age	1,528,794
4. Children with Special Health Care Needs	19,257
5. Others	5,440
<b>Total</b>	<b>2,402,844</b>



**Form Notes for Form 5b:**

None

**Field Level Notes for Form 5b:**

1.	<b>Field Name:</b>	<b>Pregnant Women</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	Data Source: Family Planning Program Data, Immunizations Program Data, and Oral Health Program Data
2.	<b>Field Name:</b>	<b>Infants Less Than One Year</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	Data Source: Newborn Screening and Genetics Program Data, Immunizations Program Data, and Oral Health Program Data
3.	<b>Field Name:</b>	<b>Children 1 to 22 Year of Age</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	Data Source: Newborn Screening and Genetics Program Data, Immunizations Program Data, and Oral Health Program Data
4.	<b>Field Name:</b>	<b>Children With Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	Data Source: Children's Medical Services Program Data
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Field Note:</b>	Data Source: Newborn Screening and Genetics Program Data

**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

**State: Georgia**

**Reporting Year 2016**

**I. Unduplicated Count by Race**

	(A) Total All Races	(B) White	(C) Black or African American	(D) American Indian or Native Alaskan	(E) Asian	(F) Native Hawaiian or Other Pacific Islander	(G) More than One Race Reported	(H) Other & Unknown
1. Total Deliveries in State	127,390	66,525	44,288	183	5,903	166	2,912	7,413
Title V Served	13,469	5,035	6,748	11	284	27	446	918
Eligible for Title XIX	59,347	24,735	28,879	89	1,326	65	1,448	2,805
2. Total Infants in State	128,765	69,084	45,073	942	5,588	411	7,667	0
Title V Served	121,525	56,002	42,855	656	5,025	209	4,422	12,356
Eligible for Title XIX	60,763	25,686	29,391	458	1,255	161	3,812	0

**II. Unduplicated Count by Ethnicity**

	(A) Total Not Hispanic or Latino	(B) Total Hispanic or Latino	(C) Ethnicity Not Reported	(D) Total All Ethnicities
1. Total Deliveries in State	108,233	17,791	1,366	127,390
Title V Served	11,925	1,511	33	13,469
Eligible for Title XIX	51,166	7,553	628	59,347
2. Total Infants in State	107,366	21,399	0	128,765
Title V Served	105,473	15,932	120	121,525
Eligible for Title XIX	50,756	9,085	922	60,763

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

1.	<b>Field Name:</b>	<b>1. Total Deliveries in State</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b> Data Source: Provisional 2016 Birth File from Georgia Department of Public Health, Office of Vital Records. Retrieved April 28, 2017.	
2.	<b>Field Name:</b>	<b>1. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b> Data Source: Provisional 2016 Birth File from Georgia Department of Public Health, Office of Vital Records. Retrieved April 28, 2017.	
3.	<b>Field Name:</b>	<b>1. Eligible for Title XIX</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b> Data Source: Provisional 2016 Birth File from Georgia Department of Public Health, Office of Vital Records. Retrieved April 28, 2017.	
4.	<b>Field Name:</b>	<b>2. Total Infants in State</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Total All Races</b>
	<b>Field Note:</b> Data Source: Projection based on Online Analytical Statistical Information System (OASIS), Population Web Query, Georgia Department of Public Health, Office of Health Indicators for Planning (OHIP). <a href="http://oasis.state.ga.us/">Http://oasis.state.ga.us/</a> . Accessed May 10, 2017.	
5.	<b>Field Name:</b>	<b>2. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>Total All Races</b>

---

**Field Note:**

Data Source: 2016 Newborn Screening (Genetics, Hearing, and Critical Congenital Heart Disease) Records. Data query from the State Electronic Notifiable Disease Surveillance System, Georgia Department of Public Health website. Retrieved May 11, 2017 from <https://sends.state.ga.us/>.

---

6.	<b>Field Name:</b>	<b>2. Eligible for Title XIX</b>
----	--------------------	----------------------------------

---

<b>Fiscal Year:</b>	<b>2016</b>
---------------------	-------------

---

<b>Column Name:</b>	<b>Total All Races</b>
---------------------	------------------------

---

**Field Note:**

Data Source: Projection based on data in rows 7, 9, and 10.

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**

**State: Georgia**

A. State MCH Toll-Free Telephone Lines	2018 Application Year	2016 Reporting 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"	Johanna Pringle	Johanna Pringle
4. Contact Person's Telephone Number	(404) 656-4782	(404) 656-4782
5. Number of Calls Received on the State MCH "Hotline"		30,670

B. Other Appropriate Methods	2018 Application Year	2016 Reporting Year
1. Other Toll-Free "Hotline" Names	Powerline (800) 300-9003	Powerline (800) 300-9003
2. Number of Calls on Other Toll-Free "Hotlines"		6,115
3. State Title V Program Website Address	<a href="http://dph.georgia.gov/MCH">http://dph.georgia.gov/MCH</a>	<a href="http://dph.georgia.gov/MCH">http://dph.georgia.gov/MCH</a>
4. Number of Hits to the State Title V Program Website		25,456
5. State Title V Social Media Websites	<a href="https://twitter.com/gadph">https://twitter.com/gadph</a> <a href="https://facebook.com/gadph">https://facebook.com/gadph</a>	<a href="https://twitter.com/gadph">https://twitter.com/gadph</a> <a href="https://facebook.com/gadph">https://facebook.com/gadph</a>
6. Number of Hits to the State Title V Program Social Media Websites		0

