

Georgia Five Year Needs Assessment

For the Maternal and Child Health Services Title V Block Grant

Draft as of 8/3/15

DRAFT

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FOR THE MATERNAL AND CHILD HEALTH SERVICES TITLE V BLOCK GRANT

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INTRODUCTION

Georgia's Title V Needs Assessment, conducted from April 2014 to June 2015, was designed to meet the requirements of the Title V Maternal and Child Health Services Block Grant to states. The Block Grant guidance was transformed in 2015 to ensure alignment of priority needs with activities outlined in a five-year plan. The Maternal and Child Health Section (MCH) of the Georgia Department of Public Health (DPH), the recipient of the Title V Block Grant, underwent a restructure during this same time period as part of an agency-wide initiative to complete the Good to Great transformation. With the alignment of the national Title V transformation and state MCH transformation, the Title V Needs Assessment provided an important opportunity to reassess capacity, identify new priorities and align the existing infrastructure to meet population needs. The needs assessment has resulted in new priorities, new partnerships and an action plan that will move the needle on the eight selected national performance measures and identified priority needs.

PROCESS FOR CONDUCTING NEEDS ASSESSMENT

Goals, Framework and Methodology Guiding Needs Assessment Process

Georgia's Title V Needs Assessment was conducted by the MCH Office of Epidemiology within DPH. MCH currently uses the following mission and vision to guide its work, including the 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, direct services, 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.

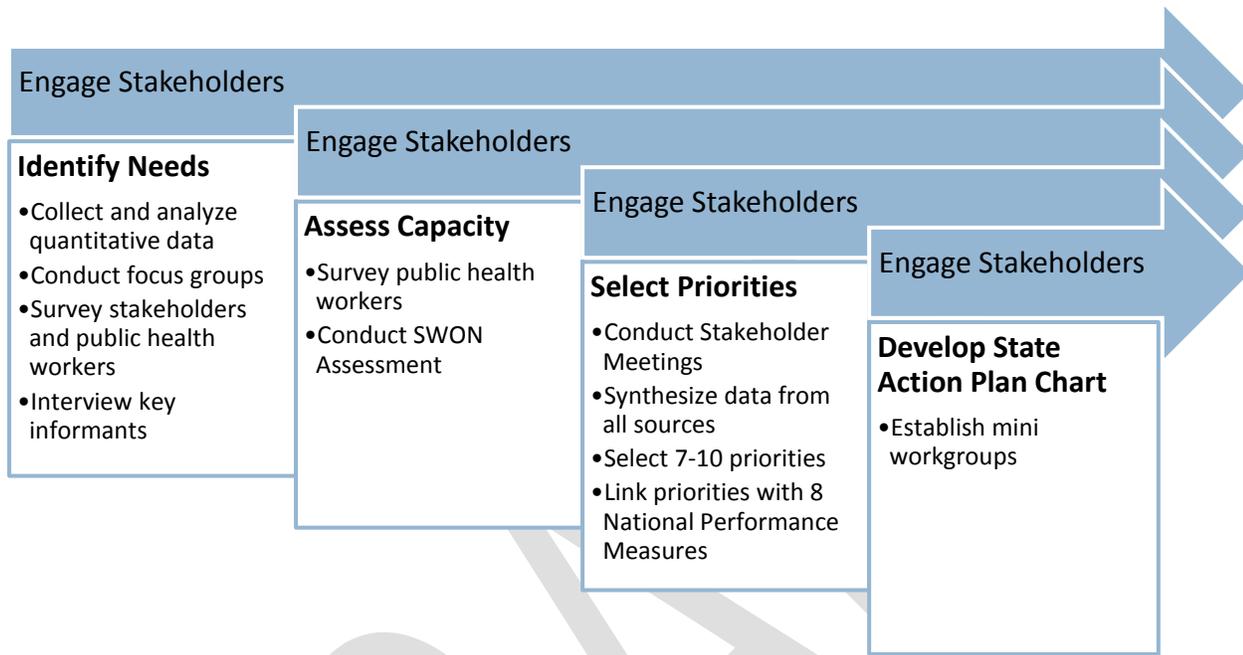


Figure 1. Georgia Title V Needs Assessment Process

Methods and Data Sources

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. First, an index of all data sources available to MCH was compiled. In order to gain a priori consensus on possible priority needs, all program and epidemiology staff in MCH were grouped by population domain. The groups were responsible for developing all indicators to be examined in the quantitative analysis portion of the needs assessment. The group was also responsible for identifying relevant stratifiers for each indicator. Indicators were selected from the National Performance and Outcome Measures, Healthy People 2020, life-course metrics and indicators examined in Georgia’s previous five-year needs assessment.

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

The Behavioral Risk Factor Surveillance System (BRFSS) is a nationwide surveillance system administered at the state level. The Georgia BRFSS is a joint effort by the Georgia Department of Public Health and the CDC since 1984. The study is conducted using random-digit-dialing techniques via landline and cellphone to recruit and survey participants ages 18 and older. Data is collected on health-related risk behaviors (ex. alcohol use; tobacco use), chronic health conditions (ex. diabetes; obesity) and use of preventive services (ex. cervical cancer screening; breast cancer screening). Data from the BRFSS is used to track trends in behavior change; determine the effectiveness of interventions; determine priority health issues; and develop plans to address issues identified. Data on emergent health topics are also collected which aids in pandemic planning (ex. vaccine shortage; prevalence of influenza-like illness).

Children's Medical Services Program Data

Children's Medical Services (CMS) is Georgia's program for children and youth with special health care needs (CYSHCN). The program data provides district-level enrollment information on CYSHCN served through the program, including demographic, outcome and financial data.

Current Population Survey

The Current Population Survey (CPS) is the result of a joint effort between the Bureau of Labor Statistics and the Census Bureau and is the main source of statistics on labor force for the United States population. This survey provides information on a wide range of issues relating to employment and earnings. For the 2015 Needs Assessment, CPS data was used to determine the proportion of specific populations without health insurance coverage.

Family Planning Program

Georgia's Title V program funds local-level family planning clinics. Data is collected and analyzed by MCH Epidemiology. The data provides demographic information on family planning clients, as well as overall enrollment data. The data also provides information on specific services that clients received during their visit.

Georgia Comprehensive Cancer Registry

The Georgia Comprehensive Cancer Registry (GCCR) is a state-wide population-based cancer registry collecting information on cancer incidence in Georgia. Data collection is conducted by the Georgia Center for Cancer Statistics at the Rollins School of Public Health at Emory University (<http://web1.sph.emory.edu/GCCS/cms/index.html>). Data from this registry improves our understanding of cancer in Georgia and aids in the development of strategies and policies aimed at cancer prevention, control, and treatment.

Hospital Discharge Data

Population-based records for hospital discharge and emergency room (ER) visits are collected by the Georgia Department of Public Health. For the 2015 Needs Assessment, these datasets were used to

determine the leading causes of hospitalization and ER visits by age group. Data defining the cause of admission and discharge to the hospital/ER are based on an international system called the International Classification of Disease (ICD). ICD codes are used to classify diseases and other health problems recorded on many types of health and vital records.

HIV Surveillance Program

The HIV/AIDS Epidemiology Section is responsible for managing the state HIV/AIDS surveillance system and epidemiologic activities for the state of Georgia. The surveillance of HIV/AIDS provides data critical to targeting the delivery of HIV prevention, care and treatment.

Georgia Maternal Mortality Review Committee

Georgia recently implemented a Maternal Mortality Review Committee. The purpose of the committee is to identify and investigate all cases of maternal mortality, determine whether the death was pregnancy related or pregnancy associated and develop recommendations to prevent maternal deaths in Georgia. Data from the committee's case review from 2012 maternal death cases were used in the needs assessment

(http://dph.georgia.gov/sites/dph.georgia.gov/files/MCH/MMR_2012_Case_Review_June2015.pdf)

Metro Atlanta Developmental Disabilities Surveillance Program

The Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP) estimates the number of children with selected developmental disabilities in 5 counties in metropolitan Atlanta. MADDSP is an initiative of the Centers for Disease Control and Prevention (CDC). Five developmental disabilities are tracked through MADDSP: Autism Spectrum Disorders, Cerebral Palsy, hearing loss, intellectual disability, and vision impairment. For this needs assessment, data were used to estimate the prevalence of Autism Spectrum Disorders in Atlanta, GA.

National Immunization Survey

The National Immunization Survey (NIS) is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers. The NIS target population is children between the ages of 19 to 35 months; NIS-teen collects data on adolescents 13 to 17 years old. The surveys collect data on vaccination coverage to identify groups at risk of vaccine-preventable diseases and to evaluate the effectiveness of programs designed to improve coverage rates. Data was accessed from <http://www.cdc.gov/nchs/nis.htm>.

National Survey of Children's Health

The National Survey of Children's Health (NSCH) is a national telephone survey conducted in English and Spanish. Telephone numbers are called at random to identify households with one or more children under 18 years of age from which one child is randomly chosen to participate in the study. The survey collects data on multiple facets of children's lives including physical and mental health status, access to care, family

life, neighborhood and social context. Data for NSCH was accessed from <http://www.childhealthdata.org/learn/NSCH>.

National Survey of Children with Special Health Care Needs

The National Survey of Children with Special Health Care Needs (NS-CSHCN) is a national survey; the most recent survey (2009/10) was conducted in English, Spanish, Mandarin, Cantonese, Vietnamese and Korean. Telephone numbers are randomly generated to identify households with one or more children under 18 years of age. Interviewers ask parents/guardians a series of questions to identify children with special health care needs. Data collected include child's health and functional status, access to health care, family-centeredness of child's health care and care coordination, access to community-based services, and transition to adulthood. Data was accessed from <http://www.childhealthdata.org/learn/NS-CSHCN>.

Online Analytical Statistical Information System

Online Analytical Statistical Information System (OASIS) is a query tool used to access health data from the Georgia Department of Public Health's standardized health data repository. Data accessed includes information on mortality, morbidity and sexually transmitted diseases (chlamydia and gonorrhea). For the 2015 Needs Assessment, data for the years 2008 to 2013 were accessed.

Pregnancy Risk Assessment Monitoring System

The Pregnancy Risk Assessment Monitoring System (PRAMS) is a nationwide survey collecting state-specific, population-based data on the maternal attitudes and experiences during the perinatal period. The Georgia PRAMS is a joint effort by the Georgia Department of Public Health and the CDC since 1993. The state's birth certificate file is used to determine eligibility for PRAMS from a population of women who have had a recent live birth. Participants complete questionnaires through mail with a telephone follow-up for non-responders. The survey collects data on numerous topics relating to the period before, during and after pregnancy including attitudes and feelings about the most recent pregnancy, prenatal care, alcohol and tobacco consumption during pregnancy, contraceptive use, and maternal knowledge of pregnancy-related health issues (ex. knowledge about benefits of folic acid).

State Vital Records

The State Office of Vital Records collects birth and death records from each of the 159 counties in Georgia. For this needs assessment, birth and death files were accessed for years 2008 to 2013 and were limited to residents only, unless stated otherwise. Birth files were used to identify patterns in infant birth weight, use of prenatal care, preterm deliveries and adolescent pregnancy. Mortality data were used to identify leading causes of death in different life-stages as well as the rate of mortality from various causes.

State Inpatient Databases

The State Inpatient Databases (SID) was developed for the Healthcare Cost and Utilization Project (HCUP). SID provides state-level data on inpatient discharges collected from community hospitals, including patient

demographics, diagnoses and procedures, payor, charges and length of stay. Data were used from SID in this needs assessment to determine state and national rates of non-fatal injury hospitalizations.

STD Surveillance Program

Infectious disease surveillance data is collected through the Georgia Department of Public Health. For this needs assessment, data were used to determine rates for chlamydia, gonorrhea and HIV and were accessed through OASIS.

Universal Newborn Hearing & Screening Program

The Georgia Universal Newborn Hearing & Screening (UNHSI) program screens for hearing loss in infants younger than 1 month old. Screening is completed before the baby leaves the birthing facility. For the purpose of this needs assessment, data from this program was used to determine the proportion of newborns who had been screened before discharge.

Youth Risk Behavior Surveillance System

The Youth Risk Behavior Surveillance System (YRBS) is a nationwide population-based survey collecting data at the state-level. The YRBS collects information on priority health-risk behaviors that contribute to the leading causes of morbidity and mortality among youth and adults. YRBS data is used to monitor the effectiveness of interventions developed to improve health outcomes for adolescents. The Georgia Department of Public Health administers the YRBS to public middle and high schools to collect information on age of initiation and prevalence of various health risk behaviors relevant to adolescents. Risk behaviors include physical activity, eating habits, tobacco use, alcohol and drug use, and behaviors that contribute to unintentional injuries and violence. A major limitation of the Georgia YRBS is that the survey does not collect information on sexual activity, sexual debut and safe sex practices. Since a primary goal of YRBS data is to assist in developing prevention strategies and evaluating program effectiveness, the absence of data related to youth and sexual activity significantly limits the ability to address and improve rates for critical health issues such as adolescent pregnancy and birth outcomes.

Youth Tobacco Survey

The Youth Tobacco Survey (TYS) is a survey among adolescents in grades 6 through 12. The survey is housed at the Centers for Disease Control and Prevention and administered through state health departments. The purpose of the survey is to assist states in designing, implementing and evaluating tobacco prevention programs among adolescents. Data on the prevalence of electronic cigarettes were used in the needs assessment.

National Vital Statistics System

The National Vital Statistics System (NVSS) is housed in the National Center for Health Statistics. The system stores data on vital events, including births, deaths, marriages, divorces and fetal deaths. The data is collected from various jurisdictions that collect vital records. For this needs assessment, the data was used to provide national comparisons to Georgia's vital records data.

Water Fluoridation Reporting System

The Centers for Disease Control and Prevention (CDC) provides water fluoridation statistics prepared by linking water system data reported by each state to the US Census Bureau state population estimates. Data on the most recent year, 2012, is provided on the following website:

<http://www.cdc.gov/fluoridation/statistics/2012stats.htm>.

Qualitative Methods

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 (≥ 30 yrs.)	Waycross	Cobb Douglas (≤7 yrs.)
Fulton (≥ 30 yrs.)	Valdosta	Augusta (≤7 yrs.)
East Metro † (≥ 30 yrs.)	Macon	Columbus (≤7 yrs.)
Dublin (< 30 yrs.)	Dalton	Gainesville (≥8 yrs.)
Albany (< 30 yrs.)		Clayton (≥8 yrs.)
Athens (< 30 yrs.)		Savannah (≥8 yrs.)
DeKalb † (< 30 yrs.)		

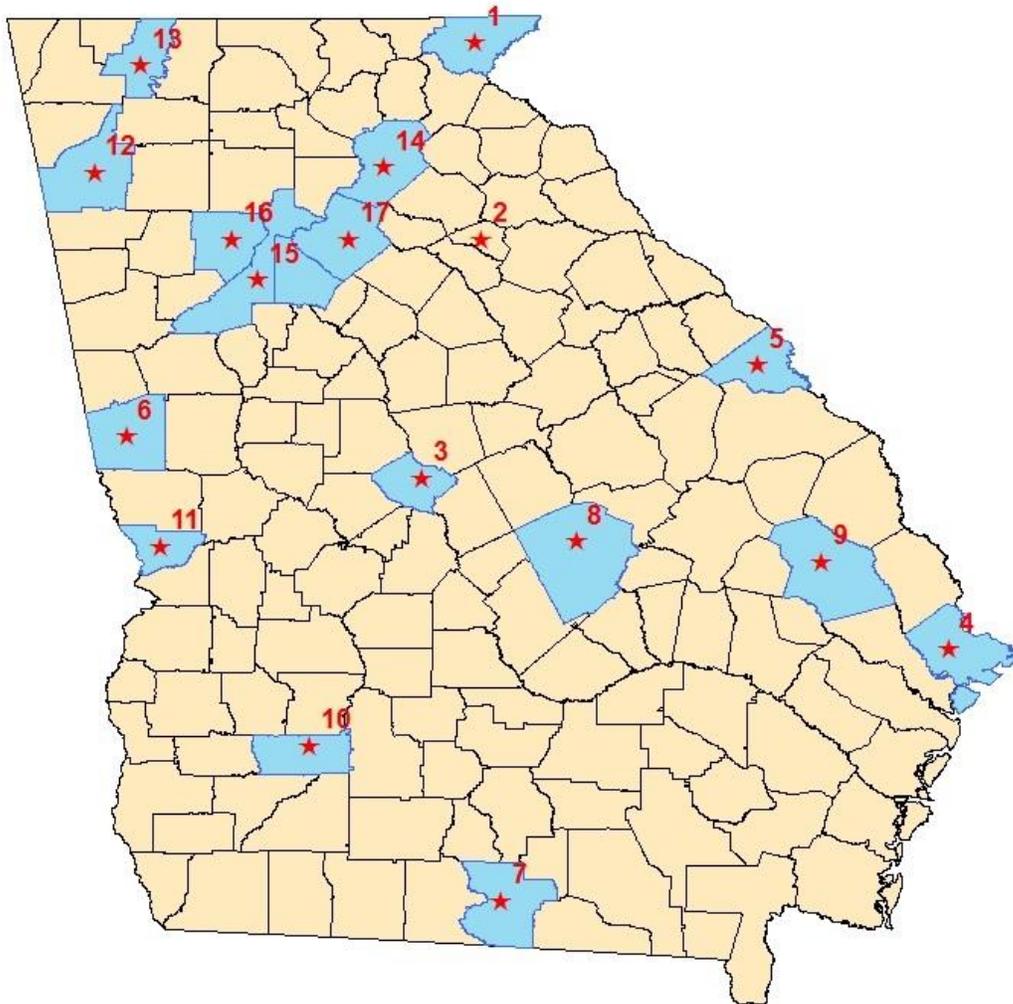
*Participants were pregnant women or had a child within the past year and either over 30 years or under 30 years of age

**Participants were parents of children ages 4 to 7 years of age

***Participants were parents of CYSHCN 7 or younger or 8 and older

† Key Informant Interviews conducted in Spanish among Latinas

Focus Group Locations



Public Health District	City	County	Public Health District	City	County
1 Clayton	Clayton	Rabun	10 Albany	Albany	Dougherty
2 Athens	Athens	Muscogee	11 Columbus	Columbus	Muscogee
3 Macon	Macon	Bibb	12 Rome	Rome	Floyd
4 Savannah	Savannah	Chatham	13 Dalton	Dalton	Whitfield
5 Augusta	Augusta	Richmond	14 Gainesville	Gainesville	Hall
6 East Mento	LaGrange	Geinnett	15 Fulton	Atlanta	Fulton
7 Valdosta	Valdosta	Lowndes	16 DeKalb	Atlanta	Hall
8 Dublin	Dublin	Laurens	17 Cobb Douglas	Marietta	Cobb
9 Waycross	Statesboro	Bulloch	18 East Metro	Lawrenceville	Qwinett

Focus Group Guide Development Georgia Department of Public Health Staff worked collaboratively with Emory University faculty to develop focus group guide questions based on the domains of interest

(perinatal health, school readiness, CYSHCN ≤ 7 and CYSHCN ≥ 8). Questions were initially developed by the Emory University team and then reviewed and revised by the focus group facilitators and NAW. A demographic form was also created to assess participants' age, educational status, number of children, as well as their familiarity with and use of variety of medical and community services in their district (see Appendix A). These were administered immediately prior to each focus group.

Eligibility Criteria Focus group facilitators were asked to recruit potential or current users of the public health system in their respective districts. Women and men were eligible to participate in the focus groups. Additional criteria for focus group participants, by topic area, included:

- Perinatal: Women who were pregnant or parents that had a baby within the past year. Focus groups were either among women less than 30 years of age, or 30 years of age and older to ensure equal age representation.
- School Readiness: Parents with school-aged children ages 4 to 7.
- CYSHCN: Parents of children and youth with special health care needs. Focus groups were either among parents with a child 7 years of age and younger, or 8 years of age and older to allow the opportunity to ask age-specific questions. Parents of younger children were asked about early identification and intervention services. Parents of older children were asked about their child's transition to adulthood.

Focus Group Facilitators and Note-takers Fifteen individuals were recruited to serve as focus group facilitators for the needs assessment. A combination of flyers, e-mail messages and bulletin board announcements were used to recruit eligible people in each of the 18 public health districts. For the purposes of recruiting and building trust with focus group participants, focus groups were conducted by members of the community who were familiar with community assets and needs. Interested persons were asked to submit applications to be considered for focus group facilitation. These applications were then reviewed for experience conducting focus groups, knowledge of maternal and child health and familiarity with their respective communities.

All facilitators completed a one-day training session conducted by Emory University staff in September 2014 to further learn the purpose of the needs assessment, review the focus group guides, and understand the fundamentals of focus group facilitation. Facilitators were then given directives to recruit potential or current users of the public health system in their respective districts, as well as logistical information needed to conduct focus groups within thirty days of completion of the training. The recruitment goal for each group was 8-10 participants, thus facilitators were encouraged to oversample (15 participants) to reach this goal. Facilitators were encouraged to hold focus groups at a mutually accessible location for all participants.

DPH employees served as note-takers and were responsible for audio-recording the focus group. To ensure consistency with note-taking, all note-takers completed a one-day training that highlighted the basics of observational data collection, as well as expanding notes to a narrative summary. All focus groups were

transcribed verbatim by DPH staff, and verified through a two step-process: an initial review by the transcriptionist and a second review by facilitators to ensure accuracy.

Participant Compensation All focus group participants were provided with a \$25 gift card at the conclusion of the focus group. Meals were also provided during the focus groups. Although multiple members of a family could participate in the focus group, only one member per family received a gift card as compensation for participation. Participants in the perinatal focus groups were allowed to bring their newborns to encourage participation. As participants in the other focus groups had children older in age, this was not encouraged, although not enforced if participants brought children.

Analysis Two researchers independently reviewed all transcripts to become familiar with the raw text and to gain an understanding of the themes and events covered during each of the focus group discussions. From this review, the two researchers created categories based on areas of inquiry provided from the initial aims of the study. Subcategories were created through additional reading of the transcripts, based on comments provided by participants, and meanings in specific text segments. All focus group data was managed using NVivo 10. The researchers also reviewed narrative summaries provided by facilitators and note-takers for each focus group, as well as baseline demographic information for participants in each district. This additional data provided contextual information to augment coded data.

KEY INFORMANT INTERVIEWS

Individual interviews were conducted with six leaders in the MCH workforce in Georgia. The purpose of the interviews was to gain the perspectives of leaders, who may not necessarily participate in surveys and who have unique perspectives on the health needs of women and children in Georgia. Leaders were identified by the NAW and invited to participate. All leaders who were invited chose to participate. One interview was conducted per population domain. The key informants had diverse backgrounds. Several served in multiple roles, including two on the Board of Public Health and one District Health Director. Their primary positions and/or professions are listed below:

- Dentist
- Pediatrician
- Executive Director of state-based advocacy organization
- Dentist who serves CYSHCN
- President of state-based health promotion organization
- Neonatologist

The interviews were recorded and analyzed using NVivo 10. The key areas discussed during the interviews included identification of needs and priorities, barriers to accessing services, areas of disparity and needs of the public health workforce.

Stakeholder Engagement

STAKEHOLDER SURVEY

An electronic survey was disseminated to stakeholders throughout the state to identify needs and priorities. The purpose of the survey was to engage stakeholders throughout the state. Although in-person meetings were held with stakeholders, the survey provided an opportunity for all stakeholders to provide input to the needs assessment regardless of location or time constraints. The survey was distributed to MCH partners, including professional organizations, providers, hospitals, other governmental agencies, universities, non-profit organizations and other MCHB grantees, however the survey was open to all citizens of Georgia. Toolkits were developed to assist Board of Public Health members and District Health Directors in raising awareness in their organizations about the stakeholder survey and subsequent public comment period. A total of 262 respondents completed the survey. Respondents were asked to rank the National Performance Measures (NPM) and identify needs specific to Georgia that are outside the scope of the NPMs.

PUBLIC HEALTH WORKFORCE SURVEY

A separate, but similar, electronic survey was disseminated to employees of DPH at the state, district and local level. As with the stakeholder survey, respondents were asked to rank the NPMs and identify additional needs related to MCH populations. Additionally, respondents were asked to identify areas of needed workforce development and agency capacity to assist MCH in understanding which needs had the capacity to be addressed. A total of 230 employees completed the survey.

PUBLIC COMMENT

Throughout the process, public input was solicited through an online public comment format. The Title V Needs Assessment findings were posted to the DPH Title V website on a rolling basis from March to July 2015. Notifications were emailed to partners, Board of Public Health members and known stakeholders with an invitation to inform the selection of priority needs, national performance measures and the development of the state action plan. A toolkit was developed for District Health Directors and Board of Public Health members to share information about the Title V Needs Assessment and public comment period within their organizations. The toolkits included a schedule of the postings, a Title V fact sheet and PowerPoint slides for presentations. Comments were emailed directly to DPH staff for review and applied to the documents as necessary.

MCH Population Findings

QUANTITATIVE ANALYSIS: MATERNAL/WOMEN’S HEALTH

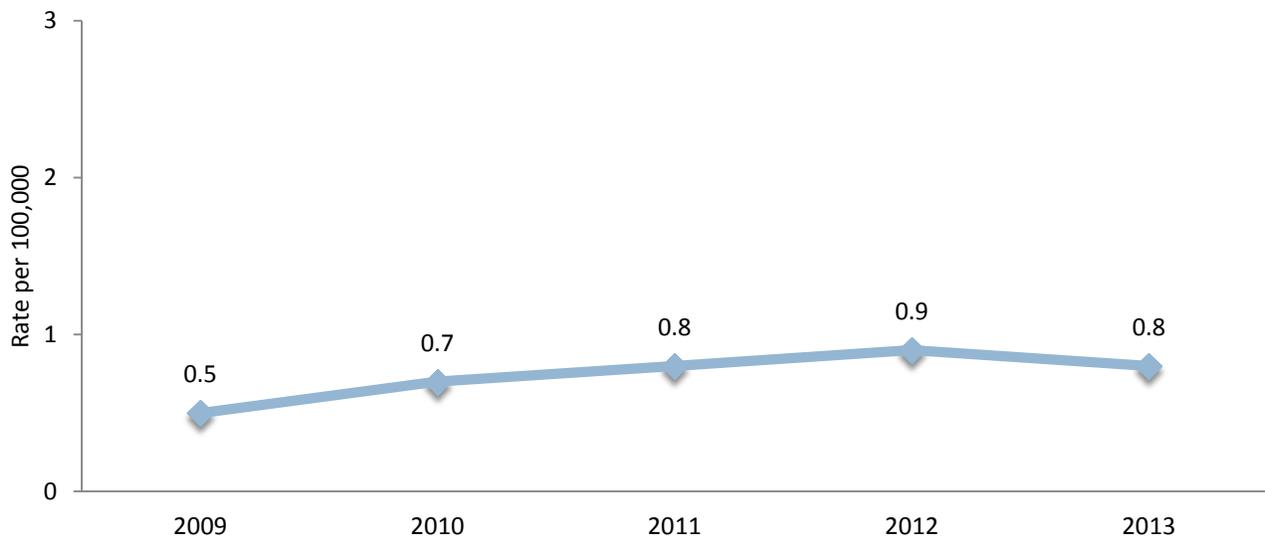
Improving maternal health outcomes, morbidity and mortality is an important priority for Georgia. Maternal well-being is indicative of many outcomes – including the well-being of children, families, and future generations. This section focuses on pregnancy behaviors and health issues due to the fact that pregnancy can be an opportunity to prevent future health risks. Additionally, assessing these indicators can help Georgia better determine program priorities and develop more cost-efficient and culturally-sensitive interventions to address disparities by race, ethnicity, age, and education level.

WOMEN OF REPRODUCTIVE AGE

Mortality

Mortality from cervical cancer rose from 2009 to 2012, then declined slightly from 2012 to 2013.

Rate of mortality from cervical cancer per 100,000 women ages 18 to 44 years, Georgia, 2009-2013



Source: Georgia Cancer Registry

Motor vehicle crashes were the top cause of death among women ages 18 to 34 from 2009 to 2013 in Georgia. However, for women ages 35 to 44 years, the top cause of death was accidental poisoning and exposure to noxious substances. Also notable is that malignant neoplasm of the breast and heart disease, two chronic diseases, were the second and third cause of death for women over the age of 35.

Top 10 causes of death for women 18 to 44 years of age by rate per 100,000, Georgia, 2009-2013

Rank	18-19 years	20-24 years	25-34 years	35-44 years
1	Motor Vehicle Crashes (n=63)	Motor Vehicle Crashes (n=163)	Motor Vehicle Crashes (n=266)	Accidental Poisoning and Exposure to Noxious Substances (n=479)
2	Assault (Homicide) (n=23)	Accidental Poisoning and Exposure to Noxious Substances (n=79)	Accidental Poisoning and Exposure to Noxious Substances (n=266)	Malignant Neoplasm of the Breast (n=383)
3	Accidental Poisoning and Exposure to Noxious Substances (n=15)	Assault (Homicide) (n=77)	Intentional Self-Harm (Suicide) (n=166)	Ischemic Heart and Vascular Disease (n=250)
4	Intentional Self-Harm (Suicide) (n=15)	Intentional Self-Harm (Suicide) (n=61)	Assault (Homicide) (n=138)	Motor Vehicle Crashes (n=247)
5	All Other Endocrine, Nutritional and Metabolic Diseases (n=7)	All Other Diseases of the Nervous System (n=35)	Human Immunodeficiency Virus (HIV) Disease (n=100)	Intentional Self-Harm (Suicide) (n=243)
6	All Other Diseases of the Nervous System (n=7)	Pregnancy, Childbirth and the Puerperium (n=33)	All Other Diseases of the Nervous System (n=82)	Essential (Primary) Hypertension and Hypertensive Renal, and Heart Disease (n=211)
7	Pregnancy, Childbirth and the Puerperium (n=7)	All Other Endocrine, Nutritional and Metabolic Diseases (n=20)	Pregnancy, Childbirth and the Puerperium (n=80)	Cerebrovascular Disease (n=204)
8	Diseases of the Musculoskeletal System and Connective Tissue (n=6)	Cerebrovascular Disease (n=18)	Malignant Neoplasm of the Breast (n=71)	Human Immunodeficiency Virus (HIV) Disease (n=189)
9	Congenital Malformations, Deformations and Chromosomal Abnormalities (n=6)	All Other Unintentional Injury (n=16)	Diabetes Mellitus (n=67)	Malignant Neoplasm of the Cervix Uteri, Uterus, and Ovary (n=183)

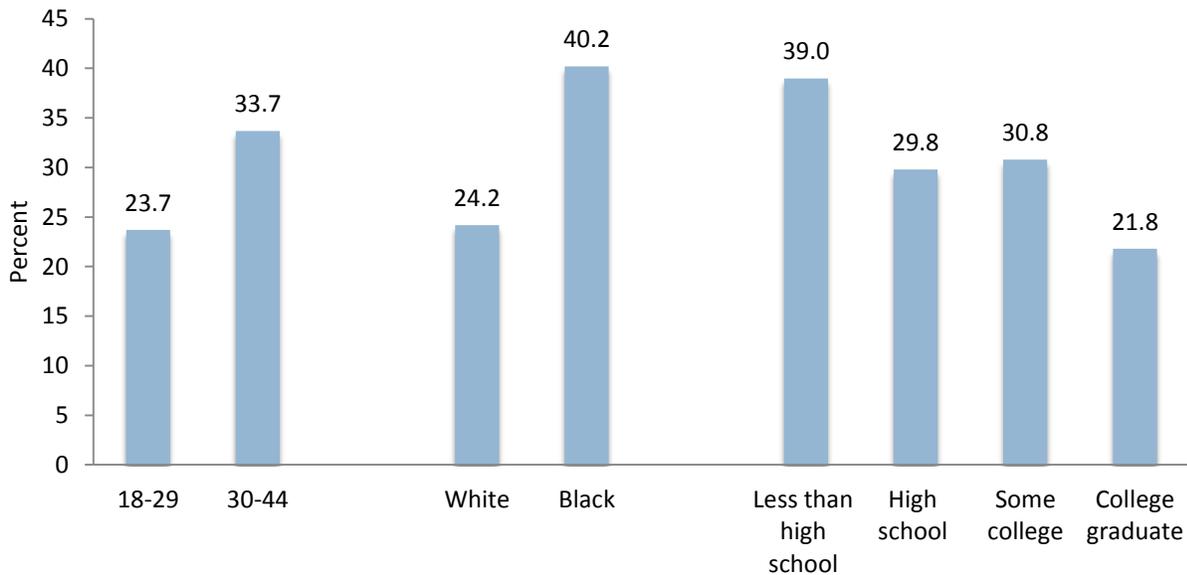
10	Septicemia (n=5)	Congenital Malformations, Deformations and Chromosomal Abnormalities (n=14)	Cerebrovascular Disease (n=64)	All Other Diseases of the Nervous System (n=158)
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Source: OASIS Community Health Needs Assessment Dashboard

Obesity

From 2012 to 2013, the percentage of reproductive aged women who are obese was higher among women ages 30 to 44 (33.7%) compared to women ages 18 to 29 (23.7%). Almost twice as many Black women reported being obese as White women. Differences are seen by educational attainment as well. Those with less than a high school degree reported being obese almost twice as often as those with a college degree.

Percent of women ages 18 to 44 who are obese by age, race/ethnicity and education, Georgia, 2012-2013

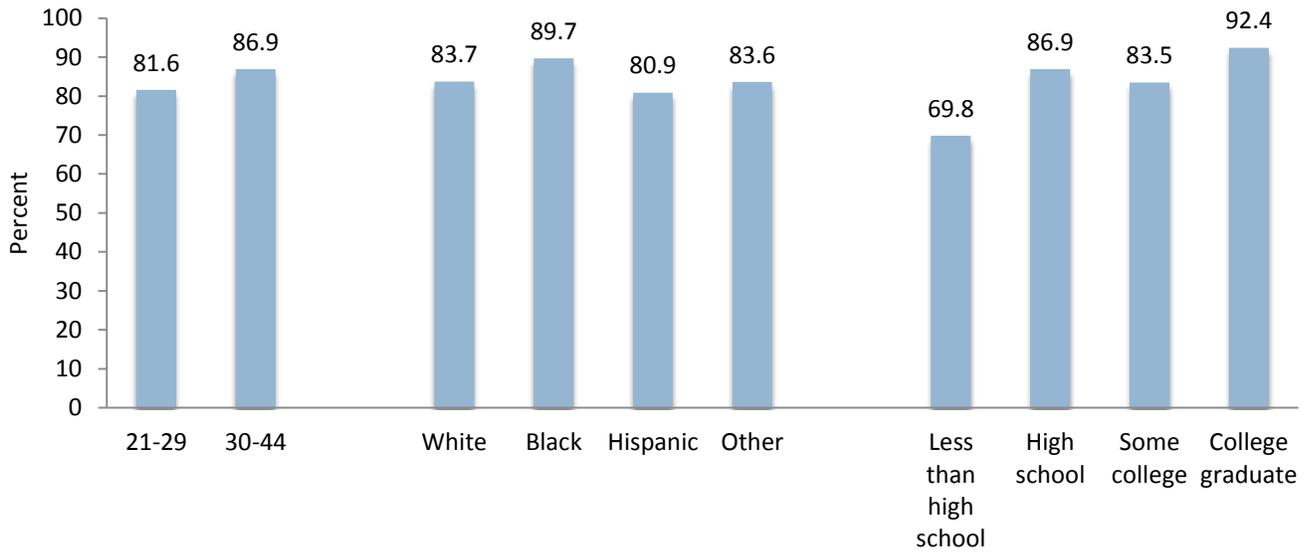


Source: BRFSS

Pap Smear

From 2012 to 2013, over 85% of women in Georgia between the ages of 21 and 44 reported having had a Pap smear during the last three years. Little variation was seen by race and ethnicity. Only Black women exceeded the state average, with nearly 90% reporting having received a Pap smear during the last three years. The percentage was marginally higher among older women (30 to 44) compared to women ages 21 to 29. Differences were seen when the data were stratified by educational attainment. Women with less than a high school degree received a Pap smear 1.3 times less often than women with a college degree.

Percent of women who reported receiving a Pap smear in the past three years by age, race/ethnicity and education, Georgia, 2012-2013

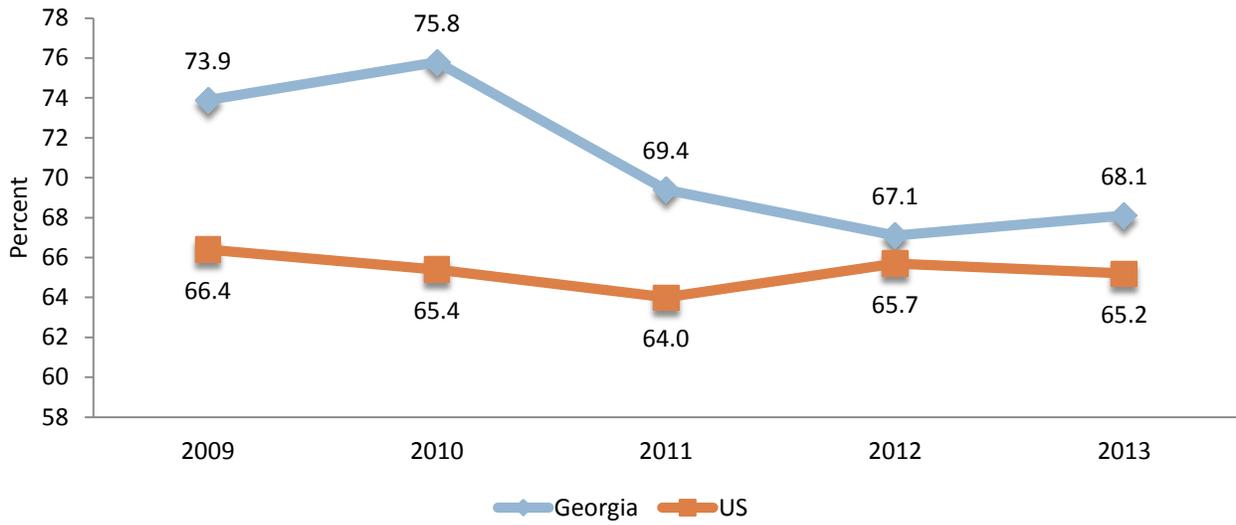


Source: BRFSS

Preventive Medical Visit

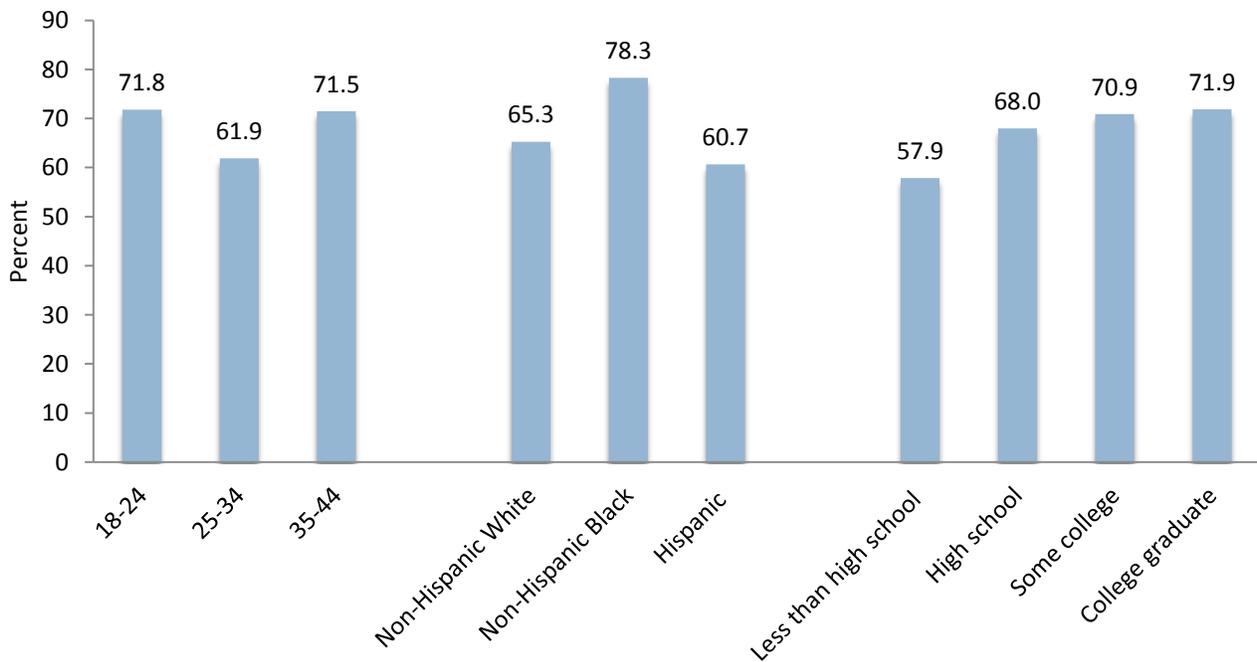
Although there was an overall decline in the percentage of women receiving a preventive medical visit between 2009 and 2013 in Georgia (73.9% compared to 68.1%), the percentage remained above the national average in all years examined. In 2013, 78.3% of non-Hispanic Black women reported having seen a provider, while only 60.7% of Hispanic women attended such a visit. Little variation was seen between women 18 to 24 and 35 to 44 years of age, however fewer women between the ages of 25 to 34 reported attending a preventive visit in the past year. The percentage of women receiving a preventive visit was higher among women with higher educational attainment. Over 70% of women with a college degree attended a preventive medical visit in the past year. For women with a high school diploma or less, the percentage was below 70%.

Percent of women 18-44 who received a preventive medical visit in the past 12 months by year, Georgia compared to the US, 2009-2013



Source: BRFSS

Percent of women 18-44 who received a preventive medical visit in the past 12 months by age, race/ethnicity and education, Georgia, 2013



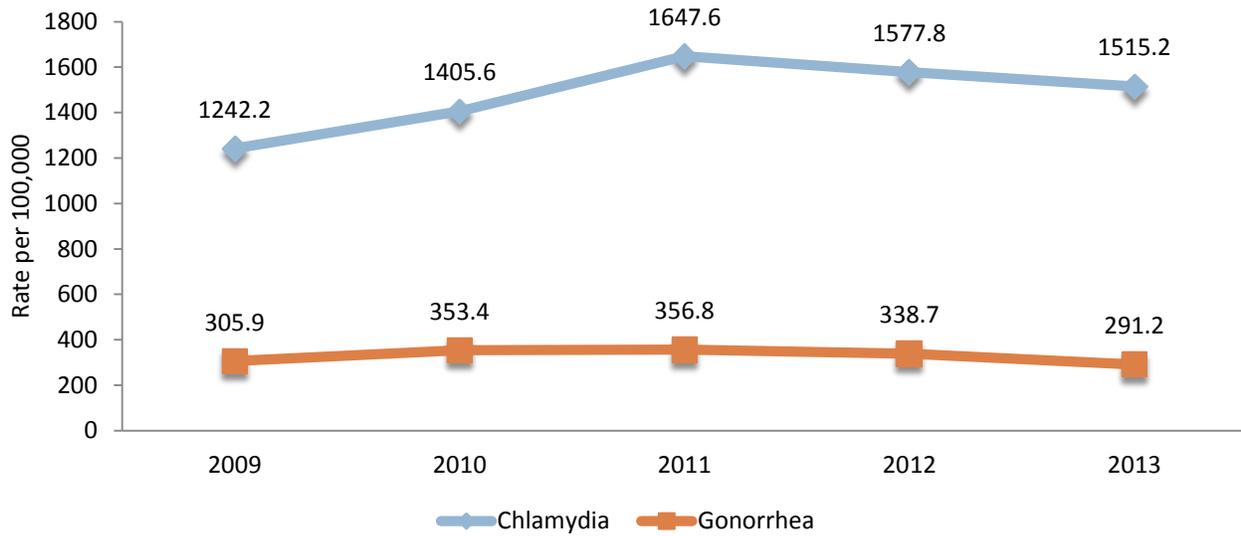
Source: BRFSS

Sexually Transmitted Infections

Chlamydia and Gonorrhea

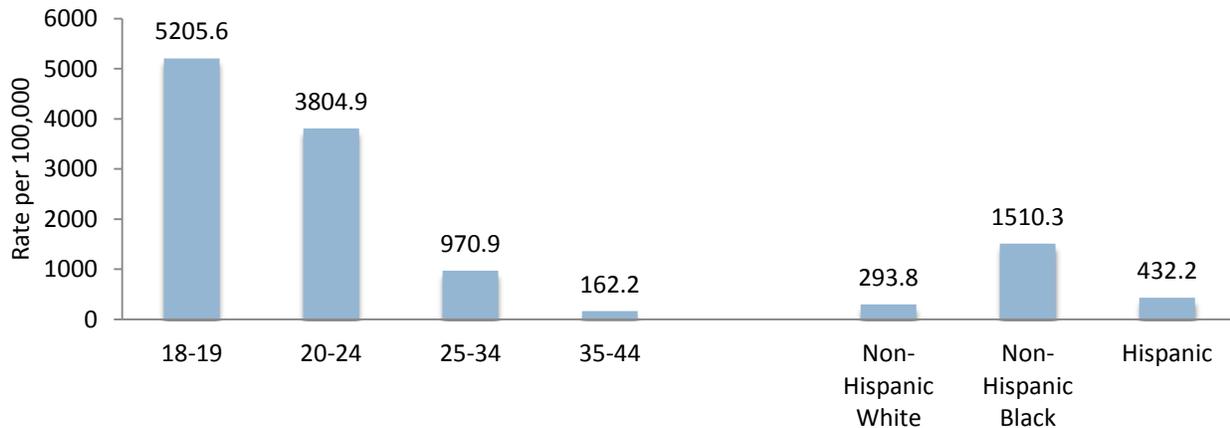
In 2013, about five times more women reported having chlamydia than gonorrhea. Both chlamydia and gonorrhea declined from 2011 to 2013. The rates of chlamydia and gonorrhea were highest among women ages 18 to 24. The lowest rates were among women 35 and older, with almost no incidence of gonorrhea among women ages 40 to 44. Non-Hispanic Black women had a far higher rate of both chlamydia and gonorrhea compared to all other women.

Chlamydia and gonorrhea prevalence per 100,000 women 18-44 by year, Georgia, 2009-2013



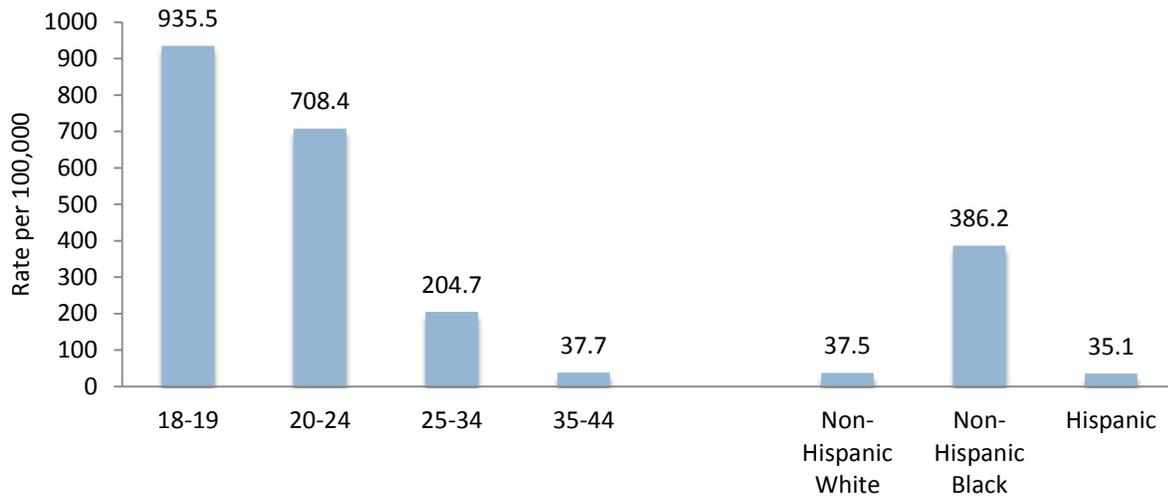
Source: OASIS

Chlamydia prevalence per 100,000 women 18-44 by age and race/ethnicity, Georgia, 2013



Source: OASIS

Gonorrhea prevalence per 100,000 women 18-44 by age and race/ethnicity, Georgia, 2013

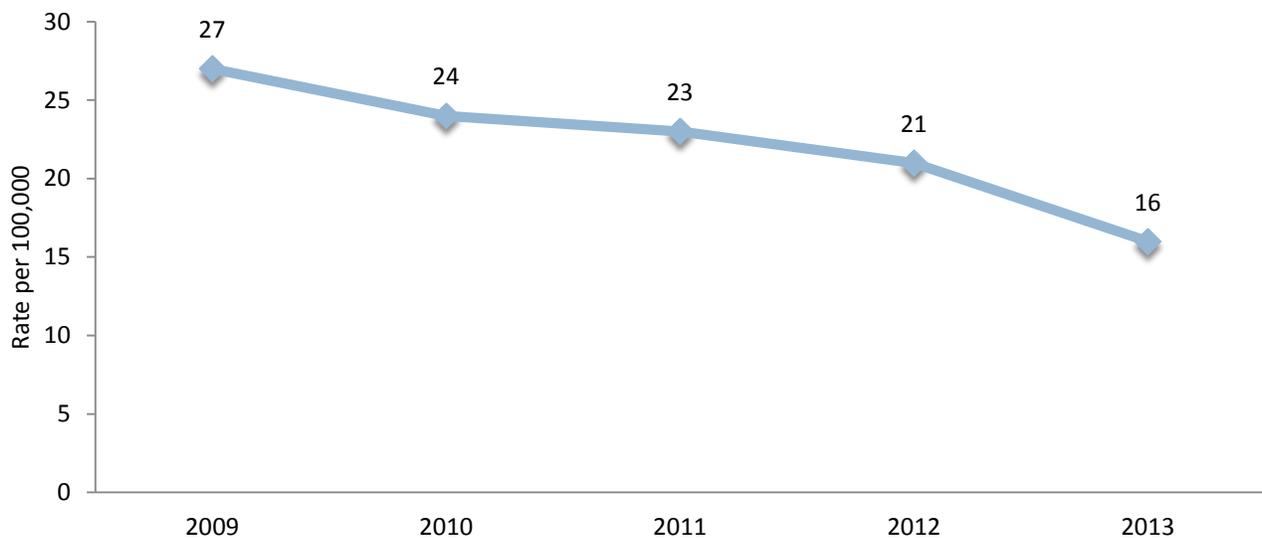


Source: OASIS

HIV Incidence

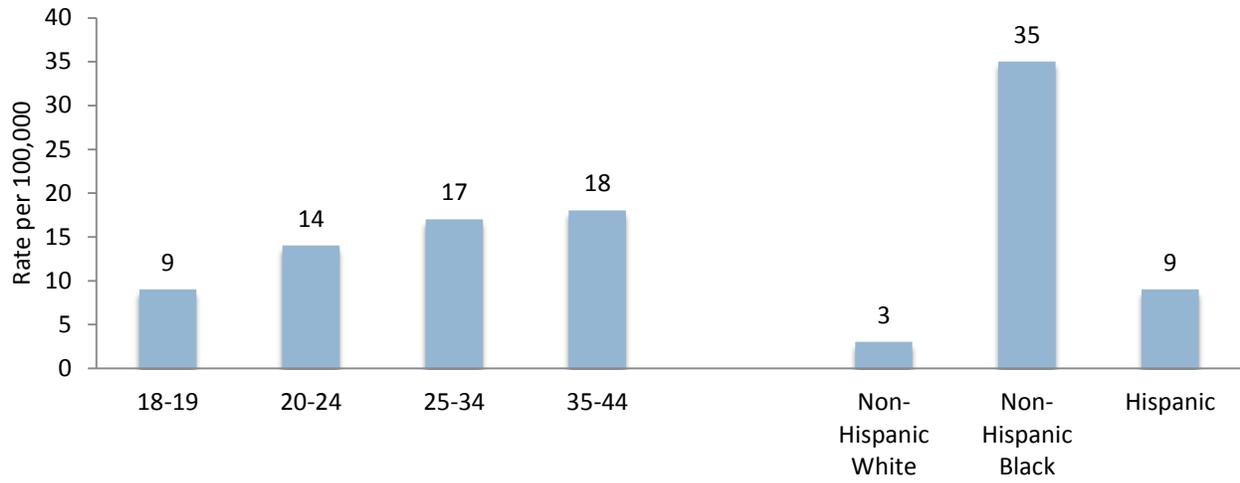
The rate of new HIV diagnoses per 100,000 women 18 to 44 years declined in Georgia from 2009 to 2013. In 2009, the rate of new diagnoses was 27 per 100,000 women, while it dropped to 16 per 100,000 in 2013. The rate was higher among older women compared to younger women. Non-Hispanic Blacks had the highest rate of new HIV diagnoses per 100,000 compared to any other race/ethnicity. The highest rates of new HIV diagnoses occurred in Clayton followed by South Central and Southwest public health districts.

Rate of new HIV diagnoses per 100,000 women 18-44 by year, Georgia, 2009-2013



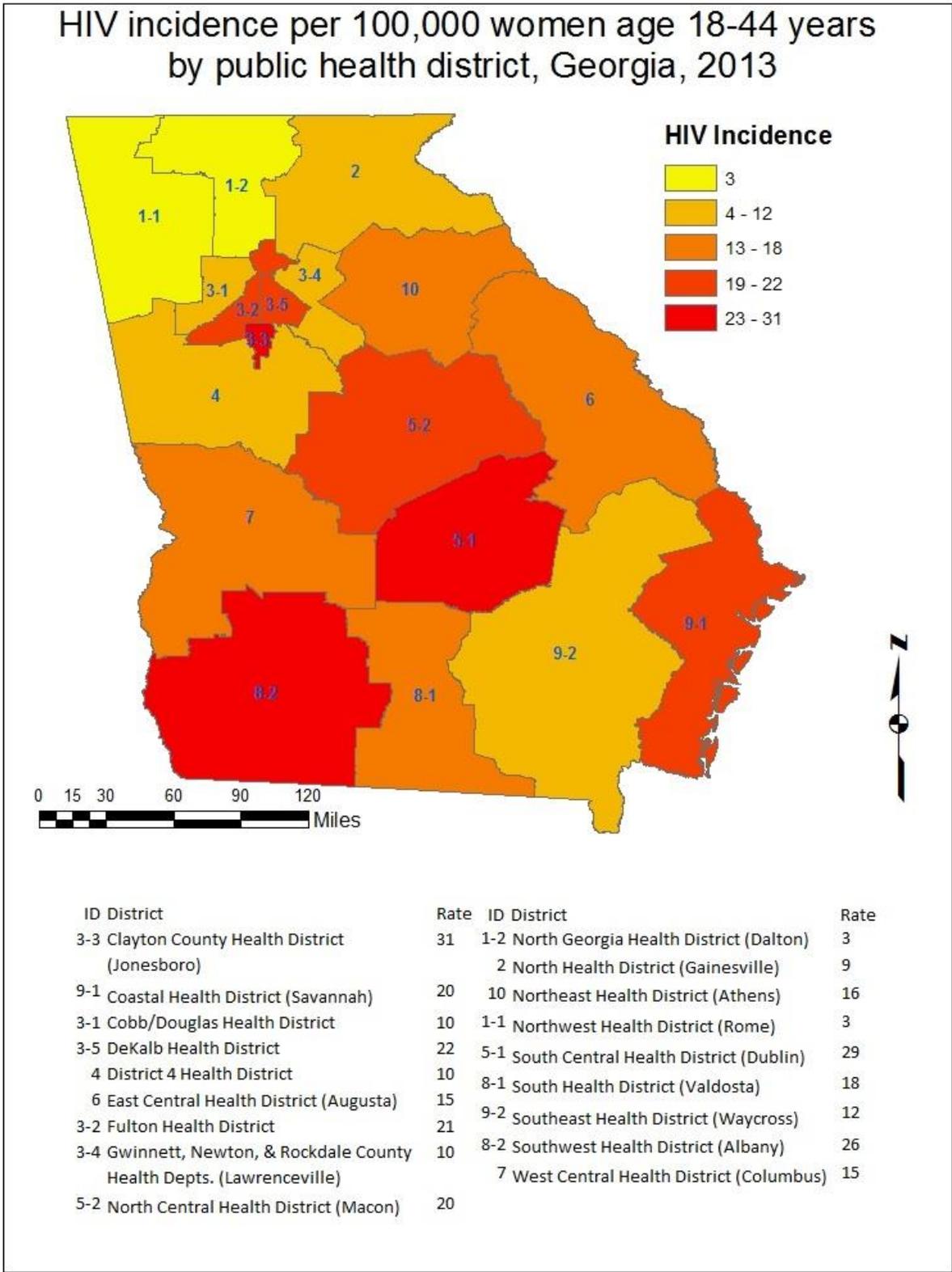
Source: HIV Surveillance Program

Rate of new HIV diagnoses per 100,000 women 18-44 by age and race/ethnicity, Georgia, 2013



Source: HIV Surveillance Program

DRAFT

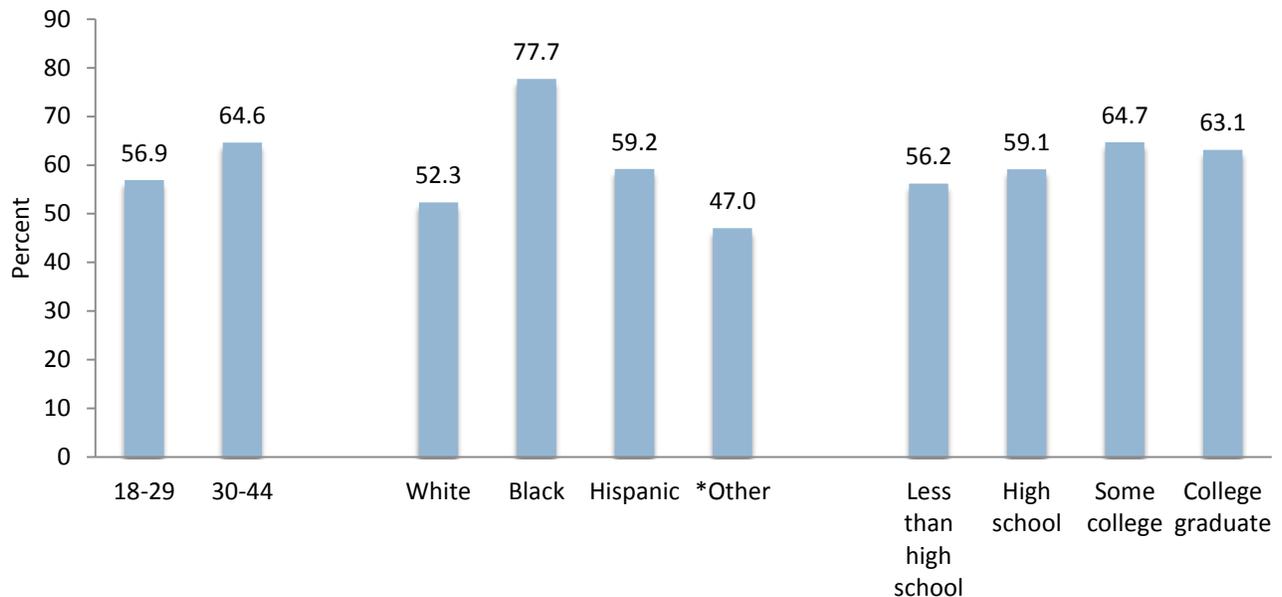


Source: HIV Surveillance Program 2009-2013

HIV Test

More women between the ages of 30 and 44 reported having ever taken an HIV test than women between the ages of 18 and 29. Black women reported taking an HIV test more often than any other race/ethnicity, with over 75% reporting having taken a test. Additionally, the percentage was higher among women with higher educational attainment.

Percent of women ages 18-44 years who reported ever taking an HIV test by age, race/ethnicity and education, Georgia, 2012-2013



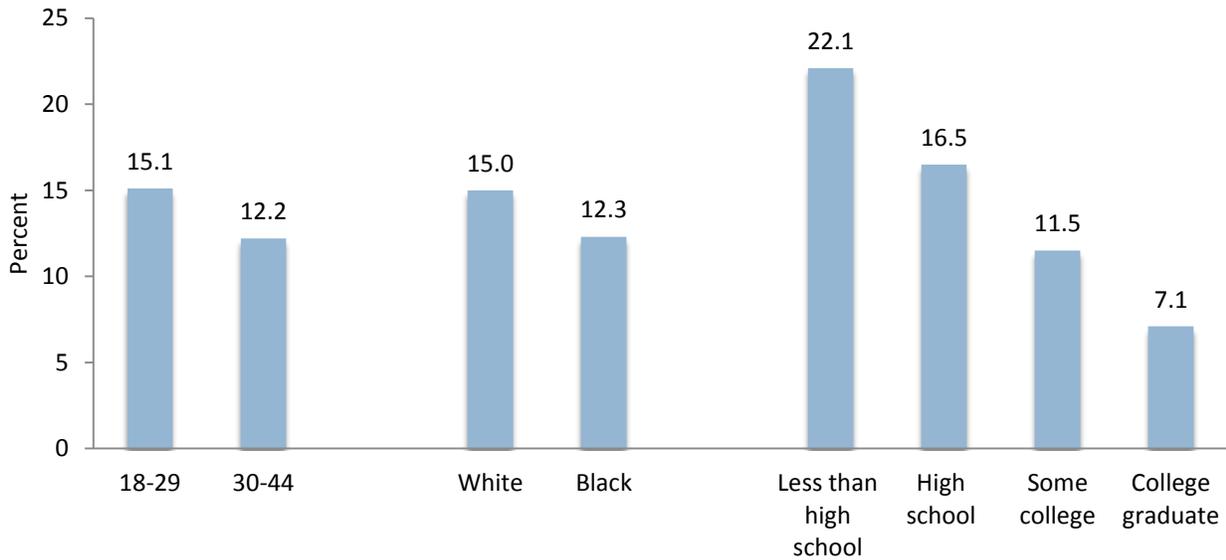
Source: BRFSS

*Other includes Asian, American Indian, Hawaiian, Alaskan Native, Mixed Race and Other

Mental Distress

About 13% of women in Georgia reported experiencing mental distress in Georgia between 2012 and 2013. White women reported experiencing mental distress at a slightly higher percentage than Black women. Patterns were seen for age and education; as age and education increased, the proportion of women reporting mental distress decreased. Women with less than a high school degree experienced mental distress three times more than women with a college degree.

Percent of women who reported 18-44 experiencing mental distress by age, race/ethnicity and education, Georgia, 2012-2013



Source: BRFSS

PRECONCEPTION PERIOD

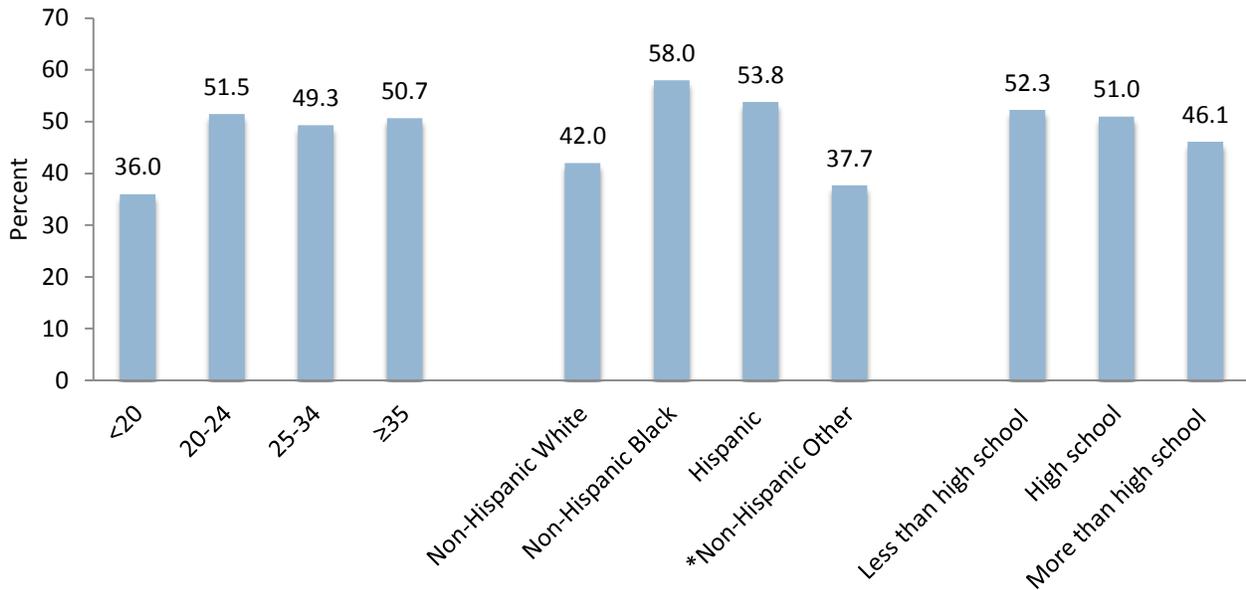
Healthy Weight Prior to Pregnancy

Healthy People 2020 Objective

MICH-16.5: Increase the proportion of women delivering a live birth who had a healthy weight prior to pregnancy to 53.4%

Nearly 50% of mothers who recently had a live birth in Georgia entered pregnancy with a BMI that places them in the overweight or obese categories (BMI greater than or equal to 25.0) from 2009 to 2011. Excess maternal weight has been linked to conditions that can affect women during pregnancy, like diabetes, hypertension and adverse maternal and infant outcomes, such as maternal, fetal, and infant death. High maternal BMI was reported more frequently among non-Hispanic Black (58.0%) and Hispanic (53.8%) mothers who recently had a baby from 2009 to 2011. The percentage of mothers who began their pregnancy with a BMI in the overweight or obese category was highest in mothers over the age of 20, but was similar among all mothers over the age of 20, at around 50.0%. Few differences were seen by educational attainment.

Percent of mothers who entered pregnancy overweight or obese (BMI ≥ 25.0) by maternal age, race/ethnicity and education, Georgia, 2009-2011



Source: PRAMS

*Non-Hispanic Other includes Asian, American Indian, Hawaiian, Alaskan Native, Mixed Race and Other

Healthy Behaviors Prior to Pregnancy

Among Georgian women who recently had a baby, 35.6% reported that they exercised three or more days of the week prior to their pregnancy to become healthy. The second most commonly reported step to ensure health prior to pregnancy was dieting to lose weight. The steps most reported least often were visiting a health care provider to be checked for diabetes and depression or anxiety.

Percent of mothers who took steps to become healthy before pregnancy, Georgia, 2009-2011	
Exercising three or more days of the week	35.6%
Dieting to lose weight	26.9%
Talked to a health care worker about family medical history	19.7%
Regularly taking prescription medicine other than birth control	12.9%
Visited a health care worker to be checked or treated for high blood pressure	11.4%
Visited a health care worker to be checked or treated for diabetes	10.3%
Visited a health care worker to be checked or treated for depression or anxiety	6.7%

Source: PRAMS

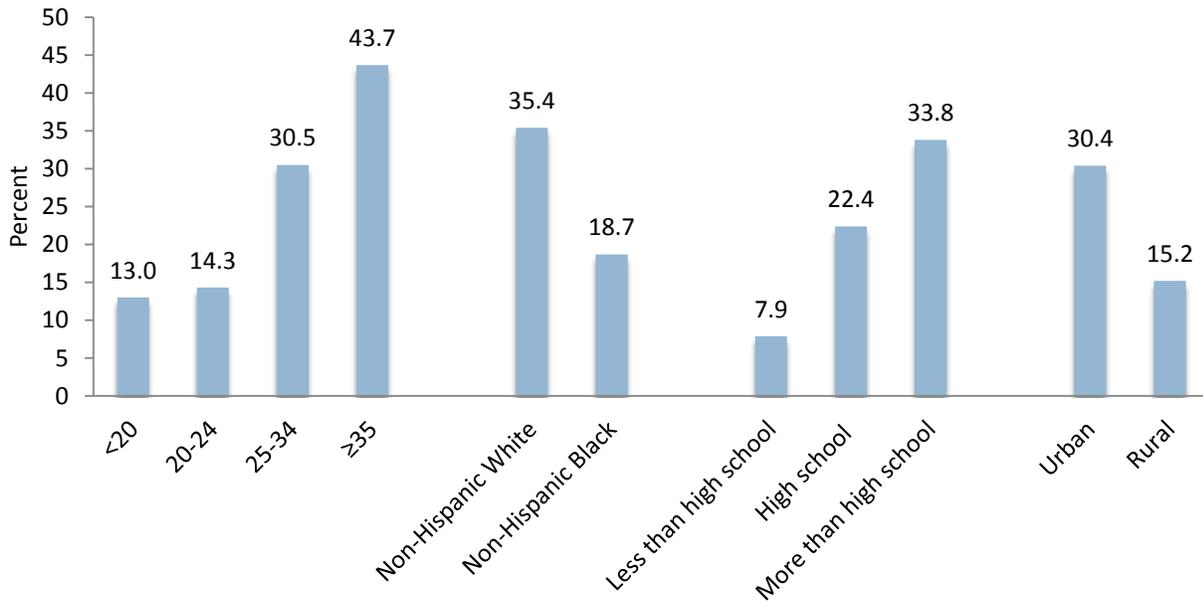
Folic Acid

Healthy People 2020 Objective

MICH-16.2: Increase the proportion of women delivering a live birth who took multivitamins/folic acid prior to pregnancy to 33.1%

In Georgia during 2011, 26.3% of mothers who recently had a baby reported daily folic acid intake for a month prior to their most recent pregnancy. In order to reach the Healthy People 2020 objective, an increase of nearly 25% needs to be seen over the next seven years. In 2011, non-Hispanic White mothers took folic acid every day in the month prior to pregnancy twice as often as non-Hispanic Black mothers. Mothers with higher educational attainment took folic acid more often than mothers with lower educational attainment. Mothers in urban areas (30.4%) reported daily folic acid intake prior to their pregnancy twice as often as mothers in rural areas (15.2%). Clinicians recommend that all women of child bearing years take 400mcg of folic acid daily.

Percent of mothers who reported using folic acid every day in the month prior to conception by maternal age, race/ethnicity, education and urban/rural status, Georgia, 2011



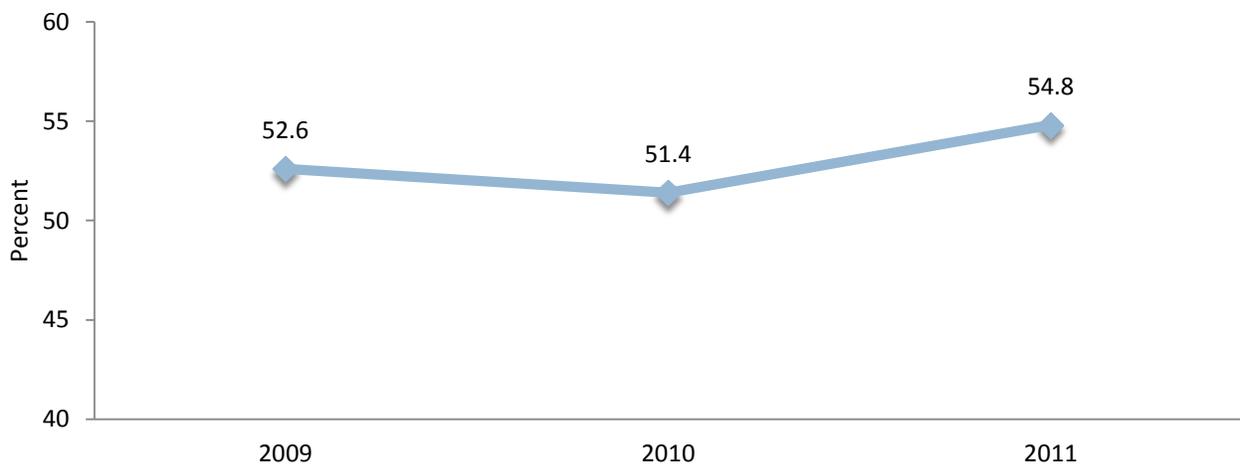
Source: PRAMS

PREGNANCY

Unplanned Births

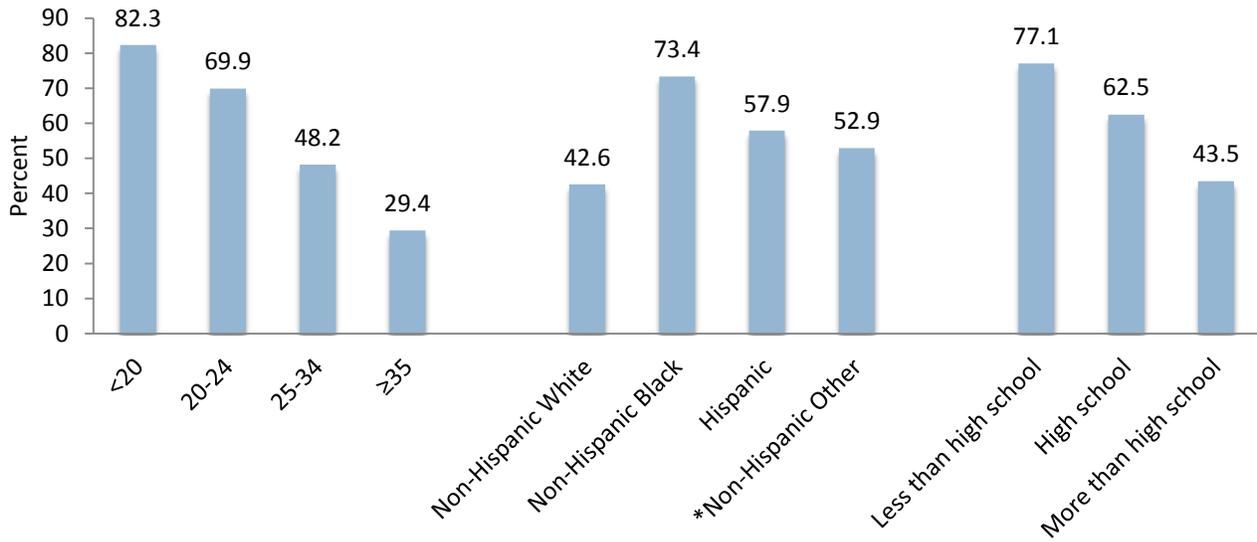
The percentage of unplanned births in Georgia varied annually, with Georgia experiencing its lowest percentage in 2010, followed by its highest during the subsequent year, 2011. Among mothers who had recently given birth, non-Hispanic Blacks experienced unplanned births more than any other race/ethnicity, at 25% higher than the state average, while the percentage was lowest among non-Hispanic Whites. The percentages among Hispanics and other racial/ethnic groups were on par with the state average in 2011. The percentage of unplanned births decreased as age increased, with 82.3% of teenagers experiencing an unplanned birth compared to women 35 years and older who experience unplanned birth less than 30% of the time. In Georgia, women with less than a high school education had an unplanned birth 23% more compared women who graduated high school and 77% more than women with more than a high school education.

Percent of births reported to be unplanned by year, Georgia, 2009-2011



Source: PRAMS

Percent of births reported to be unplanned by maternal age, race/ethnicity and education, Georgia, 2011



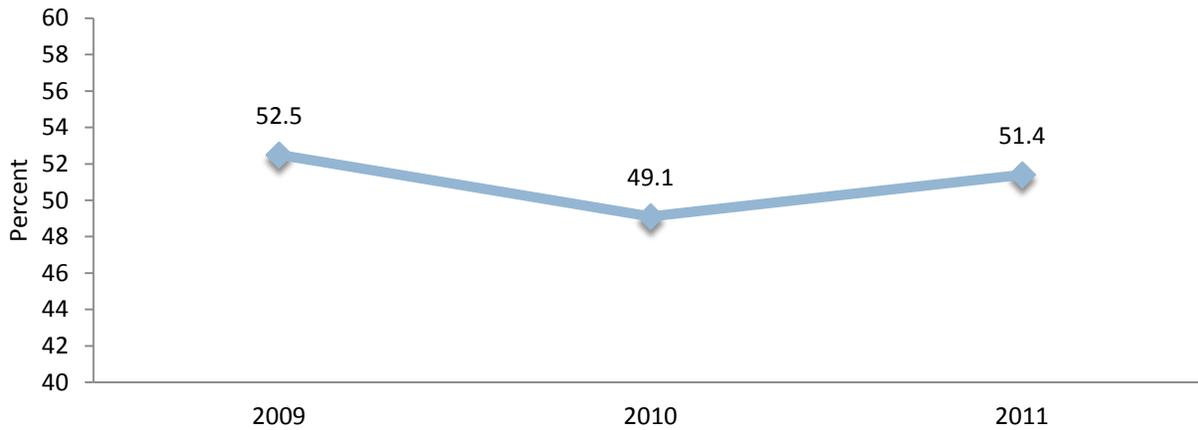
Source: PRAMS

*Non-Hispanic Other includes Asian, American Indian, Hawaiian, Alaskan Native, Mixed Race and Other

Contraception at Conception

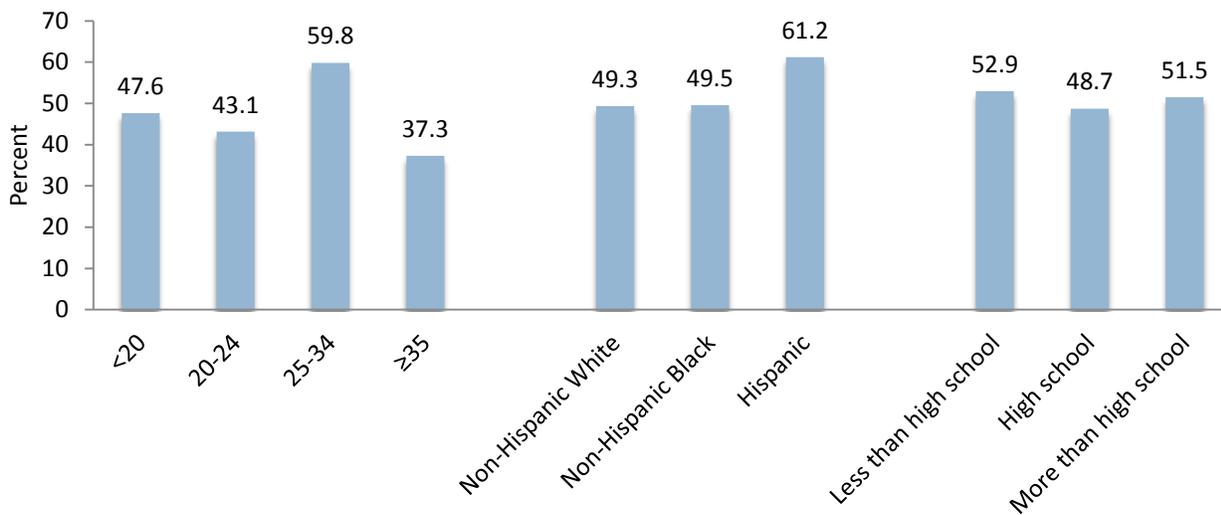
The percentage of mothers who had recently given birth and reported using contraception at the time of conception was approximately 50% from 2009 to 2011. Nearly 60% of Georgian women between the ages of 25 to 34 reported using contraception at conception, followed by women in their teen years at 47.6%. The percentage among women 35 years of age and older was lower than any other age group at only 37.3%. Data show that 61.2% of Hispanic women reported using contraception when they got pregnant while the percentage was approximately 50% among all other races. Education level did not have a great impact on women’s report of contraception at conception, with less than an eight percent difference between women who did not complete high school (52.9%) and high school graduates (48.7%).

Percent of mothers who reported using contraception at conception by year, Georgia, 2009-2011



Source: PRAMS

Percent of mothers who reported using contraception at conception by maternal age, race/ethnicity and education, Georgia, 2011



Source: PRAMS

Reasons for Not Using Contraception

Among mothers who had recently given birth and not used contraception, the most commonly reported reason was that they did not mind if they got pregnant. The second most commonly reported reason was that they thought they could not get pregnant at that time. Fewer than 10% of mothers reported that they had problems accessing birth control and that either them or their partner was sterile.

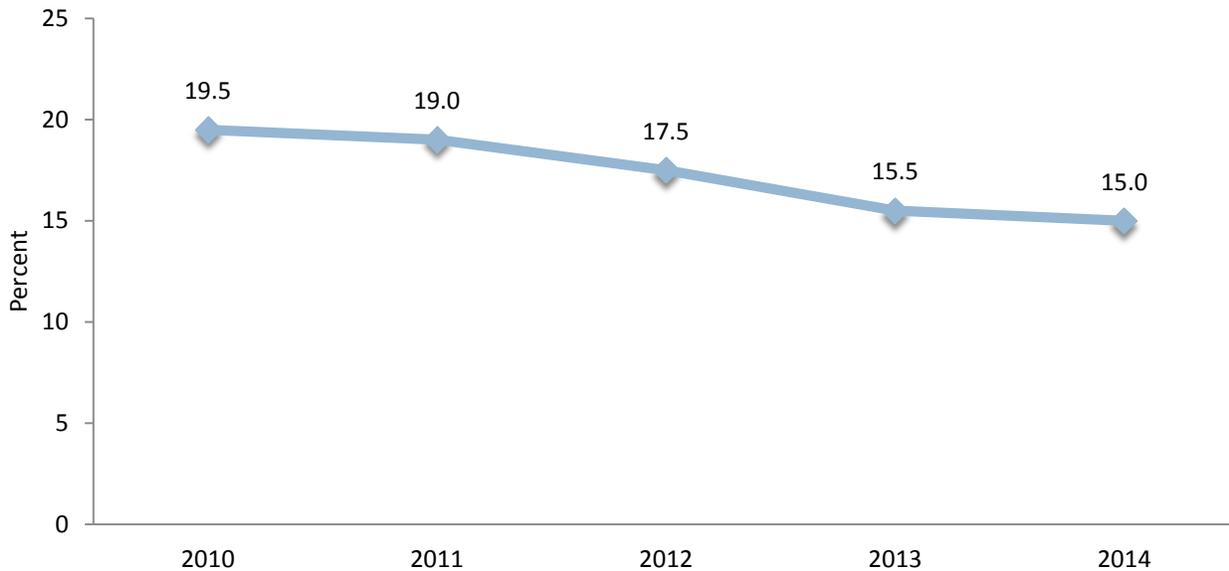
Reasons for not using contraception, Georgia, 2009-2011	
I didn't mind if I got pregnant	36.7%
I thought I could not get pregnant at that time	27.4%
My husband or partner didn't want to use anything	16.0%
I had side effects from the birth control method I was using	11.9%
I had problems getting birth control when I needed it	8.7%
I thought my husband or partner or I was sterile	5.5%

Source: PRAMS

Access to Family Planning Services

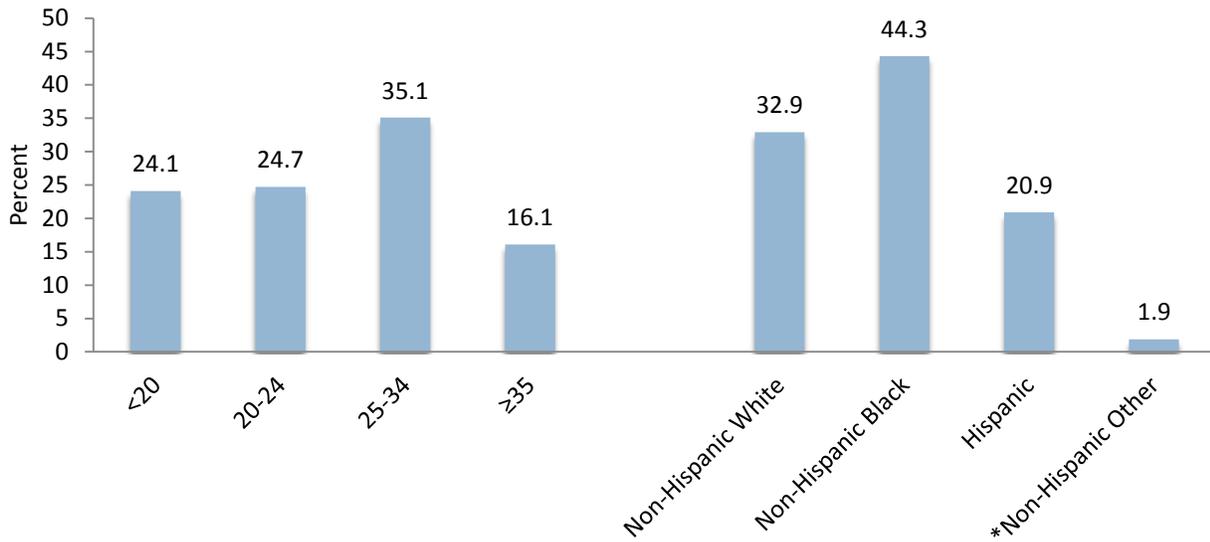
The Georgia Family Planning Program provides family planning services to women in need. Women are defined as “in need” during a given year if they are less than 45 years of age and have a family income that is under 200% of the poverty guideline. All women younger than 20 years are assumed to need publicly supported care. From 2010 to 2014, the percentage of women in need receiving services through the Georgia Family Planning Program decreased from 19.5% to 15.0%. The highest percentage of patients in 2014 was between the ages of 25 and 34. Over 40% of patients were non-Hispanic Black, while 32.9% were non-Hispanic White, 20.9% were Hispanic and 1.9% were of another race.

Percent of women in need served by Georgia Family Planning Program by year, Georgia, 2010-2014



Source: Georgia Family Planning Program

Percent of Georgia Family Planning Program Patients by age and race/ethnicity, Georgia, 2014



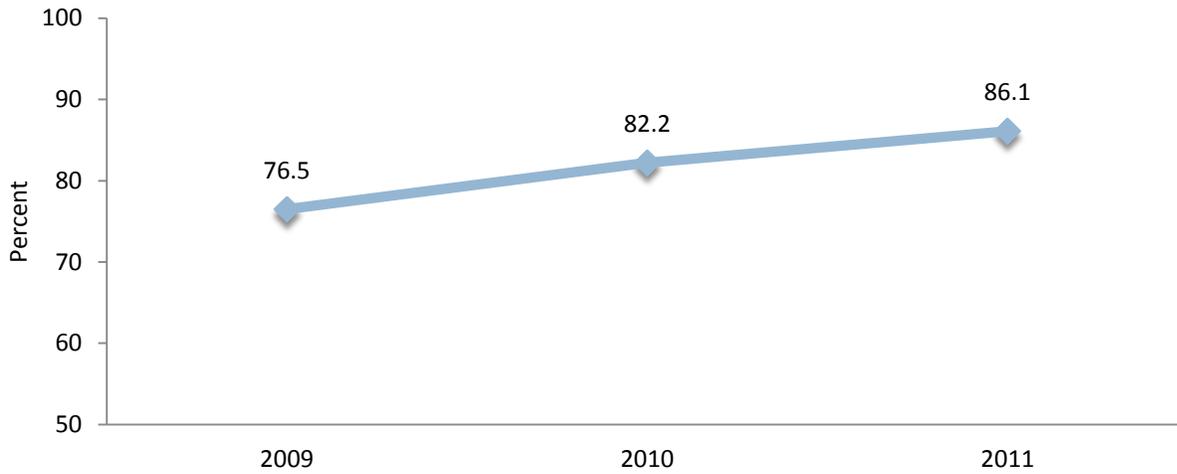
Source: Georgia Family Planning Program

*Non-Hispanic Other includes Asian, American Indian, Hawaiian, Alaskan Native, Mixed Race and Other

Prenatal Care

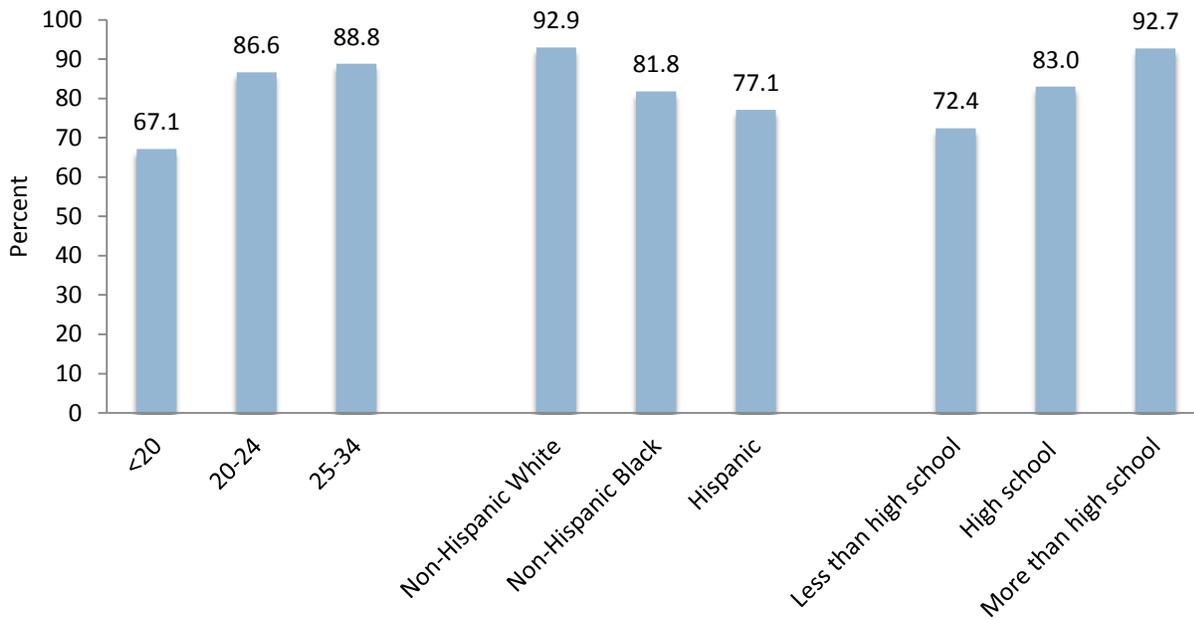
The percentage of mothers who recently had a live birth and received prenatal care beginning in the first trimester increased from 76.5% in 2009 to 86.1% in 2011. In 2011, receipt of first trimester prenatal care varied by maternal age, race/ethnicity and education. While the state average in 2011 was 86.1%, only 67.1% of teenage mothers who recently had a baby reported entering prenatal care early. The percentage among Hispanic mothers (77.1%) was also behind the state average. Fewer mothers with less than a high school diploma (74.2%) started prenatal care early compared to 92.7% of mothers who had more than a high school diploma.

Percent of mothers who received prenatal care in the first trimester by year, Georgia, 2009-2011



Source: PRAMS

Percent of mothers who received prenatal care in the first trimester by maternal age, race/ethnicity and education, Georgia, 2011



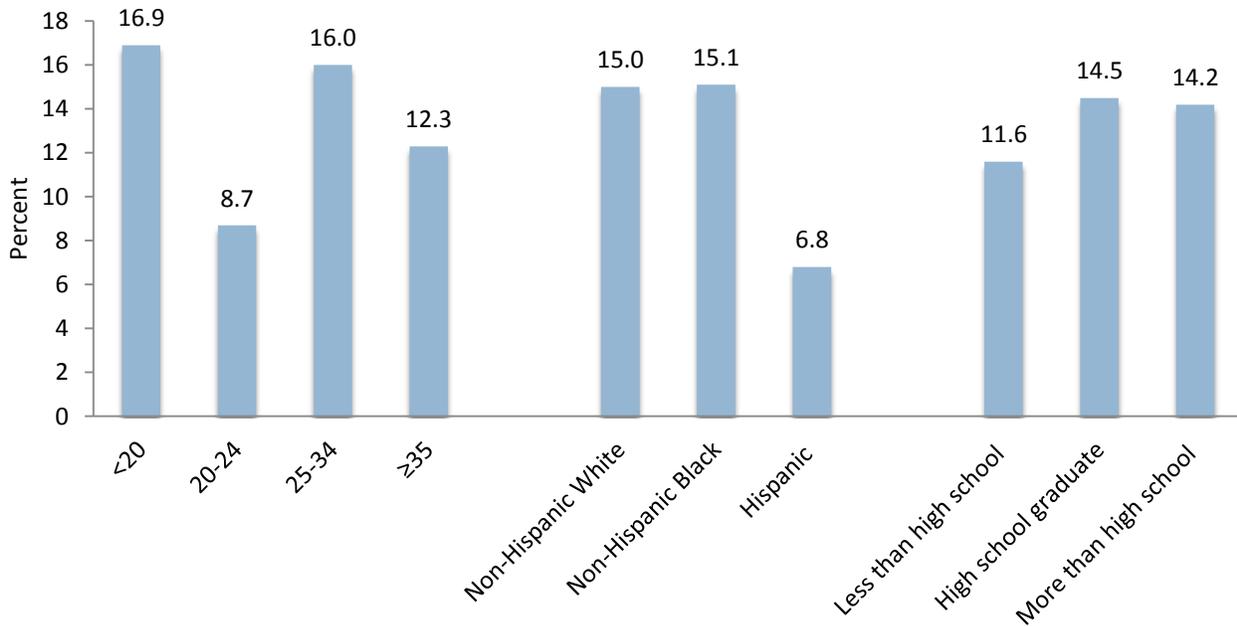
Source: PRAMS

High Blood Pressure, Hypertension, Preeclampsia or Toxemia

There were differences due to age, race/ethnicity and education among mothers who recently had a live birth reporting chronic disease during pregnancy such as high blood pressure, hypertension, preeclampsia,

toxemia or diabetes between 2009 and 2011. Mothers between the ages of 20 and 24 reported experiencing these chronic conditions during pregnancy less frequently than new mothers in all other age categories. Both non-Hispanic White and non-Hispanic Black mothers reported experiencing chronic conditions during pregnancy at about 15%, while only 6.8% of Hispanic mothers did. The percentage was higher among women with a high school diploma or more, compared to women with less than a high school education.

Percent of mothers who reported high blood pressure, hypertension (including pregnancy-induced hypertension [PIH]), preeclampsia or toxemia during pregnancy by maternal age, race/ethnicity and education, Georgia, 2009-2011

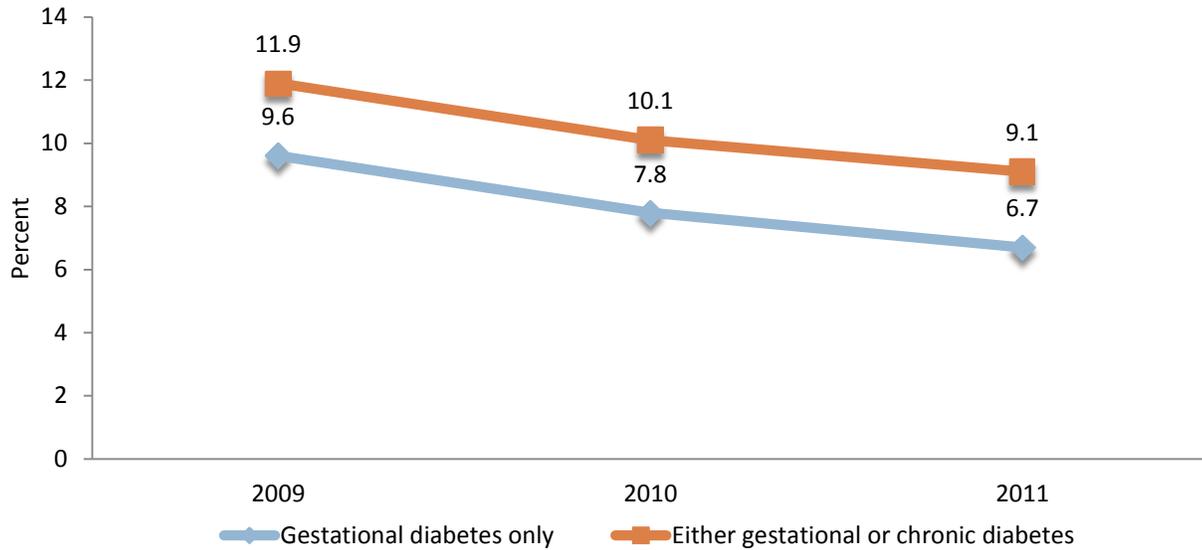


Source: PRAMS

Gestational and Chronic Diabetes

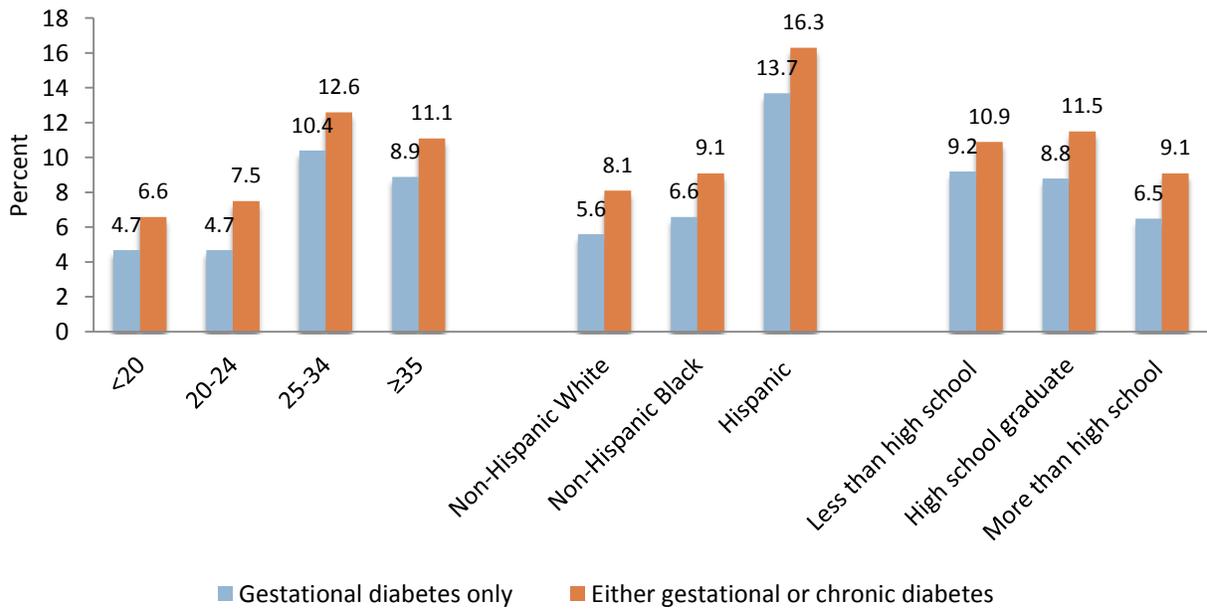
The percentage of mothers who recently had a live birth reporting gestational and/or chronic diabetes declined from 2009 to 2011. Similar patterns were seen for both forms of diabetes with regard to age, race/ethnicity and education. The percentages were higher among women 25 years of age or older compared to those under the age of 24. More Hispanic women reported gestational and/or chronic diabetes than non-Hispanic White and non-Hispanic Black women. Although the percentages were fairly consistent regardless of education status, they were slightly lower among those with higher educational attainment.

Percent of mothers who reported gestational and/or chronic diabetes by year, Georgia, 2009-2011



Source: PRAMS

Percent of mothers who reported gestational and/or chronic diabetes by maternal age, race/ethnicity and education, Georgia, 2009-2011



Source: PRAMS

Stressors during Pregnancy

From 2009 to 2011, moving to a new address was the most commonly reported stressor during pregnancy among Georgian mothers who recently had a baby. Over 15% of mothers reported arguing with their husband or partner more than usual, having difficulty paying bills and having a family member with an illness. All other stressors were reported among less than 15% of mothers. The least commonly reported stressors were participating in a physical fight, experiencing homelessness and physical abuse during pregnancy.

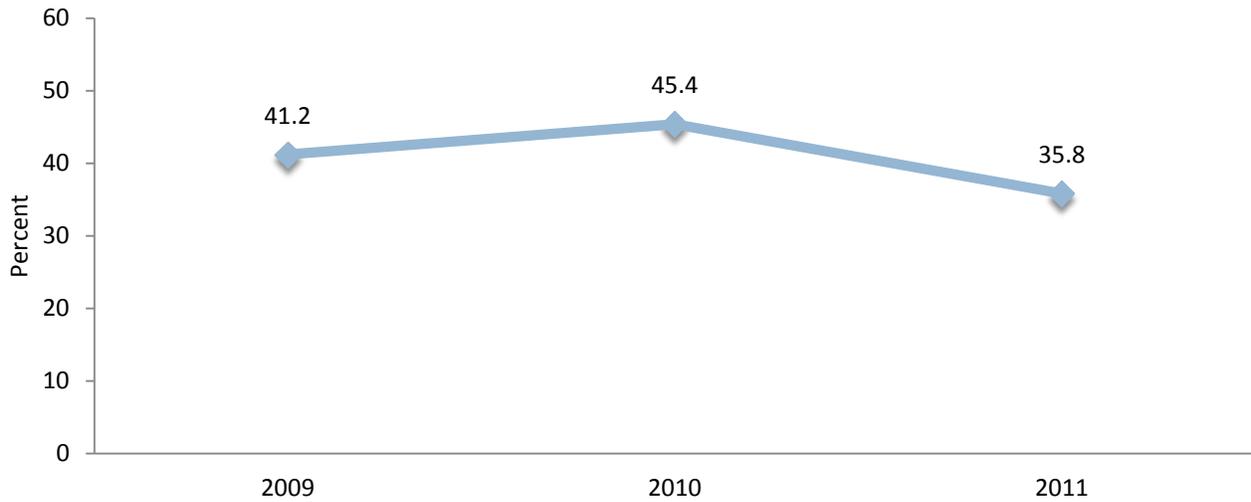
Percent of mothers who reported stressors during pregnancy, Georgia, 2009-2011	
Moved to a new address	29.3%
Argued with my husband or partner more than usual	18.4%
I had a lot of bills I couldn't pay	17.1%
Close family member was sick or had to go to hospital	15.9%
Someone very close to me died	13.5%
Husband or partner lost his job	13.3%
Lost my job even though I wanted to work	12.6%
Got separated or divorced	7.9%
Husband or partner said he didn't want me to be pregnant	7.8%
Someone very close to me had a problem with drinking or drugs	7.8%
My husband or partner or I went to jail	4.9%
I was in a physical fight	4.0%
Homeless	3.9%
Physical abuse	2.8%

Source: PRAMS

Flu Vaccination

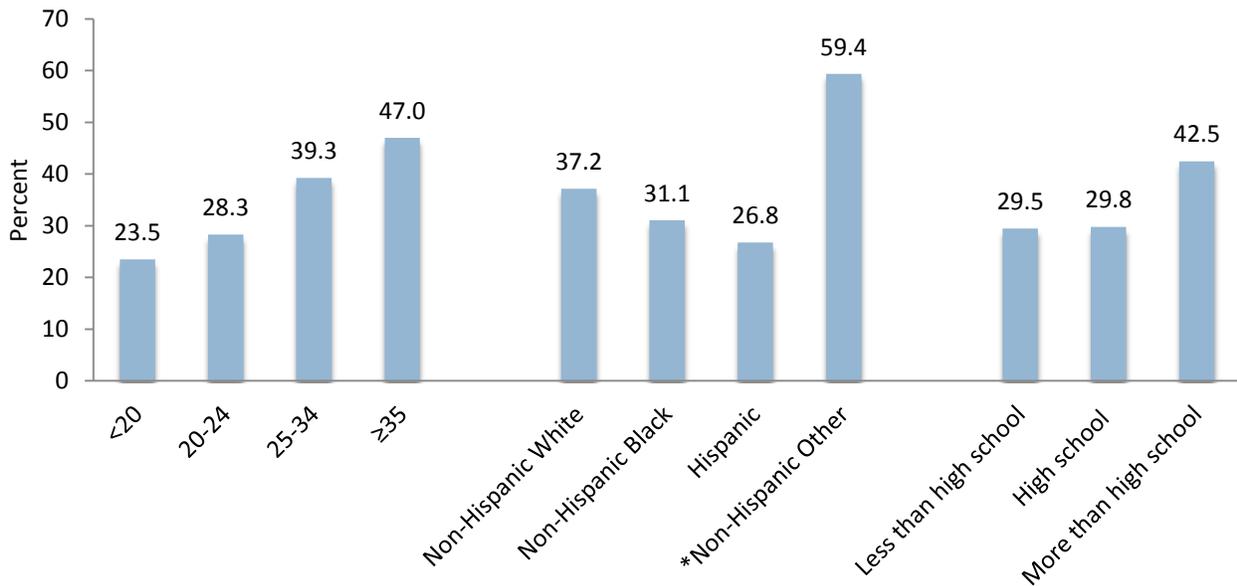
The vaccination of pregnant women against influenza reached a peak in 2010, according to the three years of data presented below. The increase may be a result of the push to vaccinate pregnant women against H1N1. In 2011, a marked decrease was present, with the prevalence of vaccination decreasing from 45.4% in 2009 to 35.8% in 2011, more than a 20% decrease. During 2011 in Georgia, more mothers who recently had a baby 25 years of age and older reported receiving a flu vaccination during pregnancy than other age groups, with 39.3% of mothers 25 to 34 years and 47.0% of mothers 35 years of age and older receiving the flu vaccine. The percentage of mothers 35 years of age and older who reported receiving vaccinations was nearly 25% higher than the state average during that time. Receiving a flu vaccination during pregnancy was reported more often among non-Hispanic Whites and mothers of other racial/ethnicity groups (37.2% and 59.4% respectively) compared to non-Hispanic Black and Hispanic mothers (31.1% and 26.8% respectively). The percentage was approximately 30% among mothers with a high school education or less, but was 42.5% among mothers with more than a high school education.

Percent of mothers who reported receiving a flu vaccination during pregnancy by year, Georgia, 2009-2011



Source: PRAMS

Percent of mothers who reported receiving a flu vaccination during pregnancy by maternal age, race/ethnicity and education, Georgia, 2011



Source: PRAMS

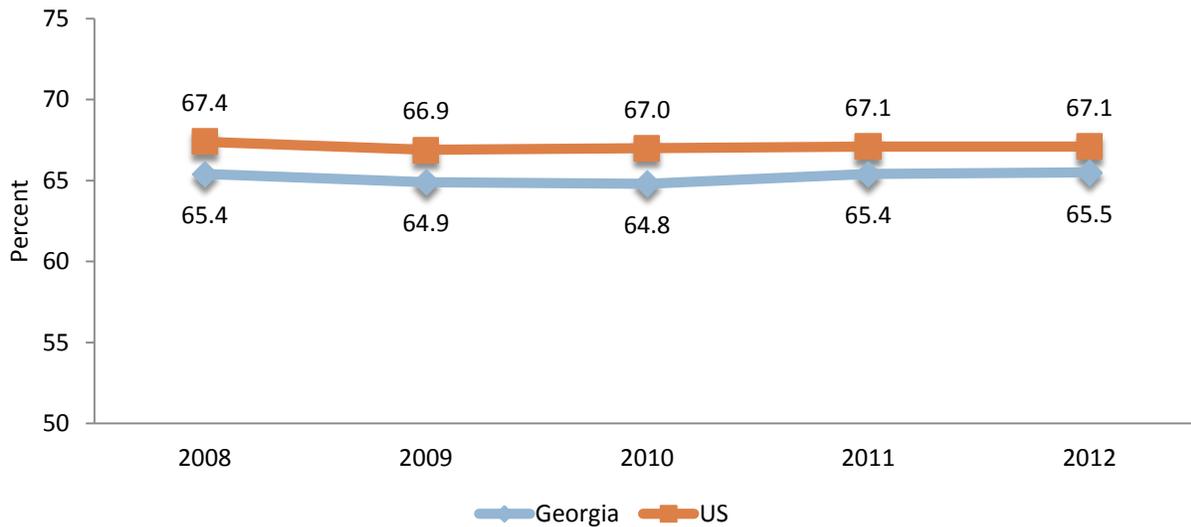
*"Non-Hispanic Other" includes Asian, American Indian, Hawaiian, Alaskan Native, Mixed Race and Other

Vaginal Deliveries

Both nationally and in Georgia, the percentage of vaginal deliveries remained relatively stable from 2008 to 2012. During this time period, Georgia's percentage was consistently two percentage points lower than the national average. In Georgia, the percentage of vaginal deliveries varied widely by maternal age, ranging

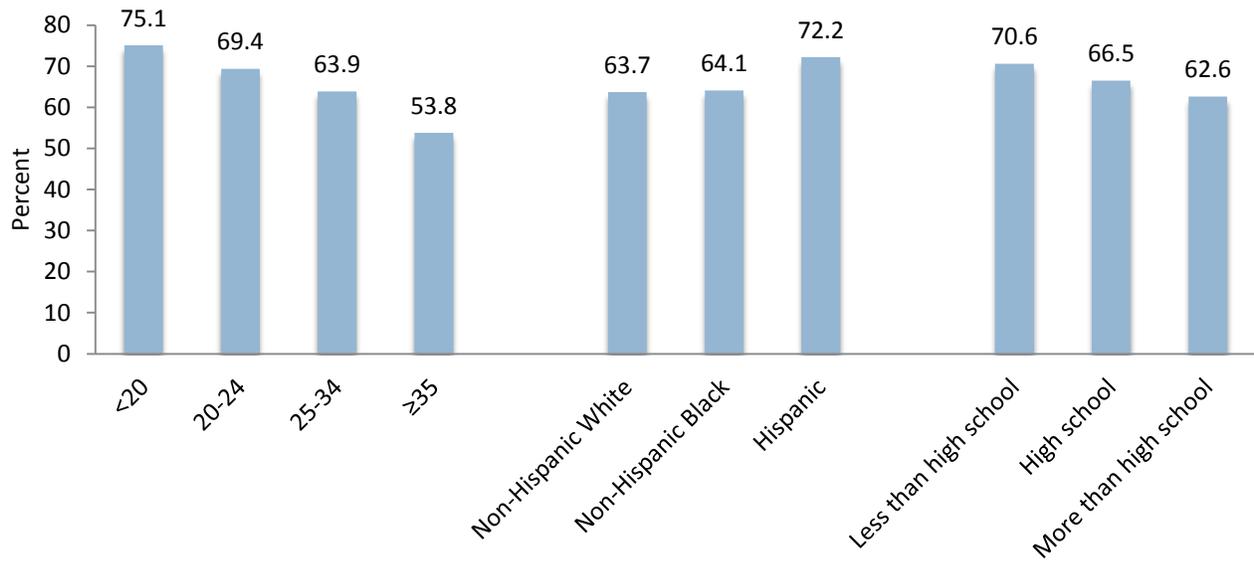
from a high of 75.1% among mothers ages less than 20 years of age to a low of 53.8% for mothers over the age of 35. The range may point to a medical necessity for cesarean delivery among women of older maternal age. The gap in vaginal deliveries by race/ethnicity is relatively small in Georgia. Non-Hispanic Whites (63.7%) and non-Hispanic Blacks (64.1%) reported virtually the same percentage of vaginal deliveries. The highest percentage of vaginal deliveries was among Hispanics at 72.2%. Among mothers with less than a high school diploma, the percentage was 70.6%. Among mothers with more than a high school education, the percentage was 62.6%. There were also geographic differences in vaginal deliveries in Georgia. Generally, vaginal deliveries were more frequent in the northern half of the state. The highest percentage of vaginal deliveries was in the Clayton County Health District followed by the North Central District. The prevalence of vaginal deliveries was lowest in the Northwest Health District and the South Central Health District.

Percent of vaginal deliveries by year, Georgia compared to the US, 2008-2012



Source: Vital Records, NVSS

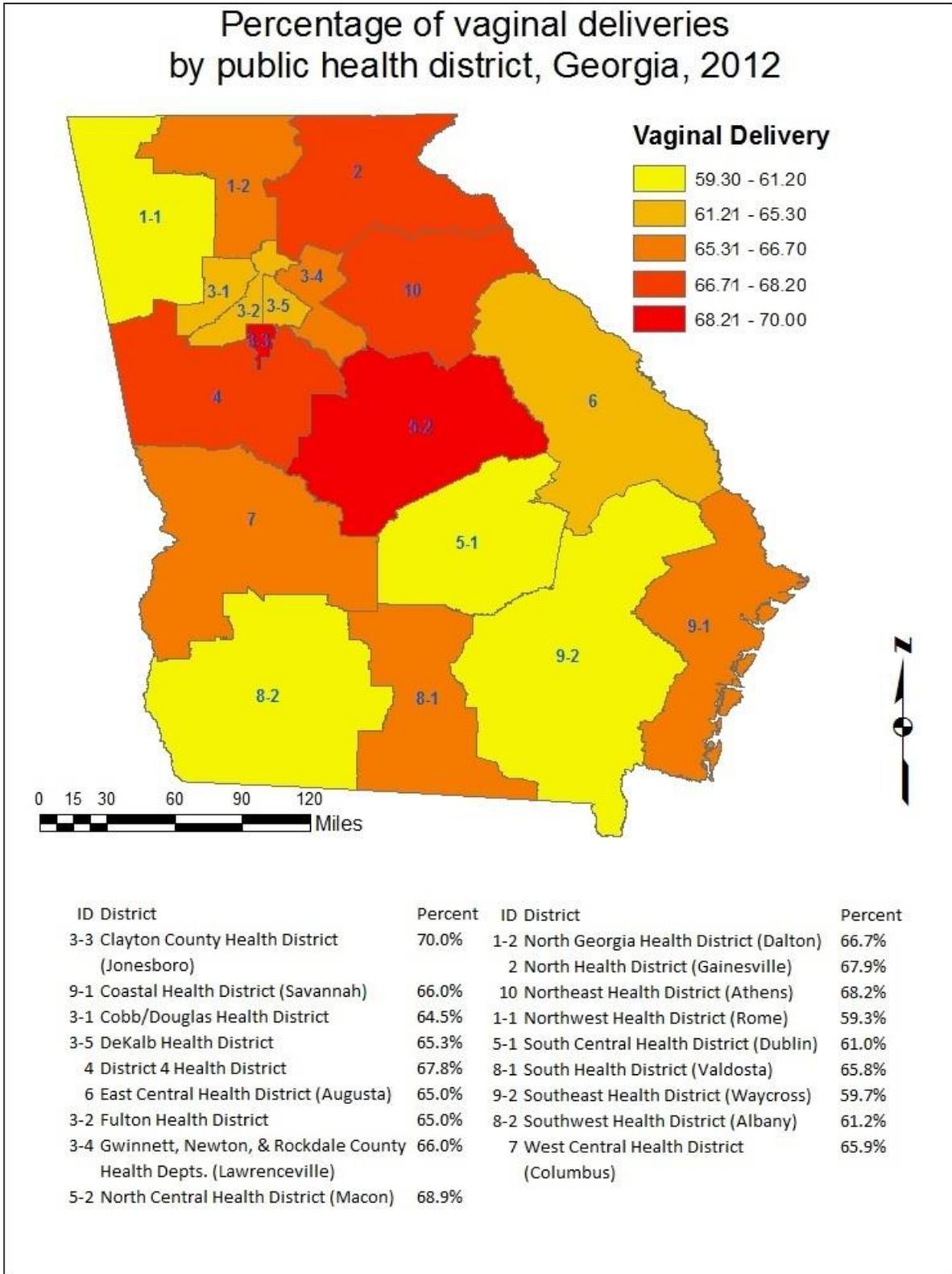
Percent of vaginal deliveries by maternal age, race/ethnicity and education, Georgia, 2008-2012



Source: Vital Records

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Percentage of vaginal deliveries by public health district, Georgia, 2012

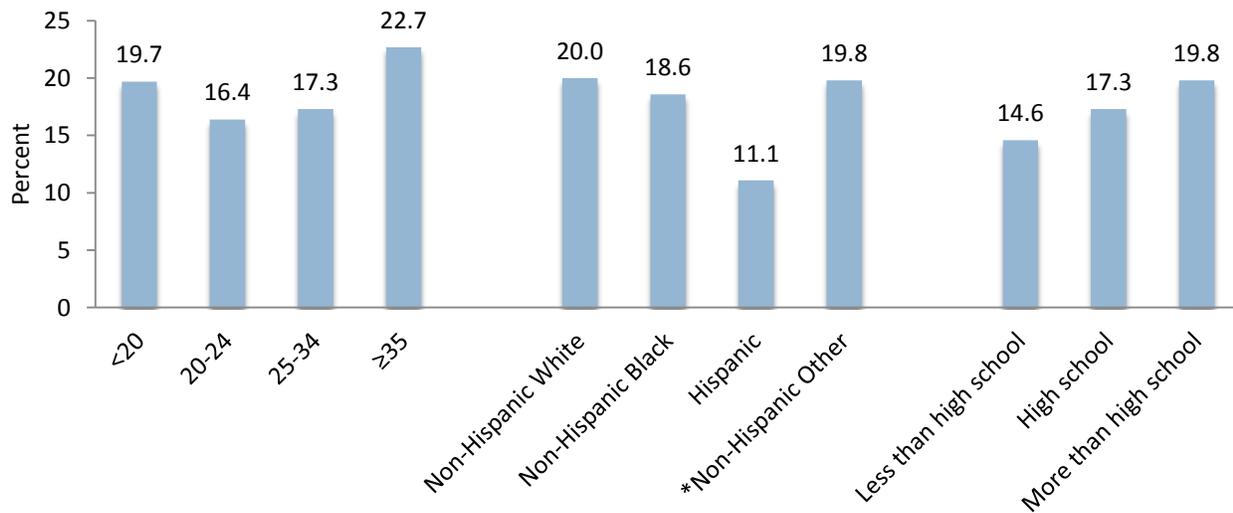


Source: Vital Records

Cesarean Deliveries

Primary cesarean sections were more prevalent than repeat cesarean sections at every age and educational level in Georgia from 2009 to 2011. Overall, 18.0% of mothers who recently had a baby reported having a primary cesarean section, while only 12.5% reported having a repeat cesarean section. Only 10.6% of mothers between the ages of 20 and 24 gave birth by a repeat cesarean section compared to 19.8% of mothers 35 and older. Finally, when stratified by race/ethnicity, it is evident that differences exist in both the prevalence of primary and repeat cesarean sections. Non-Hispanic Black mothers reported the fewest repeat cesarean sections at 10.2%, while 16.4% of Hispanic mothers had repeat cesarean sections. Of those with less than a high school degree, 9.3% had a repeat cesarean section compared to 12.9% of those with greater than a high school education.