**Form Notes for Form 7:**

None

**Form 8**  
**State MCH and CSHCN Directors Contact Information**

**State: Georgia**

**1. Title V Maternal and Child Health (MCH) Director**

Name	Johanna Pringle, MPH
Title	Title V Director
Address 1	2 Peachtree Street, NW
Address 2	
City/State/Zip	Atlanta / GA / 30303
Telephone	(404) 656-4782
Extension	
Email	Johanna.Pringle@dph.ga.gov

**2. Title V Children with Special Health Care Needs (CSHCN) Director**

Name	Sharifa Peart, MPH
Title	Interim CSHCN Director
Address 1	2 Peachtree Street, NW
Address 2	
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/Family Engagement Coordinator
Address 1	2 Peachtree Street, NW
Address 2	
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**  
**List of MCH Priority Needs**

**State: Georgia**

**Application Year 2018**

No.	Priority Need
1.	Prevent maternal mortality
2.	Improve access to family planning services
3.	Prevent infant mortality
4.	Promote developmental screenings among children
5.	Promote physical activity among children
6.	Reduce suicide among adolescents
7.	Improve systems of care for children and youth with special health care needs
8.	Promote oral health among all populations
9.	Decrease maternal substance use
10.	Improve access to specialty care for CSHCN

**Form 9 State Priorities-Needs Assessment Year - Application Year 2016**

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Prevent maternal mortality	New	
2.	Improve access to family planning services	New	This priority need is not associated with a National Performance Measure. It will be addressed by a State Performance Measure developed in the 2017 Application.
3.	Prevent infant mortality	New	
4.	Promote developmental screenings among children	New	
5.	Promote physical activity among children	New	
6.	Reduce suicide among adolescents	New	
7.	Improve systems of care for children and youth with special health care needs	New	
8.	Promote oral health among all populations	New	

**Form Notes for Form 9:**

None

**Field Level Notes for Form 9:**

None

**Form 10a**  
**National Outcome Measures (NOMs)**

**State: Georgia**

**Form Notes for Form 10a 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
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%, 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
2014	180.4	3.8 %	2,244	124,417
2013	182.5	3.9 %	2,250	123,287
2012	167.0	3.7 %	2,084	124,810
2011	164.1	3.6 %	2,076	126,486
2010	161.0	3.6 %	2,090	129,785
2009	160.0	3.5 %	2,188	136,797
2008	148.1	3.3 %	2,106	142,163

**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
2011_2015	46.2	2.7 %	302	653,787
2010_2014	39.3	2.5 %	258	656,330
2009_2013	30.8	2.2 %	205	666,761
2008_2012	23.5	1.9 %	161	684,616

**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 4.1 - 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
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%, or >10% missing data and should be interpreted with caution**NOM 4.1 - Notes:**

None

**Data Alerts: None**



**NOM 4.2 - Percent of very low birth weight deliveries (<1,500 grams)**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	1.8 %	0.0 %	2,354	131,326
2014	1.8 %	0.0 %	2,321	130,738
2013	1.8 %	0.0 %	2,350	127,627
2012	1.7 %	0.0 %	2,218	129,553
2011	1.8 %	0.0 %	2,338	131,791
2010	1.8 %	0.0 %	2,361	132,745
2009	1.7 %	0.0 %	2,414	140,396

**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 4.2 - Notes:**

None

**Data Alerts: None**

**NOM 4.3 - Percent of moderately low birth weight deliveries (1,500-2,499 grams)**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.7 %	0.1 %	10,110	131,326
2014	7.7 %	0.1 %	10,064	130,738
2013	7.6 %	0.1 %	9,714	127,627
2012	7.6 %	0.1 %	9,796	129,553
2011	7.6 %	0.1 %	9,995	131,791
2010	8.0 %	0.1 %	10,551	132,745
2009	7.7 %	0.1 %	10,776	140,396

**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 4.3 - Notes:**

None

**Data Alerts: None**

**NOM 5.1 - Percent of preterm births (<37 weeks)**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
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	11.4 %	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%, or >10% missing data and should be interpreted with caution**NOM 5.1 - Notes:**

None

**Data Alerts: None**

**NOM 5.2 - Percent of early preterm births (<34 weeks)**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	3.2 %	0.1 %	4,241	131,349
2014	3.3 %	0.1 %	4,249	130,764
2013	3.3 %	0.1 %	4,192	128,164
2012	3.2 %	0.1 %	4,120	129,705
2011	3.2 %	0.1 %	4,254	131,865
2010	3.3 %	0.1 %	4,385	133,000
2009	3.2 %	0.1 %	4,526	140,367

**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 5.2 - Notes:**

None

**Data Alerts: None**

**NOM 5.3 - Percent of late preterm births (34-36 weeks)**

Data Source: National Vital Statistics System (NVSS)

**Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.5 %	0.1 %	9,892	131,349
2014	7.5 %	0.1 %	9,809	130,764
2013	7.4 %	0.1 %	9,473	128,164
2012	7.7 %	0.1 %	10,019	129,705
2011	7.8 %	0.1 %	10,219	131,865
2010	8.1 %	0.1 %	10,708	133,000
2009	8.1 %	0.1 %	11,333	140,367

**Legends:** Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 5.3 - 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
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%, 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
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:**

 Indicator results were based on a shorter time period than required for reporting

**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
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
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
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
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
2014	287.1	14.8 %	376	130,946
2013	282.0	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
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
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 has a confidence interval width that is inestimable or >20% 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 delivery hospitalizations****Data Source: HCUP - State Inpatient Databases (SID)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	4.8	0.2 %	598	124,553
2013	3.9	0.2 %	480	123,419
2012	3.1	0.2 %	391	124,864
2011	2.4	0.1 %	305	126,542
2010	2.2	0.1 %	282	129,826
2009	1.5	0.1 %	199	136,799
2008	1.3	0.1 %	188	142,163

**Legends:** Indicator has a numerator  $\leq 10$  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)**

**FAD Not Available for this measure.**

**NOM 12 - Notes:**

None

**Data Alerts: None**



**NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)**

**FAD Not Available for this measure.**



**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 12 months**

**Data Source: National Survey of Children's Health (NSCH)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	18.6 %	1.4 %	434,496	2,340,734
<b>Legends:</b>  Indicator has an unweighted denominator <30 and is not reportable  Indicator has a confidence interval width >20% 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
2015	21.0	1.3 %	259	1,234,835
2014	19.7	1.3 %	244	1,238,114
2013	21.9	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
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
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
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

Data Source: National Survey of Children's Health (NSCH)

### Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	19.2 %	1.3 %	477,055	2,484,940
2007	20.7 %	1.5 %	523,281	2,525,483
2003	18.7 %	1.1 %	428,295	2,287,060

#### Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% 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) receiving care in a well-functioning system**

**Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2009_2010	17.4 %	1.6 %	66,655	383,614
<b>Legends:</b>				
 Indicator has an unweighted denominator <30 and is not reportable				
 Indicator has a confidence interval width >20% and should be interpreted with caution				

**NOM 17.2 - Notes:**

None

**Data Alerts: None**



### NOM 17.3 - Percent of children 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
2011_2012	1.6 %	0.5 %	33,320	2,094,067
2007	1.2 %	0.5 %	23,940	2,085,157

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

#### NOM 17.3 - Notes:

None

Data Alerts: None

**NOM 17.4 - Percent of children 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
2011_2012	8.7 %	1.0 %	182,043	2,092,833
2007	6.5 %	0.9 %	134,785	2,088,073

**Legends:**

- Indicator has an unweighted denominator <30 and is not reportable
- Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution

**NOM 17.4 - Notes:**

None

**Data Alerts: None**

**NOM 18 - Percent of children 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
2011_2012	53.4 % ⚡	6.4 % ⚡	96,846 ⚡	181,360 ⚡
2007	52.3 % ⚡	7.5 % ⚡	75,483 ⚡	144,363 ⚡
2003	60.5 % ⚡	6.2 % ⚡	82,809 ⚡	136,847 ⚡

**Legends:**

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 18 - Notes:**

None

**Data Alerts: None**

## NOM 19 - Percent of children 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
2011_2012	85.3 %	1.2 %	2,116,791	2,481,524
2007	86.2 %	1.4 %	2,177,204	2,525,404
2003	85.4 %	1.1 %	1,953,122	2,287,060

#### Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution


#### NOM 19 - Notes:

None


Data Alerts: None

**NOM 20 - Percent of children and adolescents who are overweight or obese (BMI at or above the 85th percentile)****Data Source: National Survey of Children's Health (NSCH)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2011_2012	35.0 %	2.5 %	363,667	1,039,152
2007	37.3 %	2.9 %	378,229	1,014,035
2003	31.7 %	2.1 %	300,612	948,122

**Legends:** Indicator has an unweighted denominator <30 and is not reportable Indicator has a confidence interval width >20% and should be interpreted with caution**Data Source: WIC****Multi-Year Trend**


Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	28.2 %	0.2 %	26,327	93,386
2012	28.3 %	0.1 %	30,810	108,699
2010	30.4 %	0.1 %	31,860	104,959
2008	31.9 %	0.2 %	29,913	93,912


**Legends:** Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable Indicator has a confidence interval width >20% 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	29.8 %	1.4 %	128,714	431,995
2011	30.7 %	1.4 %	135,064	439,590
2009	27.0 %	1.5 %	120,245	444,782
2007	31.7 %	1.5 %	142,398	448,896
2005	27.1 %	1.5 %	113,963	420,547

**Legends:**

 Indicator has an unweighted denominator <100 and is not reportable

 Indicator has a confidence interval width >20% and should be interpreted with caution

**NOM 20 - Notes:**

None

**Data Alerts: None**

## NOM 21 - Percent of children without health insurance

Data Source: American Community Survey (ACS)

### Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
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 that is inestimable or >20% 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
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 half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.1 - Notes:**

None

**Data Alerts: None**



**NOM 22.2 - Percent of children 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
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	52.3 %	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 95% confidence interval half-width/estimate > 0.6 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 (Female)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	54.4 %	4.8 %	188,983	347,673
2014	65.4 %	4.6 %	225,530	344,809
2013	53.7 % ⚡	5.5 % ⚡	182,469 ⚡	339,975 ⚡
2012	52.3 % ⚡	5.5 % ⚡	175,971 ⚡	336,241 ⚡
2011	48.4 %	4.6 %	163,472	337,969
2010	43.5 %	4.0 %	141,115	324,413
2009	38.6 %	4.2 %	130,355	337,460

**Legends:**

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**Data Source: National Immunization Survey (NIS) - Teen (Male)**

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	51.0 %	4.4 %	183,710	360,544
2014	41.2 %	4.6 %	148,198	359,724
2013	40.5 % ⚡	5.9 % ⚡	144,219 ⚡	356,096 ⚡
2012	19.5 %	4.3 %	68,607	352,408
2011	7.3 %	1.9 %	25,719	353,467

**Legends:**

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6 Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