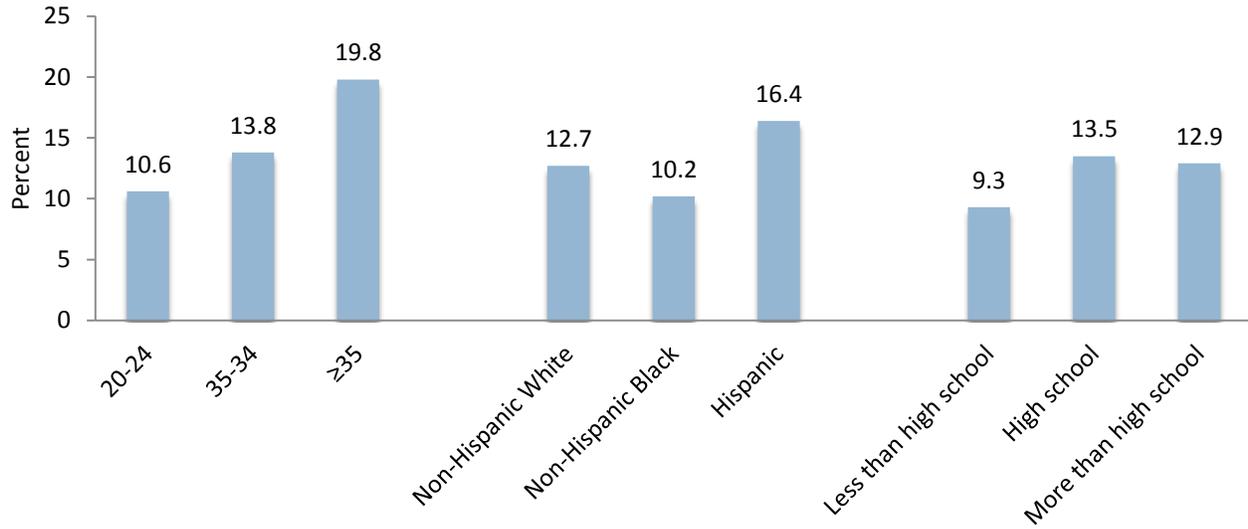
Percent of births delivered by primary cesarean sections by maternal age, race/ethnicity and education, Georgia, 2009-2011



Source: PRAMS

*"Non-Hispanic Other" includes Asian, American Indian, Hawaiian, Alaskan Native, Mixed Race and Other

Percent of births delivered by repeat cesarean sections by maternal age, race/ethnicity and education, Georgia, 2009-2011

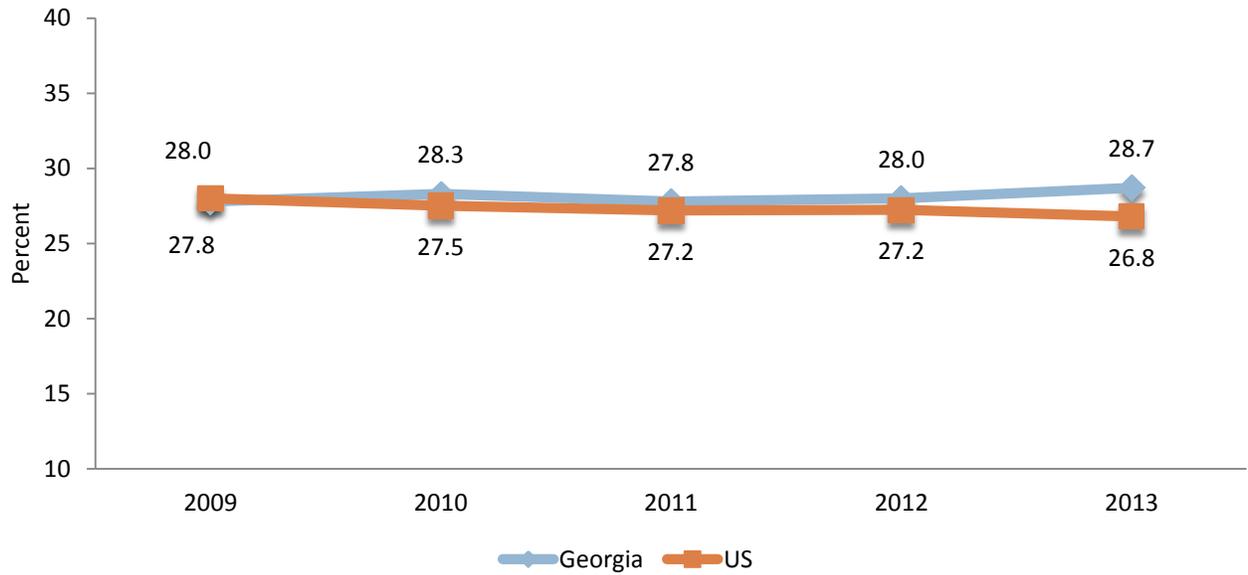


Source: PRAMS

Low-Risk Cesarean Deliveries

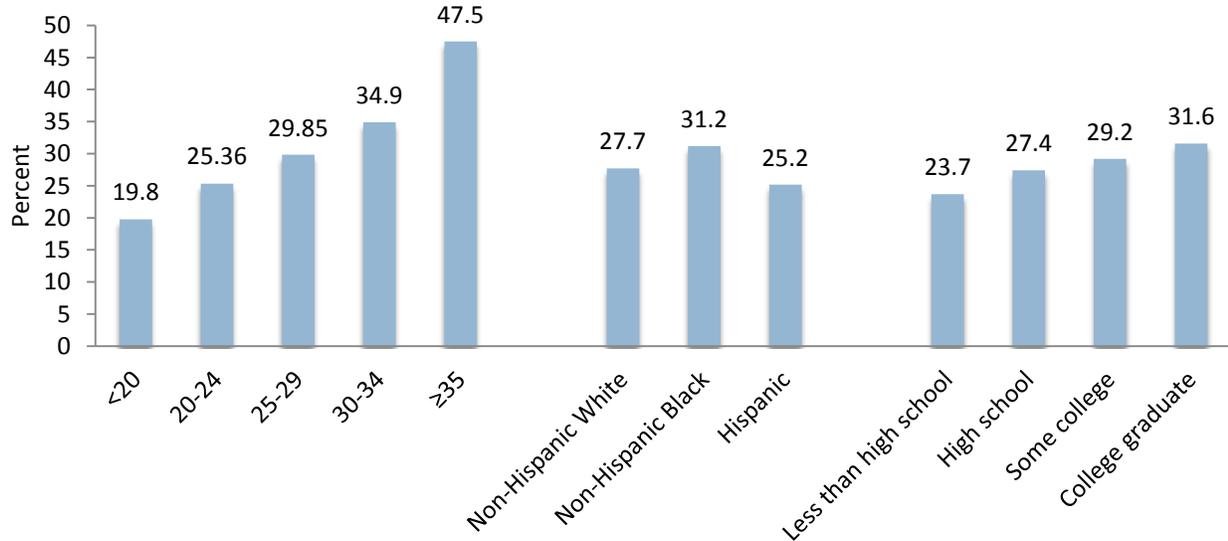
Low-risk cesarean deliveries are defined as full term (>37 weeks gestation), singleton, vertex births among women who have not previously had a live birth. The percentage of low-risk cesarean section deliveries remained relatively stable from 2009 to 2013, although there was a slight increase from 2011 to 2013. The percentage of low-risk cesarean section deliveries increased with maternal age and education level. Specifically, the percentage was 58.0% higher among mothers over 35 years of age than among mothers less than 20 years of age. When stratified by race and ethnicity, not many differences were revealed, although the percentage was highest among non-Hispanic Black women. The percentage of low-risk cesarean deliveries was between 25% to 32% across all races and ethnicities.

Percent of low-risk cesarean deliveries by year, Georgia compared to the US, 2009-2013



Source: National Vital Statistics System

Percent of low-risk cesarean deliveries by maternal age, race/ethnicity and education, Georgia, 2013



Source: NVSS

Reasons for Cesarean Delivery

It is important to understand why mothers have cesarean sections, specifically to identify factors contributing to low-risk cesarean sections and early elective deliveries. In Georgia, nearly 40% of mothers

who had recently given birth stated that their reason for having their most recent cesarean section was having had a previous cesarean section. Failed induction was the fourth reason. Less than 10% of mothers reported that their health care provider worried their baby was too big for a vaginal delivery.

Reasons for cesarean delivery, Georgia, 2011	
Reason	Percent
I had a previous Cesarean section	39.7%
My baby was in the wrong position	17.0%
I had a medical condition	15.1%
Labor inducement didn't work	15.0%
Labor was taking too long	13.9%
Baby had problems during labor	13.2%
My health care provider worried that my baby was too big	9.1%

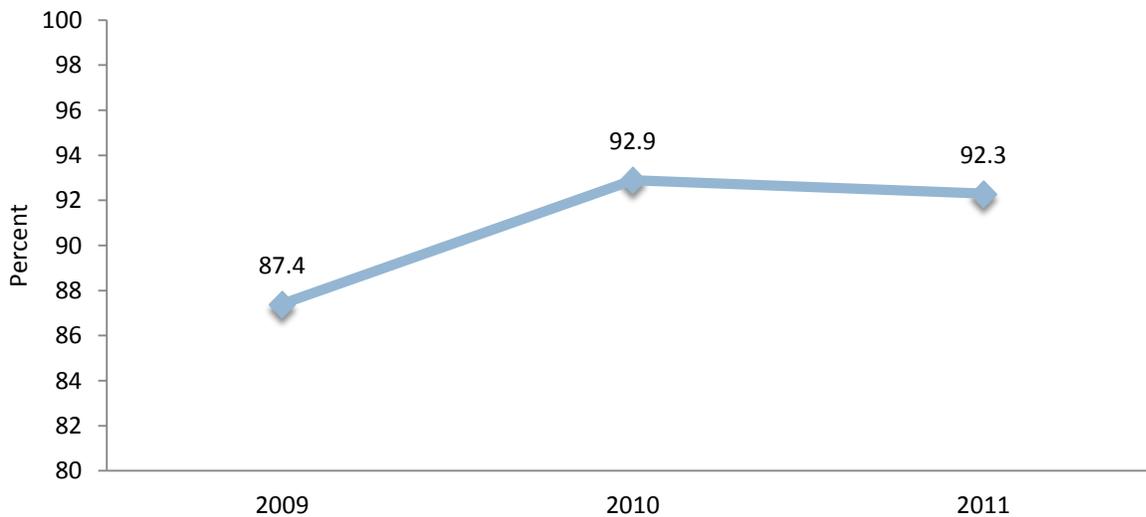
Source: PRAMS

POSTPARTUM PERIOD

Postpartum Visit

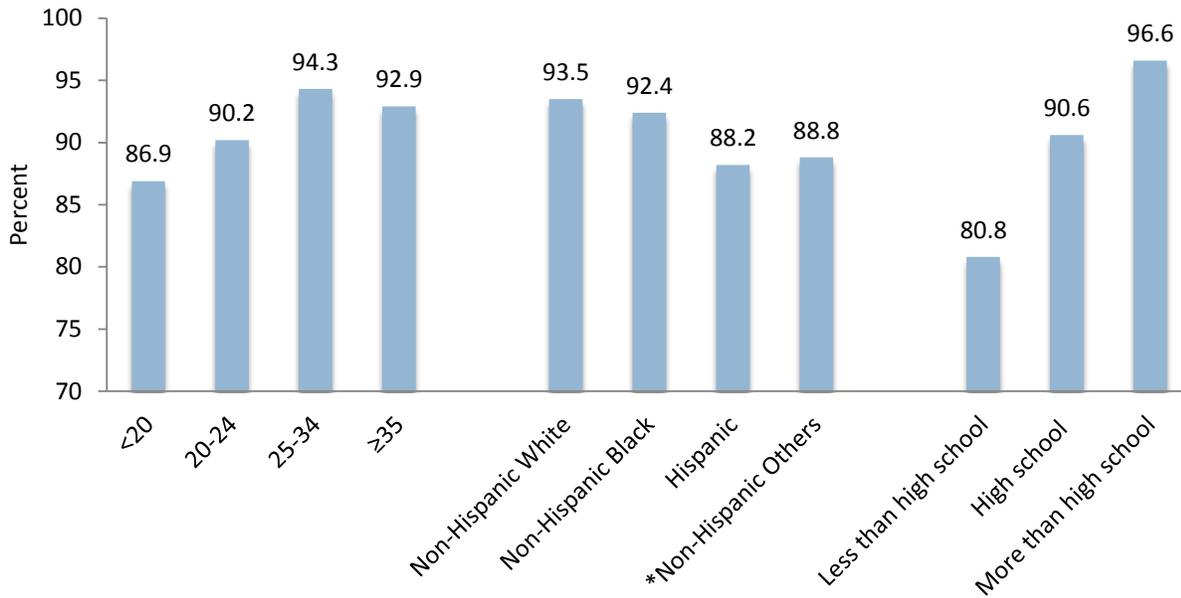
As of 2011, nearly all new mothers (92.3%) were attending their postpartum visit. Marginal differences were seen in receipt of postpartum visits when viewing the data by age and race/ethnicity. However, differences due to educational attainment were present. Twenty percent fewer mothers without a high school diploma saw a provider for a postpartum visit compared to mothers with more than a high diploma.

Percent of mothers who reported receiving a postpartum provider visit by year, Georgia, 2009-2011



Source: PRAMS

Percent of mothers who reported receiving a postpartum provider visit by maternal age, race/ethnicity and education, Georgia, 2011



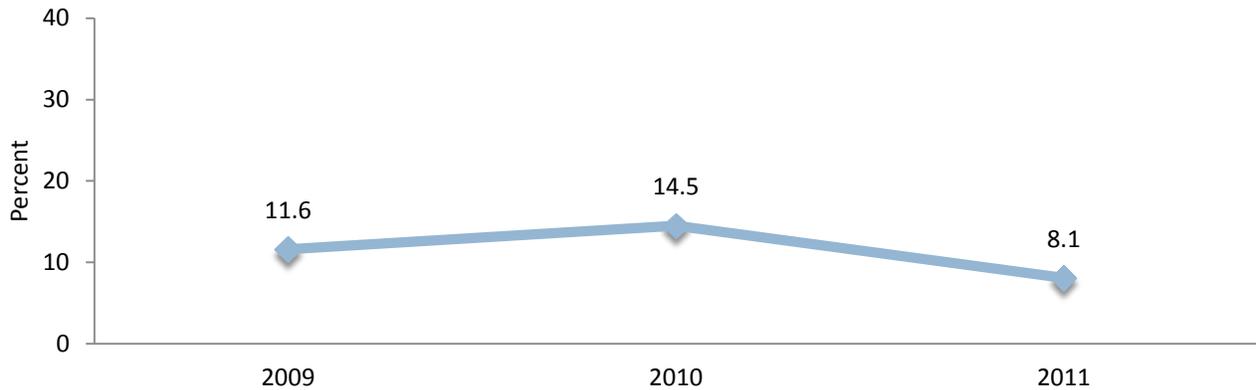
Source: PRAMS

*Non-Hispanic Other includes Asian, American Indian, Hawaiian, Alaskan Native, Mixed Race and Other

Postpartum Depression

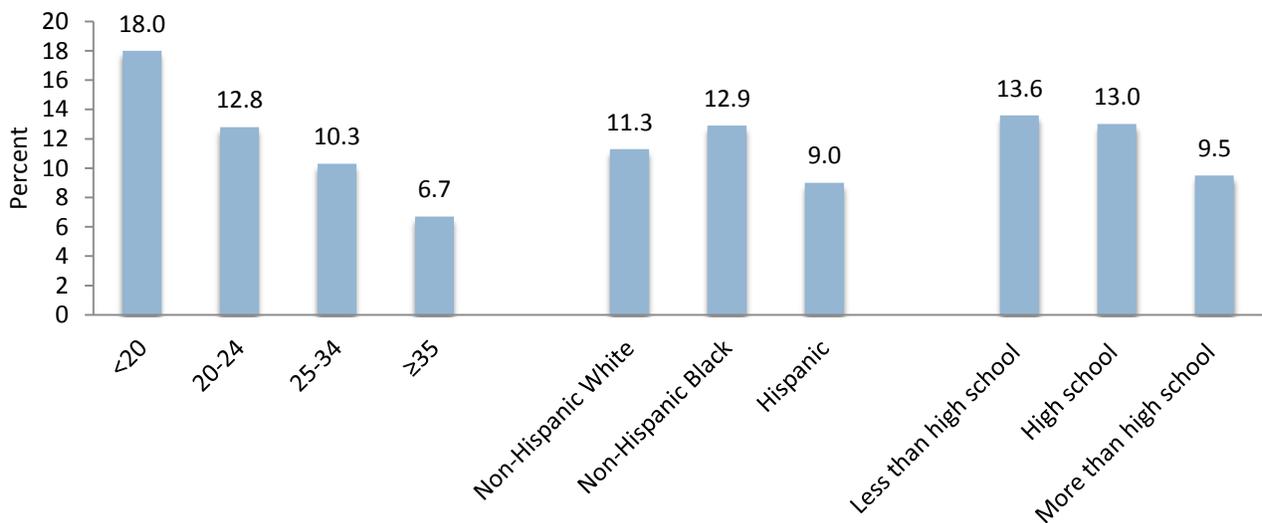
Over a three year period from 2009 to 2011, postpartum depression among mothers who recently had a baby in Georgia ranged from a low of 8.1% to a high of 14.5%. Postpartum depression was most prevalent among teen mothers, who reported experiencing postpartum depression three times as often as mothers 35 years of age and older. Non-Hispanic Blacks had a slightly higher prevalence of postpartum depression than non-Hispanic Whites and Hispanics. Mothers with more than a high school education reported postpartum depression nearly 30% less than those with less than a high school diploma.

Percent of mothers who reported postpartum depression symptoms, Georgia, 2009-2011



Source: PRAMS

Percent of mothers who reported postpartum depression symptoms by maternal age, race/ethnicity and education, Georgia, 2009-2011



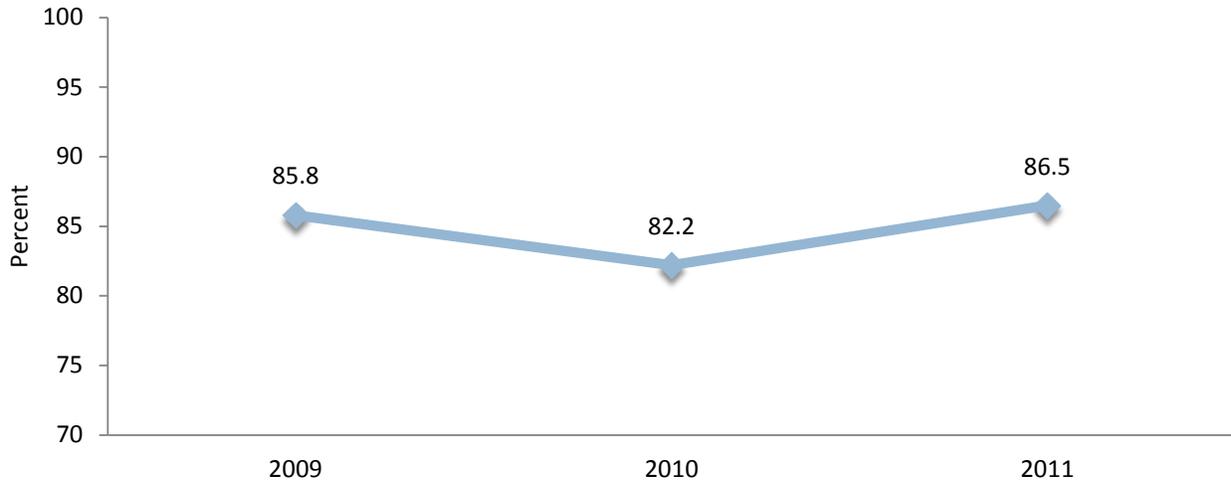
Source: PRAMS

Postpartum Contraception Use

Postpartum is the period of time immediately after birth. The percentage of new mothers who used birth control during the postpartum period remained above 80% during the three years of data represented below, with the lowest percentage in 2010 (82.2%) and the highest percentage in 2011 (86.5%). The percentage of postpartum contraception use among Georgia mothers in 2011 did not vary much by age. Usage was least frequent among 25 to 34 year olds at 85.4% and most frequent among mothers 35 years of age and older at 88.5%. Mothers characterized as “Other” in terms of race/ethnicity reported using birth control during the postpartum period least often, at 77.3%. However, differences were seen among all

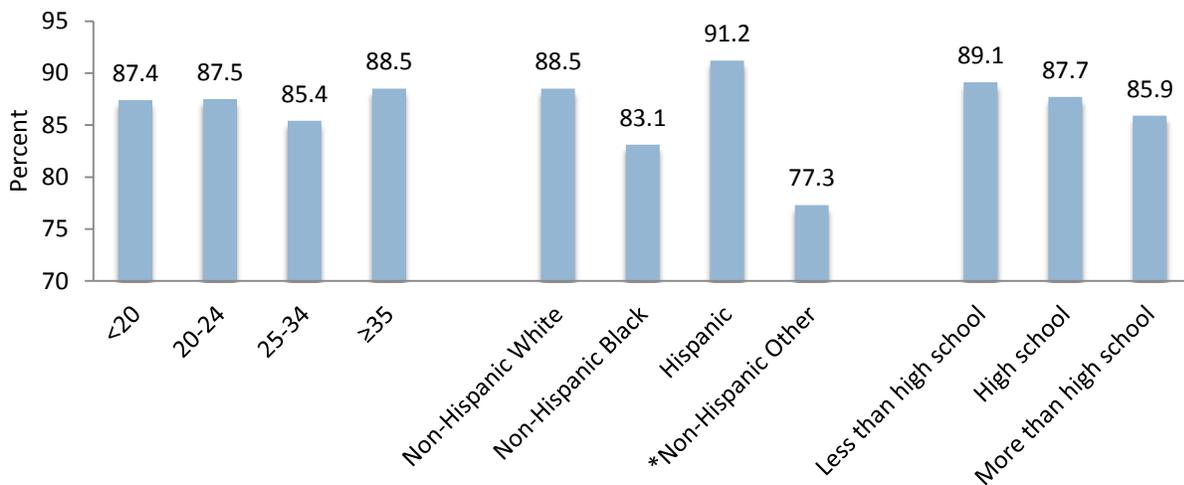
racial/ethnic groups with Hispanics (91.2%) and non-Hispanic Whites (88.5%) reporting postpartum contraception usage more frequently than the state average in 2011. Differences did not exist regarding educational status.

Percent of mothers who reported using contraception postpartum by year, Georgia, 2009-2011



Source: PRAMS

Percent of mothers who reported using contraception postpartum by maternal age, race/ethnicity and education, Georgia, 2011



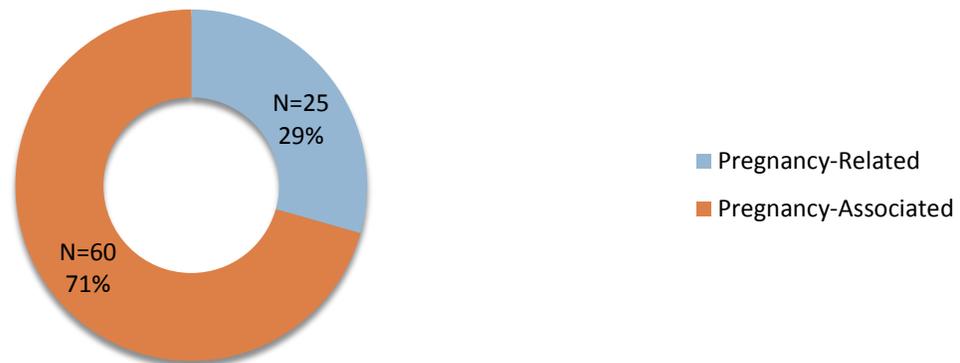
Source: PRAMS

*Non-Hispanic Other includes Asian, American Indian, Hawaiian, Alaskan Native, Mixed Race and Other

MATERNAL MORTALITY

Georgia recently implemented a Maternal Mortality Review Committee. The purpose of the committee is to identify pregnancy-related and pregnancy-associated cases of maternal mortality. A pregnancy-associated death is defined as the death of a woman while pregnant or within one year of the end of pregnancy, irrespective of the cause of death. A pregnancy-related death is defined as the death of a woman while pregnant or within one year of the end of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by her pregnancy or its management, but not from accidental or incidental causes. In 2012, the review committee identified 85 maternal mortality cases. Twenty-five cases were determined to be pregnancy-related and 60 were pregnancy-associated.

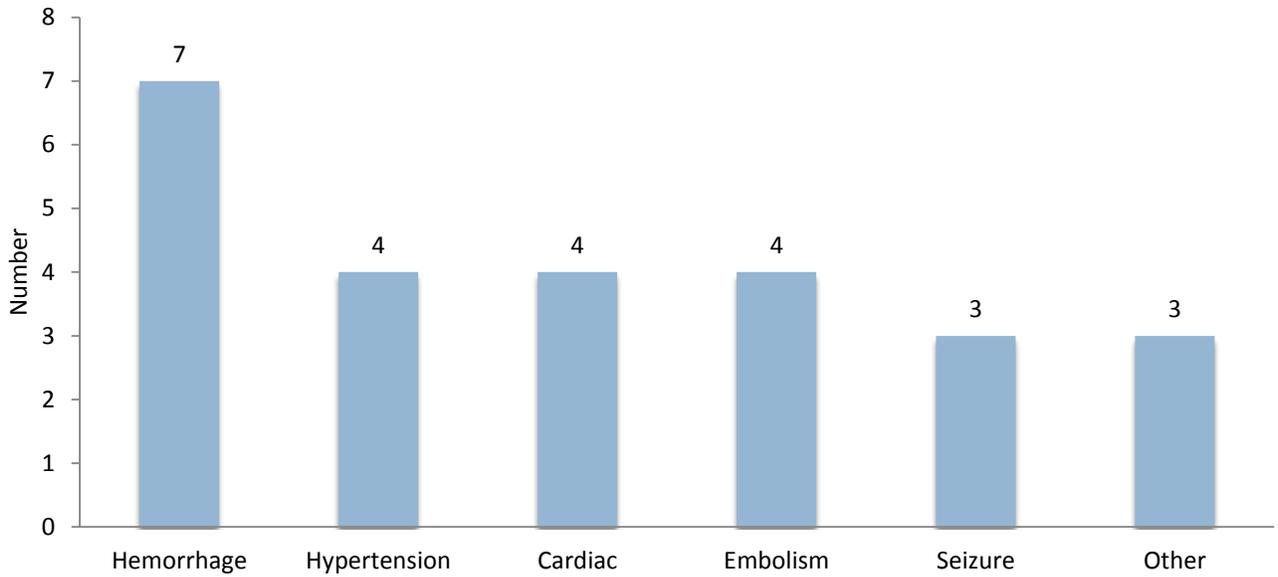
Maternal mortality cases, Georgia, 2012



Source: Georgia Maternal Mortality Review Committee

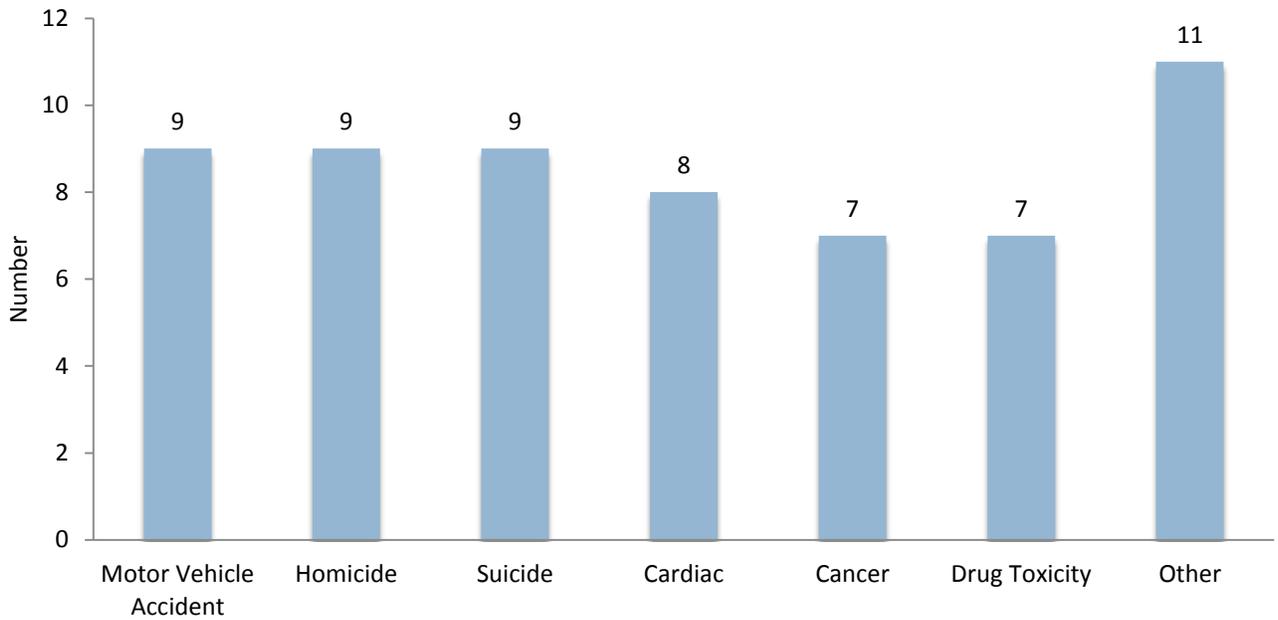
The most common cause of death among pregnancy-related cases was hemorrhage. Hypertension, cardiac conditions and embolism were each the causes of death for four cases, highlighting the importance of managing chronic conditions prior to pregnancy. Motor vehicle accidents, homicide and suicide were the most common cause of death among pregnancy-associated cases. Differences also exist by age, with the highest number of cases occurring among women between the ages of 20 to 29. The majority of pregnancy-related cases occurred among Black women. A higher number of cases were also seen among women without any form of college education.

Number of pregnancy-related deaths by cause of death, Georgia, 2012



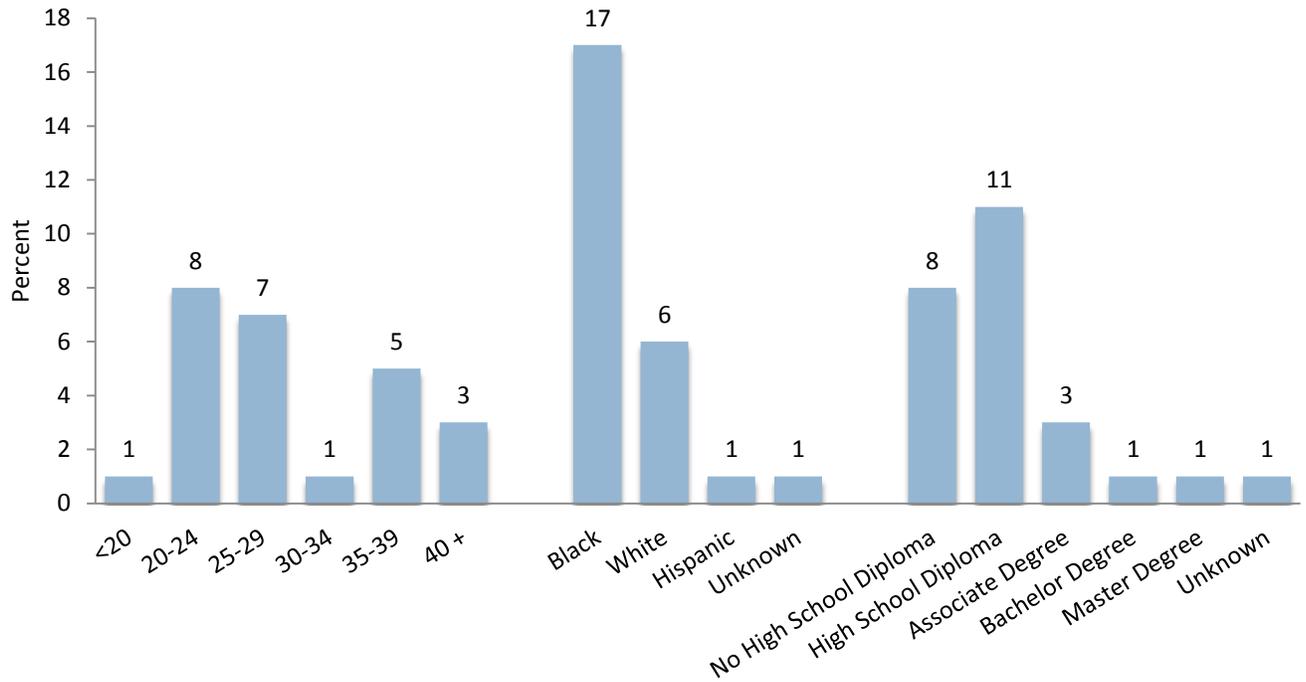
Source: Georgia Maternal Mortality Review Committee

Number of pregnancy-associated deaths by cause of death, Georgia, 2012



Source: Georgia Maternal Mortality Review Committee

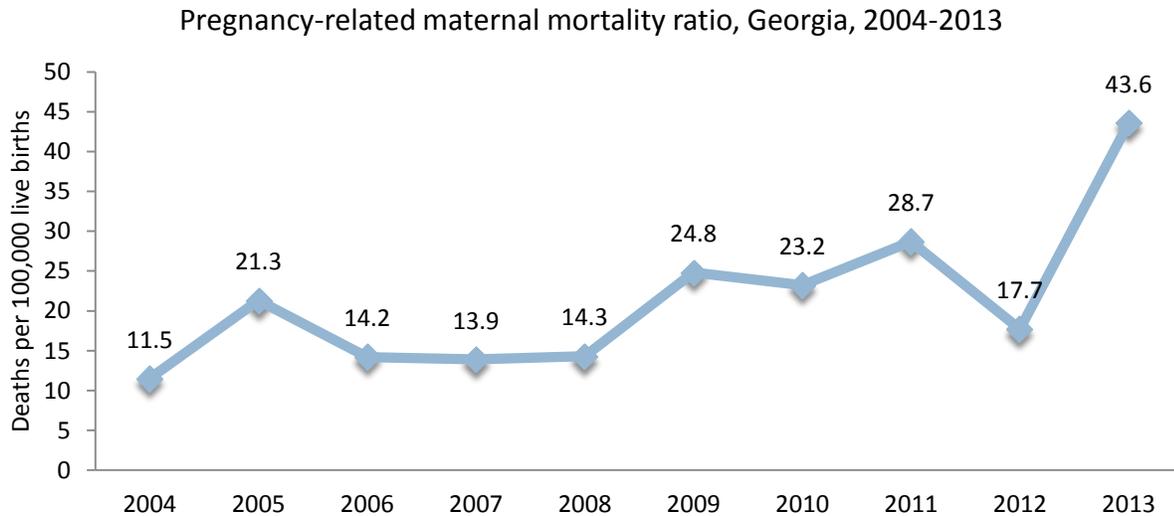
Pregnancy-related maternal mortality cases by age, race/ethnicity and education, Georgia, 2012



Source: Georgia Maternal Mortality Review Committee

DRAFT

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. These deaths were identified by ICD codes on the death certificate and cannot be compared to deaths identified through the Maternal Mortality Review Committee.



Source: OASIS

STRENGTHS AND NEEDS

Improving the health of women and mothers is essential to not only their health, but the health of their children. The quantitative data and qualitative data from the perinatal focus groups (see Qualitative Analysis: Perinatal Health) shed light on several areas of success and need in Georgia. The rate of low-risk cesarean sections has stabilized in recent years. Women in focus groups expressed pleasant experiences with services received in public health clinics and with CenteringPregnancy.

Despite these successes, several needs remain:

- Improve the overall health of reproductive age women in Georgia by reducing obesity and associated chronic conditions
- Increase utilization of preventive medical services, including well-woman visits and first trimester prenatal care
- Reduce the prevalence of STIs, particularly among non-Hispanic Blacks
- Promote family planning to prevent unplanned pregnancy and support healthy birth spacing
- Provide support services for mothers and increase availability of resources for women with postpartum depression
- Prevent maternal mortality

Improving the health of mothers, and more generally the health of reproductive aged women is important to many of the other MCH indicators included in the needs assessment.

DRAFT

QUANTITATIVE ANALYSIS: PERINATAL HEALTH

Perinatal health is most broadly defined as the period between conception and the end of the first year of life postpartum. Georgia has focused on perinatal health for a number of years because ensuring the healthiest start for babies and a healthy pregnancy for mothers will always be a priority. Many of the health indicators assessed in this section can determine the health, wellness and quality of life for mothers, infants and families. This section focuses mainly on the period between birth and the first year of life, use of medical services, sleep and feeding practices.

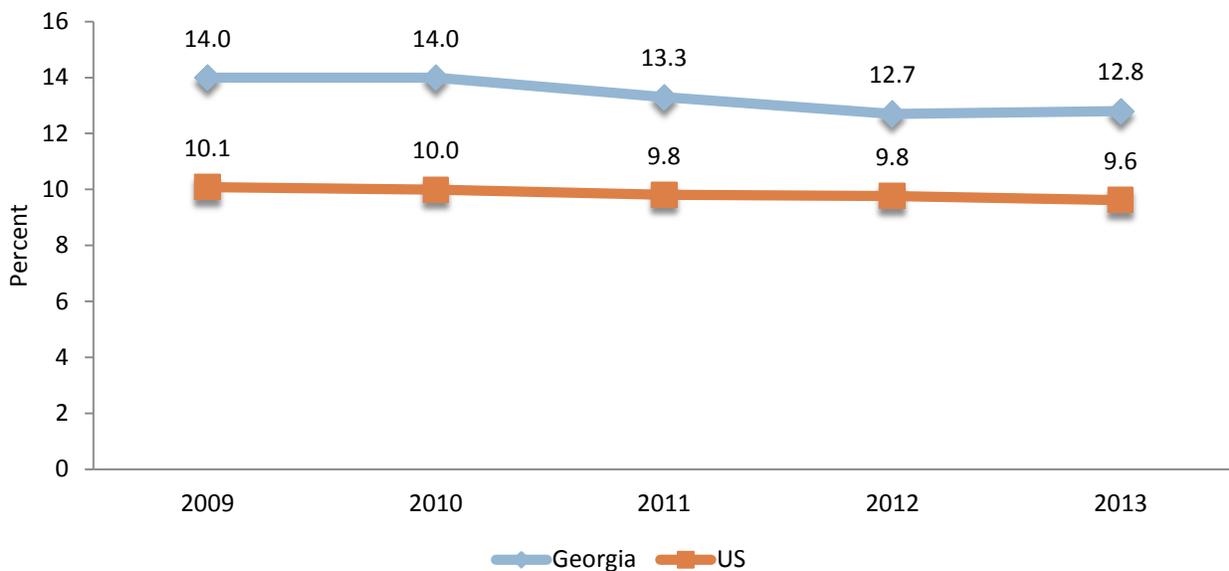
PRETERM BIRTH

Healthy People 2020 Objective

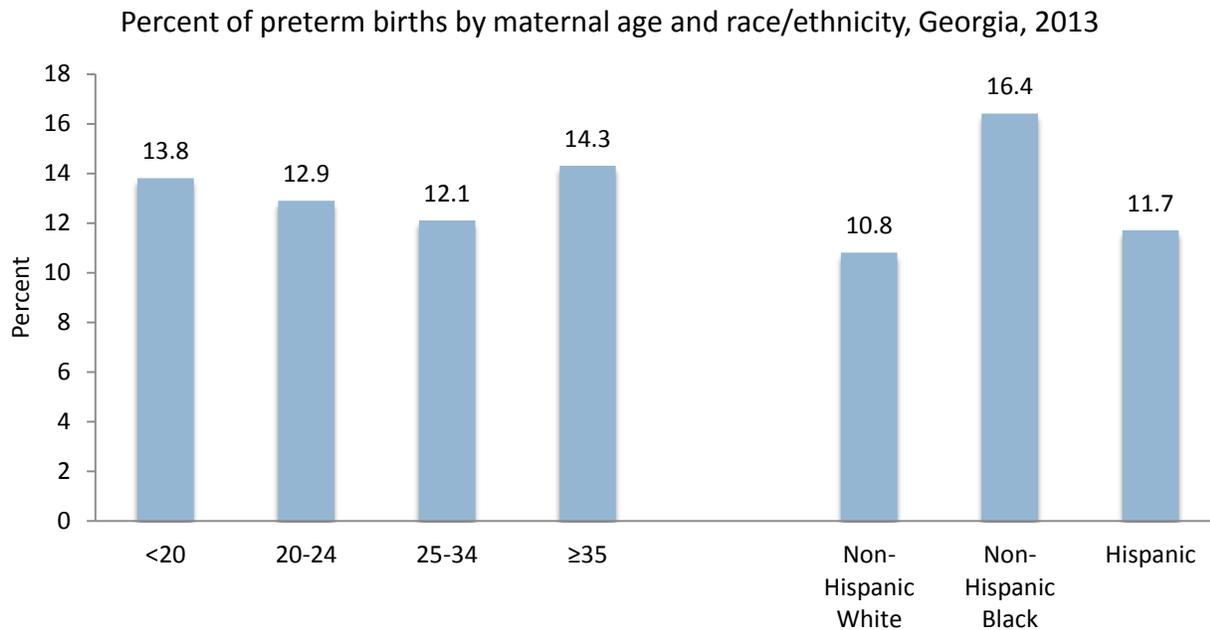
MICH-9.1: Reduce preterm births to 11.4%

The percentage of preterm births (the birth of an infant before 37 completed weeks) has steadily declined since 2010 from 14.0% to 12.8% in 2013. However, Georgia has not yet met the Healthy People 2020 objective for preterm births and has remained above the national average in all years examined. The percentage was lowest among women between the ages of 20 and 34. Women under the age of 20 and over the age of 35 had higher percentages of preterm births (13.8% and 14.3% respectively). Almost 17% of non-Hispanic Black women had a preterm birth in 2013, while the percentage was just over 10.0% for non-Hispanic Whites and Hispanics.

Percent of preterm births by year, Georgia compared to the US, 2009-2013



Source: OASIS, NVSS



Source: OASIS

Early, Moderate and Late Preterm Birth

Healthy People 2020 Objectives

MICH-9.2: Reduce late preterm or live births at 34 to 36 weeks of gestation to 8.1%

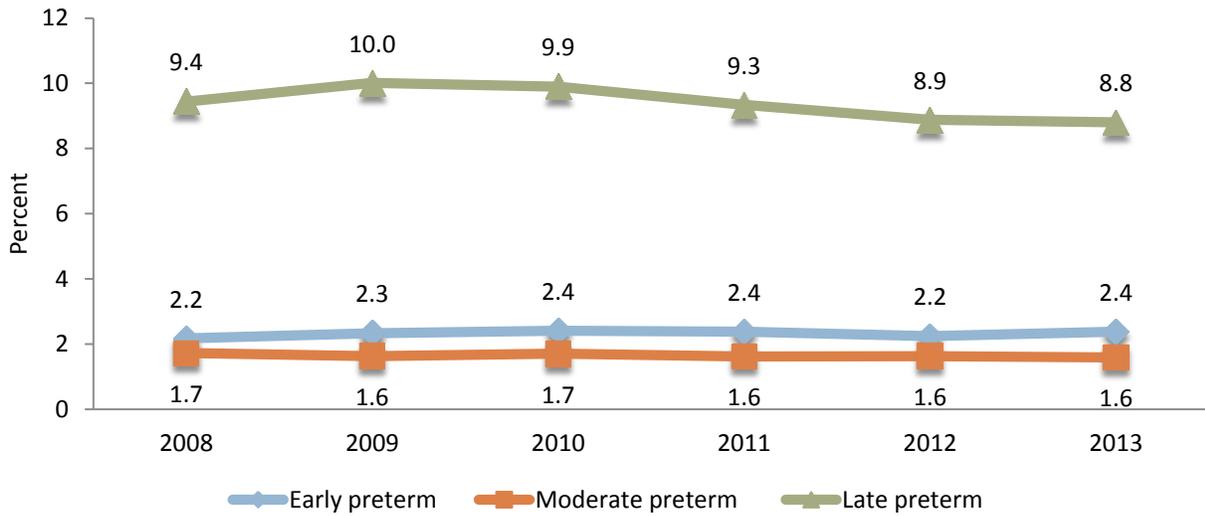
MICH-9.3: Reduce live births at 32 to 33 weeks of gestation to 1.4%

MICH-9.4: Reduce very preterm or live births at less than 32 weeks of gestation to 1.8%

Early preterm births (deliveries occurring before 32 weeks of gestation) have fluctuated between 2.2% and 2.4% of total deliveries in the Georgia between 2008 and 2013 with no clear trend. Moderate preterm births (deliveries occurring between 32 and 33 weeks of gestation) accounted for less than 2% of all deliveries between 2008 and 2013. In the past three years examined, the percentage remained constant at 1.6%. Late preterm births (deliveries occurring between 34 and 36 weeks of gestation) accounted for most of preterm births in the state. The percentage of late preterm births decreased from 10.0% in 2009 to 8.8% in 2013.

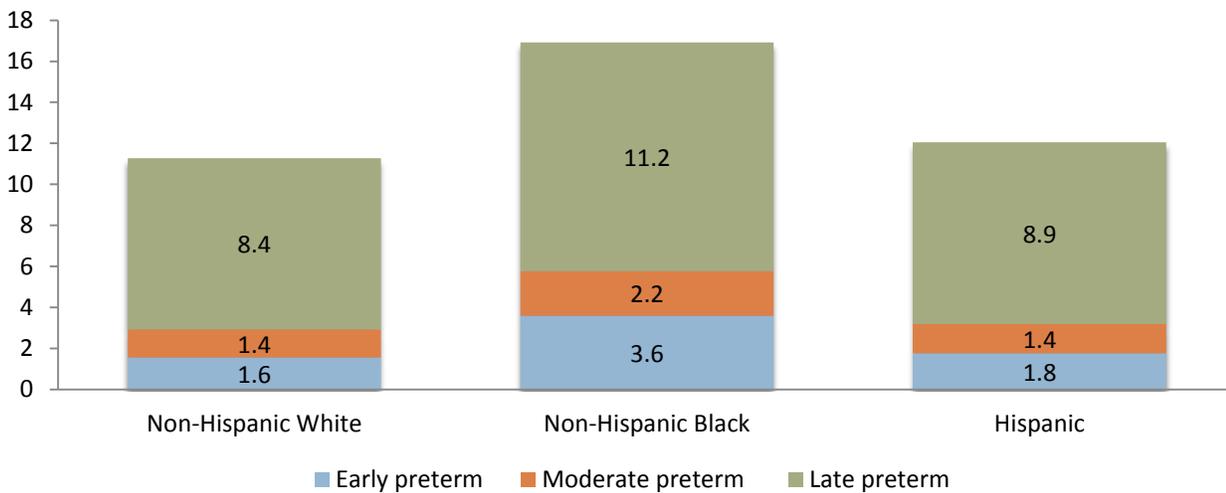
Each racial/ethnic group experienced larger percentages of late preterm deliveries when compared to early and moderate preterm deliveries. The percentage of all types of preterm deliveries was higher among non-Hispanic Black women compared to non-Hispanic White and Hispanic women.

Percent of early, moderate and late preterm births by year, Georgia, 2008-2013



Source: Vital Records

Percent of early, moderate and late preterm births by race/ethnicity, Georgia, 2008-2013



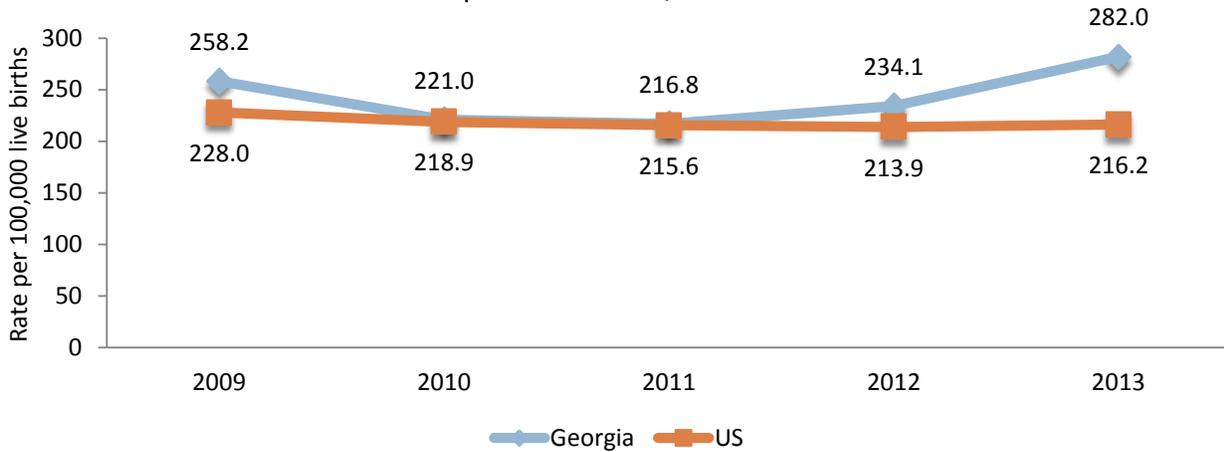
Source: Vital Records

Preterm Related Mortality

The mortality rate related to preterm deliveries increased from 258.2 in 2009 to 282.0 in 2013 in Georgia, despite a decrease to 216.8 in 2011. The trend remained more constant in the United States, where the rate decreased from 228.0 in 2009 to 216.2 in 2013. The preterm-related mortality rate was higher among

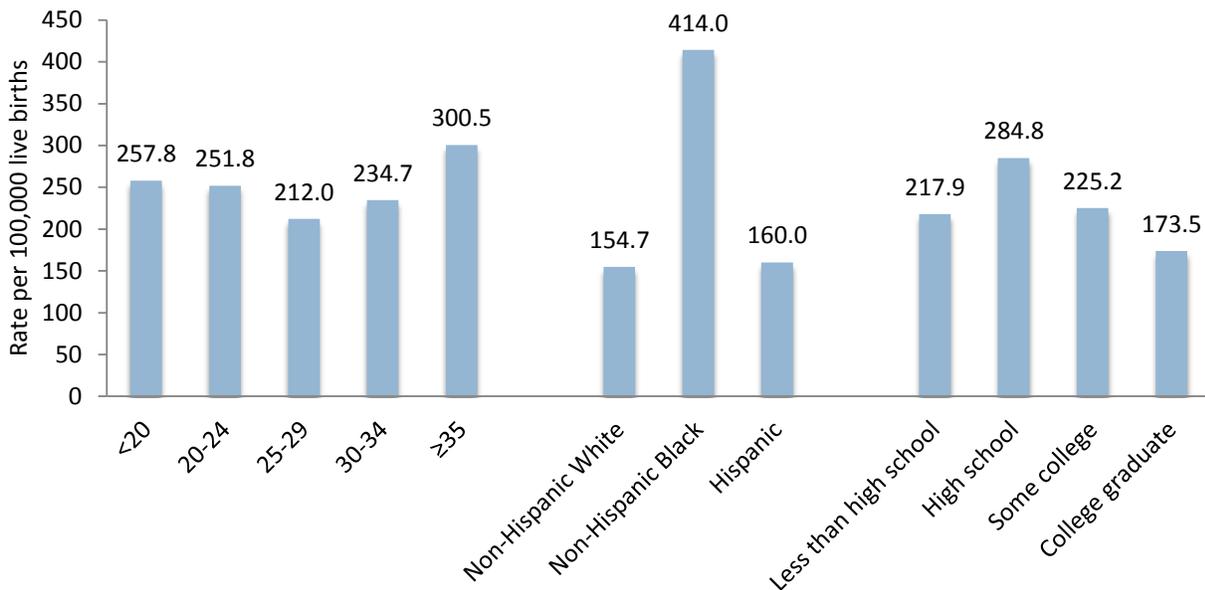
the youngest and oldest mothers (those less than 25 years of age and over 35 years of age). The rate was 2.7 times higher among Non-Hispanic Black women compared to Non-Hispanic White women (414.0 and 154.7 respectively). The rate among Hispanic women (160.0) was comparable to that of Non-Hispanic Whites. Among women with a high school diploma, the rate was 184.8. When looking at women who graduated college, the rate was 173.5.

Preterm-related mortality rate per 100,000 live births by year, Georgia compared to the US, 2009-2013



Source: NVSS

Preterm-related mortality rate per 100,000 live births by maternal age, race/ethnicity and education, Georgia, 2011-2013



Source: NVSS

BIRTH WEIGHT

Low Birth Weight and Very Low Birth Weight

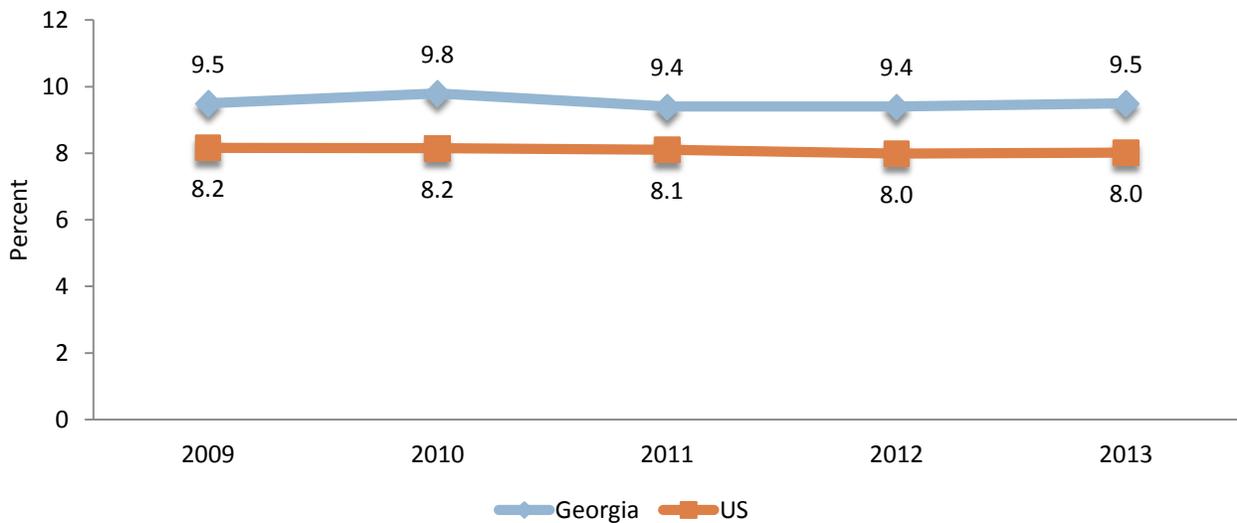
Healthy People 2020 Objective

MICH-8.1: Reduce low birth weight to 7.8%

MICH-8.2: Reduce very low birth weight to 1.4%

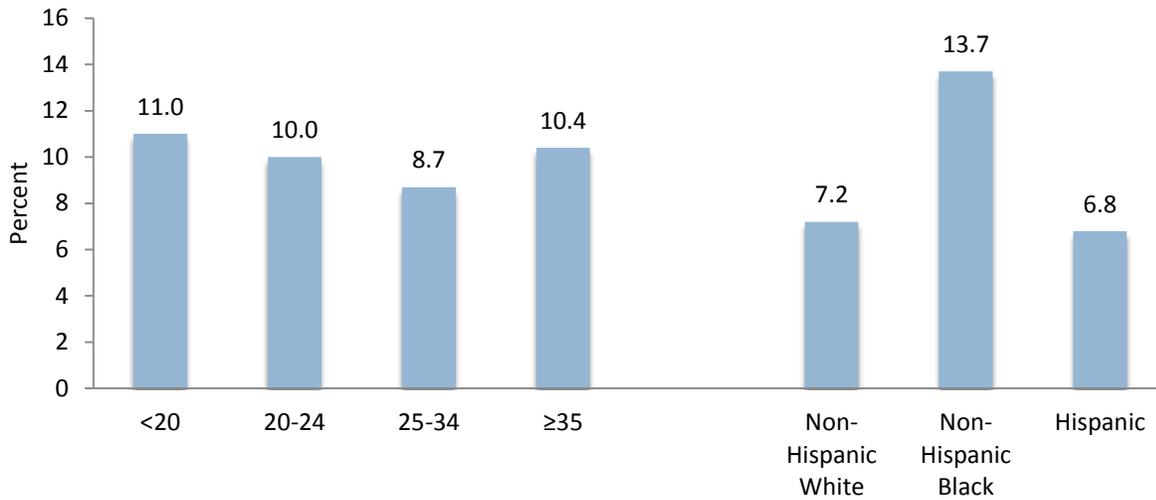
Over the five-year period reported below (2009 through 2013), the percentage of low birth weight (LBW) deliveries in Georgia varied little and remained above the Healthy People 2020 objective. Women who most often had low birth weight infants in Georgia were either of young maternal age (less than 20 years) or advanced maternal age (35 years and older). Specifically, 11.0% of mothers younger than 20 years of age and 10.4% of mothers 35 years of age or older had a low birth weight delivery, compared to approximately 8-10% of women in the 20 to 34 year old age group. Non-Hispanic Black women (13.7%) had nearly twice the percentage of low birth weight infants as non-Hispanic Whites (7.2%) and Hispanics (6.8%).

Percent of low birth weight deliveries by year, Georgia compared to the US, 2009-2013



Source: OASIS, NVSS

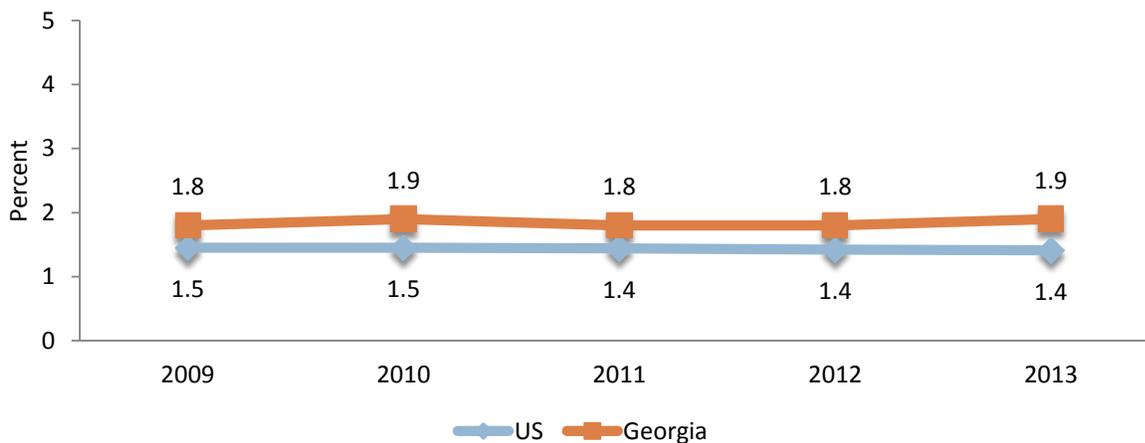
Percent of low birth weight deliveries by maternal age and race/ethnicity, Georgia, 2013



Source: OASIS

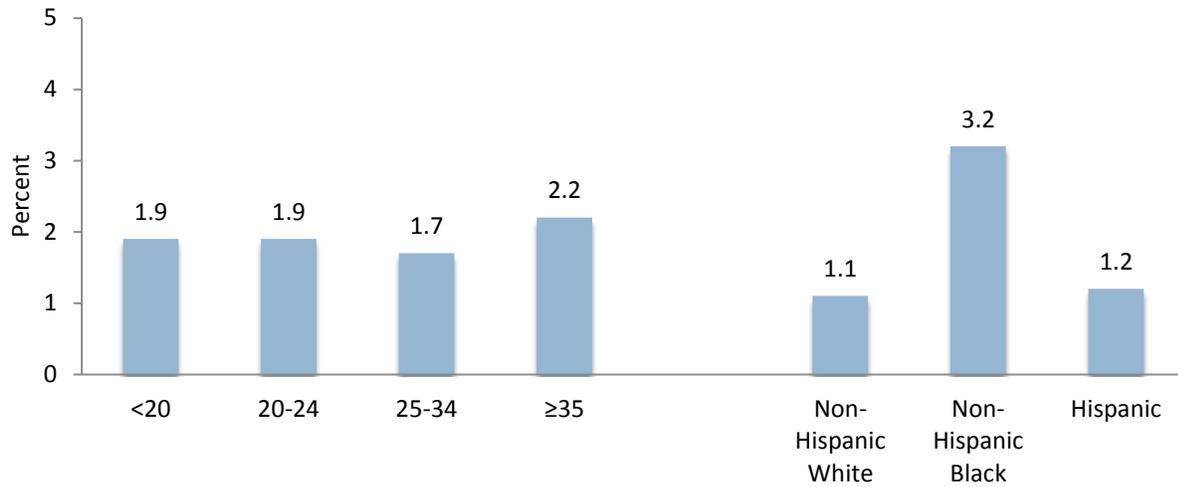
The percentage of very low birth weight (VLBW) deliveries in Georgia varied between 1.8% and 1.9% from 2009 to 2013 with no clear trend. The percentage did remain higher than both the national average and Healthy People 2020 objective. The lowest percentage of VLBW deliveries was seen among women between the ages of 25 and 34 (1.7%). Women over the age of 35 experienced the highest percentage of VLBW deliveries (2.2%). Differences were seen by race/ethnicity. The percentage of VLBW deliveries was three times higher among non-Hispanic Blacks (3.2%) compared to non-Hispanic Whites (1.1%) and Hispanics (1.2%).

Percent of very low birth weight deliveries by year, Georgia compared to the US, 2009-2013



Source: OASIS, NVSS

Percent of very low birth weight deliveries by maternal age and race/ethnicity, Georgia, 2013

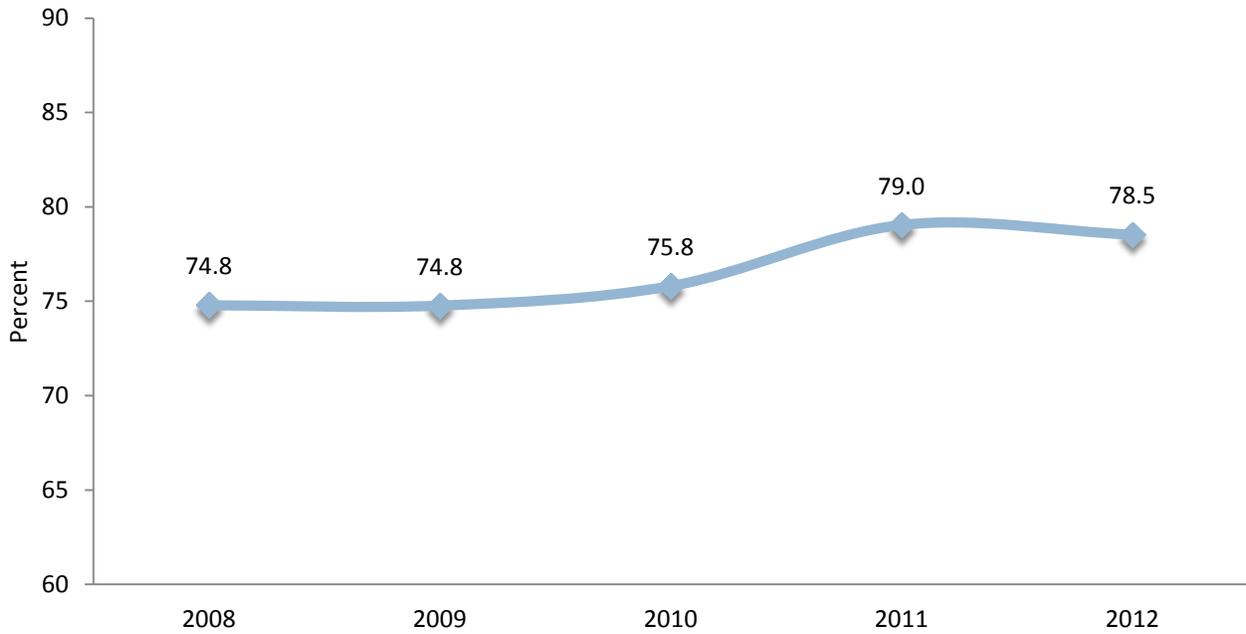


Source: OASIS

Perinatal Regionalization

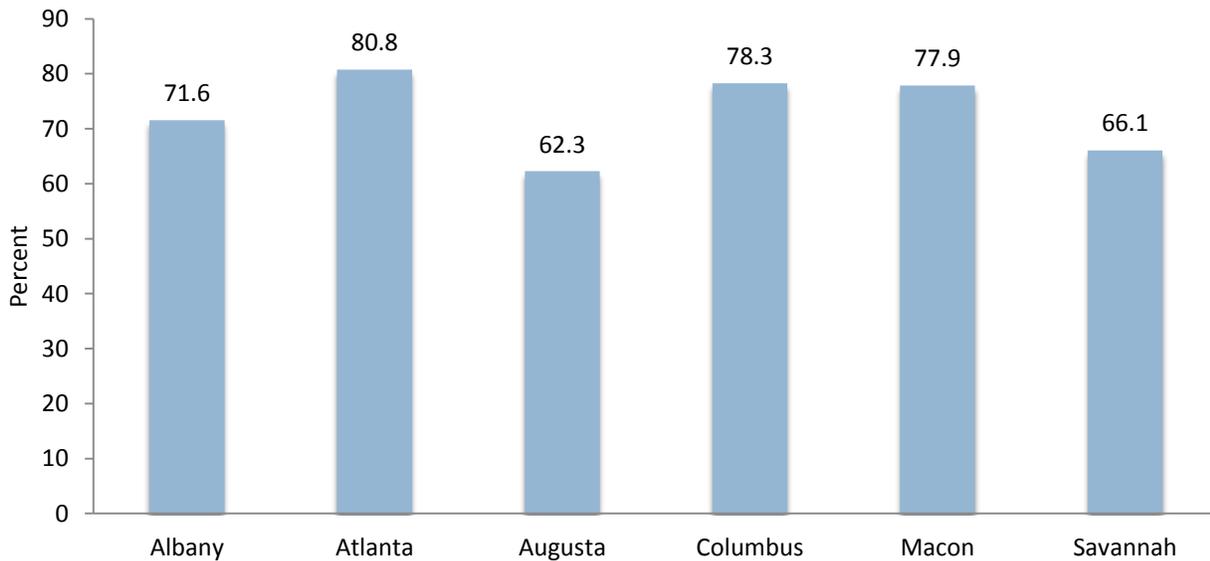
The percentage of VLBW infants delivered at Level III facilities has steadily increased, with 74.8% of babies being born in Level III facilities in 2008 compared to 78.5% in 2012. Georgia has six perinatal regions, which consist of a Regional Perinatal Center, Level III, Level II, and Level I facilities. The Atlanta perinatal region had the highest percentage (80.8%) of very low birth weight infants born at the appropriate level of care (Level III facility), compared to only 66.1% in Savannah, followed by 62.3% of babies in Augusta.

Percent of very low birth weight infants delivered in level III facilities by year, Georgia, 2008-2012



Source: Vital Records

Percent of very low birth weight infants delivered in Level III facilities by perinatal region, Georgia, 2008-2012



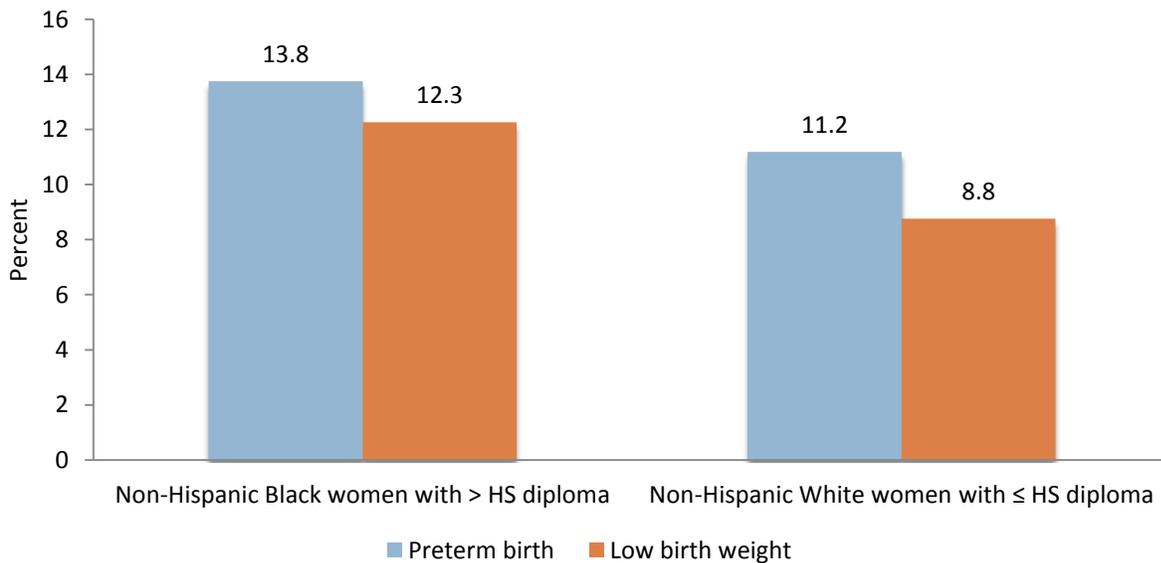
Source: Vital Records

ATYPICAL ANALYSIS

An atypical analysis was used to differentiate the effect that education and race/ethnicity have on adverse birth outcomes. Non-Hispanic Black women with more than a high school diploma had higher percentages of both preterm births and low birth weight infants than non-Hispanic White women with a high school diploma or less. The difference was most pronounced when examining low birth weight deliveries. The percentage was 12.3% among non-Hispanic Black women with more than a high school diploma compared to 8.8% among non-Hispanic White women with a high school diploma or less.

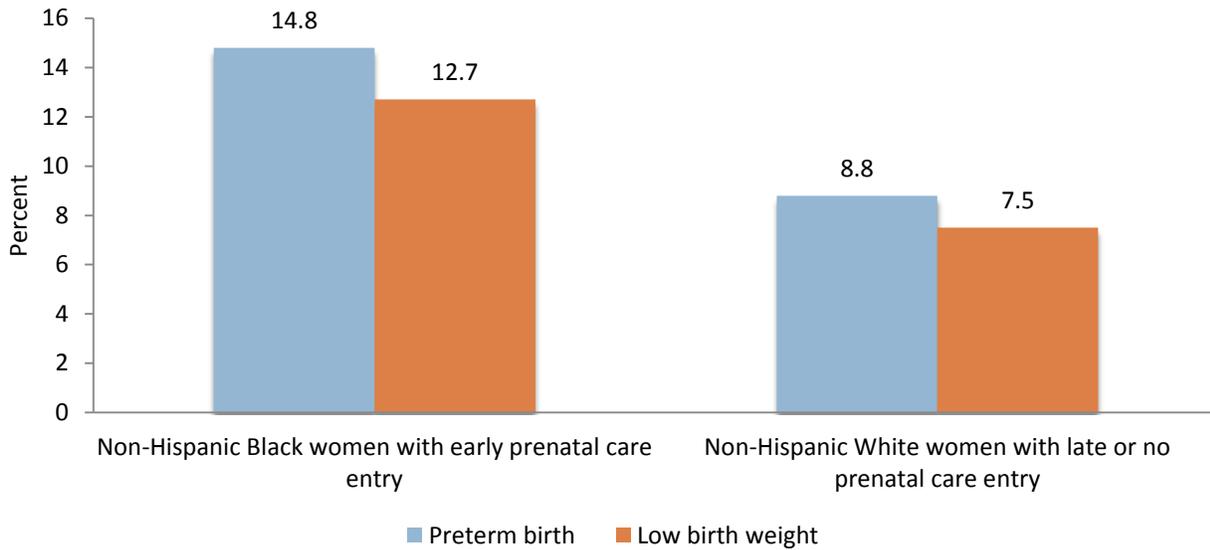
Additionally, more non-Hispanic Black women who entered prenatal care early experienced preterm birth and low birth weight deliveries (14.8% and 12.7% respectively) compared to non-Hispanic White women with late or no entry to prenatal care (8.8% and 7.5% of mothers, respectively). Again, this points to the need for additional investigation to identify the root causes for such disparities among non-Hispanic Black mothers as early entry in prenatal care does not provide the same protection against adverse birth outcomes as it provides for White women.

Percent of preterm birth and low birth weight deliveries by race and education, Georgia, 2008-2012



Source: Vital Records

Percent of preterm birth and low birth weight deliveries by race and prenatal care, Georgia, 2008-2012



Source: Vital Records

INFANT MORTALITY

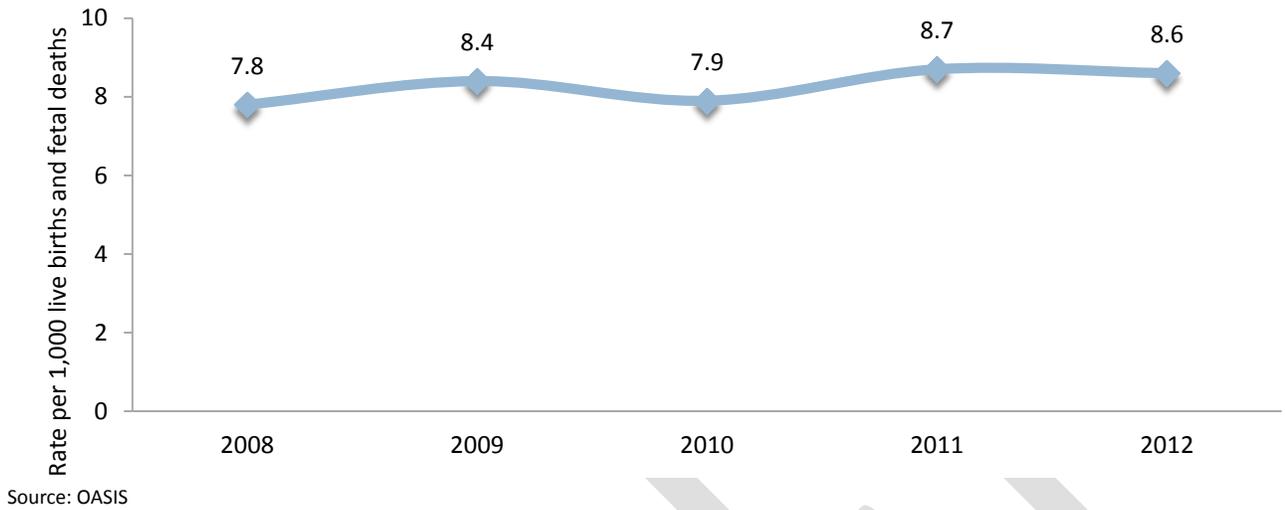
Fetal Mortality

Healthy People 2020 Objective

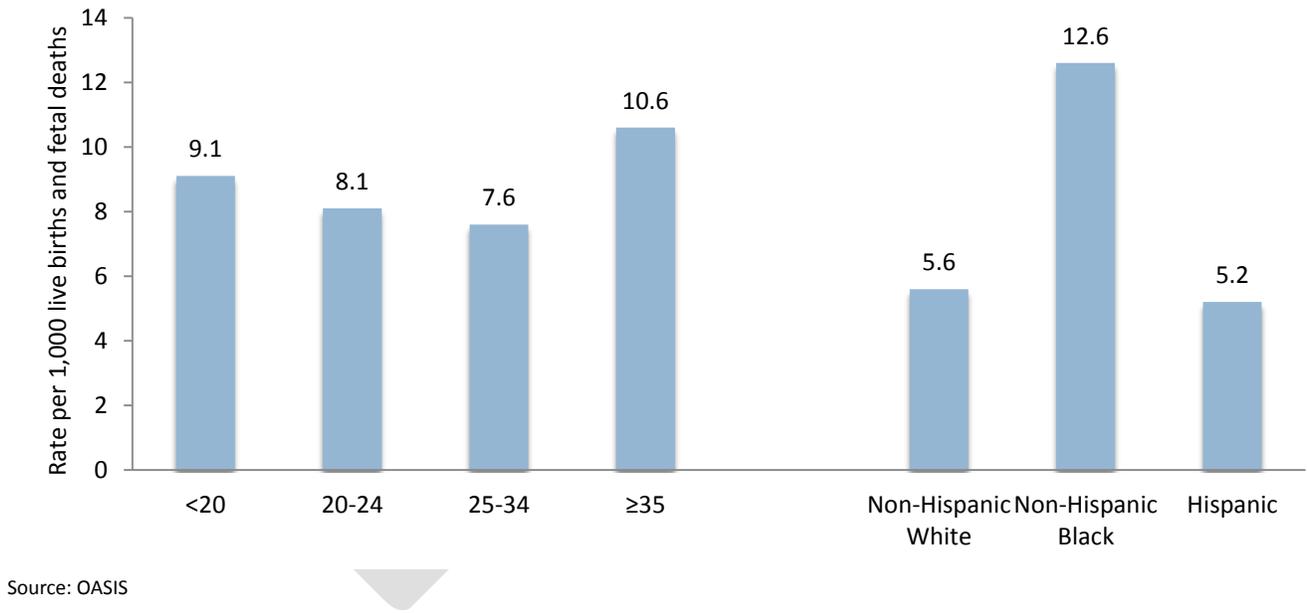
MICH-1.1: Reduce the rate of fetal deaths (20 weeks of gestation or greater) to 5.6 deaths per 1,000 live births and fetal deaths

There was an overall increase in the fetal mortality rate (death at or after 20 weeks gestation per 1,000 live births and fetal deaths) in Georgia from 2008 to 2012. In 2008, the rate was 7.8 per 1,000 live births and increased to 8.6 in 2012. This rate is trending away from the Healthy People 2020 objective of 5.6. When stratified by maternal age, it is evident that the fetal mortality rate is highest among the youngest and oldest mothers. The rate is over twice as high among non-Hispanic Blacks (12.6) compared to non-Hispanic Whites and Hispanics (5.6 and 5.2 respectively).

Fetal mortality rate per 1,000 live births and fetal deaths by year, Georgia, 2008-2012



Fetal mortality rate per 1,000 live births and fetal deaths by maternal age and race/ethnicity, Georgia, 2008-2012



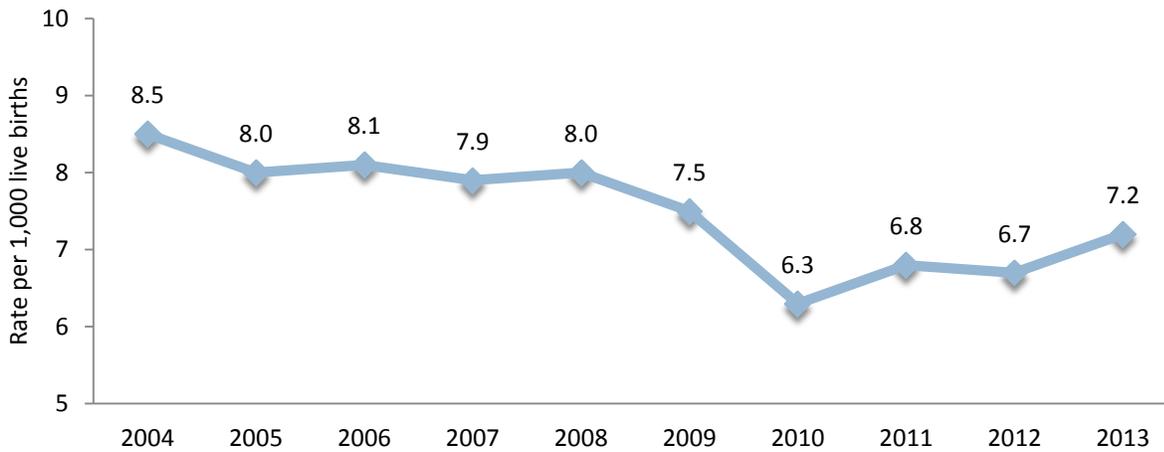
Infant Mortality

Healthy People 2020 Objective

MICH-1.3: Reduce the rate of all infant deaths (within 1 year) to 6.0 infant deaths per 1,000 live births

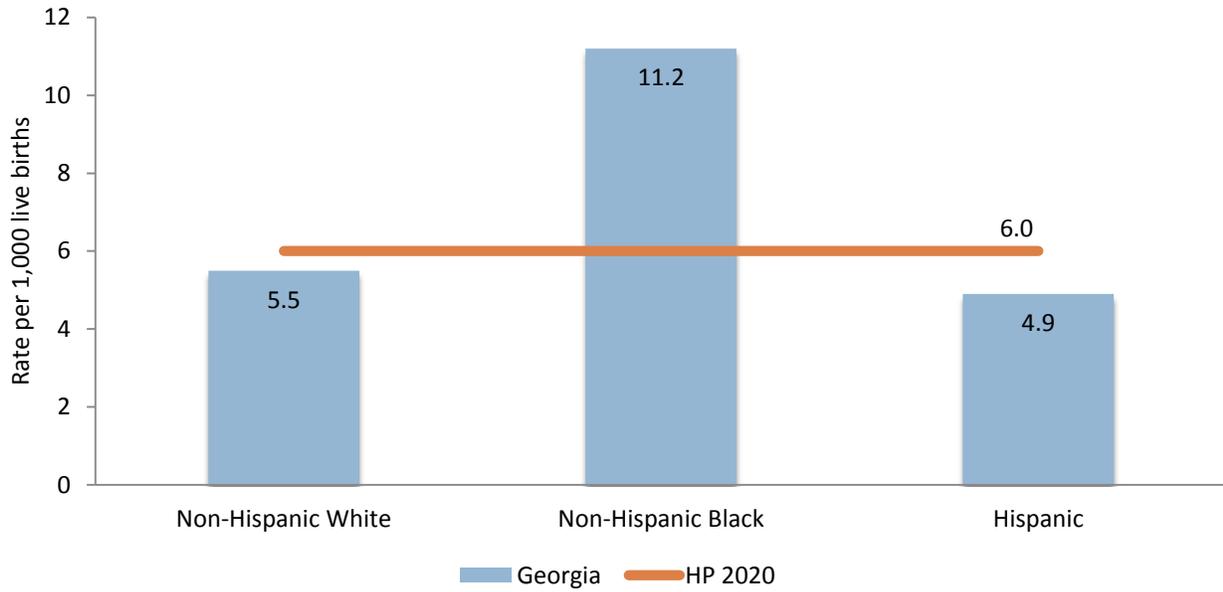
There was an overall decrease in the infant mortality rate from 8.5 in 2004 to 7.2 in 2013. The rate for 2010 (6.3) was underreported. In all years examined, the infant mortality rate in Georgia remained higher than the Healthy People 2020 objective of 6.0 infant deaths per 1,000 live births. Non-Hispanic White and Hispanic infants experienced an infant mortality rate below the Healthy People 2020 objective. However, the rate among non-Hispanic Blacks was 11.2, twice as high as that of non-Hispanic Whites and Hispanics. The ratio of the black to white infant mortality rate remained relatively stable at 2.0 between 2008 and 2012. Five public health districts had an infant mortality rate greater than 9.0 between 2008 and 2012: East Central Health District, North Central Health District, South Central Health District, Southwest Health district and West Central Health District.

Infant mortality rate per 1,000 live births by year, Georgia, 2004-2013



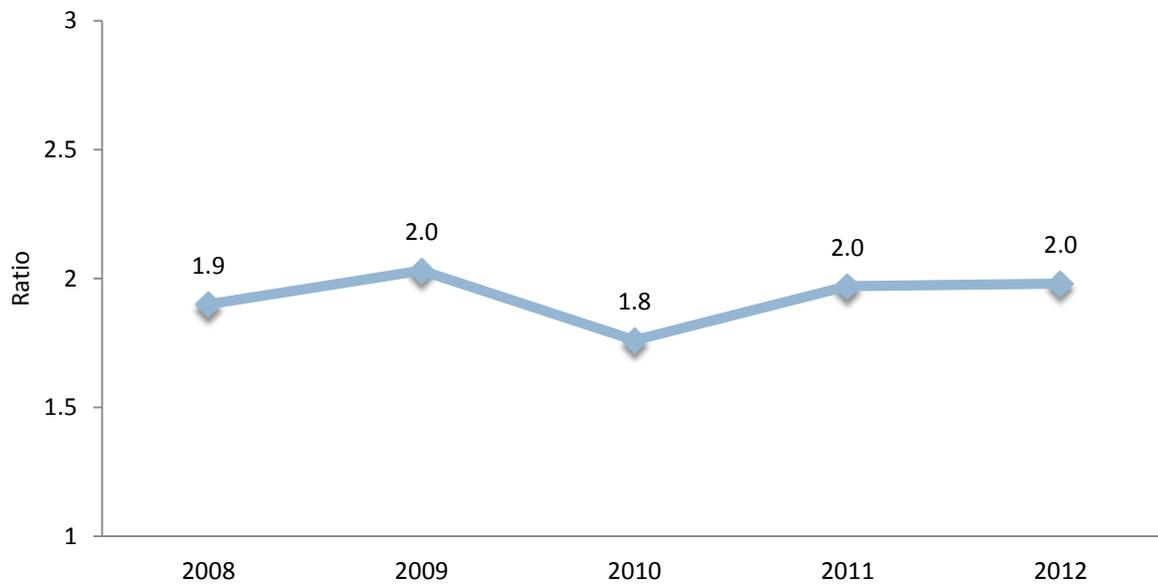
Source: OASIS

Infant mortality rate per 1,000 live births by race/ethnicity, Georgia, 2013



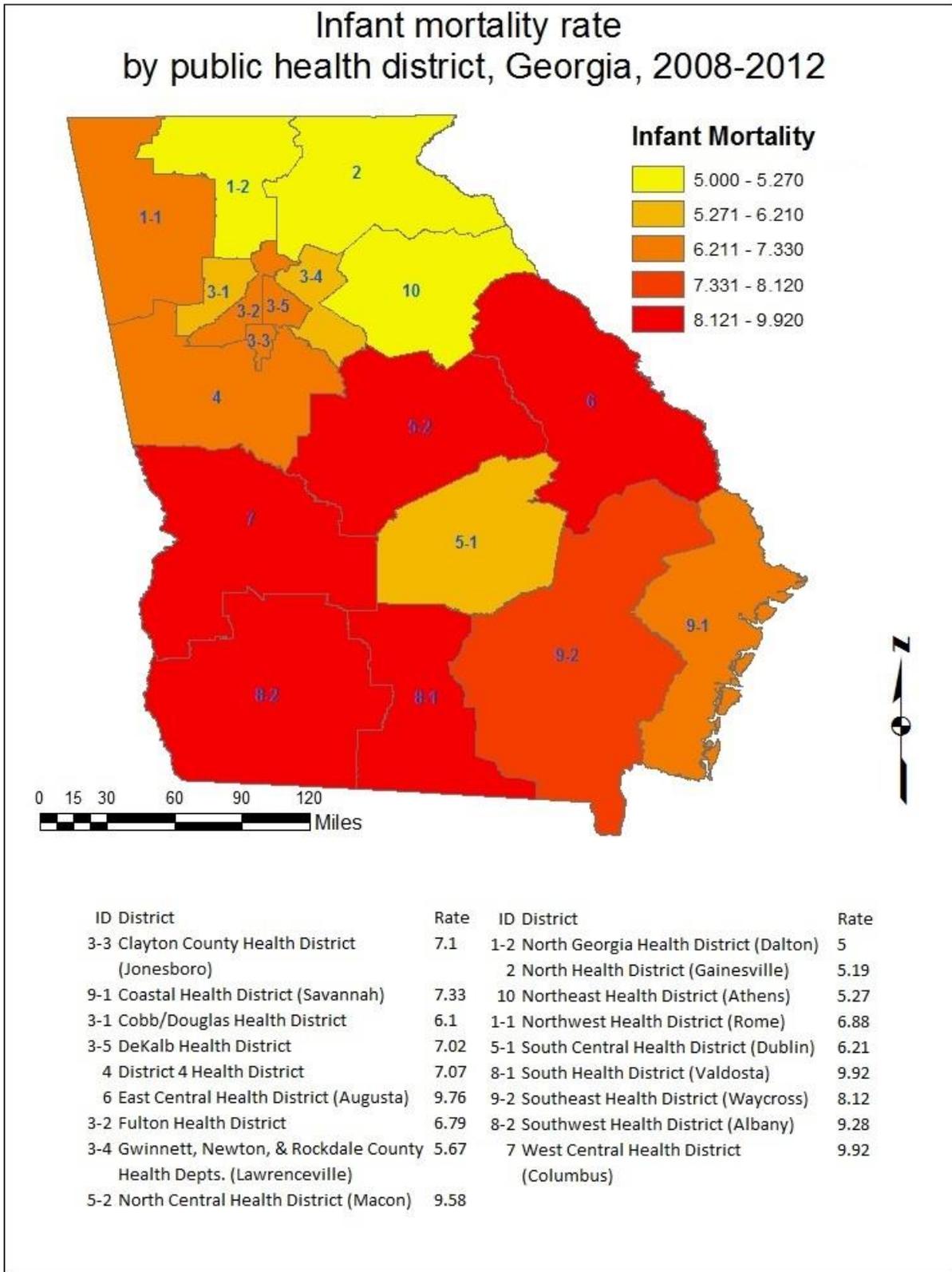
Source: OASIS

Ratio of black to white infant mortality rate by year, Georgia, 2008-2012



Source: OASIS

Infant mortality rate by public health district, Georgia, 2008-2012



Source: OASIS

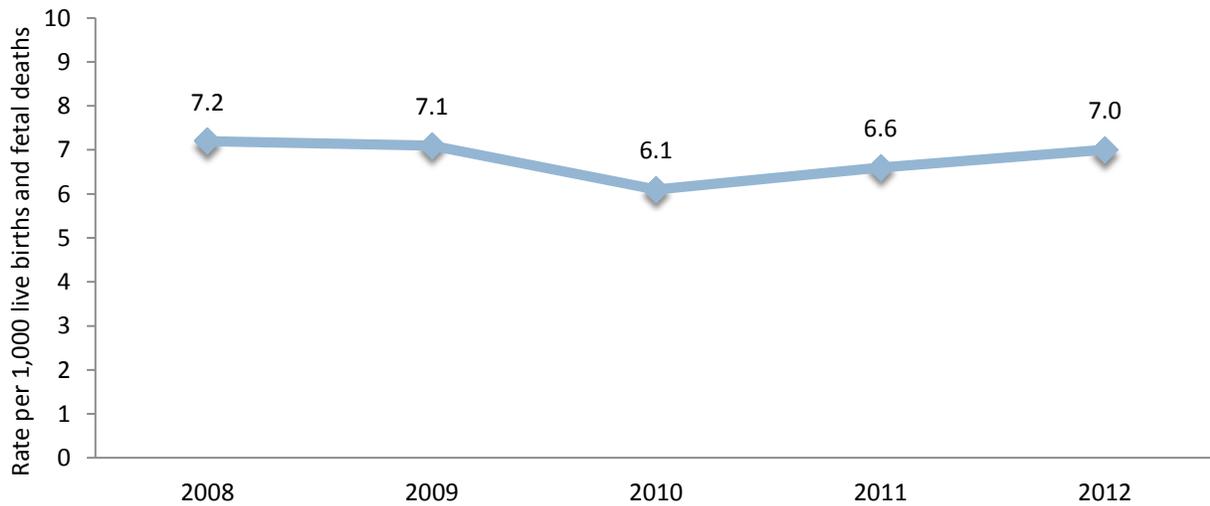
Perinatal Mortality

Healthy People 2020 Objective

MICH-1.2: Reduce the rate of fetal and infant deaths during perinatal period (28 weeks of gestation to 7 days after birth) to 5.9 perinatal deaths per 1,000 live births and fetal deaths

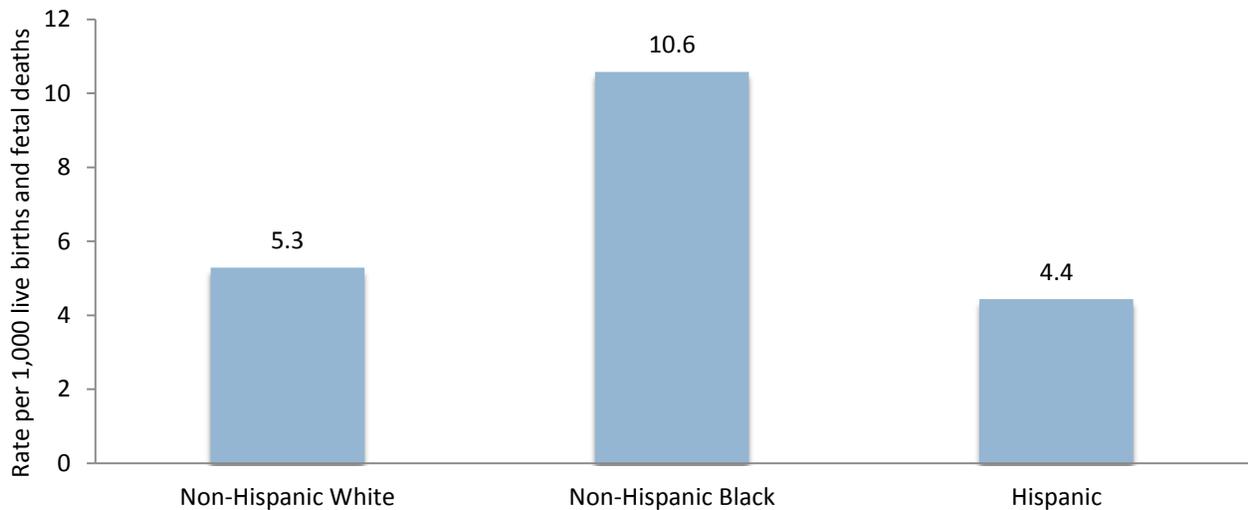
The perinatal mortality rate remained relatively constant at approximately 7.0 deaths per 1,000 live births and fetal deaths over the 5 year span. Decreases in both fetal death and early neonatal death need to be made in order for Georgia to change the trajectory of perinatal mortality. When stratified by race, disparities were present. Non-Hispanic Black mothers had a higher perinatal mortality rate (10.6 per 1,000 live births and fetal deaths) compared to a rate of 5.3 among non-Hispanic White infants and 4.4 for Hispanic infants.

Perinatal mortality rate by year, Georgia, 2008-2012



Source: Vital Records

Perinatal mortality rate by race/ethnicity, Georgia, 2008-2012



Source: Vital Records

Neonatal and Postneonatal Mortality

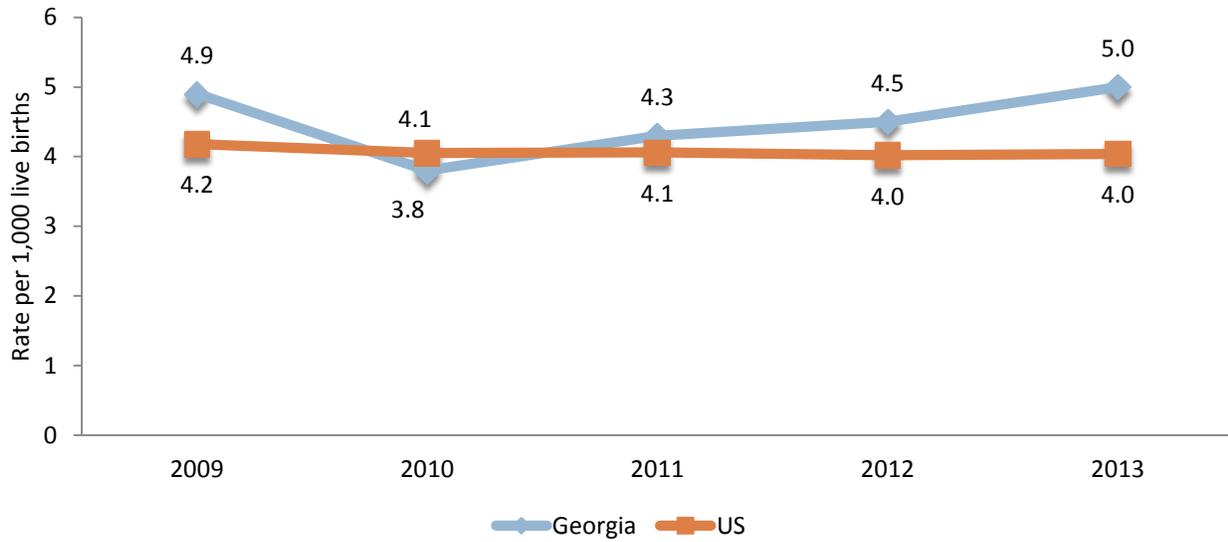
Healthy People 2020 Objectives

MICH-1.4: Reduce the rate of neonatal deaths (within the first 28 days of life) to 4.1 neonatal deaths per 1,000 live births

MICH-1.5: Reduce the rate of postneonatal deaths (between 28 days and 1 year) to 2.0 post-neonatal deaths per 1,000 live births

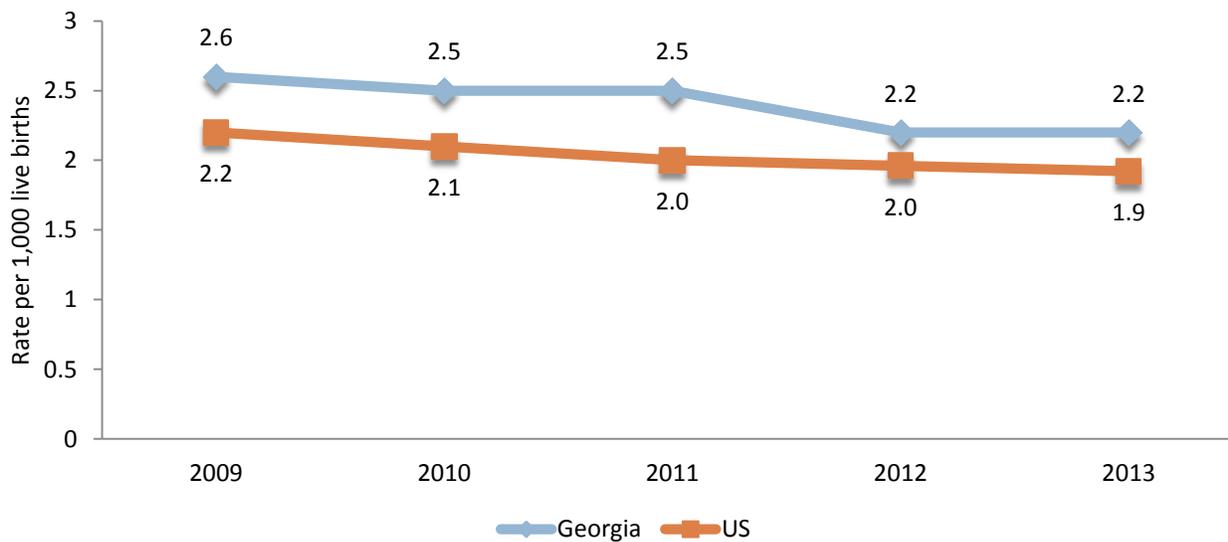
Georgia's neonatal and postneonatal mortality rates in 2013 were slightly higher than the Healthy People 2020 objectives. In Georgia, there was virtually no difference in the neonatal mortality rate in 2009 and 2013 (4.9 and 5.0). The national average only varied between 4.2 and 4.0 during the same time period. Postneonatal mortality in Georgia declined from 2009 to 2013, but remained above the national average. In 2009, the rate in Georgia was 2.6. In 2013, the rate declined to 2.2. In all racial groups examined, neonatal deaths were a larger contributor to the overall infant mortality rate than postneonatal deaths. The neonatal and postneonatal mortality rates were higher among non-Hispanic Blacks (4.0 and 7.4) compared to non-Hispanic Whites (3.5 and 2.1) and Hispanics (2.9 and 1.1). The rates were higher in the southern part of the state and lowest in the northeastern corner.

Neonatal mortality rate by year, Georgia compared to the US, 2009-2013



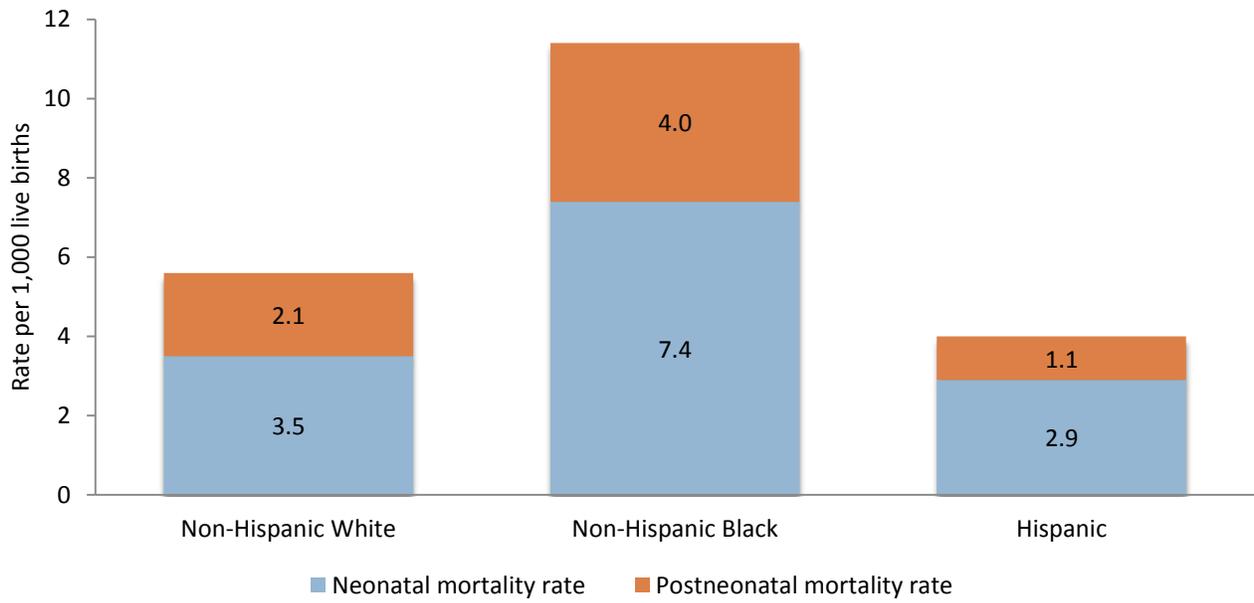
Source: OASIS, NVSS

Postneonatal mortality rate by year, Georgia compared to the US, 2009-2013



Source: OASIS, NVSS

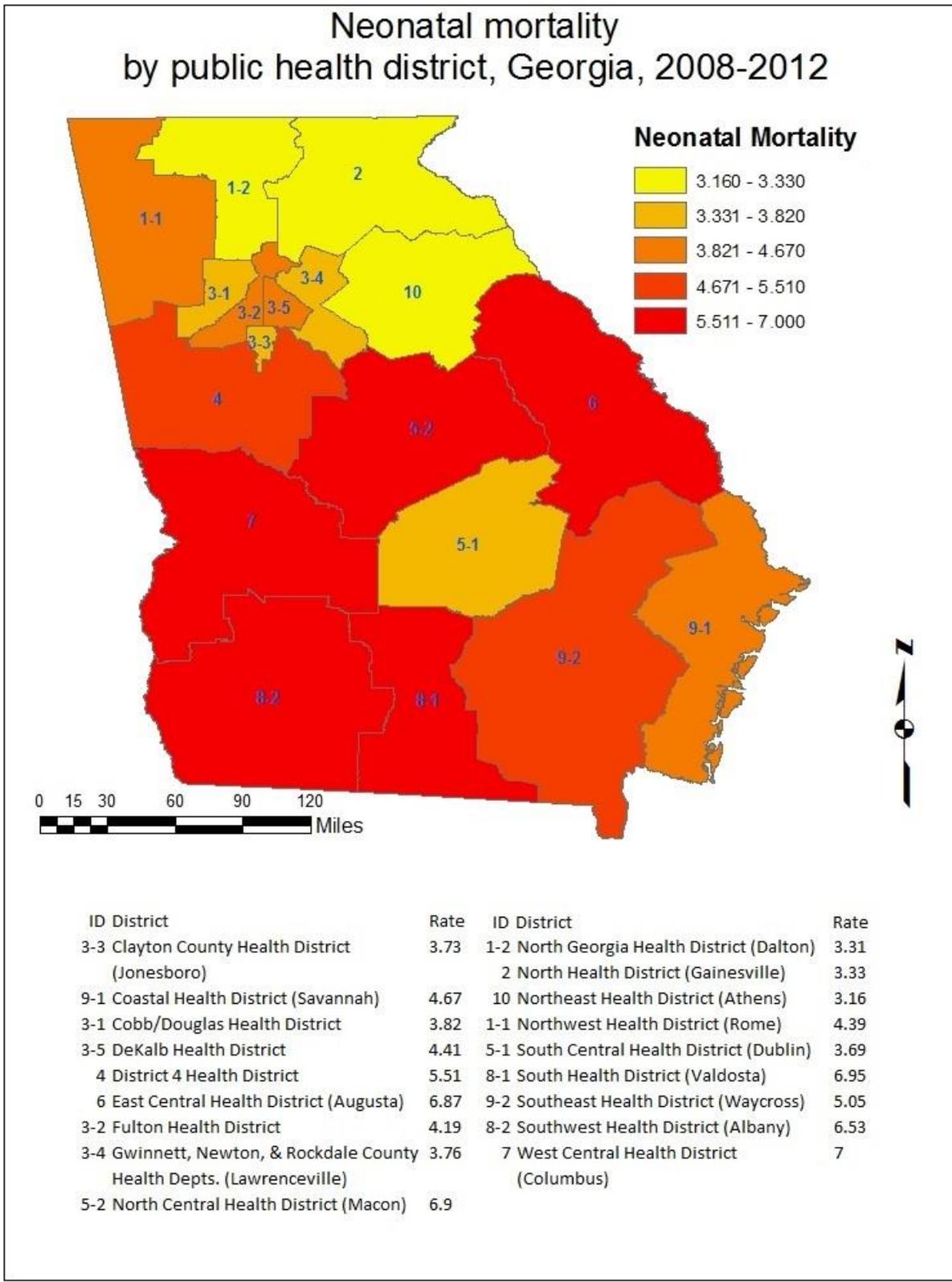
Neonatal and postneonatal mortality rate by race/ethnicity, Georgia, 2009-2013



Source: OASIS

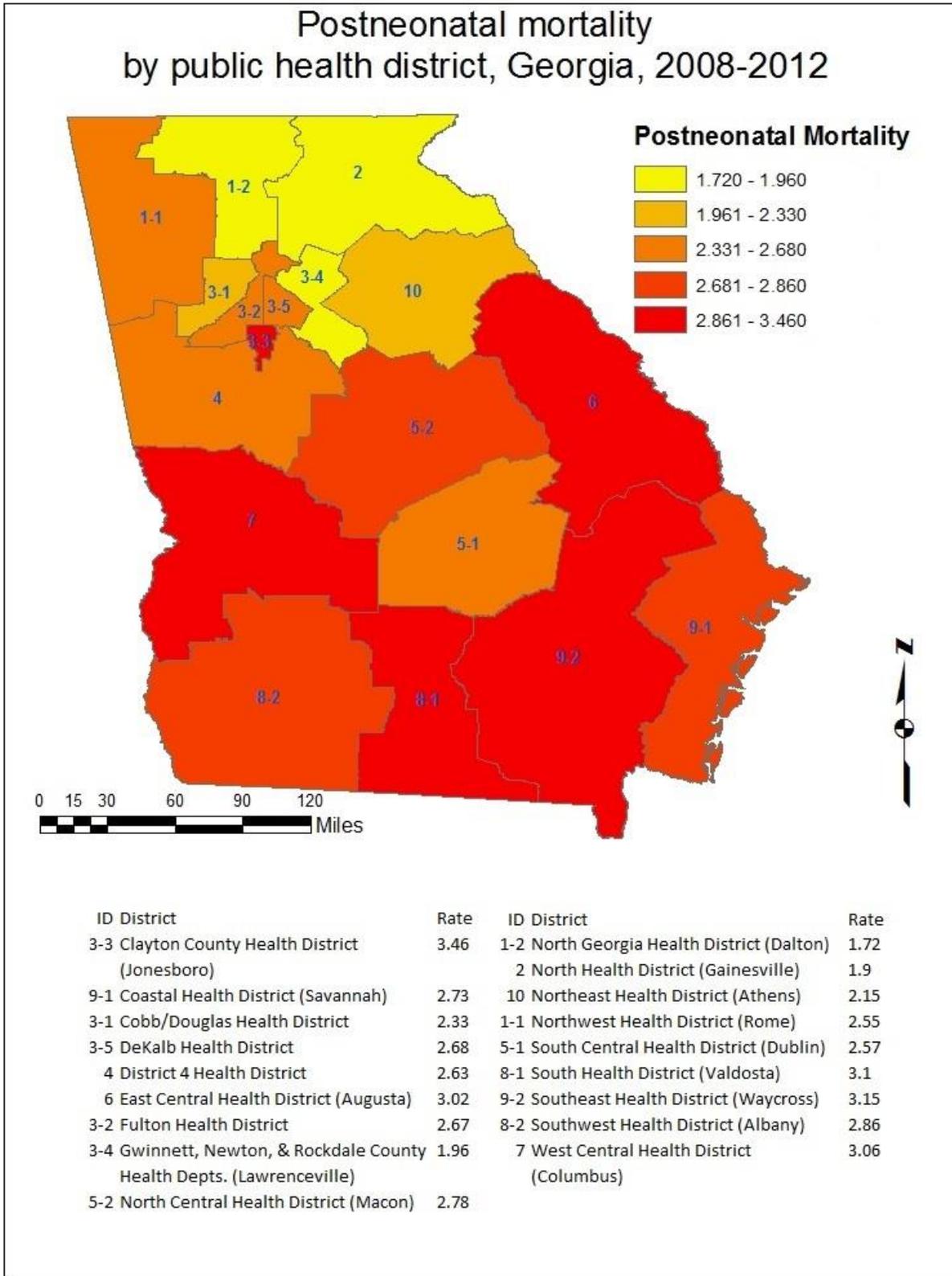
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Neonatal mortality by public health district, Georgia, 2008-2012



Source: Vital Records

Postneonatal mortality by public health district, Georgia, 2008-2012

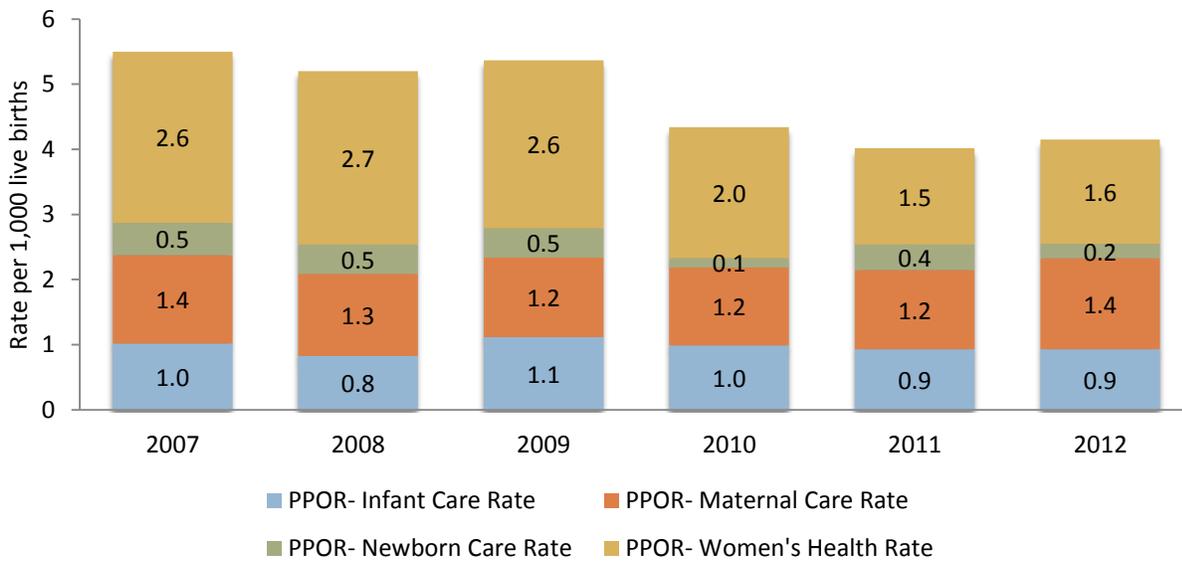


Source: Vital Records

Perinatal Periods of Risk

The Perinatal Periods of Risk framework is used to help communities understand fetal and infant death, and to provide insight into intervention strategies. In this analysis, White women 20 to 44 years of age with greater than a high school education were the reference group. It is assumed that all populations can achieve the level of infant mortality among the reference group population. The rates shown below are the excess infant deaths attributable to four different causes. While women’s health was the largest contributor to fetal and infant death in Georgia from 2007 to 2012, the overall impact of women’s health on infant mortality has declined. Overall, the data suggest that efforts should be made around improving women’s health and maternal care to see marked decreases in both fetal and infant death.

Excess feto-infant death rate per 1,000 live births using the perinatal period of risk (PPOR) framework, Georgia, 2007-2012



Source: Vital Records

HOSPITALIZATIONS

Infant Hospitalizations

The top ten causes of hospitalization for infants in Georgia from 2009 to 2013 are listed below. The number one cause was conditions that originate in the perinatal period, followed by congenital malformations. The number one cause, conditions originating in the perinatal period, was the same across all races and ethnicities.

Causes of hospital discharges for infants, Georgia, 2009-2013	
Reason for hospitalization (rate per 100,000)	Rank
Certain conditions originating in perinatal period (13,927)	1
Congenital malformations, deformations, and chromosomal abnormalities (7,773)	2
Pneumonia (3,860)	3
All other endocrine, nutritional and metabolic diseases (1,845)	4
All other diseases of the genitourinary system (1,335)	5
All other diseases of the nervous system (1,322)	6
Asthma (773)	7
Infections of the kidney (702)	8
Septicemia (554)	9
Influenza (532)	10

Source: OASIS

Emergency Room Visits

The number one cause of emergency room visits among infants from 2009 to 2013 was certain conditions originating in the perinatal period, followed by falls as the number two cause and unintentional injury as the third. Conditions that originate in the perinatal period was the number one cause among all races and ethnicities with the exception of non-Hispanic White infants, in which falls were the number one cause.