**NOM 22.5 - Notes:**

None

**Data Alerts: None**

**Form 10a**  
**National Performance Measures (NPMs)**  
**State: Georgia**

**NPM 1 - Percent of women with a past year preventive medical visit**

Federally Available Data	
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)	
	2016
Annual Objective	62.1
Annual Indicator	67.7
Numerator	1,258,025
Denominator	1,857,538
Data Source	BRFSS
Data Source Year	2015

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	62.1	63.0	63.5	64.0	65.0	65.0

**Field Level Notes for Form 10a 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)**

**FAD for this measure is not available for the State.**

State Provided Data	
	2016
Annual Objective	81.8
Annual Indicator	79
Numerator	1,898
Denominator	2,402
Data Source	Vital Records
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.0	81.0	82.0	83.0	84.0	85.0

**Field Level Notes for Form 10a NPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Data Sources: OHIP - Final Birth Table, OASIS Final, and Vital Records Provisional Birth File

**NPM 4 - A) Percent of infants who are ever breastfed**

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	79.3
Annual Indicator	69.2
Numerator	80,818
Denominator	116,817
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	80.9	81.2	81.5	82.0	82.3	83.0

**Field Level Notes for Form 10a NPMs:**

None



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

Federally Available Data	
Data Source: National Immunization Survey (NIS)	
	2016
Annual Objective	20.2
Annual Indicator	25.4
Numerator	29,130
Denominator	114,622
Data Source	NIS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	21.6	23.0	23.7	24.0	24.3	25.0

**Field Level Notes for Form 10a NPMs:**

None

**NPM 6 - Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	42.8
Annual Indicator	40.8
Numerator	257,898
Denominator	632,599
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	42.0	43.0	43.5	44.0	44.5	45.0

**Field Level Notes for Form 10a NPMs:**

None

**NPM 8 - Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day (Child Health)**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CHILD	
	2016
Annual Objective	36.6
Annual Indicator	35.9
Numerator	309,751
Denominator	863,401
Data Source	NSCH-CHILD
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	37.3	38.1	38.8	39.5	39.8	39.8

**Field Level Notes for Form 10a NPMs:**

None

**NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	25.3
Annual Indicator	16.4
Numerator	129,553
Denominator	790,591
Data Source	NSCH
Data Source Year	2011_2012

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2016
Annual Objective	25.3
Annual Indicator	25.1
Numerator	110,846
Denominator	442,284
Data Source	YRBSS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	25.0	25.0	24.5	24.5	24.0	23.5

**Field Level Notes for Form 10a NPMs:**

None

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

Federally Available Data	
Data Source: National Survey of Children with Special Health Care Needs (NS-CSHCN)	
	2016
Annual Objective	34.2
Annual Indicator	33.9
Numerator	48,646
Denominator	143,452
Data Source	NS-CSHCN
Data Source Year	2009_2010

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	34.6	34.9	35.3	35.6	36.0	36.5

**Field Level Notes for Form 10a NPMs:**

None

**NPM 13 - A) Percent of women who had a dental visit during pregnancy**

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2016
Annual Objective	39.5
Annual Indicator	29.3
Numerator	18,443
Denominator	63,060
Data Source	PRAMS
Data Source Year	2013

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	41.1	42.7	43.0	43.5	44.5	44.9

**Field Level Notes for Form 10a NPMs:**

None

**NPM 13 - B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH)	
	2016
Annual Objective	76.7
Annual Indicator	75.9
Numerator	1,773,709
Denominator	2,337,183
Data Source	NSCH
Data Source Year	2011_2012

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	77.4	78.2	79.0	79.8	79.9	80.0

**Field Level Notes for Form 10a NPMs:**

None

**Form 10a**  
**State Performance Measures (SPMs)**

**State: Georgia**

**SPM 1 - 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%.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	16.6
Numerator	9,714
Denominator	58,434
Data Source	GFPP
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	11.0	12.0	13.0	14.0	15.0	17.0

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	
		Data Source: Georgia Family Planning Program Data
		2016 Projections



**SPM 2 - 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.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1.5
Numerator	704
Denominator	477,000
Data Source	CMS Program Data and Kids Count
Data Source Year	SFY 2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.3	1.5	1.7	1.9	2.0	2.0

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Data Source: Children's Medical Services Program Data (Numerator), Kids Count (Denominator)

**SPM 3 - By 2020, decrease the rate of congenital syphilis from 13 (infants per 100,000 live births) to 11.7.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	17
Numerator	21
Denominator	123,292
Data Source	Projected Data from OASIS and SendSS, Births and C
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	13.0	12.7	12.4	12.0	11.7	11.7

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Data Source: State Electronic Notifiable Disease Surveillance System, Vital Records

**SPM 4 - By 2020, decrease the rate of infants diagnosed with Neonatal Abstinence Syndrome (NAS) from 3.2 (per 1,000 live births) to 2.0.**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	6.1
Numerator	735
Denominator	120,577
Data Source	Hospital Discharge Data, Vital Records
Data Source Year	2015
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	3.9	3.8	3.5	3.1	2.0

**Field Level Notes for Form 10a SPMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**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. Iatrogenic cases were identified and removed from consideration using Stephen Patrick's methodology as described in "Neonatal Abstinence Syndrome and Associated Health Care Expenditures." The denominator is the total number of hospital births in Georgia.

**Form 10a**  
**Evidence-Based or –Informed Strategy Measures (ESMs)**

State: Georgia

**ESM 1.1 - 1.1.1. Number of public health districts with the Every Woman video in circulation**

<b>Measure Status:</b>	<b>Inactive - This measure is being deleted due to unforeseen barriers in implementing.</b>
------------------------	---

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	GFPP Data
Data Source Year	SFY 2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	5.0	10.0	15.0	18.0	0.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 1.2 - 1.2.1. Number of staff that have been trained on preconception health appraisals****Measure Status:****Inactive - This measure was deleted due to a change in the strategy.****State Provided Data**

	2016
Annual Objective	
Annual Indicator	97
Numerator	
Denominator	
Data Source	GFPP
Data Source Year	SFY 2016
Provisional or Final ?	Final

**Annual Objectives**

	2017	2018	2019	2020	2021	2022
Annual Objective	50.0	60.0	70.0	80.0	90.0	100.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 1.3 - 1.3. Number of focus groups across the state that assess barriers to well-woman visits**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	1
Numerator	
Denominator	
Data Source	Title V On-Going Needs Assessment
Data Source Year	2017
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	5.0	10.0	15.0	18.0	0.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 1.4 - 1.4. Proportion of birthing hospitals that implement Alliance for Innovation on Maternal Health Bundles**

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	10.0	25.0	30.0	50.0	60.0	75.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 3.1 - 3.5.1. Percentage of birthing hospitals that are in compliance with neonatal level of care requirements**

<b>Measure Status:</b>	<b>Inactive - This measure is being deleted due to the reliability of the data source.</b>
------------------------	--

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	0
Denominator	79
Data Source	Women Health Program
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	0.0	40.0	60.0	65.0	65.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Georgia's birthing hospitals self identify and have not fully utilized LOCATe. Therefore the data available cannot be used at this time to assess compliance with levels of care.



**ESM 3.2 - 3.6.1. Proportion of Regional Perinatal Centers that receive a process evaluation**

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	6.0	6.0	6.0	6.0	6.0	6.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 4.1 - 3.1.1 Number of birthing hospitals that participate in the 5-STAR Hospital Initiative**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	39
Numerator	
Denominator	
Data Source	Womens Health Program Data
Data Source Year	2016
Provisional or Final ?	Provisional

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	0.0	10.0	20.0	30.0	40.0	40.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 4.2 - 3.1.2 Number of Train-the-Trainer workshops conducted**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	2
Numerator	
Denominator	
Data Source	Womens Health Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	1.0	3.0	4.0	5.0	6.0	6.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 6.1 - 6.1.1. Percentage of public health districts using at least two developmental screening methods regularly**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	44.4
Numerator	8
Denominator	18
Data Source	Children 1st Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	20.0	40.0	60.0	80.0	100.0	100.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 6.2 - 6.1.2. Number of partners reporting utilization of developmental screening tools**

<b>Measure Status:</b>	<b>Inactive - This measure is being deleted due to the challenges in assessing utilization of developmental screening tools among partners</b>
------------------------	--

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Children 1st Program Data
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	5.0	10.0	15.0	20.0	23.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 6.3 - 6.2.1. Number of formal training opportunities on developmental screening conducted in each public health district health districts each year**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	9
Numerator	
Denominator	
Data Source	Children 1st Program Data
Data Source Year	FFY 2017
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	2.0	14.0	26.0	30.0	36.0	38.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 8.1 - 7.1.1. Average HFZ measure (aerobic capacity) among students in grades 4-12**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	50.1
Numerator	379,706
Denominator	757,811
Data Source	DOE Fitnessgram
Data Source Year	2016-2017
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	56.0	57.0	58.0	59.0	60.0	61.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>Annual Objective</b>

**Field Note:**

Data Source: Georgia Department of Education Health and Physical Education Fitnessgram Data

Numerator: Male and Female HFZ for Aerobic Capacity

Denominator: Male and Female Total Attempts

Annual Objective for Males is 63% and Females is 49%, combined is 56%.

**ESM 9.1 - 8.1.1. Communication plan to promote awareness of bullying and bullying prevention among youth**

<b>Measure Status:</b>	<b>Inactive - This measure has been deleted due to unforeseen barriers</b>
------------------------	--

State Provided Data	
	2016
Annual Objective	
Annual Indicator	No
Numerator	
Denominator	
Data Source	Adolescent Health Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective						

**Field Level Notes for Form 10a ESMs:**

None



**ESM 9.2 - 8.2.1. Number of schools participating in whole school bullying prevention initiatives**

<b>Measure Status:</b>	<b>Inactive - This measure is being deleted due to a change in strategy</b>
------------------------	---

State Provided Data	
	2016
Annual Objective	
Annual Indicator	15
Numerator	
Denominator	
Data Source	Adolescent Health and Youth Development Program
Data Source Year	2016
Provisional or Final ?	Provisional

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	0.0	1.0	3.0	3.0	3.0	3.0

**Field Level Notes for Form 10a ESMs:**

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Number of schools participating in the Adolescent Health and Youth Development Step Up Step In Anti-bullying Program

**ESM 9.3 - 8.1.2. Developed at least one evidence-based strategy for suicide revention**

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective						

**Field Level Notes for Form 10a ESMs:**

None

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

<b>State Provided Data</b>	
	<b>2016</b>
Annual Objective	
Annual Indicator	250
Numerator	
Denominator	
Data Source	Children Medical Services
Data Source Year	2016
Provisional or Final ?	Final

<b>Annual Objectives</b>						
	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>
Annual Objective	200.0	250.0	325.0	350.0	375.0	500.0

**Field Level Notes for Form 10a ESMs:**

None

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

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

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

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	15.0	25.0	35.0	40.0	40.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 13.1 - 11.1.1. Number of comprehensive webinars/presentations offered**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	0
Numerator	
Denominator	
Data Source	Oral Health Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	4.0	8.0	12.0	16.0	20.0	20.0