Causes of emergency room visits for infants, Georgia, 2009-2013	
Reason for emergency room visit (rate per 100,000)	Rank
Certain conditions originating in perinatal period (20,869)	1
Falls (17,439)	2
All other unintentional injury (14,171)	3
Pneumonia (10,881)	4
All other diseases of the genitourinary system (5,756)	5
Influenza (4,845)	6
All COPD except Asthma (4,324)	7
Asthma (4,138)	8
All other endocrine, nutritional, and metabolic diseases (2,719)	9
Accidental poisoning and exposure to noxious substances (1,164)	10

Source: OASIS

BREASTFEEDING

Initiation

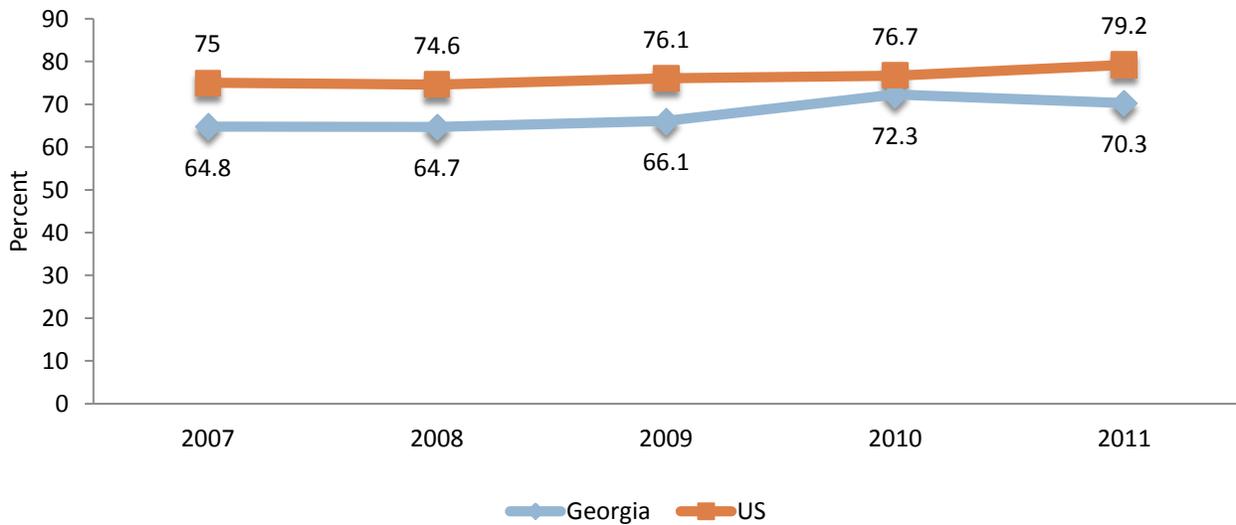
Healthy People 2020 Objectives

MICH-21.1: Increase the proportion of infants who are ever breastfed to 81.9%

MICH-21.5: Increase the proportion of infants who are breastfed exclusively through 6 months to 25.5%

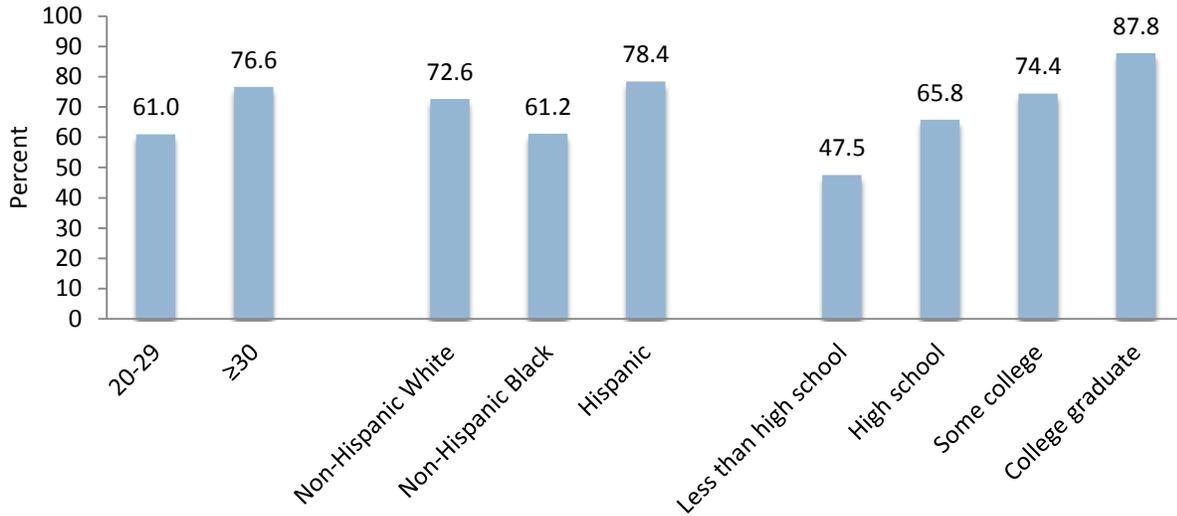
The percentage of infants who were ever breastfed in Georgia peaked in 2010, at 72.3%. The percentage declined to 70.3% in the subsequent year. Based on 2011 data, Georgia is seven percentage points from achieving the Healthy People 2020 objective for breastfeeding initiation. Georgia’s percentage was lower than the national average from 2007 to 2011. More women 30 years of age or older (76.6%) reported ever breastfeeding than women between the ages of 20 and 29 (61.0%). Initiation was lowest among non-Hispanic Blacks (61.2%) and highest among Hispanics (78.4%). The percentage was 1.8 times higher among women with a college degree compared to women without a high school diploma.

Percent of infants who were ever breastfed by year, Georgia compared to the US, 2007-2011



Source: NIS

Percent of infants who were ever breastfed by maternal age, race/ethnicity and education, Georgia, 2011

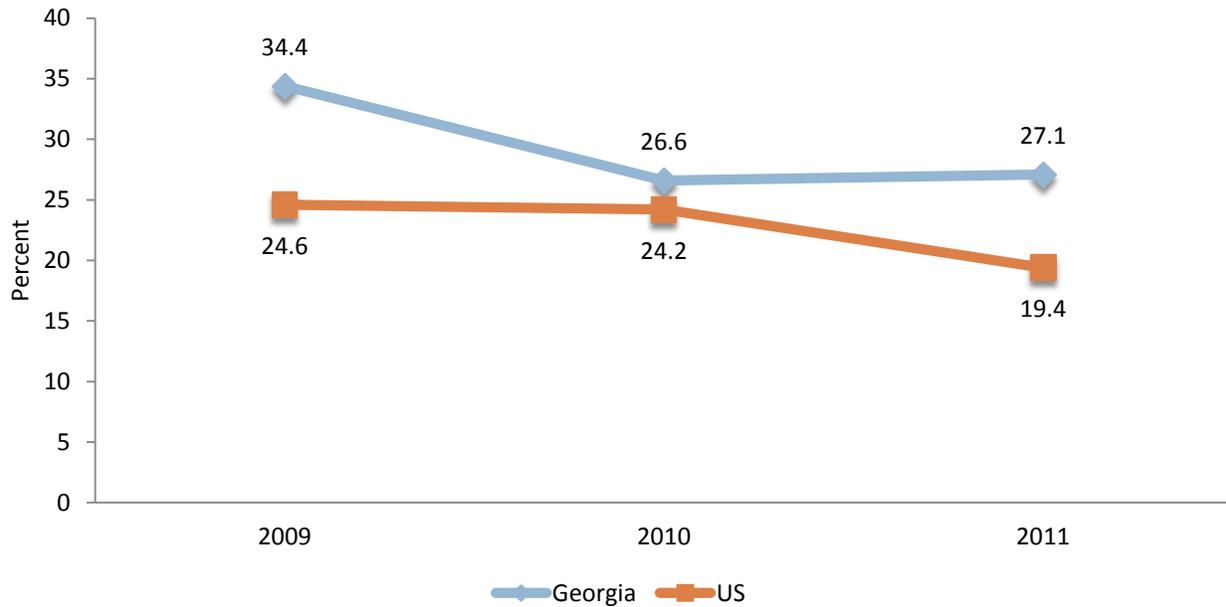


Source: NIS

Formula Supplementation

The percentage of mothers who reported formula supplementation before their infant was two days of age was higher in Georgia when compared to the nation at every reported year. The gap between Georgia and the US decreased in 2010, however the percentage continued to decline across the nation while slightly increasing in Georgia in 2011.

Percent of mothers who reported formula supplementation before 2 days of age by year, Georgia compared to the US, 2009-2011



Source: NIS

Barriers to Breastfeeding Initiation

Among mothers who recently had a live birth, the top two barriers to breastfeeding initiation reported in 2011 were that the mother didn't want to breastfeed (46.3%) and the mother didn't like breastfeeding (25.6%). The third and fourth reasons for not breastfeeding are that the mother returned to work or school or she had other children to take care of. Fewer than 10% of mothers reported that being sick or having too many household duties were barriers.

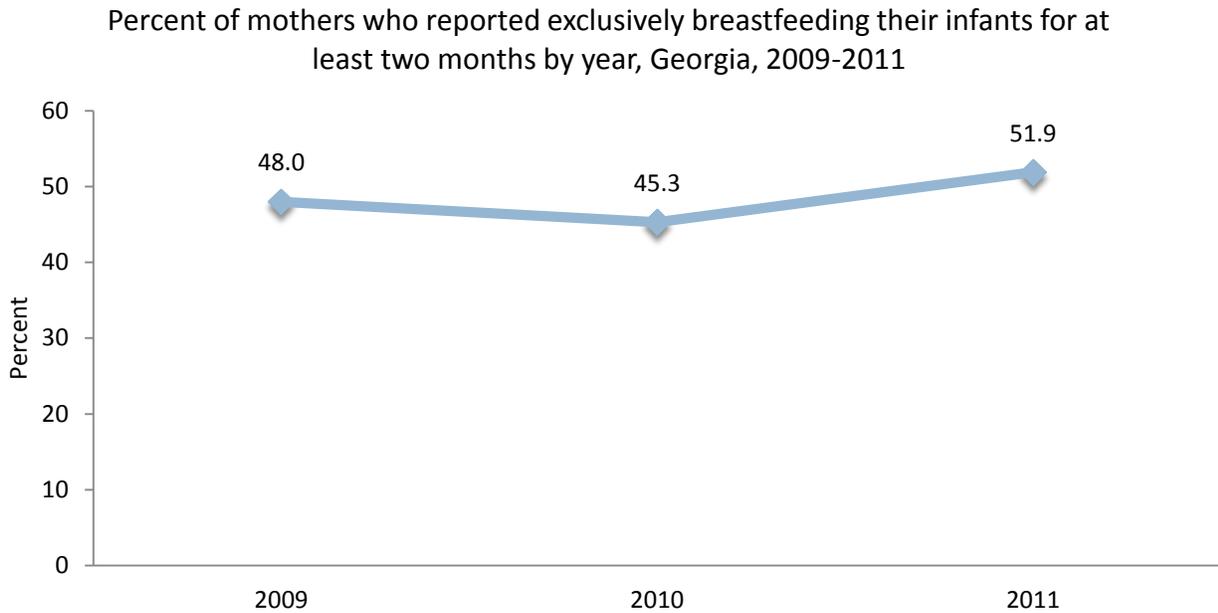
Barriers to breastfeeding initiation, Georgia, 2011	
Barriers	Percent
I didn't want to	46.3
I didn't like breastfeeding	25.6
I went back to work or school	11.7
I had other children to take care of	11.5
I tried but it was too hard	11.2
I was sick or on medicine	9.6
I had too many household duties	7.0

Source: PRAMS

Exclusivity for Two Months

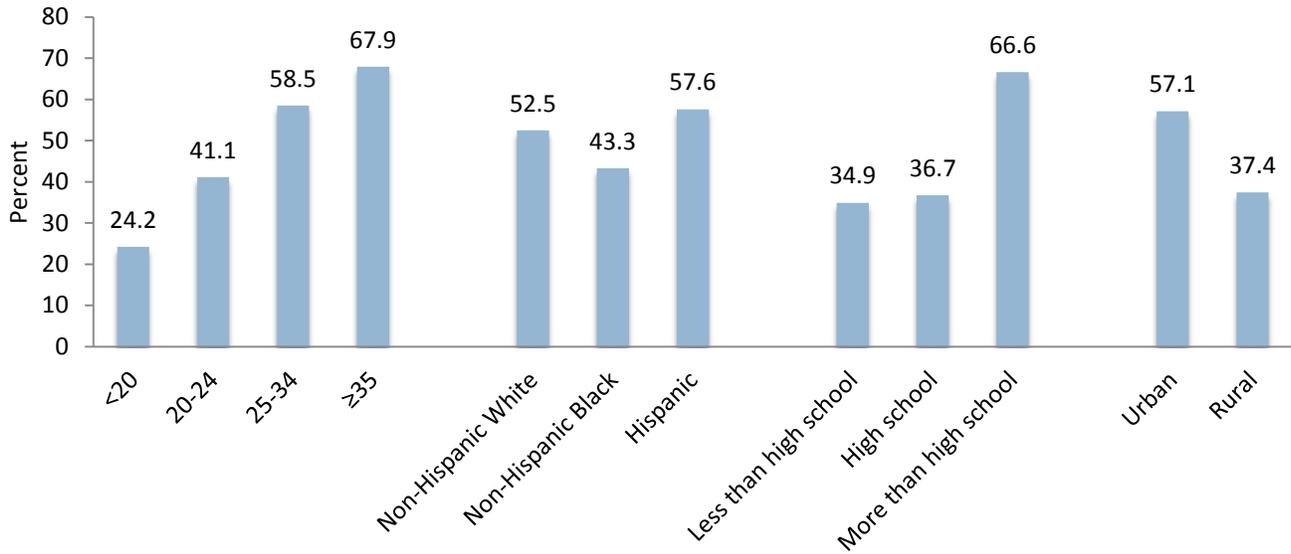
The percentage of mothers who recently had a live birth and reported exclusively breastfeeding their infant for at least two months increased from 48.0% in 2009 to 51.9% in 2011. Among mothers under the age of

20, 24.2% reported exclusive breastfeeding for two months. The percentage was 2.8 times higher among mothers 35 years of age or older. More Hispanic mothers (57.6%) exclusively breastfed their infant for two months than non-Hispanic White (52.5%) and non-Hispanic Black mothers (43.3%). The percentage was approximately 35% among mothers who have a high school diploma or less. However, two-thirds of women with more than a high school education exclusively breastfed their infant for two months. Additionally, exclusive breastfeeding for at least two months was more common in urban areas compared to rural areas (57.1% and 37.4% respectively).



Source: PRAMS

Percent of mothers who reported exclusively breastfeeding their infants for at least two months by maternal age, race/ethnicity, education and urban vs. rural status, Georgia, 2011

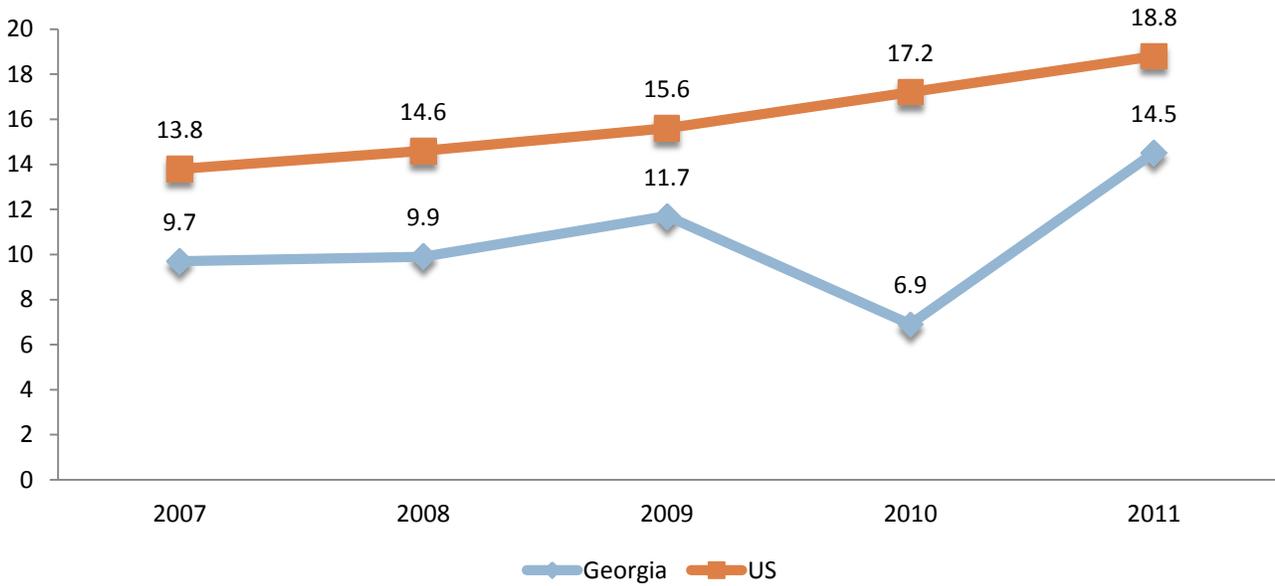


Source: PRAMS

Exclusivity at Six Months

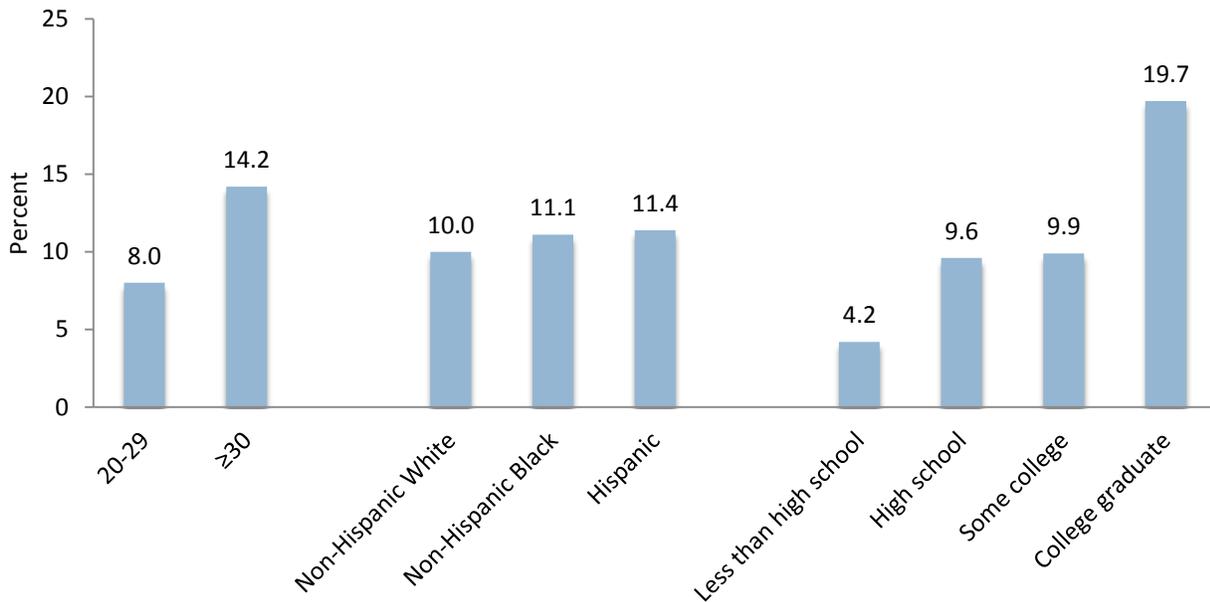
The percentage of infants who were exclusively breastfed at six months in Georgia increased from 9.7% in 2007 to 14.5% in 2011, despite a decrease to 6.9% in 2010. Nationally, the percentage increased from 13.8% in 2007 to 18.8% in 2011. The percentage in Georgia was 1.7 times higher among mothers 30 years of age or higher compared to mothers between the ages of 20 and 29. Little variation was seen by race and ethnicity. Among mothers with some college education or less, the percentage of infants who were exclusively breastfed at six months was less than 10%. However, the percentage was 19.7% among mothers with a college degree.

Percent of infants exclusively breastfed at six months by year, Georgia compared to the US, 2007-2011



Source: NIS

Percent of infants exclusively breastfed at six months by maternal age, race/ethnicity and education, Georgia, 2011



Source: NIS

Breastfeeding Cessation

The top two reasons for breastfeeding cessation reported by mothers were that breast milk alone did not satisfy their baby (37.8%) and that they were not producing enough milk (36.5%). The third and fourth reasons involved the baby having difficulty latching or nursing and the mother having to return to work or school. Fewer than 10% of mothers reported breastfeeding cessation due to feeling it was the right time to stop, illness or having too many other household duties.

Reasons for breastfeeding cessation, Georgia, 2011	
Reasons	Percent
Breast milk alone did not satisfy my baby	37.8
Not producing enough milk	36.5
My baby had difficulty latching or nursing	26.7
I went back to work or school	21.9
It was hard, painful or time consuming	19.9
Nipples were sore, cracked or bleeding	18.3
Baby was not gaining enough weight	15.8
Felt it was the right time to stop	7.7
Got sick	6.3
Too many other household duties	3.9

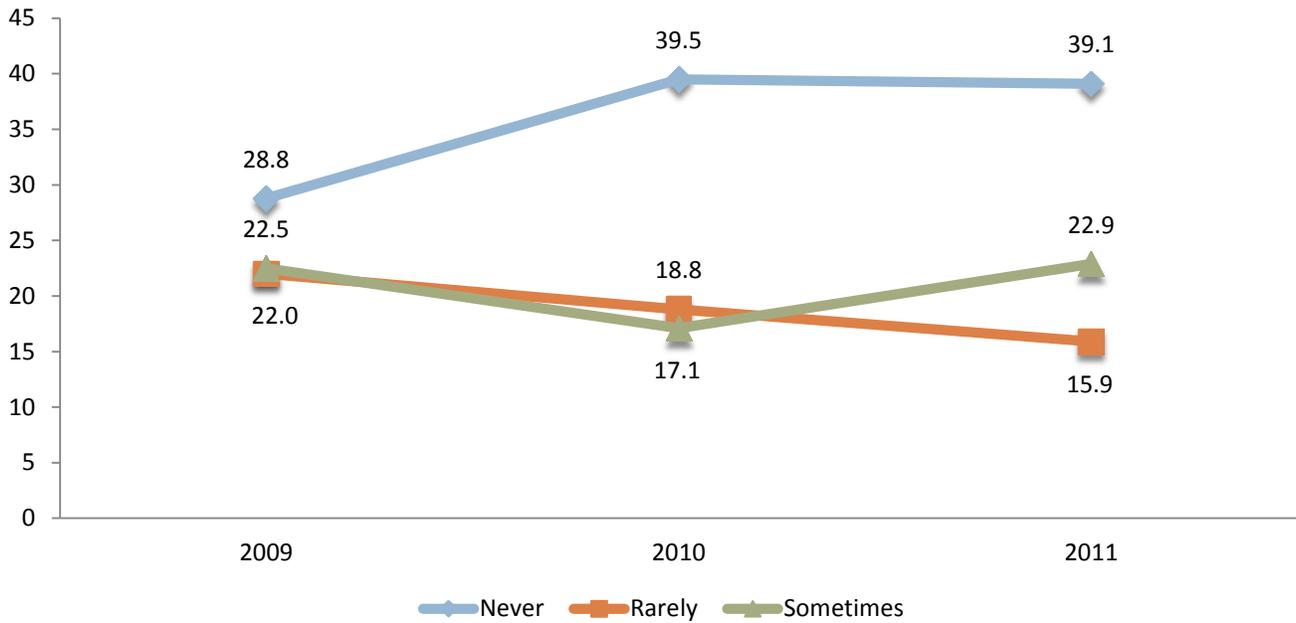
Source: PRAMS

SAFE SLEEP

Bed Sharing

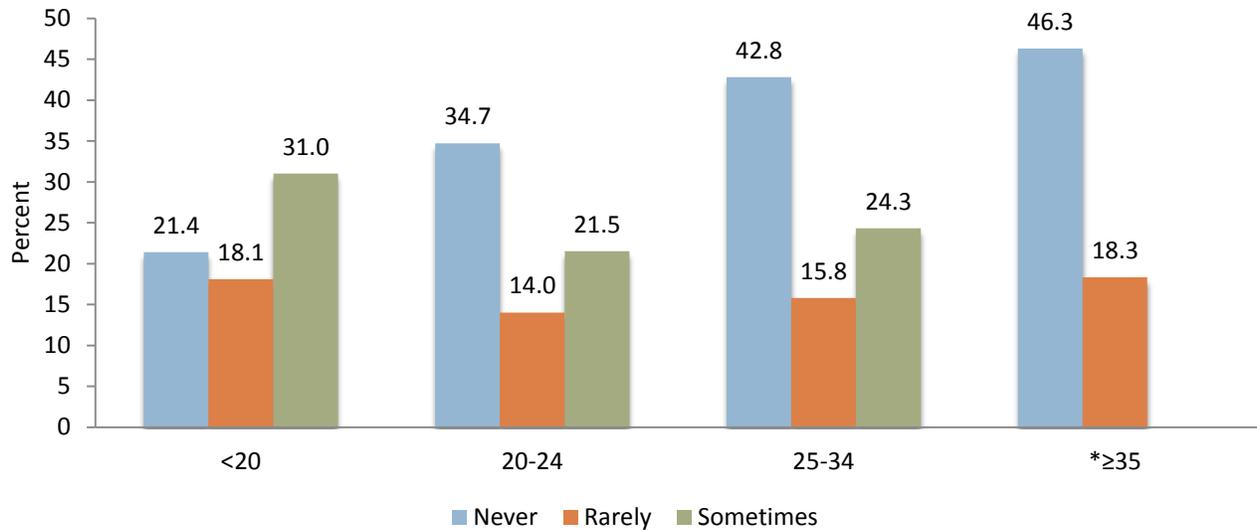
The percentage of mothers who reported their infants never bed share increased from 28.8% in 2009 to 39.1% in 2011. There was no clear trend among those who reported sometimes bed sharing. The percentage of mothers who reported rarely bed sharing decreased from 22.0% in 2009 to 15.9% in 2011. Almost twice as many mothers 25 years of age and older reported never bed sharing than mothers less than 20 years of age. The percentage of mothers who reported rarely bed sharing was fairly consistent across all age groups. The percentage of mothers who reported sometimes bed sharing was highest among younger mothers and lowest among older mothers. Differences were most pronounced by race and ethnicity. Over half of non-Hispanic White mothers reported never bed sharing, compared to only 22.0% of non-Hispanic Black mothers and 32.7% of Hispanic mothers. More mothers who had a high school education reported never bed sharing compared to those with less than a high school education and more than a high school education.

Percent of mothers who reported that their infants never, rarely, or sometimes bed share by year, Georgia, 2009 to 2011



Source: PRAMS

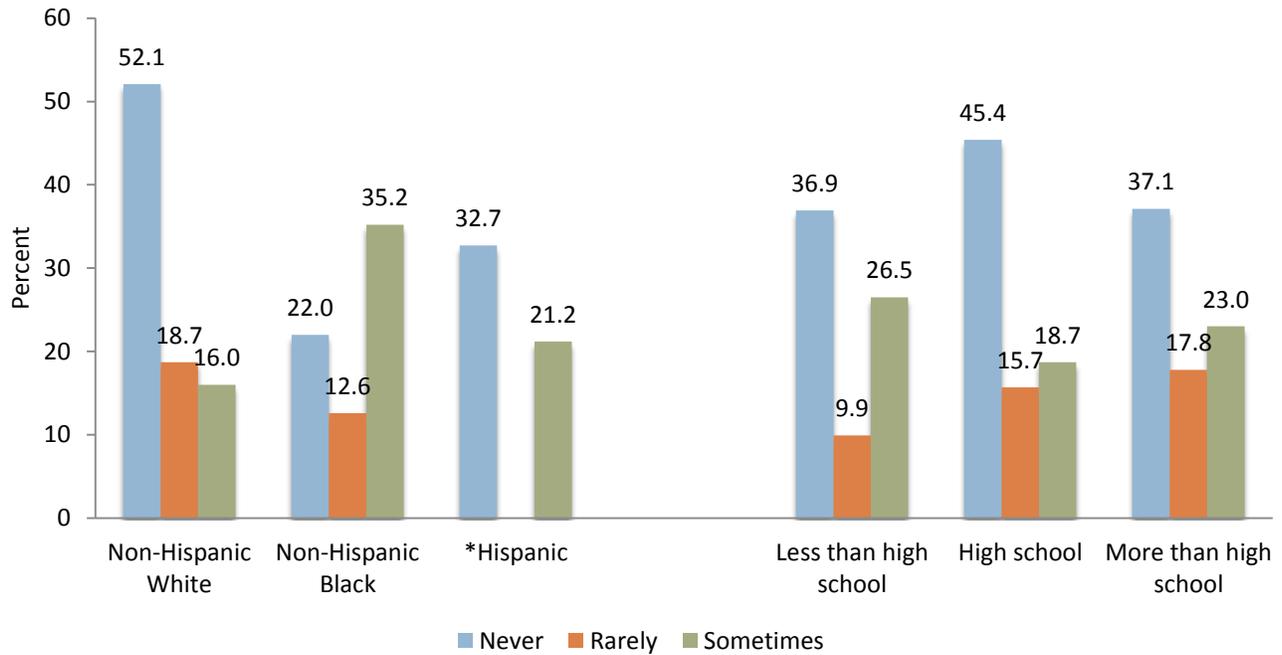
Percent of mothers who reported that their infants never, rarely or sometimes bed share by maternal age, Georgia, 2011



Source: PRAMS

*Indicator for women ≥35 who sometimes bed share is not reportable

Percent of mothers who reported that their infants never, rarely or sometimes bed share by race/ethnicity and education, Georgia, 2009-2011



Source: PRAMS

*Indicator for Hispanics that rarely bed share is not reportable

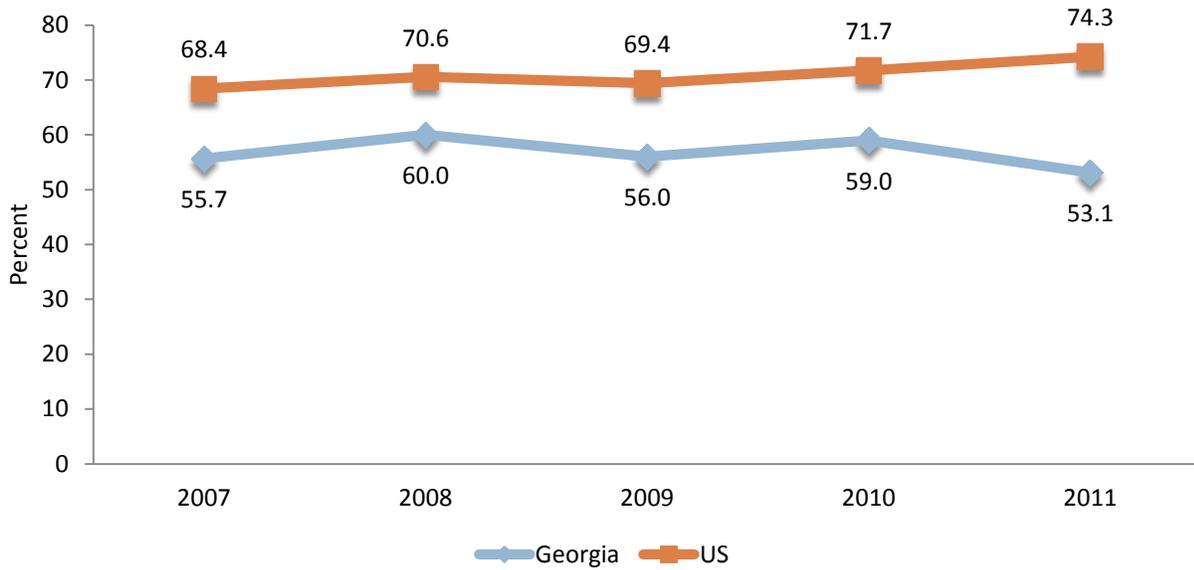
Back to Sleep

Healthy People 2020 Objective

MICH-20: Increase the proportion of infants who are put to sleep on their backs to 75.9%

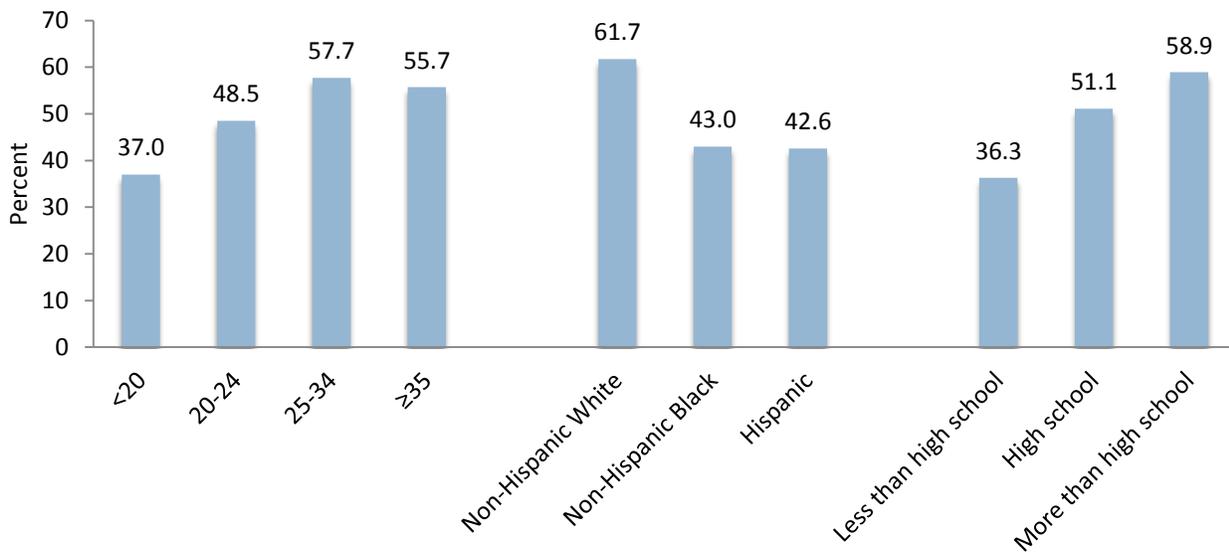
The Healthy People 2020 objective for infants sleeping on their backs is 75.9%. Georgia was more than twenty percentage points behind the Healthy People 2020 objective and the national average at only 53.1% in 2011. The youngest mothers put their infants on their back to sleep (37.0%) less often than mothers over 35 years of age (55.7%). The percentage was 61.7% among non-Hispanic White mothers, but less than half of non-Hispanic Black and Hispanic mothers placed their infant to sleep on their back. As educational attainment increased, the percentage of mothers who reported putting infants to sleep on their backs increased (36.3% of mothers with less than a high school education compared to 58.9% of mothers with more than a high school education). None of these stratified groups met or exceeded the Healthy People 2020 objective.

Percent of mothers who reported their infants are most often put on their backs to sleep by year, Georgia compared to the US, 2007-2011



Source: PRAMS

Percent of mothers who reported their infants are most often put on their backs to sleep by maternal age, race/ethnicity and education, Georgia, 2011

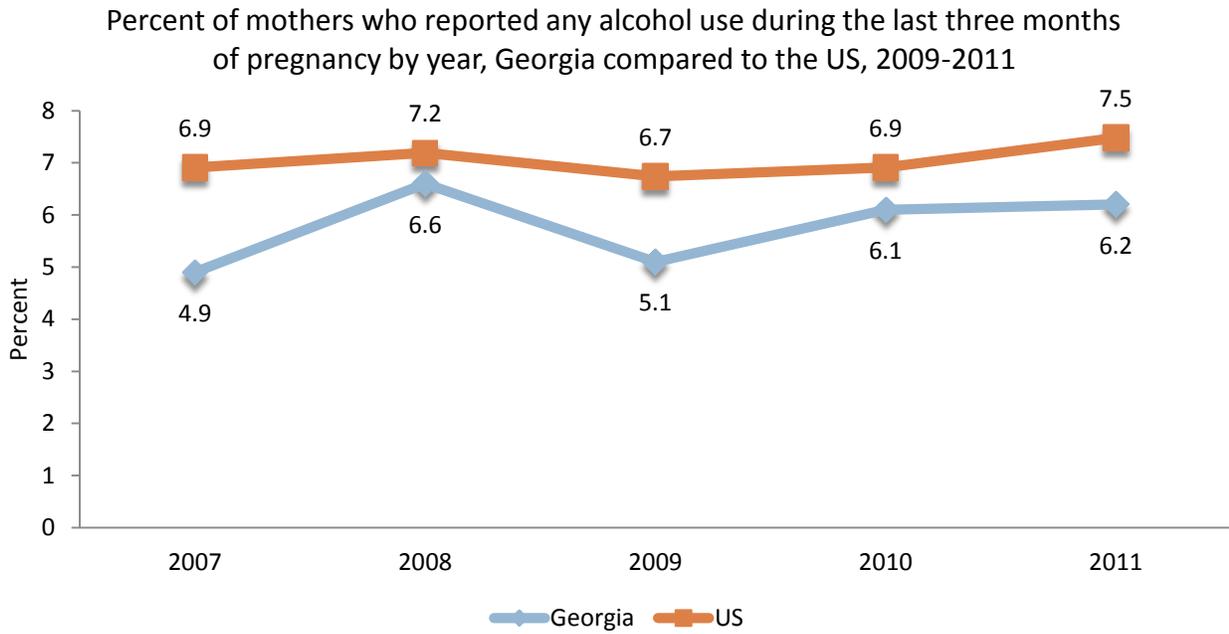


Source: PRAMS

ALCOHOL USE DURING PREGNANCY

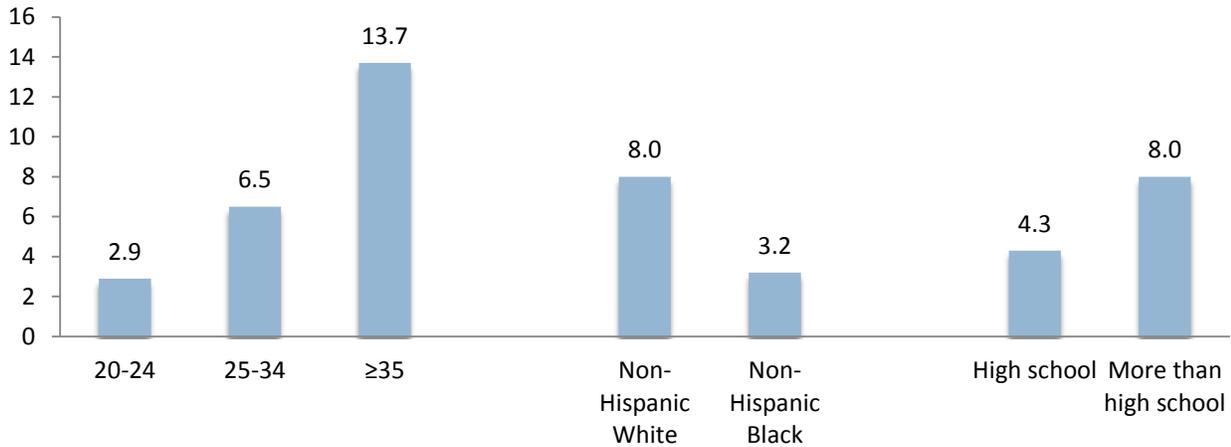
There was an overall increase in the percentage of mothers who recently had a baby reporting alcohol usage during the last three months of pregnancy in Georgia from 2007 to 2011. In 2007, 4.9% of new

mothers reported using alcohol in the last three months of pregnancy, compared to 6.2% of mothers in 2011. Despite the increase, Georgia's estimate was lower than the national average in all years examined. The percentage was higher among mothers 35 years of age or older (13.7%) than in any other age category. Non-Hispanic White mothers reported using alcohol during the last three months of pregnancy 2.5 times more often than non-Hispanic Black women. More mothers with more than a high school diploma (8.0%) reported using alcohol during the last three months of pregnancy than mothers with a high school diploma (4.3%).



Source: PRAMS

Percent of mothers who reported any alcohol use during the last three months of pregnancy by maternal age, race/ethnicity and education, Georgia, 2009-2011

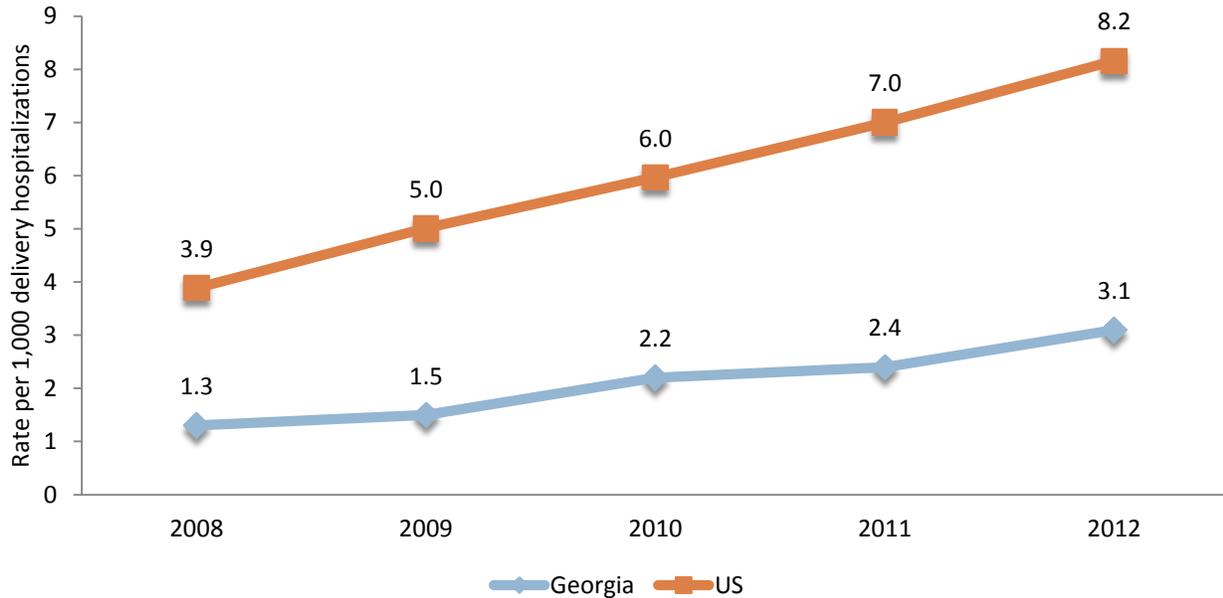


Source: PRAMS

NEONATAL ABSTINENCE SYNDROME

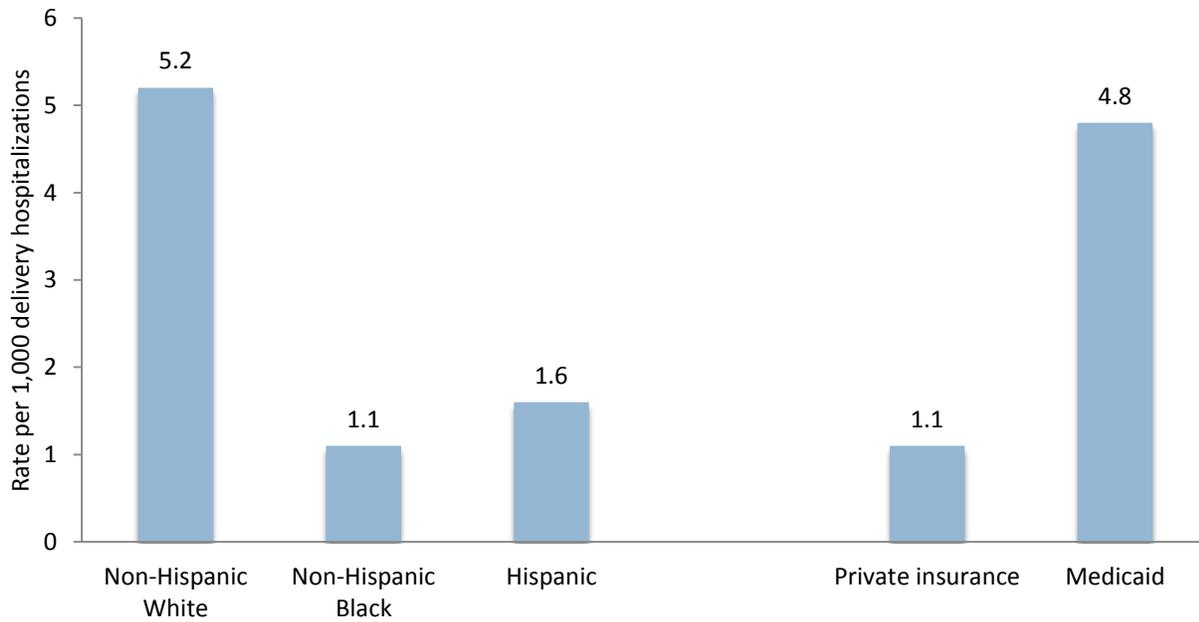
The rate of infants born with neonatal abstinence syndrome increased in Georgia and the US from 2008 to 2012. However, the rate was consistently two to three times higher in the US than Georgia throughout the same time period. In Georgia, the rate of infants born with neonatal abstinence syndrome was 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.

Rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations by year, Georgia compared to the US, 2008-2012



Source: State Inpatient Databases

Rate of infants born with neonatal abstinence syndrome per 1,000 delivery hospitalizations by race/ethnicity and type of insurance, Georgia, 2012

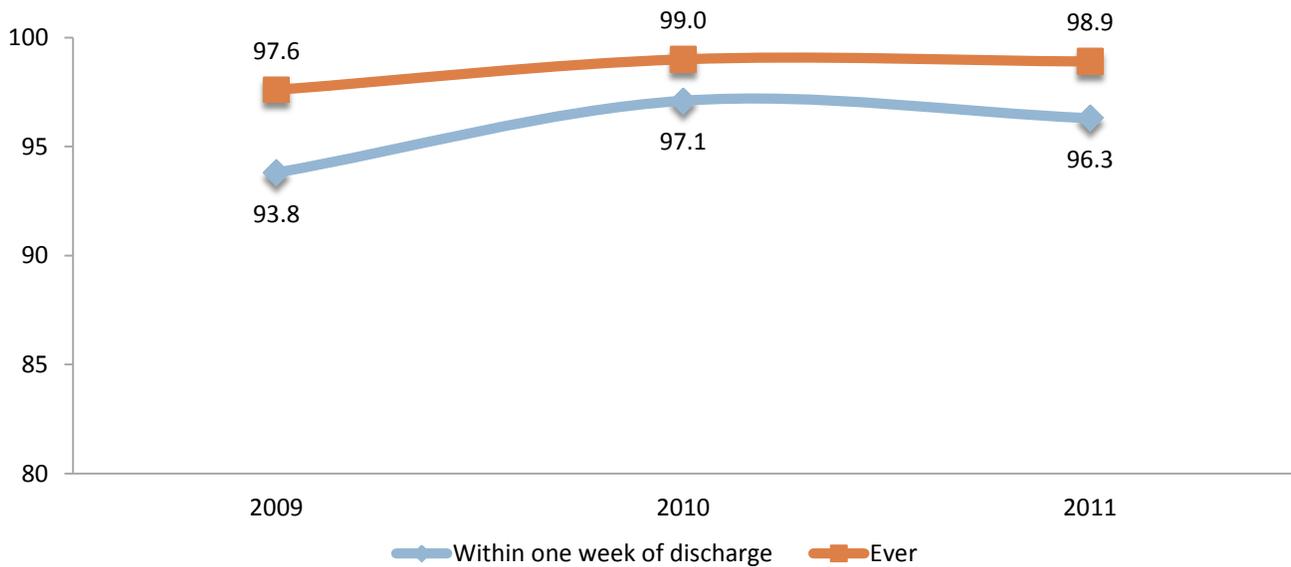


Source: State Inpatient Databases

INFANT CARE

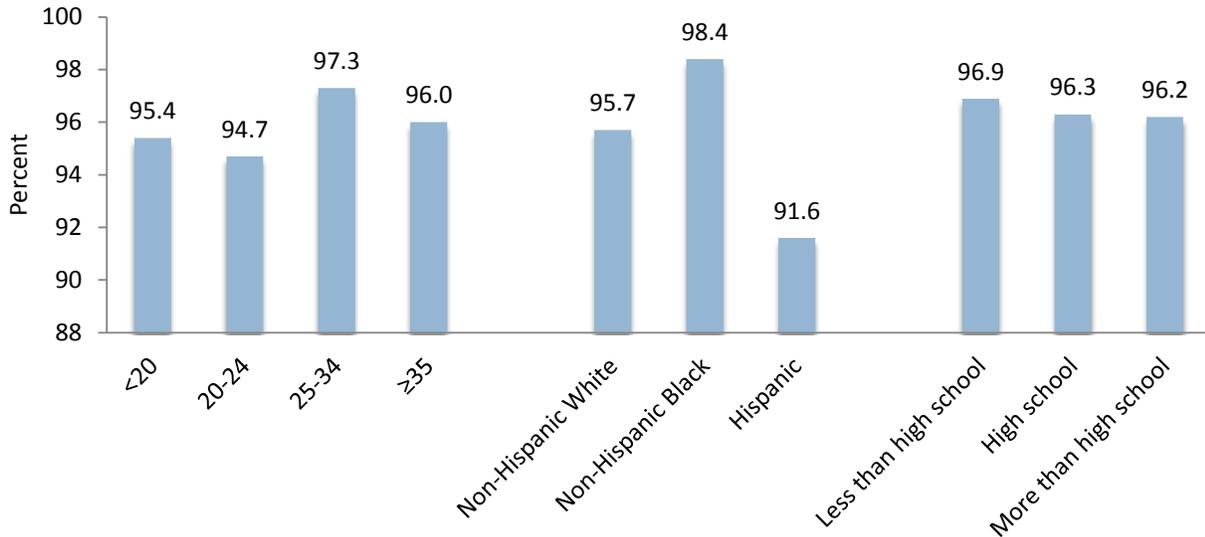
As of 2010, nearly 100% of infants received a well infant examination, with about 96% receiving that check-up within the first week of life. The percentage of infants receiving a well infant examination within one week of discharge was highest among mothers who recently had a baby that were between the ages of 25 and 34 (97.3%). The percentage was lowest among mothers between the ages of 20 to 24 (94.7%). A larger difference was seen by race and ethnicity, with 98.4% of non-Hispanic Black mothers reporting their infant received a well exam within one week of discharge compared to 91.6% of Hispanic mothers. There was little variation by educational attainment.

Percent of mothers who reported that their infant received a well infant exam by year, Georgia, 2009-2011



Source: PRAMS

Percent of mothers who reported that their infant received a well infant exam within one week of discharge by maternal age and race/ethnicity, Georgia, 2011



Source: PRAMS

QUALITATIVE FINDINGS: PERINATAL HEALTH

Four focus groups were conducted among women who recently had given birth or who were pregnant throughout Georgia. The following table presents general demographic information.

Table 3. Perinatal Focus Group Participant Demographics

	Rome N=11 n (%)	Fulton N=7 n (%)	Dublin N=5 n (%)	Albany N=39 n (%)
Age				
20-29	--	--	5 (100%)	37 (95%)
30-39	11 (100%)	7 (100%)	--	2 (5%)
40-49	--	--	--	--
50-59+	--	--	--	--
Highest level of education completed				
Less than High School	--	--	--	6 (16%)
High School/GED	3 (27%)	1 (14%)	3 (60%)	20 (53%)
Some College/Technical /Community College	4 (36%)	5 (71%)	1 (20%)	10 (26%)
College graduate or more	4 (36%)	2 (29%)	1 (20%)	2 (5%)
No response	--	--	--	--
Race/Ethnicity				
Caucasian/White	6 (55%)	--	--	1 (3%)
African-American/Black	4 (36%)	7 (100%)	5 (100%)	37 (95%)
Latino/Hispanic	1 (9%)	--	--	1 (3%)

Asian	--	--	--	--
Other	--	--	--	--
No response	--	--	--	--
Health insurance status				
Private	6 (55%)	--	1 (20%)	1 (3%)
Public (Medicaid/PeachCare/TriCare)	5 (45%)	6 (86%)	5 (100%)	36 (92%)
None	1 (9%)	1 (14%)	--	2 (5%)
No response	--	--	--	--
Number of children currently parenting				
0	1 (9%)	--	--	6 (15%)
1	4 (36%)	--	2 (40%)	12 (31%)
2	4 (36%)	3 (43%)	2 (40%)	11 (28%)
3	--	1 (14%)	1 (20%)	5 (13%)
4	2 (18%)	--	--	2 (5%)
5	--	--	--	1 (3%)
6+	--	2 (29%)	--	0 (0%)
No response	--	--	--	2 (5%)
Pregnant				
Yes	6 (55%)	1 (14%)	1 (20%)	20 (51%)
No	5 (45%)	6 (89%)	4 (80%)	17 (43%)
I don't know	--	--	--	2 (5%)
Receiving WIC				
Yes	8 (73%)	6 (86%)	5 (100%)	35 (90%)
No	5 (27%)	1 (14%)	--	4 (10%)
No response	--	1 (10%)	--	--

The participants were primarily asked about their experiences receiving family planning and pre-pregnancy services, knowledge surrounding birth spacing, pregnancy services and post-pregnancy services. Focus group guides are located in the appendix. The following two tables provide a summary of themes that appeared across all focus groups. The first table lists barriers women faced to having a healthy pregnancy and accessing perinatal services. The second table lists factors that facilitated a healthy pregnancy and any strengths of the perinatal services they received. Following the table summaries is the full report of the focus group findings.

Table 4. Barriers to accessing perinatal services

Individual-Level Barriers	
Themes	Comments
Limited or no preparation for a healthy pregnancy	<p>"I didn't really go anywhere. I wasn't trying [to get pregnant]."</p> <p>"[Pregnancy] just happens sometimes."</p>
Misinformation or misunderstanding regarding birth control	<p>"I received my birth control [from the private doctor] but it didn't work."</p>

Lack of knowledge or misinformation regarding birth spacing recommendation	“I’ve heard that it’s easier to have them close together and I’ve also heard that it’s easier to spread them out. I’ve heard both.”
Economic/lifestyle incentives for birth spacing	“Having a seventeen and a thirteen year old helping me with a three year old and a six month old is awesome. . . . It’s like you have the oldest ones that can babysit and you can actually have a date with your husband again.”
Substance use during pregnancy	“I think depending on if [using marijuana is] hurting yourself or the baby, then it should become a factor.”
Maternal stress/postpartum depression	“Baby blues are the devil. It is horrible. I cry. I get to angry sometimes. For no reason.”
Structural-Level Barriers	
Themes	Comments
Long wait times for appointments	“. . . I have waited about two or three hours even with an appointment.”
Transportation and financial barriers	“I would say transportation is an issue. I don’t always have access to a car and I live out in the country.”

Table 5. Factors that facilitated access to perinatal services

Individual-level Facilitators/Strengths	
Themes	Comments
Lack of judgment at the health department	“To me, they’re more on my level. . . . It’s the health department. Some of them used to come to the same thing when they were younger or my age. . . .They don’t sugarcoat it. They give it to you where you understand [and you don’t] have to go home and google . . .”
Familiarity with private providers	“Because when you go to your typical OB/GYN, they know you, they know your body, they know what you’ve been through as far as if you’ve had a miscarriage or anything like that, whereas the health department might know some of those things, but because of all the other services they provide, they can’t . . . [be] real in touch with what you’ve gone through.”
Breastfeeding education and support	That’s what the [lactation] coach did for me. . . . I couldn’t get her to latch on properly.” “I got breastfeeding stuff through some friends. They were advocates.”

Non-traditional providers	“. . . I took a class with a doula in hopes of having a natural child birth. I ended up having a Cesarean anyway, but I just was able to learn a lot about what goes on in your body during pregnancy and then also just with the birth and knowing about all the different medications and things . . . the interventions and all of that. So just really, a very whole education . . . way more than you get at a doctor. And I feel like you leave there not really knowing what’s going on.”
Structural-Level Facilitators/Strengths	
Themes	Comments
Comprehensive medical coverage	“But I ended up getting switched into [AmeriGroup]. And I ended up not having to pay for a lot. And pretty much, my whole pregnancy, getting medicine, the dentist. . . . All that was paid for.”
Teen friendly health department services	“I was actually sad when they sent me to the adult health department . . . I really miss Teen Matters.”
Support services for new mothers	“[WIC] really was really helpful. . . . I got a breastfeeding class, I talked to the lactation consultant, I got my vouchers, and [my child] even got checked out. I got my anemia checked out. It was a bunch of services that I didn’t come for, but was offered to me, and if it’s offered to me and I think it’s necessary, I’m going to take it.”
Social media	“Facebook is very helpful. All you have to do is put something as your status and you’ll get a lot of response back.”

Family Planning

Limited or no preparation for a healthy pregnancy

Many of the focus group participants indicated their pregnancy was not planned, therefore had no opportunity to work on improving their health and well-being before the pregnancy. As the majority of these pregnancies were unplanned, the women sought no pre-pregnancy services like getting a check-up or taking prenatal pills during the pregnancy. On the other hand, the participants that planned their pregnancy prepared themselves by taking prenatal vitamins, trying to lose weight and exercising before and during their pregnancy. Participants would like more options made available to prepare themselves during the perinatal period. They suggested more knowledge about vitamins and supplements, including which are beneficial to them and the baby and which ones they should not take. A few of the participants were concerned about smoking and using prescription drugs for chronic illnesses (i.e. asthma) while being unaware of being pregnant.

“I didn’t really go anywhere. I wasn’t trying [to get pregnant].”

“Well I don’t think [anybody] tried to get pregnant.”

“[Pregnancy] just happens sometimes.”

“[Pregnancy] was a complete surprise. Completely blind-sighted me.”

Misinformation or misunderstanding regarding birth control

Misinformation and misunderstanding regarding birth control was expressed by many of the focus group participants. Although many used birth control, including pills, intrauterine devices (IUDs), vaginal rings, condoms, implants and tubal ligation and were satisfied with what they have, a few of them found it ineffective because they got pregnant whilst on birth control. Some women expressed deep concerns about the side effects and two women shared their experience using Depo-Provera. Some participants perceived the negative side effects outweighed the benefits of birth control. Others felt they weren’t adequately informed of the risks or side effects by staff at the family planning clinics or by their doctors.

One participant claimed she was told a type of birth control would stop menstrual cycle, but her friend on the same birth control continued having her menstrual cycle throughout the year. Lack of trust based on the effectiveness of birth control was expressed by some of the participants:

“I received my birth control [from the private doctor] but it didn’t work.”

“They’ll tell you it cuts their cycle off. But then somebody else will tell you, ‘Girl I had my period a whole year.’ . . . So they need to be realistic about the side effects.”

“They gave the ring. It didn’t work.”

“They are not 100%.”

“I used the NuvaRing, the Depo shot, the pills. I tried them all. The pills are the only one that worked for me.”

Health Department Services

Teen-friendly health department services

Most of the participants that used the health departments were pleased with their experiences received services for family planning and STD testing. Many of them became aware of the services through family, friends or the WIC/Medicaid program. Before transitioning into the general health department services,

several of the mothers had previously received services from Teen Matters, a public health clinic for teens and spoke positively about their experiences. One mother mentioned she used the health department services as a teenager because she didn't need her parents' permission to receive family planning services.

"I was actually sad when they sent me to the adult health department . . . I really miss Teen Matters."

"I had a private doctor as well before I started going to Teen Matters. But . . . some stuff I don't want [my private doctor] to know. So that's when I end up going to Teen Matters."

"I want to say the health department was the first place that I went to, kind of like by myself. Like for condoms, STD testing. Because I was a teenager."

"You know you don't have to have your parents, no forms to fill out . . . no signature or nothing like that."

Lack of judgment at the health department

Participants also mentioned how comfortable the staff and providers at the health department made them feel, in comparison to some private physicians where they felt judged.

"To me, they're more on my level. . . . It's the health department. Some of them used to come to the same thing when they were younger or my age. . . . They don't sugarcoat it. They give it to you where you understand [and you don't] have to go home and google . . ."

Transportation and financial barriers

Participants expressed frustration about the health department and mentioned some of the barriers faced to accessing services there. The majority felt the waiting time for services was too long and this deterred them from receiving services. When women were not eligible for Medicaid, lack of insurance was a barrier to accessing family planning and pre-pregnancy services; they had to pay cash for services received. One participant without insurance mentioned she found it more convenient and affordable to receive care in a hospital than going to the health department. Participants indicated that transportation and childcare were the toughest barriers faced.

Conversation between a facilitator (F) and a participant (P):

F: "Is there something that prevents, or you think could prevent you, from accessing those services? For example . . . transportation, money, child care?"

P: "Yes I think those things you commented on about transportation and child care. It's harder because of that situation."

All participants from a particular county agreed that their health department wasn't sanitary or safe, so those on Medicaid used private providers. Mothers also spoke about needing a designated space for their other children to play during long wait times, as well as a space to breastfeed their child.

As the health department doesn't accept health insurance, participants went to their private doctors where they are covered by insurance and don't have to pay. Several participants indicated that services are expensive to access at the health department prior to getting pregnant.

Long wait times for appointments

“. . . I have waited about two or three hours even with an appointment.”

Private Provider Services

Familiarity with private providers

The alternative to using the health department was seeing a private doctor. Many participants mainly received services from primary care providers and believed that the health department was primarily for younger mothers. Midwives were also prevalent in one of the counties and participants' experiences with the midwives were positive.

“I went when I was younger 'cause you know it was free and I just wanted to keep my health up, but other than that, I use my private insurance and go to my OB/GYN.”

In some counties, most of the women indicated that they received family planning services mostly from their primary care physician or OB/GYN. Their preference was to visit their physician office and only used the health department as a last resort. For instance one participant said that she'd see a private provider when on Medicaid and use the health department when she wasn't. The participant's perception was that private doctors provided better support than the health department. A participant felt some issues like infertility was better handled by a private doctor.

“Because when you go to your typical OB/GYN, they know you, they know your body, they know what you've been through as far as if you've had a miscarriage or anything like that, whereas the health department might know some of those things, but because of all the other services they provide, they can't . . . [be] real in touch with what you've gone through.”

“The private doctor was better able to handle the testing I needed and the medications I needed to deal with [infertility].”

Non-Traditional Providers

“My doctor who delivered me, [she] is also a midwife. She gave me a lot of information and she also gave me a big notebook full of information on pregnancy, pre-pregnancy, how you can plan to have a baby, how you can- after you have the baby, depression, all types of different stuff that comes with pregnancy. So it’s a lot of stuff. It’s a lot that comes with the baby.”

“. . . I took a class with a doula in hopes of having a natural child birth. I ended up having a Cesarean anyway, but I just was able to learn a lot about what goes on in your body during pregnancy and then also just with the birth and knowing about all the different medications and things . . . the interventions and all of that. So just really, a very whole education . . . way more than you get at a doctor. And I feel like you leave there not really knowing what’s going on.”

“I’m actually in a program at the health department called CenteringPregnancy . . . Every month or every two weeks when you go in and you [are] just in a group with like six other girls [who are] pregnant. . . . And every time we come in we talk about different topics and stuff like that.”

Birth Spacing

Lack of knowledge or misinformation regarding birth spacing recommendation

Overall, knowledge of birth spacing was limited among the participants. Very few women were aware of birth spacing and the recommendation that women should wait for eighteen months after a birth to get pregnant again, particularly as it related to the health of the mother and infant. The women who knew about birth spacing and the recommended 18 month interval heard it from their families or friends. A participant felt that 18 months wasn’t long enough. Most participants heard of birth spacing from older family members, friends or midwives.

Information received about birth spacing was contradictory, some participants were told birth spacing was necessary while other heard that having children close together was best. Their understanding of birth spacing varied among participants and it wasn’t surprising that some participant felt that having babies closer together was better than spreading them apart, nor the revelation that the recommendation for birth spacing was 18 months.

“I’ve heard that it’s easier to have them close together and I’ve also heard that it’s easier to spread them out. I’ve heard both.”

A few other participants mentioned that although they'd heard of birth spacing, they still had children less than 18 months apart. A very small number of participants indicated that that they were counseled on birth control after delivery, while others said they received no counseling or had ever spoken to any medical professionals about birth spacing. Participants request for more information about birth control and like to know what the best is for them. It was encouraging to see participants advocate for each other and provide useful suggestions, and several had already begun planning for their contraception post-delivery.

Economic/lifestyle incentives for birth spacing

Reasons for birth spacing of their children given by participants was mostly due to economic reasons, a matter of convenience, and the time needed to manage raising that child before the next one rather than health. Participants found birth spacing beneficial and easier on the family as the older children could help with taking care for their younger siblings. They did not see birth spacing as a health issue.

“Having a seventeen and a thirteen year old helping me with a three year old and a six month old is awesome. . . . It’s like you have the oldest ones that can babysit and you can actually have a date with your husband again.”

“. . . one lady told me that it’s good to get it [out of] the way.”

Breastfeeding Education and Support

Focus group participants utilized breastfeeding education services and were aware of the benefits of breastfeeding their children, stating breastfeeding is “rewarding” and would “make the baby smart”. The majority of women were made aware of breastfeeding classes through WIC services at their local health department, hospital staff, or through private providers, including midwives in one county. Attendance in breastfeeding classes was mandatory in one county for mothers to receive WIC services. Mothers felt encouraged and supported through traditional (i.e. family, friends, providers) and non-traditional (i.e. social media) networks. While this sentiment of satisfaction with breastfeeding education was expressed across all focus groups, one participant expressed feeling “forced” to breastfeed due to the constant reminders provided by health department staff. Mothers who were not on their first pregnancy noted the importance of breastfeeding education, noting they learned something new each time. A mother of three stated:

“I still learn something new every time—a different latch, a different way to hold.”

Preferences for breastfeeding education and support services varied for focus group participants however, primarily due to privacy concerns. For example, one participant mentioned her desire to work one-on-one with a lactation coach, as opposed to a group setting with other women. Another mother mentioned participating in a baby fair in which mothers were taught how to feed their babies. Participants were aware

of lactation specialists at their local hospitals, as well as at the local health department. One participant spoke of her experience:

Conversation between a facilitator (F) and a participant (P):

P: “. . . they gave me the number to one of the lactation coaches . . . through the health department. . . . if something doesn’t seem right to me I can call and ask for advice.”

F: “And were they helpful?”

P: “Yeah, yeah. Very much so.”

Overall, participants expressed satisfaction with the breastfeeding services they received, as well as the supplemental items (i.e. breast pumps, baby carriers) provided through WIC. Mothers who received breastfeeding instruction from midwives in their county stated these services were more intimate and “hands-on” compared to the didactic instruction provided at the health department. For example, midwives provide dolls during their training to demonstrate how mothers should hold their baby. Mothers were transparent about fears associated with breastfeeding, feeling unprepared prior to enrolling in breastfeeding classes.

“...a lot of us [were] kind of scared when we came in [to the breastfeeding class].”

For participants in the focus group still grappling with breastfeeding, other mothers offered support:

“They give you the doctor reasons, I’m [going to] give you the mom reasons. At night, when she wakes up and you can just roll over . . . you’ll love that. . . . It’s hard for her to choke because it doesn’t just drip out the bottle. It’s already warm. And you can go back to sleep and then when she’s finished, she’ll unlatch.”

Comprehensive Medical Coverage

Mothers were pleased with Medicaid services, noting that “pregnancy Medicaid” is much more seamless to apply for than Medicaid. After a pregnancy confirmation test, mothers were enrolled in Medicaid—typically the same day. AmeriGroup was identified as the most comprehensive insurance coverage for mothers, offering services not typically offered through state or federal programs. Participants noted \$200 coupon books provided by AmeriGroup in order to cover over-the-counter (OTC) medication costs, as well as low copays for care. They also spoke about the eases with which they could access information about eligible providers and OTC medications via telephone or on the web.

“But I ended up getting switched into [AmeriGroup]. And I ended up not having to pay for a lot. And pretty much, my whole pregnancy, getting medicine, the dentist. . . . All that was paid for.”

Substance Use during Pregnancy

Many of the focus group participants were aware of mothers that abused prescription medication during their pregnancies, some even testing positive for drugs at birth. As this was seen as harmful to the mother and child’s health, participants seemed to believe that there should be some consequence for these mothers. The most common solution provided by focus group participants was to have mandatory screening in order for mothers to receive any state or federal assistance. If the mother tests positive, she was at jeopardy of losing WIC, food stamp, SNAP, and Medicaid services. “Scare tactics” were also suggested, such as showing videos of children affected by prescription drug use. While this sentiment was expressed across all focus groups, some felt this consequence was not beneficial for anyone involved.

“I don’t know how you would be able to tell which women are abusing [prescription drugs] without doing drug testing. And I don’t think that drug testing tied to the benefit is the best thing. It doesn’t seem to save any money or help anybody.”

Instead of penalizing these mothers, participants offered solutions, such as informing mothers of alternative methods, or holistic ways to treat their problem. Participants also discussed maternal use of non-prescription medication, specifically marijuana. Without clear science indicating how this drug may or may not harm the baby, some felt this judgment call was unfair and unwarranted. Other participants offered some stories regarding this topic:

“I know a couple of people who had marijuana babies and they [are] smart as a whip.”

“I will say that it does keep down the nausea. It gives you a great appetite. I couldn’t eat my first three months [of pregnancy]. I would sniff a cracker and throw up, so that might have helped. If that’s helping me, and I come to the doctor and you tell me, “We’re going to take your baby because you’re smoking weed.” I’d be like, “You’re smoking crack.” You get what I mean? I think depending on if it’s hurting yourself or the baby, then it should become a factor.”

Support services for new mothers

Infant care classes

Mothers in the focus groups spoke of the stress associated with becoming a new parent, and they need for support services. Some participants were currently enrolled in parenting classes at local pregnancy centers—with frequency ranging from weekly to monthly. The make-up of these groups varied from

expectant mothers only, to mothers and fathers, to mothers and members of her support system (i.e. parent). Participants shared their experiences about parenting classes offered at local pregnancy centers:

“ . . . at [my clinic], they have classes for the dad and for the mom. . . . They show videos. You get a little bit of homework but not really much. And it’s telling you things you do like playing music with the baby and stuff like that. And then even after you have your baby you can still go there.”

Mothers noted health department staff as being friendly and also highlighted support received during postpartum care, stating how that depression factored into a mother’s milk production. When asked what they considered to be the most important service received during their pregnancy, the overwhelming majority of mothers identified WIC services. Other services included pregnancy stress counseling, Lamaze, breastfeeding, perinatal specialty care, chiropractor services and doula services.

“It’s easier to just go to WIC and say, ‘Hey look, put me on the wait list.’ And the wait list was like two hours. I waited those two hours and I ended up taking the pump home. . . . It works really well.”

“[WIC] really was really helpful. . . . I got a breastfeeding class, I talked to the lactation consultant, I got my vouchers, and [my child] even got checked out. I got my anemia checked out. It was a bunch of services that I didn’t come for, but was offered to me, and if it’s offered to me and I think it’s necessary, I’m going to take it.”

Focus group participants offered a variety of recommendations for new and expectant mothers, including: weight loss and nutrition services, assistance for challenges with milk formation, education about safety issues (i.e. SIDS, shaken baby syndrome), day care options and mentoring services from more experienced mothers. Many spoke of the assumption that oftentimes parents know what they are doing with a new baby, and how important it is to assist them with basic information, such as changing a diaper. Mothers also suggested offering a tour of the hospital in which the new mother would be delivering her child – lessened the stress of having to find this location on the actual delivery date.

Social media

While satisfied with these services, focus group participants expressed a desire to have some less traditional services, including nutritional counseling, aquatic exercise, and massages. Social media was also identified as a support resource for mothers grappling with newfound motherhood.

“I [asked] people [on Facebook], “How did you deal with the baby blues or postpartum or whatever?” And people will give me ways to relax myself. I even found a group where it was women like me with multiple children and a newborn baby who had baby blues. Baby blues are the devil. It is horrible. I cry. I get to angry sometimes. For no reason.”

“Facebook is very helpful. All you have to do is put something as your status and you’ll get a lot of response back.”

“When I came home, I couldn’t get my milk to flow at first. She was on formula. I don’t know what happened, she just got really hungry. I was like, ‘Oh my goodness, I’m going to need some more milk.’ ‘Does the WIC take walk-ins?’ I put that on my status at like 6:39 Monday and they [said], “Yeah, but you gotta be there really early. Like get up and go now.” It was like ping, ping, ping, ping. You’d be surprised who’s up on Facebook at 6:30 in the morning. It’s like checking the news.”

Maternal stress/postpartum depression

Mothers agreed that fathers should be offered support services to prepare for pregnancies as well. Additionally, older focus group participants expressed the need for classes to be age-appropriate, stating challenges experienced by 18-year old mothers may be very different from 29-year old mothers.

“. . . sometimes in life you get a little discouraged and sometimes you need the help of the parenting classes, you know. So I think more parenting classes would be good.”

“The parents need an outlet, you know. . . . Being a parent in general is stressful.”

Finally, mothers recommended postpartum depression screening and counseling, feeling this condition is often overlooked as part of follow-up care.

“It’s just what I’ve seen. You’re [at the health department] for hours with your baby- and you see some of these moms, they’re just in another world. So maybe someone to talk to.”

STRENGTHS AND NEEDS

Improving the health of infants and mothers during the perinatal period is an important focus of public health in Georgia. The assessment points to areas of perinatal health where Georgia has seen improvements in the health status of infants and mothers, but also areas where Georgia may want to focus

its efforts in the upcoming years. Data from the focus groups showed that many mothers were pleased with their experiences receiving breastfeeding services. Many women are finding support through community services, including non-traditional providers such as midwives and peers on social media.

The quantitative analysis overall revealed a need to improve birth outcomes in the state, as well as increase the appropriate healthy behaviors:

- Reduce neonatal abstinence syndrome and substance abuse during pregnancy
- Improve community norms surrounding safe sleep behaviors
- Increase breastfeeding initiation and exclusivity
- Reduce adverse birth outcomes, including low birth weight deliveries, preterm births and infant mortality, particularly among non-Hispanic Blacks
- Improve the perinatal regionalization system in Georgia

Improving perinatal health is essential to ensuring the health of future generations. The assessment provided clarity on setting priorities for perinatal health.

DRAFT

QUANTITATIVE ANALYSIS: CHILD HEALTH

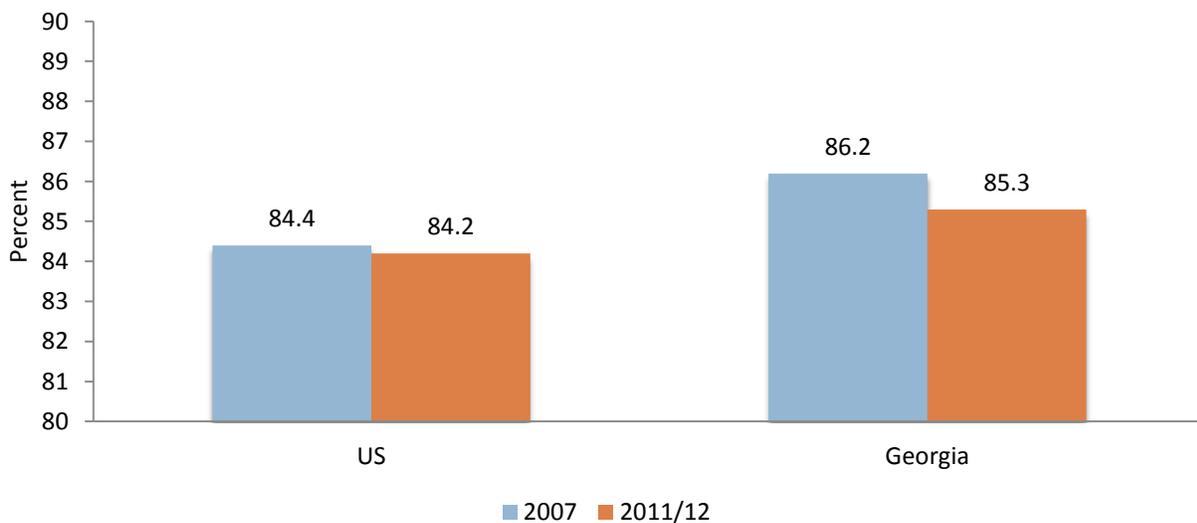
Improving the health and well-being of children is an essential priority across the nation. This section will explore the overall health status and other important indicators of children’s health in Georgia, with a focus on children ages 1 through 17. Since childhood is seen as a relatively healthy time, this section will focus on overall health status, leading causes of death and social determinants of health. Evaluating social determinants of health for children can serve as predictors for health over the life course.

OVERALL HEALTH STATUS

Nearly 85% of parents surveyed in Georgia reported their child’s overall health to be either very good or excellent in 2011/12. The percentage was slightly higher among Georgia’s children compared to the national average (84.2%). There was a slight decline in the percentage of parents reporting their child was in very good or excellent physical health from 2007 to 2011/12, both nationally and in Georgia.

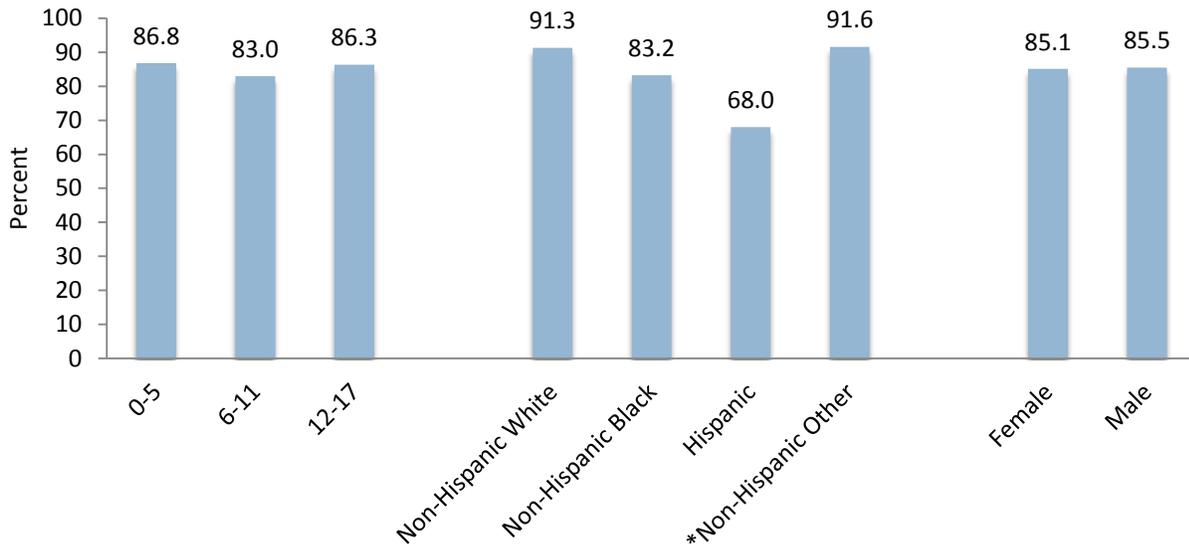
In Georgia, over 86% of parents to children ages 0 to 5 and 12 to 17 reported that their child was in excellent or very good health. For children aged 6 to 11, 83.0% of parents reported this. Fewer Hispanic parents (68.0%) than non-Hispanic White (91.3%) and non-Hispanic Black (83.2%) parents reported their child was in excellent or very good health. There was virtually no variation in health status related to gender.

Percent of children 0-17 in very good or excellent physical health by year, Georgia compared to the US, 2007 and 2011/12



Source: NSCH

Percent of children 0-17 in very good or excellent physical health by age, race/ethnicity and gender, Georgia, 2011/12



Source: NSCH

*Non-Hispanic Other includes Asian, American Indian, Hawaiian, Alaskan Native, Mixed Race and Other

MORTALITY

Motor vehicle crashes were the leading cause of death among children 1 to 19 in Georgia between 2009 and 2013. Congenital malformations, deformations and chromosomal abnormalities were the second leading cause of death among children aged 1 to 4. Suicide was the second leading cause of death among children aged 10 to 14, and the third leading cause of death among children aged 15 to 19. Homicide was the second leading cause of death in the oldest age group.

Leading causes of death among children 0-19, Georgia, 2009-2013

Rank	1-4 years	5-9 years	10-14 years	15-19 years
1	Motor Vehicle Crashes (n=101)	Motor Vehicle Crashes (n=108)	Motor Vehicle Crashes (n=100)	Motor Vehicle Crashes (n=443)
2	Congenital Malformations, Deformations and Chromosomal Abnormalities (n=81)	All Other Diseases of the Nervous System (n=40)	Intentional Self-Harm (Suicide) (n=47)	Assault (Homicide) (n=289)
3	Assault (Homicide) (n=81)	Accidental Drowning and Submersion (n=37)	All Other Diseases of the Nervous System (n=46)	Intentional Self-Harm (Suicide) (n=224)
4	Accidental Drowning and Submersion (n=74)	Malignant Neoplasms of Meninges, Brain and Other Parts of Central Nervous System	Assault (Homicide) (n=46)	Accidental Poisoning and Exposure to Noxious Substances (n=82)

Georgia Five Year Needs Assessment

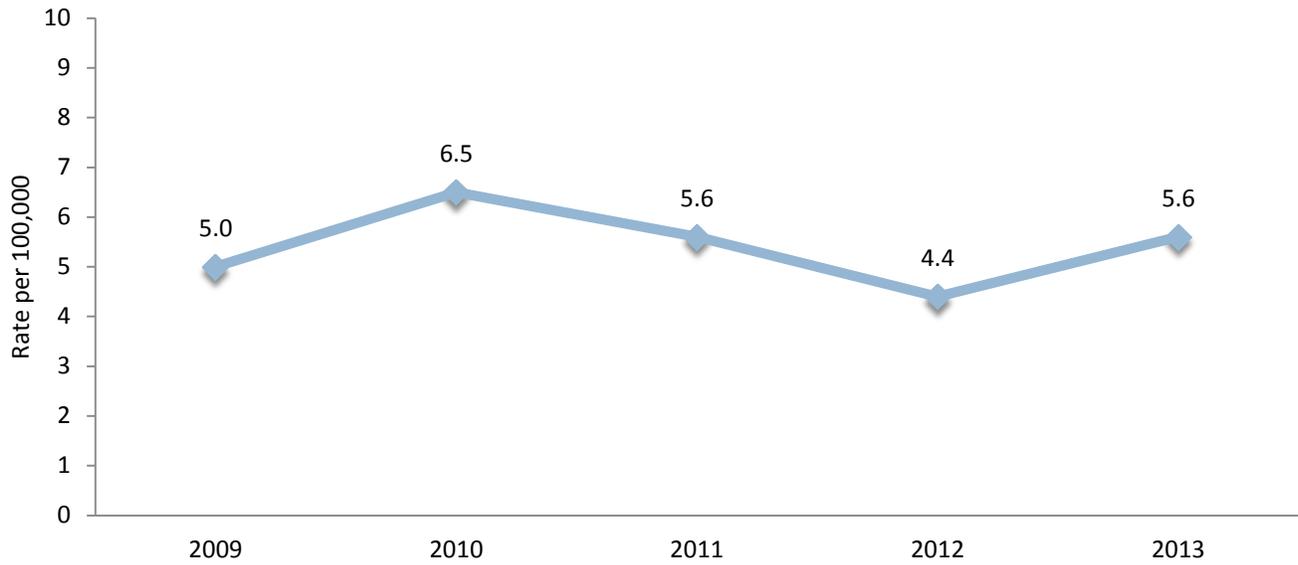
		(n=29)		
5	All Other Diseases of the Nervous System (n=45)	Congenital Malformations, Deformations and Chromosomal Abnormalities (n=24)	Leukemia (n=24)	All Other Diseases of the Nervous System (n=58)
6	Accidental Exposure to Smoke, Fire and Flames (n=38)	Assault (Homicide) (n=24)	Congenital Malformations, Deformations and Chromosomal Abnormalities (n=22)	Accidental Drowning and Submersion (n=42)
7	All Other Unintentional Injury (n=32)	Accidental Exposure to Smoke, Fire and Flames (n=20)	Accidental Drowning and Submersion (n=22)	All Other Unintentional Injury (n=39)
8	All Other Endocrine, Nutritional and Metabolic Diseases (n=28)	All Other Endocrine, Nutritional and Metabolic Diseases (n=17)	Asthma (n=18)	Congenital Malformations, Deformations and Chromosomal Abnormalities (n=36)
9	Suffocation (n=26)	All Other Unintentional Injury (n=13)	Malignant Neoplasms of Meninges, Brain and Other Parts of Central Nervous System (n=17)	Leukemia (n=23)
10	Malignant Neoplasms of Meninges, Brain and Other Parts of Central Nervous System (n=18)	Asthma (n=11)	All Other Endocrine, Nutritional and Metabolic Diseases (n=15)	All Other Endocrine, Nutritional and Metabolic Diseases (n=21)

Source: OASIS

Motor Vehicle Crashes

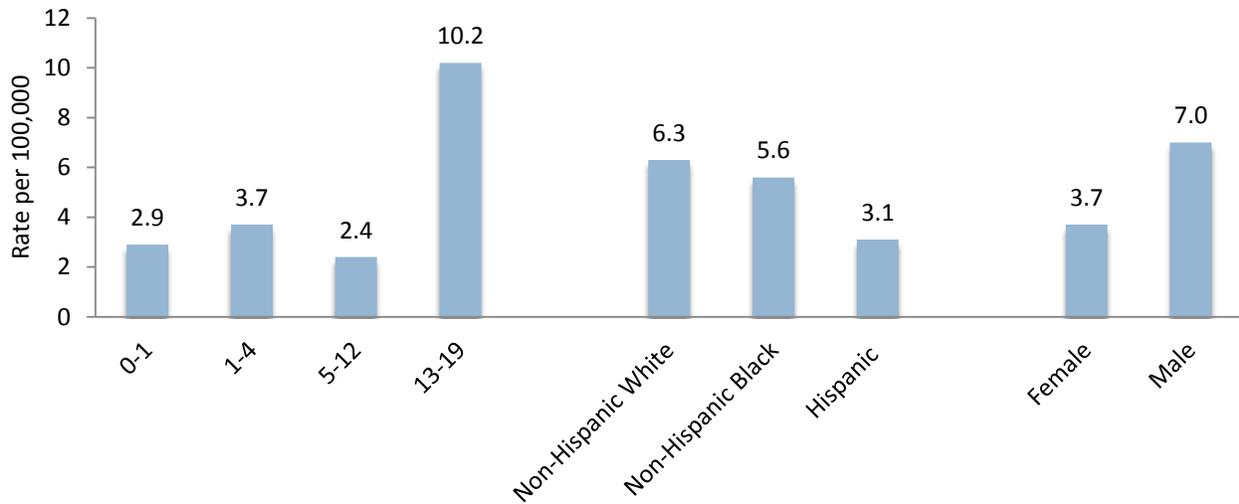
The rate of death due to motor vehicle crashes per 100,000 children aged 0 to 19 varied from a low of 4.4 in 2012 to a high of 6.5 in 2010, with no clear trend during the years examined. From 2009 to 2013, the rate remained under 5 for all children aged 1 to 12 years of age. However, the rate was 10.2 among children aged 13 to 19. The rate of death was twice as high among non-Hispanic Whites (6.3) relative to Hispanics (3.1). The rate was 5.6 among non-Hispanic Blacks. During the same years, the motor vehicle crash death rate was also nearly twice as high among males as females.

Death rate per 100,000 children ages 0 to 19 due to motor vehicle crashes by year, Georgia, 2009-2013



Source: OASIS

Death rate per 100,000 children ages 0 to 19 due to motor vehicle crashes by age, race/ethnicity and gender, Georgia, 2009-2013



Source: OASIS

EMERGENCY ROOM VISITS

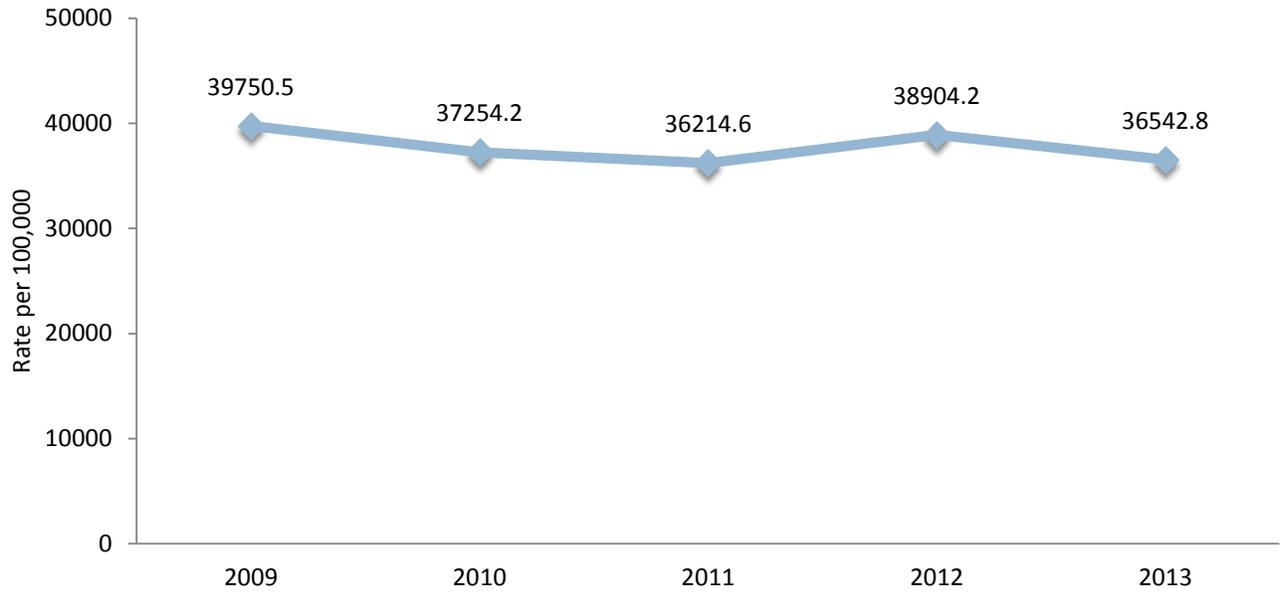
The number one cause of emergency room (ER) visits among children 0 to 19 years of age in 2013 was injury, with the second leading cause being falls in most age categories. Asthma was the third leading cause of ER visit among children 0 to 9 years of age. From 2009 to 2013, there was a decrease in the rate of

emergency room visits among children. Overall, there has been a decrease of ER discharges from 2009 to 2013. In 2013, the rate was highest among children 0 to 4 years of age, and lowest among those 10 to 14 years of age. The rate was 1.6 times higher among Blacks compared to Whites, and slightly higher among females compared to males.

Leading causes of emergency room visits among children 0-19, Georgia, 2009-2013				
Rank	0 to 4 Years	5 to 9 years	10 to 14 Years	15 to 19 Years
1	Injury (n=167,523)	Injury (n=148,583)	Injury (n=182,560)	Injury (n=177,257)
2	Falls (n=129,327)	Falls (n=88,416)	Falls (n=81,619)	Genitourinary System (n=105,131)
3	Asthma (n=49,333)	Asthma (n=46,808)	Musculoskeletal System and Connective Tissue (n=33,929)	Pregnancy Related (n=73,312)
4	Pneumonia (n=47,576)	Genitourinary System (n=23,301)	Asthma (n=28,261)	Motor Vehicle Crashes (n=58,422)
5	Genitourinary (n=28,637)	Musculoskeletal System and Connective Tissue (n=18,743)	Motor Vehicle Accident (n=22,047)	Musculoskeletal System and Connective Tissue (n=55,606)
6	Influenza (n=25,327)	Influenza (n=18,184)	Genitourinary System Diseases (n=20,557)	Falls (n=51,501)
7	Conditions from Perinatal Period (n=20,906)	Motor Vehicle Crashes (n=15,747)	Mental and Behavioral Disorders (n=18,184)	Mental and Behavioral Disorders (n=41,392)
8	COPD excluding Asthma (n=19,395)	Pneumonia (n=14,066)	Diseases of the Nervous System (n=10,293)	Diseases of the Nervous System (n=21,268)
9	Musculoskeletal System and Connective Tissue (n=15,454)	COPD excluding Asthma (n=9,016)	Influenza (n=10,003)	Homicide (Assault) (n=20,511)
10	Poisoning and Exposure to Noxious Substances (n=13,700)	Diseases of the Nervous System (n=6,344)	Homicide (Assault) (n=7,476)	Asthma (n=17,908)

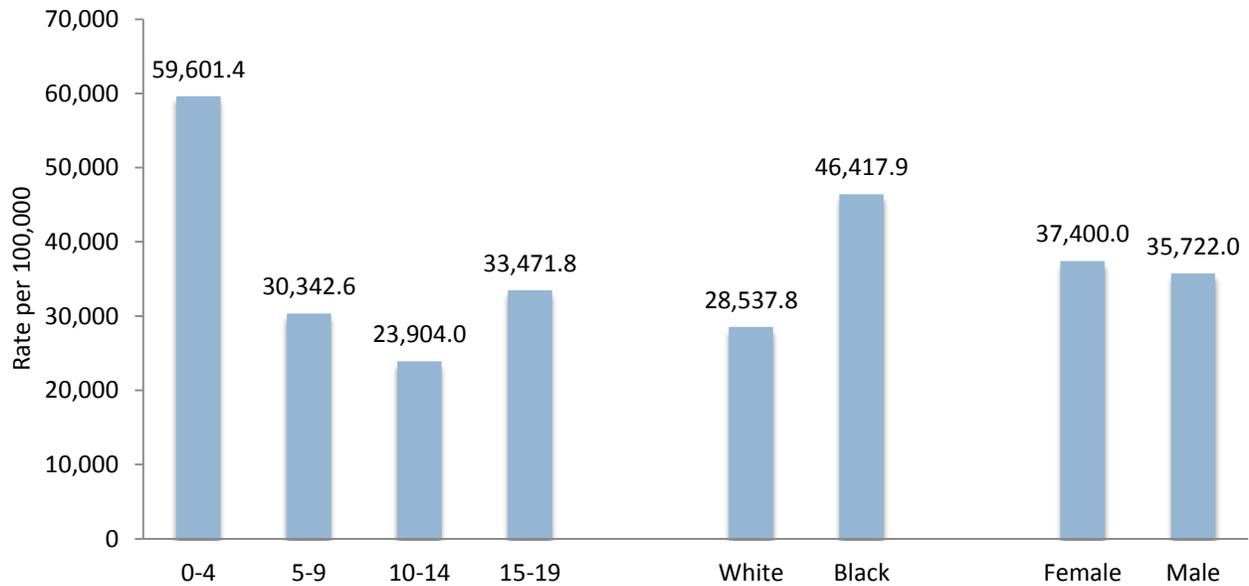
Source: OASIS

Rate of emergency room visits among children 0-19 by year, Georgia, 2009-2013



Source: OASIS

Rate of emergency room visits among children 0-19 by age, race/ethnicity and gender, Georgia, 2013

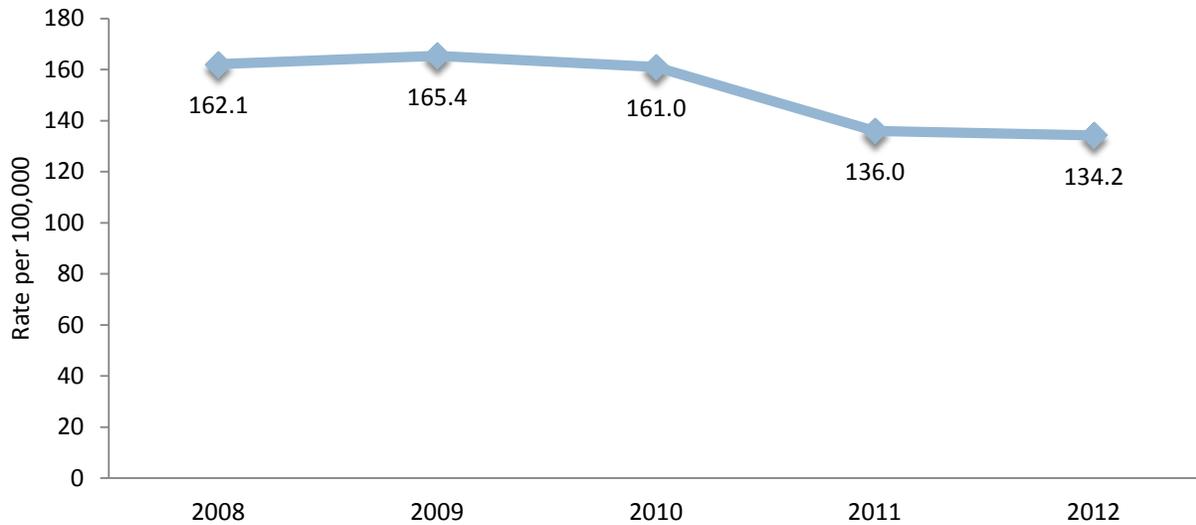


Source: OASIS

NON-FATAL INJURY

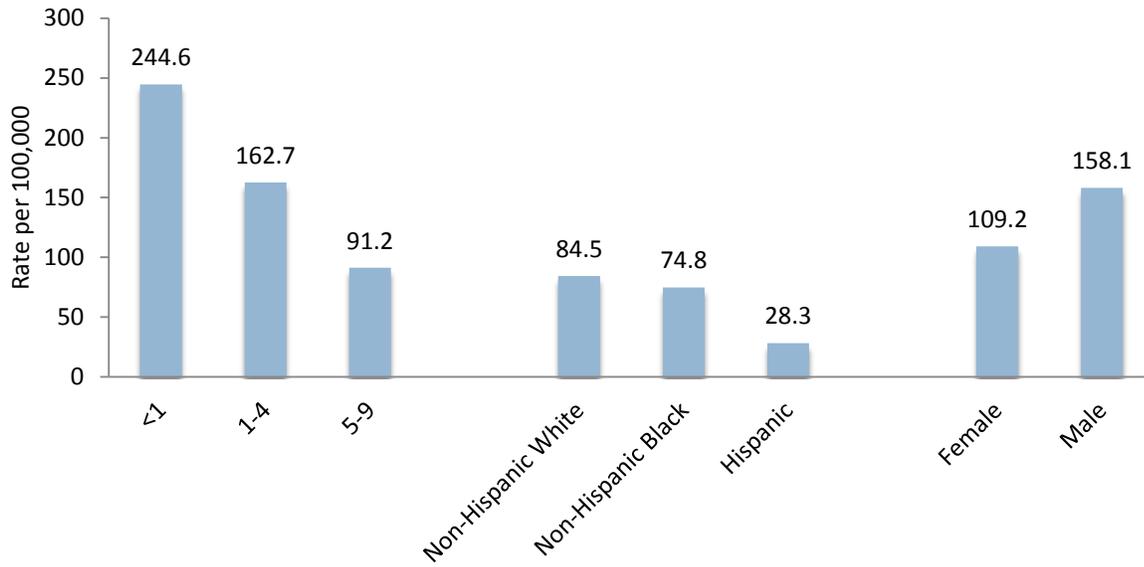
The rate of hospitalizations due to non-fatal injury among children in Georgia was 162.1 in 2008. In 2012, the rate decreased to 134.2. The rate in 2012 was highest among children under 1 year of age (244.6). It was 162.7 among children 1 to 4 years of age and 91.2 among children 5 to 9 years of age. 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.

Rate of hospitalization for non-fatal injury per 100,000 children ages 0-9 by year, Georgia, 2008-2012



Source: State Inpatient Databases

Rate of hospitalization for non-fatal injury per 100,000 children ages 0-9 by age, race/ethnicity and gender, Georgia, 2012

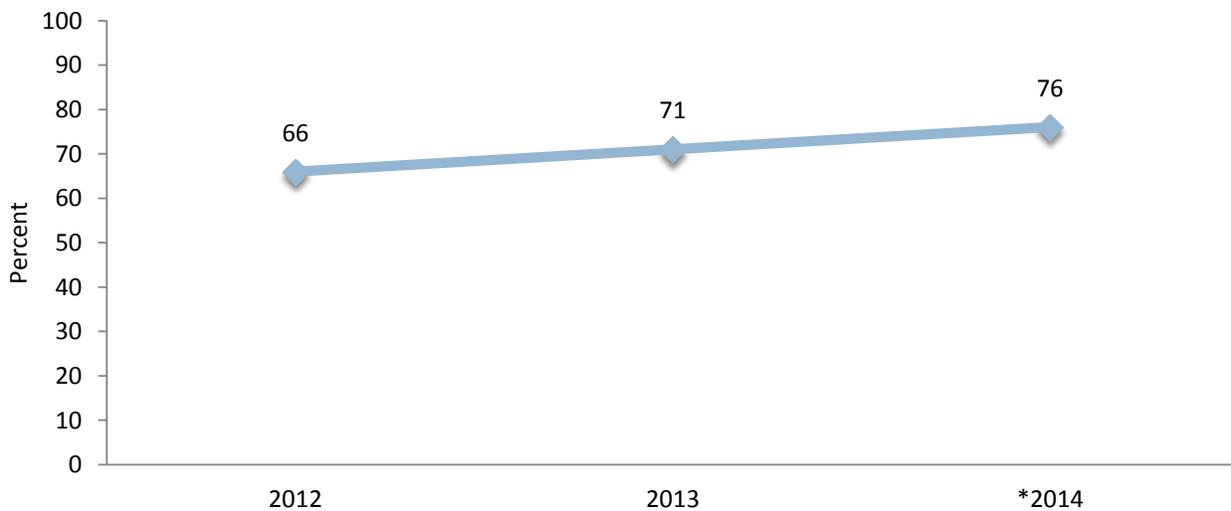


Source: State Inpatient Databases

HEARING SCREENING

The percentage of infants who were diagnosed for hearing loss by 90 days increased from 66.0% in 2012 to 76.0% in 2014. In 2012, the percentage lost to follow-up was 44.0%. In 2013, the percentage decreased to 32.0%.

Percent of infants diagnosed for hearing loss by 90 days, Georgia, 2012-2014



Source: Hearing Screening Program

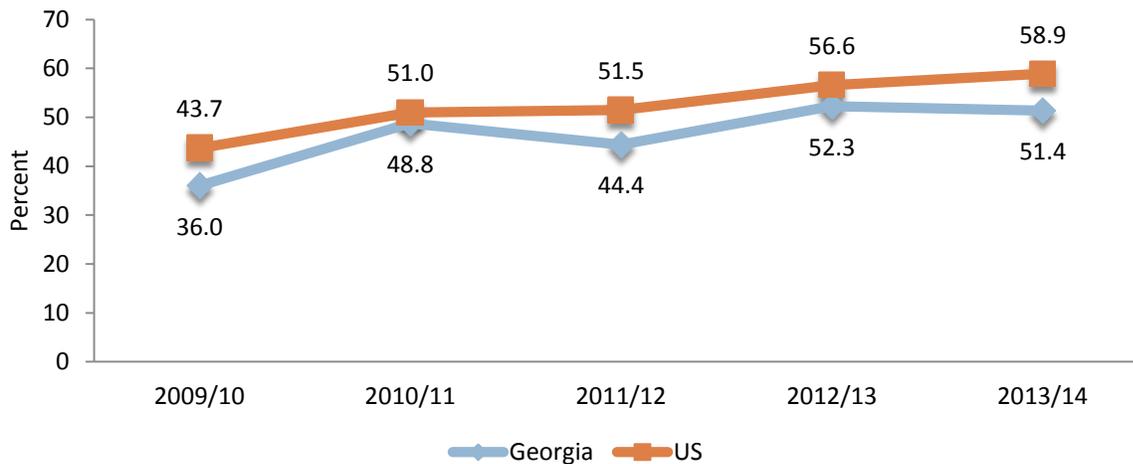
*Preliminary data

VACCINATIONS

Influenza Vaccine

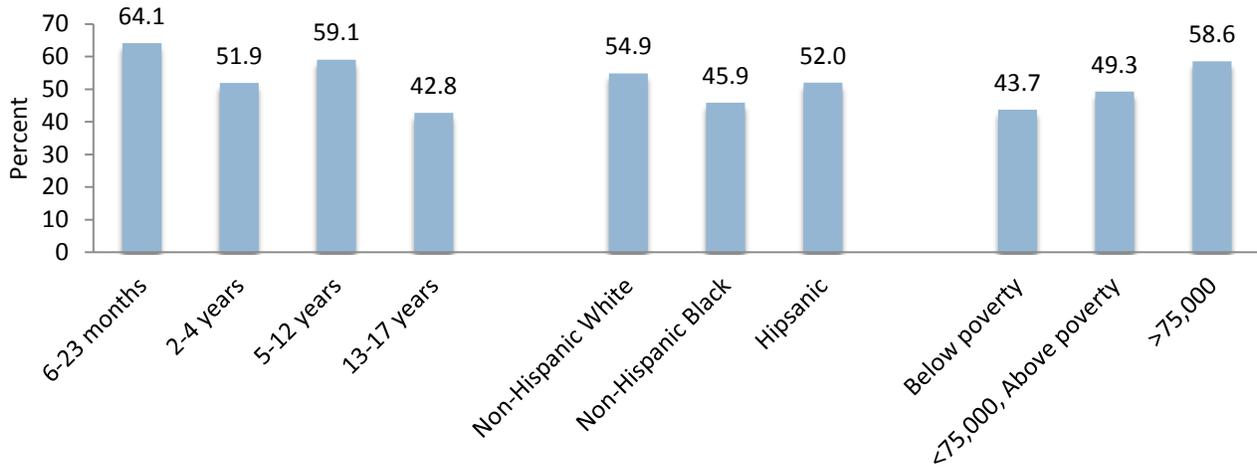
The percentage of children receiving the seasonal influenza vaccine increased both nationally and in Georgia from 2009/10 to 2013/14. In 2013/14, the percentage was higher among children in the US as a whole (58.9%) than Georgia's children (51.4%). Among children 6 to 23 months, 64.1% were vaccinated against the seasonal influenza. The percentage was lowest among those 13 to 17 years of age, with only 42.8% receiving the vaccine. Some variation existed by race/ethnicity. Less than half of non-Hispanic Black children received a vaccine against seasonal influenza, while 54.9% of non-Hispanic White and 52.0% of Hispanic children did. As household income increased, so did the percentage of children who received the vaccine.

Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza, Georgia compared to the US, 2009/10-2013/14



Source: NIS

Percent of children 6 months to 17 years who are vaccinated annually against seasonal influenza by age, race/ethnicity and household income, Georgia, 2013/14



Source: NIS

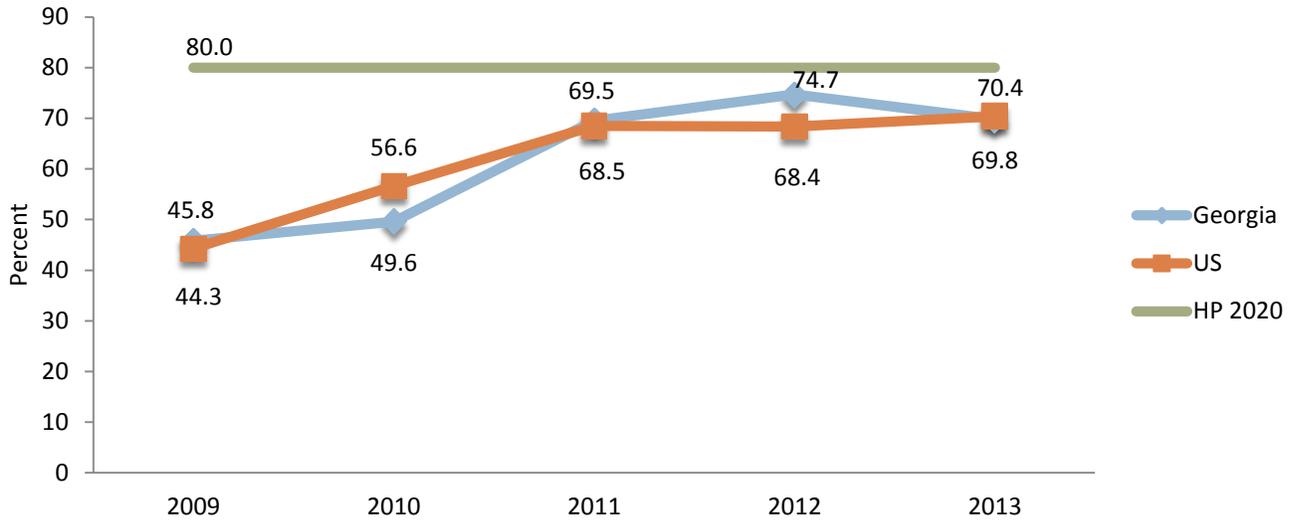
4:3:1:3(4):3:1:4 Series

Healthy People 2020 Objective

IID-8: Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polia, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine to 80%

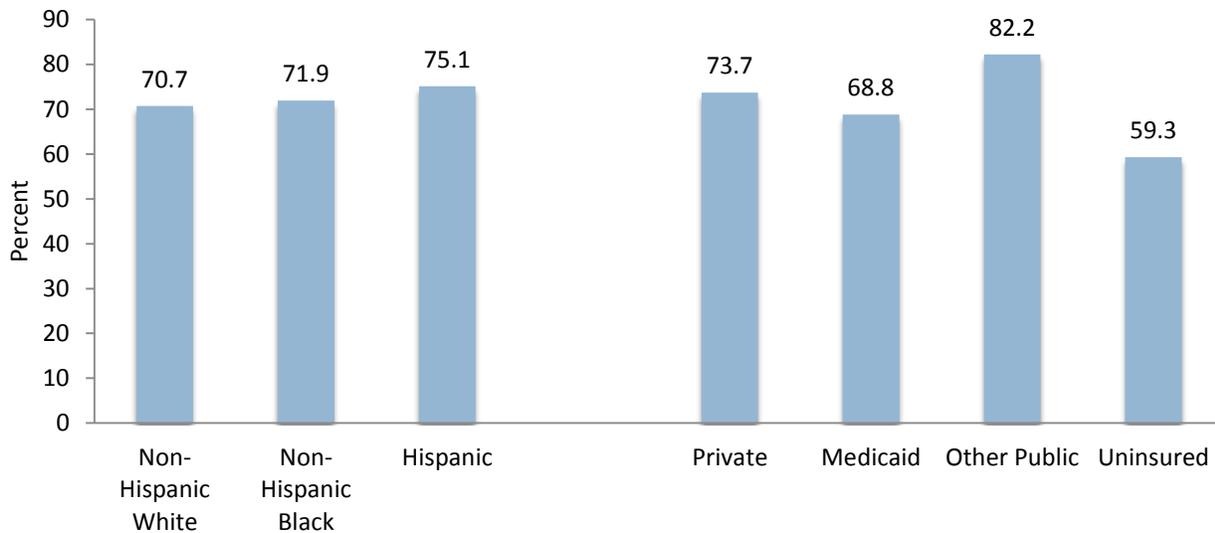
The percentage of children 19 to 35 months up to date on recommended vaccines in Georgia during 2013 was 69.8%. Although the percentage increased from 45.8% in 2009, the highest percentage of children vaccinated in Georgia was during 2012, with 74.7% of children being up to date with their vaccinations. As of 2013, Georgia had not yet met the Healthy People 2020 objective for the percentage of children vaccinated with the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV. The percentage was lowest among non-Hispanic Whites (70.7%) and highest among Hispanics (75.1%). Less than 60% of uninsured children had received the recommended vaccines, while 82.2% of children on public insurance other than Medicaid received them.

Percent of children ages 19 through 35 months who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations by year, Georgia compared to the US, 2009-2013



Source: NIS

Percent of children ages 19 through 35 months who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations by race/ethnicity and insurance status, Georgia, 2013



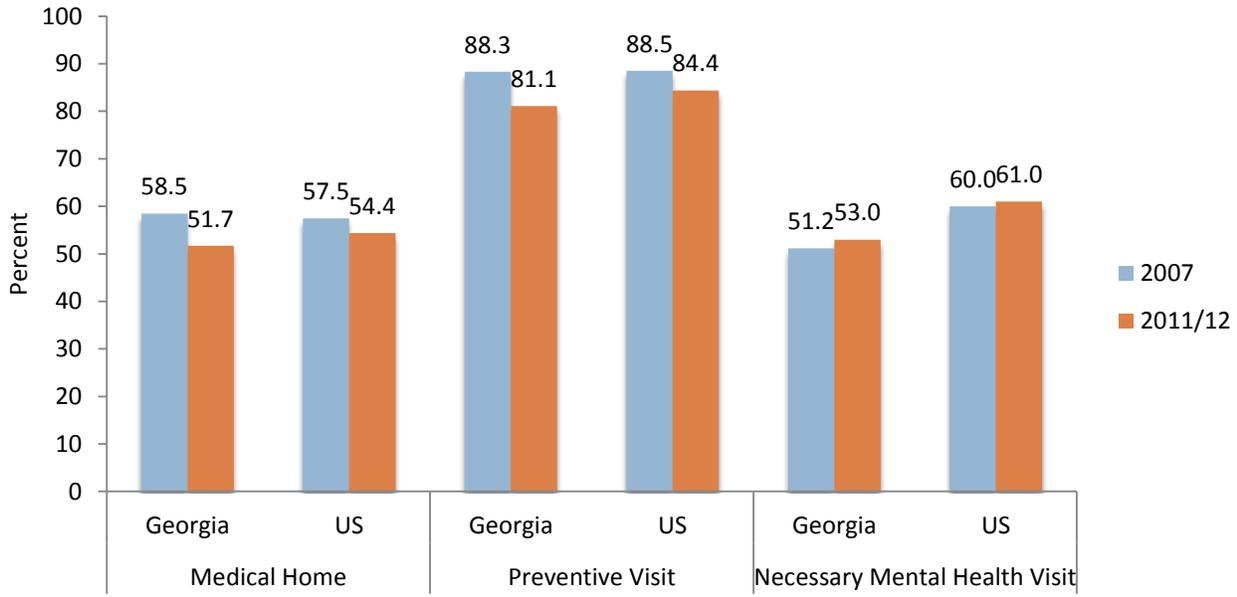
Source: NIS

MEDICAL CARE UTILIZATION

The percentage of children birth to 17 years who had a medical home or attended preventive health visits declined from 2007 to 2011/12 in Georgia. In 2007, 58.5% of children had a medical home while only 51.7%

did in 2011/12. Similarly, 88.3% of children had a preventive health visit in 2007 while only 81.1% did in 2011/12. The percentage of children who had a medical home or preventive health visit declined nationally, as well. However, the percentage of children who received a necessary mental health visit increased from approximately 50% to approximately 60% both nationally and in Georgia from 2007 to 2011/12.