**Field Level Notes for Form 10a ESMs:**

None

**ESM 13.2 - 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**

<b>Measure Status:</b>	<b>Active</b>
------------------------	---------------

State Provided Data	
	2016
Annual Objective	
Annual Indicator	15
Numerator	
Denominator	
Data Source	Oral Health Program Data
Data Source Year	2016
Provisional or Final ?	Final

Annual Objectives						
	2017	2018	2019	2020	2021	2022
Annual Objective	5.0	10.0	20.0	30.0	40.0	40.0

**Field Level Notes for Form 10a ESMs:**

None

**Form 10b**  
**State Performance Measure (SPM) Detail Sheets**

**State: Georgia**

**SPM 1 - 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%.**

**Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health**

<b>Measure Status:</b>	Active	
<b>Goal:</b>	Increase the percentage of women (ages 15-44) served in the Georgia Family Planning Program (GFPP) who use long-acting reversible contraceptives (LARC)	
<b>Definition:</b>	<b>Numerator:</b>	Number of women ages 15-44 that used a LARC
	<b>Denominator:</b>	Total number of women ages 15-44 served in GFPP
	<b>Unit Type:</b>	Percentage
	<b>Unit Number:</b>	100
<b>Healthy People 2020 Objective:</b>	Related to Family Planning (FP) Objective 1: Increase the proportion of pregnancies that are intended	
<b>Data Sources and Data Issues:</b>	Data Source: Georgia Family Planning Program Clinic Data	
<b>Significance:</b>	<p>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.</p>	

**SPM 2 - 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.**

**Population Domain(s) – Children with Special Health Care Needs**

Measure Status:	Active	
Goal:	Increase the rate of children and youth with special health care needs that have accessed their specialty health care visit through a telehealth clinic	
Definition:		
	Numerator:	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
	Denominator:	Total number of children and youth with special health care needs
	Unit Type:	Rate
	Unit Number:	1,000
Healthy People 2020 Objective:	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	
Data Sources and Data Issues:	Data Sources: Georgia Children's Medical Services Program Database, Kids Count Data Center	
Significance:	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.	



**SPM 3 - By 2020, decrease the rate of congenital syphilis from 13 (infants per 100,000 live births) to 11.7.**  
**Population Domain(s) – Perinatal/Infant Health**

Measure Status:	Active	
Goal:	Decrease the rate of congenital syphilis	
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.	

**SPM 4 - By 2020, decrease the rate of infants diagnosed with Neonatal Abstinence Syndrome (NAS) from 3.2 (per 1,000 live births) to 2.0.**

**Population Domain(s) – Perinatal/Infant Health**

Measure Status:	Active	
Goal:	Decrease the rate of infants diagnosed as having NAS	
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 1.4 per 1000 live births in 2010 to 3.2 per 1000 live births in 2014. 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. 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.	

**Form 10b**  
**State Outcome Measure (SOM) Detail Sheets**  
**State: Georgia**

No State Outcome Measures were created by the State.

**Form 10c**  
**Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets**

**State: Georgia**

**ESM 1.1 - 1.1.1. Number of public health districts with the Every Woman video in circulation**

**NPM 1 – Percent of women with a past year preventive medical visit**

Measure Status:	Inactive - This measure is being deleted due to unforeseen barriers in implementing.	
Goal:	Increase the number of public health districts that air the Every Woman video	
Definition:		
	Numerator:	Number of public health districts with the Every Woman video in circulation
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	18
Data Sources and Data Issues:	Data Source: Perinatal/Women's Health Section Program 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 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.	

**ESM 1.2 - 1.2.1. Number of staff that have been trained on preconception health appraisals**  
**NPM 1 – Percent of women with a past year preventive medical visit**

Measure Status:	Inactive - This measure was deleted due to a change in the strategy.									
Goal:	Increase the number of staff that have been trained on preconception health appraisals									
Definition:	<table><tr><td>Numerator:</td><td>Number of staff trained on preconception health appraisals</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>1,000</td></tr></table>		Numerator:	Number of staff trained on preconception health appraisals	Denominator:	Not Applicable	Unit Type:	Count	Unit Number:	1,000
Numerator:	Number of staff trained on preconception health appraisals									
Denominator:	Not Applicable									
Unit Type:	Count									
Unit Number:	1,000									
Data Sources and Data Issues:	Data Source: Perinatal/Women's Health Program 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 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.									

**ESM 1.3 - 1.3. Number of focus groups across the state that assess barriers to well-woman visits**  
**NPM 1 – Percent of women with a past year preventive medical visit**

Measure Status:	Active									
Goal:	Increase the number of focus groups across the state that assess barriers to well-woman visits from 0 to 18									
Definition:	<table><tr><td>Numerator:</td><td>Number of focus groups</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>18</td></tr></table>		Numerator:	Number of focus groups	Denominator:	Not applicable	Unit Type:	Count	Unit Number:	18
Numerator:	Number of focus groups									
Denominator:	Not applicable									
Unit Type:	Count									
Unit Number:	18									
Data Sources and Data Issues:	Data Source: Title V On-Going Needs Assessment									
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.									

**ESM 1.4 - 1.4. Proportion of birthing hospitals that implement Alliance for Innovation on Maternal Health Bundles**  
**NPM 1 – Percent of women with a past year preventive medical visit**

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.	