Percent of children 0-17 who access medical care, Georgia compared to the US, 2007 and 2011/12

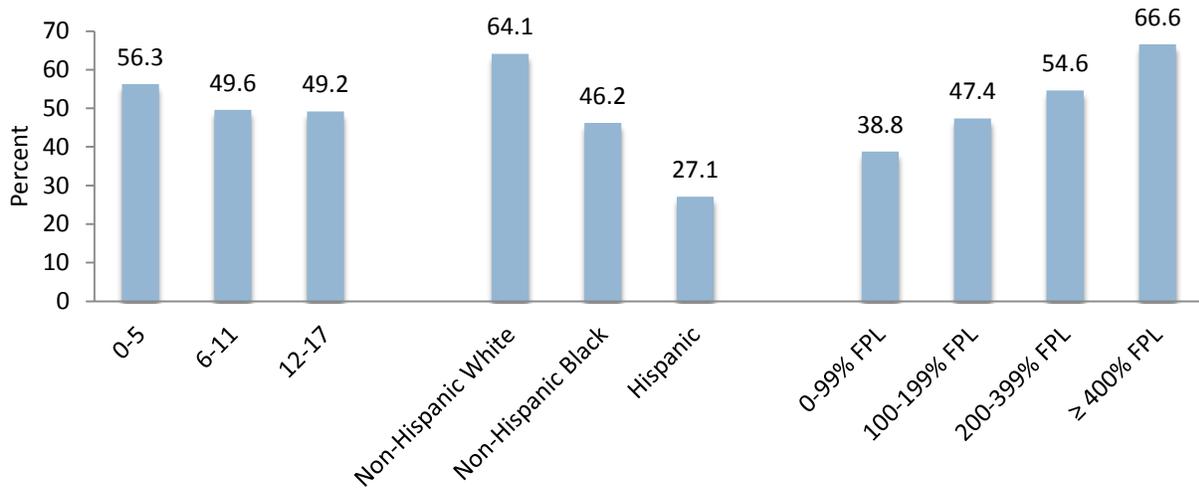


Source: NSCH

More children from birth to age 5 (56.3%) received care within a medical home in 2011/12 than children 6 to 17 years of age, in which the percentage was approximately 50%. Differences existed by race/ethnicity. Nearly 65% of non-Hispanic White children received care within a medical home, while only 46.2% of non-Hispanic Blacks and 27.1% of Hispanics did. The percentage was higher among children living in households with higher income levels. Of all categories examined, the only groups achieving the Healthy People 2020 objective of 63.3% were non-Hispanic Whites and children in households greater than or equal to 400% of the Federal Poverty Level (FPL).

Healthy People 2020 Objective
MICH-30.1: Increase the proportion of children who have access to a medical home to 63.3%

Percent of children 0-17 who receive care within a medical home by age, race/ethnicity and household income, Georgia, 2011/12

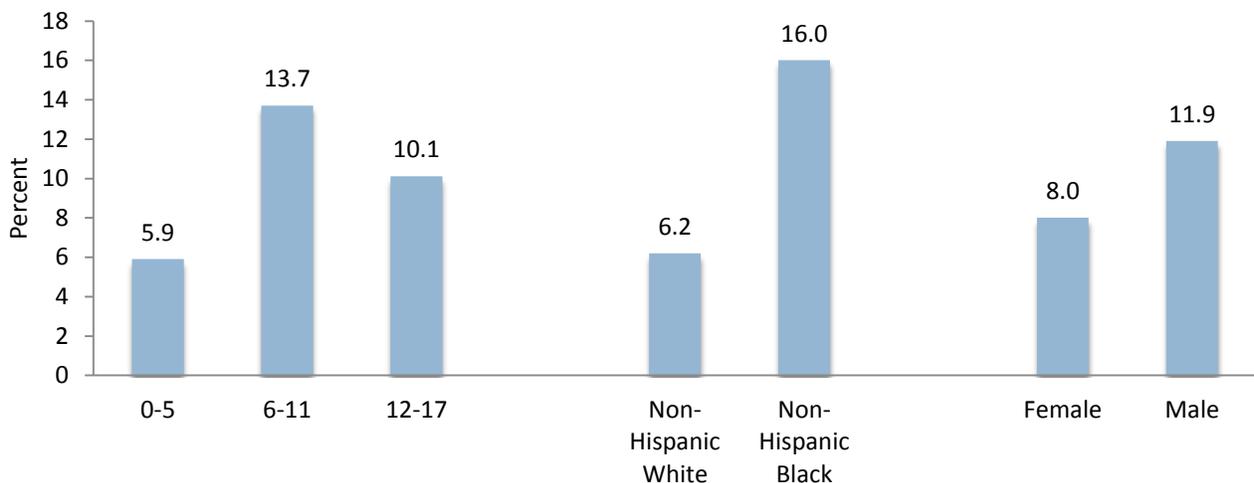


Source: NSCH

ASTHMA

Asthma was most prevalent among children 6 to 11 years of age, with over 13% of parents reporting their child had asthma. Only 5.9% of parents with children 0 to 5 years of age reported their child had asthma. Non-Hispanic Black children were reported to have asthma 60% more often than their non-Hispanic White peers in 2011/12. The percentage was higher among males (11.9%) than females (8.0%).

Percent of children 0-17 who currently have asthma by race/ethnicity and gender, 2011/12



Source: NSCH

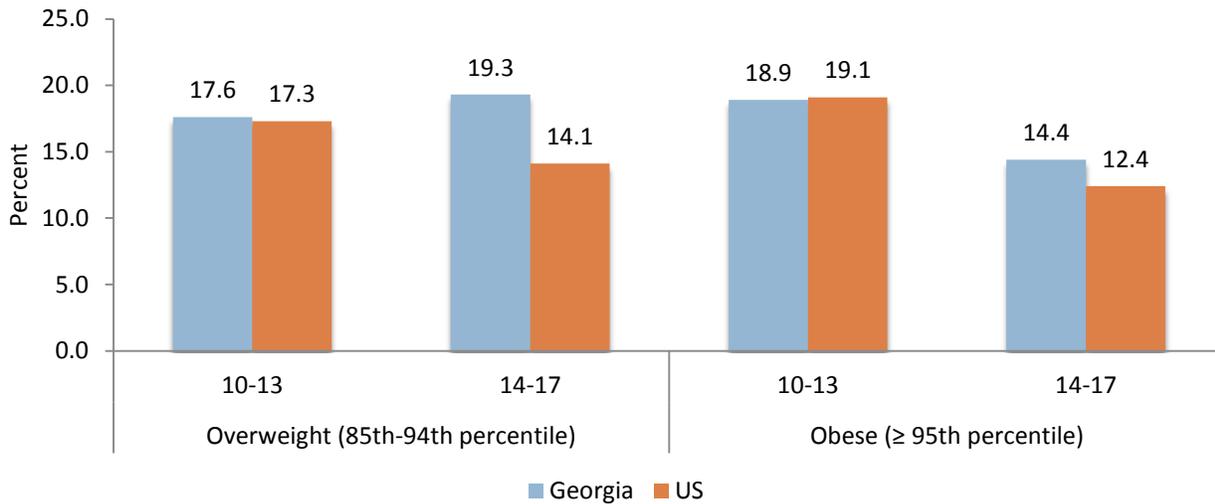
*Estimate for children 0-5 is based on a numerator less than 50 and should be interpreted with caution

WEIGHT STATUS

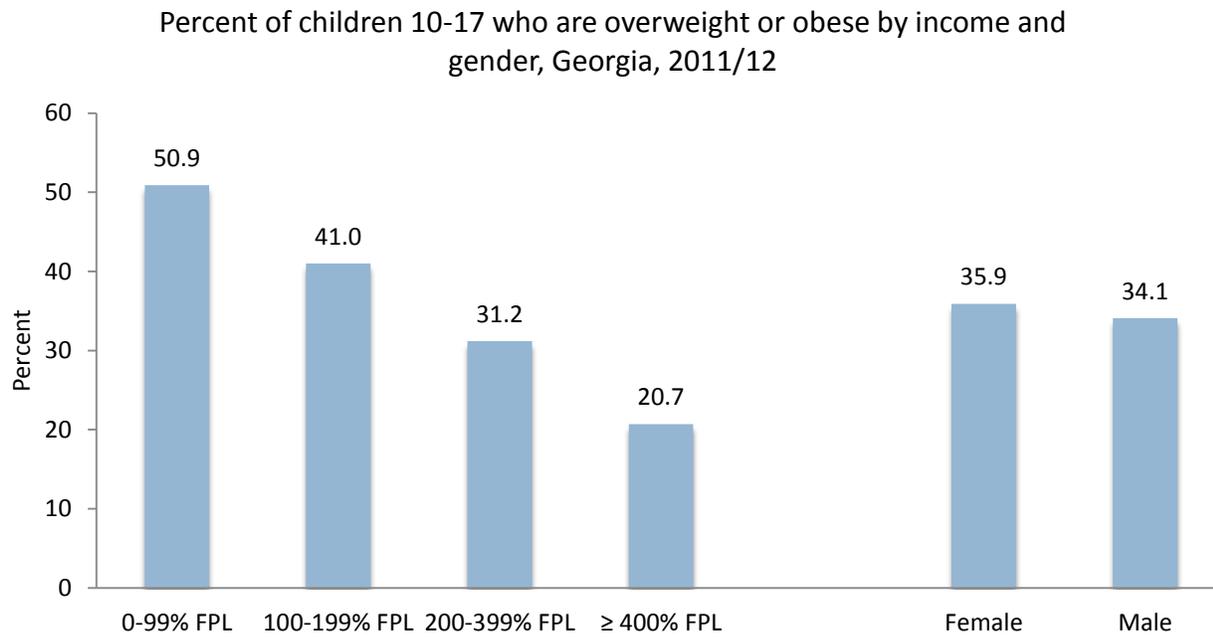
The percentage of children who were overweight and obese was slightly higher in Georgia than the US in 2011/12. Children 10 to 13 years of age in Georgia were reported to be overweight at similar levels to what was seen nationally in 2011/12. A little over 19% of 14 to 17 year olds in Georgia were overweight and 14.4% considered obese. Both of these percentages are higher than the national averages, at 14.1% and 12.4% respectively.

Higher percentages of overweight and obesity were reported among children in lower income brackets. Specifically, 50.9% of children in the 0-99% FPL income bracket were overweight or obese in Georgia, nearly 2.5 times the percentage of children in the highest income bracket (20.7%). More females than males were reported to be overweight or obese.

Percent of children 10-17 who are overweight or obese by age group, Georgia compared to the US, 2011/12



Source: NSCH

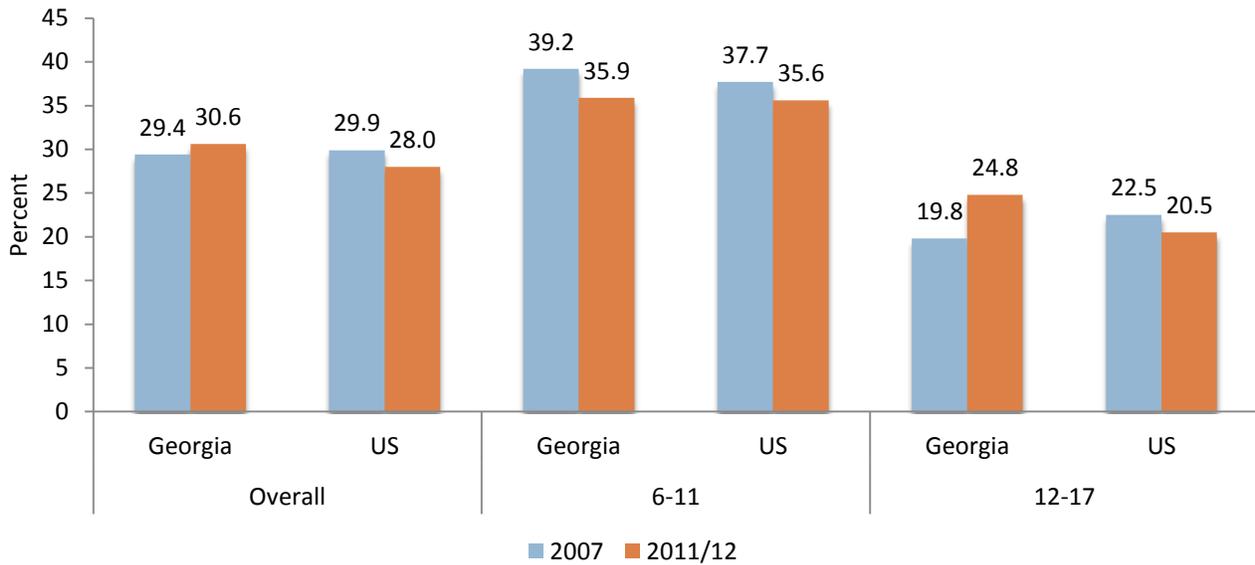


Source: NSCH

PHYSICAL ACTIVITY

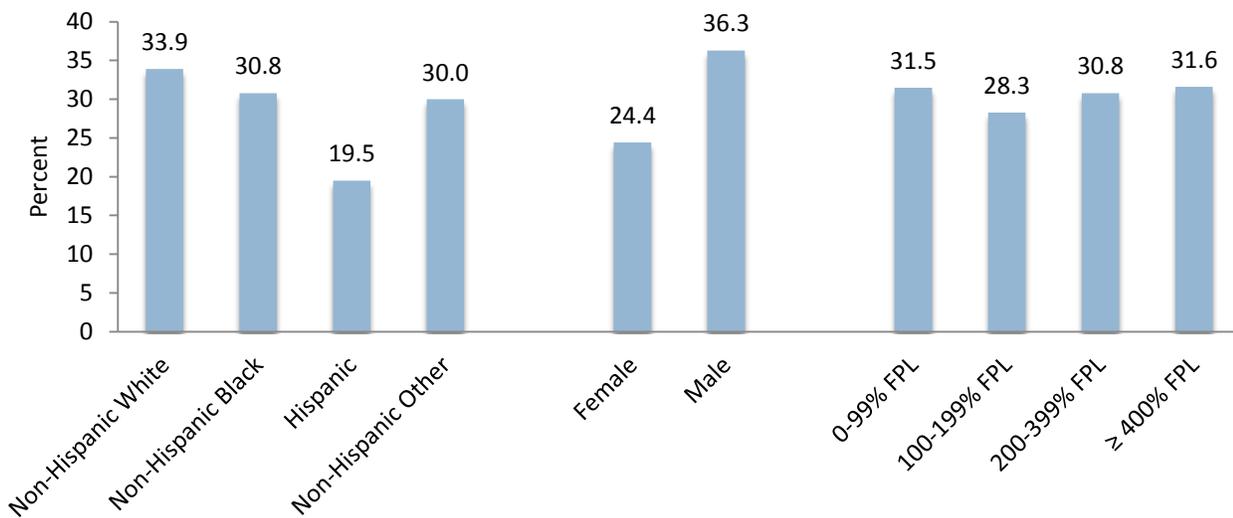
Nationally, the percentage of children 6 to 17 years of age who exercised for at least 20 minutes a day decreased slightly from 2007 to 2011/12. However in Georgia, the overall percentage increased. During both 2007 and 2011/12, more children 6 to 11 years of age exercised for 20 minutes or more per day, both nationally and in Georgia. However, the 2011/12 percentage for children in Georgia 6 to 11 years of age decreased and became very similar to the national average. While Georgia averaged 30.6% of all children exercising for at least 20 minutes daily, only 19.5% of Hispanic children did. Non-Hispanic White children (33.9%) and non-Hispanic Black children (30.8%) were similar to Georgia’s state average in 2011/12. More males exercised for 20 minutes per day than females. Children in all income brackets reported spending 20 minutes or more a day exercising at similar levels.

Percent of children 6-17 who exercise for at least 20 minutes per day by age and year, Georgia compared to the US, 2007 and 2011/12



Source: NSCH

Percent of children 6-17 who exercise for at least 20 minutes per day by race/ethnicity, gender and household income, Georgia, 2011/12



Source: NSCH

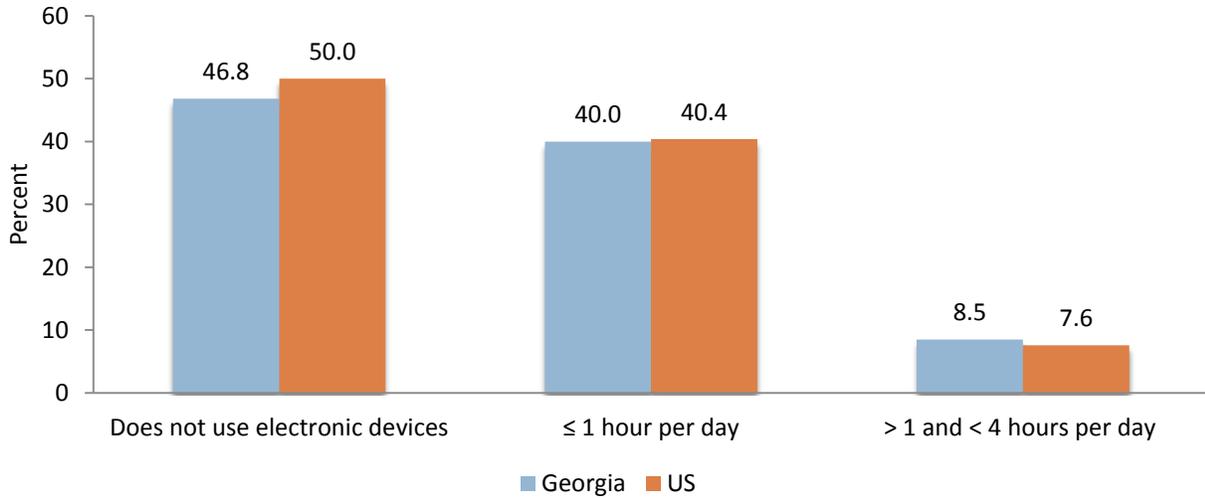
*Estimates for Hispanic and Non-Hispanic Other are based on numerators less than 50 and should be interpreted with caution

SCREEN TIME

Approximately half of children 1 to 5 years of age in Georgia and the US did not use computers, cell phones, video games or other electronic devices daily during 2011/12. Forty percent of children in Georgia used such a device for one hour or less per day. Only 8.5% of Georgia’s young children were reported to use an

electronic device more than one but less than four hours per day. Overall, the percentages among Georgia’s children were similar to the national averages. There were differences due to race/ethnicity. Among non-Hispanic White children, 57.4% were reported to not use an electronic device daily, while the percentage was 34.2% among non-Hispanic Black children and 49.4% among Hispanic children. More males (49.1%) than females (44.3%) were reported to not use an electronic device daily. The percentage was slightly higher among children in lower income brackets compared to those in higher income brackets.

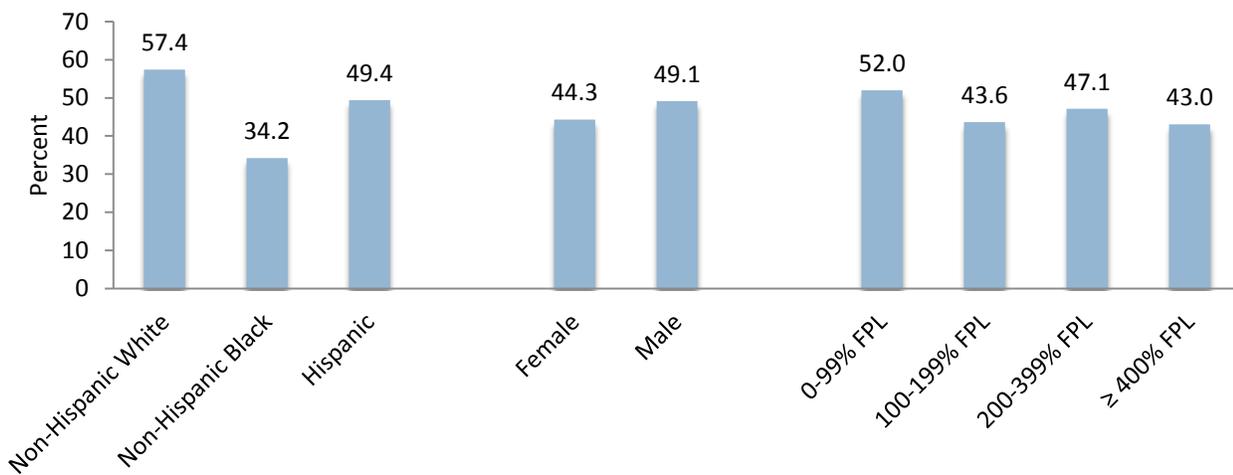
Percent of children aged 1-5 who use a computer, cell phone, video games or electronic device by amount of time, Georgia compared to the US, 2011/12



Source: NSCH 2011/12

*Estimate for Georgia’s children 1-3 is based on a numerator less than 50 and should be interpreted with caution

Percent of children aged 1-5 who do not use a computer, cell phone, video or electronic device daily by race/ethnicity, gender and household income, 2011/12



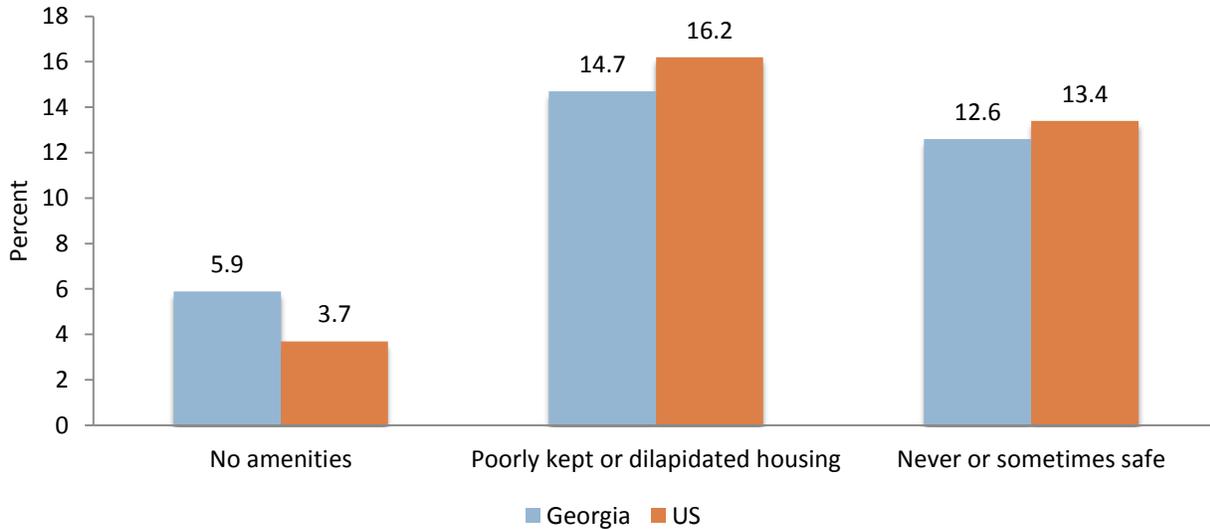
Source: NSCH 2011/12

*Estimates for Non-Hispanic Black, Hispanic and 100-199% FPL are based on numerators less than 50 and should be interpreted with caution

NEIGHBORHOOD AND BUILT ENVIRONMENT

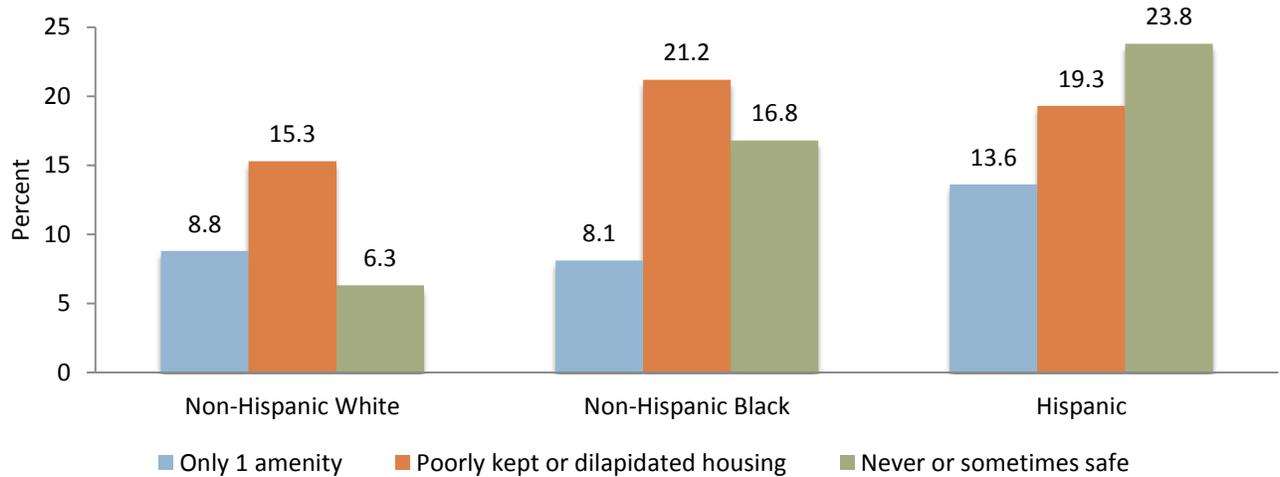
Much research, policy and programming recognizes that built environment (where we live, work and play) can impact a community’s health status. The graph below looks at three indicators of a neighborhood: amenities (such as parks, libraries, recreation centers and sidewalks), dilapidated housing and safety. Children in Georgia were reported to live in neighborhoods void of any amenities 37% more often than their peers nationwide. Moreover, 14.7% of children lived in neighborhoods with poorly kept or dilapidated housing and 12.6% of children lived in neighborhoods that are considered never or only sometimes safe. Parents of Hispanic children consistently reported higher percentages of lacking amenities and feeling unsafe compared to non-Hispanic Whites and non-Hispanic Blacks. In general, non-Hispanic Whites experienced indicators of a poor built environment less frequently than all other counterparts.

Percent of children living in neighborhoods with no amenities, dilapidated housing or no safety, Georgia compared to the US, 2011/12



Source: NSCH

Percent of children living in neighborhoods with one amenity, dilapidated housing or no safety by race/ethnicity, Georgia, 2011/12



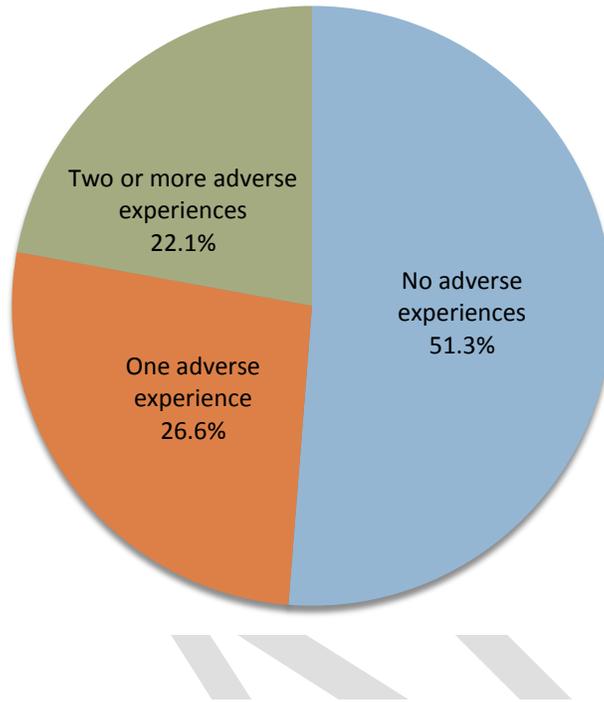
Source: NSCH

*Estimates for Hispanics and poorly kept or dilapidated housing among Non-Hispanic Blacks are based on numerators less than 50 and should be interpreted with caution

ADVERSE CHILDHOOD EXPERIENCES

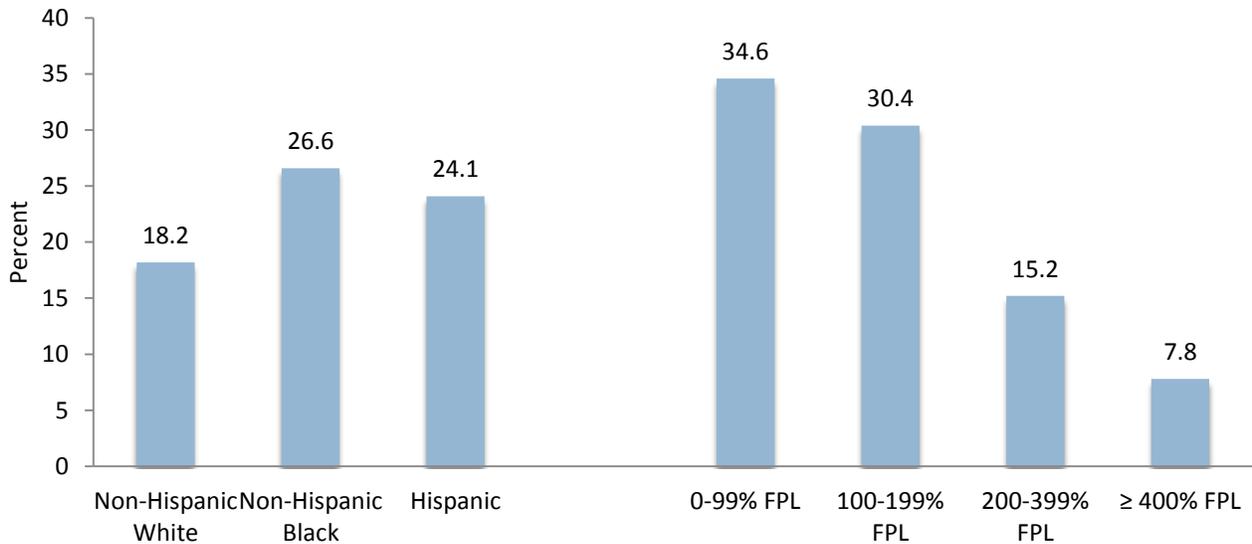
An adverse childhood experience (ACE) can have a direct impact on an individual’s emotional and physical health outcomes. An adverse childhood experience includes: abuse, neglect, household domestic violence, household substance abuse, parent separation or divorce or incarceration of a household member. Slightly more than half of Georgia’s children experienced no ACEs, while a quarter experienced one and 22.1% experienced two or more. When stratified by race/ethnicity and income, notable differences are evident. Fewer non-Hispanic White children in Georgia reported two or more ACEs compared to any other race or ethnicity in 2011/12. The prevalence of two or more ACEs decreased as income increased. Nearly 35% of children living in households with incomes of 0 to 99% FPL reported two or more ACEs compared to under 10% of children in the highest income bracket.

Prevalence of adverse childhood experiences among children 0-17, Georgia, 2011/12



Source: NSCH 2011/12

Prevalence of two or more adverse childhood experiences among children 0-17 by race/ethnicity and income, Georgia, 2011/12



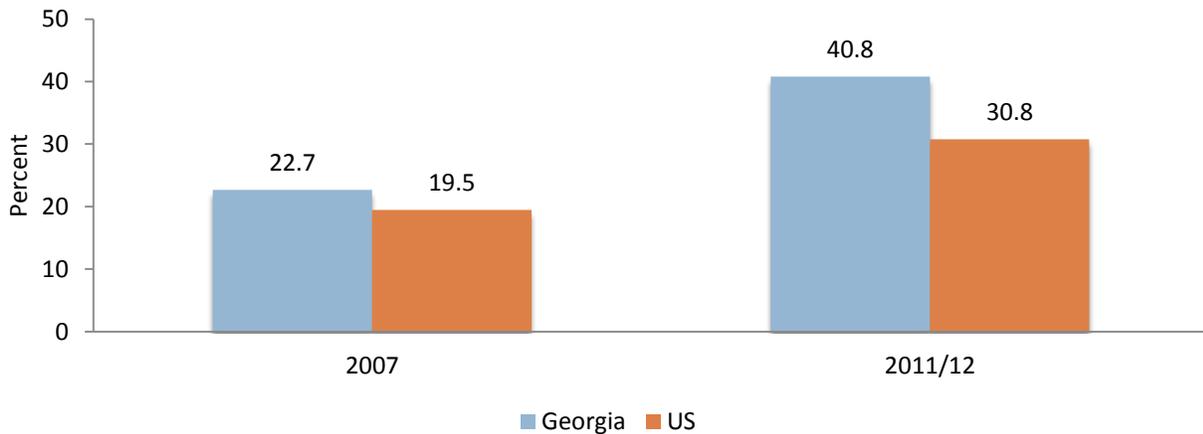
Source: NSCH 2011/12

*Estimate for Hispanic is based on a numerator less than 50 and should be interpreted with caution

DEVELOPMENTAL SCREENING

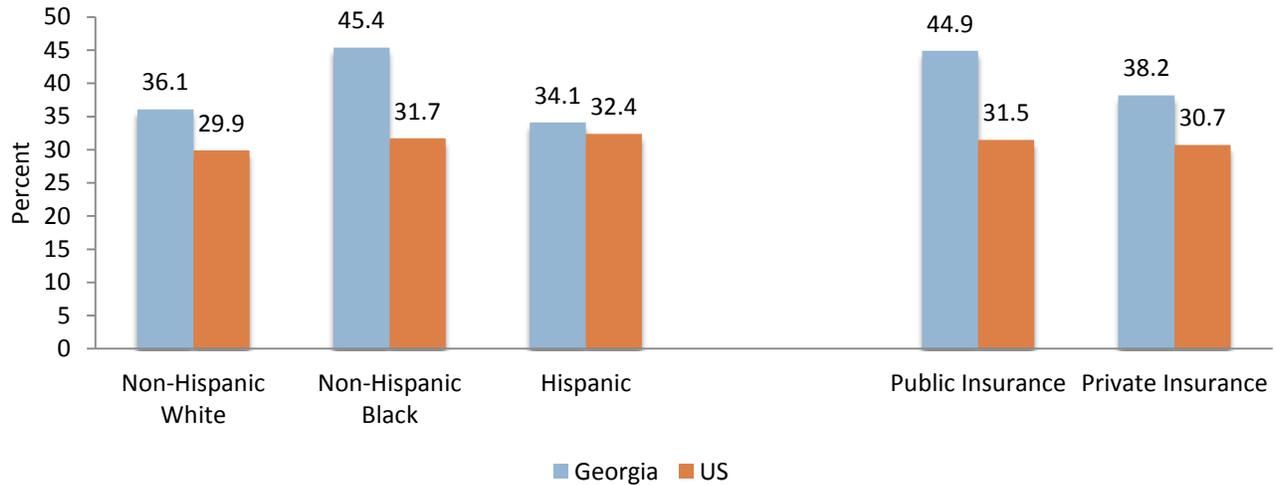
In 2011/12, 30.8% of children in the US were screened for developmental, behavioral and social delays while 40.8% of children were screened in Georgia in 2011/12. In 2007, 22.7% of Georgia’s children received a developmental screen. The percentage increased 79% from 2007 to 2011/12. A higher percentage of non-Hispanic Black children (45.4%) received a developmental screening than non-Hispanic Whites and Hispanics (36.1% and 34.1%). Additionally, more children in Georgia using public insurance received a developmental screening compared to children using private insurance (44.9% and 38.2% respectively). These differences were not present at the national level.

Percent of children 10 months to 5 years screened for developmental, behavioral or social delays by year, Georgia compared to the US, 2007 and 2011/12



Source: NSCH

Percent of children 10 months to 5 years screened for developmental, behavioral and social delays by race/ethnicity and insurance type, Georgia compared to the US, 2011/12



Source: NSCH

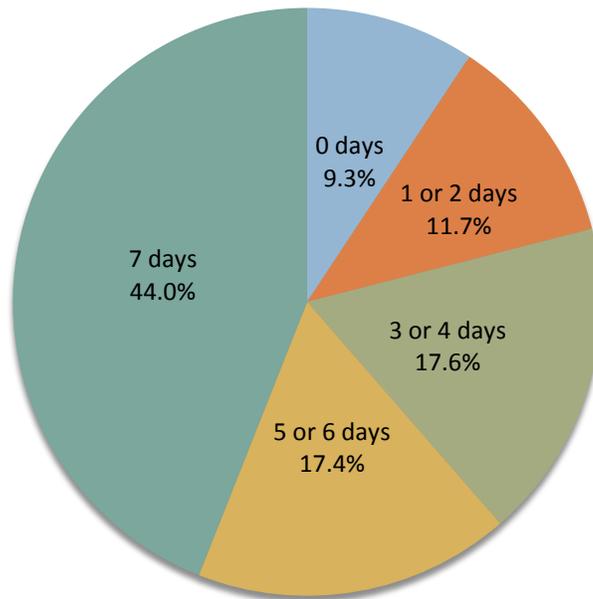
*Estimates for Non-Hispanic Blacks and Hispanics in Georgia are based on numerators less than 50 and should be interpreted with caution

SCHOOL READINESS

School readiness and proficiency is an important indicator for the well-being of children. Head Start defines school readiness as children possessing the skills, knowledge, and attitudes necessary for success in school and for later learning and life. This means that children are ready for school, families are ready to support their children's learning and schools are ready for children. Children who are unprepared for school often perform poorly in school, have low self-esteem, and are at higher risk to drop out of school, suffer unemployment, poverty and crime. School readiness often examines the social, physical and emotional environment around children in early childhood, to assess whether they are getting adequate exposure for proper language and cognitive development, literacy, math and social skills.

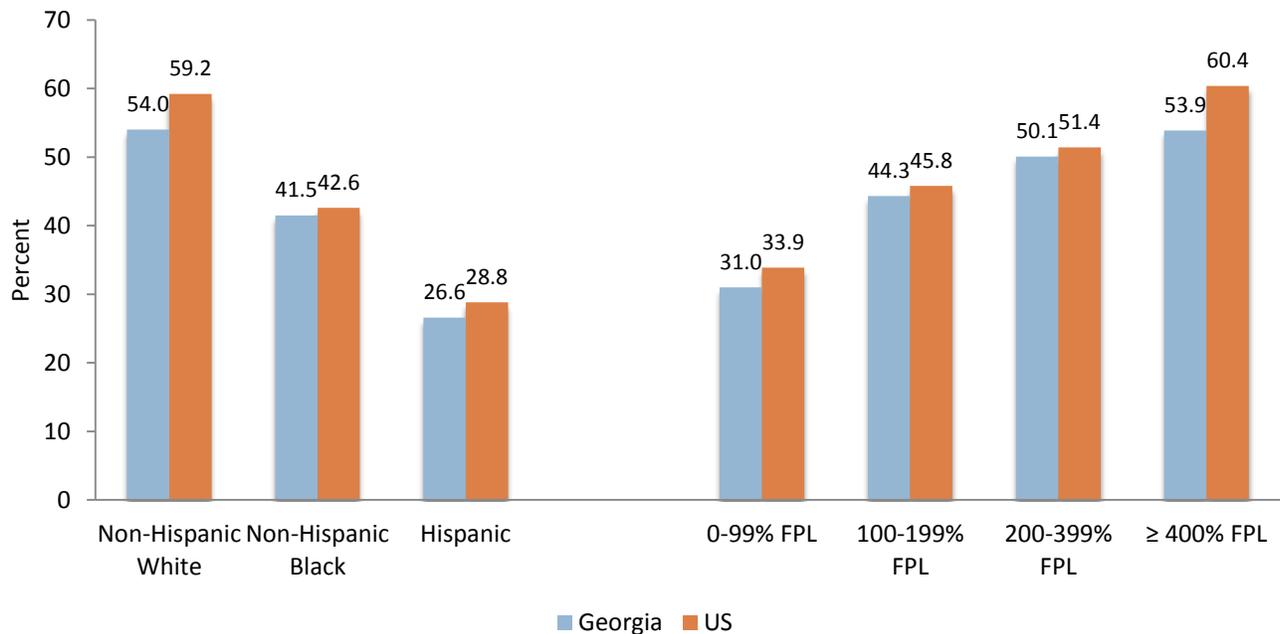
Over 40% of children in Georgia were read to 7 days per week in 2011/12. Over 90% were read to at least 1 day per week, while 9.3% were read to 0 days per week. More non-Hispanic White children were read to every day of the week both nationally and in Georgia than children of any other race or ethnicity. The percentage was lowest among Hispanic children. As education increased, so did the percentage of children who were read to every day of the week.

Percent of children 0-5 who are ready to by number of days per week, Georgia, 2011/12



Source: NSCH

Percent of children 0-5 who are read to every day of the week by race/ethnicity and household income, Georgia compared to the US, 2011/12



Source: NSCH

*Estimates for Hispanics and 0-99% FPL in Georgia are based on numerators less than 50 and should be interpreted with caution

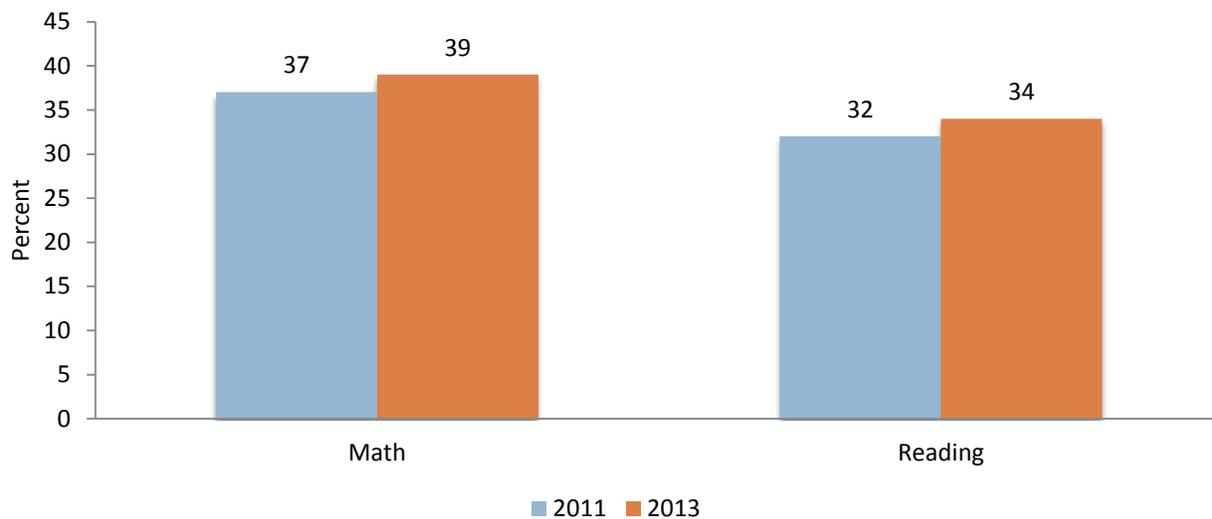
Healthy People 2020 Objectives

AH-5.3.1: Increase the proportion of 4th grade students whose reading skills are at or above proficient achievement level for their grade to 36.3%

AH-5.4.1: Increase the proportion of 4th grade students whose mathematics skills are at or above the proficient achievement level for their grade to 43%

There was a steady improvement in the percentage of children proficient or above in Math and Reading in Georgia from 2011 to 2013. In 2013, 34.0% of 4th grade students were proficient or above in Reading while 39.0% of students were proficient or above in Math. Fourth grade students in Georgia are still 6 to 10 percentage points behind achieving the Healthy People 2020 objectives in both Reading and Math, respectively.

Percent of 4th grade students who are proficient or above in Math or Reading, Georgia, 2011, 2013



Source: NAEP

QUALITATIVE FINDINGS: SCHOOL READINESS

Five focus groups were conducted among parents of children 4 to 7 years of age. The following table presents general demographic information.

TABLE 6: Participant Demographics by District

	Dalton N=13 n (%)	Macon N=10 n(%)	LaGrange N=16 n(%)	Valdosta N=12 n(%)	Waycross N=11 n(%)
Age					
20-29	4 (31%)	2 (20%)	12 (75%)	5 (42%)	3 (27%)
30-39	8 (61%)	5 (50%)	4 (25%)	2 (17%)	4 (36%)
40-49	1 (8%)	2 (20%)	--	4 (33%)	1 (9%)
50-59+	--	1 (10%)	--	1 (8%)	3 (27%)
Highest level of education completed					
Less than High School	1 (8%)	--	--	3 (25%)	--
High School/GED	6 (46%)	2 (20%)	7 (44%)	2 (17%)	4 (36%)
Some College/Technical /Community College	4 (31%)	7 (70%)	4 (25%)	4 (33%)	2 (18%)
College graduate or more	1 (8%)	1 (10%)	5 (31%)	3 (25%)	4 (36%)
No response	1 (8%)	--	--	--	--
Race/Ethnicity					
Caucasian/White	3 (23%)	1 (10%)	2 (12%)	--	4 (36%)
African-American/Black	--	9 (90%)	13 (82%)	7 (58%)	7 (64%)
Latino/Hispanic	10 (77%)	--	1 (6%)	4 (33%)	--
Asian	--	--	--	--	--
Other	--	--	--	--	--
No response	--	--	--	1 (8%)	--
Health insurance status					
Private	5 (38%)	8 (80%)	4 (25%)	3 (25%)	3 (27%)
Public (Medicaid/PeachCare/TriCare)	7 (54%)	--	6 (37%)	5 (42%)	5 (45%)
None	1 (8%)	2 (10%)	6 (37%)	4 (33%)	2 (18%)
No response	--	--	--	--	1(9%)
Number of children currently parenting					
1	3 (23%)	1 (10%)	4 (25%)	2 (17%)	3 (27%)
2	6 (46%)	3 (30%)	6 (37%)	4 (33%)	4 (36%)
3	1 (8%)	1 (10%)	5 (31%)	4 (33%)	2 (18%)
4	3 (23%)	2 (20%)	1 (6%)	--	1 (9%)
5	--	1 (10%)	--	1 (8%)	1 (9%)
6+	--	2 (20%)	--	1 (8%)	--
Pregnant					
Yes	1 (8%)	1 (10%)	--	1 (8%)	1 (9%)
No	12 (92%)	9 (90%)	16 (100%)	11 (92%)	10 (91%)
I don't know	--	--	--	--	--
Receiving WIC					
Yes	8 (61%)	2 (20%)	7 (44%)	6 (50%)	4 (36%)
No	5 (38%)	7 (70%)	9 (56%)	6 (50%)	7 (64%)
No response	--	1 (10%)	--	--	--

The participants were primarily asked about their experiences with preparing their child for school, and their child’s subsequent success in school. Parents were asked about specific public services offered, including Head Start and WIC. The discussion centered around general readiness for school, as well as how their child’s health impacted their readiness and school performance. Barriers to obtaining mandated health screenings prior to the beginning of school was also discussed. Focus group guides are located in the appendix. The following two tables provide a summary of themes that appeared across all focus groups. The first table lists barriers that parents faced when preparing their children for school. The second table lists factors that facilitated their child’s readiness for school. Following the table summaries is the full report of the focus group findings.

Table 7. Barriers to Receiving School Readiness Services

Individual-Level Barriers	
Themes	Comments
Lack of cultural competency	“They always ask you if English or Spanish is our first language, and if it isn’t, if one of the parents doesn’t speak English, then they sort of put them to the side and they treat them differently . . . automatically. They assume that my daughter was going to struggle.”
Lack of knowledge about nutrition	“Being that we have this generation that’s more prone to diabetes and obesity, I think it’s a big deal to really prepare parents and provide information on ok, “What is healthy eating?” Do parents have access to nutritious fruit, foods, everything like that? Because that really does affect learning and readiness . . . having access to good food and healthy food is important to school readiness. I know as a parent I’m very passionate about that.”
Lack of knowledge about services	“The fact that a lot of us parents don’t know what programs are out there that we can get help on, it shouldn’t be that way.” “I didn’t know [WIC] provide[s] books.”
Structural-Level Barriers	
Themes	Comments
Ineligibility for services	“. . . Head Start is for low income people, so people that are in middle class don’t qualify. So they discriminate [against] us for that reason because they say, “You make too much.” . . . Our kids are left.”
Transportation	“. . . Head Start helps, but there’s not a lot of transportation for low income families [who] don’t have reliable transportation They don’t have a bus transportation for Head Start, so a lot of kids are not going to Head Start.”

<p>Waiting times</p>	<p>“ . . . not only are you wasting half of your day at the WIC office, you have to actually go to the supermarket. Half of the things you’re able to get are not on the list. For example, the cereal. They tell you you’re allowed to get Rice Krispies. . . . Wal-Mart will allow you to get Rice Krispies. But [they] will tell you, ‘No. that’s not allowed. It’s not on the WIC [voucher].’ Or you’ll go to Publix and they will tell you, ‘Not this Rice Krispies. This Rice Krispies is the wrong size.’ So now you’re leaving with less cereal. They’ll have it to where you’re only able to get 30 ounces of cereal and you’re losing your other six. It’s not unanimous as to really what is on the list and what you’re able to get.”</p>
<p>Financial barriers</p>	<p>The [health department doesn’t] take insurance. You pay cash or you don’t get [any] services.”</p> <p>“ . . . I feel that it is imperative that they get their health screenings, but also you’re having to deal with, ‘Well should I pay the light bill or get the health screening so they can go to school but then they’re going to come home to no power?’ So you’re in that situation where, you know, it would be a blessing if the health department does help but at a reasonable cost. . . . Especially if you have more than one child. . . . Make it a little bit easier.”</p>

Table 8. Strengths of School Readiness Services

<p>Individual-Level Facilitators/Strengths</p>	
<p>Themes</p>	<p>Comments</p>
<p>Parent Involvement</p>	<p>“Because at school there’s going to be twenty kids and it’s hard to reach every child if you’re not working with them at home. So if you’re working with them at home and at school they’re working with them too it’s a double dose.”</p>
<p>Preparation through daycare services</p>	<p>“ . . .my youngest child, [I] had him a different daycare, and I guess they weren’t familiar with what they needed to learn. So . . . he had problems when he started school, and the transition was, from that daycare to the school was challenging for him ‘cause he was used to that being a play place. And the other daycare, the older son, she gave him time, taught him how to sit down, taught him ABCs, taught him colors, and you know, gave him structure where they know this is the time to be disciplined, this is the time to play. But the youngest one, all they did basically was play. So when he went to school, he would think ‘Ok, this is another play place.’”</p>
<p>Structural-Level Facilitators/Strengths</p>	

Themes	Comments
Nutrition Services through WIC	“I do like that, because I know for sure and for certain that every month at least I’m going to have money for bananas, my oranges, you know, the things that they like.”
Preparation through Head Start	<p>“My child was ready, just because I felt that the Head Start helped a lot. Because it’s smaller classes and children begin to become more independent and they’re not as afraid because it’s kind of like a daycare in a way, but still they’re structured the same way that you’re supposed to go to school.”</p> <p>“I used the Head Start for my son because his speech was delayed. That’s why I put him in there because socially he was behind. He started talking at two and a half. So when he started. . . Head Start he was three and that helped [him] socially. And the speech therapist goes to Head Start, so he got the speech. And just being involved with the other kids, that helped [him] socially.”</p>

General School Readiness

Preparation through daycare services

Of the focus group participants with children enrolled in pre-K, an overwhelming majority were satisfied with these services. There was consensus among parents regarding the importance of these services in establishing a solid foundation for their child’s academic progress in later years. Parents did however, express concern with access to these services, feeling children were being placed at a disadvantage due to a lack of capacity at local daycares. One parent noted a pre-K program’s existing familiarity with the school system and how this better ensured her child would be prepared for the transition to kindergarten—even noting the disparate outcomes between her older children that did not receive the services.

“. . .my youngest child, [I] had him a different daycare, and I guess they weren’t familiar with what they needed to learn. So. . . he had problems when he started school, and the transition was, from that daycare to the school was challenging for him ‘cause he was used to that being a play place. And the other daycare, the older son, she gave him time, taught him how to sit down, taught him ABCs, taught him colors, and you know, gave him structure where they know this is the time to be disciplined, this is the time to play. But the youngest one, all they did basically was play. So when he went to school, he would think “Ok, this is another play place.”

Ineligibility for services

Parents mentioned overcrowding as one of the major barriers to accessibility for pre-K services, and found the existing lottery system that provided spots for children to be unfair. One parent stated, “Everybody deserves a chance to do the pre-K program.” For parents with children enrolled in pre-K services, the majority were satisfied with the staff and preparation their children received prior to beginning kindergarten.

Parental involvement

Focus group participants believed that teaching begins in the home. Parents spoke in detail about measures taken to ensure their child’s readiness for school, including engagement through “word walls”, flash cards, and homemade activities. Some participants spoke of the use of technology as a tool for instruction, particularly given children’s growing affinity for technology in general. Reading was also identified as an integral part of building a child’s confidence. An overarching theme among participants was the need to reinforce information the child learned in class. Parents felt this reinforcement was their responsibility—one parent describing it as a “double dose” of instruction. Parents were very aware of the challenges that teachers and school experienced, and saw their involvement as an important factor for their children to thrive. Parents also noted the expectations in kindergarten have changed, and that children are now expected to advanced competencies.

“Because at school there’s going to be twenty kids and it’s hard to reach every child if you’re not working with them at home. So if you’re working with them at home and at school they’re working with them too it’s a double dose. [Because] kindergarten isn’t kindergarten anymore, it’s first grade. So if your baby cannot read in kindergarten, they’re not going to first grade. They have to be able to read and write three sentences with a picture. So it’s tough kindergarten. It’s not kindergarten anymore. It’s not play-based.”

Lack of cultural competency

Latino parents expressed concern with the cultural competence of teachers, highlighting a prevalent assumption that teachers “automatically” make when learning that English is not the primarily language spoken in the child’s home. Given this assumption, many participants felt the need to work diligently in the home with their child, not only ensure his or her success, but to also curtail any potential challenges associated with their child’s progression in, and transition through, milestones in school.

“. . . they always ask you if English or Spanish is our first language, and if it isn’t, if one of the parents doesn’t speak English, then they sort of put them to the side and they treat them differently . . . automatically. They assume that my daughter was going to struggle.”

Parents felt socialization was a very important skill for their children to learn at an early age. They mentioned being intentional in placing their children in settings with children of the same age, as well as

with older children and adults. Parents offered a few examples of ways in which their children have engaged with others, including interactions with older children in the home, involvement in children's church, or engagement with other children as part of their broader community.

Communication between schools and parents

Participants felt communication to be an important factor in ensuring proper placement of their children in the classroom, particularly given many felt their children were being misdiagnosed with behavioral issues and subsequently being placed in classrooms that were not conducive for their learning needs. Participants felt there was a disconnect between parents and classroom teachers, ranging from placement of their children in appropriate classrooms to more frequent exchanges of communication regarding homework and classroom assignments. While parents understood the importance of placement tests, and assessments like individualized education programs (IEPs), many felt the results of these tests were futile and lead to their child being placed in a classroom with students that were not at the same academic level. Parents also expressed frustration with attempts to communicate with teachers about classroom and homework assignments, feeling they were sometimes overworked or inaccessible.

These lapses in communication were seen as major gap in children's transition to kindergarten, as well as their success while enrolled in kindergarten. This was a heightened concern for the parents of children with special health care needs who felt their children were lost in the system, often times placed in classrooms that were not designed to meet their learning needs. As a result, children were disengaged during class, chose to isolate themselves, and sometimes left the classroom altogether. While school personnel may have identified these challenges as behavioral issues, many parents felt these behaviors were a result of children lost in a system that could not accommodate their learning needs. Of parents that were able to communicate with their children's teachers, whether in pre-K or kindergarten, the results of clear, ongoing communication was seen as mutually beneficial for parents and teachers.

Lack of knowledge about nutrition

Nutrition was identified as a challenge, as an awareness issue for parents, and as an accessibility issue for the community. Focus group participants noted the intersection of these challenges and the need for solutions to be offered in a different context—using a “big picture” approach. A lack of nutritional offerings in the community limited the extent to which parents could access nutritional options for their children. Fast food restaurants, although convenient and often offering low-cost items, were identified as a barrier for healthy food options for children. Further, parents were concerned about the quality and price of food offered in their local grocery stores—some of which neared expiration within days of purchase. The importance of education about nutrition given these challenges was a prevalent theme across focus groups.

“Being that we have this generation that’s more prone to diabetes and obesity, I think it’s a big deal to really prepare parents and provide information on ok, “What is healthy eating?” Do parents have access to nutritious fruit, foods, everything like that? Because that really does affect learning and readiness . . . having access to good food and healthy food is important to school readiness. I know as a parent I’m very passionate about that.”

Parents expressed a desire for schools to provide healthy options for children that were both appealing and filling. Focus group participants noted their children describing the food options as “nasty”, and often returned home at the end of the day hungry. Parents felt this was a result of the time at which their children were provided lunch at school, some as early as 10:30am. In many cases, this would be the only time the child had a meal during the school day. Afternoon snacks were not provided, unless the teacher covered this expense out-of-pocket. One parent questioned the food served in their child’s school, stating, “. . . even though they say that it’s healthy food. I don’t think so.” One recommendation among focus group participants was to offer a joint training with parents and school staff in order to work collaboratively on healthy menu items that were also appealing for children.

Health and school readiness

Parents also expressed misdiagnosis of medical conditions as a barrier to their children’s school readiness, specifically citing attention-related problems, like attention deficit disorder (ADD), or attention deficit hyperactive disorder (ADHD). Parents also listed a variety of conditions that affected children in their communities, including: anemia, elevated levels of lead, asthma, seasonal allergies and obesity. Parents felt physical health was just as important as academic health, and were disappointed that children did not have an opportunity to engage in physical activity as part of their school day. This, coupled with a host of other nutrition- and health-related concerns, was seen as a barrier to a child being healthy and well enough to be attentive and engaged during the school day. Lack of sleep was also identified as an issue affecting children’s ability to learn.

“I think children that don’t get the proper rest are going to have a hard time learning because they’re tired. They’re in school [laying their head down]. And I’ve seen it. I’ve been in the classroom where we’ve had children [laying their head down], and it’s not lunchtime yet, let alone time to take a nap. So the proper rest is definitely going to affect their learning.”

Bright from the Start – Early Head Start Program

Preparation through Head Start

Georgia’s Department of Early Care and Learning (Bright from the Start) is responsible for meeting the childcare and early educational needs of Georgia’s children and families. Bright from the Start oversees a wide variety of programs primarily focused on children from birth to school age and their families. These

programs are under the oversight of Bright from the Start, who provides comprehensive early childhood and family development services to children from birth to five years old, pregnant women and families.

When participants were asked about their experiences enrolling their children into the Head Start, most mentioned they were satisfied. They also believed that Head Start was a good transition from pre-K to the classroom for their children. For example, participants said:

“My child was ready, just because I felt that the Head Start helped a lot. Because it’s smaller classes and children begin to become more independent and they’re not as afraid because it’s kind of like a daycare in a way, but still they’re structured the same way that you’re supposed to go to school.”

“I used the Head Start for my son because his speech was delayed. That’s why I put him in there because socially he was behind. He started talking at two and a half. So when he started . . . Head Start he was three and that helped [him] socially. And the speech therapist goes to Head Start, so he got the speech. And just being involved with the other kids that helped [him] socially.”

They felt that teachers at Head Start were competent and prepared the students academically and socially for school. When participants were asked about their experience using the childcare, Head Start, Pre K or nutrition services, their responses were positive.

Ineligibility for services

Some parents however, had an unfavorable experience. Parents not eligible to enroll in the program expressed interest and a willingness to use the services based on their perceived value placed on the program.

These participants failed to qualify due to the income criteria and couldn’t enroll their children into the program. They said:

“. . . Head Start is for low income people, so people that are in middle class don’t qualify. So they discriminate [against] us for that reason because they say, ‘You make too much.’. . . Our kids are left.”

“. . . don’t make it so income based. . . . It was always, ‘Well you don’t qualify for this [because] your income is too high.’ Which in my head it was not. It’s still too low. But according to them and going on that gross income, it’s like, ‘Well, no you’re this much over, this much over.’”

These participants also expressed frustration at not qualifying for the Head Start programs and being left out with their children suffering significantly because they worked to maintain their household, despite being a low income family and eligible for programs including childcare, Head Start, pre-K or nutrition services.

Transportation barriers

During the discussions, some parents revealed that transportation was a barrier to receiving services as they don't always have someone to pick up their children, or the ability to cover the extra distance required to travel beyond their neighborhood to participate in the program. Examples of some transportation challenges parent faced are shown below:

“. . . Head Start helps, but there's not a lot of transportation for low income families [who] don't have reliable transportation. . . . They don't have a bus transportation for Head Start, so a lot of kids are not going to Head Start.”

“More transportation. . . . Because they say you're responsible for your own transportation if you put them in another school out of the area. But if you don't have a car, then how are you going to go?”

Lack of awareness about services

The lack of awareness by participants about Bright from the Start and other services programs provided were very obvious. There was a lot of confusion about Bright from the Start and Head Start, which was apparent in the responses of many participants. Many participants felt frustrated at the lack of communication from state on resources that were available. Parents shared that knowledge of most programs was through word-of-mouth, and that there wasn't a central place to learn about resources available to families. While most participants reported using Bright from the Start services for pre-K, they were not aware of the existence of other services and programs offered through Bright from the Start. Here are some examples of their comments:

“Bright from the Start? Is that the one that comes from the hospital?”

“I wasn't aware of it. I've heard of it, but I wasn't aware of what it consists of.”

“The fact that a lot of us parents don't know what programs are out there that we can get help on, it shouldn't be that way.”

“Well I don't know about services, I just know that's the curriculum where the people who control pre-k. So as far as services, no services were offered.”

Women, Infants, and Children (WIC) Program

The Women, Infants, and Children (WIC) Supplemental Nutrition Program is a federally-funded health and nutrition program for infants, children and fostered children from 1 to 5 years of age, pregnant women, breastfeeding mothers (up to a year) and postpartum women (up to 6 months).

Nutrition services through WIC

Participants were asked if the WIC services received prepared their children for school. The majority of the responses from participants were positive. They were pleased the program offered healthy food choices to their children. Participants were appreciative that the program was made available to them and felt it was a good safety net when they ran out of food stamps. They also mentioned that nutrition education and food vouchers were beneficial to children's preparedness for school. We know that hungry children can't learn. These are examples of participants' comments:

"They're pretty good nutritionists."

"I do like that, because I know for sure and for certain that every month at least I'm going to have money for bananas, my oranges, you know, the things that they like."

"A really good experience. I thought they were like 'Oh, here's your voucher. Go on.' And no, they're actually really well informed and really good at nutrition."

Barriers to utilizing WIC

Although overall utilization of the program was high, participant satisfaction with the program varied. While many parents were very pleased, some were dissatisfied with the services provided. Reasons for dissatisfaction were varied, but included the quality and choice of food at the grocery stores and the waiting time to receive food vouchers. Some mothers felt 1% or 2% low fat milk was watered down. Others mentioned a lack of clarity with approved items (i.e., brand, size). Participants spoke of being embarrassed going to the grocery store and unknowingly picking unapproved WIC items or brands which sometimes led to holding up the queue at the check-out while the cashier resolved the problem. Some participants found the vouchers to be complicated and weren't satisfied with the choices offered.

Many participants found the waiting times for receiving services excessive and were willing to forgo receiving services in the future from WIC as a result of these delays. Some participants expressed dissatisfaction on how brochures were handed over to them and the lack of adequate communication of useful information to go with it. They also felt a personalized nutrition education and more one-on-one counseling should be provided for parents. Below are some participants' comments about their dissatisfaction with the quality and choice of food at the grocery stores, also waiting times to receive food vouchers:

“... not only are you wasting half of your day at the WIC office, you have to actually go to the supermarket. Half of the things you’re able to get are not on the list. For example, the cereal. They tell you you’re allowed to get Rice Krispies. . . . Wal-Mart will allow you to get Rice Krispies. But [they] will tell you, ‘No. that’s not allowed. It’s not on the WIC [voucher].’ Or you’ll go to Publix and they will tell you, ‘Not this Rice Krispies. This Rice Krispies is the wrong size.’ So now you’re leaving with less cereal. They’ll have it to where you’re only able to get 30 ounces of cereal and you’re losing your other six. It’s not unanimous as to really what is on the list and what you’re able to get.”

“... I stopped using WIC with [my daughter] when I was working because taking off half a day of work to go pick up the checks, I mean it was costing me more money than to just go ahead and buy my own milk.”

During the discussion, some mothers suggested there was a need for nutritional services for children over the age of five and hoped WIC would provide this service in the future.

Lack of knowledge about services

Most participants that used WIC services found them helpful, but many were not aware of the educational component of the program or the learning benefits it offered their children. Most participants didn’t know of WIC programs that taught them to read to their kids or provide books for their children. Most participants assumed the WIC program was essentially for food vouchers and nutrition education. When participants were asked if they got referred to other programs and services, none said yes. Here are some examples of participants’ comments:

“I didn’t know [WIC] provide[s] books.”

“That’s something that’s I feel some people might want to take advantage of, but because of lack of knowledge they are not able to do so.”

“What I’m trying to say is that we as parents need to be educated on every program and know [where] to go for help.”

Health Screening

In Georgia, all children entering public school are required to have a vision, hearing, dental and nutrition screening before enrollment in public schools. When participants were asked about compliance, every one of them confirmed they had complied. However, several participants expressed how challenging they found the screening process.

Financial barriers

The long wait to get appointments to see doctors at the health department or doctor’s office, the screening tests/exams not covered under Medicaid, being out of pocket and payment in cash for screening and the limited availability of dental care especially for young children were some of the issues raised by

participants. Some participants were surprised that the health department didn't accept insurance. The majority of participants screened their children using private doctor's and the dentist's office, but not the health department. Most participants indicated a willingness to use the health department for future screening if the cost was lower, and if waiting times to see a doctor became reasonable. These comments express some of their dissatisfaction:

"That's another thing like [clinic visits] are not free. Ok, like most of us are probably in here now are probably on Medicaid so we don't have private insurance, so we're going to have to pay to take them to the doctor. Then you're going to take them to the dentist, that's money."

"Yeah, but that's the thing. It's the health department. The services that they give are supposed to be because you don't have the income to get it at a private office. So why are you charging what everybody else is charging when we can't afford to go to a private doctor?"

"They don't take insurance. You pay cash or you don't get [any] services."

". . . I feel that it is imperative that they get their health screenings, but also you're having to deal with, 'Well should I pay the light bill or get the health screening so they can go to school but then they're going to come home to no power?' So you're in that situation where, you know, it would be a blessing if the health department does help but at a reasonable cost. . . . Especially if you have more than one child. . . . make it a little bit easier."

Some parents expressed difficulties obtaining dental screenings due to their child's age.

"Dental was the challenge for me as well."

"[I] had a hard time getting my child's dental done. . . cause they wouldn't take her until she turned four."

Some participants suggested that offering screenings within the school system or using mobile dentist would make it easier for parents.

STRENGTHS AND NEEDS

The quantitative and qualitative data examined reveal several areas of achievement and areas where improvements are needed to maximize the health of children throughout the state. Based on the most recent data, Georgia is a leader in screening children for developmental delays, experiencing a 79% increase over a five-year period. Since many more activities have been conducted in this arena since data were collected in 2011/12, it is expected that there will be continued success. Although injury remains the leading cause of death among children, there has been a decrease in hospitalizations due to non-fatal

injury. Successes have been seen in vaccination rates, with large increases seen in the past 5 years for the percentage of children receiving the 4:3:1:3(4):3:1:4 series.

Despite major successes, needs were seen in the following areas:

- Prevent deaths due to motor vehicle crashes
- Promote healthy weight, physical activity and nutrition among children, particularly those in lower income families
- Reduce adverse childhood experiences
- Improve the built environment surrounding children
- Improve access to school readiness services
- Ensure children are meeting proficiency standards in school

Addressing these needs and maintaining the recent successes are important to promoting the healthy development of Georgia's children.

DRAFT

QUANTITATIVE ANALYSIS: ADOLESCENT HEALTH

This section will present a brief overview about the health status of adolescents in Georgia, with a particular focus on adolescents in middle school and high school, grades 6 through 12. Behavioral patterns established during these developmental stages are crucial to predicting young people's risks for developing chronic diseases in adulthood.

MORTALITY

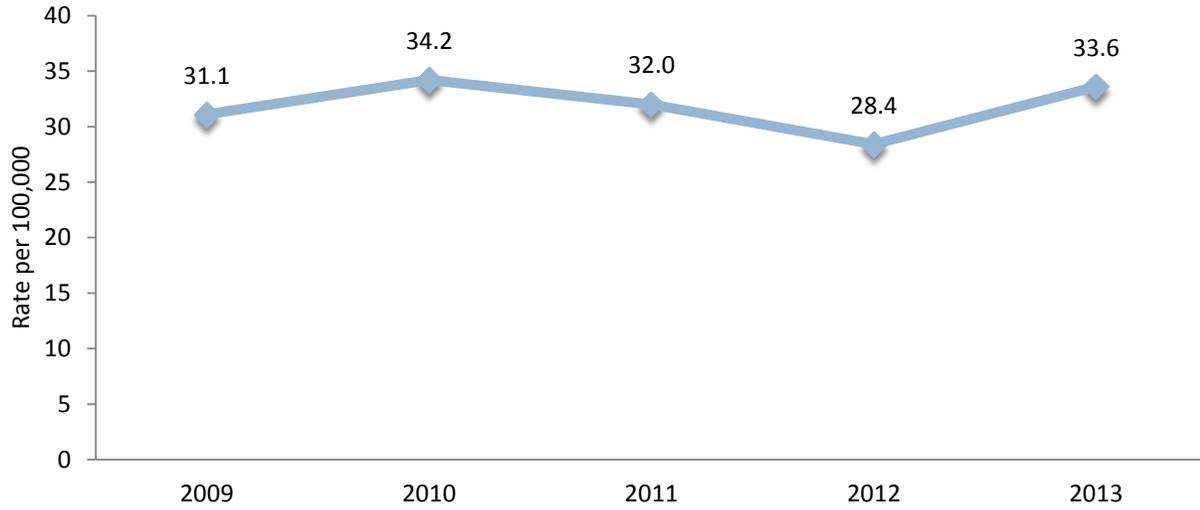
Healthy People 2020 Objectives

MICH-4.1: Reduce the rate of deaths among adolescents aged 10 to 14 years to 14.8 per 100,000

MICH-4.2: Reduce the rate of deaths among adolescents aged 15 to 19 years to 54.3 per 100,000

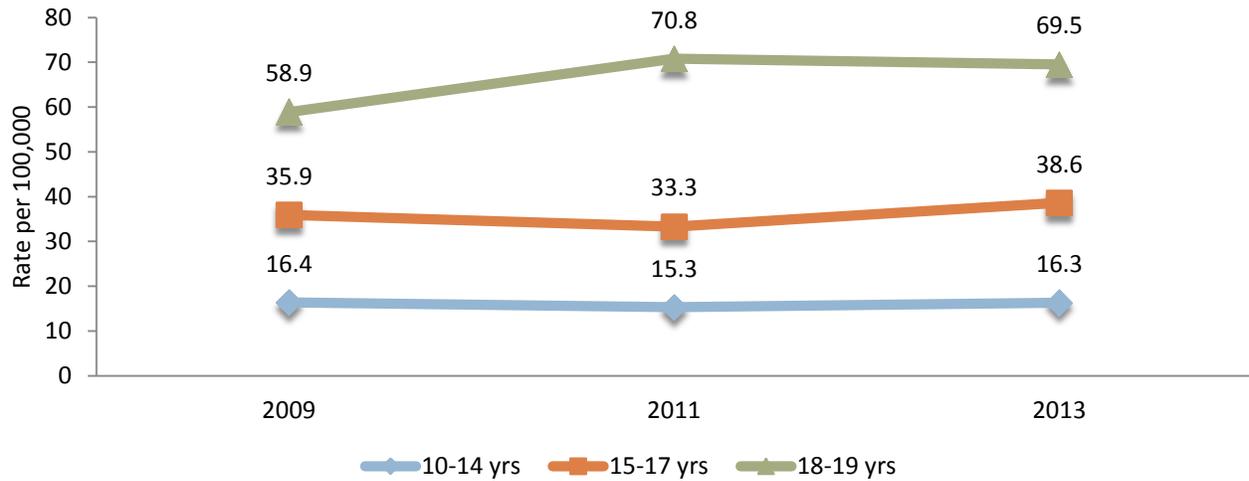
In 2010, the death rate among adolescents 10 to 19 years of age in Georgia began to decline, with the lowest rate in five years experienced in 2012. In 2013, the death rate increased to 33.6 deaths per 100,000 adolescents, nearly negating the decreases seen since 2010. As of 2013, Georgia was not meeting the Healthy People 2020 objective among 10 to 14 year olds. In 2013, the rate of deaths to children ages 10 to 14 years old was 16.3, nearly 10% above the target. The death rate for children 15 to 19 years old was 51.1, under the Healthy People 2020 objective. The highest rate of death occurred among adolescents 18 to 19 years of age, with a death rate of 69.5 in 2013. Furthermore, the death rate for 18 to 19 year olds increased from 2009, but remained relatively stable in all other age groups. From 2009 to 2013, the rate of death was highest among non-Hispanic Blacks. Additionally, the rate of male deaths were twice the rate of female deaths.

Death rate per 100,000 adolescents 10-19 by year, Georgia, 2009-2013



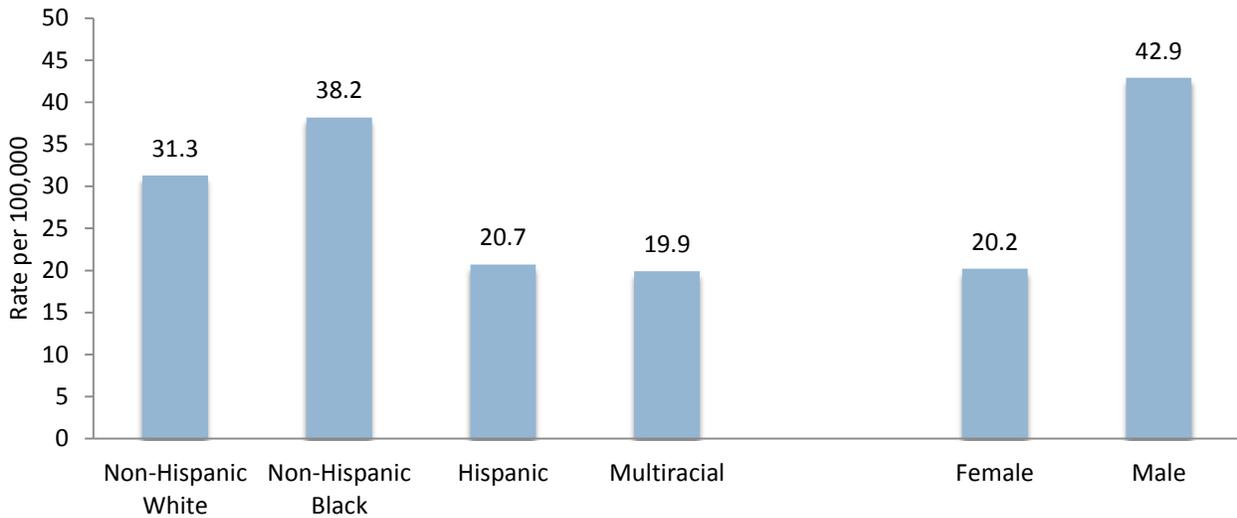
Source: OASIS

Death rate per 100,000 adolescents 10-19 by year and age, Georgia, 2009-2013



Source: OASIS

Death rate per 100,000 adolescents 10-19 by race/ethnicity and gender, Georgia, 2009-2013



Source: OASIS

Motor vehicle accidents were the number one leading cause of death among adolescents 10 to 19 years of age in Georgia from 2009 to 2013. Suicide was the number two cause of death for 10 to 14 year olds, while homicide was the second leading cause of death among 15 to 19 year olds.

Leading causes of death among adolescents 10-19, Georgia, 2009-2013		
	10 to 14 years	15 to 19 years
1	Motor Vehicle Crashes (n=100)	Motor Vehicle Crashes (n=443)
2	Intentional self-harm (Suicide) (n=47)	Assault (Homicide) (n=289)
3	All other diseases of the nervous system (n=46)	Intentional self-harm (Suicide) (n=224)
4	Assault (Homicide) (n=46)	Accidental poisoning and exposure to noxious substances (n=82)
5	Leukemia (n=24)	All other diseases of the nervous system (n=58)
6	Congenital malformations, deformations, and chromosomal abnormalities (n=22)	Accidental drowning and submersion (n=42)
7	Accidental drowning and submersion (n=22)	All other unintentional injuries (n=39)
8	Asthma	Congenital Malformations, deformations, and

Georgia Five Year Needs Assessment

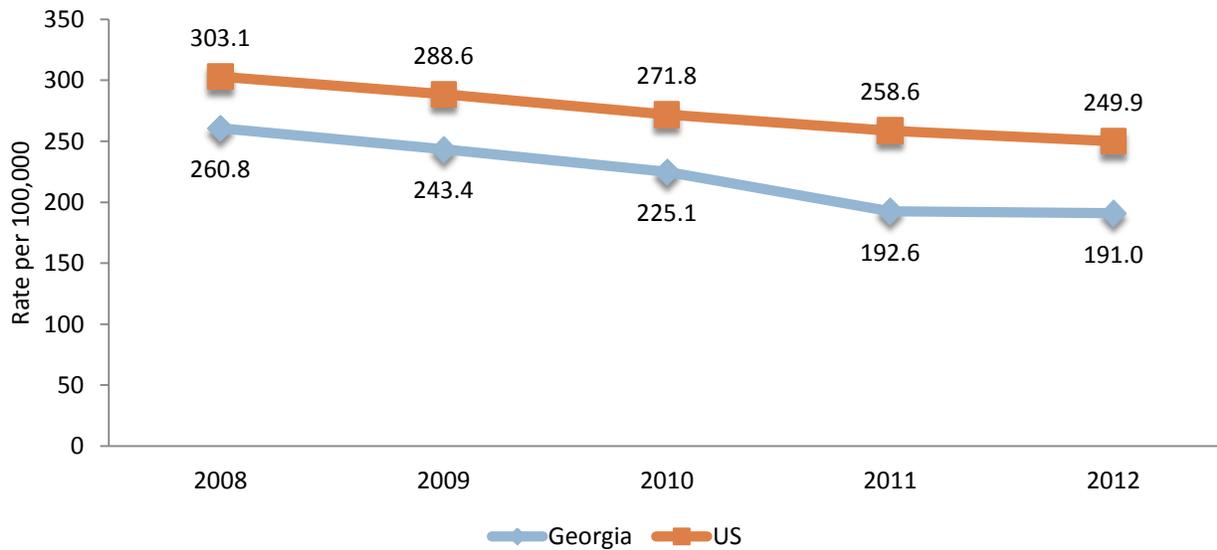
	(n=18)	chromosomal abnormalities (n=36)
9	Malignant Neoplasms of Meninges, Brain, and other parts the Central Nervous System (n=17)	Leukemia (n=23)
10	All other endocrine, nutritional, and metabolic diseases (n=15)	All other endocrine, nutritional, and metabolic diseases (n=21)

Source: OASIS

NON-FATAL INJURY

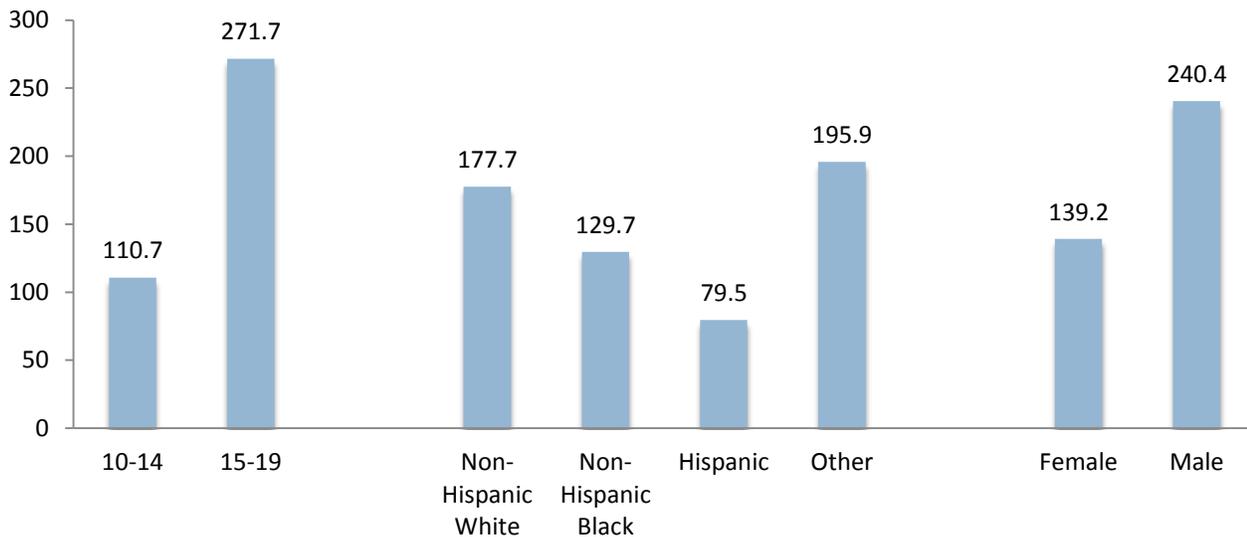
The rate of hospitalization due to non-fatal injury among adolescents decreased from 2008 to 2012. In 2008, the rate was 260.8, but decreased to 191.0 in 2012. As adolescents age, they experience more hospitalizations. Adolescents ages 10 to 14 had a non-fatal injury hospitalization rate of 110.7 in 2012, compared to 271.71 among adolescents 15 to 19 years of age. There was a difference due to gender, 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.

Rate of non-fatal injury per 100,000 adolescents 10-19 years by year, Georgia compared to the US, 2008-2012



Source: State Inpatient Databases

Rate of non-fatal injury per 100,000 adolescents 10-19 years by age, race/ethnicity and gender, Georgia, 2012



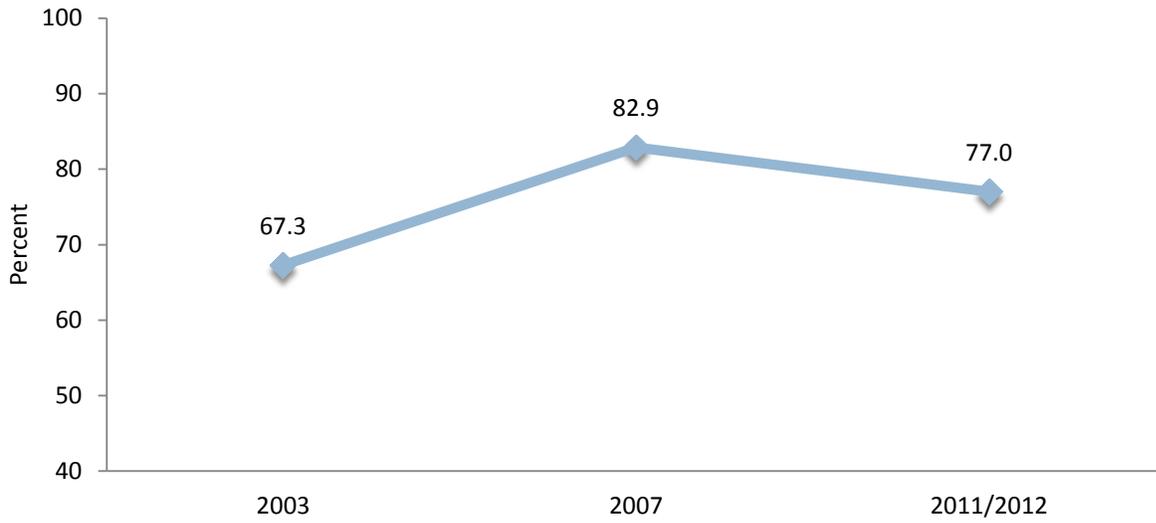
Source: State Inpatient Databases

*Other includes Asian, American Indian, Hawaiian, Alaskan Native, Mixed Race and Other

PREVENTIVE VISIT

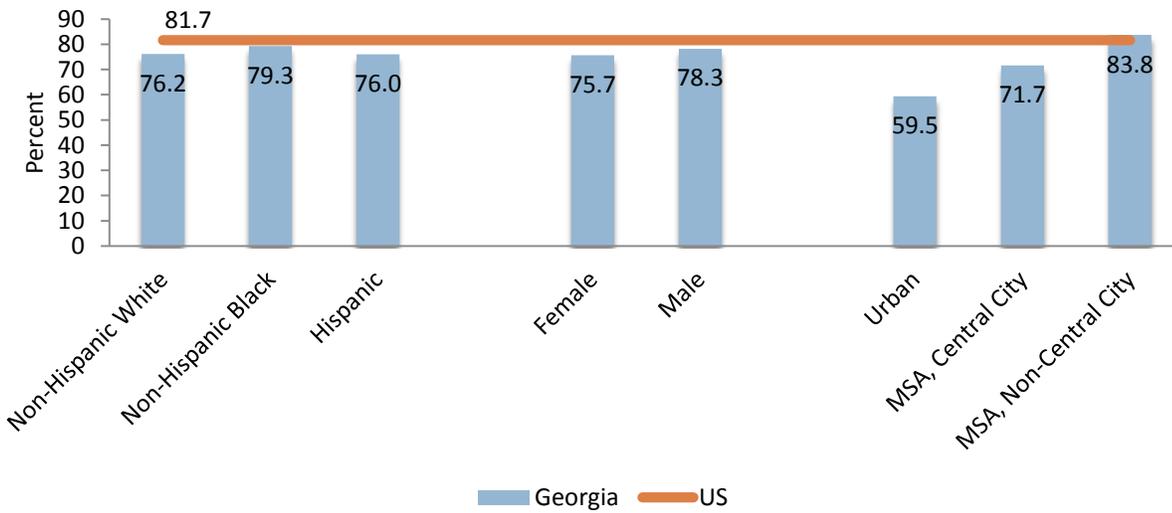
In 2007, the percentage of adolescents 12 to 17 years who saw a doctor, nurse or other health care provider for preventive care was 82.9%. This percentage decreased to 77.0% in 2011/12, less than the national average of 81.7% in 2011/12. Although the national average declined from 2007 to 2012 as well (84.2% to 81.7%), the decline was more pronounced among Georgia's adolescents. Differences exist when stratifying by gender, race/ethnicity and geography. In 2011/12, more males (78.3%) visited a provider for a preventive visit than females (75.7%). Fewer non-Hispanic White and Hispanic adolescents (76.2% and 76.0%) than Blacks (79.3%) reported a preventive visit. Adolescents in urban locations reported far fewer (59.5%) preventive visits than those living in a Metropolitan Statistical Area (MSA) (83.8%). Of all the groups examined, the only category exceeding the national average for 2011/12 was adolescents living in MSAs that are non-central cities.

Percent of adolescents 12-17 who received a preventive medical visit in the past year by year, Georgia, 2003, 2007, 2011/12



Source: NSCH

Percent of adolescents 12-17 who received a preventive medical visit in the past year by race/ethnicity, gender and place of residence, Georgia, 2011/12

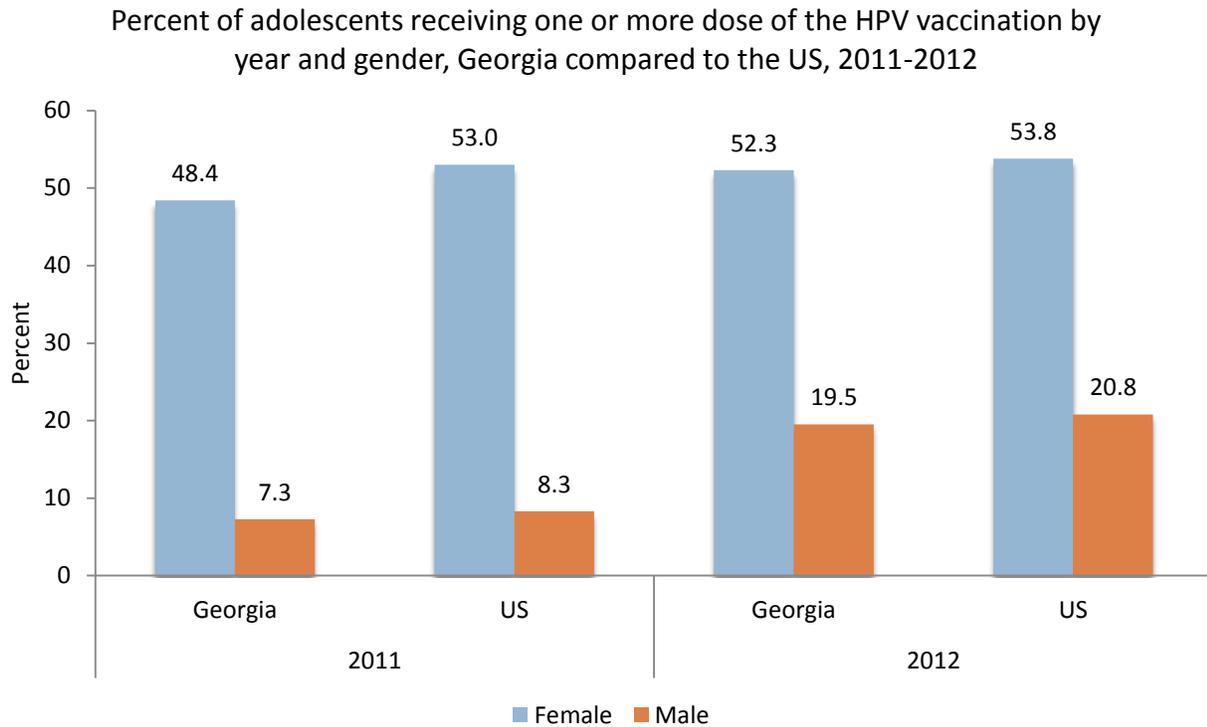


Source: NSCH

VACCINATIONS

Human Papilloma Virus (HPV) Vaccine

The percentage of adolescents receiving the HPV vaccine increased in both Georgia and the US from 2011 to 2012, particularly among adolescent males. Only 7.3% of males in Georgia received one or more dose of the HPV vaccine in 2011, while 19.5% of males received the HPV vaccine in 2012.

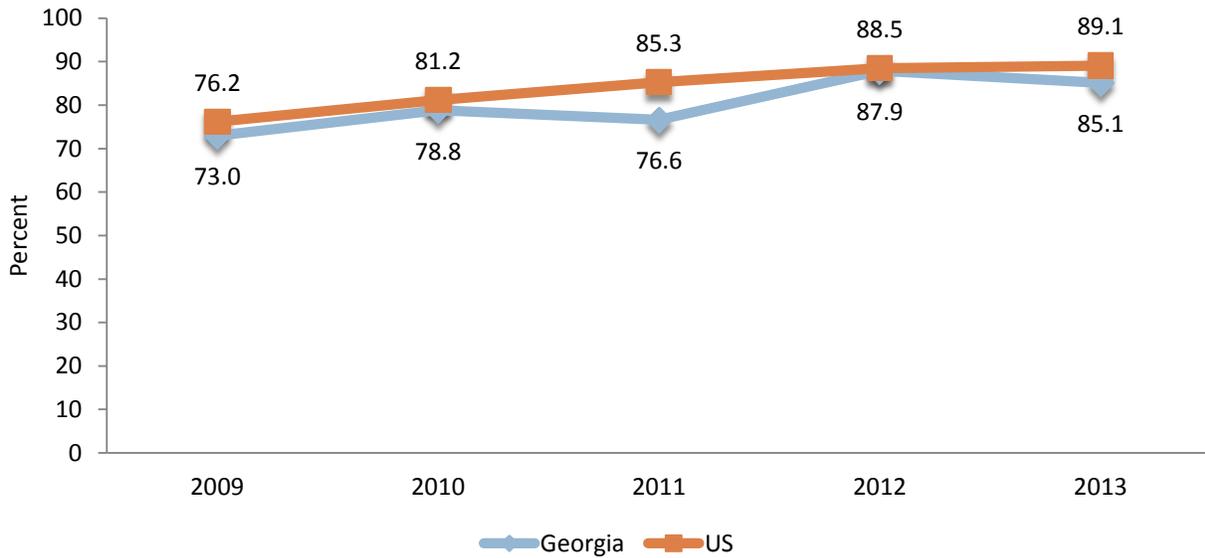


Source: NIS-Teen

Td and Tdap Vaccines

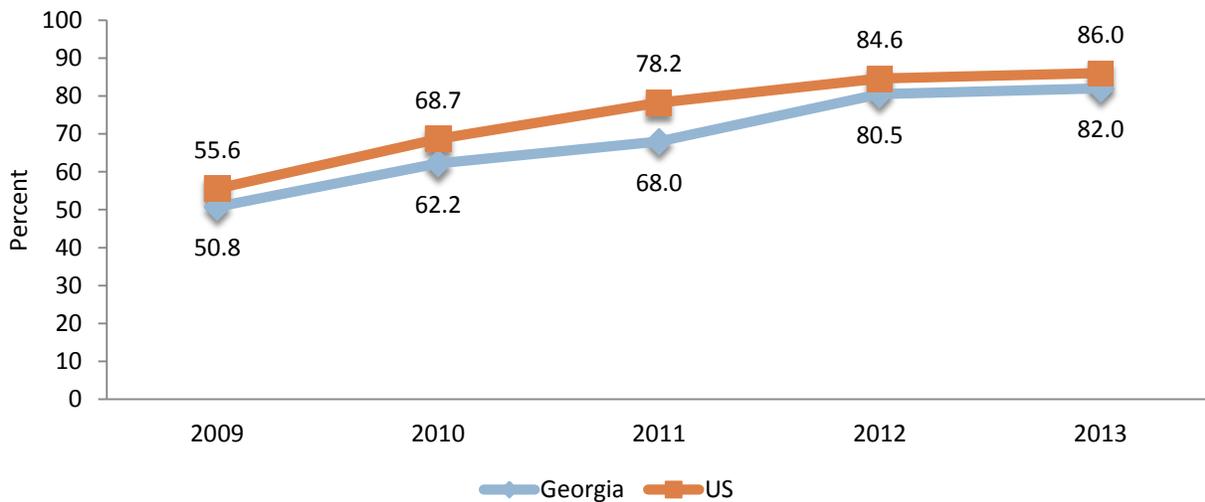
There was a steady increase in the percentage of adolescents who received one or more doses of the Td or Tdap vaccines in both Georgia and the US from 2009 to 2013. The percentages in Georgia were comparable to the US. Most notable is the increase in Tdap vaccination rates in both Georgia and the US. The percentages went from just over 50% in 2009 to over 80% in 2013.

Percent of adolescents 13-17 who received at least one dose of the Td vaccine by year, Georgia compared to the US, 2009-2013



Source: NIS-Teen

Percent of adolescents 13-17 who received at least one dose of the Tdap vaccine by year, Georgia compared to the US, 2009-2013



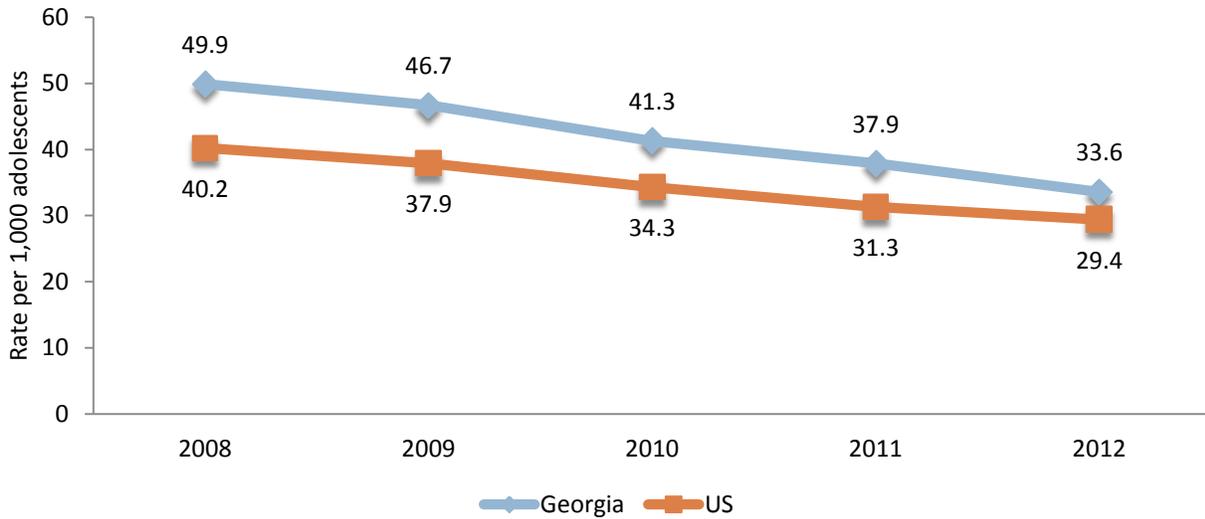
Source: NIS-Teen

BIRTH RATE AMONG ADOLESCENTS

The birth rate among 15 to 19 year olds in Georgia steadily declined from 2008 to 2012. In 2008, the birth rate among adolescents in Georgia was 49.9 while in 2012 it decreased to 33.6, a 48% decrease in just five

years. Despite the decrease, Georgia’s rate remained above the national average in all years examined. The adolescent birth rate was higher among adolescents aged 18 to 19 (59.8) compared to adolescents aged 15 to 17 (15.8). Hispanic adolescents had the highest birth rate in 2012 (49.2), while non-Hispanic Whites had the lowest (24.2). The percentage of births to adolescents that were repeat births also steadily declined from 2008 to 2012.

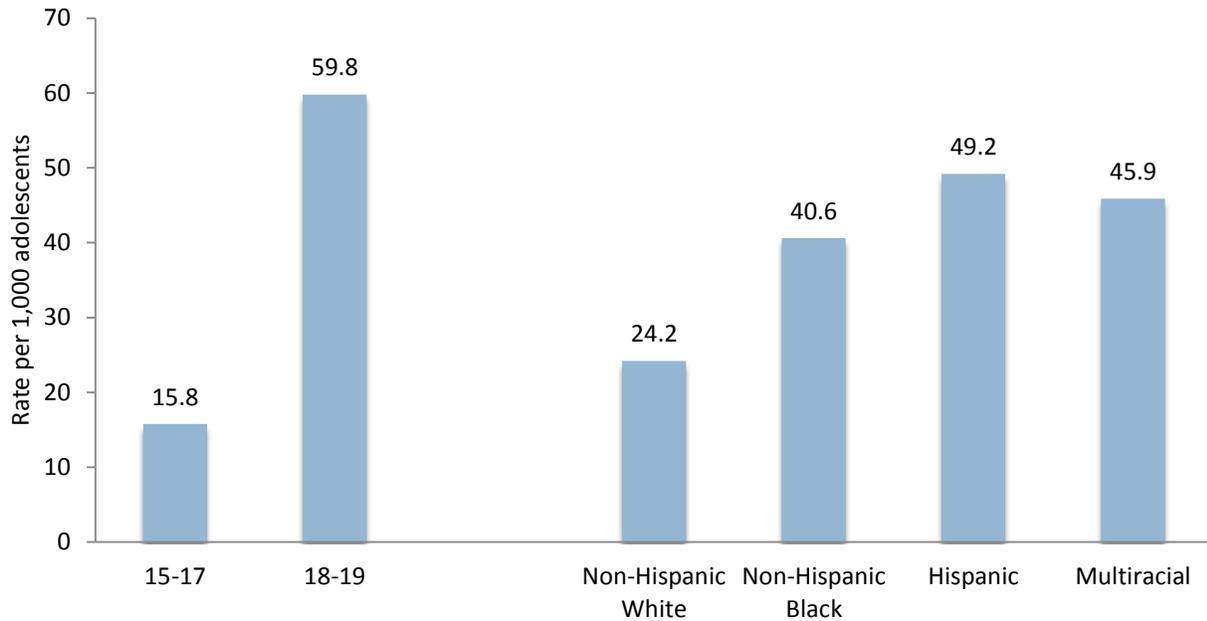
Rate of birth per 1,000 adolescents 15-19 by year, Georgia compared to the US, 2008-2012



Source: OASIS ; NVSS

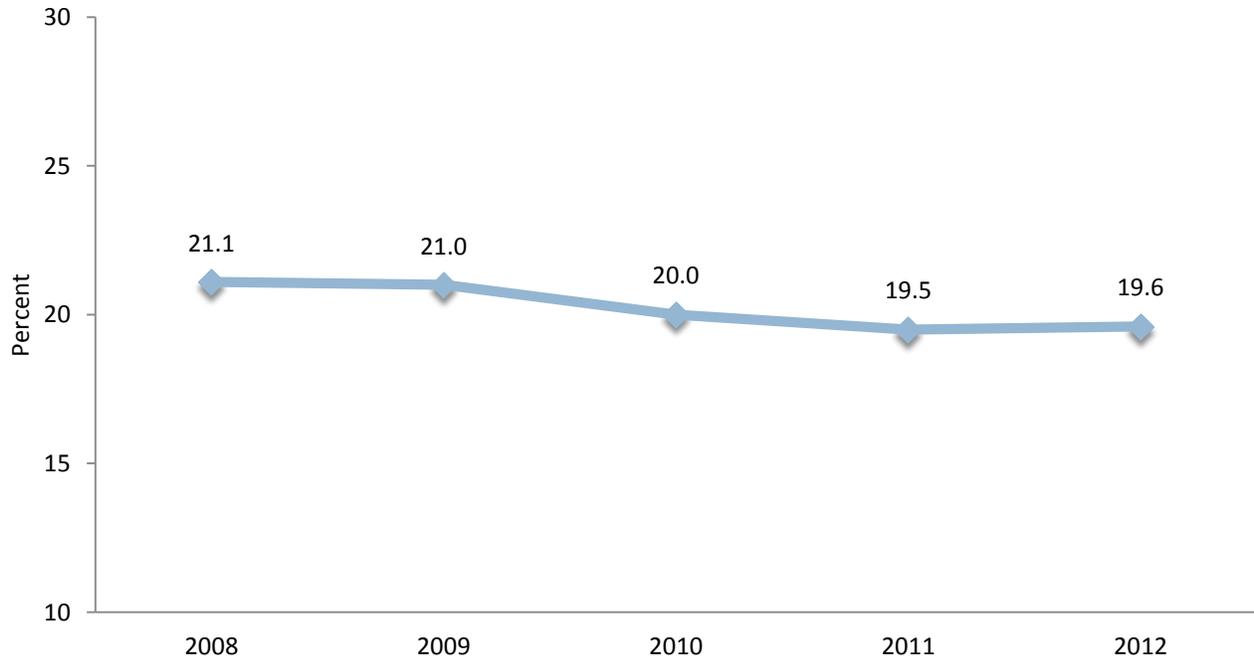


Birth rate per 1,000 adolescents 15-19 by age and race/ethnicity, Georgia, 2012



Source: OASIS

Percent of repeat births among adolescents 15-19 by year, Georgia, 2008-2012

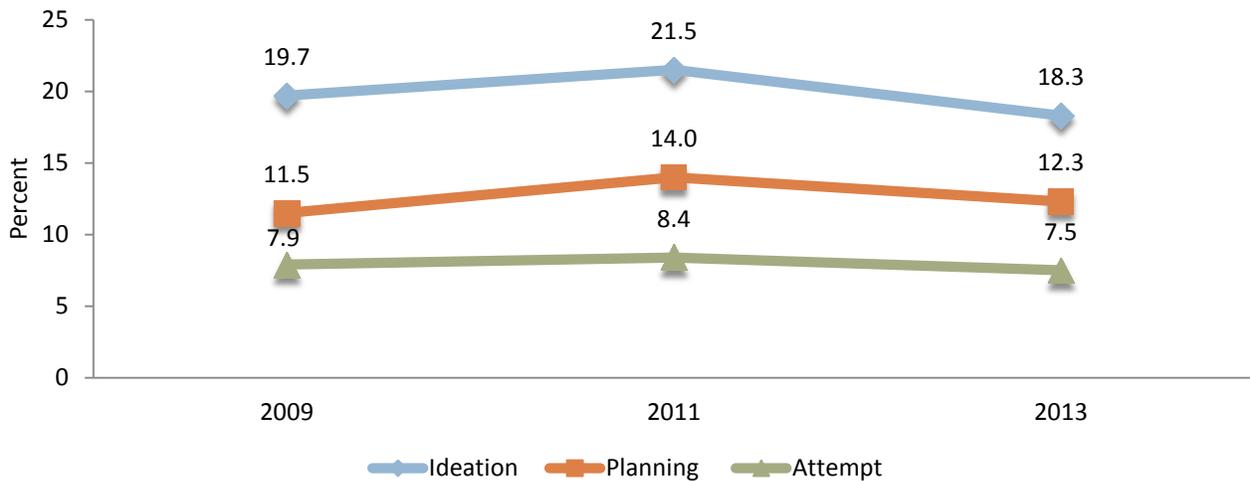


Source: OASIS

SUICIDE IDEATION, SUICIDE PLANNING AND SUICIDE ATTEMPTS

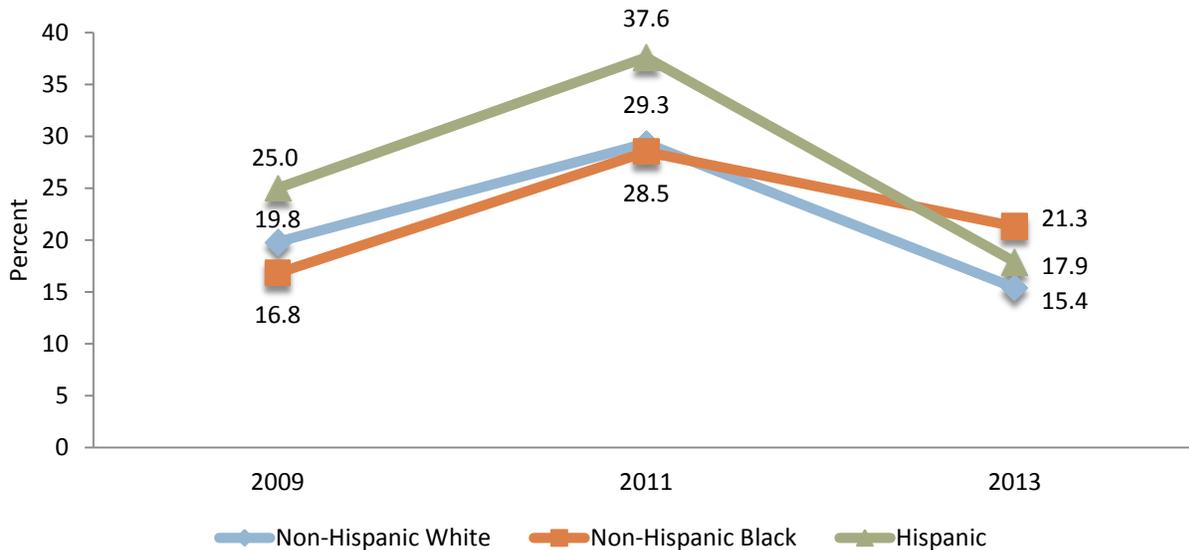
The percentages of middle school and high school students reporting suicide ideation, planning and attempts remained similar from 2009 to 2013. In 2013, 18.3% of middle school students reported suicide ideation, 12.3% reported suicide planning and 7.5% reported attempting suicide. Suicide ideation among middle school students of all races and ethnicities peaked in 2011. Among Hispanics, the percentage increased from 25.0% in 2009 to 37.6% in 2011, then decreased to 17.9% in 2013. Among high school students, 14.3% reported suicide ideation, 12.2% reported suicide planning and 8.8% reported attempting suicide.

Percent of middle school students reporting suicide ideation, planning, and attempts by year, Georgia 2009, 2011, 2013

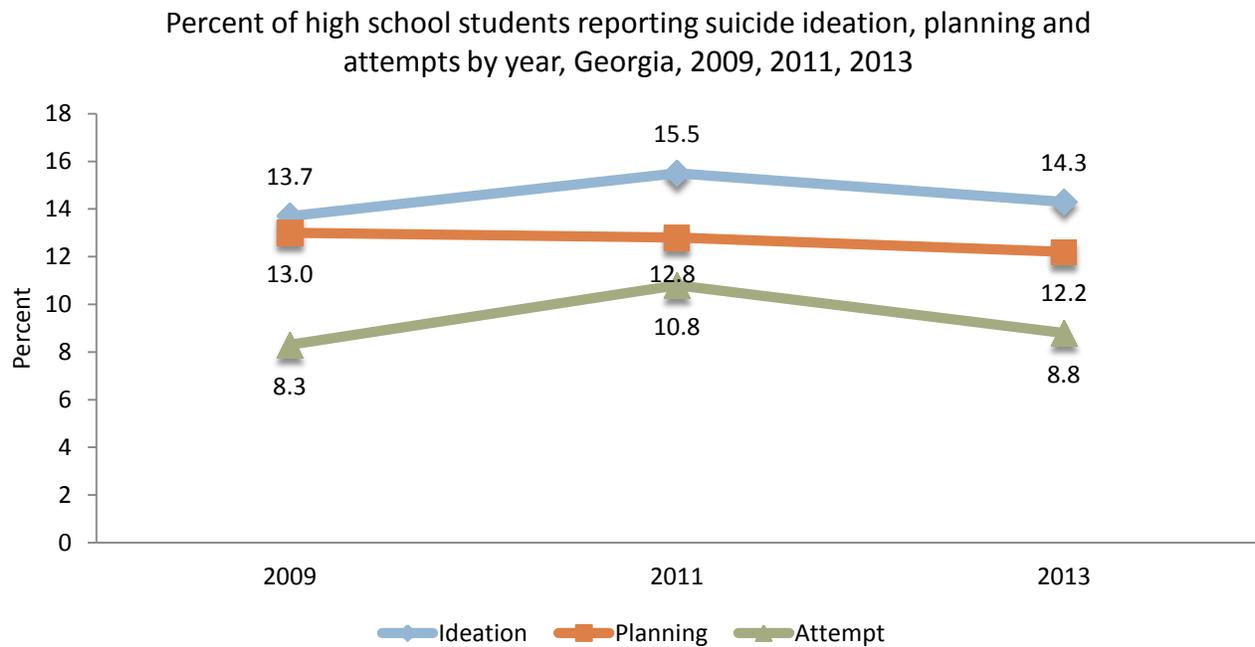


Source: YRBS

Percent of middle school students reporting suicide ideation by year and race/ethnicity, Georgia, 2009, 2011, 2013



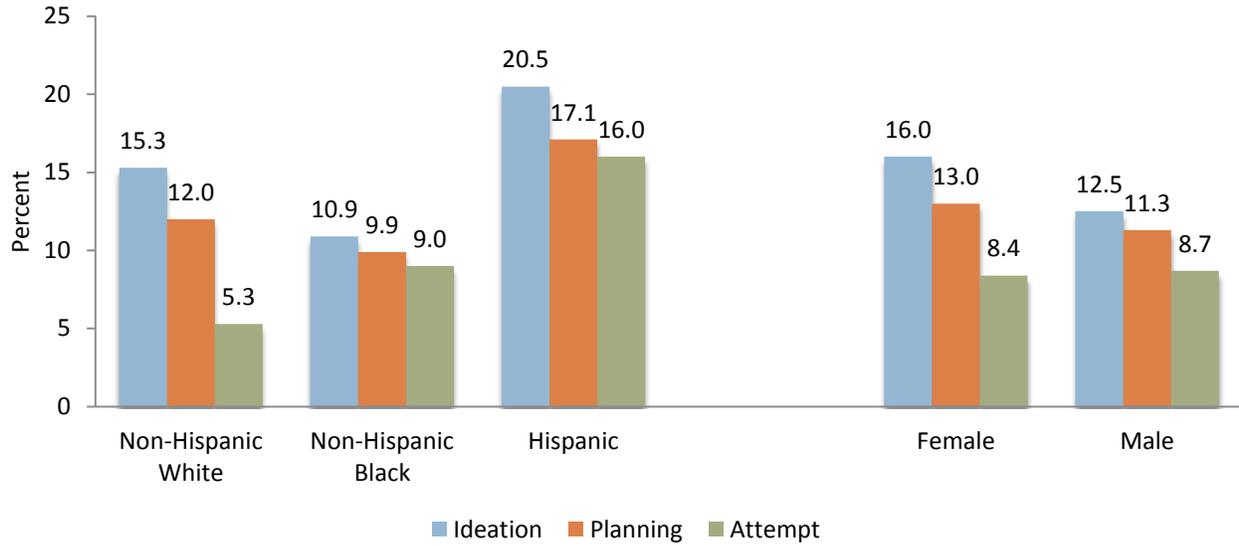
Source: YRBS



Source: YRBS

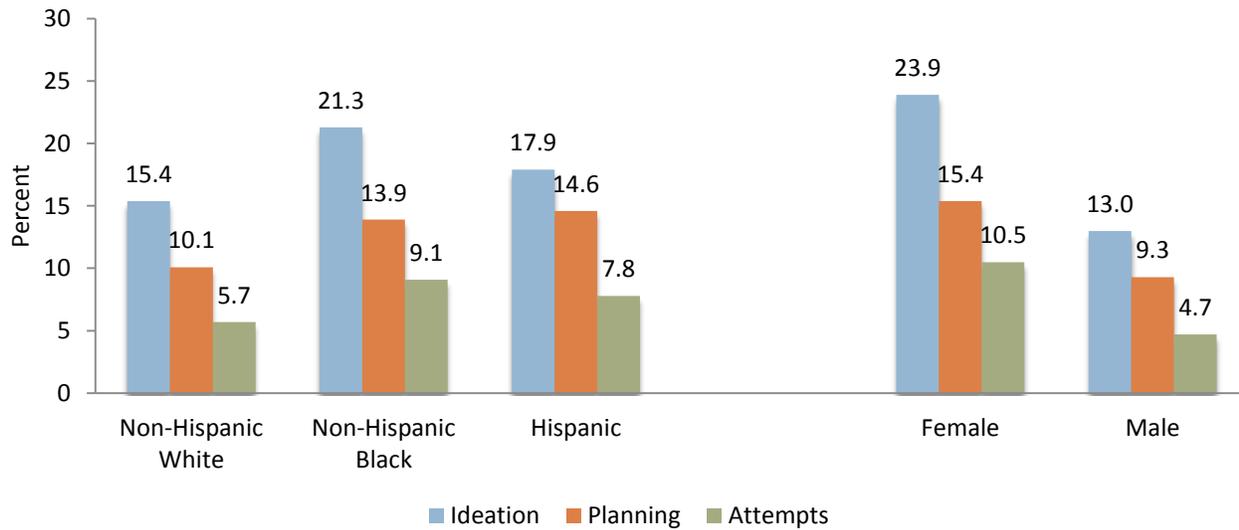
Among high school students, the percentages of suicide ideation, planning and attempts were highest among Hispanics, and slightly higher among females than males. Among middle school students, the highest percentages of suicide ideation and attempts were among non-Hispanic Blacks. More females reported suicide ideation, planning and attempts than males, and the difference between genders was more pronounced than what was seen among high school students.

Percent of high school students reporting suicide ideation, planning and attempts by race/ethnicity and gender, Georgia, 2013



Source: YRBS

Percent of middle school students reporting suicide ideation, planning and attempts by race/ethnicity and gender, Georgia, 2013



Source: YRBS

BULLYING

On School Property

Healthy People 2020 Objective

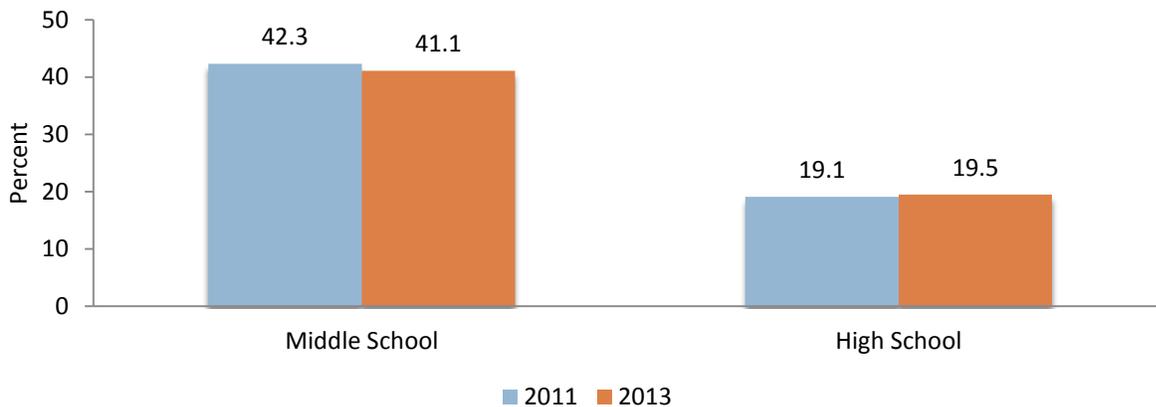
IVP-35: Reduce bullying on school property among students in grades 9 through 12 to 17.9%

Just over 40% 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% 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%) reported being bullied on school property more often than males (36.1%).

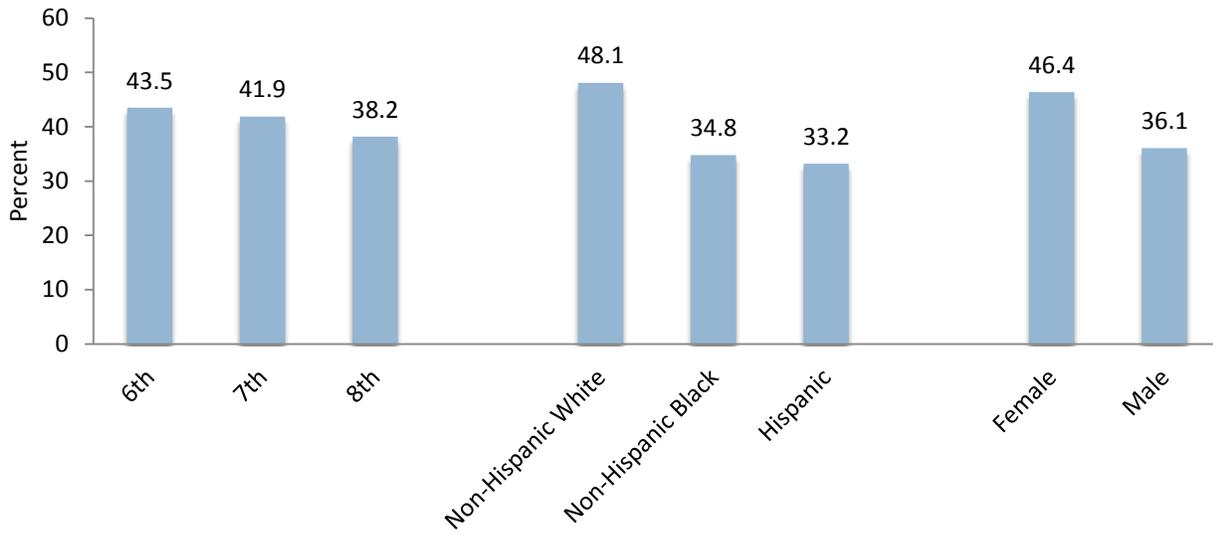
Bullying on school property during the past year was more prevalent among high school students in 9th and 10th grade (24.7% and 23.1%) compared to those in 11th and 12th grade (14.8% and 12.4%). Non-Hispanic Whites and Hispanics were bullied on school property in the past year over 1.5 times more than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

Percent of middle school students who have ever been bullied on school property and high school students who were bullied on school property in the past year by year, Georgia, 2011, 2013



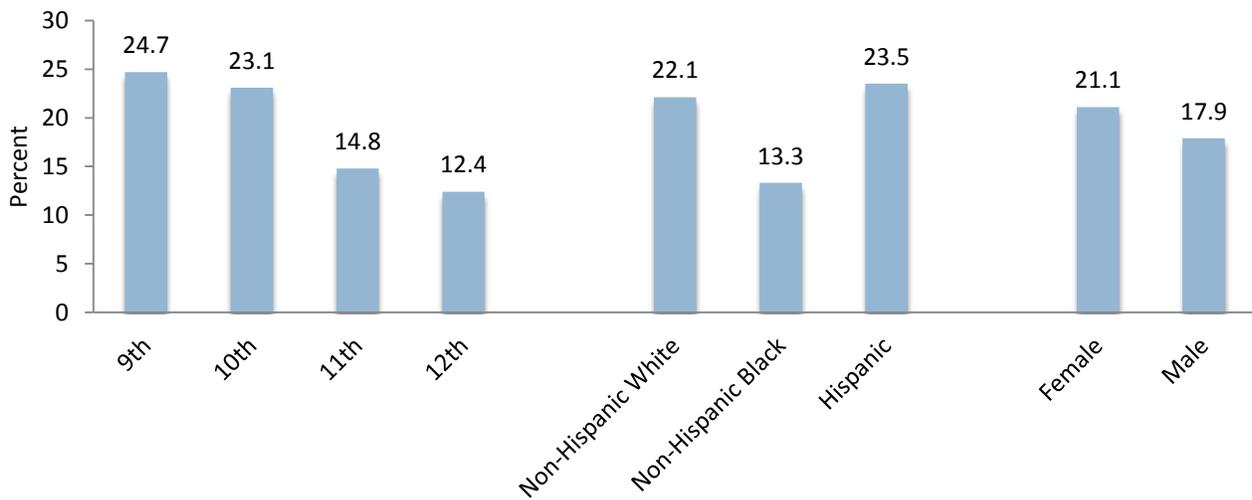
Source: YRBS

Percent of middle school students who were ever bullied on school property by grade, race/ethnicity and gender, Georgia, 2013



Source: YRBS

Percent of high school students who were bullied on school property in the past year, Georgia, 2013



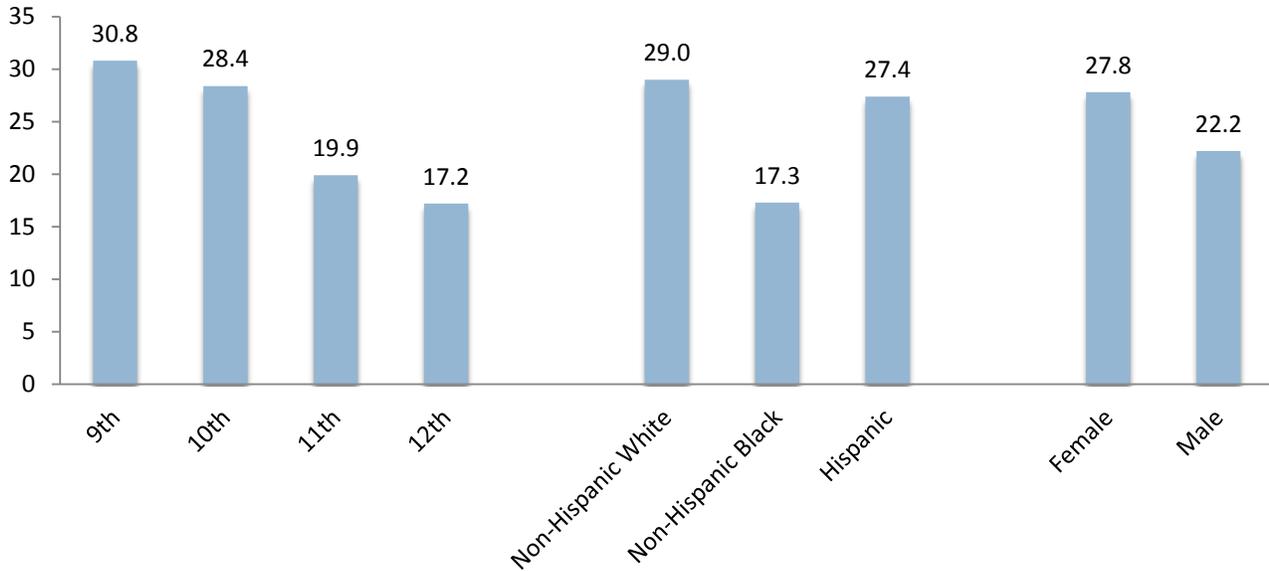
Source: YRBS

Victims and Bullies

In 2013, 25.1% of Georgia’s high school students reported either being bullied or bullying others. Almost twice as many 9th grade students reported that they were involved in bullying than those in the 12th grade (30.8% and 17.2% respectively). Racial differences were seen 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%).

Percent of high school students who were bullied or who bullied others by grade, race/ethnicity and gender, Georgia, 2013

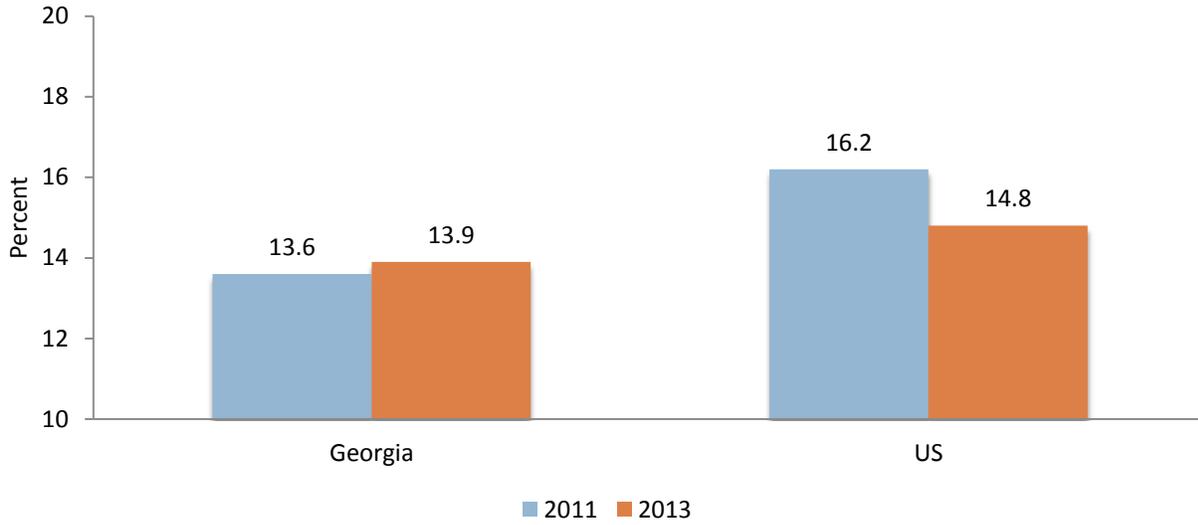


Source: YRBS

Electronic Bullying

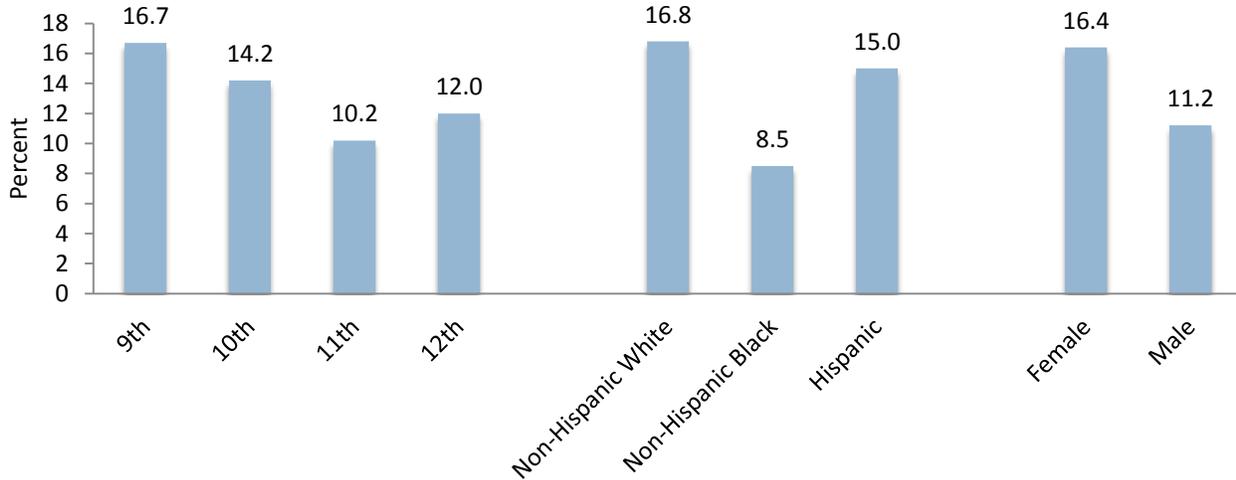
Electronic bullying was slightly less prevalent in Georgia compared to the US in both 2011 and 2013. In both Georgia and the US, the percentage increased from 2011 to 2013. Ninth graders experienced more electronic bullying than high school students in grades 10 through 12. Non-Hispanic White high school students reported experiencing electronic bullying most often (16.8%), compared to their Hispanic (16.8%) and non-Hispanic Black (8.5%) peers. Female high school students also reported more instances of electronic bullying (16.4%) compared to male high school students (11.2%).

Percent of high school students who had been electronically bullied in the past year, Georgia compared to the US, 2011, 2013



Source: YRBS

Percent of high school students who had been electronically bullied in the past year, Georgia, 2013



Source: YRBS

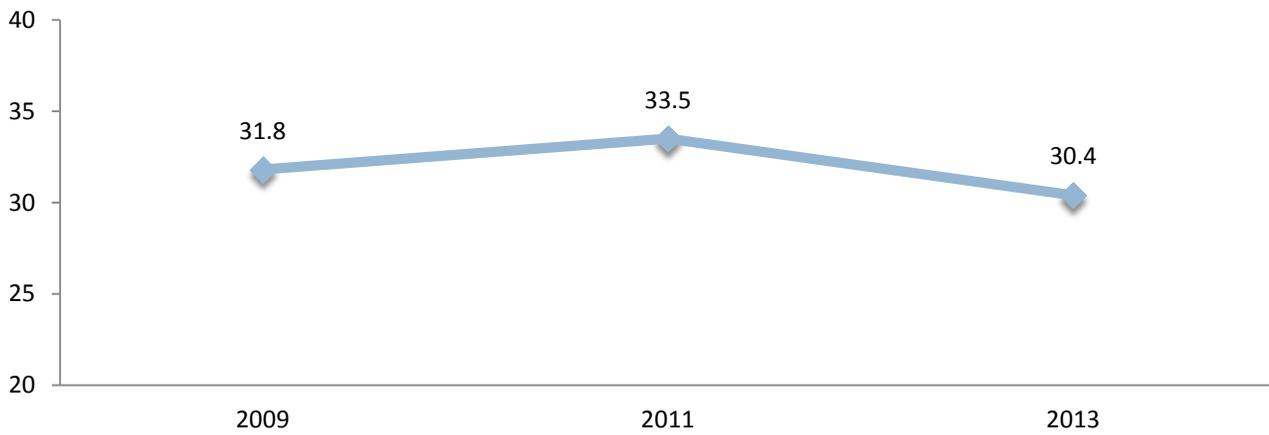
WEAPON CARRYING

Over 30% of middle school students reported every carrying a weapon, such as a gun, knife or club, from 2009 to 2013. The percentage increased as grade level increased, and was highest among non-Hispanic

Whites (36.8%) relative to other races and ethnicities. The percentage was far higher among males (42.9%) compared to females (17.6%).

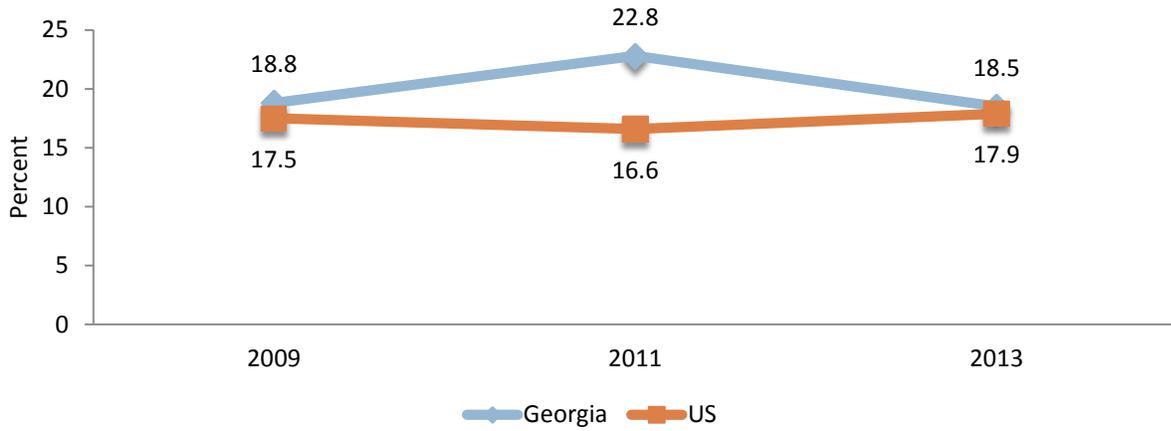
More high school students in Georgia than in the US as a whole reported carrying a weapon, such as a gun, knife or club, during the past month. When stratified by demographic characteristic, similar patterns were seen between middle and high school students. Although there was only slight variation by grade level, more students in the 12th grade reported carrying a weapon during the past month than students in all other grade levels. The percentage was highest among non-Hispanic Whites (23.1%), however was lowest among Hispanics (11.2%). Males reported carrying a weapon during the past month 4.7 times more often than females.

Percent of middle school students who reported ever carrying a weapon by year, Georgia, 2009, 2011, 2013



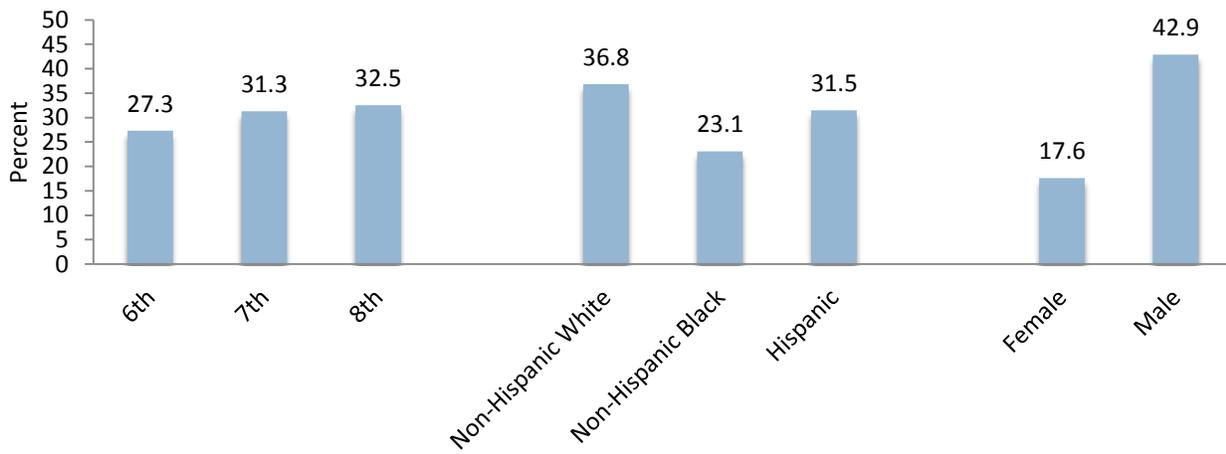
Source: YRBS

Percent of high school students who reported carrying a weapon on one or more of the past 30 days by year, Georgia compared to the US, 2009, 2011, 2013



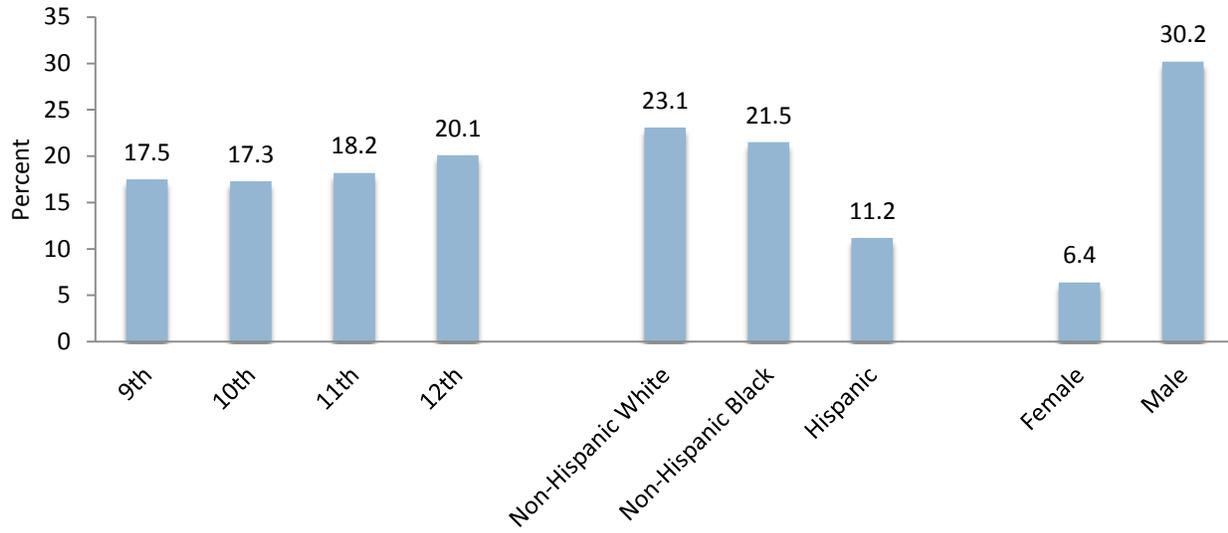
Source: YRBS

Percent of middle school students who reported ever carrying a weapon by grade, race/ethnicity and gender, Georgia, 2013



Source: YRBS

Percent of high school students who reported carrying a weapon on one or more of the past 30 days by grade, race/ethnicity and education, Georgia, 2013

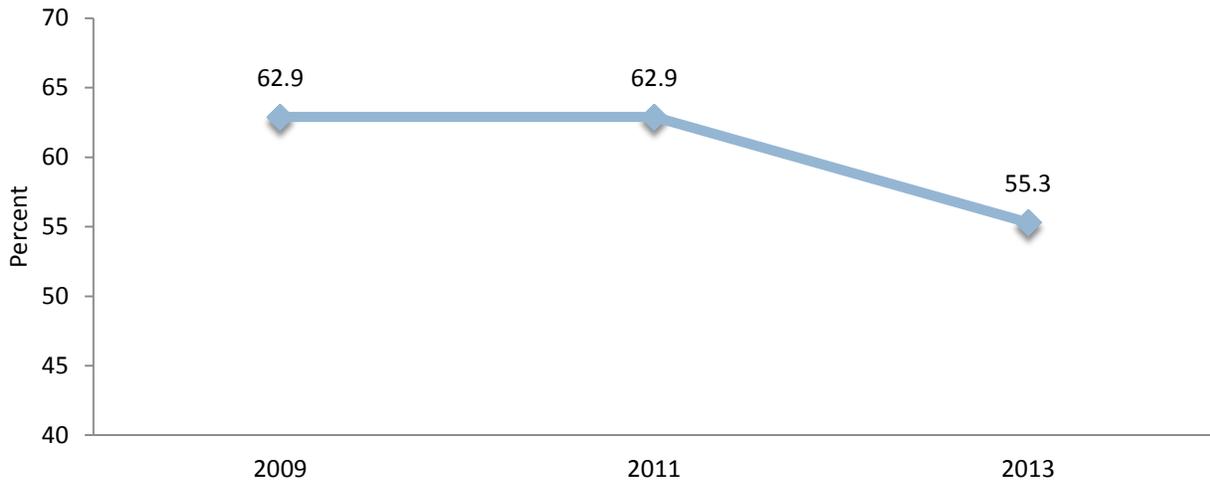


Source: YRBS

PHYSICAL FIGHTS

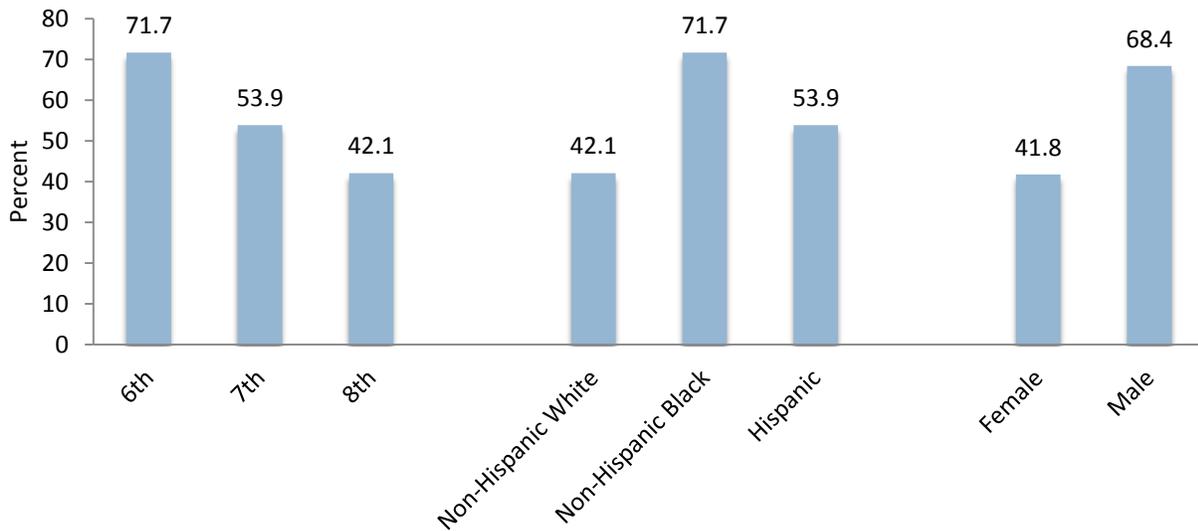
The percentage of middle school students in Georgia who reported ever being in a physical fight decreased from 62.9% in 2009 to 55.3% in 2013. Among students in the sixth grade, 71.7% reported that they had ever been in a physical fight in 2013. Among eighth grade students, the percentage dropped to 42.1%. Non-Hispanic Blacks reported ever being in a physical fight 1.3 times more often than Hispanics and 1.7 times more often than non-Hispanic Whites. The percentage was far higher among males than females.

Percent of middle school students who were ever in a physical fight, Georgia, 2009, 2011, 2013



Source: YRBS

Percent of middle school students who were ever in a physical fight by grade, race/ethnicity and gender, Georgia, 2013



Source: YRBS

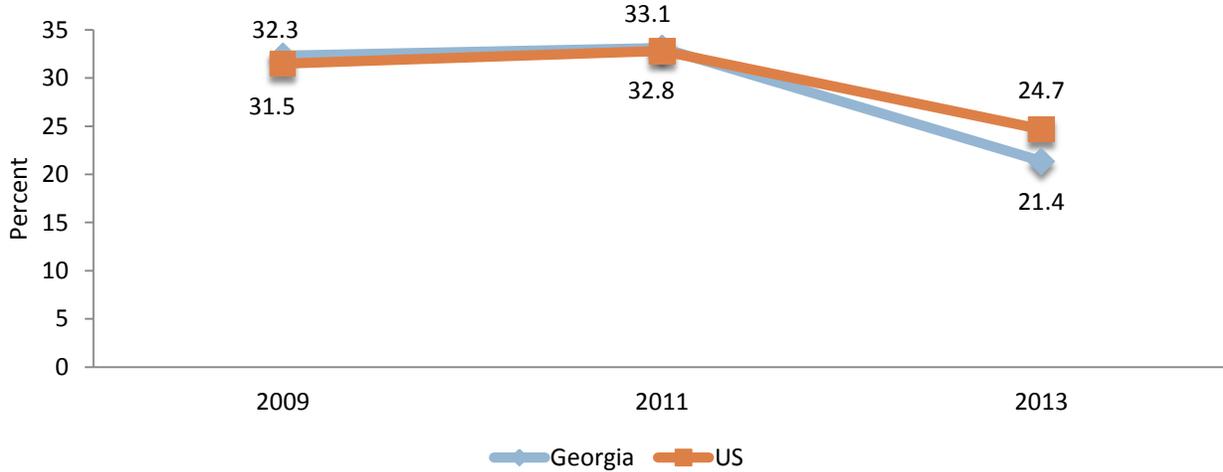
Healthy People 2020 Objective

IVP-34: Reduce physical fighting among students in grades 9 through 2012 to 28.4%

Georgia Five Year Needs Assessment

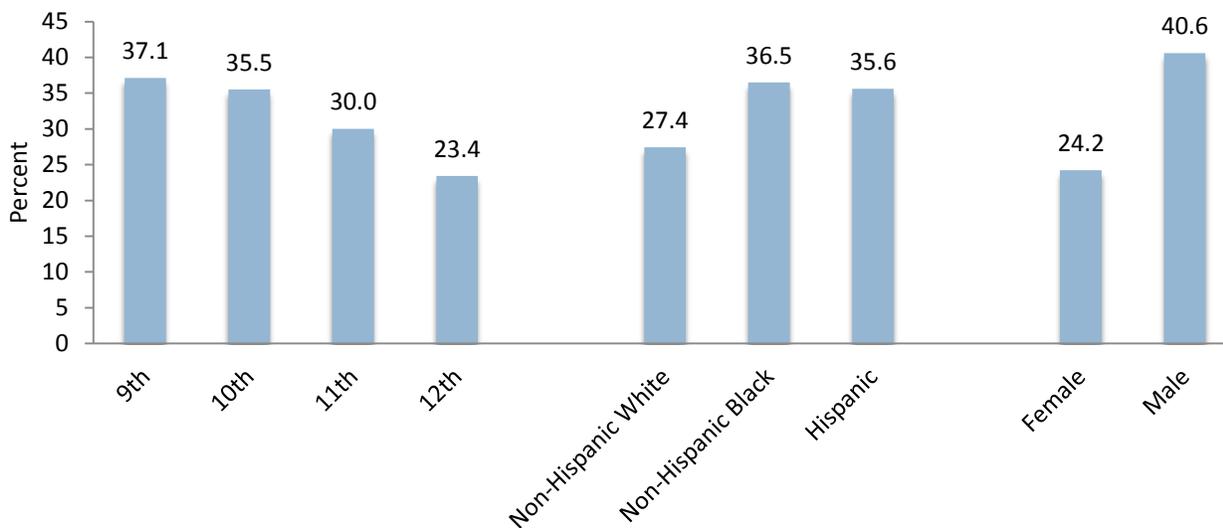
Based on the most recent available data for Georgia, approximately 21.4% of high school students reported being in a physical fight one or more times in the last 12 months, less than the Healthy People 2020 objective of 28.4%. Physical fighting was more prevalent among 9th and 10th grade students (37.1% and 35.5%) compared to 11th and 12th grade students (30.0% and 23.4%). Over 35% of non-Hispanic Black and Hispanic students were in a physical fight in the past year compared to only 27.4% of non-Hispanic White students. Males reported being in a physical fight 1.7 times more often than females.

Percent of high school students who were in a physical fight in the past year by year, Georgia compared to the US, 2009, 2011, 2013



Source: YRBS

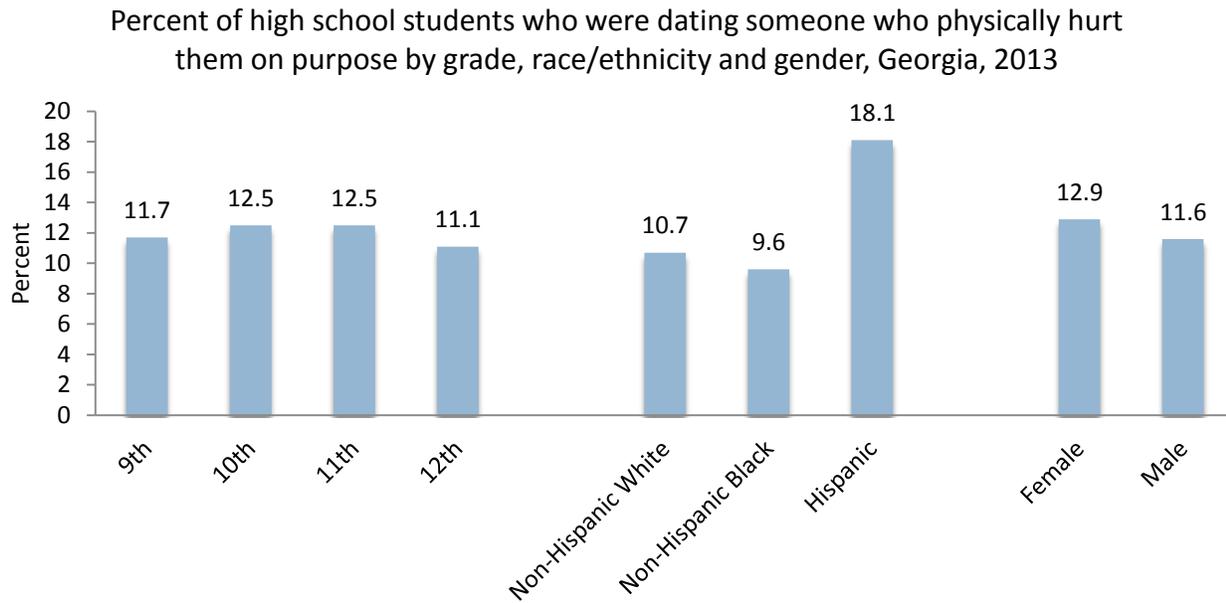
Percent of high school students who were in a physical fight in the past year by grade, race/ethnicity and gender, Georgia, 2013



Source: YRBS

DATING VIOLENCE

Little variation was seen in the percentage of high school students who experienced dating violence in 2013 between grade levels. Over 18% of Hispanics reported experiencing dating violence, while approximately 10% of non-Hispanic Whites and non-Hispanic Blacks did. The percentage was only slightly higher among females (12.9%) compared to males (11.6%).

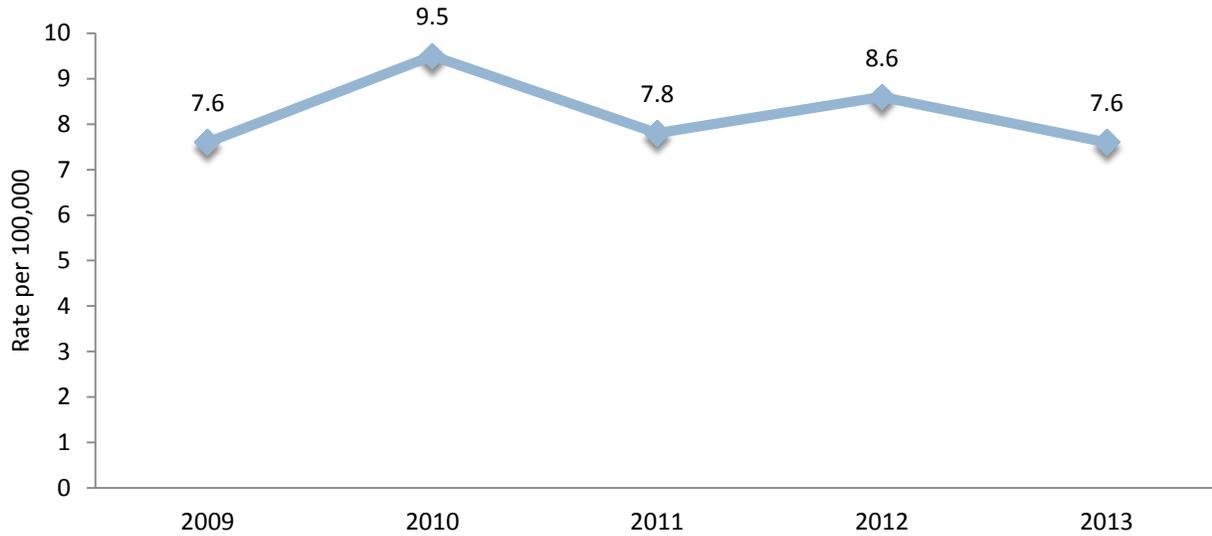


Source: YRBS

HOMICIDE

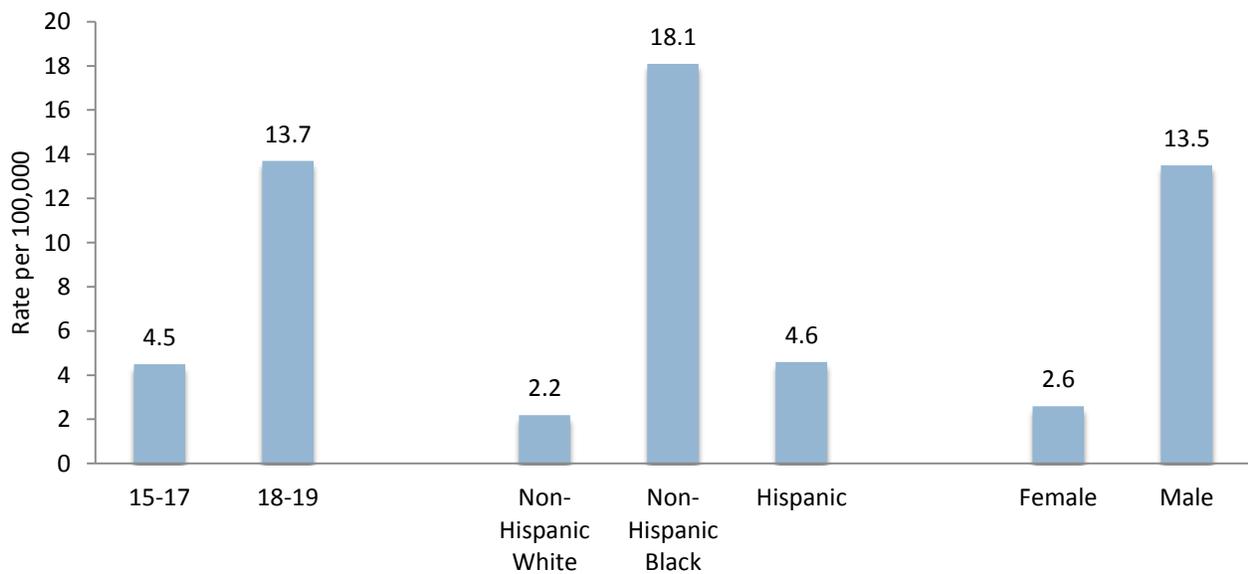
The homicide death rate among adolescents 15 to 19 years of age varied from 2009 to 2013 with no clear trend. In both 2009 and 2013, the rate was 7.6. The rate was 3 times higher among adolescents aged 18 to 19 compared to adolescents aged 15 to 17. There were clear disparities by race/ethnicity during this time period. The rate was 18.1 among non-Hispanic Blacks, but less than 5 for both non-Hispanic Whites and Hispanics. The death rate among males was 5.2 times higher than females.

Rate of deaths due to homicide per 100,000 adolescents 15-19 by year, Georgia, 2009-2013



Source: OASIS

Rate of deaths due to homicide per 100,000 adolescents 15-19 by age, race/ethnicity and gender, Georgia, 2009-2013



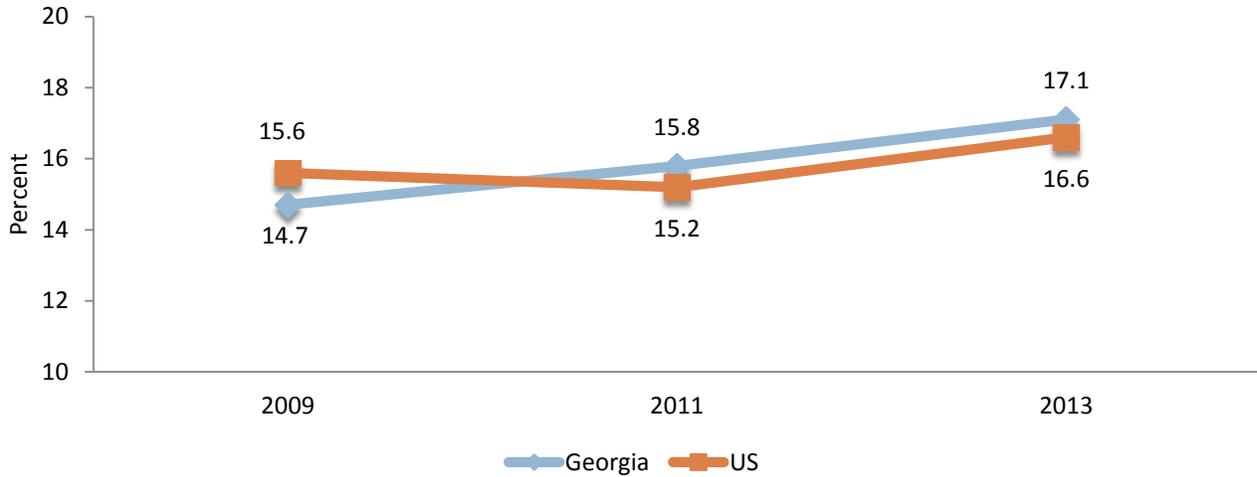
Source: OASIS

OVERWEIGHT AND OBESITY

The percentage of high school students who were overweight in Georgia was very similar to the national average from 2009 to 2013. In Georgia, the percentage increased from 14.7% in 2009 to 17.1% in 2013. More high school students were overweight than obese in 2013. The percentages were higher among non-

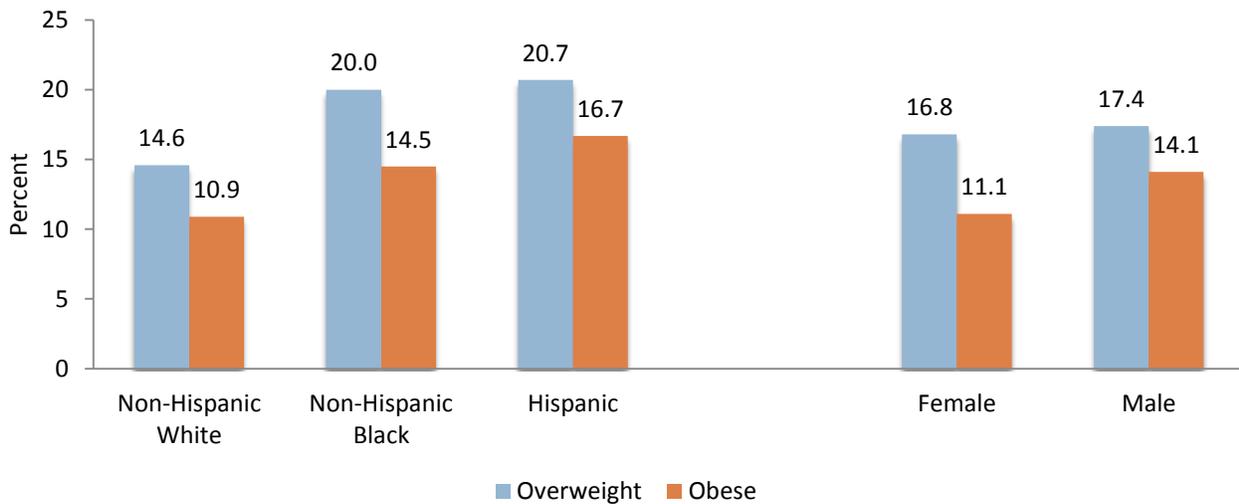
Hispanic Blacks and Hispanics. The prevalence of overweight and obesity was similar across genders, with slightly more males reporting being obese and overweight than females.

Percent of high school students who were overweight by year, Georgia compared to the US, 2009, 2011, 2013



Source: YRBS

Percent of high school students who were overweight or obese by race/ethnicity and gender, Georgia, 2013



Source: YRBS

PHYSICAL ACTIVITY

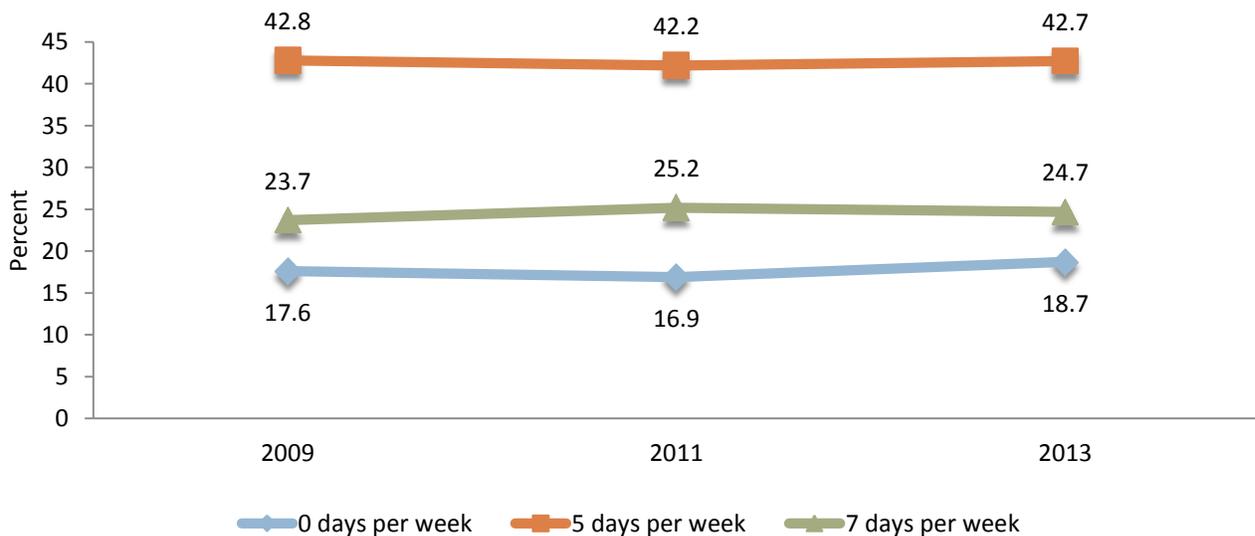
Healthy People 2020 Objective

PA-3.1: Increase the proportion of adolescents who were physically active for a total of at least 60 minutes per day on seven of the past seven days to 31.6%

From 2009 to 2013, just over 40% of Georgia’s high school students reported performing physical activity 60 minutes per day 5 days per week. Close to 25% performed physical activity 7 days per week, less than the Healthy People 2020 objective of 31.6%. Under 20% reported performing 60 minutes of physical activity on 0 days per week.

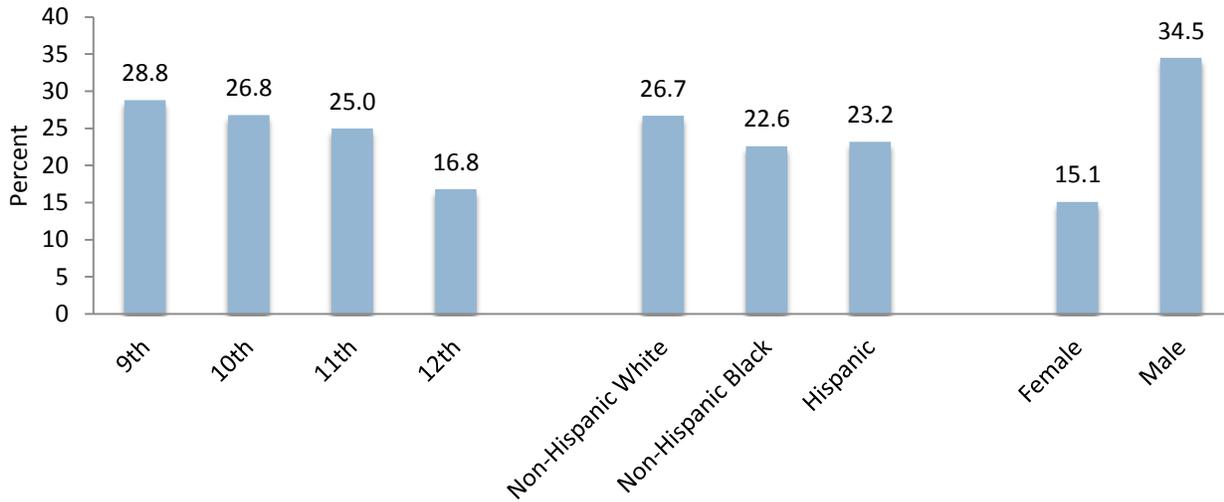
Among students in grades 9 through 11, the percentage of students performing 60 minutes of physical activity per day was over 25%. Among 12th grade students, the percentage dropped to 16.8%. Slightly more non-Hispanic Whites reported performing the recommended amount of physical activity than non-Hispanic Black or Hispanic students. Male students were the only group achieving the Healthy People 2020 objective, and were reported physical activity twice as often as their female counterparts.

Percent of high school students performing 60 minutes of physical activity by frequency and year, Georgia, 2009, 2011, 2013



Source: YRBS

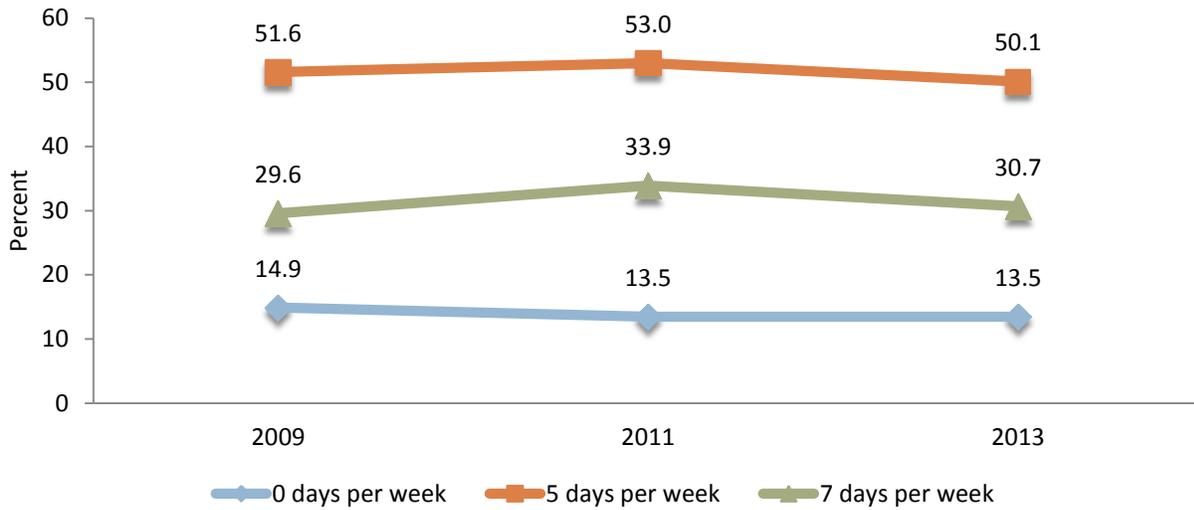
Percent of high school students who were physically active 60 minutes per day 7 days per week by grade, race/ethnicity and gender, Georgia compared to the US, 2013



Source: YRBS

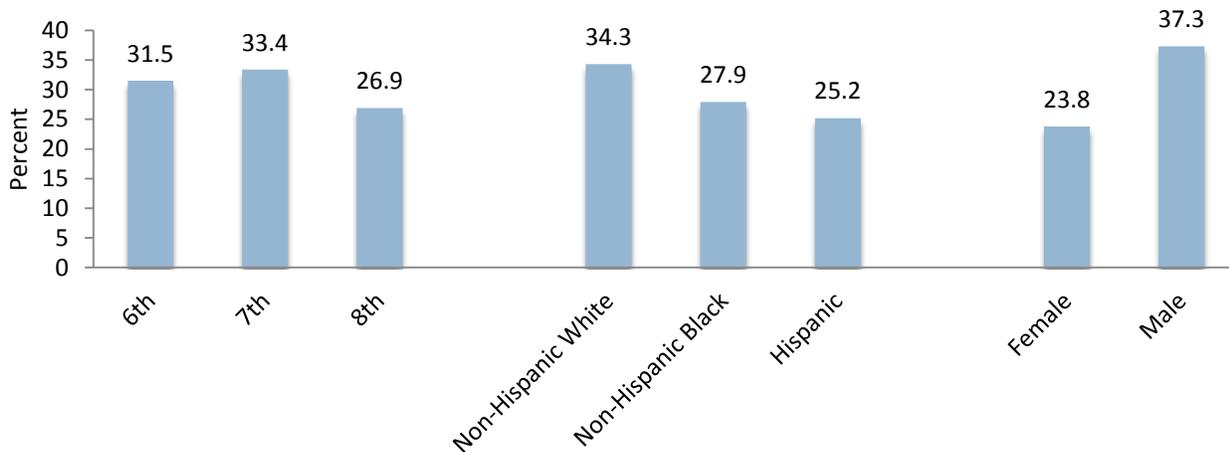
Among middle school students, approximately 50% reported performing physical activity for 60 minutes per day 5 days per week. The percentage was approximately 30% for those who performed 50 minutes of physical activity every day of the week. In 2013, 13.5% of middle school students performed 60 minutes of physical activity on 0 days out of the week. Little variation was seen from 2009 to 2013. Although there were no evident differences by grade level, slightly less students in 8th grade performed 60 minutes of physical activity every day of the week compared to students in the 6th and 7th grades. The percentage was higher among non-Hispanic Whites. More male than female middle school students were performing the recommended amounts of physical activity in 2013.

Percent of middle school students performing 60 minutes of physical activity by frequency and year, Georgia, 2009, 2011, 2013



Source: YRBS

Percent of middle school students who were physically active 60 minutes per day 7 days per week by grade, race/ethnicity and gender, Georgia, 2009, 2011, 2013



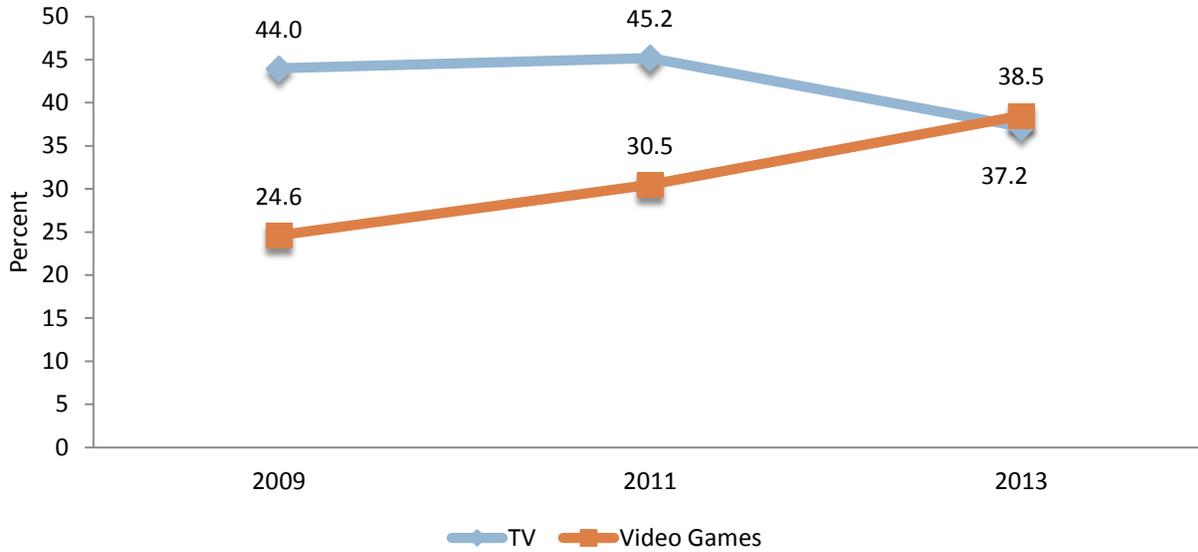
Source: YRBS

SCREEN TIME

Among Georgia’s middle school students, television watching decreased from 2009 to 2013 while video game usage increased. For both TV and video games, more middle school students than high school students reported daily screen time of three or more hours per day. The percentage of high school students reporting three or more hours of video games per day increased from 22.9% in 2009 to 35.5% in 2013.

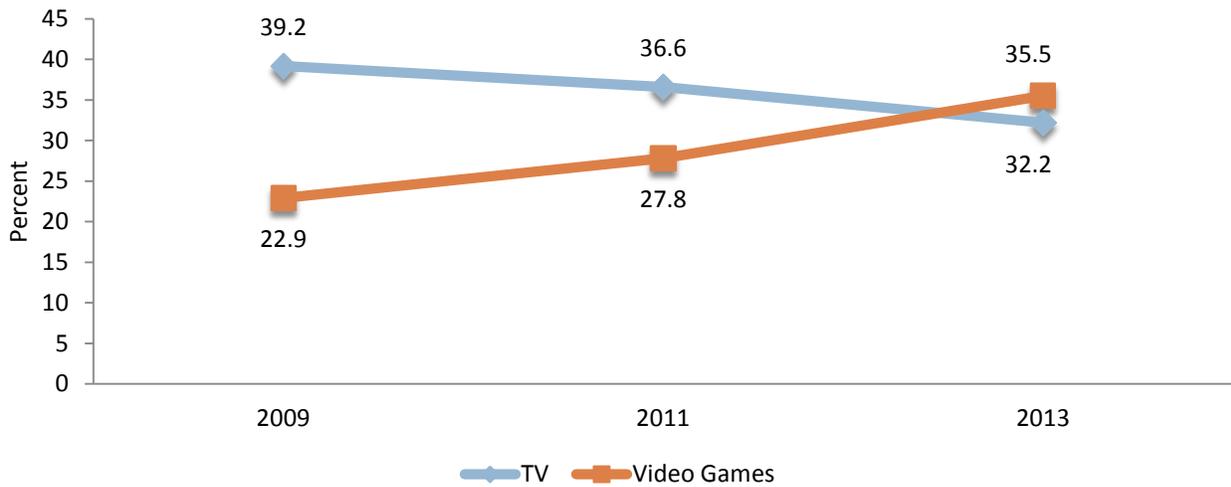
However, the percentage of high school students reporting three or more hours of television per day decreased from 39.2% in 2009 to 32.2% in 2013.

Percent of middle school students reporting three or more hours of screen time on an average school day by year, Georgia, 2009, 2011, 2013



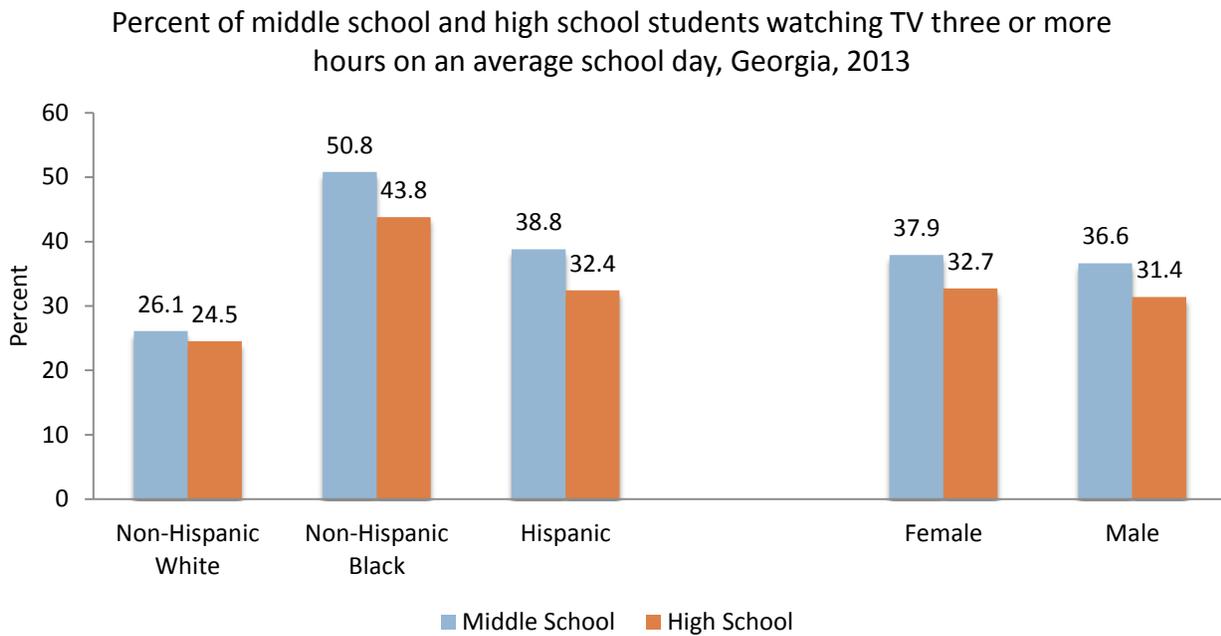
Source: YRBS

Percent of high school students reporting three or more hours of screen time on an average school day by year, Georgia, 2009, 2011, 2013



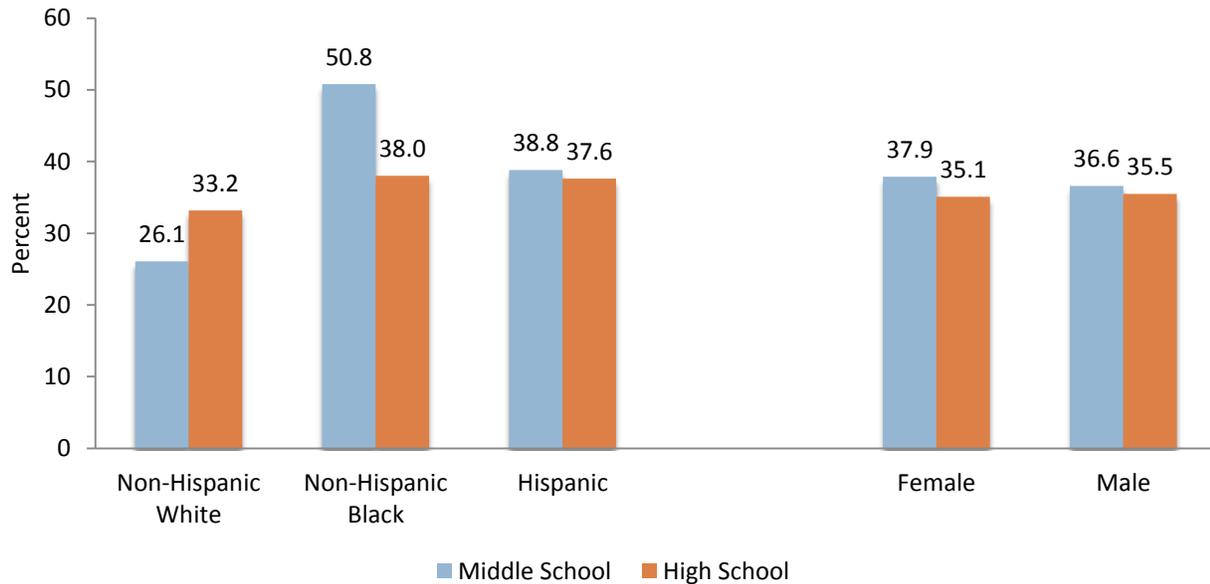
Source: YRBS

The prevalence of television watching was nearly twice as high among non-Hispanic Black middle school and high school students compared to their non-Hispanic White peers. The percentages were similar across genders. A similar pattern was seen regarding the usage of video or computer games. While most of the percentages were higher among middle school students, more non-Hispanic White high school students played video games three or more hours per day (33.2%) compared to non-Hispanic White middle school students (26.1%).



Source: YRBS

Percent of middle school and high school students playing video or computer games three or more hours on an average school day, Georgia, 2013



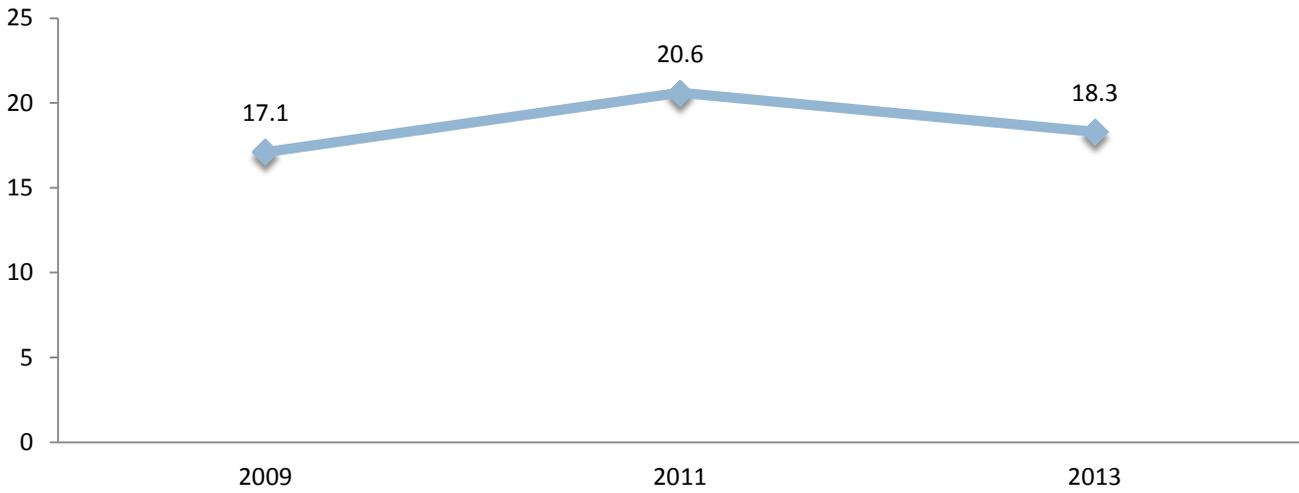
Source: YRBS

NUTRITION

Fruit and Vegetable Consumption

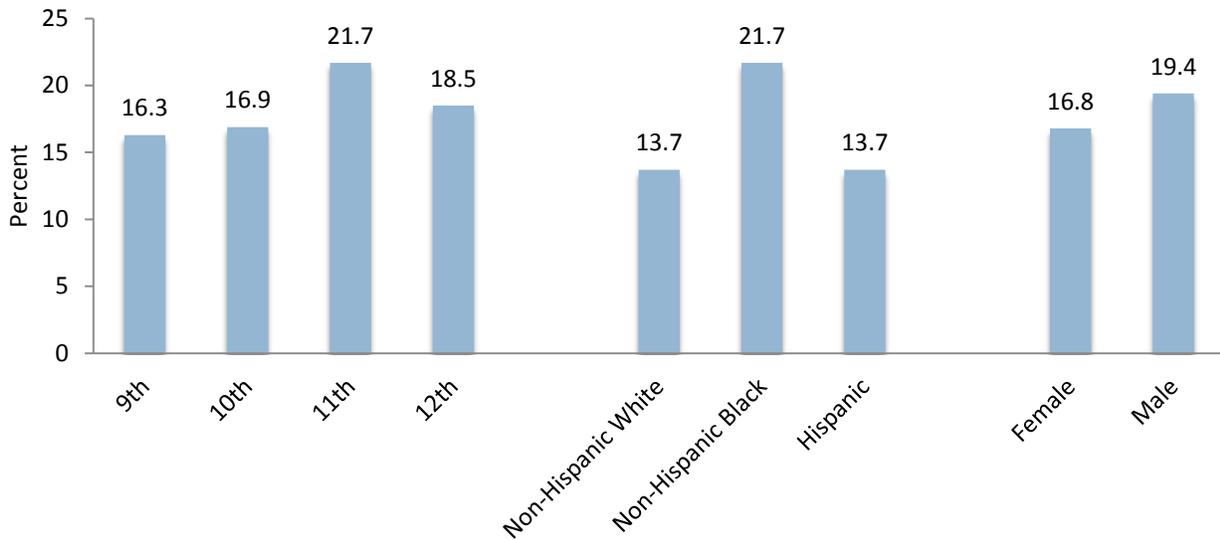
The percentage of high school students who reported eating fruit or vegetables five times per day remained fairly constant from 2009 (17.1%) to 2013 (18.3%). In 2013, less than 20% of high school students reported consuming five or more servings of fruits or vegetables daily. Slightly more students in the 11th and 12th grade reporting eating fruit and vegetables five times per day than those in 9th and 10th grade. The percentage was higher among non-Hispanic Blacks (21.7%) than non-Hispanic Whites and Hispanics, in which the percentage was 13.7% for both. Nearly 20% of high school males reported eating five servings of fruit and vegetables daily, while only 16.8% of females did.

Percent of high school students who reported eating fruit and vegetables five or more times per day during the past week by year, Georgia, 2013



Source: YRBS

Percent of high school students who reported eating fruit and vegetables five or more times per day during the past week by grade, race/ethnicity and gender, Georgia, 2013



Source: YRBS

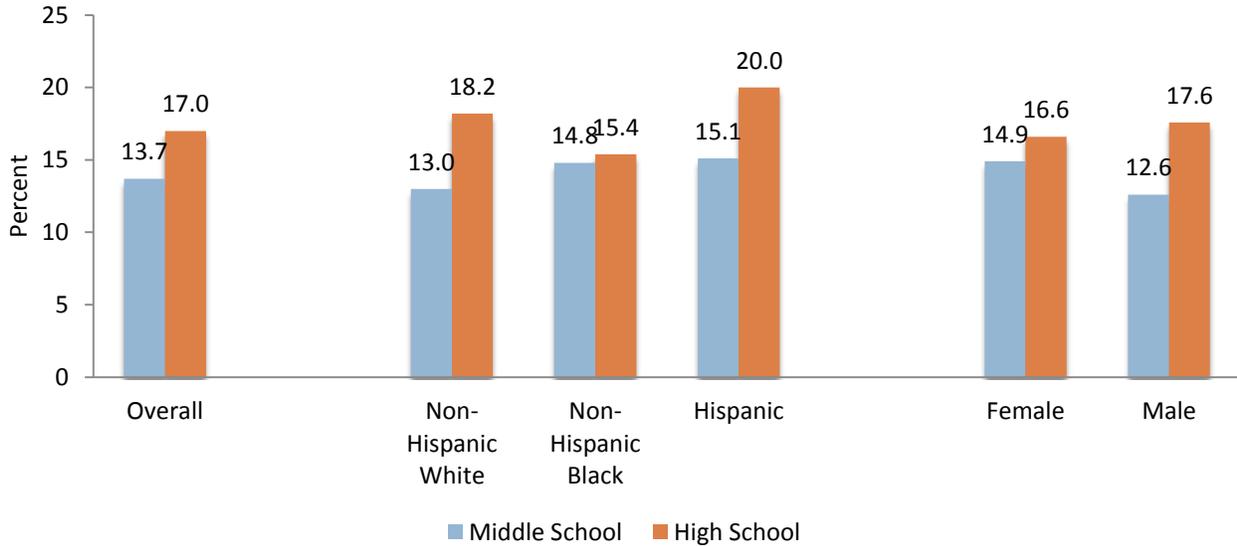
Water and Soda Consumption

Overall, 13.7% and 17.0% of middle school and high school students reported drinking soda two or more times per day in 2013. Only slight differences were seen by race/ethnicity among middle school students, but among high school students the percentage ranged from 15.4% among non-Hispanic Blacks to 20.0%

among Hispanics. More female middle school students (14.9%) reported drinking soda than males (12.6%), however the percentage was higher among high school males (17.6%) compared to females (16.6%).

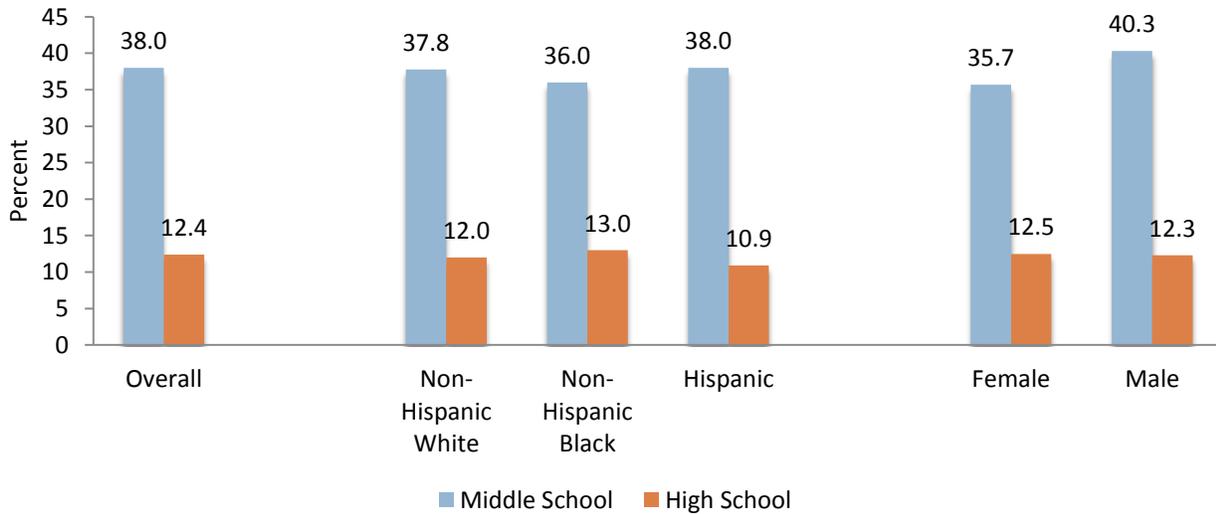
Middle school students reported drinking water three or more times per day three times more often than high school students in 2013. There were no notable differences between races and genders.

Percent of middle school and high school students who reported drinking soda two or more times per day by race/ethnicity and gender, Georgia, 2013



Source: YRBS

Percent of middle school and high school students who reported drinking water three or more times per day, Georgia, 2013



Source: YRBS

There were similarities between reasons for healthy eating among middle school and high school students. The most frequently reported reason was that they wanted to be healthy, followed by liking how healthy food tastes. Over 10% of middle school and over 12% of high school students reported eating healthy because they want to look good. All other reasons were reported among 10% of students or less.

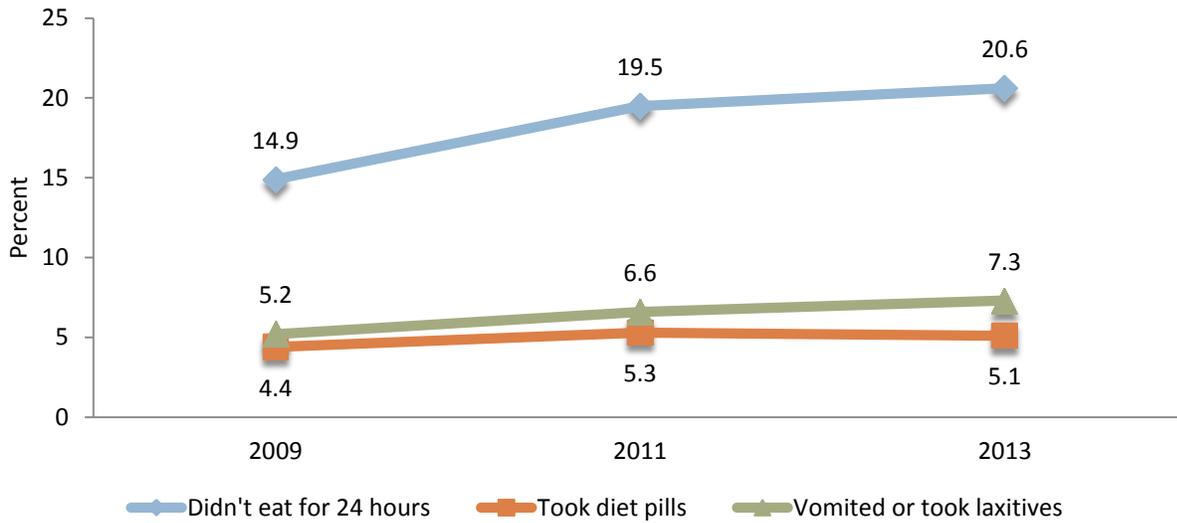
Reasons for eating healthy	Middle School	High School
I do not eat healthy foods	5.2%	10.6%
My friends are watching	3.3%	3.0%
I like how healthy foods taste	15.9%	16.1%
My family eats healthy foods	9.5%	10.6%
My doctor told me to	2.1%	2.4%
I want to look good	10.7%	12.5%
I want to be healthy	43.7%	37.8%
Some other reason	9.6%	7.0%

Source: YRBS

DISORDERED EATING BEHAVIORS

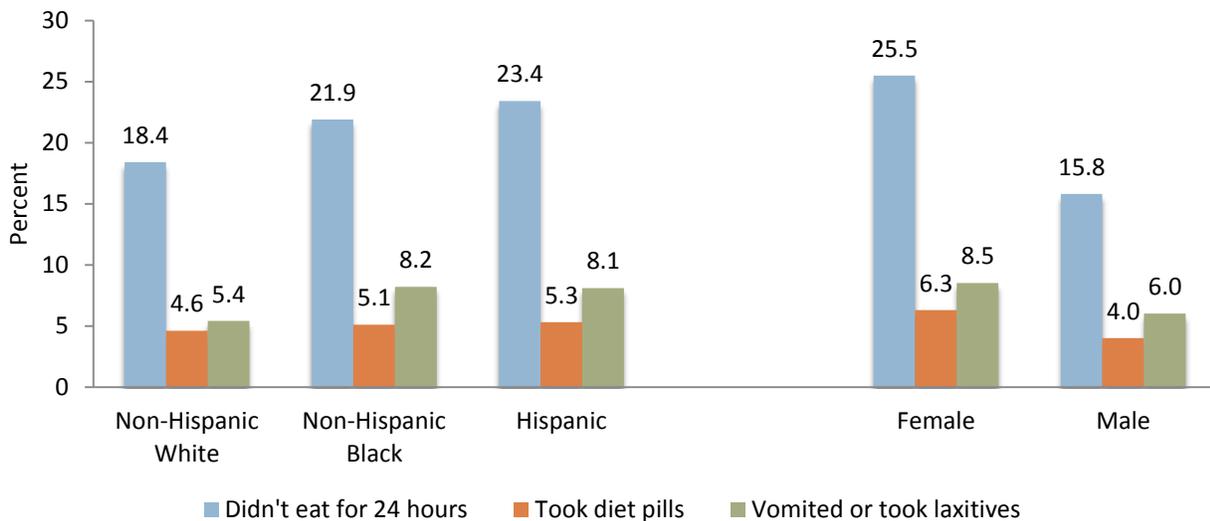
Abstaining from food for 24 hours to lose weight was the most commonly reported form of disordered eating reported from 2009 to 2013 in Georgia among middle school students. The percentages for all three increased during that time period, with the largest increase seen in the percentage of middle school students who reported ever abstaining from food for 24 hours. Hispanic middle school students (23.4%) abstained from food more often than their non-Hispanic White (18.4%) or non-Hispanic Black (21.9%) peers. There was little variation seen by race/ethnicity regarding diet pills. However, only 5.4% of non-Hispanic Whites either vomited or took laxatives, while over 8% of other races/ethnicities did. All three disordered eating behaviors were reported more often among females than males in 2013.

Percent of middle school students who ever performed disordered eating behaviors by year, Georgia, 2009, 2011, 2013



Source: YRBS

Percent of middle school students who ever performed disordered eating behaviors by race/ethnicity and gender, Georgia, 2013

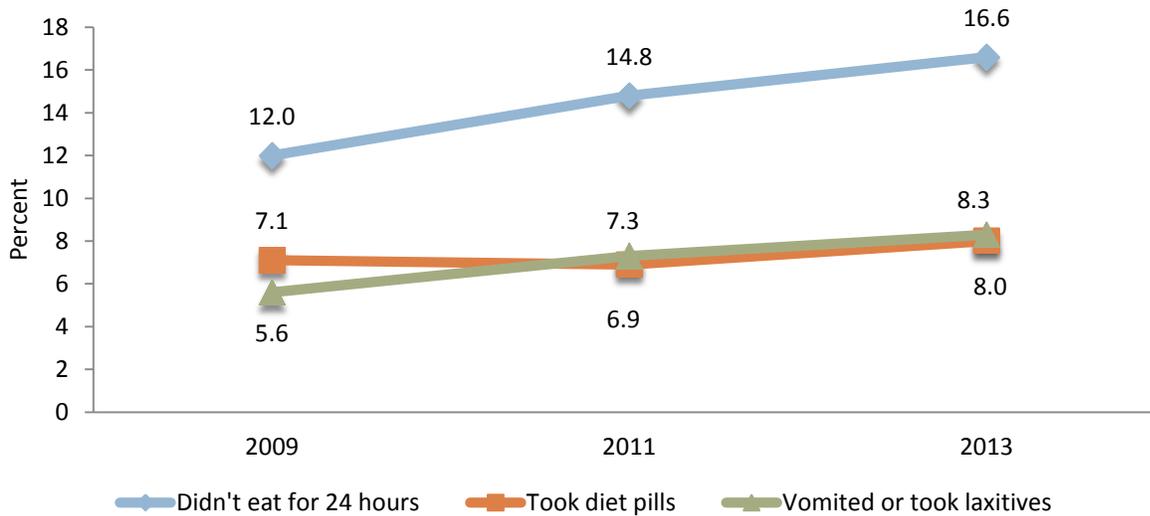


Source: YRBS

Similar patterns were seen among high school students who were currently performing disordered eating behaviors. Abstaining from food was the most commonly reported behavior from 2009 to 2011, which increased from 12.0% in 2009 to 16.6% in 2013. There was a slight increase in the number of high school students currently taking diet pills and vomiting or using laxatives during the same time period. Although

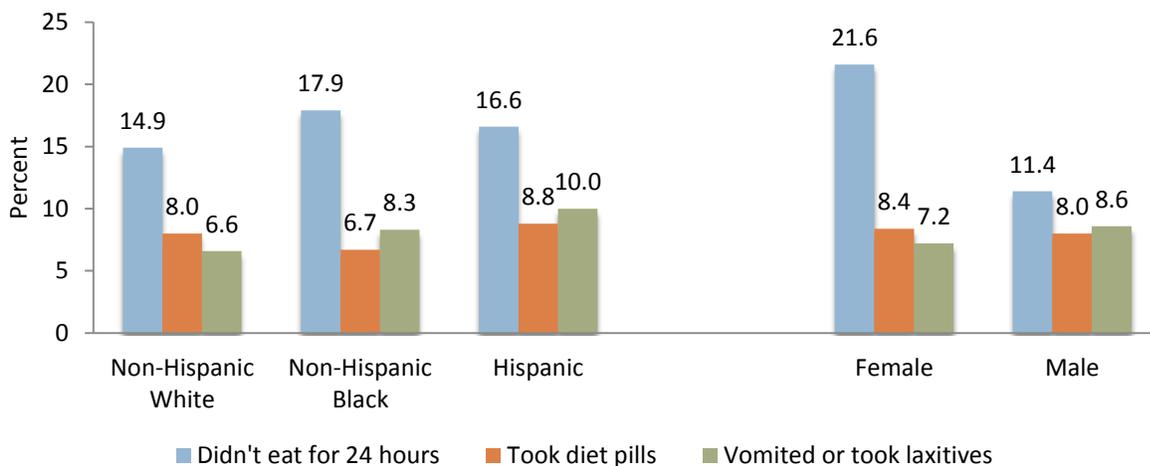
the prevalence of abstaining from food was similar across all races and ethnicities, it was highest among non-Hispanic Blacks (17.9%) and lowest among non-Hispanic Whites (14.9%). Diet pill usage and vomiting or laxatives was slightly more common among Hispanics than other races. Little variation was seen by gender, with the exception of 21.6% of female high school students reporting currently abstaining from food compared to 11.4% of males.

Percent of high school students performing disordered eating behaviors within the past 30 days by year, Georgia, 2009, 2011, 2013



Source: YRBS

Percent of high school students who performed disordered eating behaviors in the past 30 days by race/ethnicity and gender, Georgia, 2013



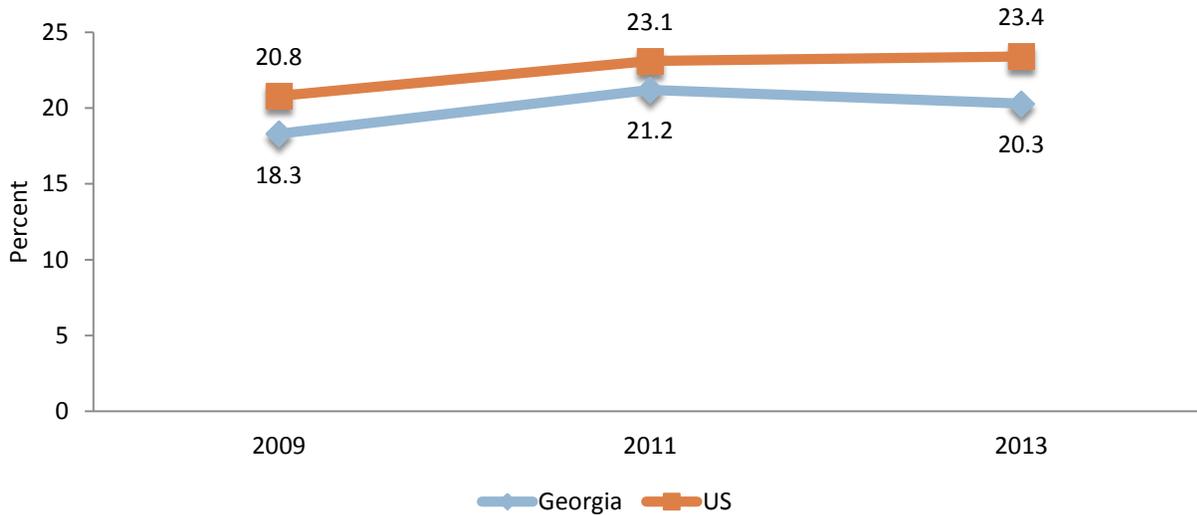
Source: YRBS

SUBSTANCE USE

Marijuana

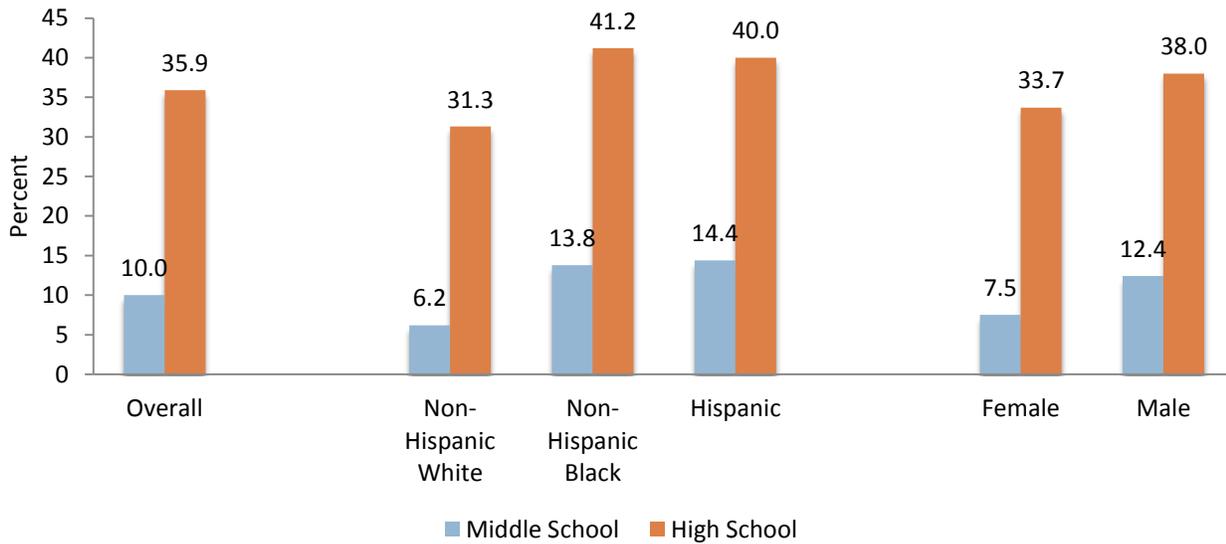
About 1 in 5 Georgia high school students reported marijuana use in the past thirty days from 2009 to 2013. The percentage among Georgia’s high school students remained slightly lower than the national average during the same time period. When examining adolescents who had ever used marijuana, the percentage was far higher among high school students overall (35.9%) compared to middle school students (10.0%). In both age groups, lifetime marijuana use was more common among non-Hispanic Black and Hispanic students compared to non-Hispanic Whites. Male middle school students reported ever using marijuana 1.6 times more often than female middle school students. The percentage was higher among male high school students (38.0%) than females (33.7%) as well.

Percent of high school students who used marijuana in the past 30 days by year, Georgia compared to the US, 2009, 2011, 2013



Source: YRBS

Percent of middle school and high school students who have ever used marijuana by race/ethnicity and gender, Georgia, 2013

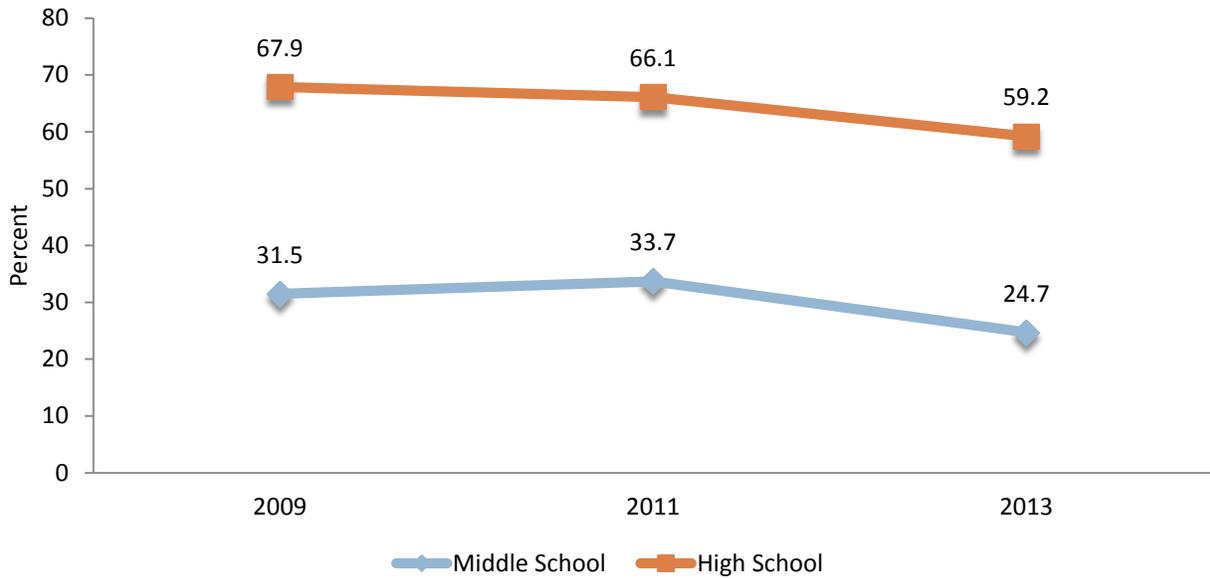


Source: YRBS

Alcohol

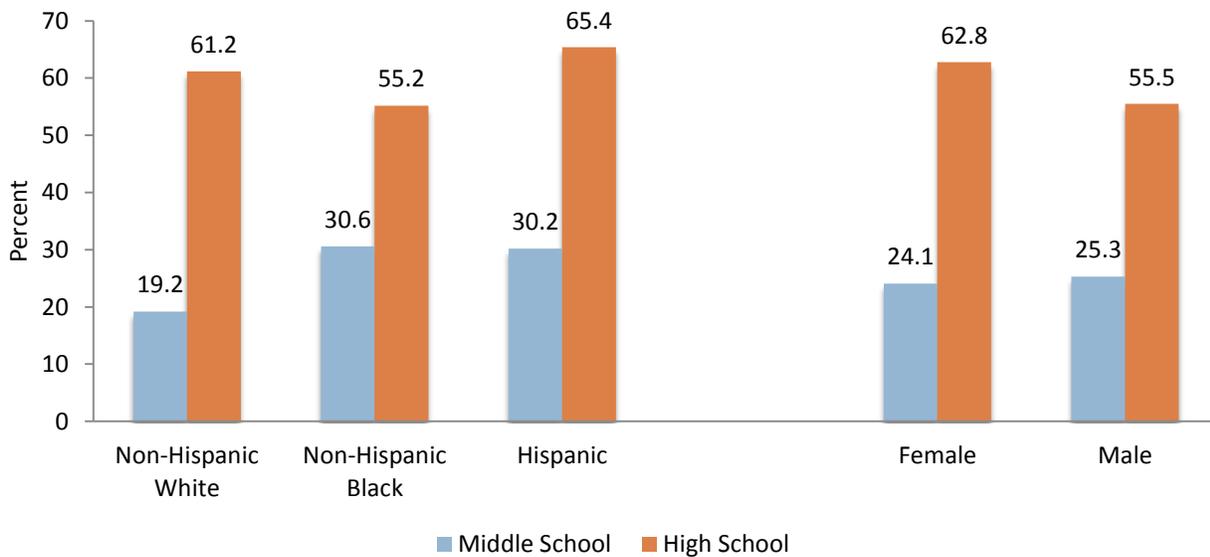
While marijuana use rose among high school students in Georgia, alcohol use among high school students declined, with 67.9% of high school students reporting lifetime use in 2009 compared to 59.2% in 2013. A similar pattern was present among middle school students, with 31.5% of middle school students reporting lifetime alcohol use in 2009 compared to 24.7% in 2013. Alcohol use was highest among non-Hispanic Black students in middle school, and Hispanic students in high school. Among middle school students, the percentages seen in males and females were very similar. However among high school students, 62.8% of females reported alcohol use, while 55.5% of males did.

Percent of middle school and high school students who ever had a drink of alcohol by year, Georgia, 2009, 2011, 2013



Source: YRBS

Percent of middle school and high school students who ever had a drink of alcohol by race/ethnicity and gender, Georgia, 2013

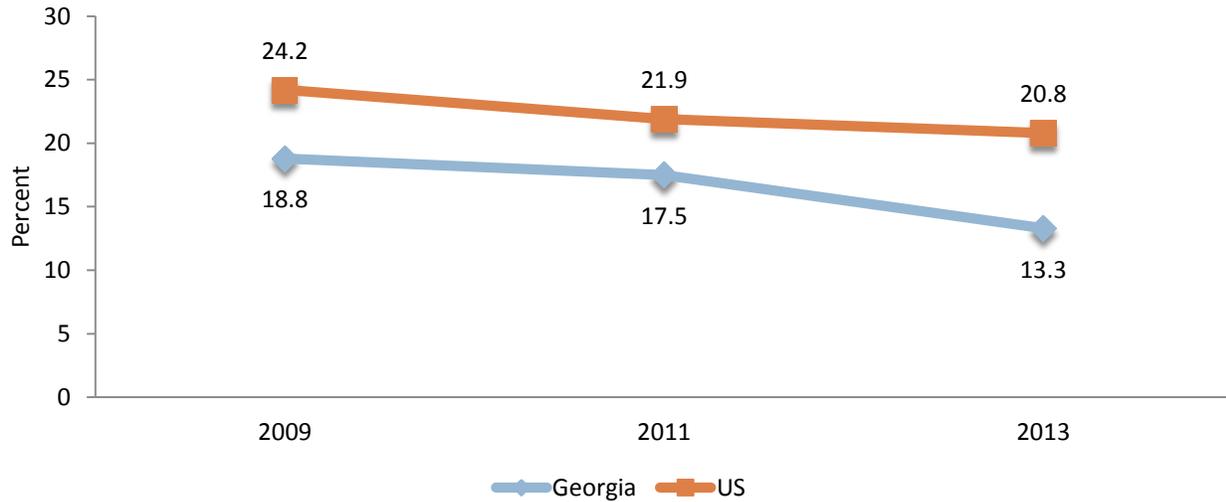


Source: YRBS

The percentage of adolescents who had five or more drinks of alcohol in a row in Georgia decreased over the five-year data period from 18.8% to 13.3%. In all years examined, fewer of Georgia’s adolescents reported having five drinks of alcohol in a row than in the nation as a whole. Heavy alcohol use was more

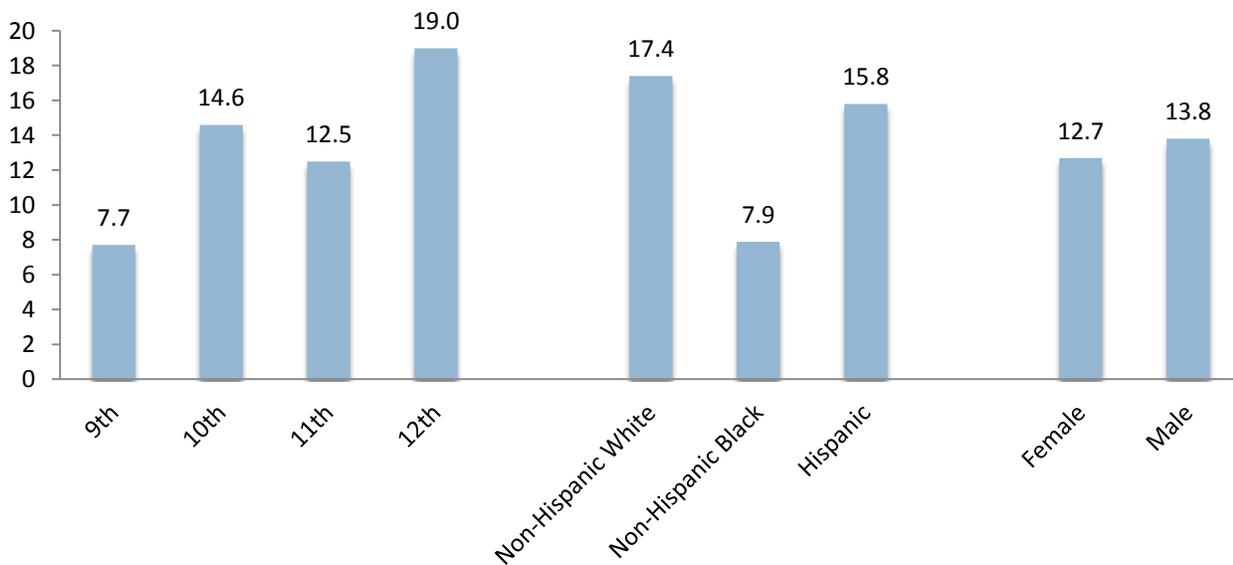
prevalent among older high school students than younger high school students in 2013. More than 17% of non-Hispanic White and 15.8% of Hispanic high school students reported binge drinking compared to 7.9% among non-Hispanic Black high school students. The prevalence of binge drinking was only one percentage point greater among male high school students compared to female high school students.

Percent of high school students who had five or more drinks of alcohol in a row during the past month by year, Georgia compared to the US, 2013



Source: YRBS

Percent of high school students who had five or more drinks of alcohol in a row during the past month by grade, race/ethnicity and gender, Georgia compared to the US, 2013

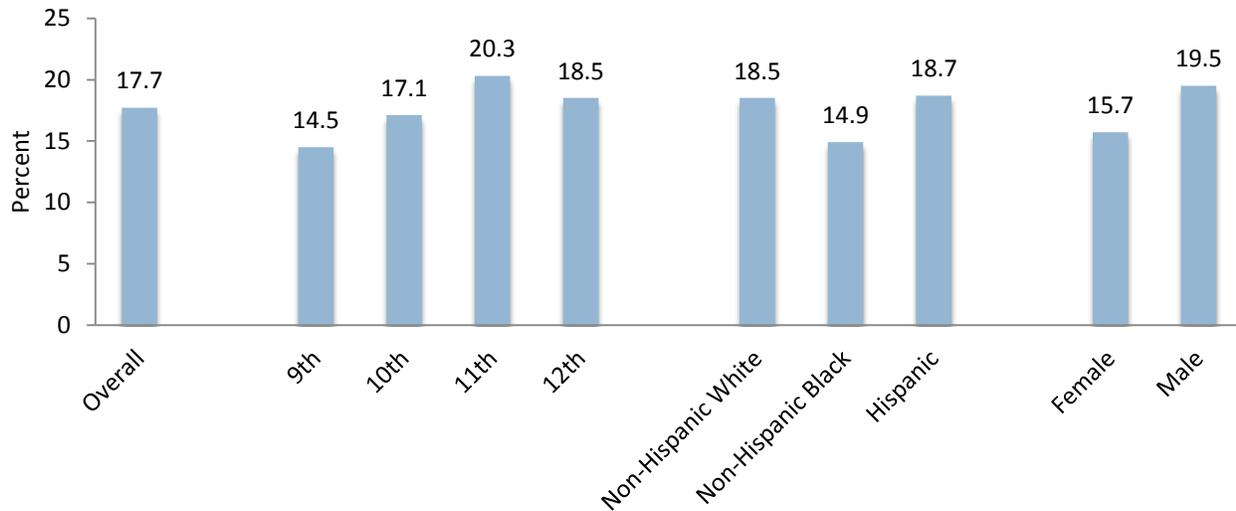


Source: YRBS

PRESCRIPTION DRUG USE

Overall, 17.7% of Georgia's high school students reported having taken a prescription drug without a doctor's prescription in 2013. The behavior was least common among students in 9th grade. Over 18% of non-Hispanic White and Hispanic students used a prescription drug, while 14.9% of non-Hispanic Black students did. More males (19.5%) reported taking a prescription drug than females (15.7%).

Percent of high school students who have taken a prescription drug without a doctor's prescription one or more times by grade, race/ethnicity and gender, Georgia, 2013

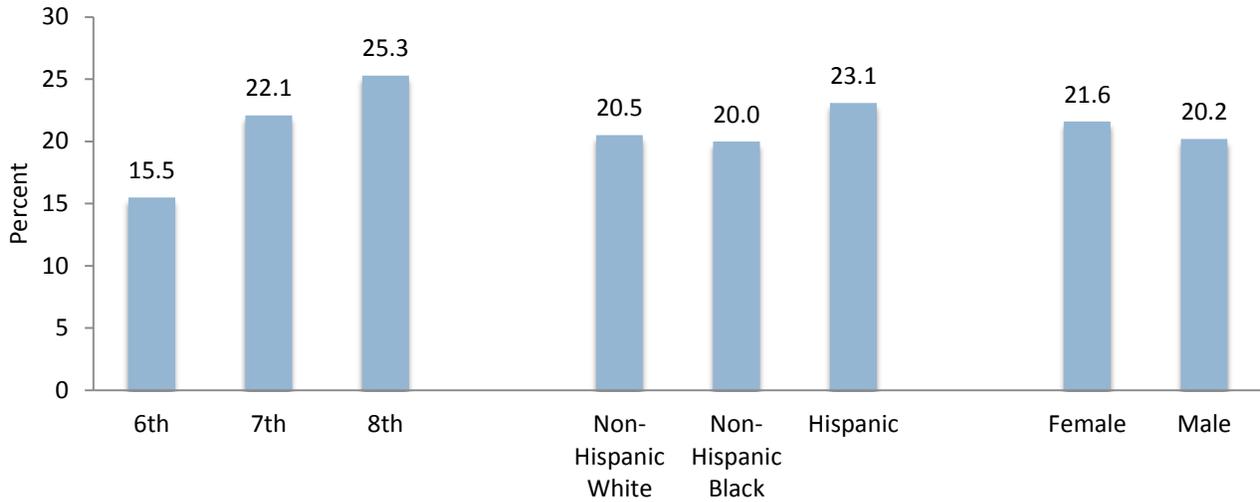


Source: YRBS

ALCOHOL USE WHILE DRIVING

Over 25% of 8th grade students in Georgia reported having ever ridden in a car with someone who was under the influence of alcohol in 2013. Among sixth grade students, the percentage was only 15.5%. There was little variation due to race/ethnicity or gender.

Percent of middle school students who have ever ridden in a car with someone driving under the influence of alcohol by grade, race/ethnicity and gender, Georgia, 2013



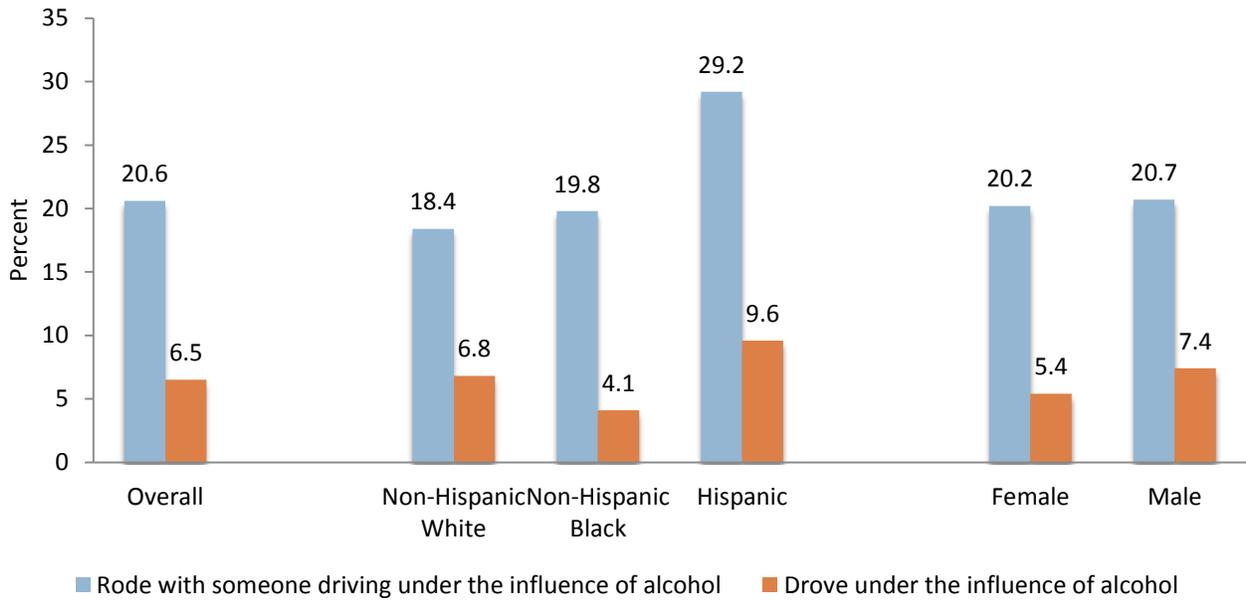
Source: YRBS

Healthy People 2020 Objective

SA-1: Reduce the proportion of adolescents in grades 9 through 12 who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol to 25.5%

The percentage of high school students in Georgia who reported riding in a car with someone under the influence of alcohol during the past month (20.6%) was higher than the percentage who reported driving under the influence of alcohol during the past month (6.5%). As of 2013, the percentage of high school students who reported riding with a driver under the influence of alcohol exceeded the Healthy People 2020 objective. More Hispanic students (29.2%) reported riding with a driver under the influence of alcohol than non-Hispanic Whites (18.4%) or non-Hispanic Blacks (19.8%). There were no differences due to gender. More Hispanics also reported driving under the influence of alcohol than their peers of other races. There was a slight difference seen by gender, with 7.4% of males driving under the influence compared to 5.4% of females.

Prevalence of alcohol use during drive during the past month among high school students, Georgia, 2013

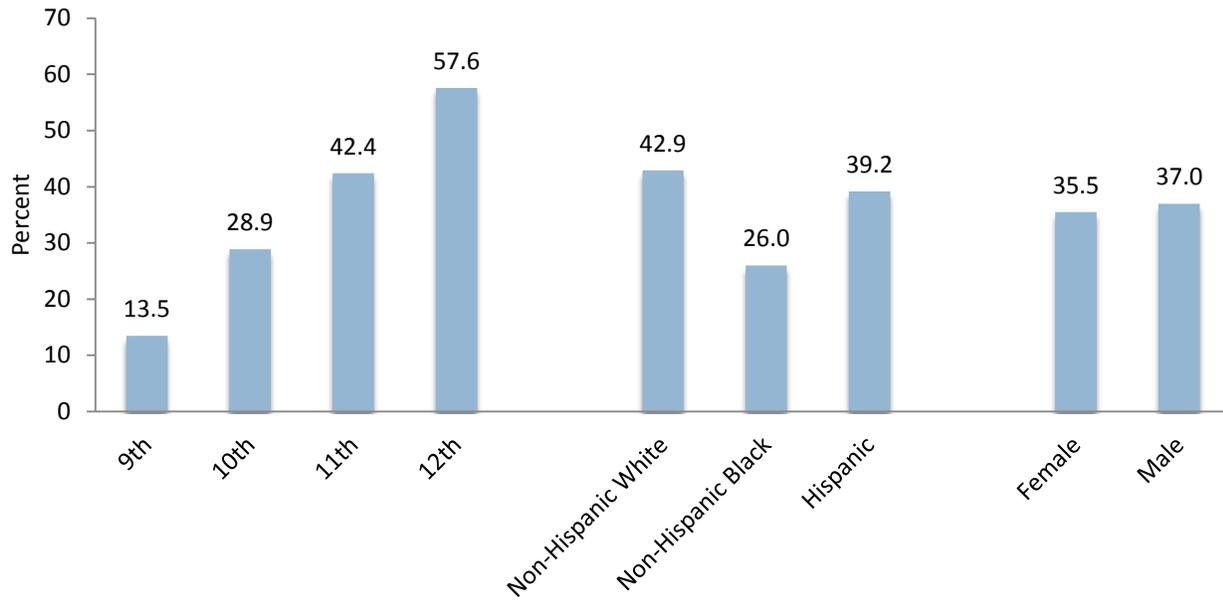


Source: YRBS

TEXTING OR EMAILING WHILE DRIVING

Over half of 12th grade students in Georgia reported texting or emailing while driving in 2013. The percentage increased with each grade level. Texting or emailing while driving was reported most commonly among non-Hispanic White students (42.9%), but remained over 25% for all other races and ethnicities. There was little variation due to age.

Percent of high school students who reported texting or emailing while driving by grade, race/ethnicity and gender, Georgia, 2013

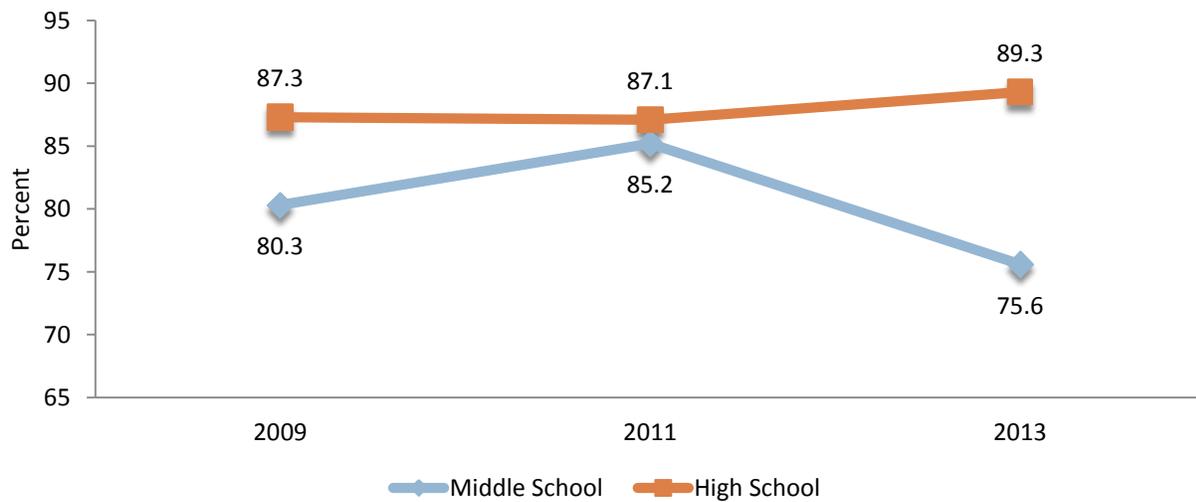


Source: YRBS

BICYCLE HELMET USE

The percentage of middle school students who never or rarely use a bicycle helmet slightly declined from 80.3% in 2009 to 75.6% in 2013, while there was a slight increase among high school students during the same time period (87.3% in 2009 and 89.3% in 2013).

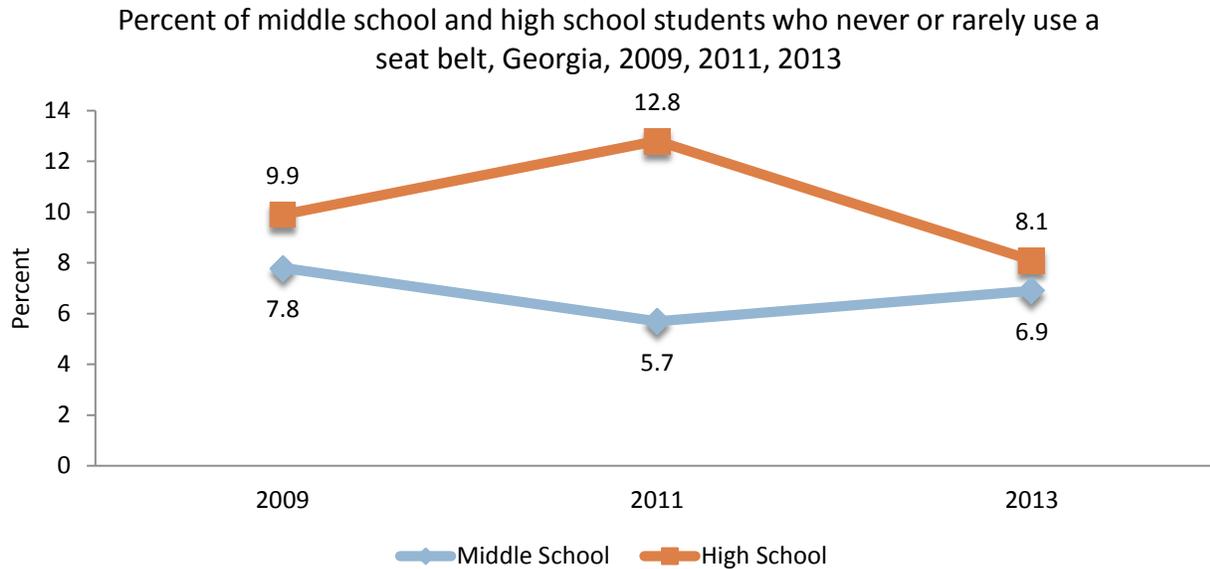
Percent of middle school and high school students who never or rarely use a bicycle helmet, Georgia, 2009, 2011, 2013



Source: YRBS

SEAT BELT USE

Less than 7% of middle school students and 9% of high school students reported either never or rarely using their seat belt in 2013. From 2009 to 2013, there was a slight decline among both middle school and high school students, despite an increase seen among high school students in 2011.

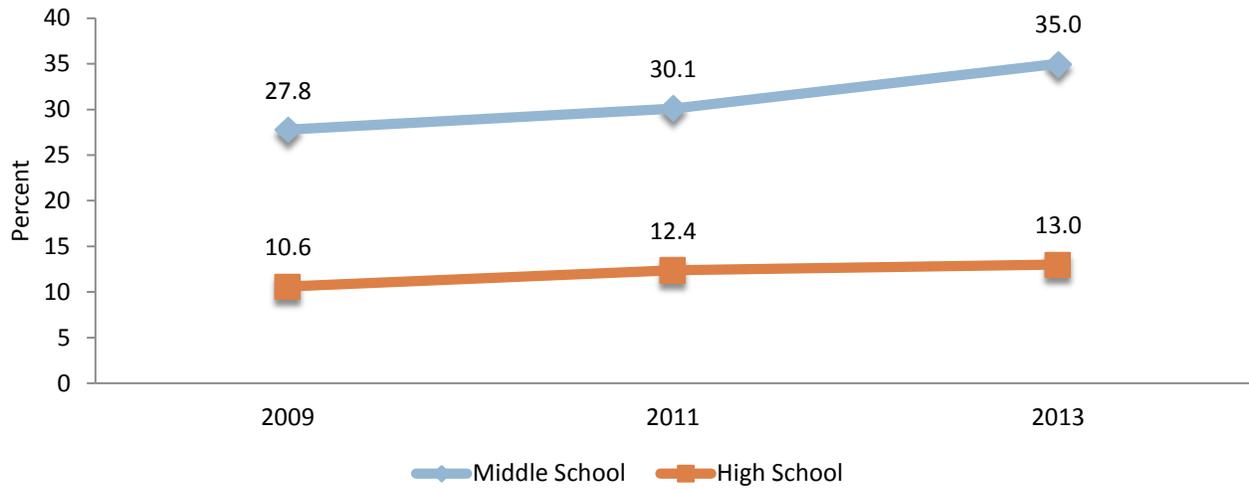


Source: YRBS

SEX EDUCATION

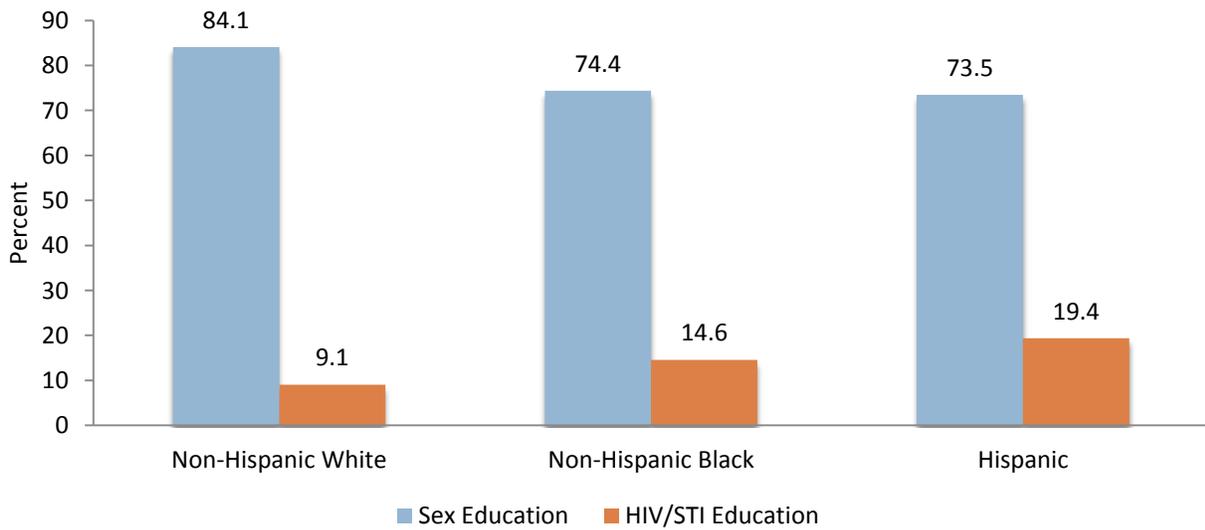
The percentage of middle and high school students that receive Human Immunodeficiency Virus (HIV) education in school steadily increased from 2009 to 2013. In 2013, 35.0% of middle school students and 13.0% of high school students reported having HIV education in school, compared to only 27.8% and 10.6% respectively, in 2009. Sex education in Georgia was more prevalent among high school students than HIV education. In 2013, over 70% of Georgia high school students received sex education in school. The percentage was highest among non-Hispanic Whites. However, when examining HIV/STI education, more Hispanics reported receiving this education in school compared to all other races and ethnicities.