**ESM 3.1 - 3.5.1. Percentage of birthing hospitals that are in compliance with neonatal level of care requirements**  
**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:	Inactive - This measure is being deleted due to the reliability of the data source.									
Goal:	Increase the proportion of birthing hospitals that are in compliance with neonatal level of care requirements									
Definition:	<table><tr><td>Numerator:</td><td>Number of birthing hospitals that are in compliance with neonatal level of care requirements</td></tr><tr><td>Denominator:</td><td>Total number of birthing hospitals</td></tr><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table>		Numerator:	Number of birthing hospitals that are in compliance with neonatal level of care requirements	Denominator:	Total number of birthing hospitals	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of birthing hospitals that are in compliance with neonatal level of care requirements									
Denominator:	Total number of birthing hospitals									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Data Source: Perinatal Health 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. This measure is endorsed by the National Quality Forum (#0477).									



**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:	<table><tr><td>Numerator:</td><td>Number of RPCs receiving one annual evaluation</td></tr><tr><td>Denominator:</td><td>Number of RPCs</td></tr><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table>		Numerator:	Number of RPCs receiving one annual evaluation	Denominator:	Number of RPCs	Unit Type:	Percentage	Unit Number:	100
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).									

**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 and B) Percent of infants breastfed exclusively through 6 months**

Measure Status:	Active	
Goal:	Increase the number of birthing hospitals that participate in the 5-STAR Hospital Initiative	
Definition:	Numerator:	Number of birthing hospitals participating in the 5-STAR Hospital Initiative
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	40
Data Sources and Data Issues:	Data Source: Women's Health 5-STAR Initiative Program Data	
Significance:	<p>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.</p>	

**ESM 4.2 - 3.1.2 Number of Train-the-Trainer workshops conducted**

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

<b>Measure Status:</b>	Active	
<b>Goal:</b>	increase the number of Train-the-Trainer workshops conducted from 0 to 6	
<b>Definition:</b>	<b>Numerator:</b>	Number of Train-the-Trainer workshops conducted
	<b>Denominator:</b>	Not applicable
	<b>Unit Type:</b>	Count
	<b>Unit Number:</b>	6
<b>Data Sources and Data Issues:</b>	Data Source: Women's Health Program Data	
<b>Significance:</b>	<p>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.</p>	

**ESM 6.1 - 6.1.1. Percentage of public health districts using at least two developmental screening methods regularly**

**NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

<b>Measure Status:</b>	Active	
<b>Goal:</b>	Increase the types of developmental screening methods that are regularly used in each public district from one to a minimum of two	
<b>Definition:</b>	<b>Numerator:</b>	Number of districts with at least two developmental screening methods being used regularly
	<b>Denominator:</b>	Number of public health districts
	<b>Unit Type:</b>	Percentage
	<b>Unit Number:</b>	100
<b>Data Sources and Data Issues:</b>	Data Source: Child Health Program Data	
<b>Significance:</b>	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.	

**ESM 6.2 - 6.1.2. Number of partners reporting utilization of developmental screening tools**

**NPM 6 – Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

Measure Status:	Inactive - This measure is being deleted due to the challenges in assessing utilization of developmental screening tools among partners	
Goal:	Increase the number of partners reporting utilization of developmental screening tools from 0 to 20	
Definition:	Numerator:	Number of partners reporting utilization of developmental screening tools from 0 to 20
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	25
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.	

**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 10 through 71 months, receiving a developmental screening using a parent-completed screening tool**

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.	

**ESM 8.1 - 7.1.1. Average HFZ measure (aerobic capacity) among students in grades 4-12****NPM 8 – Percent of children ages 6 through 11 and adolescents 12 through 17 who are physically active at least 60 minutes per day**

<b>Measure Status:</b>	Active	
<b>Goal:</b>	Increase the average HFZ measure (aerobic capacity) among students in grades 4-12 by 4%	
<b>Definition:</b>	<b>Numerator:</b>	Aerobic capacity, HFZ measure (males and females), for students grades 4-12
	<b>Denominator:</b>	Total attempts (males and females) for students grades 4-12
	<b>Unit Type:</b>	Percentage
	<b>Unit Number:</b>	100
<b>Data Sources and Data Issues:</b>	Data Source: Georgia SHAPE	
<b>Significance:</b>	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.	

**ESM 9.1 - 8.1.1. Communication plan to promote awareness of bullying and bullying prevention among youth**  
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Measure Status:	Inactive - This measure has been deleted due to unforeseen barriers									
Goal:	Create a communications plan to promote awareness of bullying and bullying prevention among youth									
Definition:	<table><tr><td>Numerator:</td><td>Communications plan to promote awareness of bullying and bullying prevention among youth</td></tr><tr><td>Denominator:</td><td>Not applicable</td></tr><tr><td>Unit Type:</td><td>Text</td></tr><tr><td>Unit Number:</td><td>Yes/No</td></tr></table>		Numerator:	Communications plan to promote awareness of bullying and bullying prevention among youth	Denominator:	Not applicable	Unit Type:	Text	Unit Number:	Yes/No
Numerator:	Communications plan to promote awareness of bullying and bullying prevention among youth									
Denominator:	Not applicable									
Unit Type:	Text									
Unit Number:	Yes/No									
Data Sources and Data Issues:	Data Source: Adolescent Health Program Data									
Significance:	<p>Bullying, particularly among school-age children, is a major public health problem. Current estimates suggest nearly 30% of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. Specifically, of a nationally representative sample of adolescents, 13% reported being a bully, 11% reported being a victim of bullying, and 6% reported being both a bully and a victim. Studies indicate 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. Evidence further suggests that people who are the victims of bullying and 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.</p>									