Percent of middle school and high school students receiving HIV education in school by year, Georgia, 2009, 2011, 2013



Source: YRBS

Percent of high school students receiving sex and HIV/STI education in school by race/ethnicity, Georgia, 2013



Source: YRBS

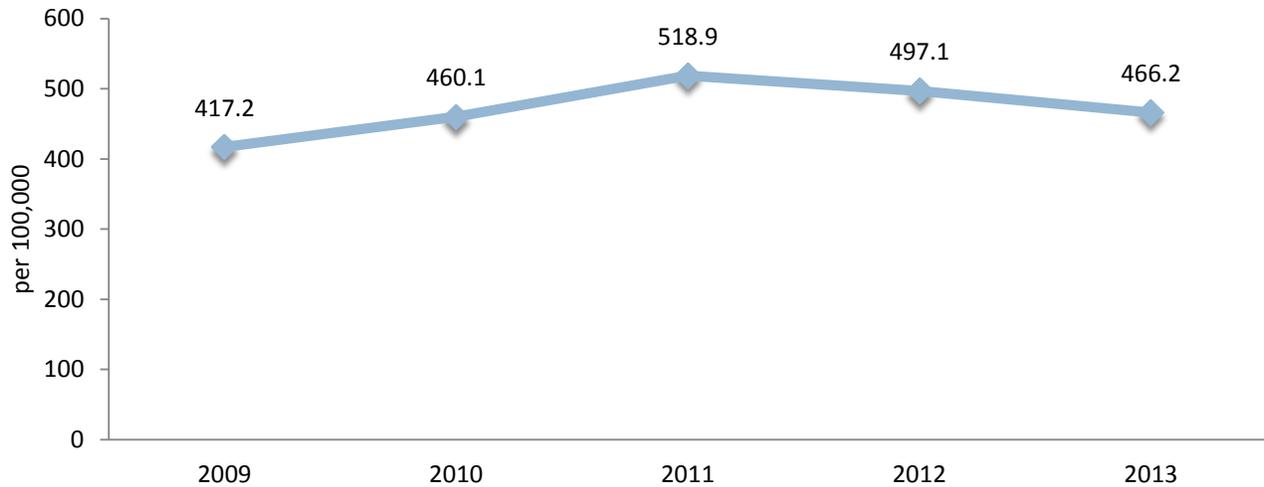
SEXUALLY TRANSMITTED INFECTIONS (STI)

Chlamydia

There was an overall increase in the rate of chlamydia among adolescents 15 to 24 years of age from 2009 to 2013, although the rate began to decline in 2011. The highest rates of chlamydia were among 18 to 19

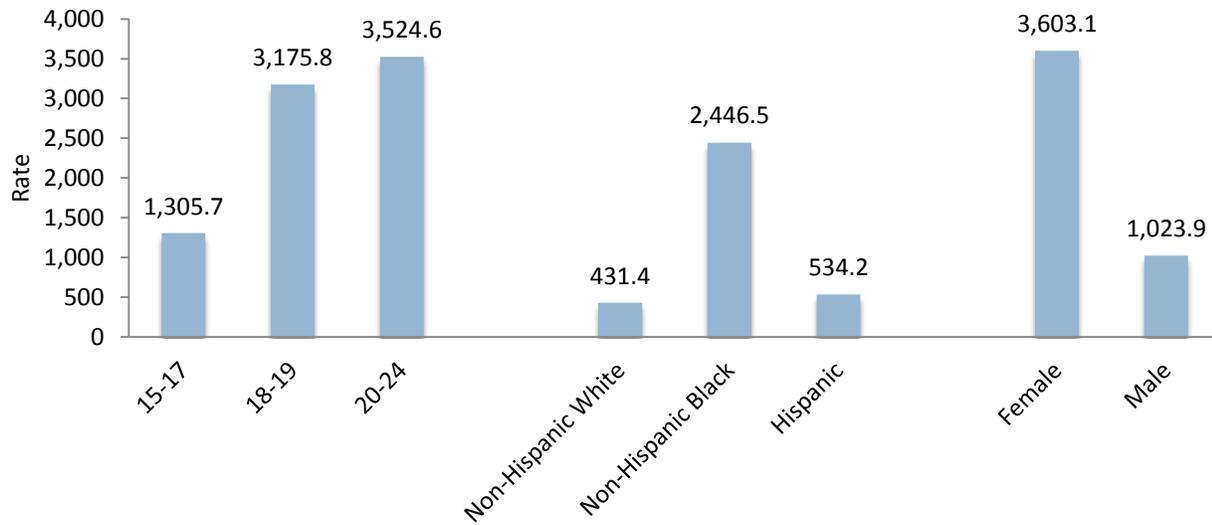
year olds. The rate in 2013 was far higher among those over 18 years of age, non-Hispanic Blacks and females.

Rate of chlamydia per 100,000 adolescents 15-24 by year, Georgia, 2009-2013



Source: OASIS

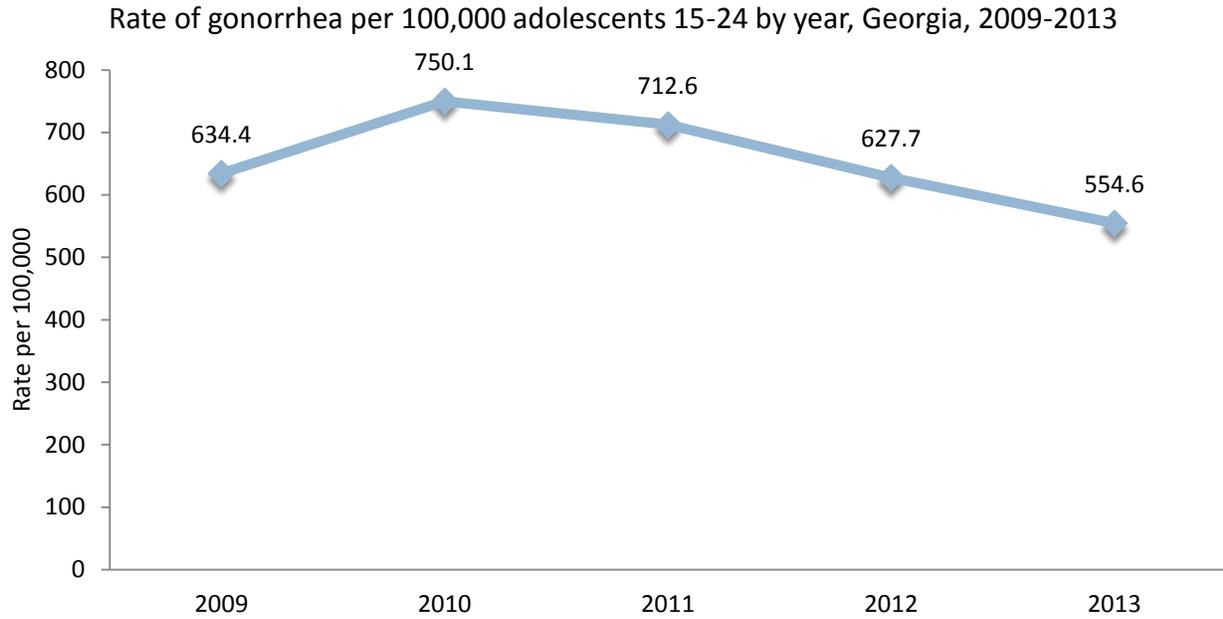
Rate of chlamydia per 100,000 adolescents 15-24 by age, race/ethnicity and gender, Georgia, 2013



Source: OASIS

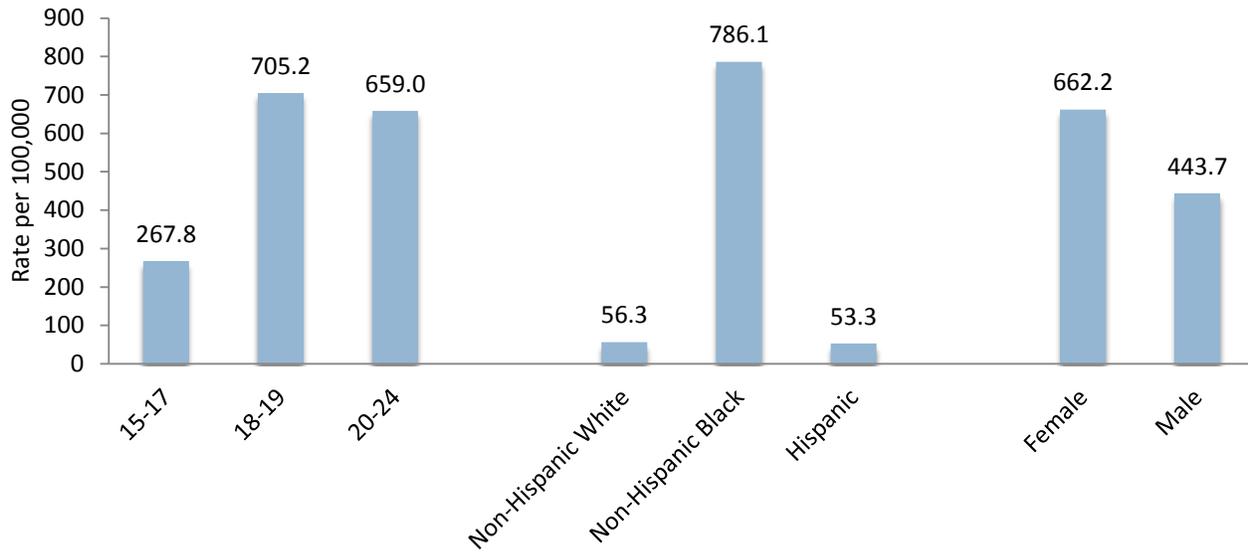
Gonorrhea

The overall rate of gonorrhea among adolescents was higher than the rate of chlamydia in 2013 (554.6 compared to 466.2 respectively). The highest rates of gonorrhea were among 18 to 19 year olds (705.2) and lowest among the 15 to 17 age group (267.8). Far more non-Hispanic Blacks (786.1) had gonorrhea in 2013 than non-Hispanic Whites (56.3) or Hispanics (53.3). Female adolescents also had higher rates of gonorrhea than male adolescents.



Source: OASIS

Rate of gonorrhea per 100,000 adolescents 15-24 by age, race/ethnicity and gender, Georgia, 2013

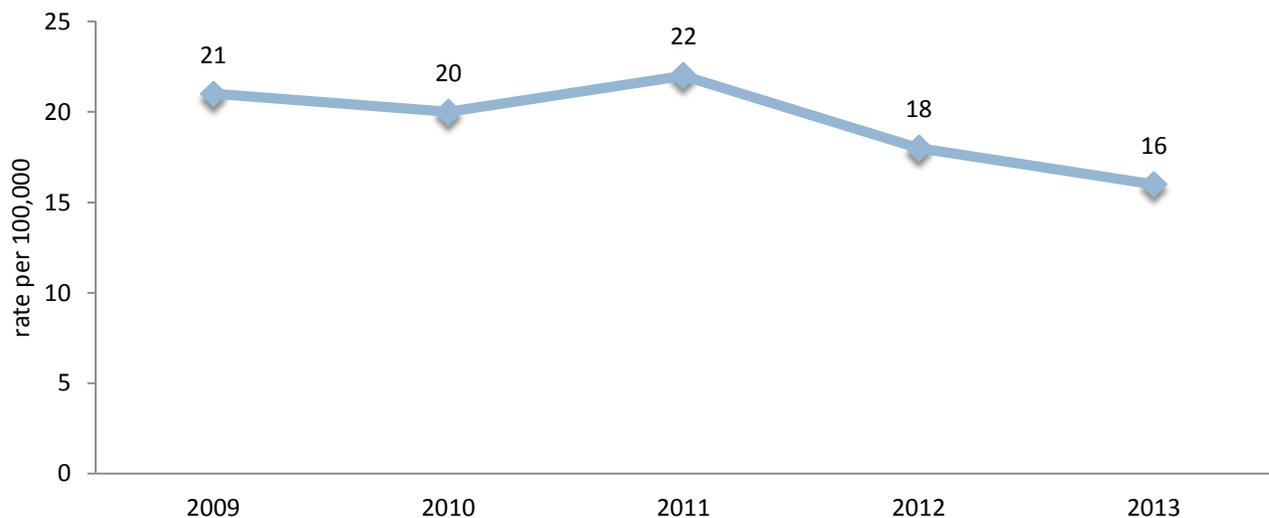


Source: OASIS

Human Immunodeficiency Virus (HIV)

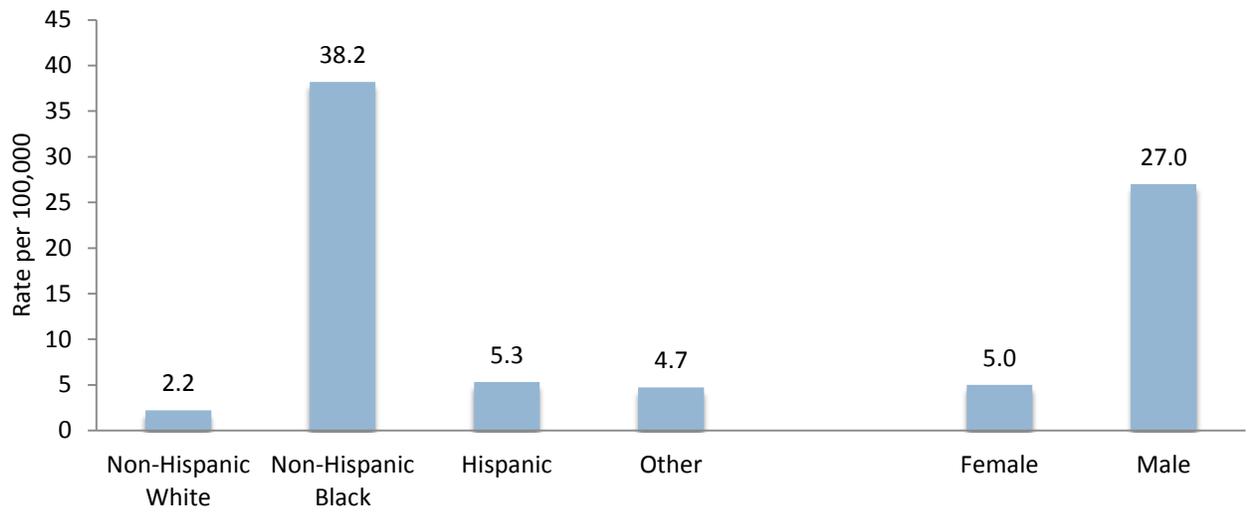
In 2009, the rate of new HIV diagnoses was 21 per 100,000 adolescents 10 to 21 years of age, then declined to 16 per 100,000. The highest incidence rate was among non-Hispanic Black (38.2) and male (27.0) adolescents, compared to non-Hispanic Whites (2.2), Hispanics (5.3), other races (4.7) and females (5.0).

Rate of new HIV diagnoses and rates among ages 10 to 21 years by year, Georgia, 2009-2013



Source: Georgia HIV Surveillance Program

Rate of new HIV diagnoses among adolescents 10-21 by race/ethnicity and gender, Georgia, 2013



Source: Georgia HIV Surveillance Program

DRAFT

STRENGTHS AND NEEDS

Many important conclusions can be drawn from the analysis of indicators on the health outcomes and behaviors among Georgia's adolescents. There are several areas where Georgia has either seen improvement or has maintained positive health rates. For example, the percentage of adolescents receiving one or more doses of HPV, Td, and Tdap vaccines has been steadily increasing over the years. Although overall rates remain higher than national averages, Georgia has experienced declines in both the adolescent birth rate as well as repeat teen births over the years. Declines have also been seen in the rate of hospitalizations due to non-fatal injury. Programmatic efforts should be continued to ensure that these positive outcomes are maintained.

There are several areas where Georgia has to improve to meet the Healthy People 2020 objective among adolescents, and in particular the 18 to 19 year old age group. The following are several areas of need:

- Reduce substance abuse among adolescents
- Reduce suicide ideation, planning and attempts
- Reduce student violence and bullying
- Improve overall physical fitness, including increased physical activity and proper nutrition
- Reduce disordered eating behaviors
- Prevent risky driving behaviors, particularly the use of electronic devices while driving
- Reduce the prevalence of STIs, particularly among older adolescents, non-Hispanic Blacks and females
- Increase awareness of the importance of well-visits and ensure access to these services

Adolescence is a time where many receive greater independence and establish personal health behavior patterns. It is important public health support programs to ensure adolescents establish behaviors that help them achieve excellent health status in their adolescence and as adults.

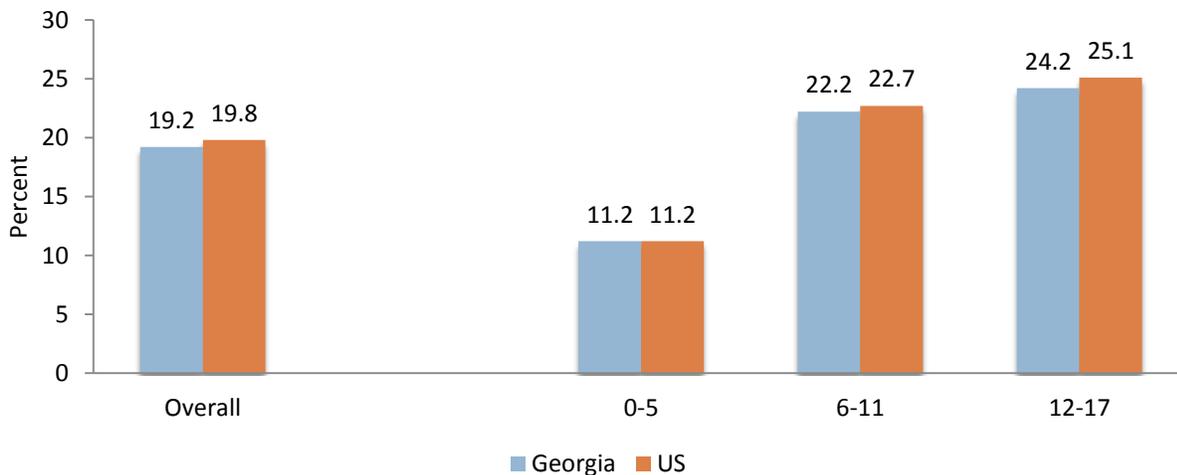
QUANTITATIVE ANALYSIS: CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Children and youth with special health care needs (CYSHCN) are a growing population in the United States and it is important to pay increasing attention to meeting their health care needs. CYSHCN are typically defined by the Maternal and Child Health Bureau as those from birth to age 21 who have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional conditions and need health and related services of a type or amount beyond that required by children generally.

PREVALENCE

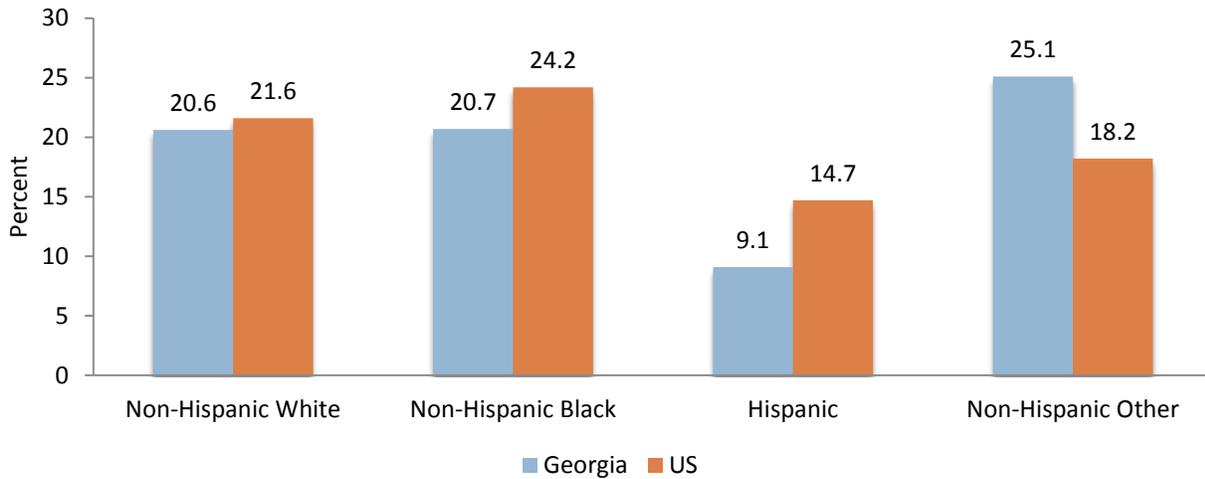
In 2011/12, the percentage of children and youth with special health care needs (CYSHCN) in Georgia was similar to national data, with 19.8% of US children ages 0 to 17 years reported having special health care needs compared to 19.2% in Georgia. The percentage of CYSHCN increased with age. Specifically, only 11.2% of children 0 to 5 years old had special health care needs in Georgia compared to 22.2% of 6 to 11 year olds and 24.2% of 12 to 17 year olds. This trend may be seen in part due to diagnoses for certain conditions, which can take up to years and are easier to diagnose in older children. When stratified by race, there are some differences seen. Fewer Hispanic children had special health care needs, with only 9.1% of Hispanic children 0 to 17 years old having special health care needs in Georgia in 2011/12. The percentage was similar among non-Hispanic Whites (20.6%), non-Hispanic Blacks (20.7%) and all other races (25.1%). These percentages were similar to national averages, with the largest differences seen among Hispanic children and children of other races and ethnicities.

Percent of children and youth 0-17 with special health care needs by age, Georgia compared to the US, 2011/12



Source: NSCH

Percent of children and youth 0-17 with special health care needs by race/ethnicity, Georgia compared to the US, 2011/12

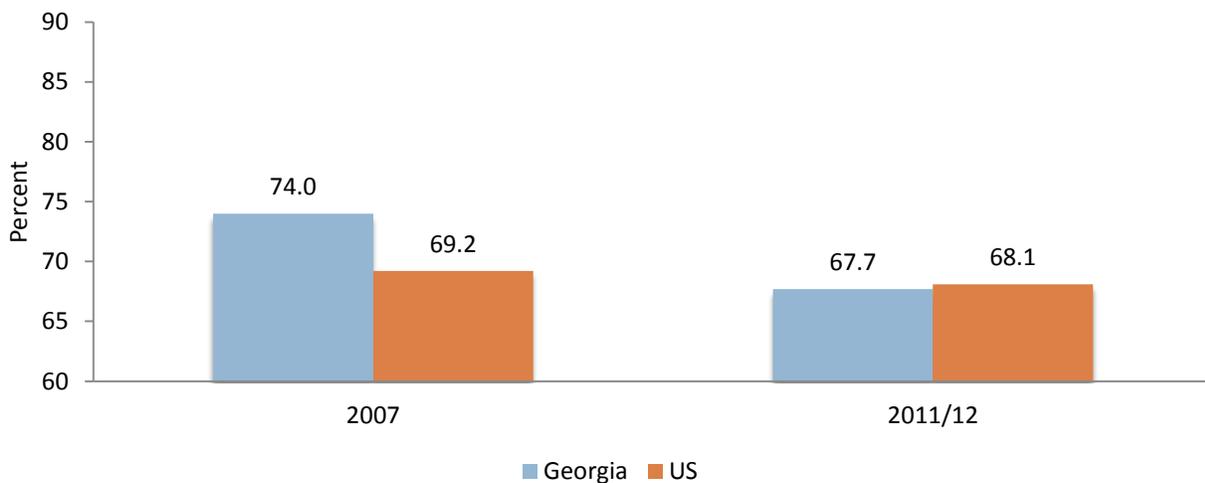


Source: NSCH

OVERALL HEALTH STATUS

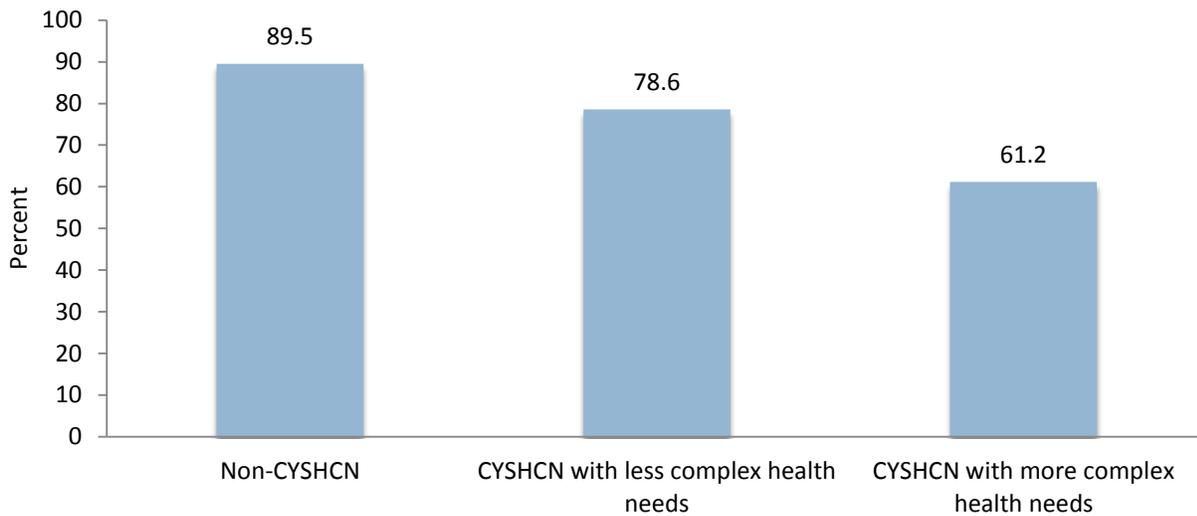
The percentage of CYSHCN 0 to 17 years of age whose overall health status is excellent or very good declined slightly from 2007 to 2011/12. For example, 74.0% of CYSHCN ages 0 to 17 in Georgia had an overall health status of excellent or very good in 2007, compared to 67.7% in 2011/12. Additionally, health status declined as complexity of needs increased. Almost 90% of children without special health care needs reported that their health is very good or excellent compared to 78.6% of CYSHCN. The percentage was even lower (61.2%) among those with more complex health needs.

Percent of CYSHCN 0-17 whose overall health status is excellent/very good by year, Georgia compared to the US, 2007, 2011/12



Source: NSCH

Percent of children 0-17 whose overall health status is excellent/very good by CYSHCN status, Georgia, 2011/12



Source: NSCH

FUNCTIONAL DIFFICULTIES

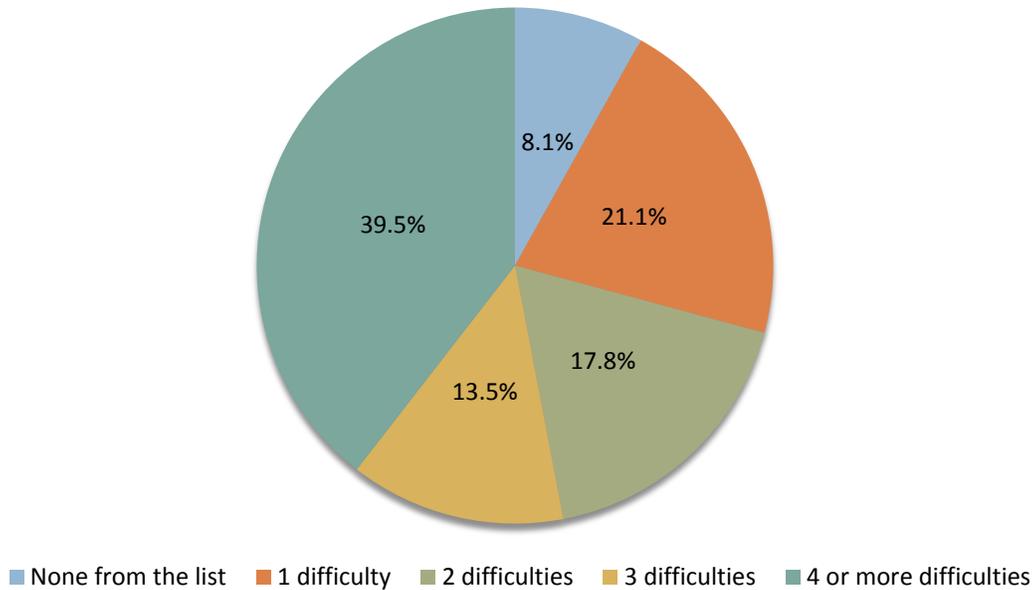
Parents of CYSHCN were asked to identify functional difficulties their child faced out of 14 possible difficulties:

- 1) Vision difficulties even when wearing glasses or contacts
- 2) Hearing difficulties even when using hearing aids
- 3) Breathing or respiratory difficulties
- 4) Swallowing, digestive or metabolic difficulties
- 5) Blood circulation difficulties
- 6) Chronic physical pain, including headaches
- 7) Difficulty with self-care activities such as eating or dressing
- 8) Coordination or movement difficulties
- 9) Difficulty using hands
- 10) Difficulty learning, understanding or paying attention
- 11) Difficulty speaking, communicating or being understood
- 12) Anxiety or depression
- 13) Behavior problems
- 14) Difficulty making or keeping friends

The lowest percentage of parents reported that their child experienced none of the functional difficulties listed (8.1%). The majority of parents reported that their child experienced at least one difficulty on the list.

The percentage of parents who reported their child experienced 4 or more functional difficulties (39.5%) was larger than in any other category.

Number of functional difficulties experienced by CYSHCN 0-17, Georgia, 2009/10

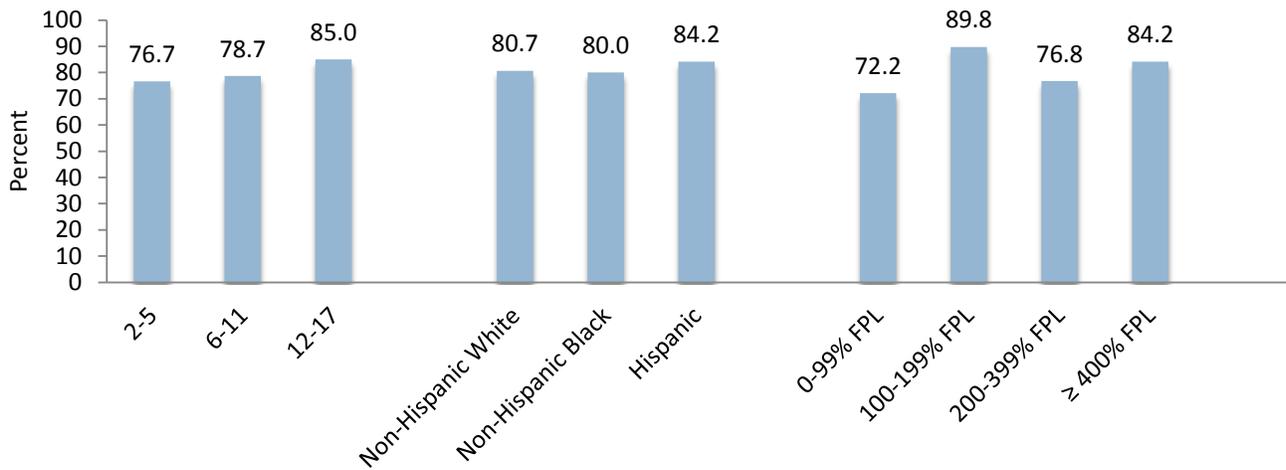


Source: NS-CSHCN

DEVELOPMENTAL DELAY

A larger percentage of CYSHCN 2 to 17 years of age in Georgia did not have a developmental delay (80.7%) in 2009/10 compared to the US as a whole (75.9%). A larger percentage of CYSHCN 12 to 17 years of age did not have a developmental delay compared to the two younger age groups. The percentage was similar across all races and ethnicities, with a slightly higher percentage of Hispanics reported to not have a developmental delay. There were variations with regard to household income. The highest percentage of CYSHCN reported to not have a developmental delay was among those in households 100-199% FPL (89.8%). The percentage was lowest in the lowest income bracket (72.2%).

Percent of CYSHCN 2-17 without a developmental delay by age, race/ethnicity and household income, Georgia, 2009/10



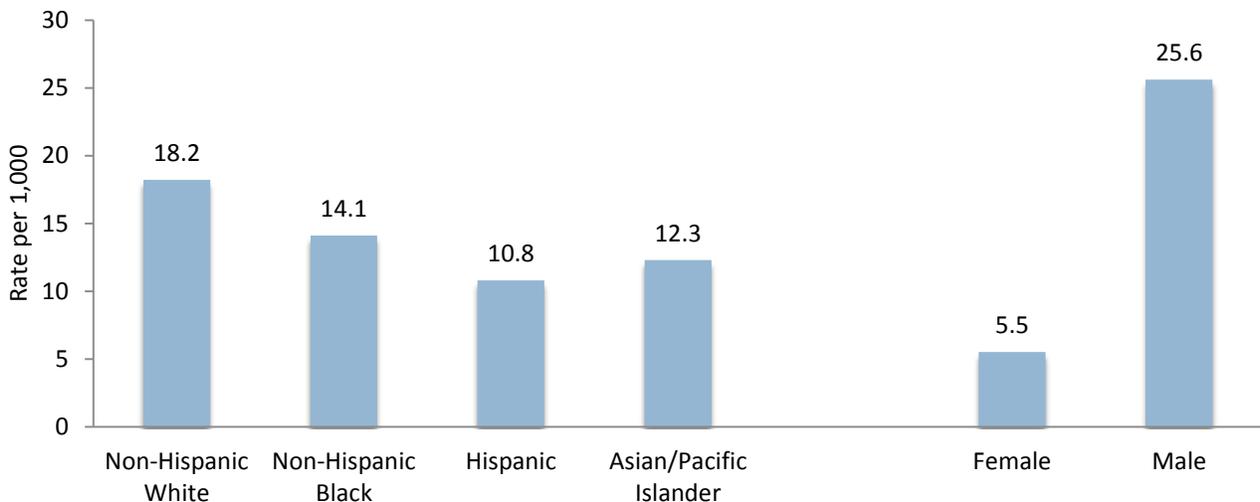
Source: NS-CSHCN

*Estimate for Hispanic is based on a numerator less than 50 and should be interpreted with caution

AUTISM SPECTRUM DISORDER

The prevalence rate for Autism Spectrum Disorder for 8 year old children in 5 counties in Georgia during 2010 was higher among boys than girls, 25.6 per 1,000 persons compared to 5.5 per 1,000 persons respectively. Among racial and ethnic groups, non-Hispanic White children had the highest prevalence rate at 18.2 per 1,000 persons.

Prevalence rate of Autism Spectrum Disorder among 8 year old children in 5 counties in Georgia by race/ethnicity and gender, Georgia, 2010



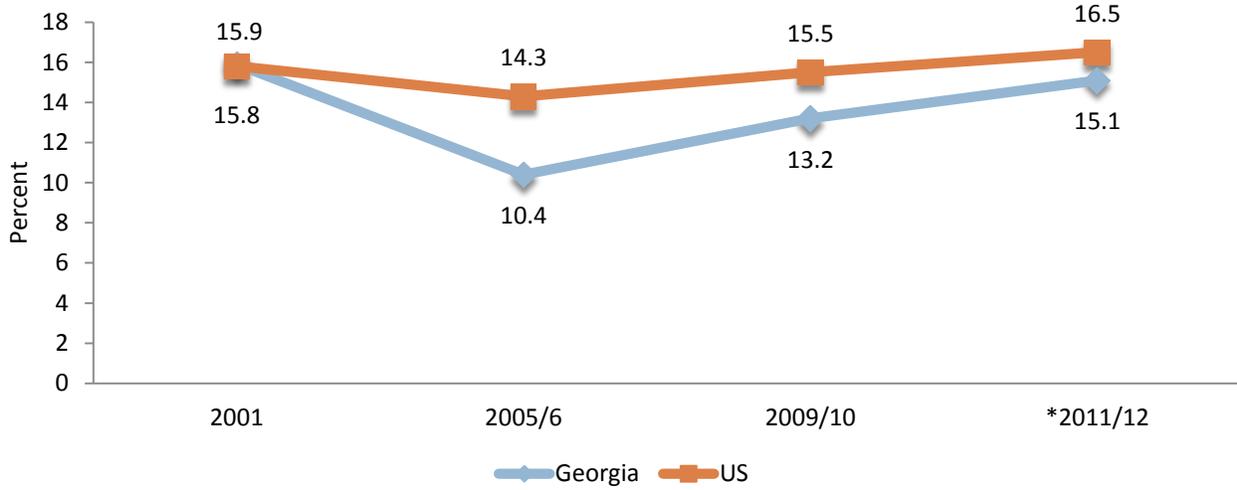
Source: MADDSP

*Counties include: Clayton, Cobb, Dekalb, Fulton, and Gwinnett

SCHOOL ABSENCES

The percentage of CYSHCN in Georgia who missed school 11 or more days due to illness was 15.9% in 2001 and 13.2% in 2009/10. The projected prevalence in 2011/12 is 15.1%. Controlling for socio-demographic characteristics revealed that the prevalence of missed school days among CYSHCN living in households below 200% of the FPL was significantly higher than for CYSHCN living in households above 200% of the FPL.

Proportion of CYSHCN 5-17 with 11 or more school absences due to illness by year, Georgia compared to the US, 2001-2011/12

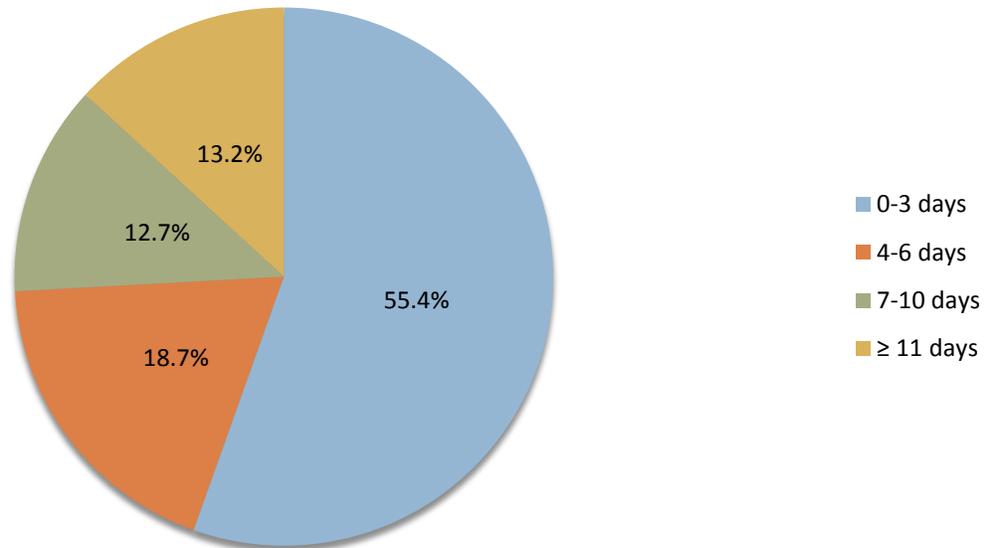


Source: NS-CSHCN

*2011/12 estimates are based on projection analysis

In 2009/10, more than half of CYSHCN ages 5 to 17 missed 0 to 3 days of school due to illness. Over 18% missed 4 to 6 days of school, 12.7% missed 7 to 10 days of school and 13.2% missed 11 or more.

Percent of CYSHCN 5-17 who missed school due to illness by number of school days missed, Georgia, 2009/10

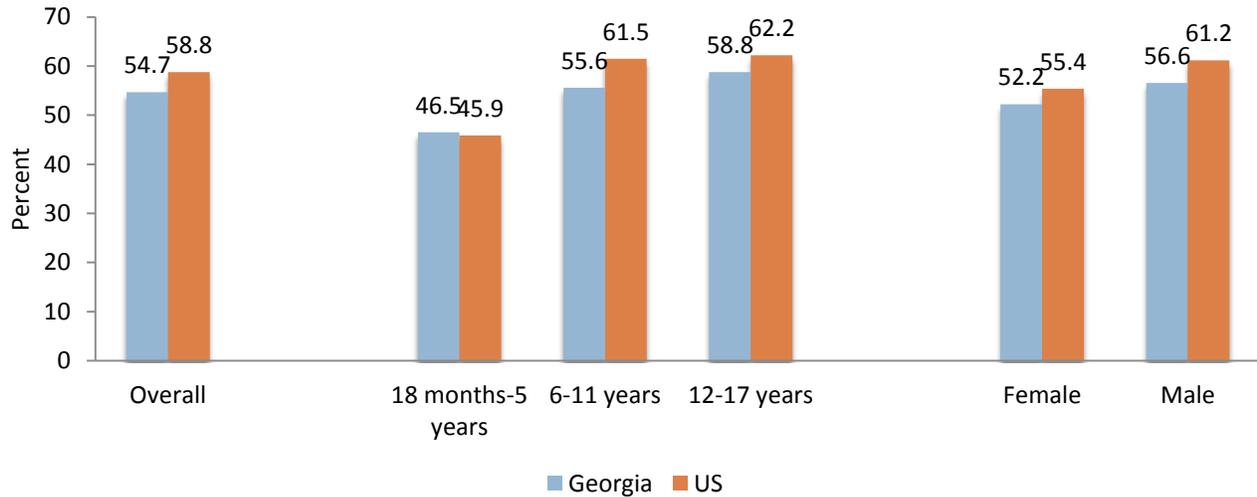


Source: NS-CSHCN

EMOTIONAL OR BEHAVIORAL PROBLEMS

Parents of CYSHCN were asked about the prevalence of emotional or behavioral problems. Emotional or behavior problems were considered to be: feeling anxious or depressed, acting-out, bullying or arguing, making and keeping friends. Over half of CYSHCN in both Georgia and the US were reported to have difficulty with one or more of the emotional or behavioral problems listed. Data for the US and Georgia showed similar patterns. As age increased, so did the percentage of CYSHCN having difficulty with one or more emotional or behavioral problems. Only slightly more males in Georgia (56.6%) were reported to have difficulty with one or more emotional or behavioral problems when compared to females (52.2%).

Percent of CYSHCN who have little or a lot of difficulty with one or more emotional or behavior problems by age and gender, Georgia compared to the US, 2009/10



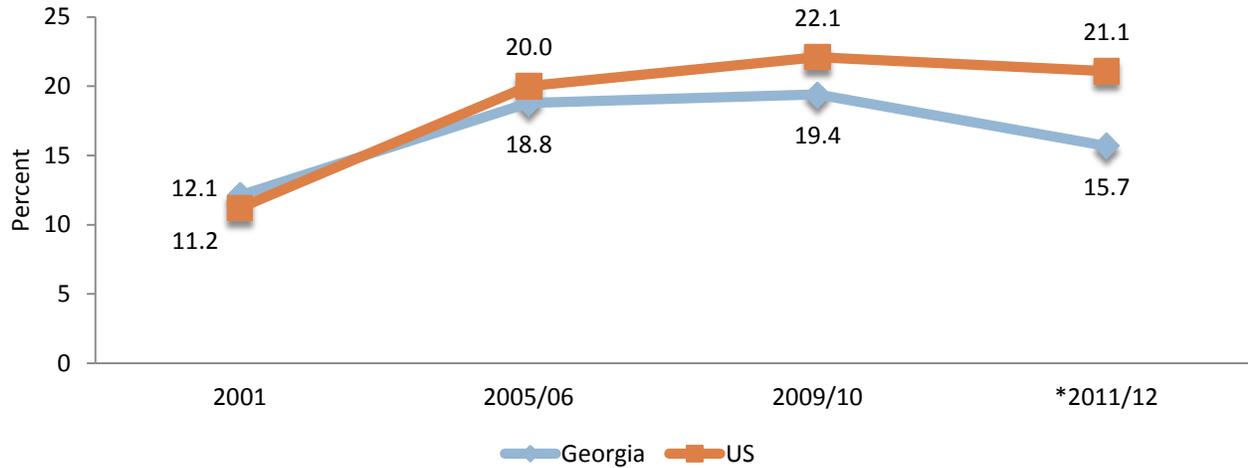
Source: NS-CSHCN

IMPACT ON THE FAMILY

Out of Pocket Medical Expenses

Overall, the percentage of families of CYSHCN who paid \$1,000 or more in out of pocket medical expenses for their child increased from 2001 to 2009/10, both nationally and in Georgia. Projection analysis was used to determine the prevalence in 2011/12 (15.7%). Based on the analysis, it is estimated that nearly 75,000 CYSHCN in Georgia have families that paid more than \$1,000 in out of pocket medical expenses in 2011/12. Controlling for socio-demographic characteristics, CYSHCN living in households 400% of the FPL or greater are significantly more likely than CYSHCN living in households below 400% of the FPL to pay high out-of-pocket expenses.

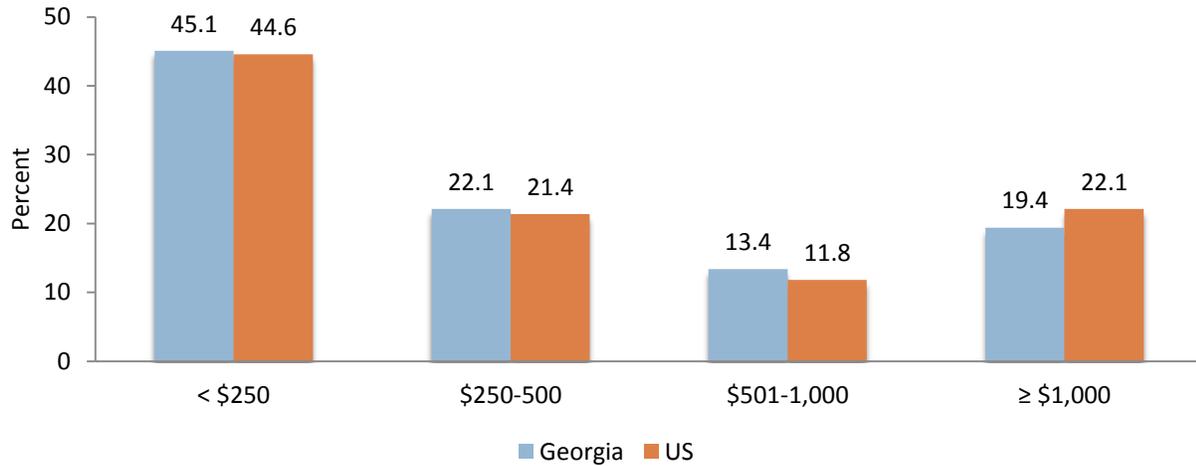
Percent of CYSHCN 0-17 whose families paid \$1,000 or more in out of pocket medical expenses in the past year by year, Georgia compared to the US, 2001-2011/12



Source: NS-CSHCN
 *2011/12 estimates are based on projection analysis

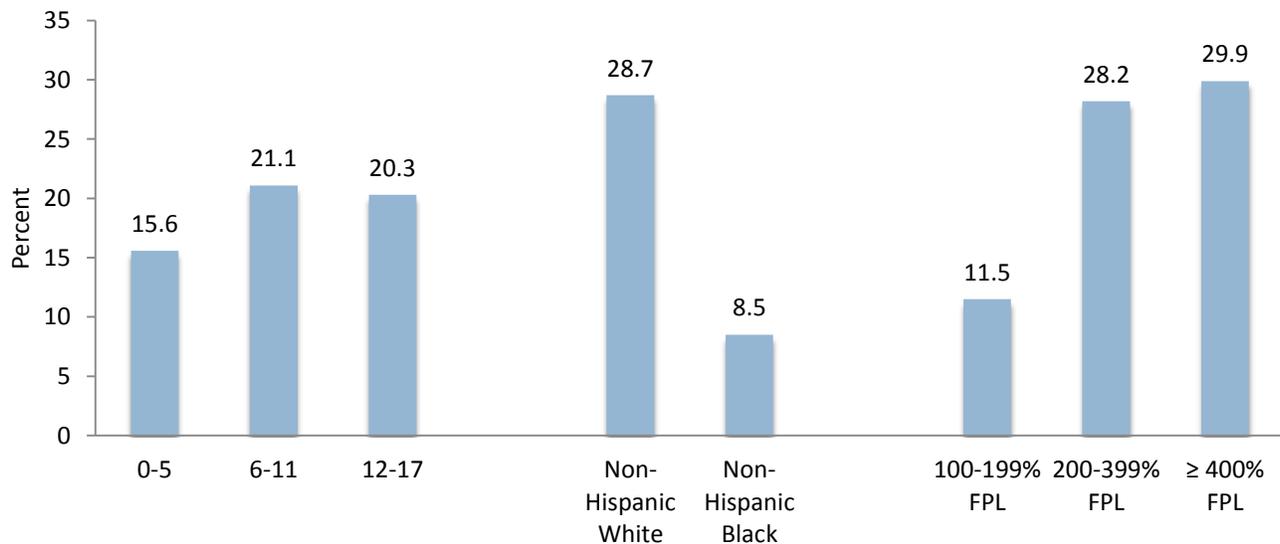
Over 40% of families in both Georgia and the US reported spending less than \$250 on their child’s medical expenses in the past year. However, nearly 20% of families spent more than \$1,000 in out of pocket medical expenses in 2009/10 in Georgia. The data in Georgia is fairly consistent with what was seen at the national level. As the age of CYSHCN increased, so did the percentage of families who paid \$1,000 or more in out of pocket expenses. Only 15.6% of families with CYSHCN 0 to 5 years of age reported paying \$1,000 or more, while 20.3% of families with CYSHCN 12 to 17 years of age reported paying that amount. Non-Hispanic White families paid \$1,000 or more in out of pocket medical expenses (28.7%) more often than non-Hispanic Black families (8.5%). More families in the highest income bracket paid \$1,000 or more in out of pocket medical expenses (29.9%) compared to only 11.5% of those in the lowest income group examined.

Percent of CYSHCN 0-17 whose families paid out of pocket in medical expenses in the past year by amount spent, Georgia compared to the US, 2009/10



Source: NS-CSHCN

Percent of CYSHCN 0-17 whose families paid \$1,000 or more in out of pocket medical expenses in the past year by age, race and household income, Georgia, 2009/10



Source: NS-CSHCN

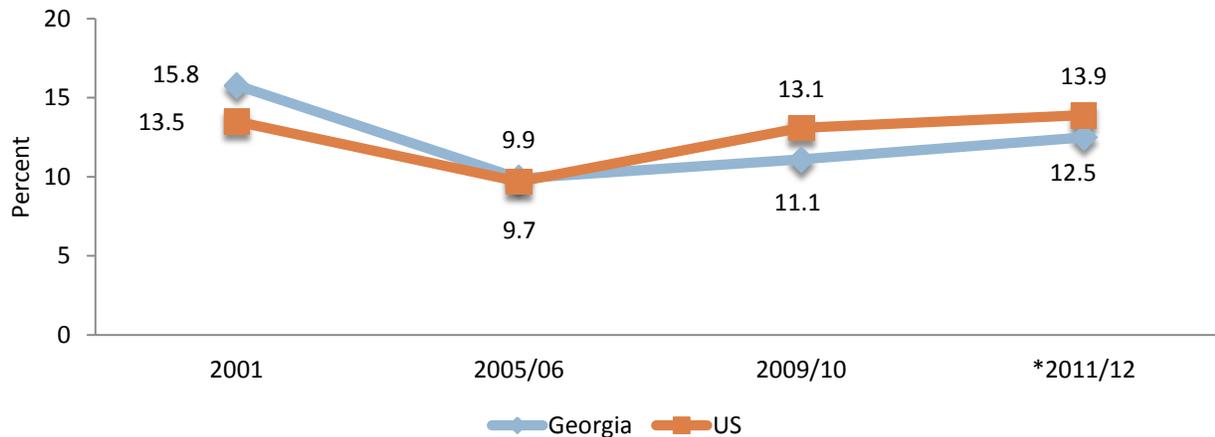
*Estimates for 0-5 years, Non-Hispanic Black and 100-199% FPL are less than 50 and should be interpreted with caution

Coordinating Care

Families of CYSHCN often coordinate their child’s health care. In Georgia during 2001, 15.8% of families of CYSHCN reporting spending 11 or more hours per week coordinating their child’s healthcare. In 2009/10, 11.1% of Georgia’s families reported spending 11 or more hours per week. The projected prevalence in

2011/12 is 12.5%, or 59,632 CYSHCN with families spending 11 or more hours providing and/or coordinating health care for the child. Controlling for socio-demographic characteristics, families of uninsured CYSHCN are projected to spend more hours providing and/or coordinating health care for the child than households with public or private insurance. Households that lived below 100% of the FPL in 2012 were also predicted to be more likely to spend 11 or more hours than families in households above 100% FPL.

Percent of CYSHCN whose families spend 11 or more hours per week coordinating their child's health care by year, Georgia compared to the US, 2001-2011/12

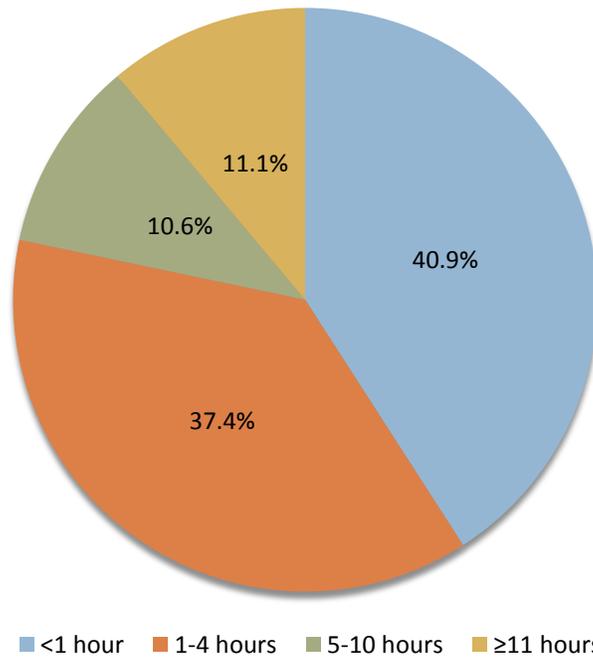


Source: NS-CSHCN

*2011/12 estimates are based on projection analysis

In 2009/10, over half of the families of CYSHCN reported spending at least one hour per week coordinating their child's care. Over 37% reported spending between 1 and 4 hours, 10.6% reported 5 to 10 hours and 11.1% reported spending eleven or more hours per week coordinating care.

Percent of CYSHCN 0-17 whose families spend time coordinating their child's health care by hours per week, Georgia, 2009/10

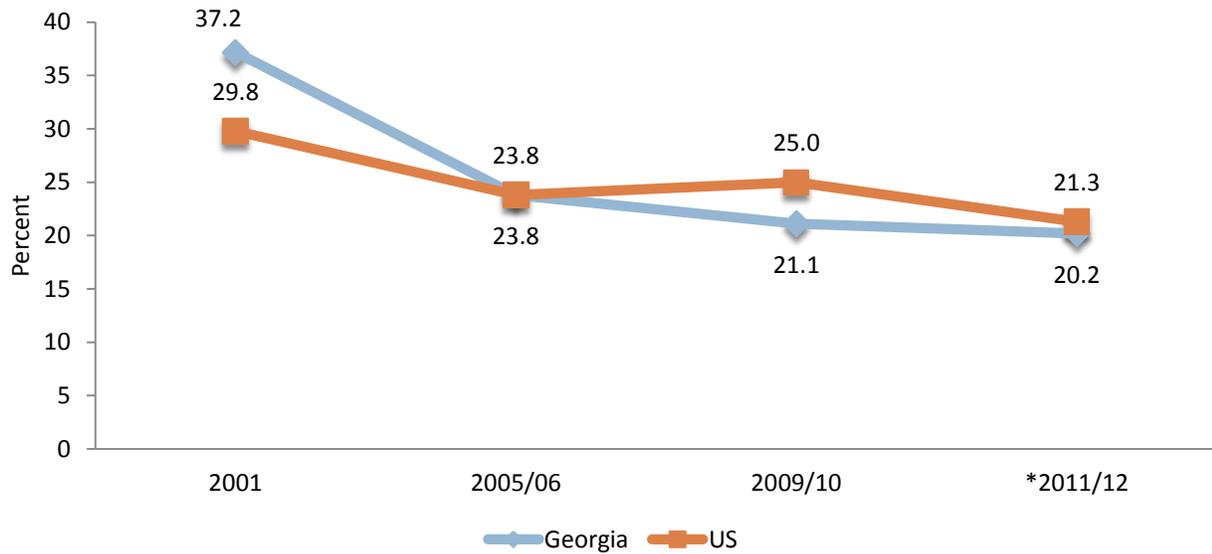


Source: NS-CSHCN

Impact on the Job

From 2001 to 2009/10, the percent of CYSHCN whose health conditions caused family members to cut back or stop working in Georgia decreased from 37.2% to 21.1%. During the time period, the percentage went from being above the national average to below the national average. The projected prevalence of CYSHCN whose health conditions cause family members to cut back or stop working in 2011/12 is 20.2%, or approximately 1 in 5 CYSHCN. Controlling for socio-demographic characteristics, CYSHCN in households at lower levels of the FPL in 2012 were projected to be much more likely to have family members who cut back or stopped working than families in households at or above 400% FPL.

Percent of CYSHCN whose health conditions caused family members to cut back or stop working by year, Georgia compared to the US, 2001-2011/12



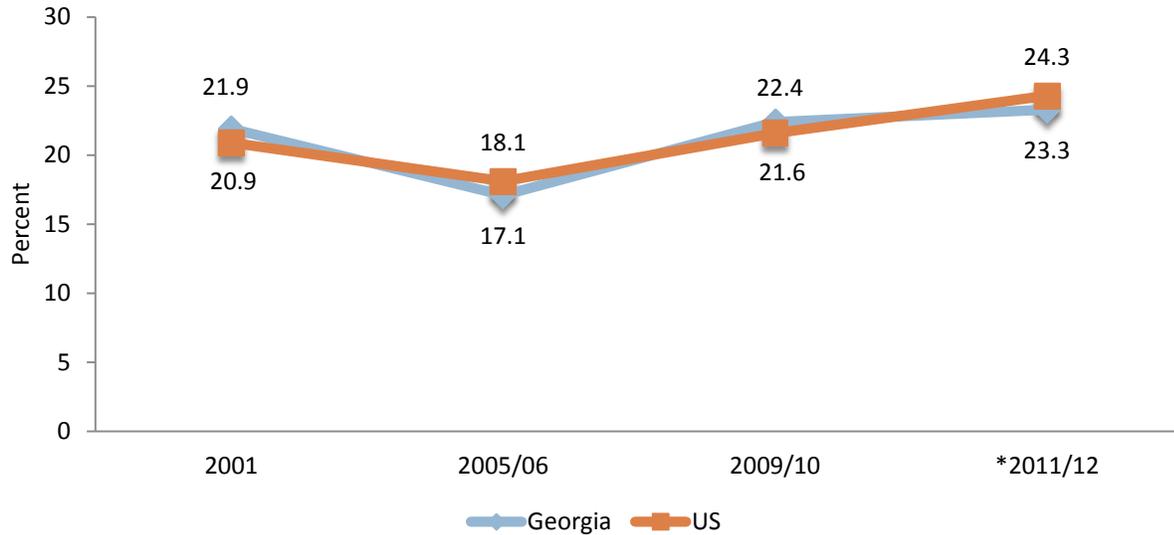
Source: NS-CSHCN

*2011/12 estimates are based on projection analysis

Financial Hardship

From 2001 to 2009/10, the percentage of CYSHCN whose families experienced financial problems due to their health care increased slightly from 21.9% to 22.4%. The projected prevalence in 2011/12 is 23.3%. Controlling for socio-demographic characteristics, CYSHCN older than 12 years of age were more likely to have health conditions that caused financial problems for their families than younger children. Additionally, the prevalence of CYSHCN with health conditions that cause financial problems for the family is higher among households at lower levels of the federal poverty level (FPL).

Percent of CYSHCN 0-17 whose families have experienced financial problems due to their child's health conditions by year, Georgia, 2001-2011/12

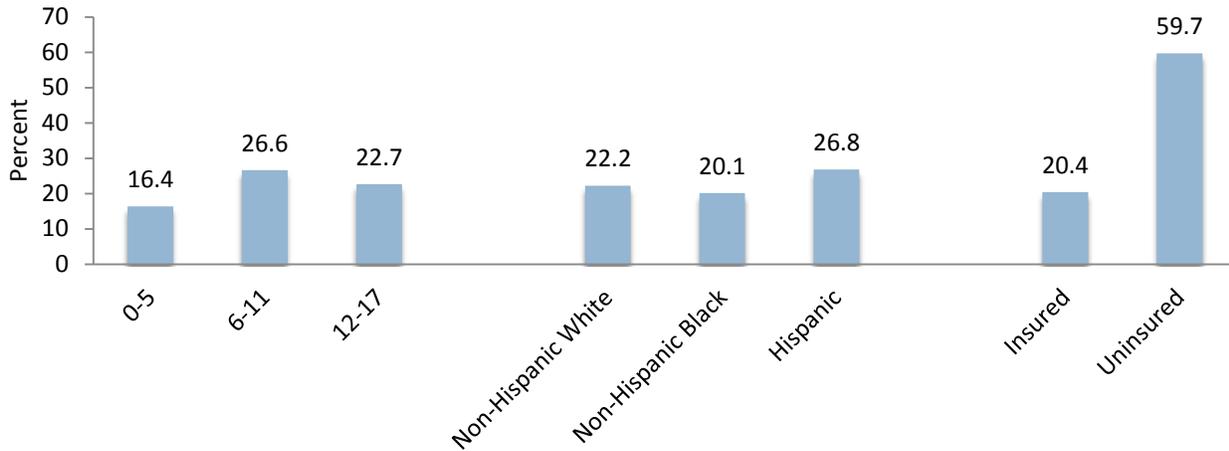


Source: NS-CSHCN

*2011/12 estimates are based on projection analysis

More families with a child between the ages of 6 and 11 reported financial hardship (26.6%) compared to families with a child 0 to 5 years of age (16.4%) and families with a child 12 to 17 years of age (22.7%). When stratified by race/ethnicity, the percentage was highest among Hispanic families (26.8%) compared to only 22.2% of non-Hispanic White families and 20.1% of non-Hispanic Black families. Uninsured families reported experiencing financial hardship three times as often as those with insurance.

Percent of CYSHCN 0-17 whose families have experienced financial problems due to their child's health conditions by age, race/ethnicity and insurance status, Georgia, 2009/10



Source: NS-CSHCN

*Estimates for 0-5, Hispanic and Uninsured are based on numerators less than 50 and should be interpreted with caution

UNMET NEED FOR HEALTH CARE SERVICES

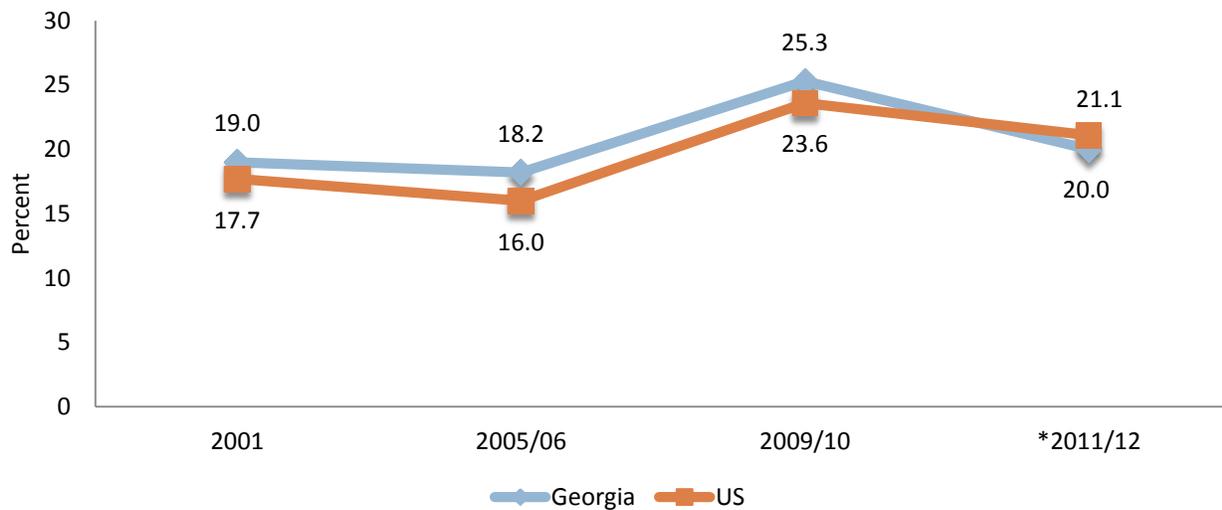
CYSHCN often lack access to needed health care services. Parents of CYSHCN were asked about an unmet need for the following 14 services:

1. Preventive medical care
2. Specialty care
3. Preventive dental care
4. Other dental care
5. Prescription medications
6. Need for physical, occupational or speech therapy
7. Mental health care or counseling
8. Substance abuse treatment or counseling
9. Home health care
10. Eyeglasses or vision care
11. Hearing aids or hearing care
12. Mobility aids or devices
13. Communication aids or devices
14. Durable medical equipment

In 2001, 19.0% of Georgia's families of CYSHCN reported having an unmet need for one of the 14 services. In 2009/10, the percentage increased to 25.3%. During that time period, Georgia's percentage remained

slightly higher than the national average. The projected prevalence in 2011/12 is 20.0%. Controlling for socio-demographic characteristics, CYSHCN between the ages of 12 and 17 are more likely to have unmet needs than younger CYSHCN, and those living in households below 200% of the federal poverty level (FPL) are significantly more likely than CYSHCN living in households that above 200% of the federal poverty level (FPL) to have unmet needs. 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.

Percent of CYSHCN with any unmet need for 14 specific health care services or equipment in the past year by year, Georgia compared to the US, 2001-2011/12



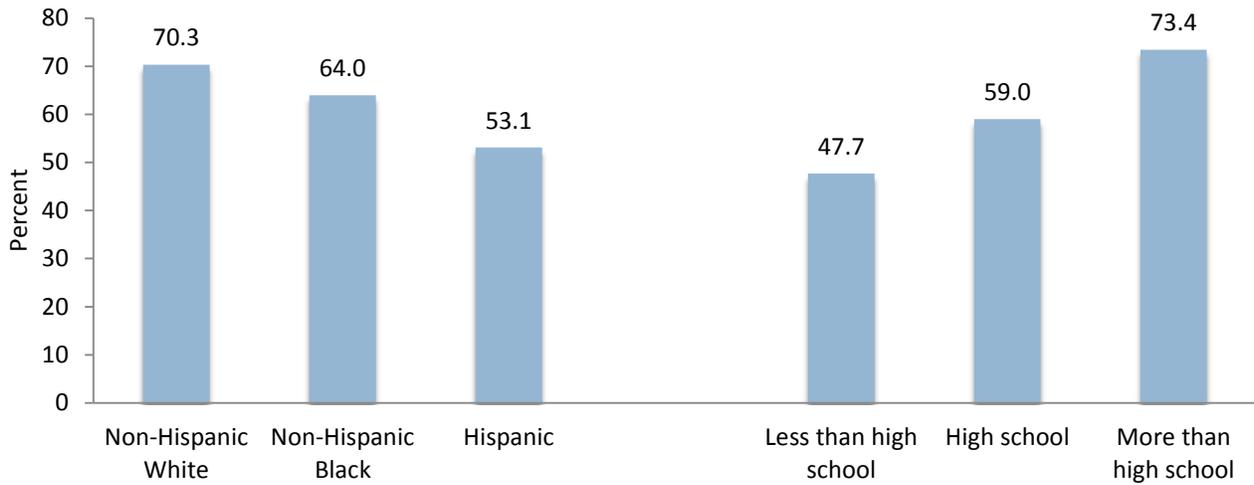
Source: NS-CSHCN

*2011/12 estimates are based on projection analysis

SHARED DECISION-MAKING

Another important measure to look at is shared decision-making for the child's optimal health. More parents of non-Hispanic White children reported sharing in decision-making (70.3%) than non-Hispanic Blacks (64.0%) and Hispanics (53.1%). The percentage of parents who reported shared decision-making increased with parental educational attainment; those with greater than a high school education reported sharing decision-making for their child's health 54% more often than those with less than a high school education. More parents of CYSHCN with private insurance only (78.1%) reported sharing in decision-making than parents of CYSHCN on public insurance only (59.1%). As income increased, so did the percentage of parents who share in decision-making. The percentage was 78.3% among those in the highest income bracket, compared to only 58.3% of those in the lowest income bracket.

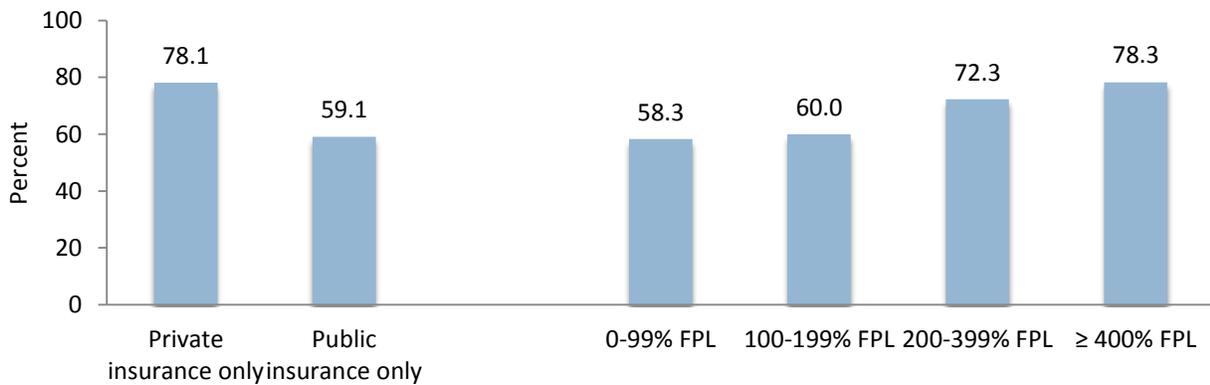
Percent of CYSHCN 0-17 whose families partner in shared decision-making for their child's health by race/ethnicity and parental education, Georgia, 2009/10



Source: NS-CSHCN

*Estimates for Hispanic and Less than high school are based on numerators less than 50 and should be interpreted with caution

Percent of CYSHCN 0-17 whose families partner in shared decision-making for their child's health by insurance status and household income, Georgia, 2009/10



Source: NS-CSHCN

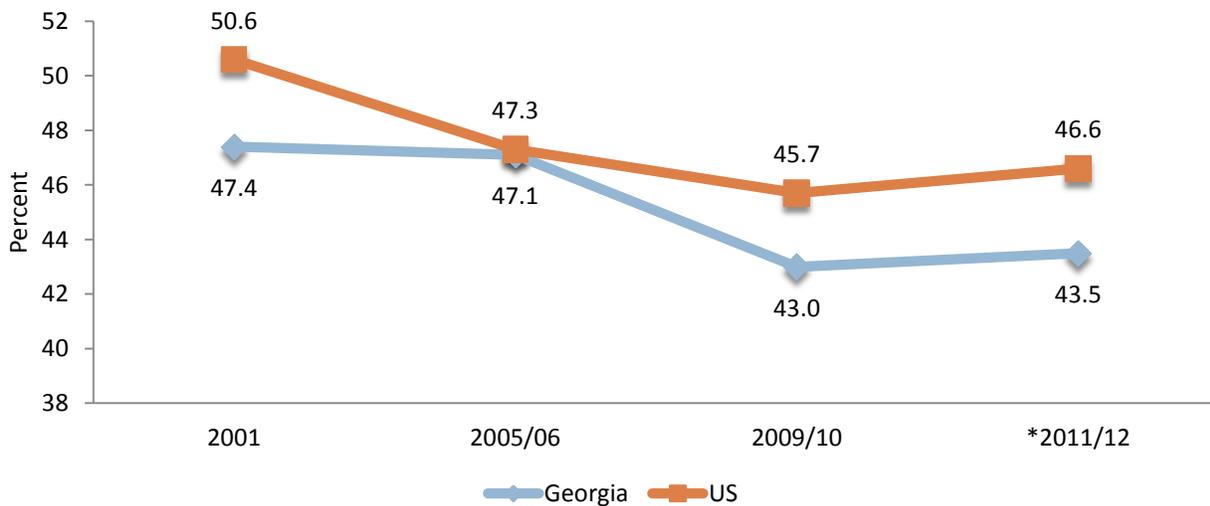
COORDINATED AND COMPREHENSIVE CARE IN A MEDICAL HOME

Healthy People 2020 Objective

MICH 30.2: Increase the proportion of children with special healthcare needs who have access to a medical home to 51.8%

The percentage of CYSHCN who receive coordinated, ongoing and comprehensive care within a medical home in Georgia decreased from 47.4% in 2001 to 43.0% in 2009/10. During the time period, Georgia’s estimates were slightly lower than the national average. Georgia’s projected prevalence in 2011/12 is 43.5%. Controlling for socio-demographic characteristics, it is projected that Hispanic CYSHCN were less likely to receive comprehensive care in a medical home than non-Hispanic White and non-Hispanic Black CYSHCN in Georgia in 2012. CYSHCN that were uninsured in 2012 were estimated to be much less likely to receive comprehensive care in a medical home than insured CYSHCN.

Percent of CYSHCN 0-17 who receive coordinated, ongoing and comprehensive care within a medical home by year, Georgia compared to the US, 2001-2011/12

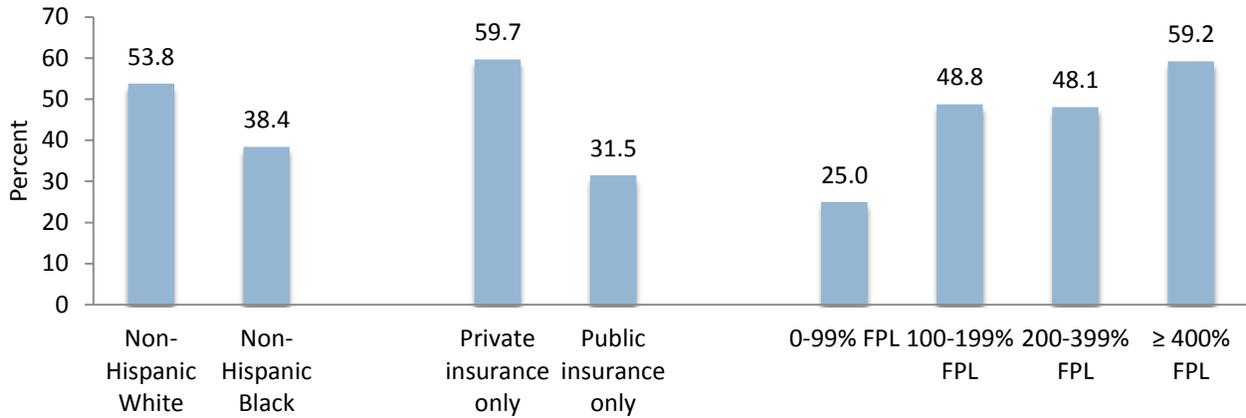


Source: NS-CSHCN

*2011/12 estimates are based on projection analysis

In 2009/10, 43.0% of CYSHCN received coordinated, ongoing, and comprehensive care within a medical home in Georgia. Fewer non-Hispanic Black CYSHCN received coordinated, ongoing, comprehensive care within a medical home than to non-Hispanic Whites. CYSHCN with private insurance only were reported to receive care within a medical home nearly twice as often as CYSHCN with public insurance only. As income level increased, so did the percentage of CYSHCN receiving care within a medical home.

Percent of CYSHCN 0-17 who receive coordinated, ongoing and comprehensive care within a medical home by race/ethnicity, insurance type and household income, Georgia, 2009/10

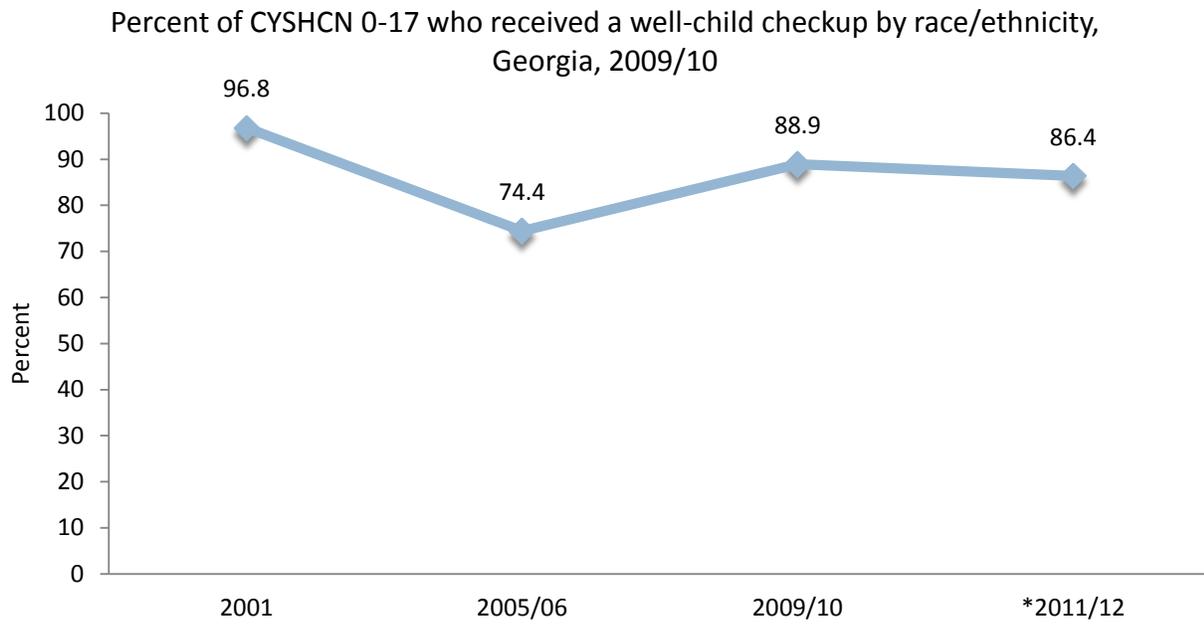


Source: NS-CSHCN

*Estimate for 0-99% FPL is based on a numerator less than 50 and should be interpreted with caution

WELL-CHILD CHECKUP

From 2001 to 2009/10, the percentage of CYSHCN who received a well-child checkup decreased from 96.8% to 88.9%. The projected prevalence in 2011/12 is 86.4%. Type of health insurance, household poverty level and age were all found to be predictive of changes in the projected prevalence of this measure among CYSHCN in Georgia in 2012. Uninsured CYSHCN, those living in households below the FPL, and youth (ages 12-17) with special health care needs were estimated to be less likely to receive all needed preventive medical care than other subgroups.



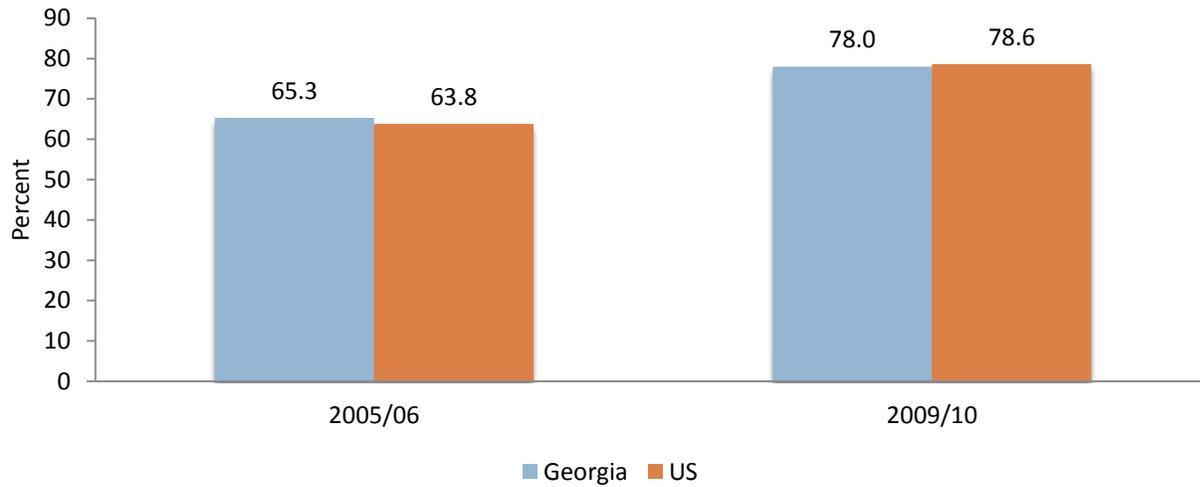
Source: NS-CSHCN

*2011/12 estimates are based on projection analysis

SCREENING

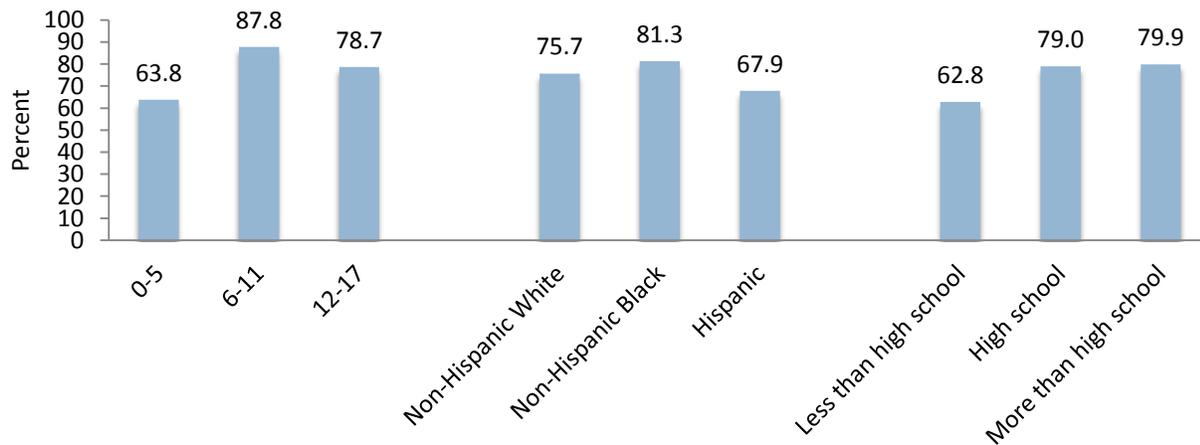
The percentage of CYSHCN who were screened early and continuously for special health care needs in Georgia increased from 65.3% in 2005/06 to 78.0% in 2009/10. Georgia's data were very similar to the national averages. The percentage was highest among those 6 to 11 years of age. More non-Hispanic Blacks reported being screened early and continuously than non-Hispanic Whites and Hispanics. Almost 80% of CYSHCN whose parents had more than a high school diploma were reported to receive such screenings, compared to 62.8% of CYSHCN whose parents had less than a high school diploma.

Percent of CYSHCN 0-17 who were screened early and continuously for special health care needs by year, Georgia compared to the US, 2005/06



Source: NS-CSHCN

Percent of CYSHCN 0-17 who were screened early and continuously for special health care needs by age, race/ethnicity and parental education, Georgia, 2009/10



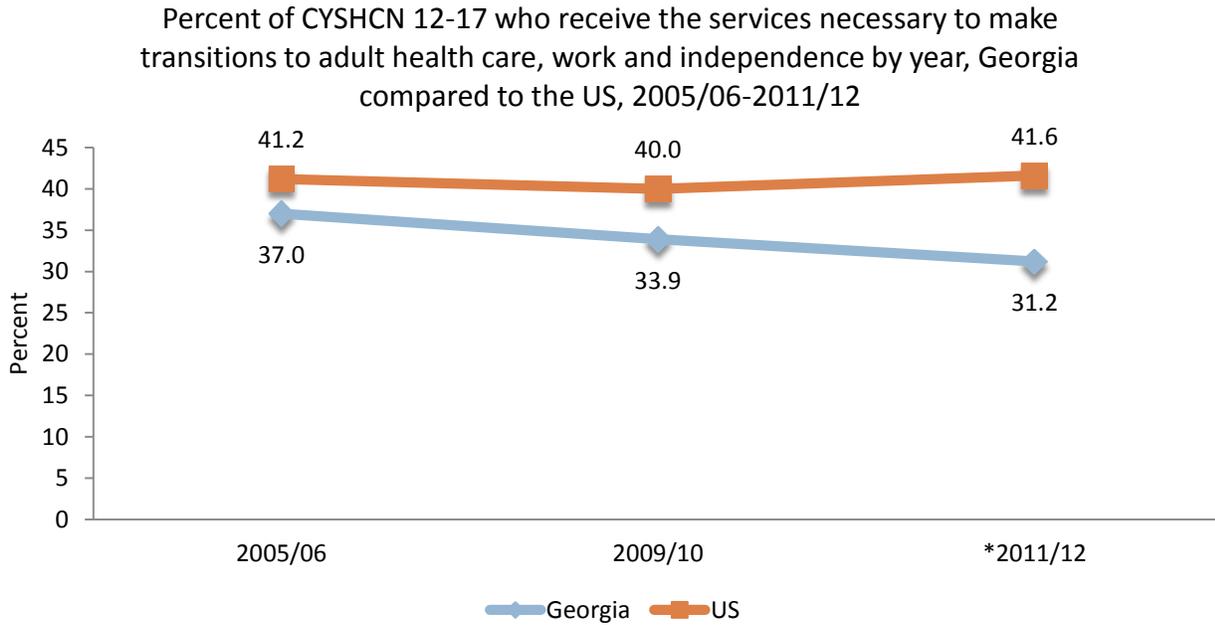
Source: NS-CSHCN

*Estimates for Hispanic and Less than high school are based on numerators less than 50 and should be interpreted with caution

TRANSITION TO ADULTHOOD

From 2005/06 to 2009/10, the percentage of CYSHCN who received services necessary to transition to adult health care, work and independence in Georgia decreased from 37.0% to 33.9%. The percentage was lower in Georgia than in the US as a whole in both years examined. The projected prevalence in Georgia during 2011/12 is 31.2%. Type of health insurance, household poverty level and race were all found to be predictive of changes in the projected prevalence of this measure among CYSHCN in Georgia in 2012.

Uninsured CYSHCN and those living in households below the FPL were estimated to be less likely to make proper transitions to adulthood.

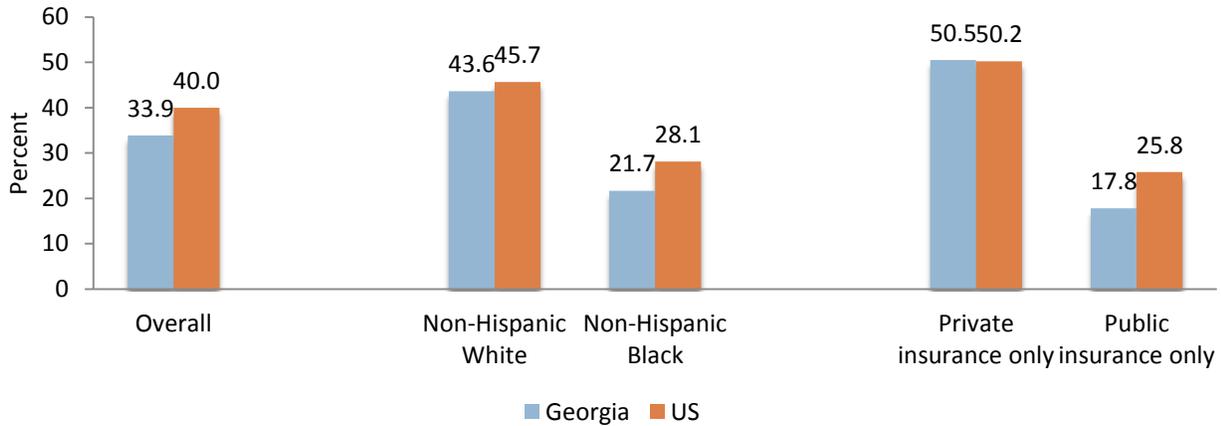


Source: NS-CSHCN

*2011/12 estimates are based on projection analysis

In 2009/10, fewer non-Hispanic Black CYSHCN received services necessary to transition (21.7%) compared to 43.6% of non-Hispanic White CYSHCN. Additionally, Georgia’s percentages were below the nation’s estimates in nearly every category examined. About half of CYSHCN on private insurance only received transition services, while less than 20% of those on public insurance only did in Georgia.

Percent of CYSHCN 12-17 who receive services necessary to make transitions to adult health care, work and independence by race/ethnicity and type of insurance, Georgia compared to the US, 2009/10



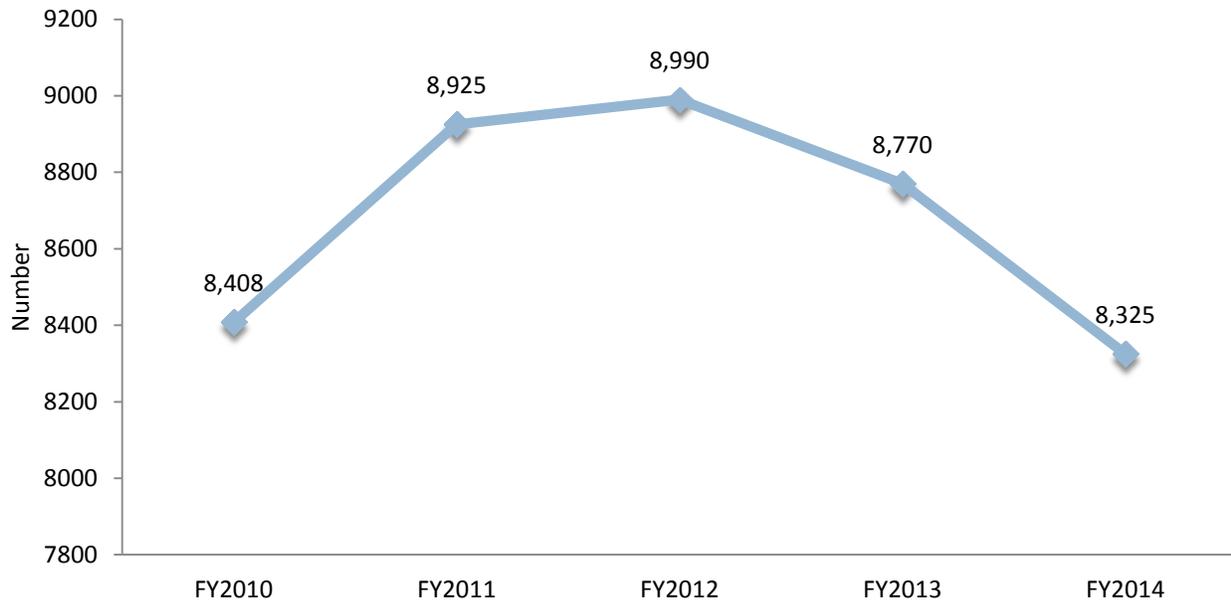
Source: NS-CSHCN

*Georgia’s estimates for Non-Hispanic Black and Public insurance only are based on numerators <50 and should be interpreted with caution

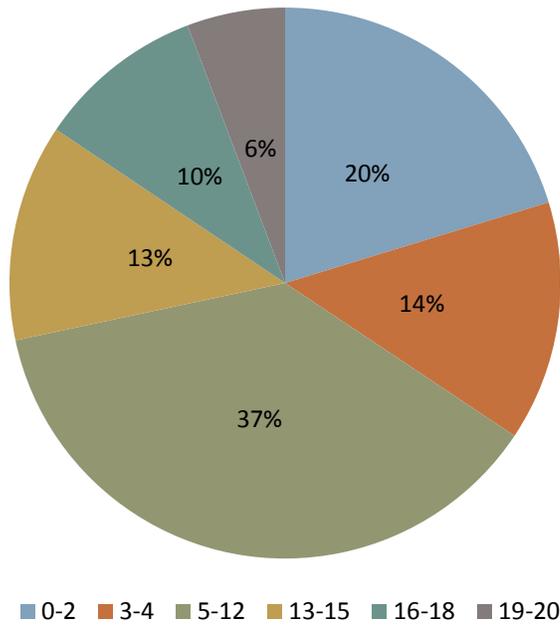
CHILDREN’S MEDICAL SERVICES

Children’s Medical Services, Georgia’s program for CYSHCN, enrolled 8,325 CYSHCN in the 2014 fiscal year (FY). The number represents an overall decline from FY2010, in which 8,408 CYSHCN were enrolled. In 2014, the highest percentage of enrollees were between the ages of 5 and 12. About 1 in 5 enrollees are between the ages of 0 and 2. Just under 80% of outcomes were met in FY2014, and approximately 20% of outcomes were partially met.

Children's Medical Services Enrollment by year, FY2010-FY2014

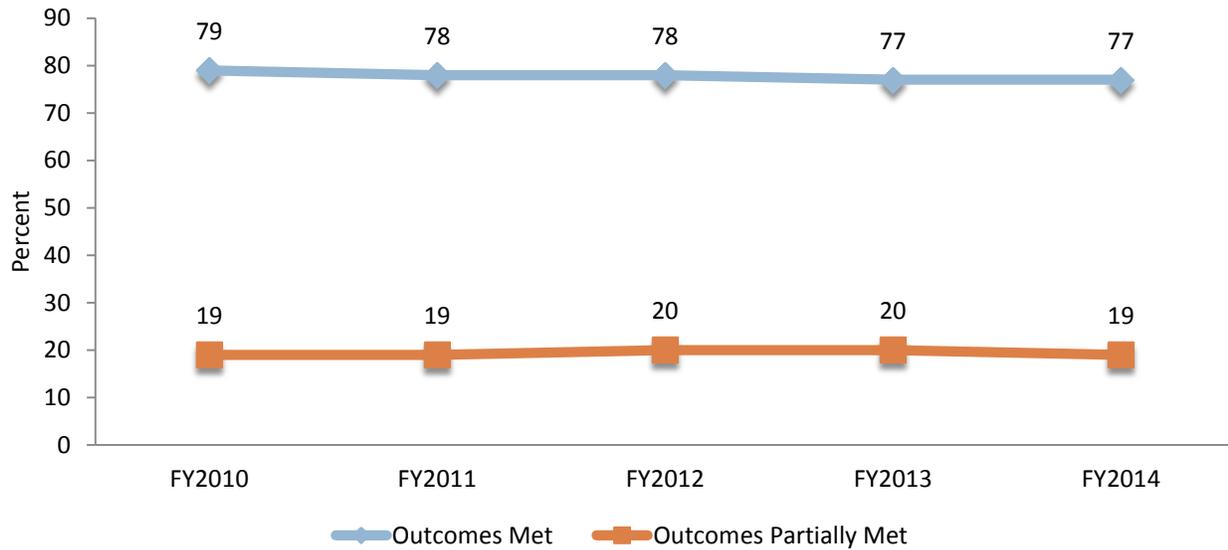


Children's Medical Services Enrollment by age, FY2014



Source: CMS

Percent of outcomes met or partially met in Children's Medical Services, FY2010-FY2014



Source: CMS

QUALITATIVE FINDINGS: CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Focus groups were conducted among parents of children and youth with special health care needs in counties that span six of Georgia’s public health districts. Demographic information on focus group participants are provided below.

Table 9. Children and Youth with Special Health Care Needs Focus Group Demographics

	Gainesville N=12 n (%)	Cobb-Douglas N=13 n (%)	Clayton N=8 n (%)	Augusta N=7 n (%)	Columbus N=8 n (%)	Savannah N=10 n (%)
Age						
20-29	2 (17%)	3 (23%)	--	2 (29%)	1 (13%)	1 (10%)
30-39	1 (8%)	5 (38%)	5 (63%)	2 (29%)	6 (75%)	2 (20%)
40-49	5 (42%)	5 (38%)	--	2 (29%)	--	6 (60%)
50-59+	4 (33%)	--	3 (38%)	1 (14%)	1 (13%)	1 (10%)
Highest level of education completed						
Less than High School	--	--	--	1 (14%)	--	1 (10%)
High School/GED	1 (8%)	2 (16%)	1 (13%)	1 (14%)	3 (38%)	3 (30%)
Some College/Technical /Community College	4 (33%)	5 (38%)	5 (63%)	2 (29%)	4 (50%)	3 (30%)
College graduate or more	2 (17%)	8 (62%)	2 (25%)	3 (43%)	1 (13%)	3 (30%)

No response	5 (41.7%)	--	--	--	--	--
Race/Ethnicity						
Caucasian/White	12 (100%)	4 (31%)	--	2 (29%)	2 (25%)	4 (40%)
African-American/Black	--	7 (54%)	8 (100%)	4 (57%)	6 (75%)	5 (50%)
Latino/Hispanic	--	1 (8%)	--	1 (14%)	--	--
Asian	--	1 (8%)	--	--	--	--
Other	--	--	--	--	--	1 (10%)
No response	--	--	--	--	--	--
Health insurance status						
Private	8 (73%)	6 (46%)	2 (25%)	3 (43%)	4 (50%)	6 (60%)
Public	4 (36%)	7 (54%)	5 (63%)	3 (43%)	5 (63%)	5 (50%)
None	2 (18%)	3 (23%)	1 (13%)	1 (14%)	--	--
No response	--	--	--	--	--	--
Number of children currently parenting						
0	--	--	--	--	--	--
1	4 (33%)	--	5 (63%)	2 (29%)	2 (25%)	5 (50%)
2	7 (58%)	3 (43%)	1 (13%)	2 (29%)	3 (38%)	3 (30%)
3	--	1 (14%)	2 (25%)	1 (14%)	1 (13%)	1 (10%)
4	--	--	--	2 (29%)	2 (25%)	1 (10%)
5	1 (8%)	--	--	--	--	--
6+	--	2 (29%)	--	--	--	--
No response	--	--	--	--	--	--
Pregnant						
Yes	--	1 (14%)	--	1 (14%)	1 (13%)	1 (10%)
No	12 (100%)	6 (89%)	8 (100%)	6 (86%)	7 (88%)	9 (90%)
I don't know	--	--	--	--	--	--
Receiving WIC						
Yes	--	1 (8%)	--	2 (29%)	3 (38%)	1 (10%)
No	12 (100%)	12 (92%)	8 (100%)	5 (71%)	5 (63%)	9 (90%)
No response	--	--	--	--	--	--

Parents were asked about the barriers they face to obtaining medical care and therapy for their children with special health care needs. In focus groups where parents had children 7 years of age or younger, they were asked about early intervention services and experiences with diagnoses and receiving referrals. Parents with children 8 years of age or older were asked about their experiences transitioning their children to adulthood. All focus group participants were asked to discuss their experiences accessing both medical and community services. The table below provides a summary of the themes that arose during the focus groups, followed by a full discussion of the needs that emerged.

Table 10. Barriers to receiving services for CYSHCN

Individual-Level Barriers	
Themes	Comments
Lack of referrals to early intervention services	“ . . . there is that gap where your pediatrician isn’t referring you to things. And you don’t even know about it or how to even look for it.”
Lack of shared decision-making	<p>“A lot of these doctors that have these initials after their names, they don’t stop and realize we have initials after our name. It’s M-O-M or D-A-D. So those are the initials that matter the most. You aren’t more qualified to tell me about my child than me. You know the textbook. We live with them 24/7.”</p> <p>“I feel a lot of times they’re just trying to push you out the door. They’re not listening.”</p>
Lack of care coordination	“Could I be my own medical home? I’m serious. I do everything. Every single thing that she has to have, I have to research. I have to find these people, hunt them down, go to the pediatricians’ office.”
Limited information about existing services	<p>“I got information [about Babies Can’t Wait] but I never got any detailed information on what services were or what they offered.”</p> <p>“I looked [BCW] up on the Department of Health website and still, just not enough information.”</p>
Safety concerns	“He actually had a nurse that tried to get his social security number routed to her bank account- his social security check. So you know you can’t trust people and they don’t get that.”
Lack of employment and financial preparation services	“ . . . one of the biggest steps you can do to ensure your child’s future after you’re gone is like a special needs trust and a will, but most of us in this room can’t afford the cost to have that done because it’s very expensive.”
Structural-Level Barriers	
Lack of adequate health care professionals	<p>“I find that mostly in Atlanta you can find a great amount of autistic doctors that understand it so that’s really the problem that we’ve been having.”</p> <p>“That’s our problem. We are very rural . . . most of the time we have to travel to Atlanta or Augusta, or at least to Gainesville.”</p>
Eligibility restrictions	“I used [CMS] anytime when he was younger but obviously they have an income bracket, so once you exceed that income bracket they no longer want to help you regardless of the severity of the child or not. So that’s the issue that I ran into.”

Lack of safe recreational places	“Play is a form of therapy, a form of socialization. And it doesn’t matter if it’s just autism or any other situation, we don’t have anything like that. We just have the regular recreational centers. And those are dangerous areas.”
Long waiting lists for appointments	“...We’ve had to wait eight months to get a new neurologist...We were on the waiting list for that. To me, that’s not acceptable...If your child is having a lot of seizures then you don’t want to be on the waiting list.”
Lack of adult medical homes	“I wish that there was an adult onset developmental disability medical professional that you could go to that would be like your medical home for somebody who is transitioning out of pediatric services. That would be amazing.”

Table 11. Strengths of Services for CYSHCN

Individual-Level Facilitators/Strengths	
Themes	Comments
Access to medical services	<p>“So far, my son’s on Medicaid and he goes to the dentist and he goes to the doctor and goes to the psychologist and gets the prescriptions, he goes to the dermatologist if he needs to. So I haven’t had any problems with those services.”</p> <p>“Well my son’s therapist does a very good job with his therapy. They’re trying to teach him how to tie his shoes. They even nominated him for an exercise bike. One of those three-wheeled bikes that help him with his motor skills and everything. I feel like it’s really going great.”</p> <p>“... Babies Can’t Wait did well for my child. They come into the home . . .”</p>
Access to community support services	<p>“In our area we are very blessed to have. . . a group started by an occupational therapist. . . And we work very hard to bring some educational services to our parents, times where we can meet and discuss things as parents and also there are different activities . . . to promote inclusion. So we’re very blessed in that aspect.”</p> <p>“... I had a phone call from our school teacher this past Saturday and she wanted to know everything I could tell her about my daughter, and this is the first time, and she’s ten, that a teacher . . . has reached and truly, I mean an hour and a half on the phone Saturday. And I emailed her Sunday morning saying, ‘Thank you for your time. I feel my daughter is in the best of hands.’”</p>
Structural-Level Facilitators/Strengths	

Gap-filling services	“But we’ve used CMS a lot to pay for things on his wheelchair Medicaid won’t cover. Like Medicaid doesn’t think the tray is medically necessary. So it covers the tray for his new chairs. We’ve used CMS a lot.”
Transportation service availability	“In my county they offer someone to come pick my child up to receive services.”
Provider availability in urban areas	“There are a lot of specialty doctors in Atlanta and I never have a problem being connected to various doctors.”

Early and Continuous Screening

Early and continuous screening is critical in the identification and treatment of a variety of conditions among children with special needs. Early detection of developmental challenges can lead to timely access of community, therapy and medical services. Parents were asked about the screening services they received, their thoughts or experiences during the process and about other similar programs where care for their children requiring special needs were sought when applicable. This assessment is aimed at focusing on participants’ knowledge about available services and programs, use of medical and community services and care coordination for their children with special needs.

Lack of referrals to early intervention services

Most of the participants indicated that their children either received no referral or were referred late to early intervention services. Parents cited that their child was not referred either because the diagnosis occurred too late, or because physicians themselves were not aware of where to refer patients. Parents seem to find the referral process unsatisfying as they felt they had to take the initiative in the care of their children for referrals.

“There was no referral to anything. I just happened to find out about Babies Can’t Wait and then called them. And then they helped me, you know.”

“... there is that gap where your pediatrician isn’t referring you to things. And you don’t even know about it or how to even look for it.”

“It’s just a lot of constantly calling you know. ‘Did you refer? Did we get the referral yet?’”

Limited information about existing services

Some parents were not familiar with the Babies Can’t Wait program. Those that were familiar learned about the program through the providers that evaluated their children, social workers, pediatricians or by word of mouth. Some participants expressed difficulties accessing the services initially and felt there was a

need for clarity regarding available information or resources about health care for children with special needs. Participants expressed dissatisfaction with getting quality BCW evaluations and found the process difficult. This dissatisfaction indicates that many parents don't have access to services or programs that their children need.

"For the Babies Can't Wait program, is there a certain criteria that is out there that providers know about and they're supposed to recommend it? We weren't referred. I didn't find out about Babies Can't Wait till my sons- I have twins, they were over three years old."

"I got information [about Babies Can't Wait] but I never got any detailed information on what their services were or what they offered."

"I looked them up on the Department of Health website and still, just not enough information."
"I don't think now having a special needs child I would have heard of [Babies Can't Wait] and I'm in social work."

"I had the blessing of getting a job working with young adults with autism. If it weren't for that, I would have no clue [about Babies Can't Wait]."

"We don't know [programs] exist."

Experiences with the Babies Can't Wait Program

The majority of participants that used BCW had an excellent or positive experience, but few felt they didn't. Parents found the program useful for identifying and screening health, including occupational, physical and speech therapy for their children. Many of the participants in BCW also used other similar programs or services. Some participants received services from private providers, nonprofit organizations, health departments and the school system. A participant mentioned how pleased she was that the prenatal screening she received prepared her for her child's condition, and she was able to connect with the appropriate program immediately after the birth of her child. Experiences of some parents are mixed, for example:

"Babies Can't Wait did well for my child. They come into the home . . ."

"Our speech experience was excellent with Babies Can't Wait. We loved his speech therapist with Babies Can't Wait. We did that for six months from about two . . . to two and a half years old. And then with my daughter we did Babies Can't Wait physical therapy with her and that experience was not good. Our experience with our coordinator was not good at all and that's what affected our decision to leave Babies Can't Wait and pursue private therapy."

Lack of adequate health care professionals for children with special needs

Many participants indicated a shortage of health care professionals in their districts. For example, parents living in more rural areas had to travel back and forth to Atlanta to receive services. A parent mentioned that she discovered that their current doctor knew very little about autism. She had to take her son to several clinics throughout her district to obtain appropriate medical care, speech therapy and occupational therapy, with no central location to receive care. Parents noted a decrease in the number of physicians willing to accept AmeriGroup and WellCare because of the paperwork requirement. The most dissatisfied participants resided in rural districts.

“Now don’t get me wrong, I love Babies Can’t Wait. They helped my baby a lot from where he was at. But my main complaint was when they came out with all three of his therapists, neither one of them knew sign language. So what was the point of them teaching my child anything? You want them to cooperate with you but you don’t have sign language experience.”

“I had to find a developmental pediatrician and I couldn’t get in with one [here] soon enough so I found one in Atlanta. So now I’ve been with that doctor since she was four. So three or four times a year, unless I need it more, we’re trucking it up to Atlanta because currently [our hospital] does not have a developmental pediatrician on staff.”

“Yeah it just took me seven months to find a dentist that would take WellCare. Seven months. There were two on the list I was given out of a hundred and seventy-five.”

“The issue my family has been having is basically pinpointing doctors that understand autism and can actually help us in that aspect. For example, in this area we find that there’s not a lot of autistic specific doctors that understand children that have eating disabilities. . . . I find that mostly in Atlanta you can find a great amount of autistic doctors that understand it so that’s really the problem that we’ve been having.”

“That’s our problem. We are very rural in Hart County and Franklin County and most of the time we have to travel to Atlanta or Augusta, or at least to Gainesville.”

Ease of Use of Community and Medical Services

There are community and medical services that help parents take care of their children with special needs. Participants were asked about their experiences using the community and medical services for their children. Medical services cover all services received from doctors, nurses and therapists, while community services cover non-medical services, e.g. educational services, Women Infants and Children (WIC), transportation and other services that help them care for their children. Parents expressed the challenges faced.

Lack of telemedicine

Participants agreed that the best medical care available for their children was through one of the more metropolitan hospitals within the state. They discovered that local hospitals and clinics in rural areas lacked the health providers and that the general pediatricians had limited knowledge required to provide adequate care for children with special needs. None of the participants had heard of telemedicine services, they indicated that it is not available in their district, but expressed interest in using this technology.

Access to community support services

Participants sought other community services from organizations that provided respite and pastoral care and family support. Participants stated that taking into account nonprofit, parents' organizations and churches, there weren't enough community services for families of children with special needs. Some parents found that adequate services for children with special needs in the school system are lacking, while others reported that the schools actually were the primary navigators in assisting families with special healthcare needs to achieve the resources they required. Participants would like to have access to respite and after school services for children with special needs. One parent said she only heard about resources from community advocates.

"WIC helped me out a lot because that milk was expensive. So that milk really helped. Because you know they give you the formula and everything too when they're infants."

"In our area we are very blessed to have. . . . a group started by an occupational therapist. . . . And we work very hard to bring some educational services to our parents, times where we can meet and discuss things as parents and also there are different activities . . . to promote inclusion. So we're very blessed in that aspect."

"Someone at the Department of Behavioral Health and Disabilities. He was a huge advocate for us and I just couldn't have done it without him."

Lack of shared decision-making

Participants were generally satisfied with the care received from their health care providers, but some were concerned that their opinions and expertise with their children were not considered. Parents mentioned that some doctors don't listen to what they have to say concerning their children's health. Many parents felt that they were more aware of what their children needed than the providers.

“I feel a lot of times they’re just trying to push you out the door. They’re not listening.”

“They need to care first and foremost. . . . It’s just a job to them, or at least the ones that we’ve met. Like they’re not very passionate about especially these kids that are clearly special. A lot of them, they just don’t really care.”

“A lot of these doctors that have these initials after their names, they don’t stop and realize we have initials after our name. It’s M-O-M or D-A-D. So those are the initials that matter the most. You aren’t more qualified to tell me about my child than me. You know the textbook. We live with them 24/7.”

Structural barriers to services

Challenges or barriers faced by parents using community and health services within their communities are: transportation, language, safe recreational places, long waiting time for appointments, cumbersome paperwork requirements and eligibility for program/service applications. A parent without transportation expressed how difficult it was for her to continue to receive services when her child’s developmental doctor moved. Waiting and traveling times to meet scheduled appointments was very frustrating for some parents, in addition to more waiting time for transportation providers to pick them up at their medical appointments. The income cap and their lack of eligibility for certain services, caused some participants to believe their children were being deprived of needed quality care. Some mentioned providing false information in order to meet eligibility requirements, especially if income requirements were based on a two parent family income. The out of pocket cost of health care for unqualified parents was of great concern and some said they had been in debt for years. A parent mentioned that for families not fluent in English, it was difficult to navigate the health care system, and also a challenge between such parents and the therapists providing the services. A recommendation by parents was the need for Spanish speaking therapists or an interpreter during therapy sessions. Parents expressed desire to have a park or safe recreational space for their children to socialize and play.

“This family needs an interpreter.”

“When I look at my child and insurance will cover 30 visits per year, PT, OT together and when you do PT twice a week and OT twice a week, we’re done in ten weeks. So I’ve got forty-two weeks. The remainder of the year I have to pay out of pocket or she does not go. . . . I added it up. \$14,000 out of pocket for her for one year of therapy. And I looked at [the doctor] and I said, ‘What do we do?’ And that’s when somebody said, ‘Well let’s look into Katie Beckett.’ Well then I got sick. I couldn’t do it. Somebody should have helped me with that.”

“Like parks and recreational center, the city is known for cutting everything. They cater as best as they can to adults with programs or whatever. But there’s nothing for children unless you’re paying for it. Play is a form of therapy, a form of socialization. And it doesn’t matter if it’s just autism or any other situation, we don’t have anything like that. We just have the regular recreational centers. And those are dangerous areas. We recently had a kid that was assaulted and his pants pulled down. I actually knew his mother. And I was mortified. Thankfully, he wasn’t assaulted any further. But that was a recreational center . . . they don’t have no staff. And recreation for our children makes a difference.”

Communication between health care professionals and parents

Communication was identified as the most important factor to guide parental decision-making related to their child’s care. Communication challenges were conceptualized in various forms for participants—most obviously the absence of communication between parents and providers, but also lack of communication between providers. In the absence of communication, parents felt their children slipped through the cracks, leaving critical windows of time in which their child could receive individualized care tailored to their need. Parents also, however, spoke about challenges with communication that *did* occur with their child’s providers related to development milestones. One focus group participant shed light on her challenge in understanding the doctor’s inquiry about her child “sitting”, and how this miscommunication hampered the extent to which she and the provider could make informed decisions about her child’s care.

“. . . And then ask those developmental questions the right way. ‘Can your baby sit?’ That is not what you meant. Ask what you mean. ‘Can your baby get to a sit?’ That would have totally- not that three months would have mattered, but we would have started the therapy earlier.”

Many parents felt the concerns they communicated to their doctors about their child’s development were dismissed, either due to provider lack of knowledge about special needs conditions or more specific language barriers. Many participants stated they were told their child would “grow out of it” when they expressed concern to their providers. In spite of the challenges, parents understood barriers that physicians faced in their communities when it came to treating children with special needs.

All in all, parents wanted to be involved in the decision-making process, and often stated “listen to us” when taking about communication with their provider.

Need for community support

The prevalent sentiment expressed by parents was the desire to have a “team” or “advocate” to assist them with the day-to-day challenges experienced with medical and social services. These relationships were seen as key to not only meeting the needs of their children, but also serving as a source for support and care. Parents noted the benefit of this collaborative process in ensuring their child’s needs were met academically, socially and emotionally and to alleviate parental exhaustion and frustration with breakdowns in communication or fragmented services. Teachers, therapists, developmental specialists, nurses and pediatricians and were commonly mentioned as individuals that listened to parental concerns, and assisted in their making informed decisions for their children.

“Because it is a team. It is the school, it’s the therapist, it’s the doctors, it’s the parents, it’s the friends, it’s the extended family, it’s everybody supporting this child. And when things are rocky with her, things are rocky with all of us. . . . I told the teacher, I said, ‘If you will let me know. . . . if she starts to slip at school and I mean, her work, her behavior, anything. Then that’s a red flag to me.’ . . . You want to catch it before it- and it is communication.”

“. . . I had a phone call from our school teacher this past Saturday and she wanted to know everything I could tell her about my daughter, and this is the first time, and she’s ten, that a teacher. . . has reached out and truly, I mean an hour and a half on the phone Saturday. And I emailed her Sunday morning saying, ‘Thank you for your time. I feel my daughter is in the best of hands.’”

Parents also expressed the frustration of being a new parent of a child with special needs and not being equipped with the tools or knowledge to address the associated challenges. Focus group participants often expressed a sentiment of “We don’t know” when it came to their child’s developmental or health challenges, and felt resources were not made available to them to assist them with making informed decisions regarding their child’s care. A challenge for parents that did receive services (e.g., home nursing or therapy services) was high-turnover of staff. Some parents attributed this turnover to low wages and long travel time for these providers.

“I have told the Y and the Y seems to have lots of this information. I said, ‘You need a table and brochures and you need to be a go to because you have the adaptive program pull right there. People that have special needs are coming to you already. Some people may know about Katie Beckett, some people may not.’”

“You may not be a first time parent, but you’re a first time parent in this situation and you don’t know.”