**ESM 9.2 - 8.2.1. Number of schools participating in whole school bullying prevention initiatives**  
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Measure Status:	Inactive - This measure is being deleted due to a change in strategy	
Goal:	Expand the Step Up Step In (SUSI) Sexual Bullying Prevention Initiative to 3 additional schools	
Definition:		
	Numerator:	Number of additional schools participating in the Step Up Step In Sexual Bullying Prevention Initiative
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	15
Data Sources and Data Issues:	Data Source: Adolescent Health Program Data	
Significance:	<p>Bullying, particularly among school-age children, is a major public health problem. Current estimates suggest nearly 30% of American adolescents reported at least moderate bullying experiences as the bully, the victim, or both. Specifically, of a nationally representative sample of adolescents, 13% reported being a bully, 11% reported being a victim of bullying, and 6% reported being both a bully and a victim. Studies indicate 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. Evidence further suggests that people who are the victims of bullying and 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.</p>	

**ESM 9.3 - 8.1.2. Developed at least one evidence-based strategy for suicide revention**  
**NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others**

Measure Status:	Active	
Goal:	Identify at least one evidence-based strategy to reduce suicide rate in communities with high suicide rates by 2018	
Definition:		
	Numerator:	Not Applicable
	Denominator:	Not Applicable
	Unit Type:	Text
	Unit Number:	Yes/No
Data Sources and Data Issues:	Title V Program Data	
Significance:	Preventing suicide was identified as the priority need through quantitative data and by stakeholders. The suicide death rate among adolescents was 1.5 times higher in 2013 compared to 2012. Reducing suicide was chosen because it was rated highest in the adolescent health domain and in the top 10 overall.	

**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 who received services necessary to make transitions to adult health care**

<b>Measure Status:</b>	Active	
<b>Goal:</b>	Increase the number of youth, families and professionals trained on health care transition	
<b>Definition:</b>	<b>Numerator:</b>	Number of youth, families, professionals trained on health care transition
	<b>Denominator:</b>	Not applicable
	<b>Unit Type:</b>	Count
	<b>Unit Number:</b>	500
<b>Data Sources and Data Issues:</b>	Data Source: Children's Medical Services Program Data	
<b>Significance:</b>	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.	

**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 who received services necessary to make transitions to adult health care**

Measure Status:	Active	
Goal:	Increase the number of pediatric and adult medical providers who have a health care transition policy within their practice	
Definition:	Numerator:	Number of pediatric and adult medical providers who have a health care transition policy within their practice
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	45
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.	

**ESM 13.1 - 11.1.1. Number of comprehensive webinars/presentations offered**

**NPM 13 – A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17 who had a preventive dental visit in the past year**

<b>Measure Status:</b>	Active	
<b>Goal:</b>	Increase the number of comprehensive webinars/presentations offered to health professionals from 0 to 20	
<b>Definition:</b>	<b>Numerator:</b>	Number of comprehensive webinars/presentations offered
	<b>Denominator:</b>	Not applicable
	<b>Unit Type:</b>	Count
	<b>Unit Number:</b>	20
<b>Data Sources and Data Issues:</b>	Data Source: Oral Health Program Data	
<b>Significance:</b>	<p>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.</p>	
	<p>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.</p>	
	<p>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.</p>	

**ESM 13.2 - 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 – A) Percent of women who had a dental visit during pregnancy and B) 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 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	
Definition:	Numerator:	number of dentists, hygienists and staff educated on four specific dental services for individuals with special needs and the oral health connection and services
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	45
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, 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.	

**Form 11**  
**Other State Data**  
**State: Georgia**

The Form 11 data are available for review via the link below.

[Form 11 Data](#)

## **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](#)



## Abbreviated State Action Plan Table

State: Georgia

### Women/Maternal Health

State Priority Needs	NPMs	ESMs	SPMs
Prevent maternal mortality	NPM 1 - Well-Woman Visit	ESM 1.1 <i>Inactive</i> ESM 1.2 <i>Inactive</i> ESM 1.3 ESM 1.4	
Improve access to family planning services			SPM 1

### Perinatal/Infant Health

State Priority Needs	NPMs	ESMs	SPMs
Prevent infant mortality	NPM 4 - Breastfeeding	ESM 4.1 ESM 4.2	
Prevent infant mortality	NPM 3 - Risk-Appropriate Perinatal Care	ESM 3.1 <i>Inactive</i> ESM 3.2	
Decrease maternal substance use			SPM 4
Prevent infant mortality			SPM 3

### Child Health

State Priority Needs	NPMs	ESMs	SPMs
Promote developmental screenings among children	NPM 6 - Developmental Screening	ESM 6.1 ESM 6.2 <i>Inactive</i> ESM 6.3	
Promote physical activity among children	NPM 8 - Physical Activity	ESM 8.1	

### Adolescent Health

State Priority Needs	NPMs	ESMs	SPMs
Reduce suicide among adolescents	NPM 9 - Bullying	ESM 9.1 <i>Inactive</i> ESM 9.2 <i>Inactive</i> ESM 9.3	

### Children with Special Health Care Needs

State Priority Needs	NPMs	ESMs	SPMs
Improve systems of care for children and youth with special health care needs	NPM 12 - Transition	ESM 12.1 ESM 12.2	
Improve access to specialty care for CSHCN			SPM 2

### Cross-Cutting/Life Course

State Priority Needs	NPMs	ESMs	SPMs
Promote oral health among all populations	NPM 13 - Preventive Dental Visit	ESM 13.1 ESM 13.2	