Medical Home

Lack of care coordination

When asked if participants had a medical home, the majority were not familiar with the term. Subsequent clarity provided by the facilitators indicated that participant's children had medical homes at their primary pediatricians. Some participants reported seeking services outside of their health district due to the difficulty of finding the right services for children with special needs. There was consensus among participants that they were primarily in charge of coordinating their children's medical care. A parent stated, *"Could I be my own medical home? I'm serious. I do everything. Every single thing that she has to have, I have to research. I have to find these people, hunt them down, go to the pediatricians' office."* Among participants who had a medical home, some were dissatisfied with the lack of coordination of care. Some mentioned a metropolitan hospital as being their medical home and considered it best in terms of coordination and health care services their children received. Some participants expressed a general distrust of the medical community in their health district, while others complained about the limited resources available outside the metro Atlanta area. Parents support the idea of a one-stop shop that will help coordinate resources for speech, occupational therapy, specialists, and other community support services.

"My thing with the patient centered medical home is it's not coordinated correctly. I remember when it rolled out, being in the medical profession. . . . It's not coordinated well and as parent it wasn't coordinated well for me. . . . I'm not putting down the services because it seemed like everybody had really good experiences, but I just feel like I got so frustrated trying to seek things out that we just basically paid for what we needed. Because it's so frustrating trying to get the services and waiting for the coordination and waiting for the authorization to receive services."

Children's Medical Services

Gap-filling services

Overall, knowledge of Children's Medical Services (CMS) was very low among focus group participants. A very small number was familiar with the formal title used to describe the array of services provided under the umbrella of CMS. Of the focus group participants whose children were enrolled in these services, each expressed high satisfaction with medical and non-medical providers. Parents also spoke of the support they received from these providers, including staff that advocated on behalf of parents for referrals, medication authorization and opportunities for parents to learn more about children with special needs and services in their districts. Through CMS, parents were able to access specialty services to diagnose and treat their children, including nephrology, gastroenterology, orthopedic care and genetic testing. Parents also noted CMS filling a critical gap where other services, like Medicaid, did not cover services or medical devices for their children.

“But we’ve used CMS a lot to pay for things on his wheelchair Medicaid won’t cover. Like Medicaid doesn’t think the tray is medically necessary. So it covers the tray for his new chairs. We’ve used CMS a lot.”

Lack of access to CMS

One county mentioned a lack of access to CMS support services due to transportation challenges to Atlanta. Accessibility to CMS was not limited to transportation, however. Many parents felt the income cap to qualify for services was too low, as illustrated by one participant that spoke about losing eligibility after an increase in pay. This was further complicated when the child’s treatment regimen included medication that was medically necessary (i.e., insulin). Parents found this to be unfair for children that demonstrated a clear need for care.

“I used [CMS] anytime when he was younger but obviously they have an income bracket, so once you exceed that income bracket they no longer want to help you regardless of the severity of the child or not. So that’s the issue that I ran into.”

One parent mentioned receiving phone communication as well as information through the mail from CMS, but had difficulty receiving follow-up communication from the staff with whom she had spoken. As a result, she gave up and never sought out the services again.

Financial barriers, such as lack of reimbursement for costs incurred during medical treat, made it impossible for providers to continue offering care. Parents cited increased paperwork and failure of insurance to cover procedures as major problems for clinicians. Parents also acknowledged the inherent limitations of medical training, stating medical school training did not require physicians to be specialists on every condition. As one participants stated, *“It’s not their fault.”* To curtail some of the previously mentioned issues, parents suggested offering providers continuing education credits as an incentive for providers to learn more about special needs conditions. Suggestions for these supplemental trainings included in-person workshops and webinars.

Transition to Adulthood

Focus group participants expressed deep concern for their children as they transitioned to adulthood. An overwhelming majority of parents felt their children lacked the skills to function as independent adults (e.g., maintain their emotional or physical well-being, seek employment, or manage a household). When asked to rank their confidence on a scale from 0-10 in their child’s ability to live independently as an adult, many of the parents gave a value of “0”. The remaining parents offered values along the spectrum, with the great majority of responses below “7”. When asked what their greatest concern was regarding this transition, one parent responded, *“If I die.”* Parents expressed concern with their children’s ability to care for themselves in common day-to-day activities (e.g., taking medication as prescribed, preparing nutritious

meals, cleaning, seeking and maintaining employment), concerns about their child's safety, as well as being taken advantage of due to their "gullible" nature.

Safety concerns

One parent expressed a concern over safety in the context of their child being placed in a nursing home, while another spoke about her child's social security numbers being taken by a trusted caregiver. Without parental guidance, parents felt their children were susceptible to being taken advantage of or in danger of harming themselves. Parents felt a sense of hopelessness in providing for their children, particularly without provision of care from entities that currently provided medical and ancillary services.

" . . . he wants people's attention, you know, people take advantage of people like that. . . . He actually had a nurse that tried to get his social security number routed to her bank account- his social security check. So you know you can't trust people and they don't get that."

Lack of adult medical homes

As many agencies terminate children's eligibility for medical and community services after the age of eighteen, parents also worried about continuity of care (and physician readiness) for special needs patients outside of the scope of pediatric services. These fears were not only experienced by parents, however, as children were also apprehensive about their transition to adulthood. One parent stated, *"He's scared to death. I'm scared to death. We're all scared to death."*

"I wish that there was an adult onset developmental disability medical professional that you could go to that would be like your medical home for somebody who is transitioning out of pediatric services. That would be amazing."

Lack of employment and financial preparation services

For parents with children that were able to function independently, some felt that employers would be hesitant about hiring individuals with disabilities.

"I think right now everything is so different with everyone having such a struggle getting a job. Jobs aren't . . . as available as they used to be when I was growing up as a teenager. And so, people are afraid to give a person with a disability a chance to prove their worth. And they look right at my son and see his wheelchair and say, 'No.' And they don't even give him five minutes to talk to them, you know? So it's very unfortunate."

Parents undertook a variety of measures to maximize their children's success in the working world—including requiring their child to complete a high school diploma, as opposed to a graduation equivalency degree. Participants also raised concern with their child securing the "right" job to meet their needs—

beginning preparation early in their child's life and communicating to their children their progression in school may be slightly longer than other students.

"Well I've been planning for it since his diagnosis of developmental delay since four months old 'cause I knew, he's not going to have a regular job, you know he's going to have something that's a creative profession that allows everything that is his personality in the next five minutes to be expressed. He is not going to be a doctor, you know. God bless but he's not going to be able to do that."

"But she's going to go to college. We've already done her transition plan. She knows what she has to do to stay in college to be successful. She is not going to finish in four years . . . she understands it's going to take her maybe six. She can't take a full load. So we've been working on that and telling her how to control her bipolar so that she can be successful in life. I've prepared my daughter . . . I've always talked to her and treated her like that and always forced her to learn to take care of herself. I've just made her very independent and not just let your disability, don't just let people see your disability first."

In addition to academic and professional preparation for adulthood, parents expressed concerns about the financial security of their children. While fully acknowledging the importance of these monies for their child's future security, many focus group participants found establishment and preparation of trust funds or wills to be impossible.

". . . one of the biggest steps you can do to ensure your child's future after you're gone is like a special needs trust and a will, but most of us in this room can't afford the cost to have that done because it's very expensive. You have to get a knowledgeable attorney for that. It could cost you thousands of dollars to get that set up and done and we just don't have the money for it."

Focus group participants that felt their children were equipped to transition to adulthood (and ranked their children higher when asked about their confidence), noted familial support as a major contributor to their child's transition, as well as support through existing support services. Parents were also proactive in seeking services for their children to address any diagnosed, and possibly undiagnosed, conditions.

STRENGTHS AND NEEDS

As the CYSHCN population increasingly grows, states must begin to think about more targeted programming to meet the needs of this unique and diverse population. The quantitative and qualitative data revealed areas where Georgia has made successes, as well as areas where improvements are needed.

The qualitative data showed that parents were overall satisfied with the services they received from both Babies Can't Wait and Children's Medical Services. Additionally, families with private insurance seemed to

fare better with accessing medical homes, care coordination services and access to specialty care. Families receiving care in Atlanta spoke very highly of their providers and the services received.

Despite these positive experiences, several needs were shown through the quantitative data and expressed by families in focus groups:

- Provide a resource portal and information on existing services
- Reduce the financial burden on families of children and youth with special health care needs, particularly for lower income families
- Assist families with care coordination
- Increase access to specialty services, particularly in rural areas
- Increase family involvement in decision-making for their child's care
- Increase medical home access
- Assist families with transitioning their youth to adulthood

Improving the health of children and youth with special health care needs is an important focus in Georgia. It is essential to consider how to best improve these outcomes among families

DRAFT

QUANTITATIVE ANALYSIS: CROSS-CUTTING ISSUES

Cross-cutting issues in MCH are public health issues that impact multiple MCH populations and have an influence throughout the life-course. Issues such as oral health, tobacco use, and insurance status are often central to an individual’s overall health status. Despite this, oral health is often neglected due to numerous barriers, including lack of access, oral health education and insurance.

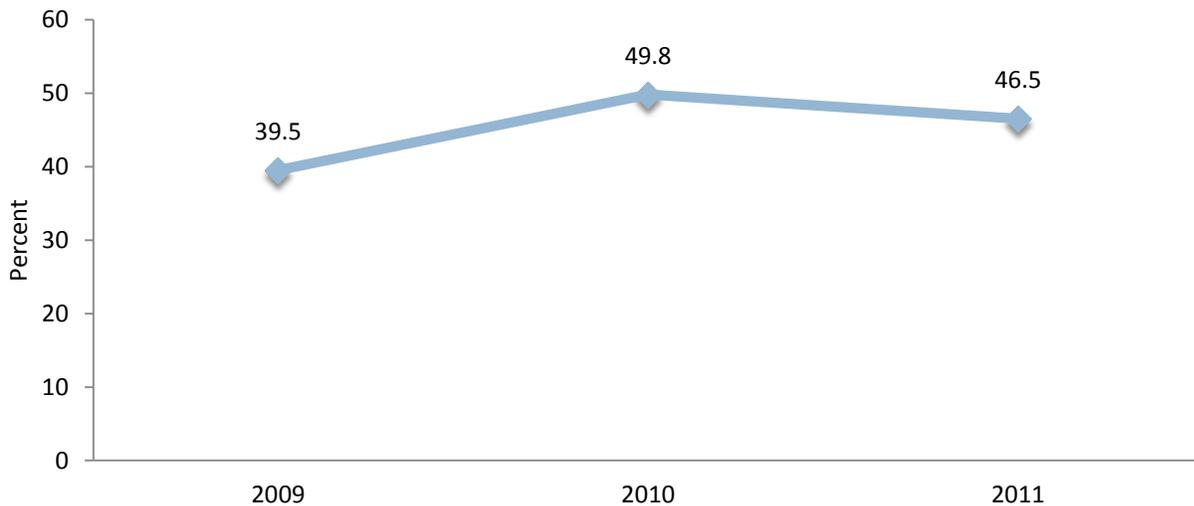
ORAL HEALTH

Pregnant Women

Teeth Cleaning Prior to Pregnancy

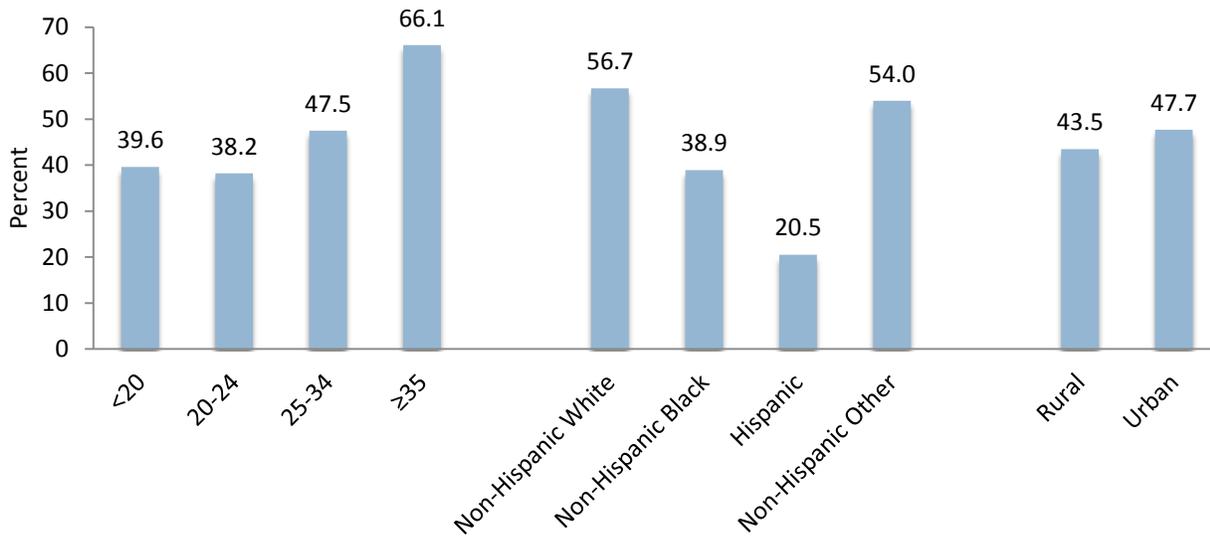
Among mothers who recently had a live birth, the percentage who reported having their teeth cleaned during the year prior to pregnancy increased from 39.5% in 2009 to 46.5% in 2011. Additionally, more older mothers had teeth cleanings compared to younger mothers. In 2011, only 38.2% of 20 to 24 year old women reported having their teeth cleaned the year before their pregnancy compared to 66.1% of mothers who are 35 and older. Upon stratifying by race/ethnicity and urban and rural status, some differences appear. Only 20.5% of Hispanic mothers reported having their teeth cleaned the year before their pregnancy compared to 56.7% of non-Hispanic Whites. The percentages were very similar among mothers living in both urban and rural areas of the state, with 47.7% of mothers in urban areas reporting teeth cleanings compared to 43.5% of mothers in rural areas.

Percent of mothers who had their teeth cleaned the year before pregnancy by year, Georgia, 2009-2011



Source: PRAMS

Percent of mothers who had their teeth cleaned the year before pregnancy by age, race/ethnicity and urban/rural status, Georgia, 2011



Source: PRAMS

The majority of mothers who had their teeth cleaned the year before pregnancy received insurance through their job (64.2%). Only 8.4% of mothers were insured by Medicaid and 4.7% were insured through TRICARE.

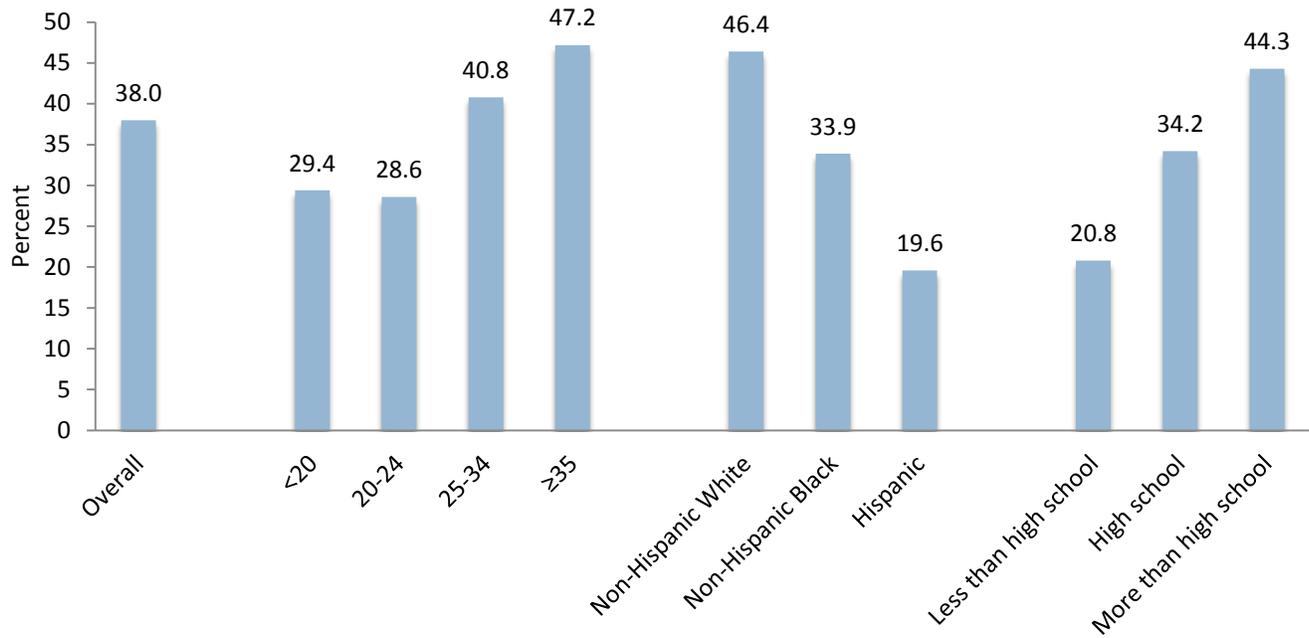
Percent of mothers reporting having a teeth cleaning the year before pregnancy by payor, Georgia, 2011	
Payor	Percent
Insurance paid by job	64.2%
Insurance paid by someone else	5.8%
Insurance paid by Medicaid	8.4%
Insurance paid by TRICARE/Military	4.7%

Source: PRAMS

Teeth Cleaning during Pregnancy

Overall, 38.0% of mothers who recently had a live birth had their teeth cleaned during pregnancy. Only 29.4% of mothers less than 20 years of age saw a dentist or dental hygienist during pregnancy, compared to 47.2% of mothers over 35 years of age. Non-Hispanic White mothers (46.4%) had their teeth cleaned during pregnancy more often than their non-Hispanic Black and Hispanic (33.9% and 19.6%) counterparts. Mothers with more than a high school diploma reported having their teeth cleaned during pregnancy over twice as often as mothers with less than a high school diploma.

Percent of mothers who had their teeth cleaned during pregnancy by age, race/ethnicity and education, Georgia, 2012



Source: PRAMS

Children

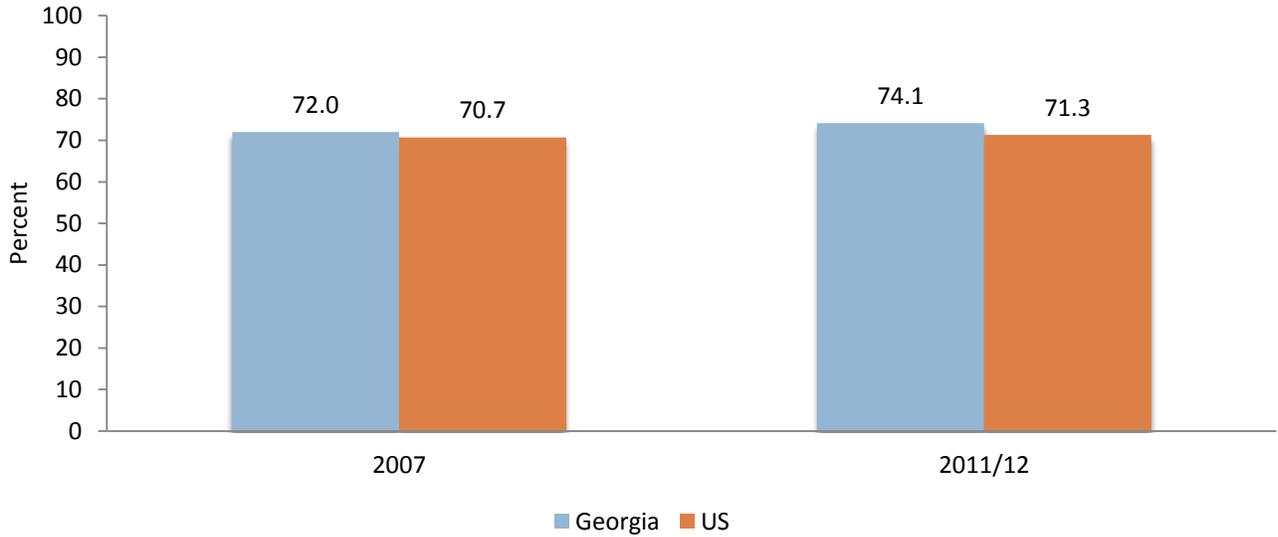
Excellent/Very Good Oral Health

Approximately 70% of children in the US have excellent or very good teeth. Although the percentage of children with excellent or very good teeth was slightly higher in Georgia compared to the nation during 2007 and 2011/12, the percentages were similar. Among both populations, the percentage increased slightly from 2007 to 2011/12. In 2011/12, the percentage of children with teeth in excellent or very good condition in Georgia was highest among 1 to 5 year olds and lowest among 6 to 11 year olds.

Non-Hispanic White children were reported to have teeth in excellent or very good condition at a higher level than any other racial/ethnic group. Hispanics were reported to have teeth in excellent or very good condition 50% less often than non-Hispanic White children. The percentage was slightly lower among females compared to males.

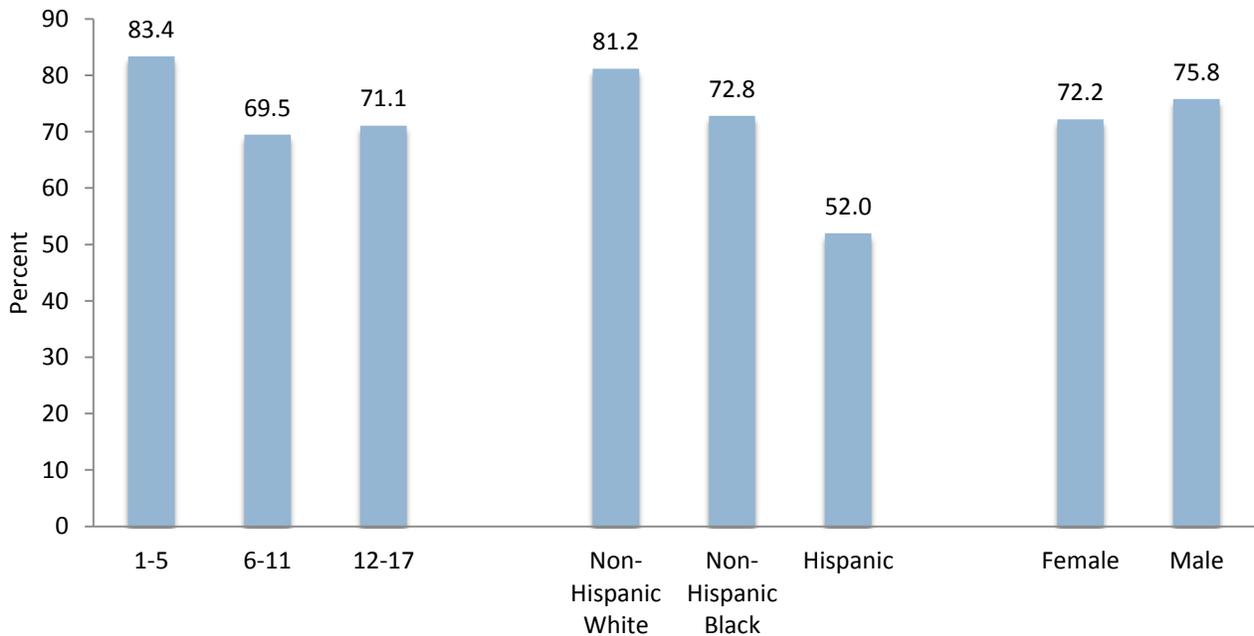
The percentage was 87.8% among those in the highest income category, compared to 61.4% among those in the lowest income category. Over 75% of children without special health care needs reported having teeth in excellent or very good condition. Among CYSHCN, the percentage was less than 70%.

Percent of children 1-17 whose teeth are in excellent/very good condition by year, Georgia compared to the US, 2007 and 2011/12



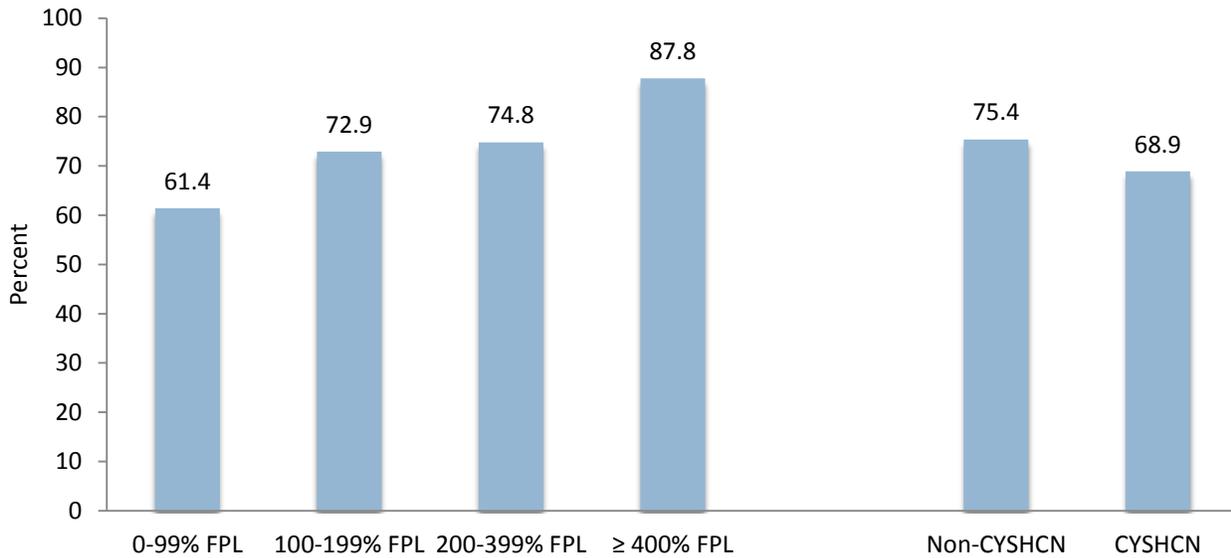
Source: NSCH

Percent of children 1-17 whose teeth are in excellent/very good condition by age, race/ethnicity and gender, Georgia, 2011/12



Source: NSCH

Percent of children 1-17 whose teeth are in excellent/very good condition by income and CYSHCN status, Georgia, 2011/12

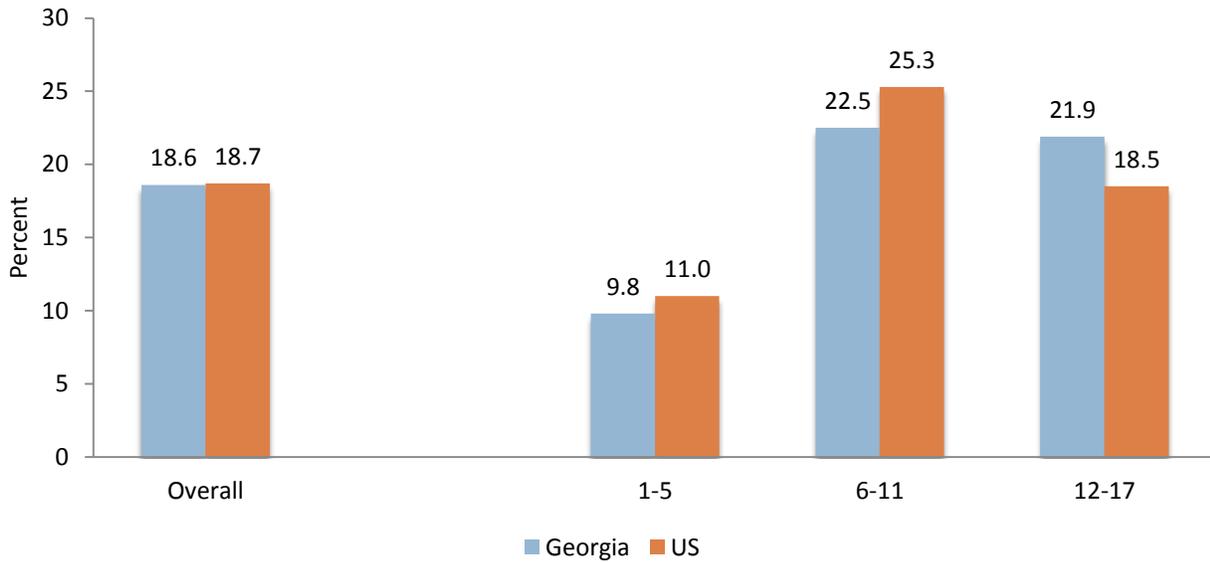


Source: NSCH

Oral Health Problems

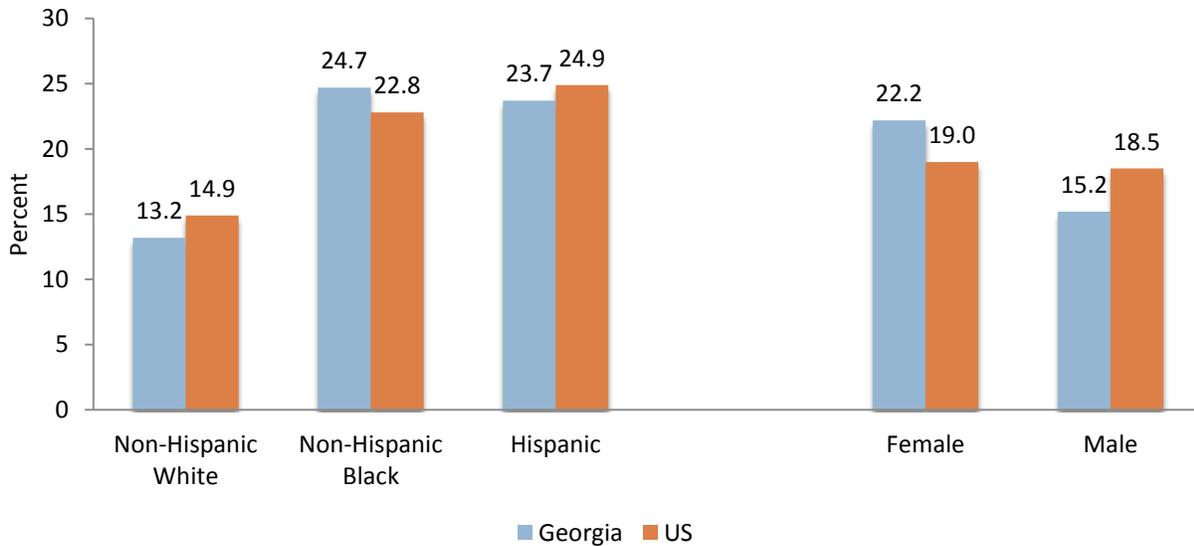
Overall, approximately 18% of children, both nationally and in Georgia, experienced one or more oral health problems (decayed teeth or cavities) in 2011/12. Among Georgia’s children, the percentage was highest among children 6 to 11 years of age (22.5%). Less than 10% of children 1 to 5 years of age and 21.9% of those 12 to 17 years of age were reported to have one or more oral health problems in the past year. Non-Hispanic White children had the lowest percentage of oral health problems in Georgia compared to their minority counterparts. The percentage was 24.7% among non-Hispanic Blacks and 23.7% among Hispanics. More females than males were reported to have oral health problems in the past year. The percentage in the highest income group was nearly 2.5 times lower than those who lived in families earning 0 to 99% of the FPL. More CYSHCN in Georgia were reported to have one or more oral health problems than children without special health care needs.

Percent of children 1 to 17 who had one or more oral health problems in the past year by age, Georgia compared to the US, 2011/12



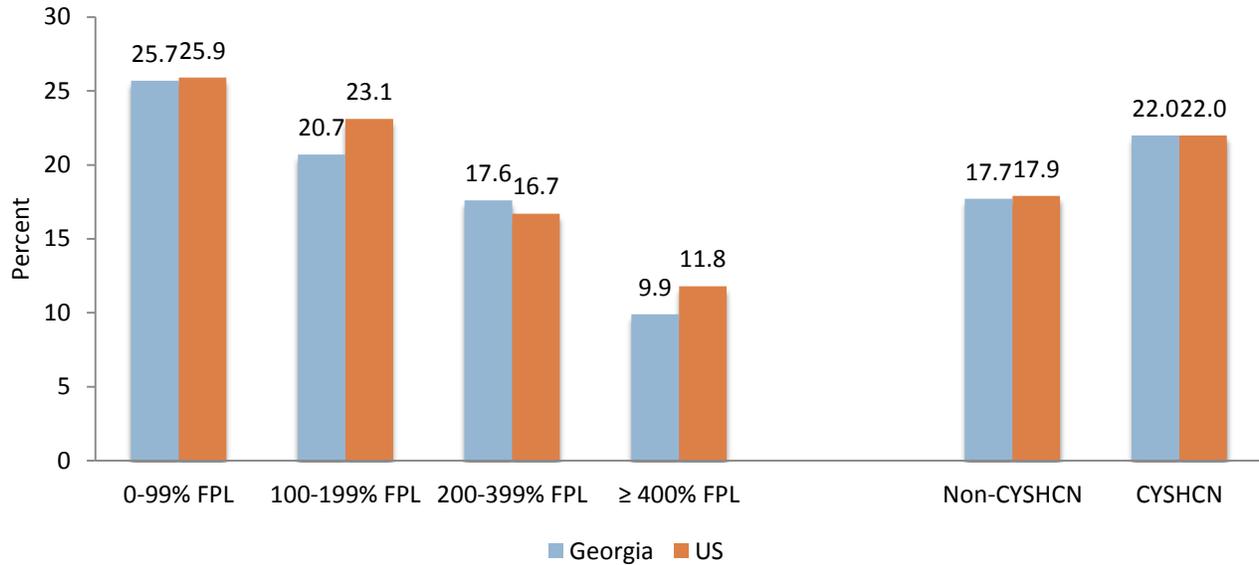
Source: NSCH

Percent of children 1 to 17 who had one or more oral health problems in the past year by race/ethnicity and gender, Georgia compared to the US, 2011/12



Source: NSCH

Percent of children 1 to 17 who had one or more oral health problems in the past year by household income and CYSHCN status, Georgia compared to the US, 2011/12

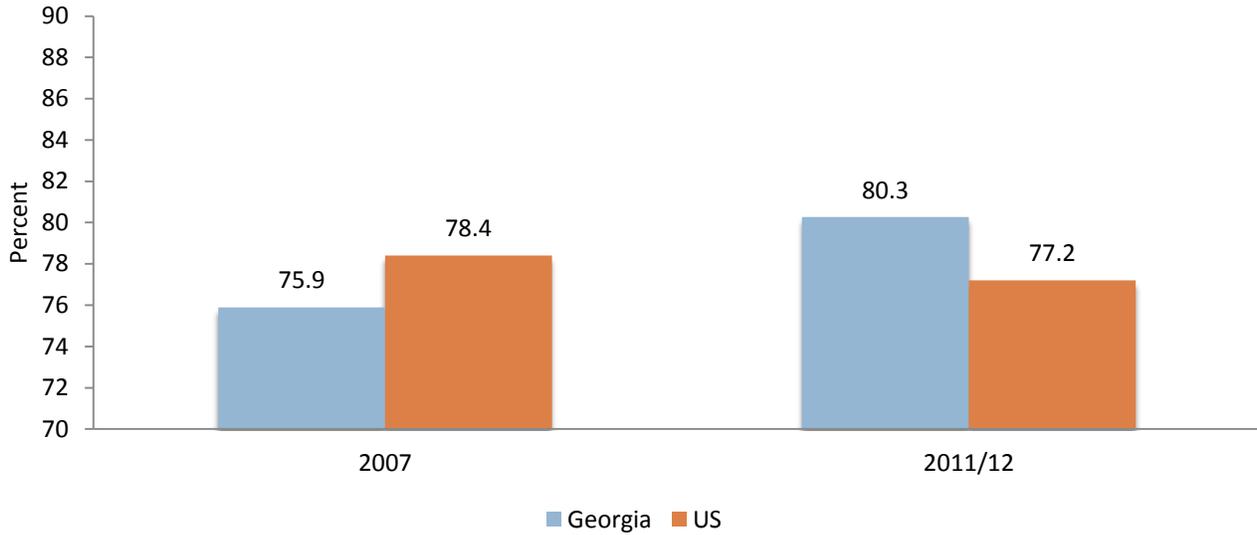


Source: NSCH

Preventive Dental Visit

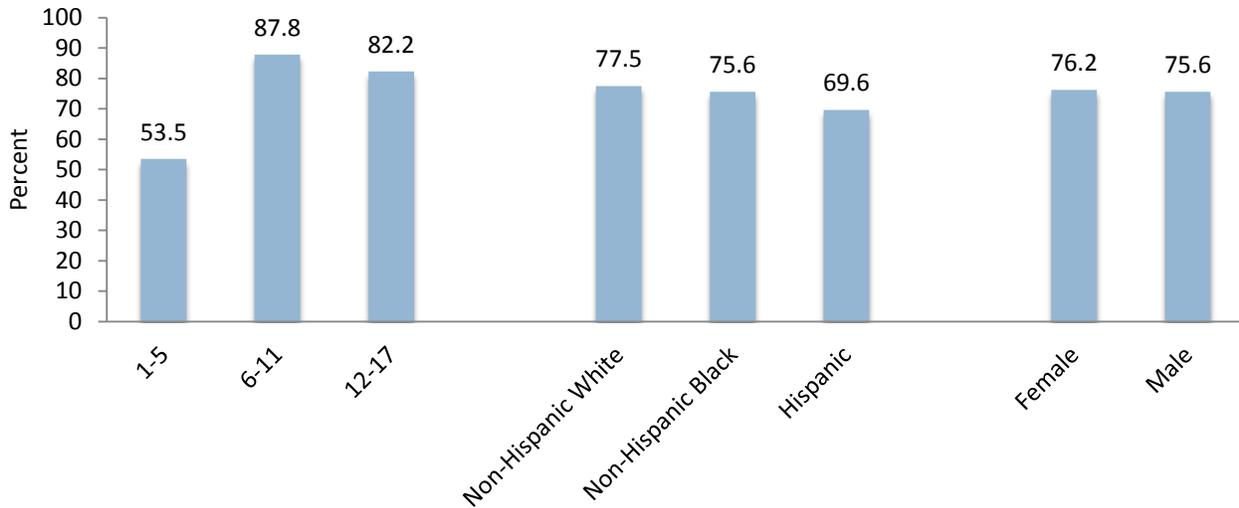
In Georgia, the percentage of children 1 to 17 years of age who received a preventive dental visit in the past year increased from 75.9% in 2007 to 80.3% in 2011/12. Little change was seen in the national average, at 78.4% in 2007 compared to 77.2% in 2011/12. The percentage was over 80% among children 6 to 17 years of age, but only 53.5% among children 1 to 5 years of age. More non-Hispanic Whites were reported to receive a preventive dental visit (77.5%) than non-Hispanic Blacks (75.6%) or Hispanics (69.6%). The percentage was very similar between females and males. The percentage steadily increased as household income increased, with 87.3% of those in the highest income category receiving a preventive dental visit compared to 67.3% of those in the lowest. The percentage was higher among CYSHCN (82.3%) compared to non-CYSHCN (74.3%).

Percent of children 1-17 who received a preventive dental visit in the past year by year, Georgia compared to the US, 2007 and 2011/12



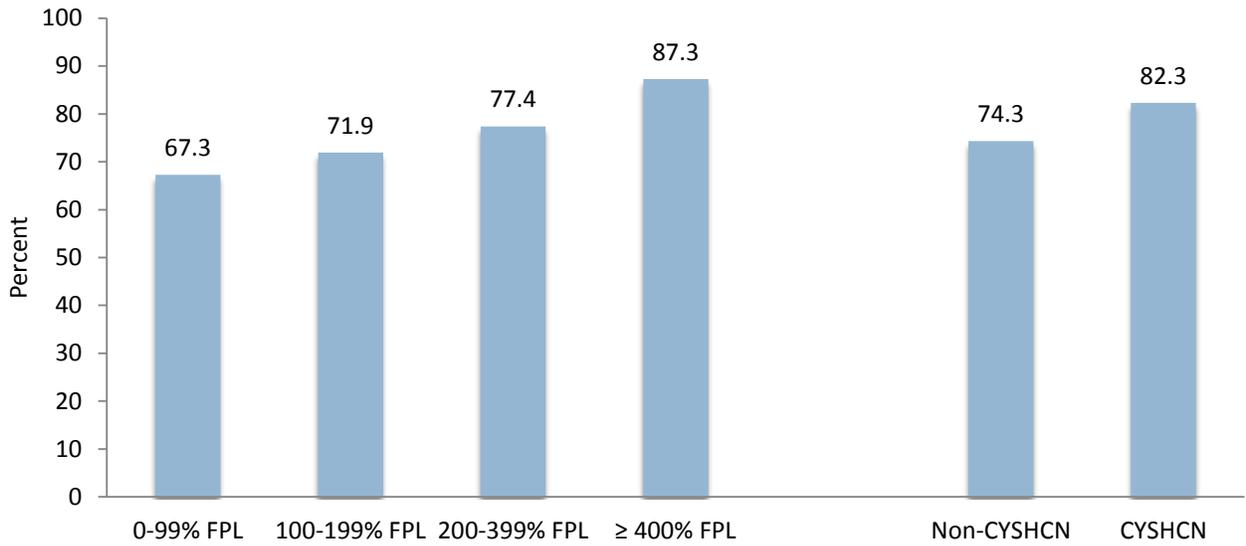
Source: NSCH

Percent of children 1-17 who received a preventive dental visit in the past year by age, race/ethnicity and gender, Georgia, 2011/12



Source: NSCH

Percent of children 1-17 who received a preventive dental visit in the past year by household income and CYSHCN status, Georgia, 2011/12



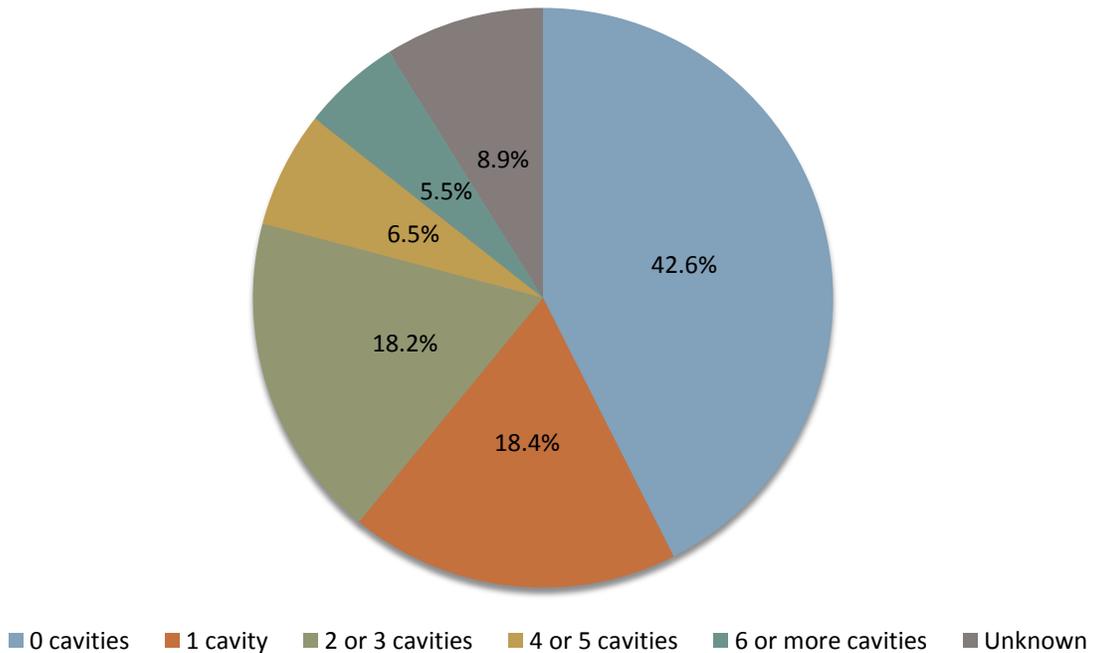
Source: NSCH

Adolescents

Cavities

In 2013, over half of adolescents reported having cavities in their permanent teeth. The percentage was over 18% among those reporting 1 cavity and those reporting 2 or 3 cavities. Less than 10% reported having either 4 or 5 cavities or 6 or more cavities.

Percent of high school students who had cavities in their permanent teeth,
Georgia, 2013

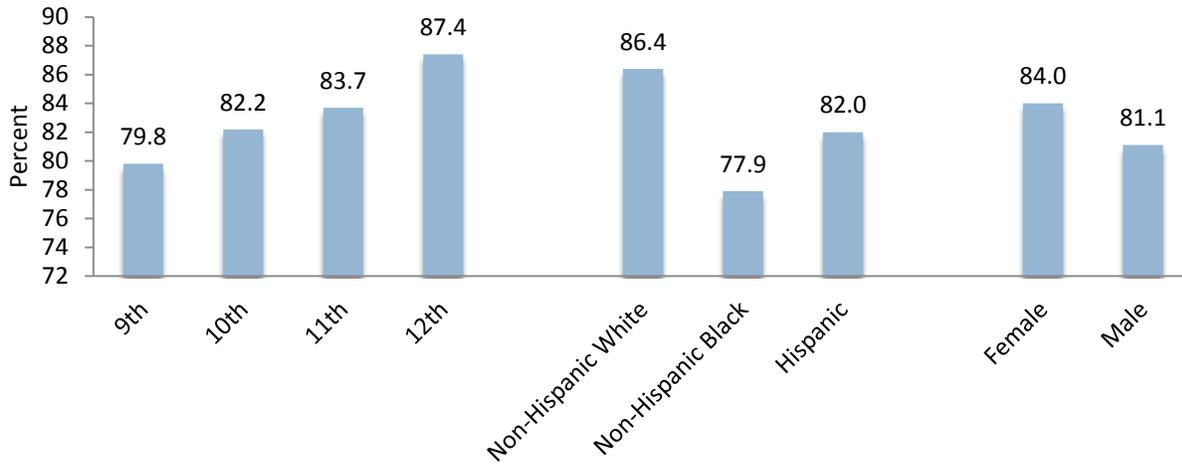


Source: YRBS

School Absence Due to Oral Health Problems

In 2013, 82.7% of Georgia's high school students reported missing 0 school days in the past 12 months due to problems with their teeth or mouth. The percentage increased with grade level. Specifically, 87.4% of high school seniors missed 0 days due to oral health, while 79.8% of 9th grade students did. The percentage also varied by race/ethnicity. More non-Hispanic Whites (86.4%) than non-Hispanic Blacks (77.9%) or Hispanics (82.0%) missed 0 school days due to oral health problems in the past year. More females than males reported never missing school for problems with their teeth or mouth.

Percent of high school students who missed school 0 days in the past 12 months due to problems with their teeth or mouth by grade, race/ethnicity and gender, Georgia, 2013



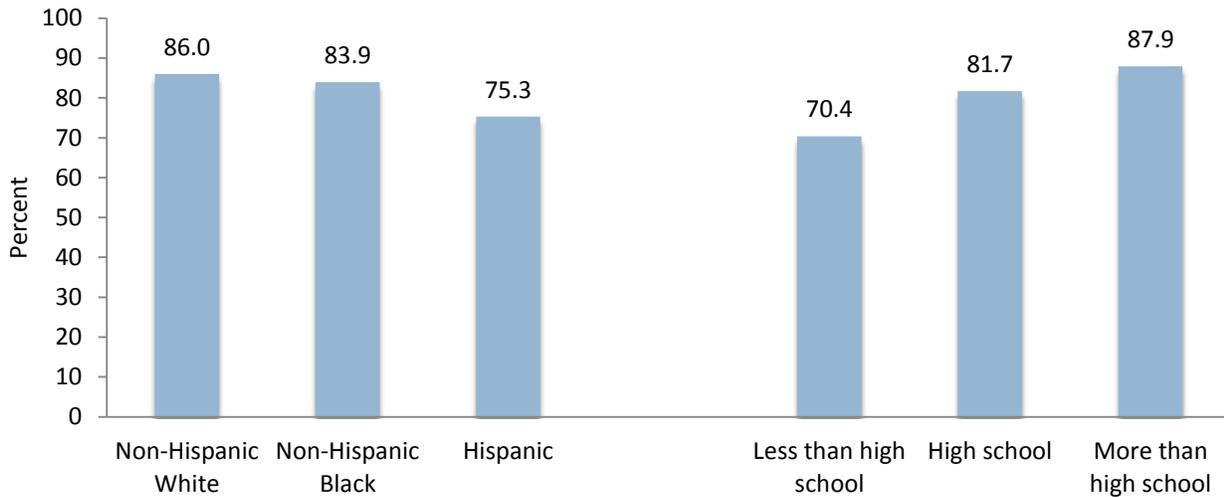
Source: YRBS

Children and Youth with Special Health Care Needs

Preventive Dental Visit

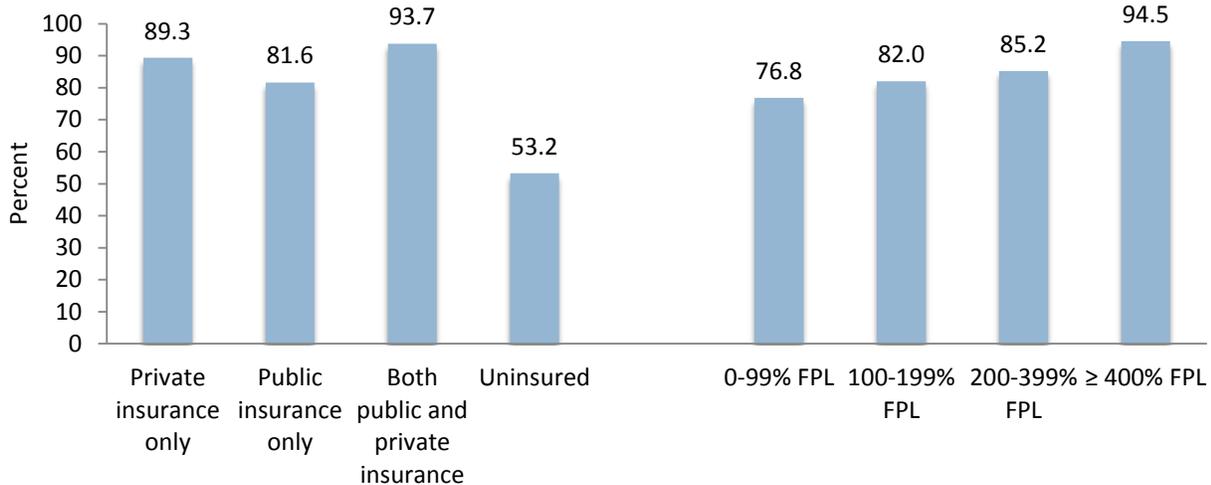
In 2009/10, 88.4% of CYSHCN reported receiving a needed preventive dental care visit in the past 12 months. The percentage was highest among non-Hispanic Whites. Only 75.3% of Hispanics were reported to have received a preventive dental visit. The percentage was also lower among those whose parents had lower educational attainment. Specifically, 70.4% of CYSHCN who had parents with less than a high school education received a preventive dental visit compared to 87.9% of those who had parents with more than a high school education. Only 53.2% of uninsured CYSHCN received a dental visit compared to over 80% of those who had public, private, or both types of insurance. The percentage was 76.8% among those in the lowest income category compared to 94.5% of those in the highest income category.

Percent of CYSHCN 1 to 17 who received a preventive dental visit in the past 12 months by race/ethnicity and parental education, Georgia, 2009/10



Source: NS-CSHCN

Percent of CYSHCN 1 to 17 who received a preventive dental visit in the past 12 months by insurance type and household income, Georgia, 2009/10



Source: NS-CSHCN

Community Water Fluoridation

One of the many successes Georgia has had in terms of oral health is in the proportion of the population receiving fluoridated water. In Georgia, 96.3% of Georgia’s residents receive fluoridated water while only 74.6% of people do nationally. The Healthy People (HP) 2020 goal is to increase the proportion of the US population to be served by community water systems with optimally fluoridated water to 79.6%. Georgia

has exceeded these standards and this serves as an example where Georgia is leading the rest of the nation.

TOBACCO USE

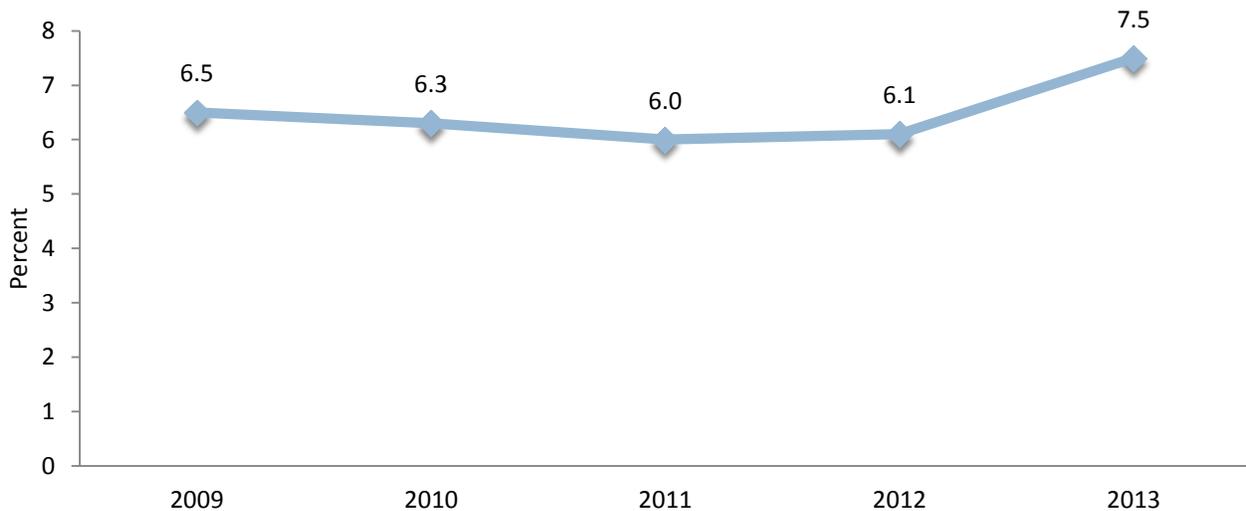
Pregnant Women

Tobacco Use during Pregnancy

From 2009 to 2013, the percentage of mothers who smoked during pregnancy remained steady at about 6%, with a slight increase seen in 2013. The percentage of live births where the mother smoked during pregnancy was highest among mothers 24 years of age or less. Over 10% of non-Hispanic White women used tobacco during pregnancy, while less than 5% of non-Hispanic Black and Hispanic women did.

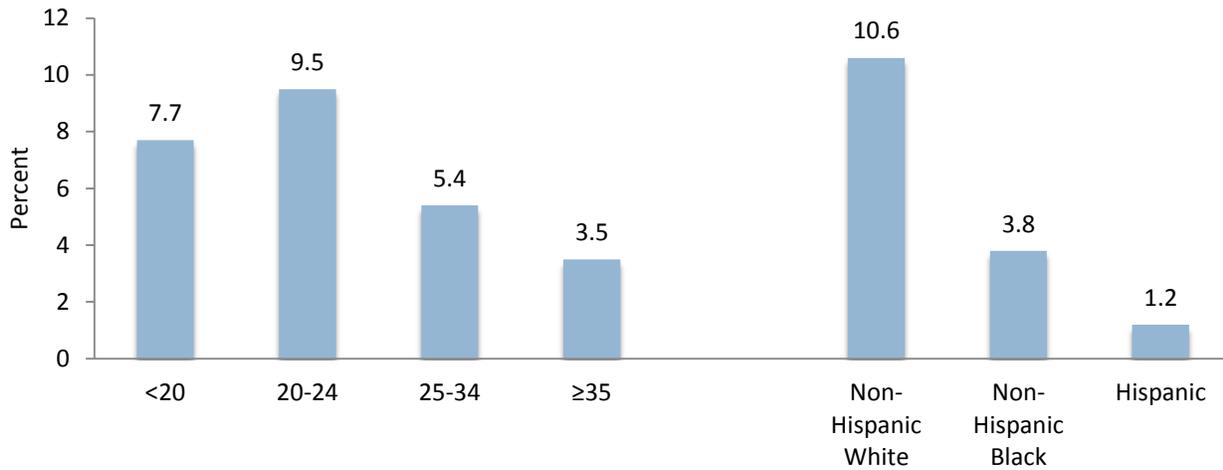
The percentage of live births where the mother smoked during pregnancy between 2008 and 2012 was over 10% in six public health districts: Northwest Health District, LaGrange Health District, South Central Health District, North Central Health District, Southeast Health District and Northeast Health District.

Percent of births with reported tobacco use during pregnancy by year, Georgia, 2009-2013



Source: OASIS

Percent of births with reported tobacco use during pregnancy by maternal age and race/ethnicity, Georgia, 2009-2013



Source: OASIS

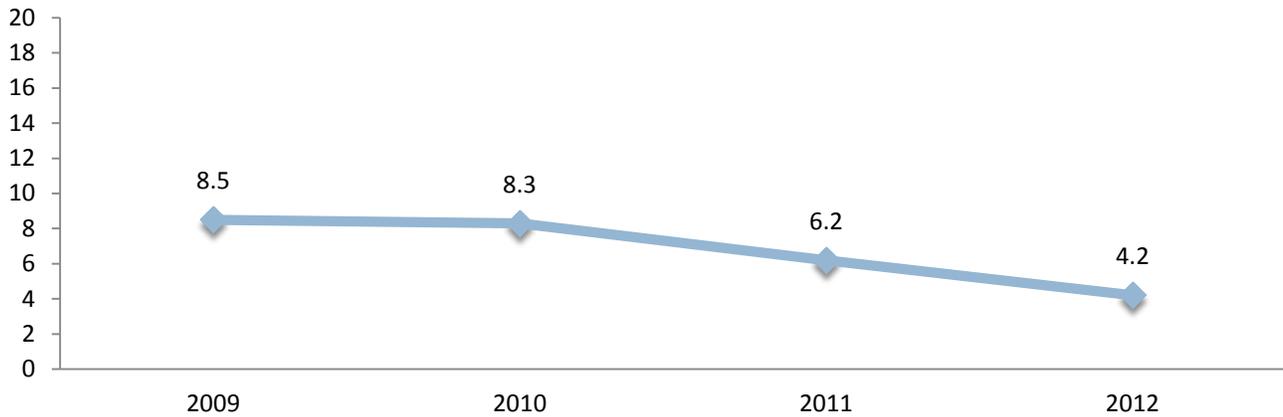
Percent of births with reported tobacco use during pregnancy by public health district, Georgia, 2009-2013	
Public Health District	Percent
Northwest Health District (Rome)	14.7%
North Georgia Health District (Dalton)	6.4%
North Health District (Gainesville)	7.2%
Cobb/Douglas Health District	2.9%
Fulton Health District	2.6%
Clayton County Health District (Jonesboro)	3.8%
East Metro Health District (Lawrenceville)	2.6%
DeKalb Health District	1.8%
LaGrange Health District	10.1%
South Central Health District (Dublin)	12.7%
North Central Health District (Macon)	10.6%
East Central Health District (Augusta)	6.6%
West Central Health District (Columbus)	7.5%
South Health District (Valdosta)	5.5%
Southwest Health District (Albany)	4.9%
Southeast Health District (Waycross)	13.8%
Coastal Health District (Savannah)	7.2%
Northeast Health District (Athens)	10.1%

Source: OASIS

Smoking in the Third Trimester

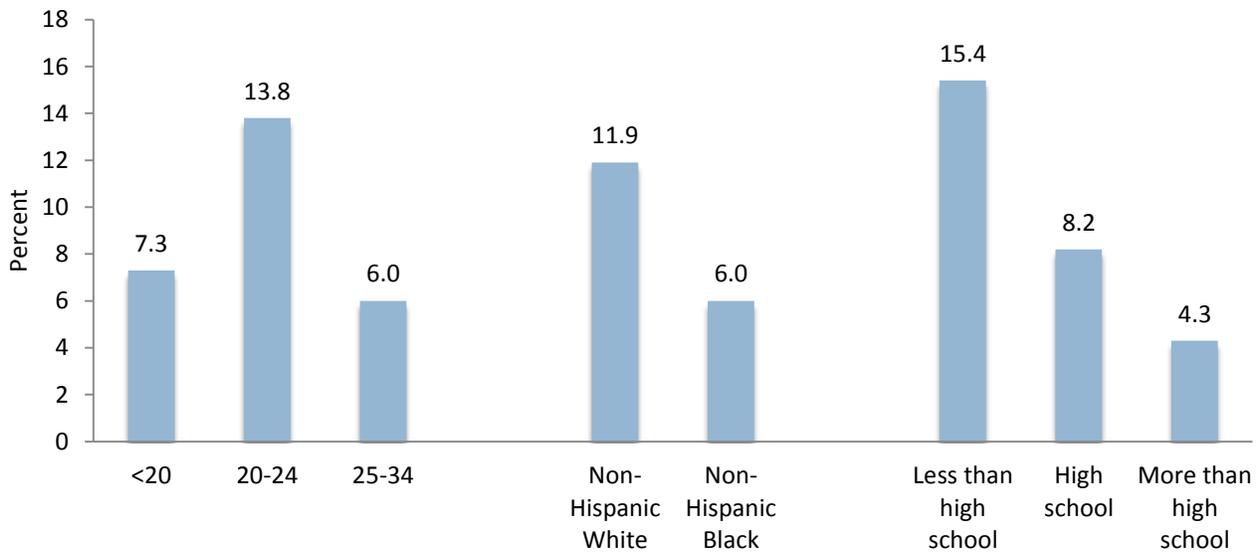
Among mothers who recently had a live birth, the percentage who reported smoking during the last 3 months decreased from 8.5% in 2009 to 4.2% in 2012. In 2011, nearly twice as many mothers 20 to 24 years of age reported smoking during the last 3 months of pregnancy compared to mothers of all other age categories. The percentage was also almost twice as high among non-Hispanic Whites (11.9%) as non-Hispanic Blacks (6.0%). Among those with less than a high school education, the percentage was 15.4%, while it declined to 4.3% among those with more than a high school diploma.

Percent of women who reported smoking during the last 3 months of pregnancy by year, Georgia, 2009-2012



Source: PRAMS

Percent of mothers who reported smoking during the last 3 months of pregnancy by maternal age, race/ethnicity and education, Georgia, 2009-2011

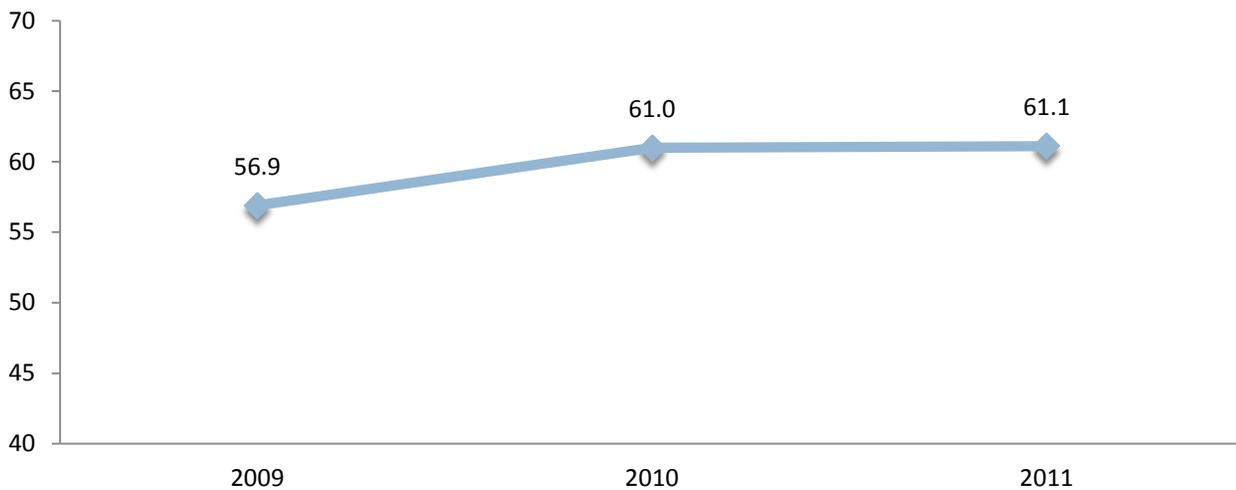


Source: PRAMS

Smoking Cessation during Pregnancy

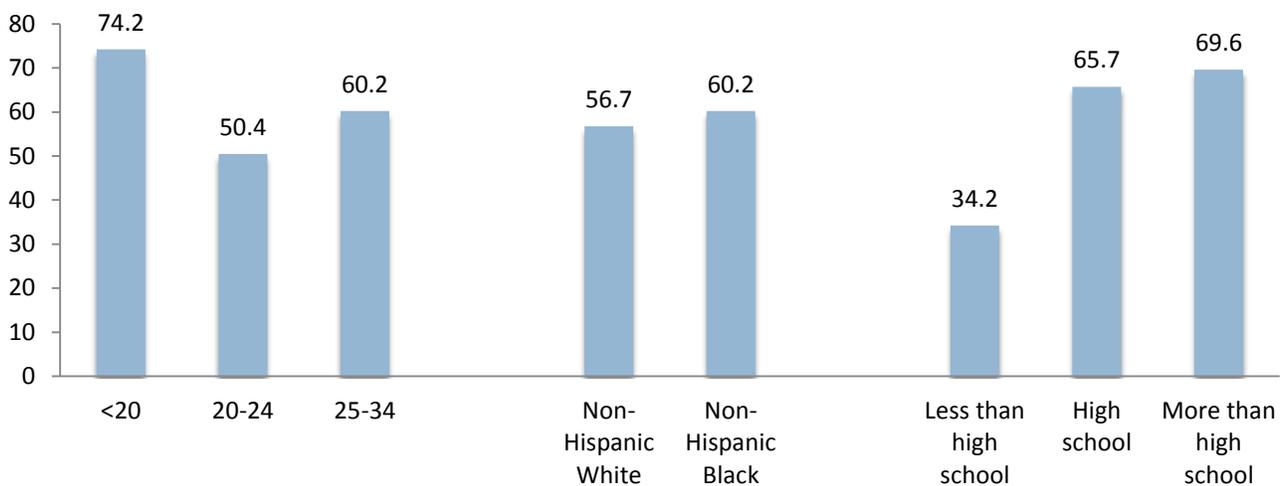
Among mothers who recently had a live birth and reported themselves to be smokers, the percentage who quit during pregnancy increased from 56.9% in 2009 to 61.1% in 2011. Additionally, the percentage who quit was highest among smokers less than 20 years at 74.2%. The percentage was nearly equal between non-Hispanic Whites and non-Hispanic Blacks. Only 34.2% of mothers with less than a high school diploma reported quitting smoking during pregnancy, while the percentage was over 65% among mothers of all other levels of educational attainment.

Percent of mothers who smoked and reported to have quit smoking during pregnancy by year, Georgia, 2009-2011



Source: PRAMS

Percent of mothers who smoked and reported to have quit smoking during pregnancy by year, Georgia, 2009-2011



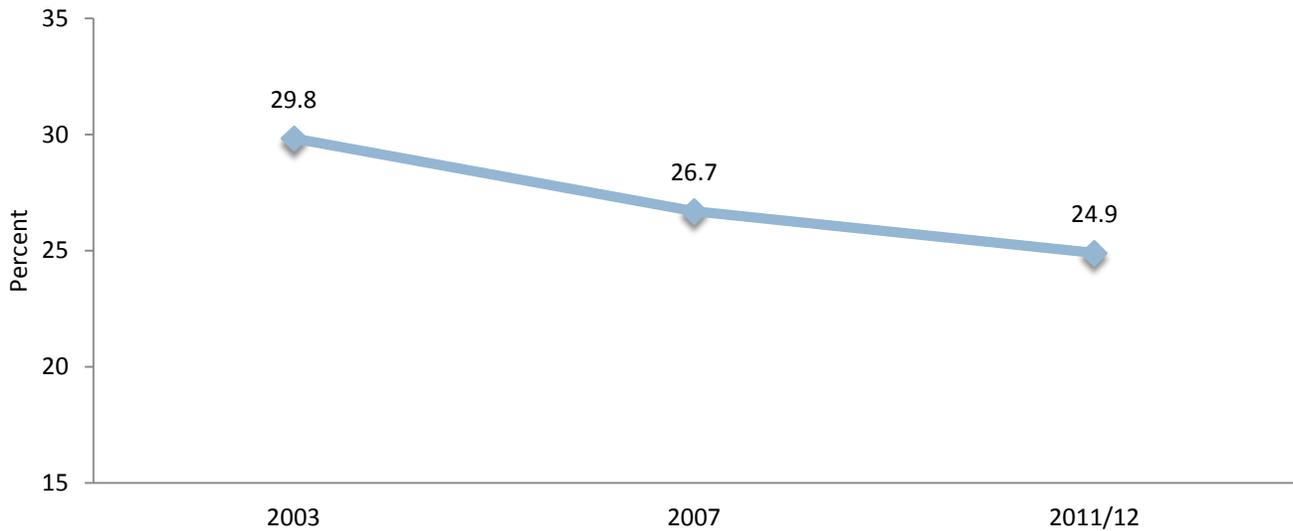
Source: PRAMS

Children

Nearly a quarter of children ages 0 to 17 years in Georgia lived in homes where someone smokes in 2011/12. The percentage decreased from 29.8% in 2003. In 2011/12, 14.4% of Hispanic children lived in a home where someone smokes compared to 29.6% of non-Hispanic White children and 22.2% of non-Hispanic Black children. Children within the lower income brackets were reported to live in a home where someone smoked more often than children in the highest income category, with only 11.2% of children in the highest income level living in homes where someone smokes in 2011/12. Slightly more CYSHCN than non-CYSHCN were reported to live in a household where someone smokes.

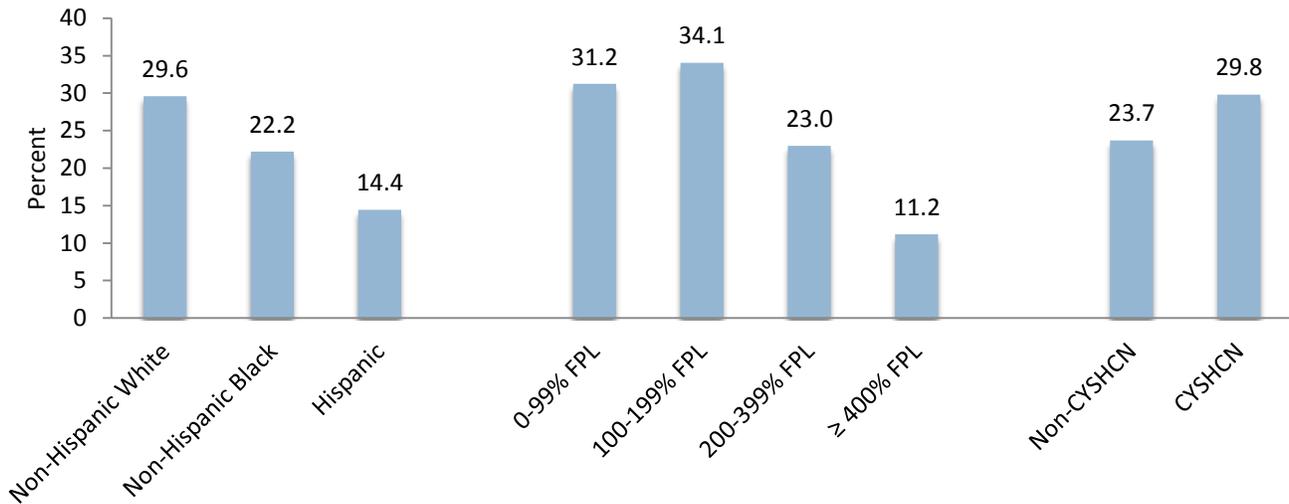
Second Hand Smoke Exposure

Percent of children 0-17 who live in a household where someone smokes by year, Georgia, 2003, 2007 and 2011/12



Source: NSCH

Percent of children 0-17 who live in a household where someone smokes by race/ethnicity, household income and CYSHCN status, Georgia, 2011/12



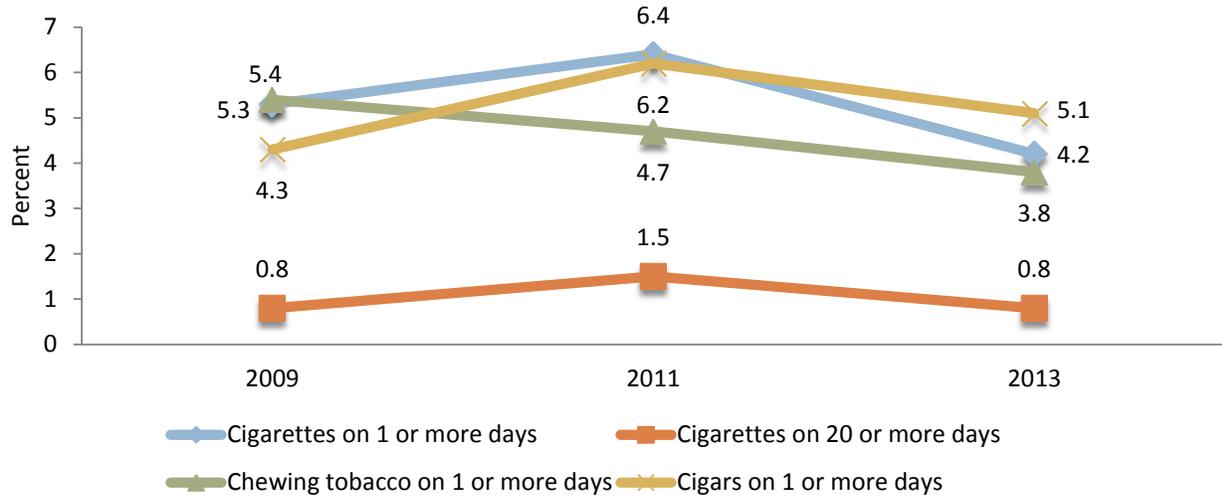
Source: NSCH

Adolescents

Tobacco Use

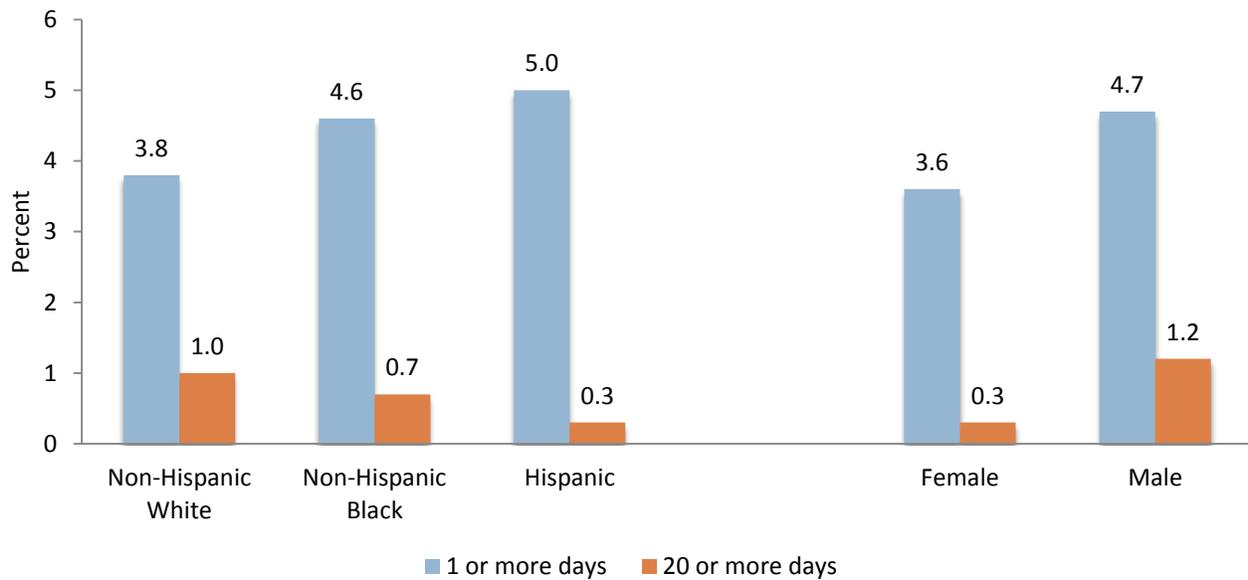
Cigars, cigarillos and little cigars were the most common type of tobacco used among middle school students in 2013. Cigarette usage on 20 or more days during the past month was reported least often among middle school students. Of all types of tobacco use, there was little change seen in the trend from 2009 to 2011. The use of chewing tobacco decreased from 5.4% in 2009 to 3.8% in 2013. Cigarette use on at least one day out of the month was most common among Hispanics, while cigarette use on 20 or more days out of the month was most common among non-Hispanic Whites. Slightly more male than female middle school students reported smoking cigarettes at any frequency in 2013. More non-Hispanic Whites reported using chewing tobacco, snuff or dip in 2013 than any other racial or ethnic group. The percentage was 2.5 times as high among males as females. The use of cigars was over twice as high among non-Hispanic Blacks and Hispanics compared to non-Hispanic Whites. It was also more common among males than females.

Percent of middle school students reporting tobacco use in the past 30 days by year, Georgia, 2009-2013



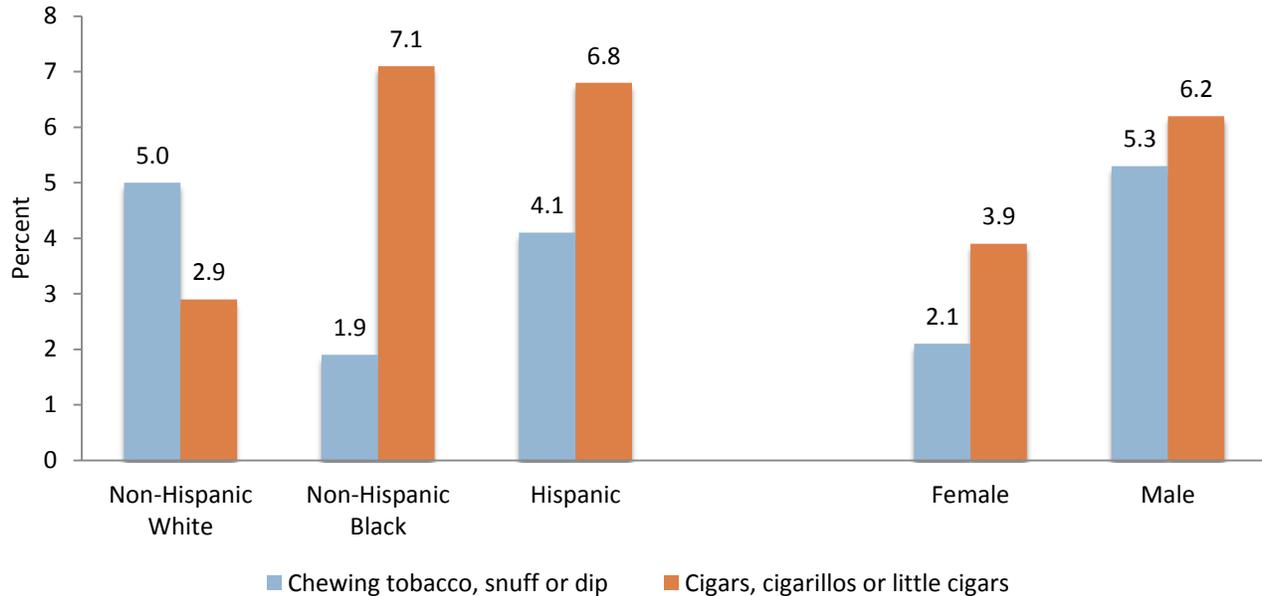
Source: YRBS

Percent of middle school students who smoked cigarettes in the past 30 days by race/ethnicity and gender, Georgia, 2013



Source: YRBS

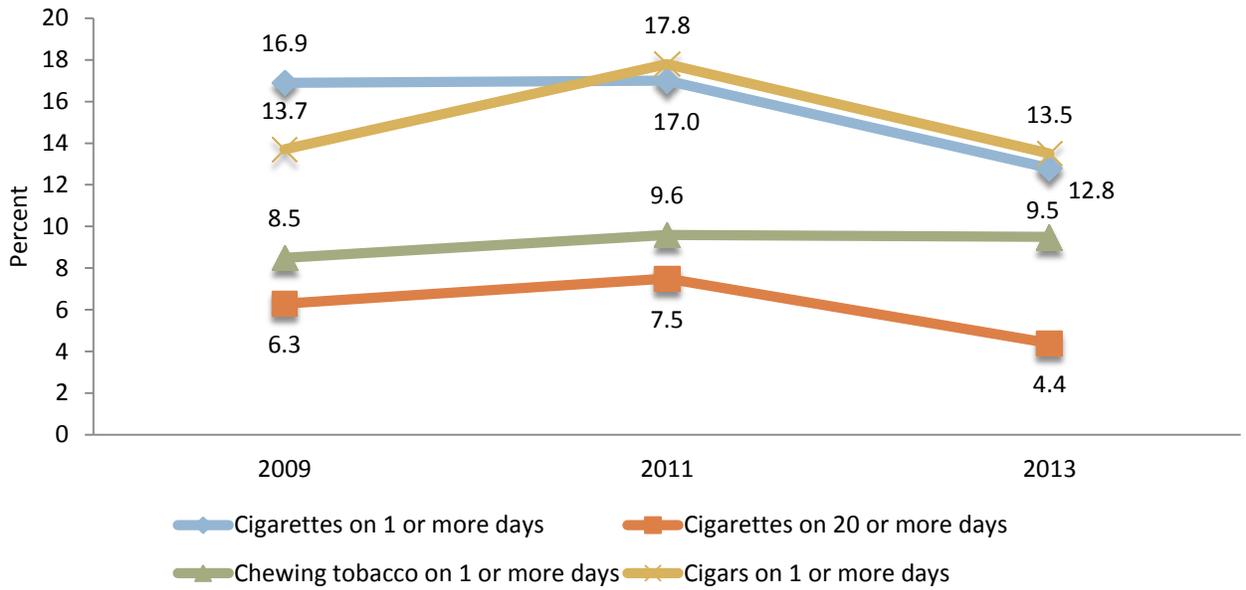
Percent of middle school students who used tobacco on one or more of the past 30 days by race/ethnicity and gender, Georgia, 2013



Source: YRBS

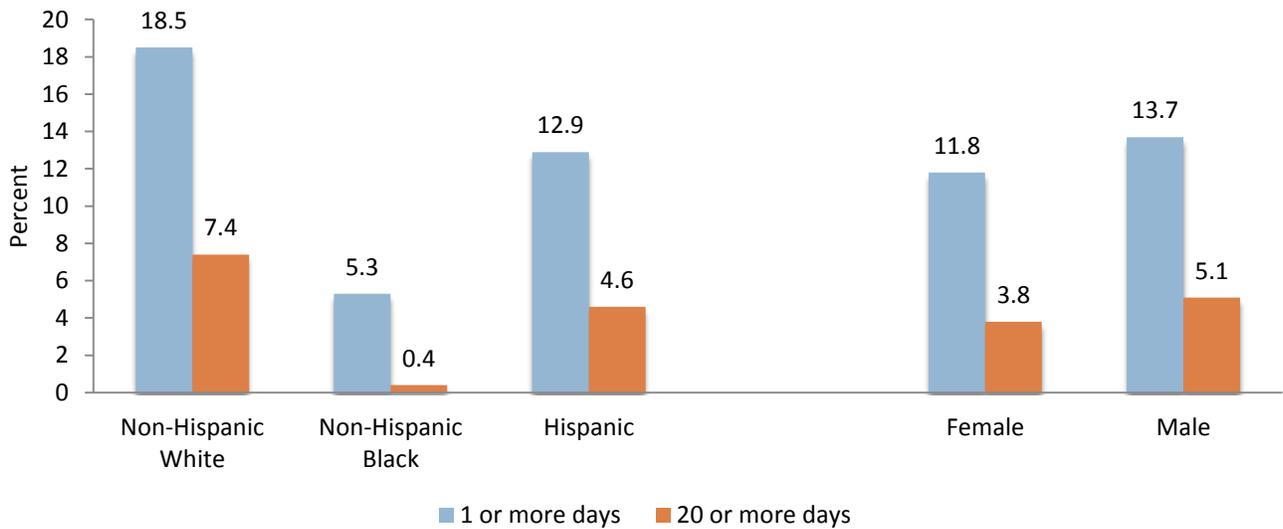
Cigars (13.5%) and cigarettes on at least one day of the month (12.8%) were the most commonly reported types of tobacco used by Georgia's high school students in 2013. Use of chewing tobacco (9.5%) and cigarettes on 20 or more days of the month (4.4%) were reported least often. Little variation was seen from percentages in 2009 to 2013, with the exception of the percentage of high school students smoking on one or more days out of the month decreasing from 16.9% to 12.8%. In 2013, cigarette usage on at least one day per month was more prevalent among non-Hispanic Whites (18.5%) than non-Hispanic Blacks (5.3%) or (Hispanics 12.9%). Slightly more males than females reported smoking cigarettes on one or more days out of the month. When looking at the percentage of high school students who reported smoking 20 or more days out of the month, similar patterns were seen. More non-Hispanic White and Hispanic students reported heavy smoking than non-Hispanic Black students, in which the percentage was nearly 0%. More males than females reported smoking 20 or more days out of the month. Chewing tobacco was reported most frequently among non-Hispanic White high school students (12.5%), followed closely by Hispanics (10.5%). Non-Hispanic Blacks reported chewing tobacco, snuff or dip least often (4.4%). The percentage was 5.6 times higher among males than females. Similar patterns were seen for the percent of high school students who used cigars, cigarillos or little cigars on one or more of the past 30 days, with more non-Hispanic Whites and Hispanics using cigars than non-Hispanic Blacks. The percentage was fairly similar between females and males.

Percent of high school students reporting tobacco use in the past 30 days by year, Georgia, 2009-2013



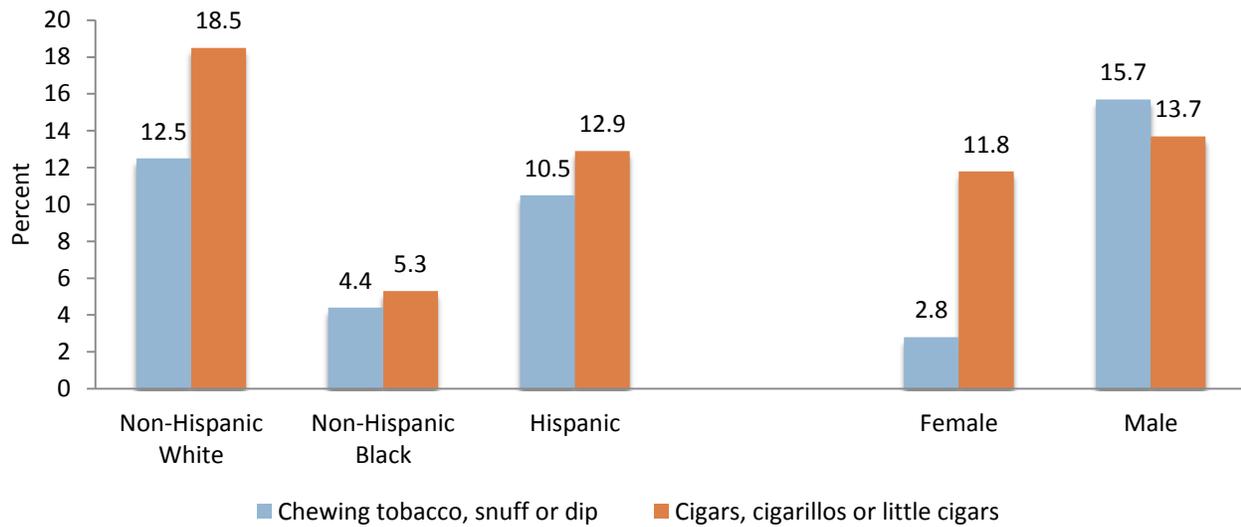
Source: YRBS

Percent of high school students who smoked cigarettes in the past 30 days by race/ethnicity and gender, Georgia, 2013



Source: YRBS

Percent of high school students who used tobacco on one or more of the past 30 days by race/ethnicity and gender, Georgia, 2013

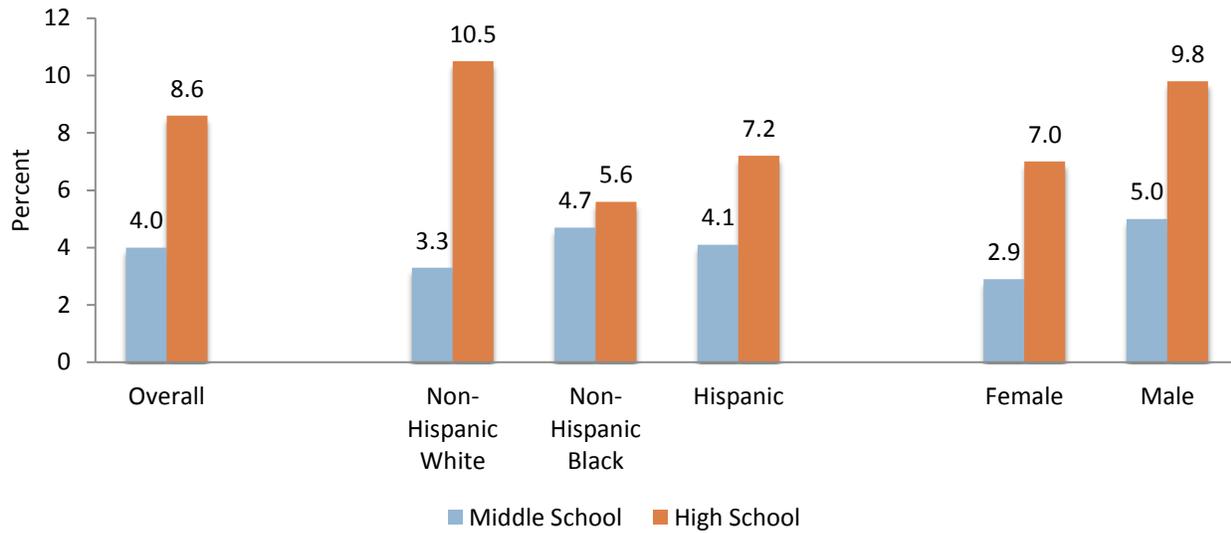


Source: YRBS

Electronic Cigarettes

In 2013, the overall prevalence of e-cigarette usage in Georgia was 4.0% among middle school students and 8.6% among high school students. There were minor differences between middle school students of different races and grade levels, however more males smoked e-cigarettes than their female counterparts. When stratifying by race/ethnicity among high school students, there are similar patterns to traditional tobacco use. More non-Hispanic White high school students reported e-cigarette use than non-Hispanic Blacks or Hispanics. Additionally, more males than females reported using e-cigarettes.

Percent of middle school and high school students who smoked e-cigarettes in the past 30 days by race/ethnicity and gender, Georgia, 2013



Source: YTS

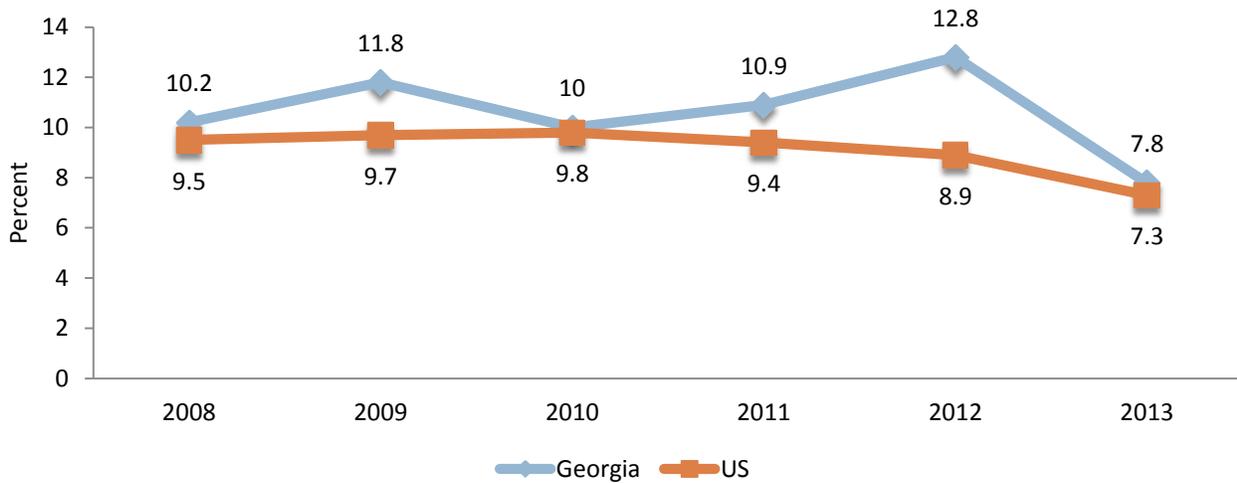
HEALTH INSURANCE

Children

Uninsured

There was an overall decrease in percentage of Georgia’s children 0 to 17 years of age who are uninsured from 10.2% in 2008 to 7.8% in 2013. In all years examined, the percentage of children without health insurance was higher in Georgia than in the US as a whole.

Percent of children 0-17 years without health insurance coverage by year, Georgia compared to the US, 2008-2013

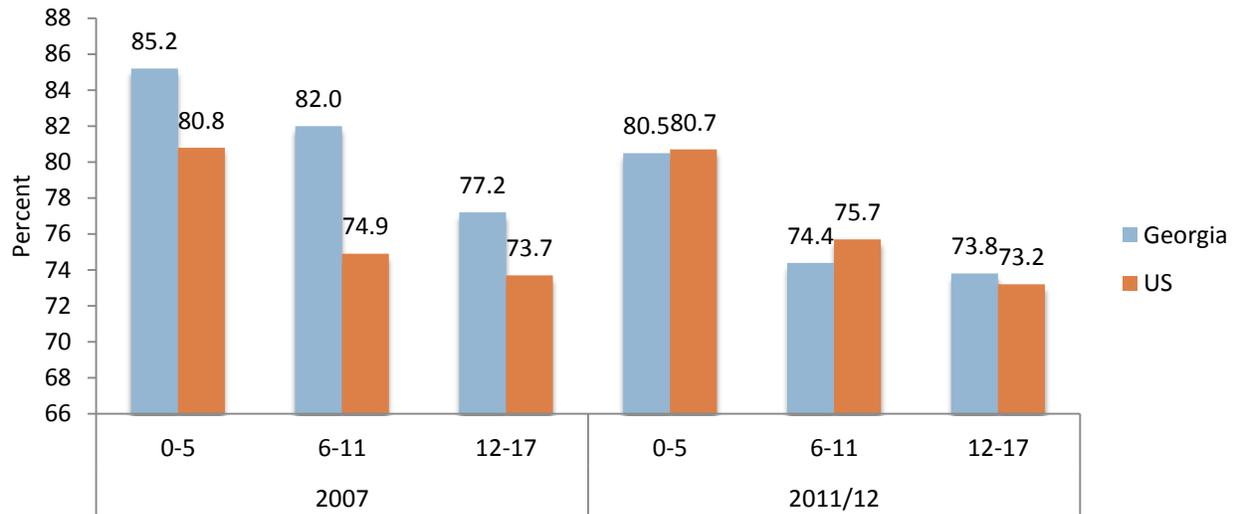


Source: CPS

Adequacy of Insurance

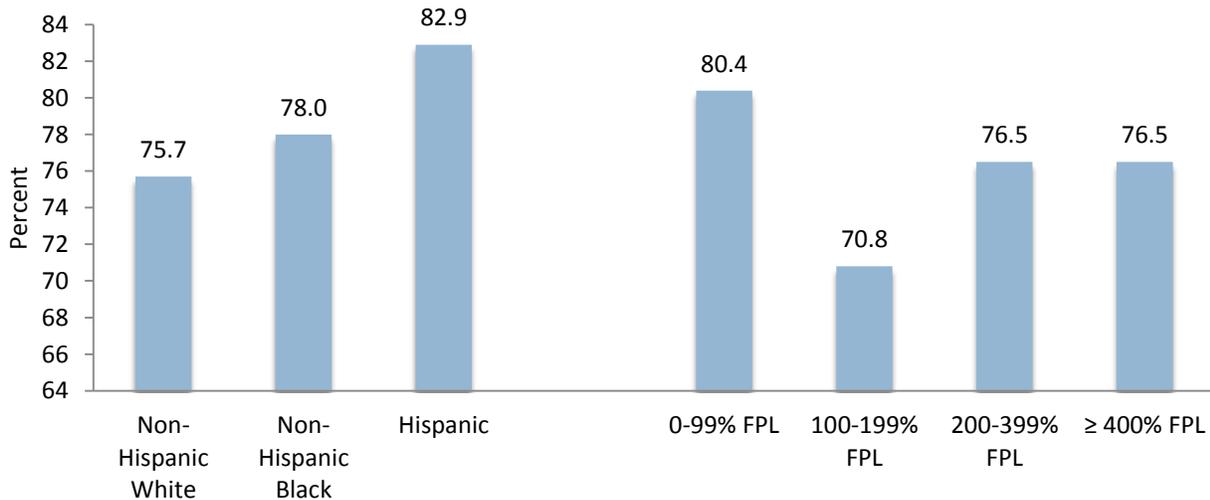
IN 2011/12, more than 70% of all children were adequately insured in every age category, both in Georgia and in the US. The highest percentage was among the youngest children (0 to 5 years of age). Georgia’s percentages were consistently higher than the national average in 2007, however they decreased to become more similar to national averages in 2011/12. In 2011/12, more Hispanic children were adequately insured than non-Hispanic white or non-Hispanic Black children. When stratified by income, more than 80% of children 0 to 17 years old living in households 0 to 99% FPL were adequately insured, compared to only 70.8% of children who live in households where the income lies between 100 to 199% FPL.

Percent of children 0-17 who are adequately insured by year and age, Georgia compared to the US, 2007 and 2011/12



Source: NSCH

Percent of children 0-17 who are adequately insured by race/ethnicity and household income, Georgia, 2011/12

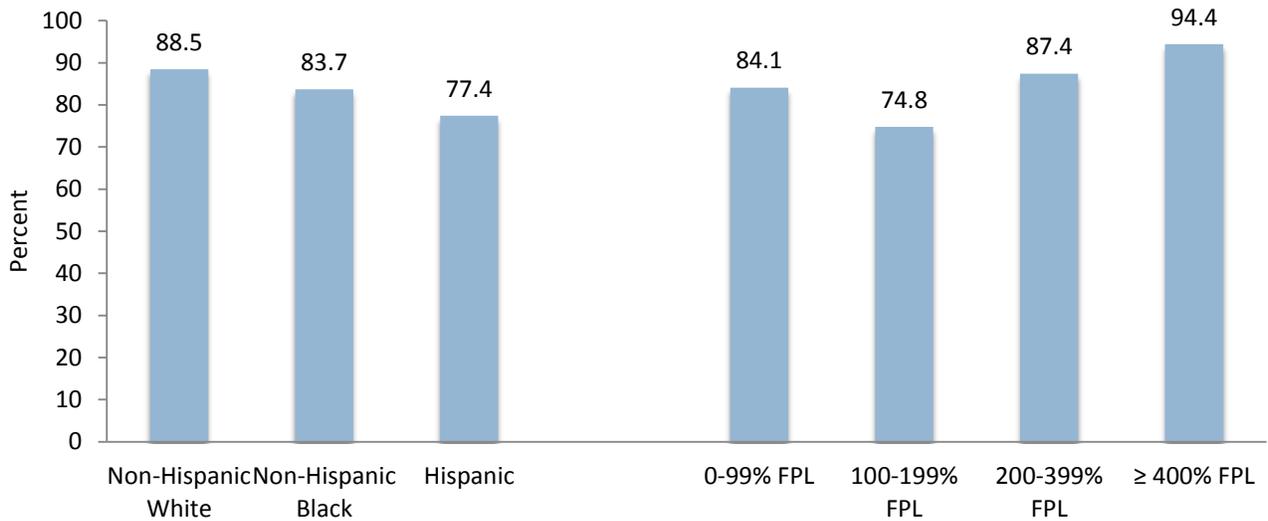


Source: NSCH

Gaps in Insurance

In 2011/12, the percentage of Georgia’s children who experienced no gaps in insurance coverage during a 12 month period was 85.2%. When examined by race/ethnicity, the percentage ranged from a low of 77.4% among Hispanic children to a high of 88.5% among non-Hispanic White children. Less than 85% of children in the two lowest income categories had no gaps in coverage in Georgia, compared to 94.4% of children in the highest category.

Percent of children who are currently insured and had no gaps in insurance in the past 12 months by race/ethnicity and household income, Georgia, 2011/12



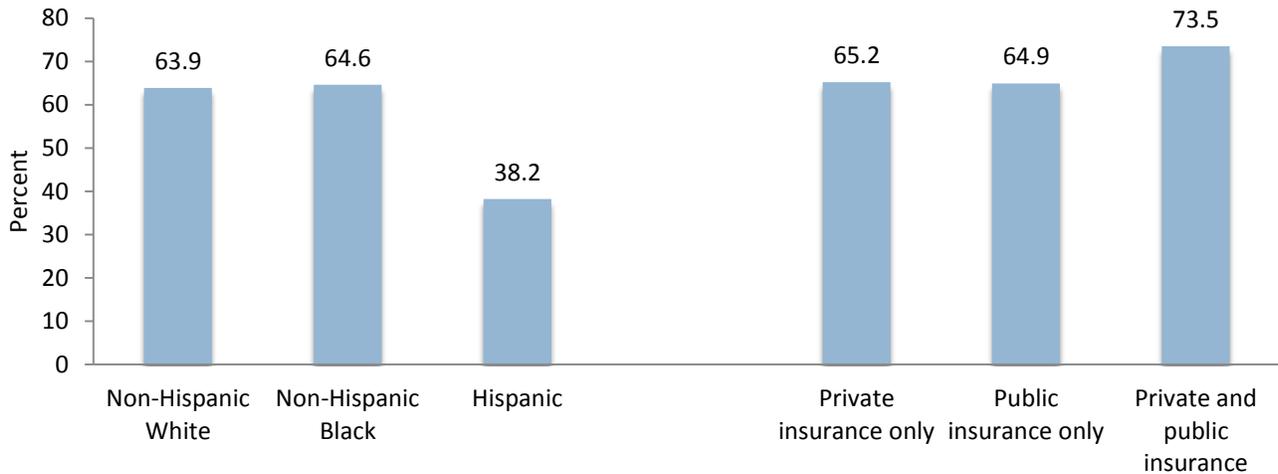
Source: NSCH

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS

Consistency and Adequacy of Insurance

Over 62% of CYSHCN in Georgia and 60% of CYSHCN in the US had consistent and adequate private and/or public insurance to pay for the services they needed in 2009/10. Only 38.2% of Hispanic CYSHCN had consistent and adequate private and/or public insurance compared to more than 60% of all the other races. The percentage was higher among those on both private and public insurance, compared with those who had either private insurance only or public insurance only.

Percent of CYSHCN whose families have consistent and adequate insurance to pay for the services they need by race/ethnicity and insurance type, Georgia, 2009/10



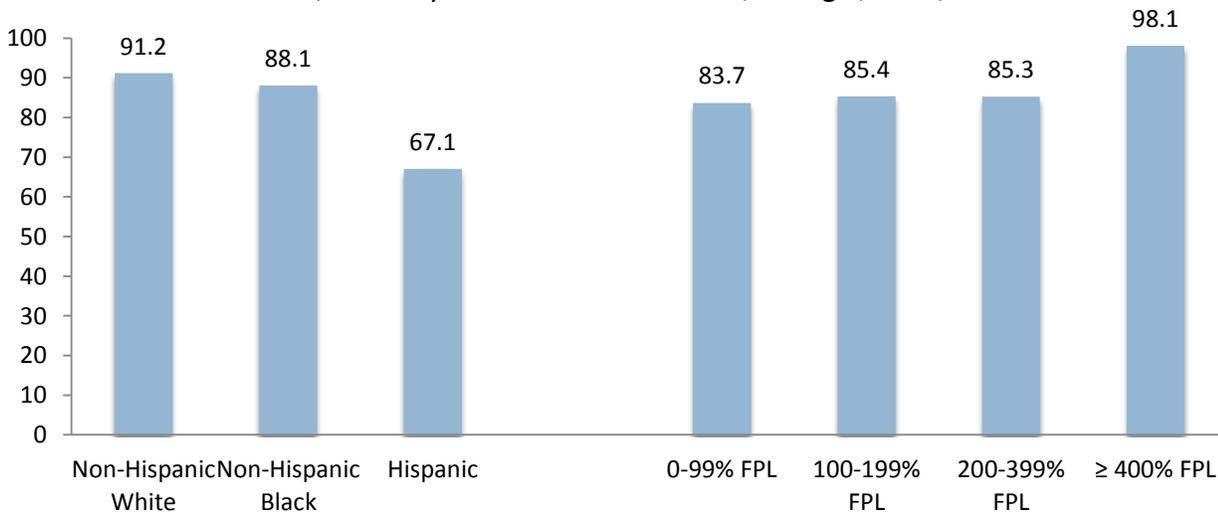
Source: NS-CSHCN

*Estimates for Hispanic and Private and public insurance are based on a numerator less than 50 and should be interpreted with caution

Gaps in Insurance

In 2009/10, the percentage of CYSHCN with no gaps in health insurance coverage in the past year was 91.2% among non-Hispanic Whites, 88.1% among non-Hispanic Blacks and 67.1% among Hispanics. Little variation was seen among CYSHCN living in households less than 400% of the FPL. However, among CYSHCN in the highest income category, 98.1% of CYSHCN experienced no gaps in insurance coverage in the previous year.

Percent of CYSHCN with no gaps in coverage in the past year by race/ethnicity and household income, Georgia, 2009/10

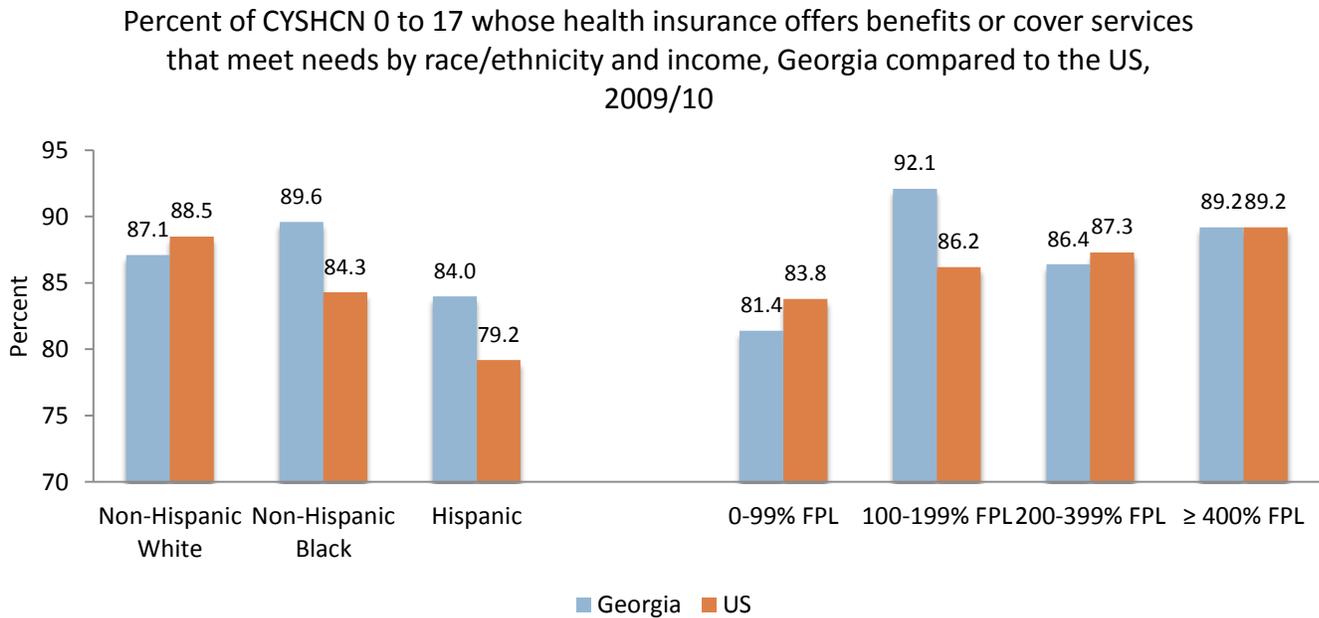


Source: NS-CSHCN

*Estimate for Hispanic is based on a numerator less than 50 and should be interpreted with caution

Health Insurance Meets Needs

In Georgia during 2009/10, 87.3% of CYSHCN were reported to have health insurance that offers benefits or cover services to meet their needs. In the US, the percentage was highest among non-Hispanic Black CYSHCN. However in Georgia, the percentage was highest among non-Hispanic Whites. Both nationally and in Georgia, Hispanics reported the lowest percentages of CYSHCN whose health insurance offered benefits or covered services to meet their needs. In the US, the percentage steadily increased as income level increased. That pattern was seen in Georgia, with the exception of those living between 100-199% FPL, in which the percentage was higher at 92.1%.



Source: NS-CSHCN

*Georgia’s estimate for Hispanic is based on a numerator less than 50 and should be interpreted with caution

STRENGTHS AND NEEDS

Georgia has seen several successes in areas that cross-cut all MCH populations. For example, Georgia has demonstrated excellence in ensuring its residents have access to fluoridated water, with over 96.4% of individuals in Georgia having regular access to fluoridated water. Increasing access to fluoridated water is not only a public health success, but Georgia’s excellence in this area provides an example for other states to follow. Although tobacco use remains prevalent and necessitates more work around the area, rates been on the decline overall, particularly among pregnant women.

However, there is room for improvement related to oral health and health insurance coverage in the state. The data indicates the need to focus on the following areas:

- Increasing the awareness of the importance of oral health to overall health status and well-being to children ages 6 to 11 and to Hispanic and low income populations

- Increasing dental visits during pregnancy
- Reducing smoking among White mothers during pregnancy
- Reducing tobacco use among adolescents
- Improving health insurance coverage

Cross-cutting areas are essential to address, as they impact all MCH populations and several of the key health indicators examined in the other population domains. It is also important to think about these issues within the life course framework to identify critical periods for intervention and ensure health equity.

DRAFT

KEY INFORMANT INTERVIEWS

Key informant interviews were conducted among leaders in maternal and child health throughout Georgia to give MCH a better sense of the needs and priorities in the state. One key informant was chosen for each population domain. Although key informants were chosen for a specific expertise by population domain, they were invited to speak on any MCH topics that they were knowledgeable about. Questions asked of the key informants related to the National Performance Measures, barriers to services, health disparities and workforce development needs. The following tables provide an overview of the major themes that were identified by the key informants. Themes were grouped by individual-level factors, structural-level factors and priority needs identified.

Table 12. Key Informant Interview Themes

Priority Needs	
Family planning	<p>“I know on a national level teen pregnancy rates are decreasing, but, in this area, especially in some of our counties, we have substantially higher teen pregnancy rates than the state.”</p> <p>“We’re fourth in the nation in repeat teen pregnancies, so I think we have a tremendous amount of work to do in that area.”</p>
Low birth weight	<p>“... I think healthier pregnant women would help a lot more with our low birth weight problem.”</p> <p>“We rank really poorly. I think we’re 45th in low birth weight in the nation. . . . That may be [impacted by] a lot of things [such as] interconception care, better access to high-risk care during pregnancy.”</p>
Maternal mortality	<p>“... we’re sometimes 50th, sometimes 49th, but we rank very poorly [in maternal mortality], so I think we have a huge amount of work to do in that area.”</p>
Well-woman visits	<p>“There’s still a need for primary care in the area, a place for women to get their regular, routine and preventive care.”</p> <p>“Well-woman visits and the perinatal oral health is critical to addressing smoking among pregnant mothers smoking.”</p> <p>“Clearly when we talk about well-woman visits, if we could identify mothers that are diabetic, mothers that have hypertension, mothers that are deficient in folic acid, mothers that have a relationship or sexual abuse, spousal abuse, or even drug abuse that may be a problem, that you could help identify those situations where it may be difficult or somewhat complicated for them as far as becoming pregnant and the completion of their pregnancy. And it also helps with planning pregnancy.”</p> <p>“... Even though we do have good prenatal care, we haven’t been able to make that significant of an impact on infant mortality and pregnancy-related</p>

	complications.”
Managing chronic conditions before pregnancy	“Women need to understand what their issues are around obesity, hypertension [in order to] help them to be healthy between pregnancies and live a healthier life.”
Successes in low-risk C-sections	“The low-risk cesarean I think is an initiative that we’ve been working on for several years and I think we’ve made extremely good progress. . . . So, I say we’ve done quite a bit of work there and that we might be ready to keep an eye on it, but be moving along to other things.”
Increase marketing of existing programs	“The only stop-gap measure we have right now is the P4HB . . . and we’re not marketing it well enough and it’s not out there well enough. [It] should be providing birth control for low-income and Medicaid women between pregnancies.”
Expanding medical homes to OB services	“We would love for women to have a medical home, which is their obstetrician gynecologist, but at a minimum they need it for pregnancy. So an OB medical home is a new concept, but I think they’re doing it in some other states, and maybe we need to look at how that’s being done and can we also make that happen here in Georgia.”
Perinatal regionalization	<p>“In a nutshell, we’re doing ok, but we’re not doing great. But it’s in part due to the fact that there’s a lot of forces that work against us. . . . There are forces in the day to day services of a hospital that makes them want to provide this service when probably they can’t.”</p> <p>“I think we need to have more official ways of designating [level of care] both on the obstetrical and the neonatal side. And we have guidance from both ACOG and AAP now that we could use in order to help that regional perinatal system improve in those hospitals within those different regions, improve as to where they really are on the designations, and I think there’s a tremendous amount of work that needs to be done around that. So that should be a very high priority.”</p>
Breastfeeding	<p>“I think the tides are really turning. Are we there yet? The answer is no. There are certain things that we need to do to get there from that standpoint. One of the things that the Department of Public Health has done is trying to get Baby-Friendly Hospital designations. I think that’s increased the awareness dramatically.”</p> <p>“We need to increase breastfeeding and start a donor breast milk program in the state of Georgia.”</p> <p>“We need additional funding sources to help promote breastfeeding.”</p> <p>“There are breastfeeding resources for WIC-eligible participants through WIC, but hospitals may not have the resources to provide breastfeeding support once woman goes home after delivery.”</p>
Nutrition	“Obesity is not on [a national priority area]. . . the physical activity piece is, but not nutrition. And there are still significant issues with access to healthy foods and those kinds of things.”

Oral health of adolescents	“Oral health of adolescents is a problem due to their lifestyle and diet (smoking, tobacco use, e-cigarette, carbonated beverages and sport drinks).”
Perinatal oral health	<p>“Perinatal oral health has an impact on mothers, birth outcomes and early childhood decay.”</p> <p>“[There is a] Need for women to be aware of the importance of dental care during pregnancy.”</p> <p>“Many expectant moms receive dental care for the first time when they’re pregnant due to changes that may occur, e.g. bleeding gums.”</p> <p>“[Pregnancy provides] an opportunity for oral health providers to address mothers who are actually smokers and refer them to perinatal care.”</p>
Oral health among children	<p>“Parents lack awareness regarding seeing a pediatric dentist before the age of one.”</p> <p>“Early childhood caries is essentially a problem.”</p>
Oral health among CYSHCN	“Education of caregivers for special need population is to me a huge need. In the population that are not so fortunate, they have several problems. One, there are no caregivers and they are usually incapable of taking care of their own oral health. Two, the caregivers that they have are usually stretched pretty thin and they are really either not interested in or not capable of providing adequate oral health care. And three, they are usually in facilities where their diet is not monitored or the foods that they are given, the considerations for their dental health are not paramount.”
Oral health disparities	“Of course ethnicity plays a part. You see quite a predominance of gingivitis and the early stages of periodontal disease, you see that more readily in African Americans . . . the Hispanic population as well, we’ve seen an increased number of caries as well in the Hispanic population growing almost as readily as other ethnicities or our non-Hispanic populations. I’m not sure if it’s more to do with diet and lifestyle or access to care, but we’re seeing a rampant increase in that.”
Workforce development services	“I think some of the challenges that we have in trying to develop our workforce have to do with a lot of training needs. . . . I would love to see us be able to provide other trainings in a more centralized way, to help better support our staff. Instead of staff going to conferences, for us to be able to provide that through the Department.”
Case management	“But I can see where parents would need a lot of support. That’s where I can see a medical home would be so extremely helpful, and to have more case management-type activity, and to help parents navigate through that system.”
Transitions to adulthood	“There are of course more folks with special needs who are living into adulthood now and so there appears to be more of a need for a better transition of care for those folks from their pediatric homes into an adult medical home. And so we’re working with the pediatricians now on beginning to look at how should that happen. And that also would need to encompass the family physicians and the internal medicine physicians, as well as us on making sure that there’s a transition method for adolescents and those growing into adulthood,

	transitioning into adult care.”
Elderly populations	“I’m not sure how much direction is addressed toward adult populations and elderly. . . . That’s a population that’s getting readily left behind. . . . there is just a lot of research showing how oral health is connected to a lot of chronic diseases, such as diabetes, stroke, cardiovascular disease, almost 200 different diseases that it has a direct or indirect connection to. So if you can get that oral health taken care of, it can actually improve the health of these adults in these populations. But it doesn’t seem like there’s a lot being geared toward that in Georgia.”
Barriers	
Lack of insurance between pregnancies	“[There is a] Problem with the setup of Medicaid system. Women are only insured through Medicaid while they’re pregnant, eight weeks after their pregnancy is completed, they’re rolled off Medicaid and they’re uninsured between pregnancies.”
Insurance reimbursement systems for perinatal regionalization	“Medicaid payment schedule is complicated if prenatal care is done in one place and delivery in somewhere else.”
Lack of access to mental health care	“There is a serious problem with mental health, drug abuse and psychosocial issues for pregnant women.” “[There are a] Lack of facilities/clinic to send pregnant women when issues are identified.” “There are barriers to accessing mental health services of care.”
OB provider shortages	“There are 40 counties without any obstetrical care at all.” “Outside of Metro Atlanta, there 65 obstetrical units left to serve the entire 159 counties in the state as far as deliveries.” “Women travel 45 minutes or longer to delivery hospital because of the decrease in access and are at 1.5 times higher risk of delivering premature infants.”
Labor and delivery unit closures	“. . . Two of our hospitals no longer provide deliveries. They’re no longer birthing hospitals. And I’m afraid that dynamic is going to continue.” “We need to stop as soon as we can, the closure of any more labor and delivery units, because once your labor and delivery unit closes, your whole system of care for that particular rural area goes away.”
Insurance reimbursement as a barrier	“Reimbursement for dental care for special needs population is extremely low for dental work.” “Finances and access to providers is an issue regarding with different government-funded insurance and different regular private insurance.” “Private practitioners or pediatric dentists who work in the hospital, do not take Medicaid for the dental fees but tend to provide the best level of care.”
Lack of knowledge about	“Patients not being aware of the resources that are available is a barrier to them navigating the system.”

resources	“Patients’ lack of knowledge about the services provided by health department.”
Integration between oral health care and medical care	<p>“Physicians don’t generally know much about the mouth, or care to know much about the mouth. I say this as an expert because I am working with several physicians here at the hospital to try and get that changed. To physicians and PA’s, the mouth is a mystery. And for dentists, we look at physicians as, ‘Oh, they’re real doctors.’ So there’s a very weird barrier between medicine and dentistry. And that carries over to including dentistry as routine inputs to medical care. Where a significant part of the population will visit a pediatrician, will visit a primary care physician at some point. The inclusion of dental is at best cursory but hugely missing . . . in my experience.”</p> <p>“Ideally what needs to eventually happen is doing a comprehensive coordinated collaborative approach to health care where oral health care is kind of included in a lot of other things.”</p>
Lack of information disseminated	“My big concern and what I have noticed the most is a lack of a centralized agency or a program or a group of individuals who will focus on the sole purpose of just gathering and disseminating information and making that information readily and easily available to the developmentally disabled community.”
Lack of specialty care in rural areas	“[My practice] covers 28 counties, so it may be that a family needs access to what we provide, but they just live so far away. And we do everything we can to provide them with the help that’s needed but that doesn’t mean that we get all those patients.”
Lack of public health dental clinics	“It is a problem that not all health departments have dental services.”

PRIORITY NEEDS

Breastfeeding

Most of the informants interviewed reported that an increased focus on breastfeeding was necessary to affect change in the health of women across the state. They viewed breastfeeding as having the ability to make a larger impact across the board and being able to positively impact nutrition for the mother and the child, as well as playing a key role in the reduction of SIDS and other adverse birth outcomes. They also noted the importance of breastfeeding for infants who are born preterm or at a low birth weight.

Well-Woman Visits

Many key informants recognized the importance of well-woman visits for their patients ages 18 to 44 with regards to their preventive health care. They cited well-woman visits as essential to improving birth outcomes in the state, and attributed poor health status prior to pregnancy as a leading cause of preterm deliveries, low birth weight, infant mortality and maternal mortality. Additionally, participants identified well-woman visits as being the gateway to focusing on other issues of importance to the woman, such as prenatal care and smoking.

Oral Health

Oral health emerged consistently as a need for women across the state, particularly women in rural areas. They recognized the connection between oral health, perinatal health, and outcomes in children. The context within which oral health care was delivered was also noted, particularly in rural areas or in specialty clinics that focused on developmentally disabled clients. Key informants also cited funding for oral health as an issue in the delivery of quality care. Additionally, providers focused on children and adolescents and their oral health as a lifestyle-related problem that needed to be addressed. Oral health emerged as a particular issue for individuals with special needs, as they often lack caregivers trained to ensure their oral hygiene. One key informant noted that a resource directory of all oral health providers for patients with special needs is critical to ensuring the health of this population.

Family Planning

The need for family planning services was mentioned by most key informants. Participants mentioned that the delivery and payment for birth control for low-income women was an issue in the proper spacing of births. Key informants noted that birth outcomes will not be improved without the proper planning of pregnancy. They identified this as a particular area of need due to a lack of other programs in the state addressing family planning. Three of the six participants mentioned that they were concerned about the prevalence of teen births. A particular emphasis was placed on the need for clinics throughout the state to provide teen-friendly family planning services.

Additional Needs

Although not mentioned by all participants, several other needs emerged through the key informants' comments. A participant noted, "Injuries caused by school accidents, sports activities, and school playground need to be addressed." Other participants did not address this issue further. One participant noted that everyone woman needs a medical home, but this is especially important when they are pregnant. Other participants did not address this issue further. The importance of mental health was addressed. One mentioned that there was unmet need for mental health services throughout the state, particularly for women during pregnancy and the postpartum period.

The key informants saw parents as untapped resources. They found that irrespective of socioeconomic level, there is a fairly large subset of parents and some caregivers actively searching for information on available resources who have the ability to disseminate information to others in their network. Providers indicated that resources have to be available and user-friendly, but feel that resources or websites for government agencies are not user-friendly enough. One participant also emphasized the importance of community outreach, and felt that technology could not replace the feel of a person or a touching hand.

Successes

Key informants mentioned several areas where they felt Georgia had made significant progress in recent years. One key informant noted that work had been done to reduce cesarean sections without medical

necessity. Participants also noted that although there is much work to be done to promote safe sleep, the Back to Sleep and Safe to Sleep campaigns have greatly raised awareness throughout the state.

BARRIERS

Adequate Insurance Coverage

Key informants commented on the linkages between adequate insurance coverage and women's health across the pregnancy period. Specifically, they mentioned frustration with women losing Medicaid coverage shortly after delivering. Additionally, the length of time for reimbursements to be processed for Medicaid was mentioned as a barrier to services.

Lack of Primary and Specialty Care

The participants consistently referenced a lack of primary and specialty care for clients across the state, particularly in rural areas. Four out of the six participants pointed to a shortage of specialized health care professionals within their districts. They also drew attention to the shortage of dentists for special needs, Maternal-Fetal Medicine Specialists (MFMs), Obstetrics and gynecologists (OBGYNs), physical, occupational and speech therapists. To highlight the enormity of the problem, one participant stated that in the state of Georgia, there were 16 counties that had no dentist. Another participant stressed the urgency to educate caregivers on oral health, as only a limited number of the currently available caregivers were capable of providing this required service to individuals with special needs. Another important point that was highlighted referred to the lack of OBGYNs in the area, and that more needed to be done to keep current OBGYNs. There was also a shortage of Maternal-Fetal Medicine Specialist (MFMs) that has been trained to take care of high-risk pregnancies. As it currently stands, the MFMs are located in the larger cities where many women find it difficult to get an appointment, or, are unwilling to travel to, due to transportation problems. As a result, women with high-risk pregnancies living outside the cities or in rural areas usually don't have access to appropriate care. A suggestion made by a provider was to increase the use of telemedicine for both high-risk care and routine prenatal care to eliminate some of the disparities pointed out.

The effect of the shortage of health care providers extends beyond the health care system. For example medical care through the health care system continues in the school system, especially among children with special health care needs. A participant mentioned that even within the school system, it is a struggle to recruit therapists, because there aren't enough of them in this area. A provider stressed the importance of providing training for both clinical and non-clinical staff. Despite the limited number of health care providers and facilities for high risk pregnant women, providers were very concerned about the closure of labor and delivery units in hospitals, and worried if this trend continued.

To curtail workforce shortage issues, participants have suggested that health departments start providing trainings for clinical, non-clinical and support staff. These trainings should include in-person workshops, conferences, and other interactive methods using technology. The need for qualified staff to evaluate the

effectiveness of these programs and initiatives was emphasized. Participants recognize the enormous challenges caused by the shortage of workforce and how this shortage creates barriers that lead to health disparities. Participants also stressed that training and development of the existing workforce is required in order to provide better services for their clients.

Additionally, participants stated the need to educate the public on the closure of hospitals, and advocate for an increase in funding to educate OBGYNs and to find ways to keep newly qualified OBGYNs from leaving the state to practice somewhere else.

Partnerships among Health Care Professionals

One participant noted that a partnership between oral health professionals and medical care professionals is essential to improving the overall health of Georgians. The key informant stated that the two professions didn't work together and have been separated over the years due to a number of reasons, including but not limited to, the dichotomy between medical and dental insurance and the practice models of a hospitals versus independent offices. Because dentists see early signs of chronic conditions, it was recommended that both professions take a holistic approach to health when assessing their patients and make the appropriate referrals.

DRAFT

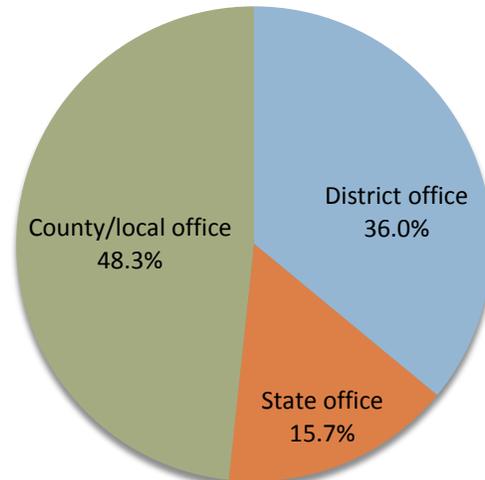
PUBLIC HEALTH WORKFORCE AND STAKEHOLDER SURVEYS

DEMOGRAPHICS

Department of Public Health Employees

Responses were gathered from employees of the Department of Public Health at the state, district and local level offices. A total of 300 responses were received, although only 230 individuals responded to more than the demographic portion of the survey. Of the respondents, 15.7% were from the state office, 36.0% were from a district office and 48.3% were from a county/local office. Of state office respondents, 70% worked in the Maternal and Child Health Section and 20.4% worked outside of MCH. Nearly 7% were the parent of a child with special health care needs (n=20). The majority of the public health staff respondents work on issues affecting infants (69.8%), children (61.1%), women (60.1%), adolescents/teens (54.2%), pregnant women (50%), and families (45.9%).

Survey respondents by office of employment



Stakeholders

The survey was also administered to key stakeholders throughout the state. A total of 467 submitted responses, although only 262 responded to more than the demographic portion of the survey. Respondents ranged from public health workers, to advocacy groups, physicians, and academics, as well as a wide range of other stakeholders. The majority of respondents were from either non-profit groups (29.1%), other

governmental agencies (25.5%) or hospitals (15.6%). Almost a quarter of respondents (23.8%) were the parents of children with special health care needs (n=111). Nearly 45% of respondents had college degrees, and about 39% had master’s degrees, 9.4% of which were in public health, and 19% had either a medical or doctorate degree. Degrees were not mutually exclusive; therefore some people may have been counted in more than one category. Nearly a quarter of those responding to the survey identified as having a child with special health care needs. The majority of the public health staff respondents work on issues affecting infants (47.1%), children (40%), women (37.5%), adolescents/teens (36.2%), pregnant women (32.1%) and families (41.5%).

PRIORITIZATION OF NATIONAL PRIORITY AREAS

Survey respondents were asked to rank each of the 15 national priority areas, regardless of population domain from 1 to 15, with 1 being most important and 15 being important. Respondents were asked to draw upon their experiences and needs of their communities when conducting the ranking.

To determine the importance of the national priority areas among DPH employees and stakeholders in Georgia, two methods of analysis were used. First, the percentage of employees who ranked each national priority area first (1) and last (15) was assessed. Second, an index was developed to determine the priority areas that were being ranked higher and lower overall. The index is as follows:

- 1-3: Very important
- 4-6: Moderately important
- 7-9: Somewhat important
- 10-12: Important
- 13-15: Least Important

Highest Ranked Priorities

RANKING

When comparing the percentage of DPH employees and other stakeholders who ranked each national priority area first, the percentage was highest for ensuring adequate insurance coverage. Over 35% of stakeholders and 29.6% of DPH employees ranked this priority area first. Increasing well-woman visits was ranked first by 17.4% of DPH employees, however only 5.3% of stakeholders ranked it first. Stakeholders ranked developmental screenings first 10.7% of the time, which was the second highest percentage after ensuring adequate insurance.

Table 13. Percent of respondents who ranked each national priority area first (1)

National Priority Area	DPH Employees	Stakeholders
Ensure adequate insurance coverage among all ages	29.6%	35.1%
Increase well-woman visits	17.4%	5.3%
Improve breastfeeding rates	9.1%	8.4%
Increase rates of developmental screenings for children	7.4%	10.7%

Increase safe sleep among infants	6.9%	5.7%
Improve access to medical homes for CYSHCN	5.2%	4.2%
Decrease injury among children	5.2%	6.1%
Increase physical activity among children and adolescents	3.9%	3.8%
Decrease low risk cesarean deliveries	3.5%	4.2%
Decrease smoking among all ages	3.5%	2.7%
Strengthen perinatal regionalization	2.2%	4.9%
Decrease bullying among adolescents	2.2%	0.8%
Improve oral health among all ages	1.7%	1.9%
Increase adolescent well visits	1.3%	1.5%
Improve transition to adult care for CYSHCN	0.9%	4.6%

To assess which national priority areas were ranked as least important to stakeholders and DPH employees in Georgia, the percentage of respondents who ranked each priority area last (15) was assessed.

Among DPH employees, over 10% of respondents ranked ensuring adequate insurance coverage, decreasing smoking and strengthening perinatal regionalization 15. It is important to note that ensuring adequate health insurance was ranked first and last most often among DPH employees. The percentage of stakeholders who ranked ensuring adequate insurance last was about half the percentage of DPH employees who did. Priority areas that were ranked last by 10% or more of stakeholders area decreasing low-risk cesarean deliveries, decreasing smoking, strengthening perinatal regionalization, decreasing bullying and improving oral health.

Table 14. Percent of respondents who ranked each national priority area last (15)

National Priority Area	DPH Employees	Stakeholders
Ensure adequate insurance coverage among all ages	17.0%	8.8%
Increase well-woman visits	7.8%	8.4%
Improve breastfeeding rates	4.4%	3.4%
Increase rates of developmental screenings for children	1.3%	1.5%
Increase safe sleep among infants	1.7%	3.4%
Improve access to medical homes for CYSHCN	1.7%	1.9%
Decrease injury among children	3.5%	2.3%
Increase physical activity among children and adolescents	0.4%	0.8%
Decrease low risk cesarean deliveries	9.6%	13.4%
Decrease smoking among all ages	10.4%	10.7%
Strengthen perinatal regionalization	14.4%	13.4%

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Decrease bullying among adolescents	7.4%	10.3%
Improve oral health among all ages	8.3%	11.1%
Increase adolescent well visits	3.5%	3.8%
Improve transition to adult care for CYSHCN	8.7%	6.9%

INDEX

Using the index to evaluate importance of priority areas, interesting differences were seen.

Among DPH employees, adequate health insurance coverage and well-woman visits were tied as most important, 36.5% of respondents ranking them very important. Safe sleep was the second highest priority with over 25% of people ranking it as very important, followed by breastfeeding, with over 24% of public health workers ranking it within the very important category. Increasing physical activity was the fourth highest ranked priority, with 23.5% of public health workers ranking it within the very important category. Physical activity was followed closely by increasing developmental screening, as a little over 23% of public health workers deemed it as very important.

Among stakeholders, the top two priorities remained insurance and developmental screenings. Nearly 50% reported adequate insurance coverage as very important and a little over 30% reported increasing developmental screening among children as very important.

The lowest ranked priorities among DPH employees using the index were smoking and oral health. Both were ranked as the lowest priority by 35.7% of respondents. They were followed closely by strengthening perinatal regionalization, with about a third of respondents (32.6%) ranking it as least important. Close to 30% of the public health workers surveyed reported decreasing low risk cesarean sections as least important. Other national priorities ranked as least important by more than 20% of Georgia's public health workforce were ensuring adequate insurance (26.1%), improving transition to adult care for children and youth with special health care needs (23.9%), increasing well women care (22.2%) and decreasing adolescent bullying (21.7%).

When employing the index on data from stakeholders, major differences were seen. The lowest ranked priorities were oral health, perinatal regionalization and low risk cesarean sections, all with 30% or more of respondents ranking these priority areas as least important.

INDICATION OF ADDITIONAL NEEDS

Public health workers were asked, in an open ended question, to state additional need, outside of the national priority areas, by population domain. Responses were reviewed and placed into categories for each population domain.

Maternal/Women's Health

In the maternal/women's health domain, 32.1% of DPH employees identified access to care (access to consistent and affordable care, adequate insurance and care provided in language spoken by clientele) as a need among maternal and women's health, while 23.3% and 16.0% identified chronic health conditions

(heart disease, diabetes, auto immune disorders) and healthy lifestyles (unhealthy eating, premarital sex, drugs and alcohol) as needs. Finally, 13.0% mentioned education (formal education as well as understanding the importance of seeking care), while 9.3% and 8.8% mentioned home/domestic issues (domestic violence, abuse, and poverty) and prenatal care.

Similarly, 31.5% of stakeholders indicated access to care was needed to improve maternal and women's health, while 23.7% and 16.6% mentioned healthy lifestyles and chronic issues. Finally, just under 13% indicated home/domestic issues while only 10.5% and 6.1% identified education and prenatal care.

Table 16. Additional maternal/women's health needs

Maternal/Women's Health		
Priority Need	DPH Employees	Stakeholders
Access to care	32.1%	31.5%
Chronic issues	23.3%	16.6%
Healthy lifestyle	16.0%	23.7%
Education	13.0%	10.5%
Home/domestic issues	9.3%	12.7%
Prenatal care	8.8%	6.1%

Perinatal Health

With respect to perinatal health, results were grouped into seven main areas. Public health workers identified access to care issues, such as insurance/Medicaid and medical cost, as a top need in perinatal health, with 30% of respondents mentioning the need. Access to care was followed by 21.8% of respondents mentioning the need to improve birth outcomes (prematurity, infants born at the appropriate level of care, and appropriate pre and post-natal care) and 13.5% mentioning education (formal education as well as knowledge of prenatal issues). Under 10% of workers identified the following categories as needs: domestic/home issues (domestic violence, drug/alcohol/tobacco addictions), nutrition, screening and intervention (well checkups, knowledge and understanding of routine screening) maternal/child interaction (breastfeeding, co-sleeping).

Stakeholders also identified access to care most often, with 27.6% of stakeholders mentioning the need, followed by 22.6% identifying improved outcomes and 17.1% identifying domestic/home issues. Under 12% of workers identified the following categories: education, screening and intervention, nutrition, and maternal/child interaction respectively.

Table 17. Additional perinatal health needs

Perinatal Health		
Priority Need	DPH Employees	Stakeholders
Access to care	30.0%	27.6%
Improving outcomes	21.8%	22.6%

Education	13.5%	11.6%
Domestic/home issues	9.8%	17.1%
Nutrition	7.7%	8.3%
Screening and intervention	5.7%	8.8%
Maternal/child interaction	5.7%	8.3%

Child Health

For the child health domain, seven main categories of responses were seen. Among DPH employees, the greatest number of responses (28.0%) fell into the healthy lifestyles category (diet and exercise, refraining from drugs, alcohol, and tobacco), followed by 19.2% who believed access to care was important (frequency of doctor visits, availability of pediatricians, inadequate insurance coverage for the poor). Over 16% of employees’ responses included chronic health issues (obesity, asthma, Type I diabetes) while 10.3% named social support (broken homes, absentee parents, and bullying). Finally, 7.8%, 7.2% and 4.1% mentioned immunizations, education (lack of knowledge), and abuse (domestic abuse and neglect) respectively.

When stakeholders were asked about child health, differences were seen. Among them, access to care was identified most often, with 28.6% of stakeholders identifying the need. Additionally, 24.7% and 20.1% believed chronic health issues and healthy lifestyles were a need. Under 10% of stakeholders identified education, social support, immunizations and abuse.

Table 18. Additional child health needs

Child Health		
Priority Need	DPH Employees	Stakeholders
Healthy lifestyles	28.0%	20.1%
Access to care	19.2%	28.6%
Chronic health issues	16.6%	24.7%
Social support	10.3%	9.3%
Immunizations	7.8%	4.9%
Education	7.2%	9.9%
Abuse	4.1%	2.7%

Adolescent Health

More than 30% of public health workers identified reproductive health (teen pregnancy, STD and STIs and birth control) as the number one priority when thinking about adolescent health. Followed closely was healthy lifestyles (lack of parental involvement, inactive lifestyle and poor diet), with 28.1% of employees identifying the need. Just under 20% of the public health workforce believed substance abuse/mental

health (drug and alcohol abuse, peer pressure and self-image) to be a need, while 16.9% believed it was routine access to care (not seeking health care, not following up on vaccinations) and 6.7% believed it to be education (lack of knowledge and sex education).

Interestingly, the needs among stakeholders regarding adolescent health were different than DPH employees. More than 25% of stakeholders identified substance abuse/mental health as a need, followed by 22.9% identifying reproductive health. Under 20% of stakeholders mentioned routine access to care, healthy lifestyle, education and injury.

Table 19. Additional adolescent health needs

Adolescent Health		
Priority Need	DPH Employees	Stakeholders
Reproductive health	30.1%	22.9%
Healthy lifestyles	28.1%	11.2%
Substance abuse/mental health	19.1%	25.1%
Routine access to care	16.9%	16.7%
Education	6.7%	5.0%
Injury	0%	3.3%

Children and Youth with Special Health Care Needs

When asked about CYSHCN, the majority (35.7% and 25.7%, respectively) of public health employees identified inadequate resources (limited resources and providers) and access to care (uninsurance or underinsurance); 11.2% mentioned chronic health issues (diabetes, asthma, obesity, and seizure disorders), while 7.3%, 6.7% and 6.7% mentioned education (lack of knowledge, specifically knowledge about transition, and falling behind in formal schooling), home/domestic issues (neglect, abuse, and family support), and mental health (behavioral health services, ADHD, and other mental health disorders).

The results were very similar among stakeholders, in which 50.8% and 21.5%, respectively, mentioned access to care and inadequate resources as their number one priorities. Under 10% of stakeholders mentioned home/domestic issues, chronic health issues, education and mental health.

Table 20. Additional needs among children and youth with special health care needs

Children and Youth with Special Health Care Needs		
Priority Need	DPH Employees	Stakeholders
Inadequate resources	35.7	21.5
Access to care	25.7	50.8
Chronic health issues	11.2	7.9
Education	7.3	5.6
Home/domestic issues	6.7	9.0
Mental health	6.7	3.3

Oral Health

Finally, a high percentage (38.0%) of public health employees identified access to care (no insurance, or the cost associated with dental care being absorbent) as a need related to oral health, followed by 20.3% who believed mentioned routine care/hygiene (not going for routine care, poor daily hygiene). However, still a reasonable percentage, 13% and 11.3% respectively, mentioned lack of resources (limited providers or lack of transportation) and education (lack of knowledge about the oral health and that cavities are a bacteria that can be spread). Finally, 3.4% and 2.2% identified nutrition (too much sugar in diet, poor nutrition, malnutrition) and substance abuse (tobacco, alcohol, and drugs) as areas needed to improve oral health.

Among stakeholders, 43.8% mentioned access to care as a need when thinking about oral health, followed by 9.7% who identified the need to improve routine care/hygiene. However, 15.5% and 11.3% mentioned education and lack of resources. Finally, 5.1% and 3.2% mentioned nutrition and substance abuse.

Table 20. Additional oral health needs

Oral Health		
Priority Need	DPH Employees	Stakeholders
Access to care	38.0%	43.8%
Routine care/hygiene	20.3%	18.1%
Lack of resources	13.0%	9.7%
Education	11.3%	15.5%
Nutrition	3.4%	5.1%
Substance Abuse	2.2%	3.2%

CAPACITY ASSESSMENT

In the survey previously described, employees of the Department of Public Health were also asked to answer questions regarding workforce development and assessing the capacity of the agency to address needs of the maternal and child health populations.

When asked what barriers they face to meeting the needs of MCH populations in Georgia, the top three responses were lack of funding (77.7%), understaffing in the agency (52.1%) and lack of coordination and/or communication between agencies (49.3%).

When asked what things might make their job more easier or make them more effective at meeting MCH needs in Georgia, the top three responses were to improve working relationships and communication between state, district and local offices (72.5%), decrease turnover among staff (55.0%) and improve communication with federal agencies (46.0%).

Results from the survey were used to inform the Strength Weakness Opportunity Need (SWON) analysis.

Strengths Weaknesses Opportunities Needs Analysis

A SWON analysis was used to determine capacity of MCH and the broader Title V program in Georgia for each of the six federally-defined population domains. The assessment was adapted from the CAST-5 methodology developed by The Association of Maternal and Child Health Programs, Johns Hopkins University Women's and Children's Health Policy Center and the Maternal and Child Health Bureau.

The following definitions were used:

Strengths: Human resources, fiscal resources, social/political factors that facilitate the delivery of services.

Weakness: Human resources, budgetary restrictions and financial resources, technological resources and social/political factors that hinder the delivery of services.

Opportunities: Human resources, statutory/regulatory changes, community/business resources, social/political changes, technological developments that have the potential to facilitate the delivery of services.

Needs: Human resources, fiscal resources, technological resources, statutory/regulatory changes that are needed to improve public health.

Structural Resources: Financial, human and material resources; policies and protocols; and other resources held by or accessible to the program that form the groundwork for the performance of core functions.

Data/information systems: Technological resources enabling state of the art information management and data analysis.

Organizational relationships: Partnerships, communication channels and other types of interactions and collaborations with public and private entities, including but not restricted to, local, state and federal agencies, professional associations, academic institutions, research groups, private providers and insurers of health care, community-based organizations, consumer groups, the media and elected officials.

Competencies/skills: Knowledge, skills and abilities of Title V staff and/other other individuals/agencies accessible to Title V program staff

Table 21. SWON Analysis

Maternal/Women’s Health	
Structural Resources	S: MCH uses non-Title V federal funds, Title V funds and state funds to promote maternal/women’s health. MCH supports family planning clinics and the Maternal Mortality Review Committee.
	W: Medicaid does not cover preventive visits. DPH is no longer awarded the Title X grant.
	O: There is potential to integrate interventions, including the promotion of well-visits, into the family planning clinics to promote overall health.
	N: There is a need to promote well-woman visits among all women in the state, not just those served by the family planning programs.
Data/Information Systems	S: PRAMS, Vital Records, BRFSS, Maternal Mortality Review Committee data and Family Planning Program data are readily available to MCH. Title V supports the MCH Epidemiology team.
	W: PRAMS and the BRFSS do not provide county-level data. Data on the type of contraception used are limited.
	O: There is an opportunity to partner with Medicaid to assess health care utilization through claims data. Potential exists for OASIS to add more MCH indicators.
	N: MCH needs to increase our understanding of barriers to receiving preventive visits and locations in the state with the greatest need.
Relationships/ Partnerships	S: Activities could be incorporated into translation activities from the Maternal Mortality Review Committee, Cancer and HIV screens, Healthy Mothers Healthy Babies, OB/GYN Society, March of Dimes and Women’s Health Coordinator trainings.
	W: Although several partnerships exist, more active partners could be engaged to support women’s health.
	O: Partnerships can be leveraged to implement data to action projects from the Maternal Mortality Review Committee.
	N: There is a need to identify and engage partners committed to the work around the national priority areas.
Competencies/Skills	S: MCH operates programs and initiatives to promote family planning services and prevent maternal mortality.
	W: The needs assessment indicates a need to reduce chronic conditions to promote overall health and adverse outcomes for women and pregnant women. This is a new endeavor for MCH. As a result, there is a lack of institutional knowledge regarding the effectiveness of interventions.
	O: New staff are being hired to support women’s health initiatives. The Maternal Mortality Review Committee is relatively new. There are opportunities to continue to refine processes and develop effective interventions.
	N: The Maternal Mortality Review Committee would benefit from more data abstractors.
Perinatal Health	
Structural Resources	S: MCH provides funding for the perinatal regionalization system. Grant-in-Aid programs support outreach activities, including the Baby Luv program and other pilot projects to improve health for high risk pregnancies. MCH also supports breastfeeding

	<p>and infant mortality initiatives, including safe sleep. MCH is participating in the Safe Sleep, Perinatal Regionalization and Social Determinants of Health CoINs.</p> <p>W: DPH lacks the authority to regulate perinatal levels of care.</p> <p>O: New staff are being hired to address infant mortality. A fully-staffed team of capable individuals are essential to improving perinatal health in the state.</p> <p>N: A breastfeeding coordinator has not yet been identified.</p>
Data/Information Systems	<p>S: MCH has access to the state Vital Records, PRAMS, NSCH, WIC and NIS data. MCH Epidemiology is supported by Title V.</p> <p>W: Hospitals are not required to recertify their perinatal level of care and current levels may be inaccurate. Birth files do not contain historical information on neonatal levels of care and trends cannot be assessed. MCH lacks reliable county-level data on safe sleep practices.</p> <p>O: The RPC quarterly reporting tool is being revised to better capture information from regional hospitals.</p> <p>N: A standardized method for periodically assessing neonatal levels of care is needed. There is a need for workplace lactation program data in the state.</p>
Relationships/ Partnerships	<p>S: There is a high level of commitment from partners at the state level to improve perinatal health. Several partnerships exist to support breastfeeding initiation, including ASTHO and ROSE. Outreach coordinators at the RPCs serve an important role by educating community hospitals on best practices. WIC partners with MCH to promote breastfeeding among public health employees. The DPH strategic plan to prevent infant mortality combines several sections of the agency to address this need.</p> <p>W: While there are several partnerships at the state level, partnerships at the community and local levels are needed to change community norms regarding safe sleep and breastfeeding.</p> <p>O: GaPQC is a fairly new collaborative. Opportunities remain to build this collaborative and use it to address MCH priorities. Injury Prevention is strengthening partnerships with non-traditional organizations to change community norms regarding safe sleep practices.</p> <p>N: MCH needs to further engage partnerships around promoting worksite lactation programs.</p>
Competencies/Skills	<p>S: MCH has several long-standing initiatives to support perinatal health. There is institutional knowledge on activities that have worked well and challenges that were faced.</p> <p>W: DPH needs dedicated positions for Perinatal Health at the state-level.</p> <p>O: Through participating in the Social Determinants of Health CoIN, there will be opportunities to build the skills of MCH staff to address health equity.</p> <p>N: A breastfeeding coordinator needs to be identified to move the work forward.</p>
Child Health	
Structural Resources	<p>S: MCH has funds to support child screenings. Through the MCH transformation, a Child Health Screenings unit was developed to coordinate all screening programs. Title V also supports Injury Prevention and Georgia Shape.</p> <p>W: Injury Prevention and Georgia Shape are located outside of MCH and are supported by other grants and funding sources in addition to Title V.</p> <p>O: Georgia Shape is expanding the program to promote nutrition and physical activity. There is also an opportunity to collaborate with Talk With Me Baby on early brain development.</p> <p>N: There is a need for greater collaboration among all Title V funded programs</p>

	impacting children.
Data/Information Systems	S: SendSS and BIBS are used to capture screening data. National survey data is available as well. Georgia Shape captures Fitnessgram data from schools throughout the state.
	W: National survey data does not provide county-level data.
	O: DPH is undergoing a data system transformation to integrate child health data systems. The transformation is expected to take five years.
	N: Developmental screening data is not reported by the district DPH offices.
Relationships/ Partnerships	S: MCH is partnering with DECAL Race to the Top, DOE, academic institutions, GAAAP, Marcus Autism and Emory Autism Center. Georgia Shape is a collaborative effort between several state and private entities.
	W: Child Health programs within DPH are not located in the same section.
	O: There is an opportunity to work more closely with all early childhood development programs in DPH.
	N: MCH needs to further engage private providers on developmental screening efforts.
Competencies/Skills	S: MCH staff are experts in the field of developmental screening. There are also well-qualified staff to support injury prevention, obesity and early brain development efforts.
	W: Although several hires have been made, the child health teams are not yet fully staffed.
	O: The MCH restructure provides an opportunity to position staff to work collaboratively and share expertise.
	N: Child health teams need to work closely with one another and with Child Health Interventions.
Adolescent Health	
Structural Resources	S: MCH has a long-standing partnership with Adolescent and School Health. Family planning clinics located within MCH serve adolescents.
	W: DPH's adolescent health programs are not located within MCH or supported by Title V. MCH has not previously directed funds or personnel to programs for adolescents.
	O: MCH has hired a Director of Special Projects that will be able to partner with adolescent health initiatives. There are also opportunities to serve more adolescents through family planning clinics.
	N: More funding through additional grant opportunities is needed to promote adolescent health.
Data/Information Systems	S: YRBS data are available. An adolescent Health EPI is available to analyze adolescent health data. OASIS and Vital Records are also available.
	W: YRBS does not collect county-level data.
	O: There is an opportunity for MCH Epidemiology to enhance the partnership with Epidemiology.
	N: There is a need for qualitative data on adolescent health.
Relationships/ Partnerships	S: Adolescent and School Health has strong partnerships with schools.
	W: MCH has few direct partnerships to promote adolescent health.
	O: There is an opportunity to build more partnerships through Adolescent and School Health.
	N: There is a need for MCH to have more direct partnerships to promote adolescent health.
Competencies/Skills	S: Adolescent and School Health employ staff with expertise in adolescent health. Their programs target risky behaviors, bullying and asthma.
	W: MCH does not have expertise in adolescent health.

	<p>O: MCH can take advantage of resources supplied by MCHB and AMCHP to develop skills related to the NPMs in the adolescent health domain.</p> <p>N: Workforce development initiatives are needed to train MCH in adolescent health.</p>
Children and Youth with Special Health Care Needs	
Structural Resources	S: CMS and BCW are located within MCH. Both programs provide direct services for children and youth with special health care needs.
	W: CMS has income eligibility restrictions. Medicaid will cover non-income eligible children up to age 19.
	O: There is an opportunity to reevaluate how services are provided.
	N: Georgia needs more adult primary care physicians that can treat youth with special health care needs in adulthood.
Data/Information Systems	S: CMS and BCW have data systems. NS-CSHCN is used for state-wide data.
	W: The CMS data system only collects district-level data and not individualized data. The NS-CSHCN has not been conducted in several years.
	O: Qualitative data can be useful to fill the gap from the lack of quantitative data.
	N: Personnel are needed to collect and enter individualized historical data into the system and to develop a CMS web-database housed within DPH.
Relationships/ Partnerships	S: DPH partners with several external partners (AAP, AFP, CHOA, GRU and Parent to Parent).
	W: Several partnerships exist to promote early intervention services, but there are fewer partnerships to support transition services.
	O: Opportunities remain to partner directly with the community and families.
	N: YSHCN Transition Advisory council that includes parents, providers (Physicians and Therapist), state agencies, community agencies.
Competencies/Skills	S: MCH has staff that are experts in serving children and youth with special health care needs. A parent consultant is on staff.
	W: Several of the state staff are newer to their positions.
	O: There is an opportunity to increase the use of telemedicine.
	N: Rural areas lack specialty providers for both children and adults.
Cross-Cutting (Oral Health, Smoking, Health Insurance)	
Structural Resources	S: The Oral Health program is funded through state funds, Title V, CDC funds and private donations. There is a tobacco cessation program within DPH that receives non-Title V funds.
	W: There is a shortage of oral health providers throughout the districts. MCH does not have authority to address health insurance.
	O: Dental hygienists can be used in areas without dentists.
	N: More specialized dentists are needed.
Data/Information Systems	S: Several data sources are used, including PRAMS, NSCH, Basic Screening Survey, Older Adult Survey, Head Start Survey, CPS and NS-CSHCN.
	W: The Oral Health does not currently have an Oral Health Epidemiologist; however, MCH has a PRAMS Epidemiologist.
	O: Smoking data is analyzed in Epidemiology. There is an opportunity for MCH to collaborate with them further. CMS is beginning to collect data on dental visits. A cross-cutting epidemiology team has been developed within MCH.
	N: An Oral Health Epidemiologist is needed.
Relationships/ Partnerships	S: Oral Health has several partners (WIC, private providers, dental hygiene programs, GRU's dental school, Oral Health Coalition, Board of Public Health and CDC).
	W: The Oral Health team can partner with the community more.

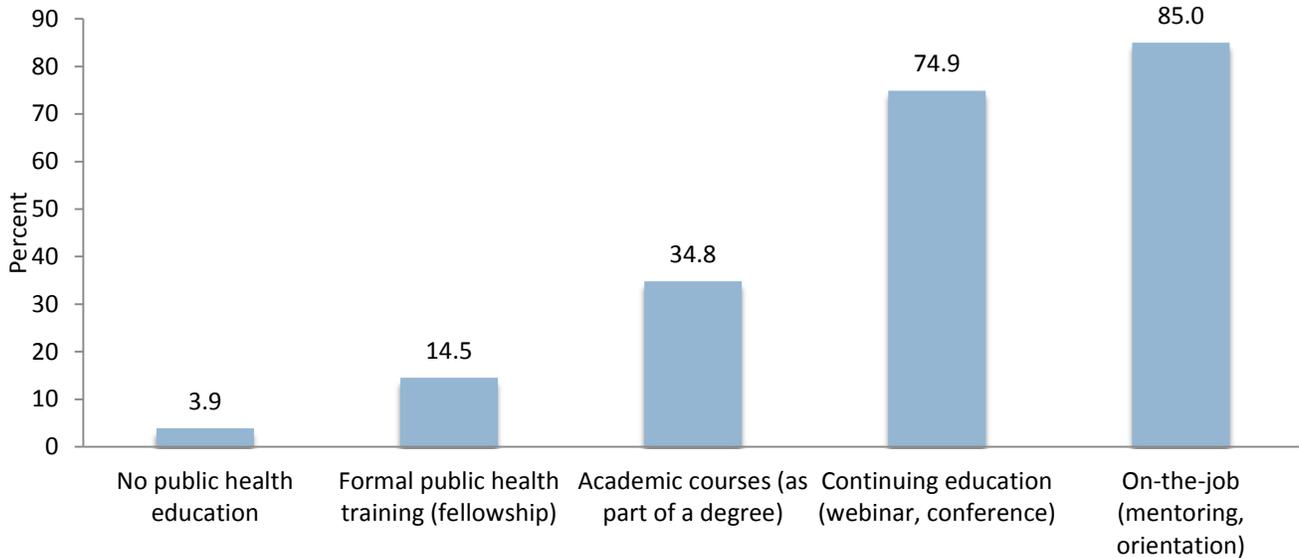
	<p>O: There are opportunities for further collaboration between Oral Health and Tobacco Cessation.</p> <p>N: Relationships are needed to develop a resource database for dental providers serving CYSHCN.</p>
Competencies/Skills	<p>S: The Oral Health program staff has dental and public health experience.</p>
	<p>W: There are few mid-level dental providers.</p>
	<p>O: With the oral health and smoking as new Title V NPMs, there will be training opportunities from AMCHP and MCHB.</p>
	<p>N: Oral Health personnel to train District oral health staff on special consideration and treatment needs for special needs patients</p>

Workforce Development

MCH is in the middle of a transformation. The purpose of the transformation was to create an organization structure for MCH that facilitated coordination across programs. Several new staff have been hired through the transformation. As a result, the workforce in MCH is very new to the organization and would benefit from workforce development.

A survey was distributed to DPH employees of maternal and child health programs at the state, district and local level to determine their perceptions of workforce development needs. The majority of respondents indicated that they received their education in public health through on-the-job training. Very few indicated having no public health training or formal public health training.

Source of public health education



The participants were also asked about the tenure of their employment with DPH and previous experience in public health. Over 20% indicated that they had worked in their current position for 1-5 and 6-10 years, at the department for 1-5 years and more than 20 years and in public health for 1-5 years and more than 20 years.

Table 22. Tenure of DPH workforce

	Less than one year	1-5 years	6-10 years	11-15 years	16-20 years	More than 20 years
Worked in your current job title?	16.5%	34.5%	22.8%	9.7%	5.3%	11.2%
Worked with DPH?	9.0%	27.9%	15.4%	13.9%	11.9%	21.9%
Worked in public health?	7.1%	23.7%	17.2%	14.1%	13.1%	24.7%

Respondents were also asked what topics they were trained on when they started working at DPH. Participants were able to select multiple responses. The top three responses were public health issues, maternal and child health topics and cultural competency. The responses selected least often were fundraising/grant writing, epidemiology, budget development and program management. The results indicate that more training should be offered in these competencies.

Table 23. Type of training received when employees began their jobs

Type of training received at the beginning of employment	Percent
I received no training when I began my job	23.2%
Public Health Issues	39.6%
Maternal and Child Health Topics	35.7%
Health Education Methods	22.2%
Cultural competency	30.9%
Leadership Training	24.2%
Management skills	23.7%
Fundraising/Grant Writing	5.3%
Epidemiology/Data Analysis	4.8%
Budget Development	10.6%
Program Management	18.4%

Employees indicated that their agency most often provided their training (76.3%), while 35.3% indicated their agency pays for them to receive training and 17.9% indicated that an outside agency provides their training.

Overall, the majority of respondents agreed that they were able to perform the Public Health core competencies. On average, 60.3% of respondents Agreed or Strongly Agreed that they were able to perform the competencies listed compared to 11.4% of responses that Disagreed or Strongly Disagreed.

< 50% of participants AGREED with feeling competent in relation to the following skills:

- Identify internal and external facilitators and barriers that may affect the delivery of the 10 Essential Public Health Services (e.g., using root cause analysis)
- Contribute to the public health evidence base
- Describe public health funding mechanisms (eg. grants, tobacco taxes, third-party reimbursement)
- Describe the importance of community-based participatory research

> 20% of participants DISAGREED with competency in relation to the following skills:

- Describe public health funding mechanisms (eg. grants, tobacco taxes, third-party reimbursement)
- Contribute to development of program budgets

INTERFACE BETWEEN NEEDS ASSESSMENT DATA, PRIORITY NEEDS AND NATIONAL PERFORMANCE MEASURES

OVERVIEW

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. Staff individually indicated their top needs based on the data reports and then a consensus was developed across all members. They were asked to primarily consider whether the data indicated an area of need, whether MCH had the capacity and authority to address the need and if the need was measurable. 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 attended 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 24. Linkage Between Priority Needs and National Performance Measures

Population Domain	Priority Need	National Performance Measure(s)
Maternal/Women's Health	Prevent maternal mortality	Well-woman visit
	Improve 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.

PROCESS

Overview

Stakeholders were engaged through two meetings that lasted one day and a half per meeting. One meeting was held in Atlanta, Georgia. Another meeting was held in Valdosta, Georgia. The participants were presented with information on the history of Title V, then presented with some key findings from the needs assessment. Each table had full reports of their respective domain. Each participant had summary documents that included data for each potential priority need to be rated. In their folders, participants received a definition sheet to facilitate ranking. Each table was assigned domains based on their expertise.

Priority Need Mapping

First, tables created a priority need map. The purpose of the map was to help groups come to a consensus on their top priority need. They were asked to come up with areas where Georgia has done well, in addition to areas where there is a need for Georgia to improve. On the needs, the stakeholders were asked to only talk about the list which DPH had already provided. The groups reported out on their entire priority need map to give context to the entire group their rationale and inform the thinking of others. Participants were told that while results from the priority need mapping would be given weight, primary weight would be given to the ranking that followed. After each group identified their top need, all participants were able to identify potential activities to address the priority needs, to assist in the planning of the state action plan

chart. The results of the priority need map from Valdosta (VAL) and Atlanta (ATL) by domain are listed below.

Table 25. Priority Need Map Results: Maternal/Women’s Health

Maternal/Women’s Health	
Top 1	Rationale
Increase the number of women receiving well-women visits	<p>ATL Table 1: The group agreed that addressing well-women visits encompasses addressing planned pregnancies which can decrease maternal mortality and help the woman understand the importance of regular medical care.</p> <p>VAL Table 1: The group discussed that increasing the number of women receiving well-women visits will impact her overall health and well-being. It also will increase the number of planned pregnancies, prenatal care/postpartum care and decrease the maternal mortality ratio.</p>
Increase proportion of women receiving care in the first trimester	<p>ATL Table 3: The group agreed that increasing the proportion of women receiving first trimester care can have an increase in the efforts to increase postpartum long-acting reversible contraception (LARC) placement and a decrease in C-sections.</p>
Increase the number of pregnancies that are planned	<p>ATL Table 2: The group identified increasing the number of planned pregnancies was the top priority because of its effects on birth outcomes.</p> <p>VAL Table 2: The group suggested that increasing the number of intended pregnancies would increase proportion of women receiving first trimester care and also increase postpartum LARCs placement and decrease C-section.</p>

INCREASE THE NUMBER OF WOMEN RECEIVING A WELL-WOMEN VISIT

- Increase preventive visits
- Increase well-women visits and provide education regarding family planning
- Link women who test negative for pregnancy and indicate lack of desire to pregnant to family planning services
- Maintain the waiver for women to get family planning visits under Medicaid
- Educate women about why they need well/healthy women checks
- Advocate for Medicaid expansion
- Increase education surrounding preventive measures related to healthy outcomes and disease prevention
- Educate patients on preconception health
- Match birth control method to the time they want to be pregnant
- Use a voluntary mandated plan of care to evoke well visits
- Offer well-women visits in every health district on a sliding scale

- Slide teens to zero for well-women visits
- Accept all private insurances, Medicaid and self-pay on sliding scale fee, and advertise this to the public
- Increase education on the importance of well-women visits
- Outreach/marketing on well-women visits

INCREASE THE PROPORTION OF WOMEN RECEIVING CARE IN THE FIRST TRIMESTER

- Provide education on benefits
- Increase CenteringPregnancy sites
- Offer weekend/evening hours for care
- Provide case management for pregnant women
- Expand forms of group prenatal care
- Increase access to OBs in areas of the state with shortages
- Subsidize transportation in rural areas
- Educate women earlier

INCREASE THE PERCENTAGE OF PREGNANCIES THAT ARE PLANNED

- Provide access to various methods of birth control at low or not cost
- Improve access to contraceptives for teens
- Early education to adolescents on reproductive life plan and goals
- Apply for another family planning grant
- Increase education and importance of contraceptive use with emphasis on use of LARCs
- Educate youth in the school system earlier
- Provide family planning education
- Educate and encourage women to get to get well-women exams
- Restore family planning funding
- Ensure private insurance coverage for well-women services

Table 26: Priority Need Map Results: Perinatal Health

Perinatal Health	
Top 1	Rationale
<p>Reduce the number of infants born with a low or very low birth weight (LBW and VLBW)</p>	<p>ATL Table 1: The group agreed that reducing the number of infants born with a low or very low birth weight would reduce the number of preterm births. The group also noted that substance abuse should be addressed to prevent LBW and VLBW deliveries.</p> <p>ATL Table 3: The group agreed that reducing the number of infants born with a low or very low birth weight can reduce the number of preterm births.</p> <p>VAL Table 2: The group discussed that reducing the number of LBW and VLBW infants born requires reducing substance abuse</p>

	during pregnancy and preterm births, both of which are needs in Georgia.
Increase the number of infants who are breastfed/Reduce substance use during pregnancy	VAL Table 1: The group decided that breastfeeding and substance abuse during pregnancy should both be addressed as a mechanism to prevent infant mortality. Substance abuse during pregnancy can lead to poor birth outcomes, such as preterm births and low birth weight. Breastfeeding improves the health of infants who are born preterm or at a low birth weight. Therefore, both needs should be priorities.
Reduce the number of infants born preterm	ATL Table 2: The group identified decreasing low birth weight and very low birth weight deliveries and decreasing preterm births as the top two needs. The top 1 issue was unanimously voted as decrease preterm births because of the level of seriousness and importance.

REDUCE THE NUMBER OF INFANTS BORN WITH A LOW OR VERY LOW BIRTH WEIGHT (LBW AND VLBW)

- Provide prenatal and interconception health education
- Increase other health provider engagement on perinatal health
- Increase support for nurse family partnership
- Make it a priority to determine why Black infants die twice as often as White infants
- Match Medicaid payment to hospital facility designation not to care provided
- Reaching out to prevent adolescent pregnancies at a young age
- Increase early prenatal care to identify risk factors for preterm birth and low birth weight
- Support breastfeeding and birth spacing initiatives
- Increase availability of LARCs immediately after delivery
- Increase community education about the importance of delivering at a Level III facility
- Offer (or ensure payment for) highly effective contraception
- Do more maternal, not neonatal transfer
- Increase treatment options for pregnant women who use substances
- Increase access to OB care and Maternal-Fetal Medicine (MFM) through improving Medicaid payment
- Strengthen the regional perinatal system
- Educate patients/providers on optimal interpregnancy intervals
- Do not criminalize pregnant substance abusers, but offer rehab
- How can we address the racial disparity? Are they receiving quality care?
- Are medical providers culturally sensitive to the needs of minority populations? Address cultural competency to affect disparities

INCREASE THE NUMBER OF INFANTS WHO ARE BREASTFED

- Offer statewide breastfeeding curriculum via telehealth
- Create a pump loaner program
- Implement a breastfeeding campaign targeted to specific demographics

- Provide more education and support for breastfeeding moms
- Develop education program for expectant moms on the importance of breastfeeding
- Support and education for other families members to encourage breastfeeding moms
- Train staff on the importance of breastfeeding and how to educate parents
- Begin education and support for breastfeeding during prenatal visits
- Teach the importance of breastfeeding during middle school
- Increase WIC breastfeeding/peer visits
- Enhance/fund breastfeeding support for non-WIC eligible women
- Develop breastfeeding videos

REDUCE SUBSTANCE USE DURING PREGNANCY

- Provide education
- Set up treatment centers
- Educate the community/parents on the developmental problems that children will have coming from parents that were substance abusers by showing pictures
- Support groups
- Intervention centers
- Provide education during family planning on pregnancy outcomes
- Social group activities (mentors, teen meetings, sororities, fraternities)
- Radio/TV campaigns to educate statewide about the effects of maternal substance abuse
- Take the "cool" our of using drugs during pregnancy and focus on the risks
- Train "health outreach workers" (e.g. Area Health Education Centers (AHEC) healthcare promoters model) to reach parents without access to transportation

REDUCE THE NUMBER OF INFANTS BORN PRETERM

- Provide education on the benefits of early prenatal care
- Promote the preconception toolkit
- Teach courses in high school on (1) parenting (talking to the child) (2) family life (3) good health
- Teach teens about good preventive and sexual health
- Increase support for nurse family partnership
- Expand labor laws to be more maternal friendly and minimize pressure to deliver earlier
- Incentivize OB clinicians to stay in high need areas
- Promote CenteringPregnancy
- Increase community resources for underinsured and uninsured pregnant women
- Educate physicians about preterm delivery risks
- Decrease unplanned pregnancies
- Encourage birth spacing
- Provide mental health services for pregnant women to decrease depression
- Afford women access to LARCs at little or no cost
- Mental health services for pregnant women to decrease depression
- Educate and market OB/GYN practices servicing Medicaid patients
- Engage male counterparts; teach about the signs and symptoms or preterm labor
- Decrease unplanned pregnancies
- Employ dental hygienists in OB offices for proper screening and patient education (Registered dental hygienists are more cost effective than dentists and great educators)
- Preconception care

- Preterm labor assessment tools
- Simplify systems to increase access to care in first trimester (Medicaid and CMOs)
- Increase OB/GYN care in Georgia
- Use telemedicine for prenatal care and high risk care
- Increase use of midwives for low risk pregnancies
- Educate OB/GYNs regarding risks of planned preterm birth
- Increase provider engagement on perinatal health
- Insure all women all the time, not just during pregnancy
- Expand Medicaid
- Extend insurance coverage to undocumented women
- Offer weekend/evening hours for care
- Meet people where they are by engaging schools and workplaces in health initiatives
- Think outside the box (include men in Maternal and Child Health)
- Collaborate across sections

Table 26: Priority Need Map Results: Child Health

Child Health	
Top 1	Rationale
Decrease adverse childhood experiences	<p>ATL Table 7: The group decided that decreasing adverse childhood experiences will have an impact on health disparities and economic conditions.</p> <p>ATL Table 9: The group agreed that decreasing adverse childhood experiences would prevent the impact of emotional abuse that can lead to child abuse/neglect, violent crimes and incarcerations. Addressing adverse childhood experiences early could reduce the need for mental health resources.</p>
Increase physical activity among children	<p>ATL Table 10: The group selected to focus on increasing physical activity physical activity in order to help improve socialization skills, health care and outcomes. Teaching children the importance of physical activity will instill healthy habits early in life.</p> <p>VAL Table 3: The group selected increasing physical activity in order to impact obesity as well as promote the general health of children.</p> <p>VAL Table 4: The group suggested that increasing physical activity among children was an overall priority for children because it will prevent adverse childhood experiences and obesity.</p>

VAL Table 5: The group chose physical activity in order to promote overall healthy lifestyles.

DECREASE ADVERSE CHILDHOOD EXPERIENCES (ACE)

- Increase advertising of the "Maternal and Child Helpline" to provide resources and referrals for parents and children in their local communities
- Obtain help from private foundations
- Include child developmental specialists in pediatrician offices
- Conduct more research on ACEs
- Promote evidence-based programs that do child abuse and neglect prevention
- Increase support for home visiting work
- Incorporate developmental screening of all children public health touches (CHD, WIC, HVD) to be more comprehensive and vet our own services to provide what we can and refer appropriately
- Screening children for developmental delays and ACEs, especially those who are low SES and served by public health
- Develop a process for identifying toxic stress and linking families to resources
- Employ the protective factors for families
- Increase collaboration and coordination between state agencies that work with child abuse and neglect prevention
- Focus more on prevention
- Use Parent Café's

INCREASE PHYSICAL ACTIVITY AMONG CHILDREN

- Add more time for physical activity during the school day
- Do public health 5k with prizes and involve schools and parents
- Increase recess and physical education opportunities in school
- Increase access to sports teams (boys and girls club, school recess department, etc.)
- Encourage schools to implement or re-implement physical activity programs
- Incorporate use of the MyPlate within the home/school to make plates colorful with vegetables
- Give feet necklaces in K-5 (1 foot charm given for each 1/4 mile around the playground)
- Offer many more organized physical activities and team sports in schools open to all students, to encourage team play, increase physical activity and improve health
- Join a gym or take advantage of local middle or high school track or parks
- Collaborate with other leadership within the community to grow community gardens
- Transplant poorer kids to South Georgia Medical Center and back for bike safety day - they can win bikes
- Increase green spaces, bike trails, walking trails, places to play, soccer, football, etc.
- Spend at least 30 minutes or more per day doing outside activity with your children
- Require 30 minutes exercise outside activity twice a day at school
- Increase physical activity after school family health day 1 time per week (1 mile walk, stretching, aerobics, etc.)
- Incorporate movement and physical activity at school

- Include hybrid homework assignments technology and active assignments
- Include outside learning and active assignments
- Include outside learning labs at school
- Teach parents how to actively play with children
- Partner with the police department, neighborhood watch and the parents in the neighborhood to create safe environments

Table 27: Priority Need Map Results: Adolescent Health

Adolescent Health	
Top 1	Rationale
Increase the percentage of adolescents receiving a well-visit	ATL Table 4: The group chose to promote well-visit out of the concern that sport physical visits are replacing traditional well-visits. Additionally, well-visits can provide education on unplanned pregnancy prevention, unintentional injuries, depression, suicide and any other problems that adolescents may face.
Increase physical activity among adolescents	ATL Table 5: The group chose to focus on increasing physical activity because of the feasibility to address this need. The group felt that peer leaders can be utilized to influence and increase physical activity among adolescents.
Reduce the percentage of adolescents who are bullied or who bully others/Reduce unplanned teen pregnancies	<p>VAL Table 7: The group selected bullying because of health disparities and the seriousness of suicide. The group felt that bullying targets those who are new to school, look different and speak a different language. The anonymity and pervasiveness of social media has possibly facilitated the problem as well. The group felt bullying can lead to suicide, which needs to be prevented.</p> <p>VAL Table 8: The group discussed that bullying is a new trend that have long term impacts requires to be addressed to avoid adverse mental and physical health outcomes.</p> <p>Both groups emphasized the importance of preventing unplanned pregnancies among adolescents.</p>

INCREASE THE PERCENTAGE OF ADOLESCENTS RECEIVING A WELL-VISIT

- Educate on the difference between a physical and comprehensive exam
- Standardize education for all primary care providers related to family planning and counseling
- Meet students where they are by increasing school-based health centers
- Require education on HPV and oral cancer to prevent cervical cancer
- Promote well-visits at the health department via other public health programs
- Include regular dental hygienists in wellness check in order to check for decay and periodontal disease, not just abscess

- Require well-visits for the Medicaid population
- Encourage school tracking with enrollment (e.g. Forsyth)
- Provide more comprehensive services for males
- Ensure discussion about LGBTQ issues
- Support electronic medical records and avoid explanation of benefits for adolescents receiving confidential services
- Require well-visits for those entering Kindergarten, middle school and high school
- Provide comprehensive sexual education
- Increase access to mental health services for adolescents
- Increase access to birth control
- Increase mental health screenings
- Have a child development specialist in the well visit
- Incorporate measures to solve injuries (motor vehicle crashes, risky behavior drowning, suicide, homicide and bullying) into well-visits, as they may be related
- Encourage initial reproductive health visit for those 13 to 15 years old
- Educate providers, parents and teens about comprehensive topics to be covered (e.g. vaccines, contraceptives, mood stress and physical activity)
- Provide culturally sensitive counseling on contraception
- Increase education on how to make practices teen-friendly
- Increase middle providers in adolescent medicine
- Partner with school system for adolescent screens
- Increase access to teen clinics
- Educate parents on the importance of adolescents receiving well check or preventive visits

INCREASE PHYSICAL ACTIVITY AMONG ADOLESCENTS

- Focus on creating safe neighborhoods to increase physical activity
- Engage low-income youths in sporting events that they are not likely to pursue (golf, lacrosse, tennis) in order to increase their eligibility for sports scholarships
- Limit use of electronics, including phone
- Implement exercise programs in schools
- Increase opportunities for low income students to play sports in school
- Create more bike trails for healthy communities
- Mandate recess in school
- Incentivize programs in schools
- Make recreational sports more affordable and available in low income communities
- Put mandatory PE back in schools (60 minutes per day) to reduce suicide rates, reduce teen pregnancies and improve both mental and physical health
- Increase safe public spaces to play and be physically active
- Mandate physical education in grades K-12
- Re-introduce physical education classes in the school system
- Develop more hiking/biking trails around high schools and colleges
- Implement sidewalks in neighborhoods
- Develop after-school sports programs for all age groups
- Offer free community centers open to all people

REDUCE THE PERCENTAGE OF ADOLESCENTS WHO ARE BULLIED OR WHO BULLY OTHERS

- Educate on social media safety and password safety
- Educate on the effects of instantaneous messaging and effects on others
- Educate through videos and setting examples
- Provide educational bullying sessions with examples of the effects
- Develop more anti-bullying campaigns at local schools
- Create a website where teens or children that are experiencing bullying can feel like their voice is being heard, while also getting help keep it confidential
- Monitor social media and provide consequences for cyber bullying
- Make parents aware of cyber-bullying
- Provide more peer to peer education within school districts
- Increase access to teen centers
- Implement safe talk houses or hot lines
- Teach the importance of respect
- Need people on the ground, such as public health educators to do teen outreach
- Develop more programs to focus on improving self-esteem
- Provide stricter punishment laws for malicious bullying
- Consider working with/partnering with Department of Education and local school systems to provide counseling services in the schools themselves
- Formalize partnership between DPH Injury Prevention and Department of Education for promotion/campaign
- Campaign on social media etiquette
- Teach kindness

REDUCE UNPLANNED TEEN PREGNANCIES

- Counsel the whole family on preventive measures
- Open teen centers
- Educate teens on the importance of being abstinent (demonstrate with different diseases that can be caught by not using protective sex)
- Increase access to LARCs
- Provide more sex education classes for teens in middle and high school
- Implement peer program for prevention
- Implement overall curriculum on positive choices
- Provide more education to teen boys on pregnancy and STDs
- Increase access to family planning services for all ages, especially adolescents
- Create options for pregnancy education at the school level
- Educate high-risk teens
- Improve self-esteem through counseling and community involvement
- Create scenarios to mimic real-life situation at crucial age
- Reopen more teen centers
- Provide education, teen centers and incorporate women's health/family planning education earlier
- Provide birth control measures at no cost
- Develop teen curriculum to teach abstinence and pregnancy prevention in schools
- Increase funding for teen health centers throughout the state
- Conduct workshops in the schools as special events
- Teach parents intervention skills

- Open more teen family planning clinics
- Restore Title X

Table 28: Priority Need Map Results: Children and Youth with Special Health Care Needs

Children and Youth with Special Health Care Needs	
Top 1	Rationale
Increase care coordination services	<p>ATL Table 6: The group selected to improve care coordination services because it impacts early intervention and transition to adulthood.</p> <p>ATL Table 8: The group chose to increase care coordination because it is more feasible for public health to impact how the community talks to their doctor, rather than how doctor’s talk to one another.</p> <p>ATL Table 9: The group chose to focus on improving care coordination because it also facilitates access to a medical home and provides adequate specialty care and transition services.</p> <p>ATL Table 10: The group selected to improve care coordination services in order to connect families with a medical home model of care.</p>
Increase access to specialty care	<p>ATL Table 7: The group selected to increase access to specialty care because it would also improve transitions to adult health care and meet all needs such as health care, education, employment, community living and insurance coverage.</p> <p>VAL Table 3: The group chose to increase access to specialty care in order to address provider shortages and transportation and language barriers.</p> <p>VAL Table 5: The group discussed that not having access to specialty care increases the hours and time spent on coordinating the services and has a negative economic impact on those in the rural areas of the state.</p> <p>VAL Table 6: The group felt that it was most important to increase access to specialty care because it impacts the overall health and development of CYSHCN.</p>

Increase the percentage of youth with special health care needs who receive services necessary to transition to adulthood

VAL Table 4: The group felt that CYSHCN over age 18 experience gaps in care due to difficulties the financial difficulties that accompany transitions to adulthood. Many providers not willing to accept Medicaid or self-pay patients.

CARE COORDINATION

- Improve payment to primary care providers and specialists to get them to take more patients and expand the network
- Provide education and updates to physicians on community resources
- Provide in-hospital discharge packet and medical home resources
- Put posters and marketing materials in hospitals
- Educate hospitals on medical homes and enable them to give resources at discharge
- Explain to people what a medical home means
- Offer training and incentives to emergency responders
- Offer nurse navigators to represent the family
- Develop a curriculum for medical colleges on the concept of a medical home
- Coordinate with hospitals with "Family-Centered Care Programs" for ideas and strategies
- Encourage comprehensive care in pediatrician offices
- Provide more community education on what a medical home is and the importance of it
- Blend funding streams better
- Implement home visiting work
- Provide continuing education (CEU/CME) for providers to encourage participation in public health agencies
- Model the "EHDI Champion" AAP program with other conditions to encourage practitioner participation
- Provide education on AAP Bright Futures Schedule
- Increase staffing
- Correct Medicaid issues that affect the medical home when services are disrupted

INCREASE ACCESS TO SPECIALTY CARE

- Provide child care for parents while they attend appointments
- Provide loan forgiveness for working under in underserved areas
- Identify providers statewide, formalize agreements at a state level and utilize telehealth access districts; loan forgiveness for providers working in underserved areas
- Increase use of telemedicine
- Recruit specialist for rural areas
- Use telehealth for specialists willing to provide services remotely
- Increase reimbursement rates for providers to be more accepting of Medicaid
- Increase the number of Medicaid transportation companies
- Improve reimbursement rates for transportation and health care providers
- Have specialists set up clinics in rural areas
- Make telemedicine and telehealth payable by third party payors
- Increase the availability of in-network specialists
- Provide more funding for telemedicine
- Provide help for the districts on how to advertise training and allow districts to accept students in training

- Provide services to transport families with special needs
- Have reliable transportation services and expand them beyond just Medicaid families
- Create a toll-free interpretation line to set up medical appointment NET (non-emergency transportation) for non-English speaking families
- Technology and equipment to support in home, health department and community services
- Motivate providers to become telehealth/telemedicine providers, i.e., tax breaks, tuition reimbursement, etc.
- Gather data at access and use to staff and provide fiscal support for districts with issues (budgeting) to reduce disparities
- Explore grant opportunities to help support districts who need additional support for access services
- Provide transportation where parent can bring other children additional adults to take special needs children to visit doctor
- Provide more telemedicine opportunities that are reimbursed for specialists
- Bring doctors/specialists dentists to area by offering loan forgiveness rural areas, incentives
- Start VICS for telemedicine
- Support potential providers with work incentives
- Partner with other entities (community partners) to access services (mental health, school system, etc.)

INCREASE THE PERCENTAGE OF YOUTH WITH SPECIAL HEALTH CARE NEEDS WHO RECEIVE SERVICES NECESSARY TO TRANSITION TO ADULTHOOD

- Create transition advocate for patients
- Increase ways to follow up with special needs children into adulthood
- Extended Medicaid to disabled adults and make it easier to continue on it
- Expand Medicaid to allow insurance for low and no income people
- Increase the number of providers that YSHCN can transition to
- Partner with community partners create transition teams
- Teach parents what their rights are at this transition planning
- Make review of all transition plans via transition committee
- Compile resource directory of all physicians the type of insurances they accept
- Create a program in each district to guide youth as they transition
- Create a step program for transition from pediatric provider to adult provider
- Based on local district's needs, implement program to assist with transition to adult care
- Provide transportation for disabled adults
- Increase age limit for Medicaid
- Develop more clinics for CSHCN to work on sliding scale, self-pay bases
- Educate parents and guardians when services begin.

Table 28: Priority Need Map Results: Cross-Cutting/Life Course

Cross-Cutting/Life Course	
Top 1	Rationale
Increase the percentage of women receiving a dental visit during pregnancy	<p>ATL Table 4: The group thought improving dental visits during pregnancy was most important because it prevents periodontal diseases and increases the likelihood that children will access care.</p> <p>ATL Table 5: The group chose to increase the percentage of women receiving a dental visit during pregnancy because it links them to education on health and nutrition during pregnancy, oral concerns with frequent snacking, infant oral health, tobacco use and cessation and a better understanding on diseases and disorders.</p>
Increase the percentage of children and youth, including those with special health care needs, receiving a preventive dental visit/Decrease the percentage of children, including those with special health care needs, exposed to second hand smoke at home	<p>ATL Table 6: The group chose to increase preventive dental visits for children because it is often overlooked and can result in serious health issues if problems are not addressed. The group also felt that reducing second-hand smoke exposure is important because it leads to serious health outcomes later in life.</p>
Decrease tobacco use among adolescents/ Increase dental visits for low income children	<p>VAL Table 7: The group felt that decreasing tobacco and nicotine use among adolescents is important because of the high prevalence. The group also felt that dental visits among low income children should be promoted.</p>

DENTAL VISIT AMONG PREGNANT WOMEN

- Increase dental referrals by OB/GYNs
- Increase available dental services for adults
- Expand safety net settings for dental hygienists
- Ensuring pregnant women on Medicaid are aware of preventive dental care opportunities for the duration of their pregnancies
- Increase perinatal providers referring to oral health providers
- Engage oral health providers in tobacco counseling
- Hire and engage dental hygienists in prenatal settings to educate mothers on infant oral health care, her oral healthcare, nutrition, smoking cessation, health risks with preterm/low birth outcomes and prevention of disease
- Bring dentists to the community rather than depending on families coming in to the office

INCREASE THE PERCENTAGE OF CHILDREN AND YOUTH, INCLUDING THOSE WITH SPECIAL HEALTH CARE NEEDS, RECEIVING A PREVENTIVE DENTAL VISIT

- Educate parents on the benefits of early ongoing dental exams
- Advocate for Medicaid expansion
- Maintain good reimbursement for dentists caring for patients on Medicaid
- Maintain good dental hygiene at home and keep scheduled appointments
- Increase mobile dental van in high risk areas throughout the districts
- Lower dental costs
- Offer more dental education classes
- Mandate dental sealants prior to school enrollment
- Implement mobile dentist clinics at local schools
- Encourage doctors to ask if a dental visit has been scheduled
- Educate parents on the need for early intervention in dental care
- Offer Medicaid reimbursement for public health dental hygienist services
- Increase mid-level dental hygiene services
- Promote brushing teeth at daycare and preschool
- Increase Medicaid adult dental benefit to include preventive care
- Research what percentage of community is actually consuming fluoridated water vs. bottled water

DECREASE THE PERCENTAGE OF CHILDREN, INCLUDING THOSE WITH SPECIAL HEALTH CARE NEEDS, EXPOSED TO SECOND HAND SMOKE AT HOME

- Enforce the new law prohibiting smoking in cars with kids
- Change child abuse laws to include smoking in cars or closed areas (room, home, etc.) if children present

DECREASE TOBACCO USE AMONG ADOLESCENTS

- Fund programs demonstrated to be effective to prevent tobacco use in adolescents
- Continue to have meetings with teens to discuss the hazards of smoking
- Create more tobacco free schools
- Make smoking illegal until age 21, like alcohol

STATE SELECTED PRIORITY NEEDS

Selection Process

Georgia has used the following definition for a priority need: a gap in the health status of the population due to trend or disparities 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 assessment, stakeholders were asked to rate needs identified in the assessment by MCH staff at the Stakeholder Meetings. Results from the meetings were treated as a recommendation and the ultimate selection of priority needs was determined by MCH leadership to ensure the selected needs were best addressed by 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 corroborate

findings. 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. When appropriate, the NPM became priority needs.

Needs Strongly Considered

Table 29 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. Ratings for each criteria were averaged, multiplied by their weight, and added together to determine the final rating score for each priority need.

Table 29. 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	Addressed by improving systems of care for CYSHCN
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	Not selected: Preventing infant and maternal mortality were seen as higher priorities. This need could possibly be addressed through increasing access to family planning services and increasing well-woman visits
8	Increase the percentage of VLBW infants born in a Level III facility	59.0	Selected as an NPM

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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

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	Will be addressed by an SPM
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	49.0	Not selected due to higher community support for other needs

	during an emergency		
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

Rationale for State Selected Priority Needs

1. 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 the state with the highest maternal mortality ratio in the nation (cite). 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.

2. Improve 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.

3. 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 increased from 6.3 in 2010 to 7.2 in 2013. Strong racial disparities are present and should be addressed to achieve health equity. Although preventing infant mortality was not independently ranked 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 through the public input period.

4. Promote developmental screenings among children

Despite the percentage of children receiving developmental screens being higher among Georgia's children than nationwide, 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 at the stakeholder meetings, however through surveys and public input, a high level of community support was shown to support this need.

5. Promote physical activity among children

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

6. 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. Strong support for reducing bullying, an associated NPM, was also displayed at the Stakeholder Meetings.

7. 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 and medical home, lack access to specialty providers and do not feel prepared to transition to adulthood.

8. Improve oral health among all populations

Both quantitative and qualitative data examined support the selection for improving health as a priority need. Racial differences 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.

Priority 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 30 presents a comparison of these similarities and differences between priority needs for 2011-2015 and 2016-2020.

Table 30. Priority Need Comparison, 2011-2015 and 2016-2020

2016-2020	2011-2015
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
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 206-2020. 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) has a common theme with increasing physical activity (2016-2020) as an avenue for decreasing obesity. An increase in developmental screening has remained a priority for the state. Although there have been some improvements, there are considerable gaps across different populations in the state and efforts from 2016-2020 will target all children, not just those in need. Preventing maternal mortality, preventing suicide among adolescents and promoting oral health among all populations are priority needs for 2016-2020 that are not related to a similar need identified for the 2011-2015 reporting cycle.

LINKAGE OF STATE SELECTED PRIORITIES WITH NATIONAL PERFORMANCE MEASURES

Eight national performance measures were selected to address priority needs based on their relevance to factors related to the priority needs, as well as considering the national outcome measures they impact. The selected NPMs and their corresponding priority are displayed in Table 31. Improving access to family planning services does not have an associated NPM, but will be addressed by a State Performance Measure.

Table 31. 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	Improve 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

Annual Objective Setting Methodology

Annual performance objectives were set for each NPM to set achievable targets from 2016 to 2020. These performance objectives will be used each year to assess the progress that has been made toward improving the national performance measures. To develop the annual performance objectives, the available data points for each measure were first examined and compared to any available national data points and Healthy People 2020 objectives. For NPMs where more than two data points were present, the data were projected into the future to estimate the current percentage for both Georgia and the US. Depending on the direction of the trend, 5% and 10% improvements from the projected value in 2015 were also calculated. When this method was not appropriate, alternative methods were used. Larger improvements

were sometimes considered based on the level of intended impact from programmatic efforts. For measures where there were too few data points to assess a reliable trend, 1% annual improvements were considered. Each of the lines were graphed to show what the indicator would be in 2020 for several different levels of improvement. The 2020 indicator was then compared to the projected national average and Healthy People 2020 objective. For each NPM, the most achievable trajectory was chosen based on current trend and the expected impact of programmatic activities in the state. Below is the rationale for the selection of each NPM and the annual objectives that were chosen.

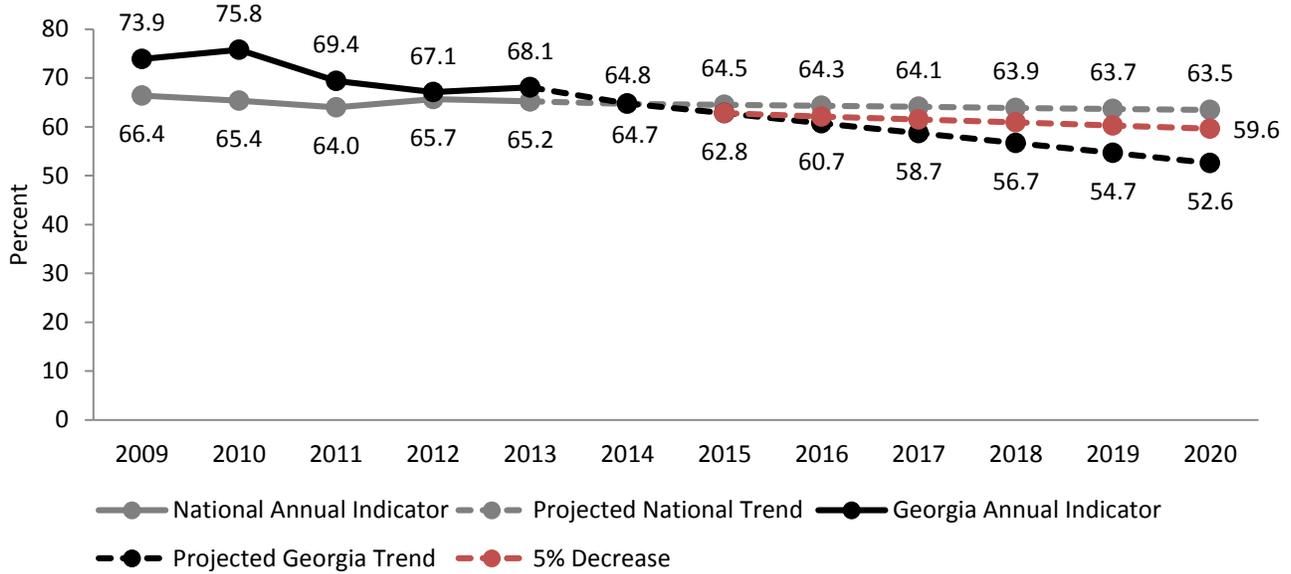
NPM 1: Well-woman visit (Percent of women with a past year preventive medical visit)

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 overweight or obese entering pregnancy. It is essential that Georgia ensure 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, differences 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- and interconception 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 measure to address in Georgia and it should be noted that by promoting well-woman visits these outcomes will be impacted as well.

Data for this measure are available from 2009 to 2013 for both Georgia and the US. Using the available data, the indicator was projected to 2015. A 5% decrease from 2015 to 2020 was used to set the annual performance objective for NPM 01. A 5% decrease from 2016 to 2020 was selected for the annual objective, which is a less severe decrease than what we would expect based on the current trend.

NPM 01: Percent of women with a past year preventive medical visit, Georgia
Annual Performance Objectives, 2016-2020



Source: BRFSS

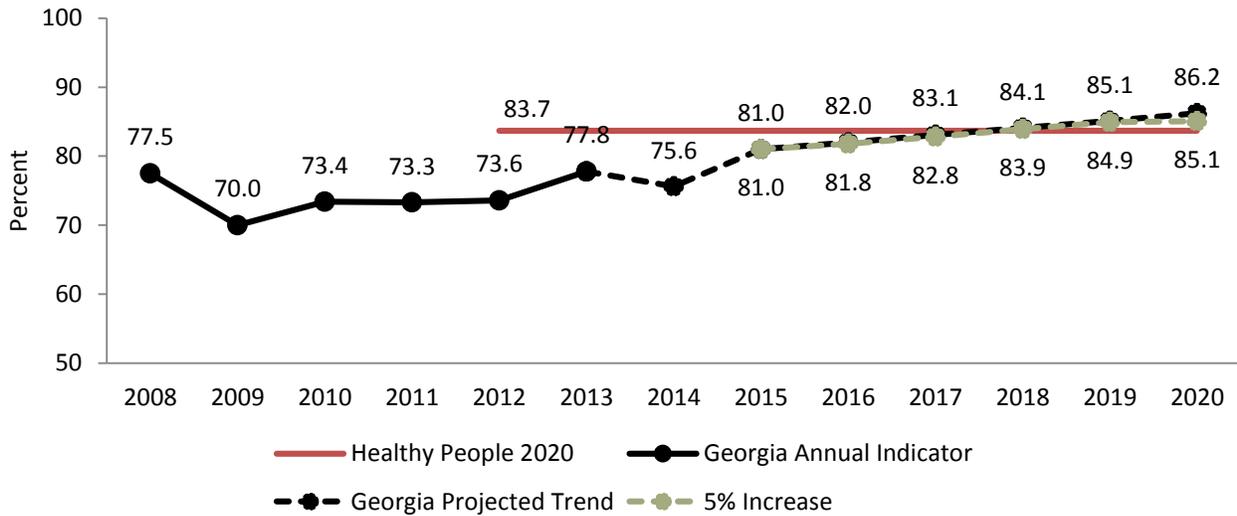
NPM 3: Perinatal regionalization (Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU))

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 ensure that mothers and infants are born in a facility that provides the most appropriate level of care for their level of risk. Racial and regional differences indicate that there is room to improve the system.

Data for this measure are available from 2008 to 2013 in Georgia, however no national estimates are available. The HP 2020 objective is 83.7%. Georgia’s data were projected to 2015 to determine a baseline. A 5% increase from the projected prevalence in 2015 to 2020 was used to determine the annual performance objectives for NPM 03, which is very similar to the projected trend and higher than the Healthy People 2020 objective. Using the current projected trend or a larger increase were not chosen due to the limitation of programmatic activities to regulate neonatal levels of care.

NPM 03: Percent of VLBW infants born in a level III facility, Georgia Annual Performance Objectives, 2016-2020



Source: Vital Records

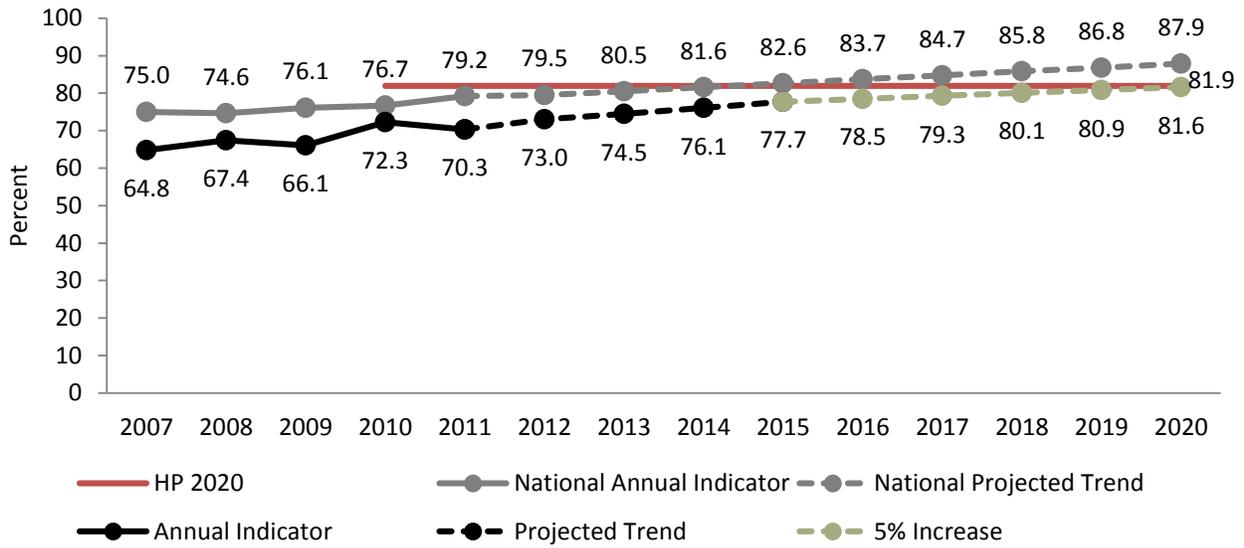
NPM 4: Breastfeeding (A. Percent of infants who are ever breastfed and B. Percent of infants breastfed exclusively through 6 months)

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.

Data for breastfeeding initiation are available from 2007 to 2011 for Georgia and the US. In order to determine current estimates, the data were projected to 2015. A 5% increase from 2016-2020 was selected for the annual performance objectives, which would allow Georgia to come within very close range of achieving the HP 2020 objective.

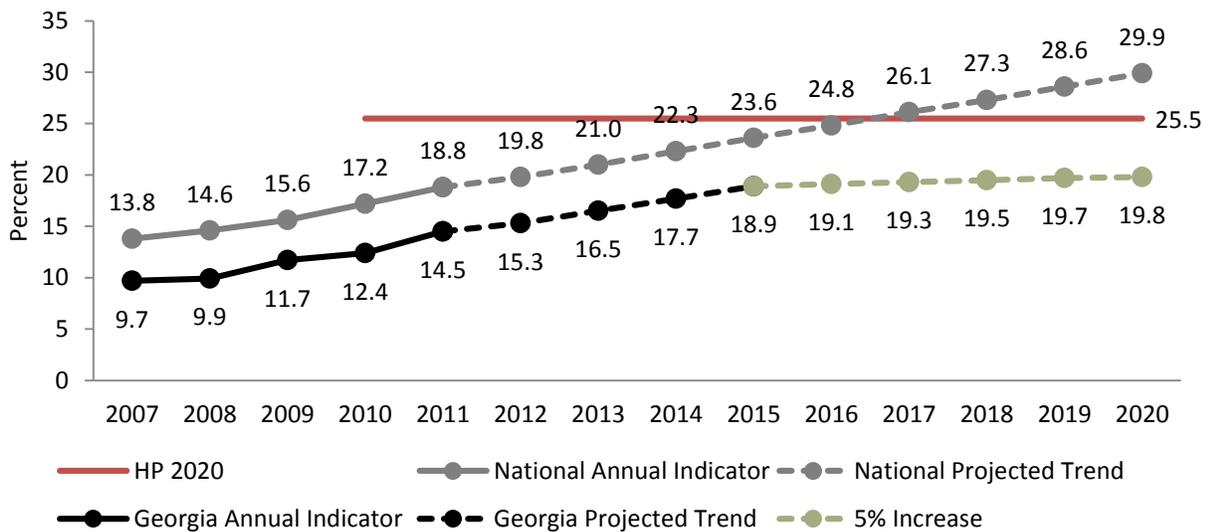
NPM 04: Percent of infants who are ever breastfed, Georgia Annual Performance Objectives, 2016-2020



Source: NIS

Breastfeeding exclusivity estimates for Georgia and the US are also available from 2007 through 2011 and were projected into 2015. A 5% increase from 2015-2020 was chosen for the annual performance objectives. Although conservative, a 5% increase is realistic considering low initiation rates in the state.

NPM 04B: Percent of infants who are breastfed exclusively through six months, Georgia Annual Performance Objectives, 2016-2020



Source: NIS

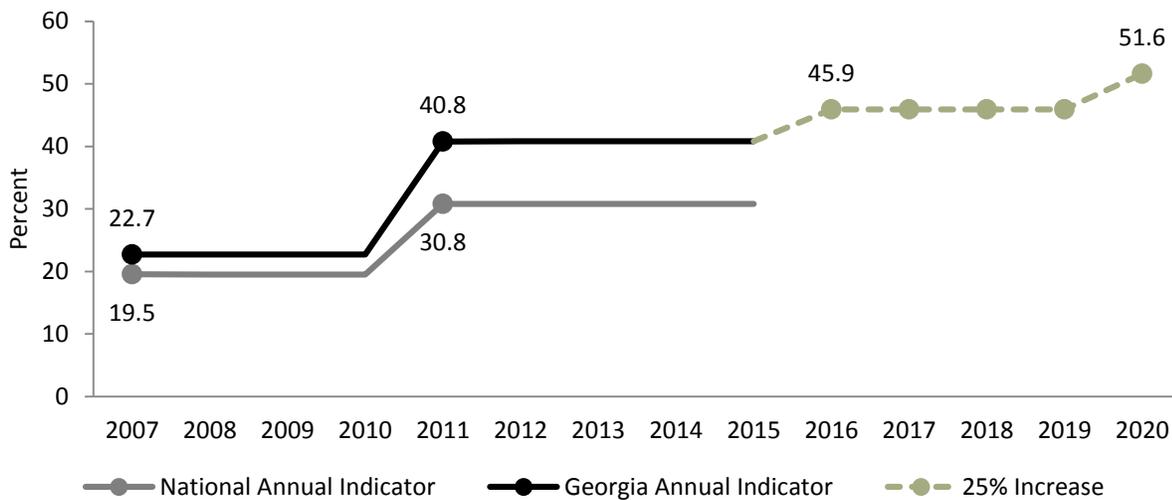
NPM 6: Developmental screening (Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool)

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 promote developmental screenings 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.

Only two data points are available for this measure, therefore a reliable projection was not able to be calculated. A 25% increase was applied to the most recent data point to set annual performance objectives. Although this increase is higher than what was used for other performance measures, it is realistic given the large increase seen from 2007 to 2011/12 both nationally and in Georgia. There have also been programmatic efforts that would have likely led to an increase since 2011/12.

NPM 06: Percent of children who received a developmental screen, Georgia Annual Performance Objectives, 2016-2020



Source: NSCH

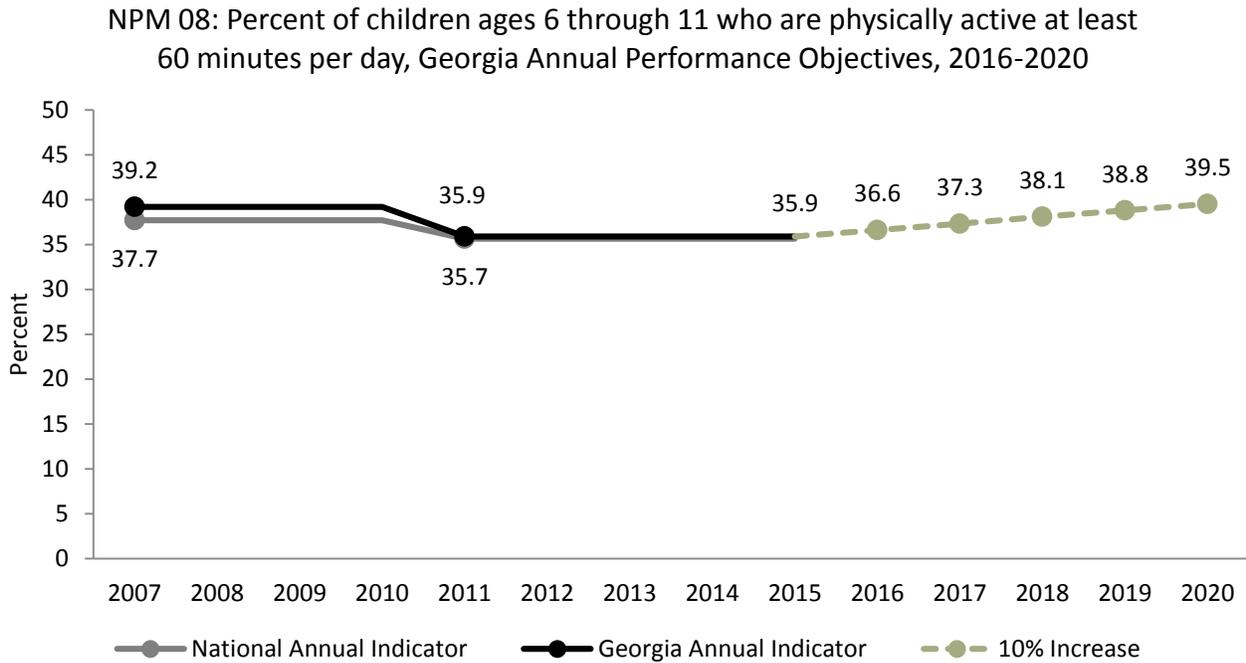
NPM 8: Physical activity (Percent of children ages 6 through 11 who are physically active at least 60 minutes per day)

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. Differences are seen 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.

Because there are only two data points for this measure available in 2007 and 2011/12, a reliable trend could not be assessed. A 10% increase from the most current data point was chosen to develop annual performance objectives, which is realistic given the reach of programmatic activities in the state.



Source: NSCH

NPM 9: Bullying (Percent of adolescents, 12 through 17, who are bullied or who bully others)

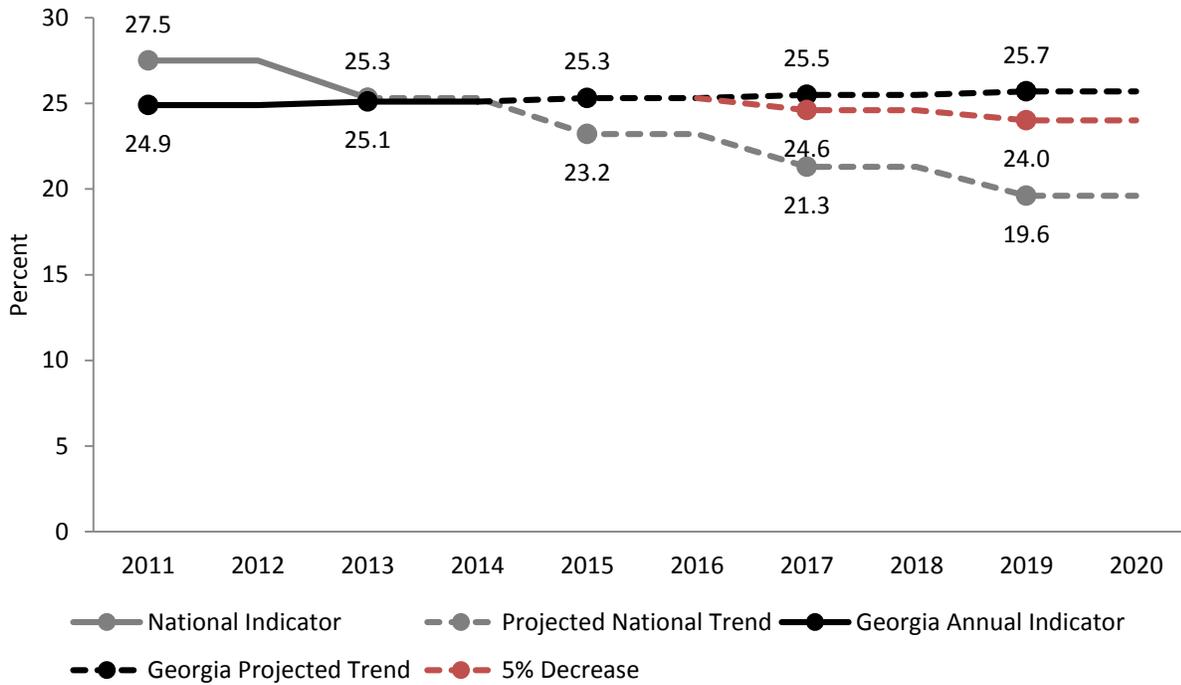
Priority Need: Prevent suicide among adolescents

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 suicidal 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, it also promotes overall health by preventing feelings of depression and associated behavior, including violence. Electronic bullying is an area that should be examined in 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.

Only 2011 and 2013 data for Georgia and the US are available for this measure. The data were projected to 2015. A 5% decrease from 2016-2020 was selected to set annual performance objectives. Because the YRBS

occurs every other year, the objectives were only set to decreasing during years where data will be collected.

NPM 09: Percent of adolescents, ages 12 through 17, who are bullied or who bully others, Georgia Annual Performance Objectives, 2016-2020



Source: YRBS

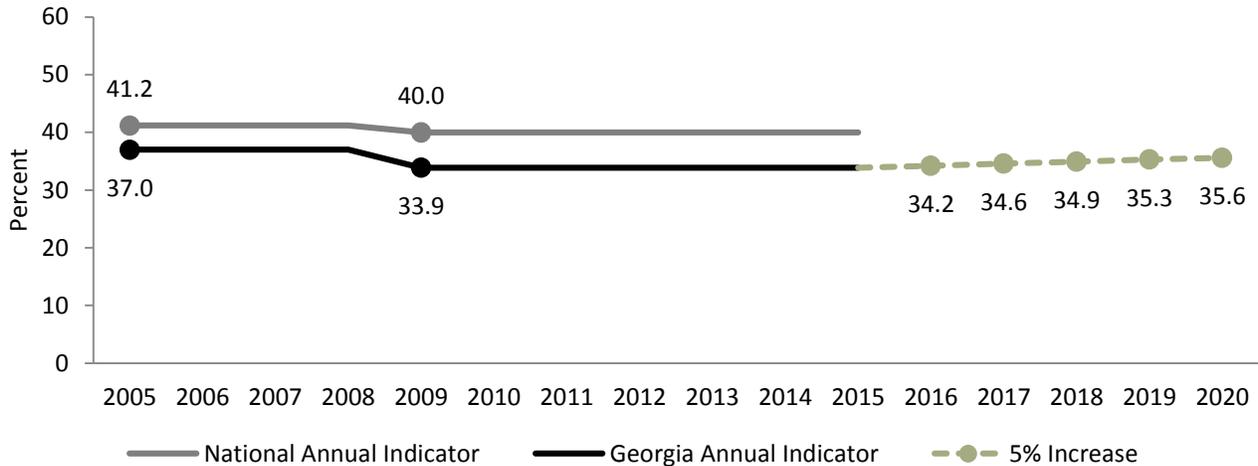
NPM 12: Transition (Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care)

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 their source of pediatric care to an adult medical home. It is essential that families receive services to assist as families 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 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.

Because there were only two data points and a true trend could not be assessed, a 5% increase from 2015-2020 was applied to the most recent data point to set annual performance objectives. Although there is a potential downward trend in Georgia and the US, the indicator is anticipated to increase as a result of programmatic efforts in the state.

NPM 12: Percent of adolescents with special health care needs who received services necessary to make transitions to adult health care, Georgia Annual Performance Objectives, 2016-2020



Source: NS-CSHCN

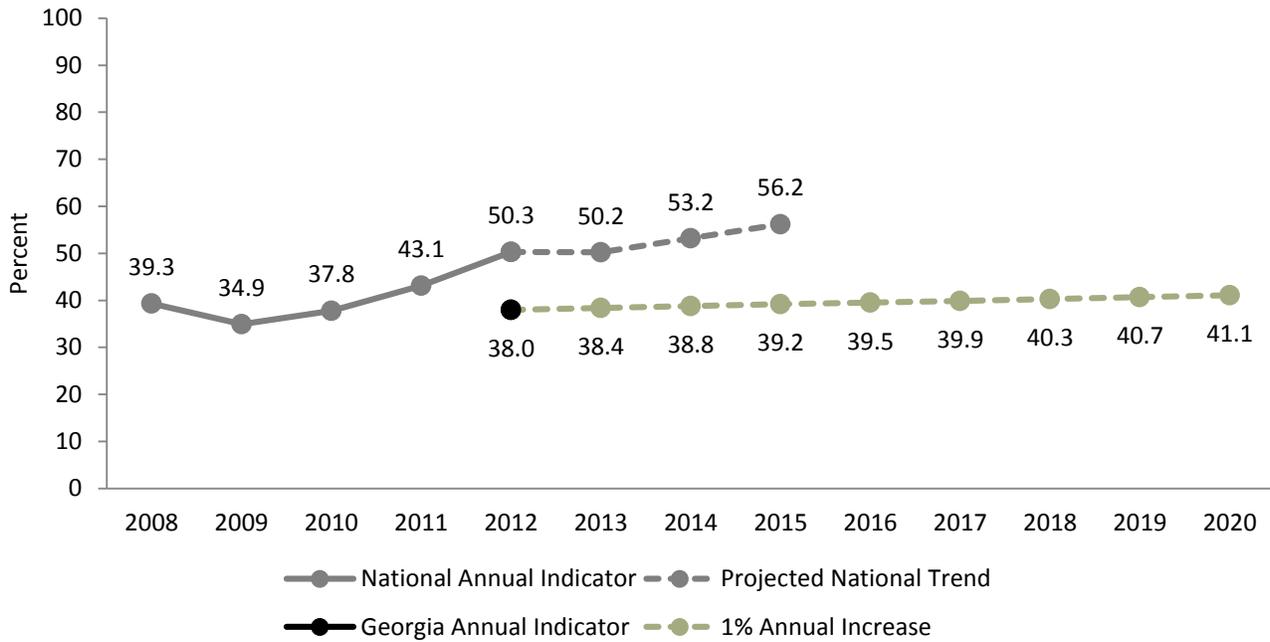
NPM 13: Oral health (A. Percent of women who had a dental visit during pregnancy and B. Percent of children, ages 1 through 17, who had a preventive dental visit in the past year)

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 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 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 concern in Georgia, as it is vital to ensuring that Georgians achieve an excellent health status overall.

Because there was only one data point for Georgia, a true trend of this indicator could not be assessed. A 1% annual increase from 2012 to 2020 was chosen for the annual performance objectives.

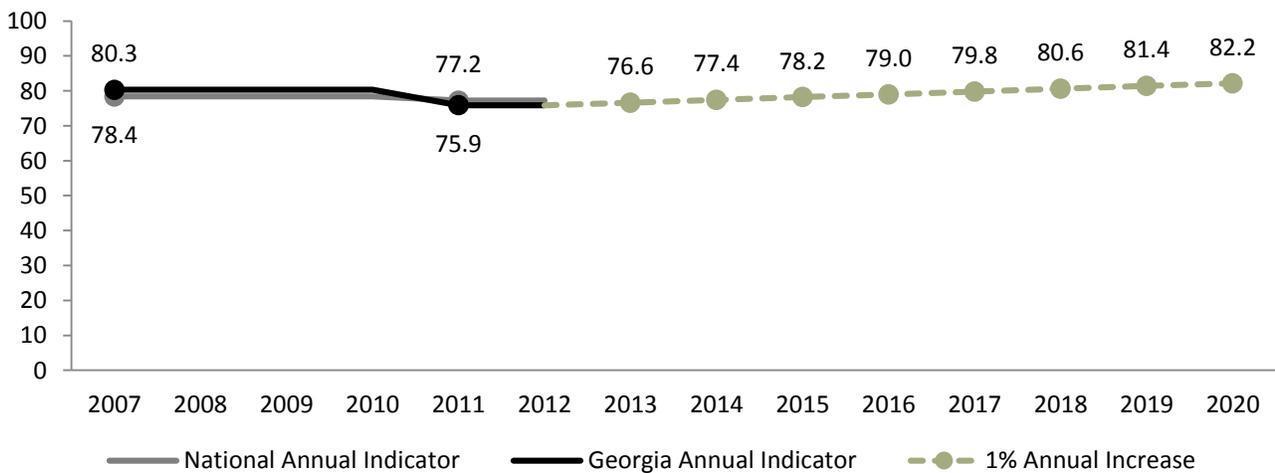
NPM 13A: Percent of women who had a preventive dental visit during pregnancy, Georgia, 2008-2020



Source: PRAMS

Only two data points exist for the second portion of NPM 13 as well. Despite a potential downward trend, a 1% annual increase was used to set annual performance objectives. The 1% increase to return Georgia’s average to previously seen levels by 2020.

NPM 13B: Percent of children who received a preventive dental visit in the past year, Georgia, 2007-2020



Source: NSCH

APPENDIX

DRAFT

APPENDIX A. FOCUS GROUP DISCUSSION GUIDE: PREGNANCY/PERINATAL

We're going to ask you about some of the services you used before, during and after your most recent pregnancy (just before and during if you are still pregnant).

Family Planning and Pre-Pregnancy Services (10-15 minutes)

We will start off talking about services that you may have used or wanted before you got pregnant.

Family planning services are services that help you control when you get pregnant. This means birth control as well as services to help you get healthy before you get pregnant – STD testing, pregnancy testing, counseling.

- 1. Have any of you used family planning services at the health department (either before your current pregnancy or since your recent pregnancy)?**

PROBE: We noticed that most of you indicated in your forms that you used the health department for _____ services. How often did you seek such services from the health department?

PROBE: Did you use a family planning clinic at the health department or primary care clinic? Teen clinic?

- 2. If you didn't use family planning services at the health department, did you get these services somewhere else? Where?**

PROBE: Private doctor's office - such as a family physician or private OBGYN?

PROBE: Why did you choose to get your family planning there?

- 3. What steps did you take to get healthy before you got pregnant?**

PROBE: Prenatal counseling? Prenatal vitamins/folic acid? Quitting smoking, alcohol or drug abuse? Weight loss? Dental cleanings? Check up?

PROBE: Where did you get these services?

- 4. If you did not seek services to get healthy before your pregnancy, Why not?**

- 5. Which types of services would you like to have access to before your next pregnancy? (if you are planning another pregnancy)**

PROBE: Which services would be most important?

PROBE: If none, please let us know why not? Is it due to lack of time/work commitment? Transportation? Too expensive? Lack of childcare?

Birth Spacing (7-10 minutes)

Now we are going to talk about birth spacing or the amount of time between the birth of your youngest child and your next pregnancy.

6. Tell us what you have heard about spreading the births of your babies apart?

PROBE: Has anyone ever talked to you about the idea that you should have a certain amount of time between pregnancies to have the healthiest babies?

PROBE: Who told you?

PROBE: When did they tell you about this? After your most recent pregnancy? Before getting pregnant?

PROBE: Do you know how much time you should have been pregnancies to ensure a healthy infant?

PROBE: Why do you think it is important to spread births apart?

7. The recommendation is that women should wait 18 months after a birth to get pregnant again. What do you think about the idea of spacing your pregnancies?

PROBE: Why would women not want to wait until their youngest child is at least 18 months?

Pregnancy Services (15-20 minutes)

Now we are going to move on to talking about services during pregnancy.

8. During your pregnancy (either your current pregnancy or your most recent pregnancy if you have an infant), what were the most important services that you used?

PROBES: prenatal medical care, pregnancy/infant education classes, breastfeeding classes or support, Medicaid referrals, WIC referrals, housing assistance, other?

Moderator should write down list of services on flip chart.

9. Which of these services, if any, did you get at the health department?

Moderator should note on the flip chart. (Place HD next to services received at health department)

10. If you received these services at your health department, how did you find out about them?

PROBES: Used them before? Friend or family told you? Knew they were available because you use the health department for other services? Medicaid referred you there?

11. What was your experience seeking these services at the health department?

PROBE: What was good about your experience?

PROBE: What was bad about your experience?

12. If you didn't get these services at the health department, where did you get them?

Moderator should make note of where different services were received.

PROBE: Private doctor's office,, such as a family physician or OBGYN? Another public health clinic, such as a federally qualified health center?

PROBE: Why did you choose to get prenatal/pregnancy services at a private provider (or other non-health department provider)?

PROBE: Would you have liked to have been able to get those services at the health department? Why or why not?

13. A lot of attention is being placed now on helping pregnant women who have prescription drug abuse problems. This means taking prescription drugs when they are not prescribed for you or being addicted to prescription medication and taking it for too long. We are not talking about Tylenol or Tums or other over the counter medications. We are also not talking illegal drugs like Heroin or Cocaine, although that is certainly a problem as well. Even if prescription drug abuse isn't an issue for you personally, is this something that you have seen in your community?

PROBE: If so, what do you think needs to be done to better help these women?

Post-Pregnancy Services (5-8 minutes)

For those of you who have already had a baby, we'd like to learn what services you used at the health department after you gave birth, or would like the health department to offer.

14. After your pregnancy, did you visit the health department for post-pregnancy services?

PROBE: If so, which services? Six weeks after delivery checkup, breastfeeding counseling, family-planning, new parenting classes, general wellness visits for mom, WIC or Medicaid referrals

PROBE: If you did not seek these services from your health department, where did you go? And for what services did you seek help for? Why did you go elsewhere for these services and not the health department?

Final Question (3-5 minutes)

15. Are there any pregnancy or pregnancy related health care services we didn't ask you about that you think are really important? Or anything else that you would like to be able to get from your health department related to pregnancy?

Thanks so much! This wraps up our focus group discussion for today. Do you have any questions for us, or anything that you would like to share? We appreciate your time and your comments. It has been very helpful.

DRAFT

APPENDIX B. SCHOOL READINESS FOCUS GROUP DISCUSSION GUIDE

Now we're going to start talking about school readiness and how to better serve families like yours.

School Readiness (5-8 minutes)

School readiness is the idea that all children start school ready to learn. This means that any health problems that make it difficult to learn have been found and addressed, that they have appropriate social and communication skills, that kids show early literacy skills (like knowing letters and understanding parts of a story) and that they have a general understanding of how the world works.

- 1. Tell us about your experiences with your child and his/her readiness for school. Did you feel he/she was ready to learn and succeed when he/she began school? Why or why not?**

PROBE: What types of skills do you wish your child had more of in order to be better prepared for school?

PROBE: How do you think other parents could get help getting these services for their children?

- 2. What types of things did you do to help your child develop social and learning skills?**

PROBES: Reading to them regularly, putting child in daycare/preK/Head Start, socializing your child with other children

- 3. What services related to school readiness would you like to have access to for your child/ren?**

PROBES: Reading, math, socialization?

Health and School Readiness (5-8 minutes)

One area that we are very interested in is thinking about kids being healthy enough to succeed in school.

- 4. Can anyone tell us about a situation with your child (or a friend or family member's child) where not being healthy got in the way of them succeeding in school?**

PROBE: Hearing/vision issues that made it hard for child to learn; dental issues that made it hard for the child to eat or the child was in pain; other?

- 5. For those kids, were they able to get services or help with what they needed for school readiness? Why or why not?**

Bright from the Start (5-10 minutes)

In Georgia, a lot of the school readiness services come from the Bright from the Start Program. This program includes helping families find childcare, including Head Start and Pre-K programs as well as nutrition services.

6. By show of hands, how many of you have used any of these services from Bright from the Start or other community agencies?

PROBE: Which services have you used? Finding childcare? Pre-K?

PROBE: How did you learn about these services?

7. For those of you who have used childcare, Head Start, Pre K or nutrition services, what has been your experience?

PROBE: What did you like about this program?

PROBE: What didn't you like about the program?

PROBE: What can be improved about the program?

8. For those of you who haven't used any of these kinds of services, were you aware that they existed?

PROBE: IF so, why didn't you use these services?

PROBE: Have you used any of these services from a different program? If so, tell us about this program.

If you weren't aware of these services, we will provide more information for you at the end of today's focus group.

WIC (5 - 10 minutes)

There are also a lot of other programs that help school-age children succeed, like WIC (Women, Infants and Children), which provides nutrition services and counseling, as well as many other services.

9. By show of hands, how many of you have used WIC?

10. What WIC services did you receive that helped your child get ready for school?

PROBE: What WIC services were most helpful to you? Helping you get healthy foods or understand the importance of healthy foods? Referrals to other health care programs? Learning about reading to my child?

Health Screenings (8-10 minutes)

In Georgia, all children entering public school must have a vision, hearing, dental and nutrition screening before they enroll in a public school for the first time. You may know it as the 3300 Form. *(Moderator to show a blank copy of this form.)*

11. Did you get all of these screenings for your child/ren before they started school?

PROBE: Did you have any difficulty getting these screenings for your kids?

PROBE: Where did you get the screenings? Private Doctor's office, health department, school clinic, dentist's office, other?

12. For those of you who did not get the screenings at the health department, if all of these screenings were available at your local health department, would you have used them?

PROBE: Why or why not?

Now I want to switch for a minute and talk to any of you who were not able to get these required screenings for your kids prior to enrolling your child in school.

13. Which types of screening were difficult for you to get for your child or did you not get at all? Why was it difficult to get these services?

PROBES: Unable to access a provider to get screening; didn't know it was required; too expensive; transportation difficulties; didn't know where to get screening.

Final Question (5 minutes)

14. Is there anything else you would like to tell us about how the health departments or other programs could help better prepare your kids or kids in your community for school?

Thanks so much! This wraps up our focus group discussion for today. Do you have any questions for us, or anything that you would like to share? We appreciate your time and your comments. It has been very helpful.

APPENDIX C. CHILDREN WITH SPECIAL NEEDS FOCUS GROUP DISCUSSION GUIDE

We're going to ask you about some of the services you have used or would like to use for your children. Please keep in mind that while we understand that some of you have other children as well, for today's discussion, we are particularly interested in talking about children with special needs.

Early and Continuous screening (10-15 minutes)

We will begin by talking about screening services for your child. We want to talk about Babies Can't Wait, a program for infants and toddlers with special needs from birth to age 3. Some Babies Can't Wait services include screenings, help getting medical services, therapy for your child and help with transportation.

1. What services did you get for your child?

PROBE: Evaluation/assessment? Hearing screening or services? Counseling? Therapy (occupational, physical, speech)? Social work services to help connect your family to non-medical services like WIC? Other?

2. What has been your (or your family/friends' experience with the Babies Can't Wait program?

PROBE: If you have not used the program, why not?

PROBE: Didn't know about the program? Did not know that your child would qualify? Moved from another state? Services were too expensive? Wait times were too long? Other?

3. For those who are familiar with Babies Can't Wait, how did you learn about the program?

4. What other programs or places have you gone to seek care for your child with special needs?

PROBE: Private provider? Other state program?

PROBE: Which services from these programs/providers did your child receive?

5. Were there screening or services that you wanted or needed for your young child (when he/she was 3 or younger) but were not able to get? What were they? Why couldn't you access them?

Ease of use of community and health services (8-10 minutes)

Now we are going to move on to talking about community and medical services for your child. Medical services are all those services that you get from doctors, nurses and therapists. Community services means things that aren't really medical, like educational services, Women Infants and Children (WIC), transportation and other services that help you care for your child.

6. Please describe your experiences getting any medical services for your child with special needs.

PROBE: What have you found to be easy about seeking medical care for your child?

PROBE: What have you found to be difficult about seeking medical care for your child?

7. What kind of community services that you want or need for your child have you been unable to get?

PROBE: Why have you been unable to get these services?

PROBE: What would make it easier for you to get these services?

PROBE: Are services available within your community? Do you have to travel? How far? Is Tele health (using computers for long distance health services) available?

Medical Home (5 minutes)

Now we're going to talk a little about who coordinates all the care for your child with special needs. There is something called a medical home, which means that you have one main medical provider who you see most of the time and who coordinates the care for your child with other, specialty providers.

8. Does your child have a medical home (one main provider) that he or she sees for most/all of his medical care or who coordinates medical care?

PROBE: Where is this medical home? (Who is his/her main health care provider?)

PROBE: Do you always see the same provider in the practice?

PROBE: Are you happy with your medical home? Why or why not?

Children Medical Services (8-10 minutes)

CMS (Children's Medical Services) is a program that provides or arranges specialty medical/health care services for children with chronic medical conditions in Georgia. This includes arranging and paying for services such as physical evaluations, diagnostic tests, medical treatments and therapy. CMS also helps families coordinate care and transition to adult services for their children with special needs.

9. What has been your (or your family/friends') experience with the Children's Medical Services (CMS) program?

PROBE: What CMS services do you think are most helpful for families with a special needs child? Nurse home visiting? Care coordination?

PROBE: Were there services you needed for your child that you couldn't get?

PROBE: What do you think are some reasons why someone might not use CMS services?

10. What other services could help a family get better care for their child with special needs that are currently not offered?

Family Partnering in Decision Making (10-15 minutes)

We know families who have a child with special needs have to make a lot of medical and community support decisions.

- 11. Which types of doctors/nurses/professionals listen to what you have to say about the care that your child needs?**
PROBE: which professionals are best at considering your opinions for decision making?
- 12. What could be done to help professionals work better with your family to make decisions for your child together?**
- 13. Thinking now about people who help you get non-medical services (WIC, transportation, education, etc.), which providers in community agencies really listen to what you have to say about what your child needs?**
- 14. What suggestions do you have to help all professionals do a better job of working with your family to make care decisions for your child?**
PROBE: train the providers, create a form for parents to write down their opinions

Thanks so much! This wraps up our focus group discussion for today. Do you have any questions for us, or anything that you would like to share? We appreciate your time and your comments. It has been very helpful.

APPENDIX D: CHILDREN AND YOUTH WITH SPECIAL NEEDS FOCUS GROUP DISCUSSION GUIDE (≥8)

We're going to ask you about some of the services you have used or would like to use for your children. Please keep in mind that while we understand that some of you have other children as well, for today's discussion, we are particularly interested in talking about children with special needs.

Ease of use of community and health services (8-10 minutes)

Now we are going to move on to talking about community and medical services for your child. Medical services are all those services that you get from doctors, nurses and therapists. Community services means things that aren't really medical, like educational services, Women Infants and Children (WIC) or healthy food services, transportation and other services that help you care for your child.

1. Please describe your experiences getting any medical services for your child with special needs.

PROBE: What have you found to be easy about getting medical care for your child?

PROBE: What have you found to be difficult about getting medical care for your child?

2. What kinds of community services that you want or need for your child have you been unable to get?

PROBE: Why have you been unable to get these services?

PROBE: What would make it easier for you to get these services?

PROBE: Are services available within your community? Do you have to travel? How far? Is Tele health (using computers for long distance health services) available?

Medical Home (5 minutes)

Now we're going to talk a little about who coordinates all the medical care for your child with special needs. There is something called a medical home, which means that you have one main medical provider who you see most of the time and who coordinates the care for your child with other, specialty doctors or therapists.

3. Does your child have a medical home (one main provider) that he or she sees for most/all of his medical care or who coordinates medical care?

PROBE: Where is this medical home? (Who is his/her main health care provider?)

PROBE: Do you always see the same provider in the practice?

PROBE: Are you happy with your medical home? Why or why not?

Children Medical Services (8-10 minutes)

CMS (Children's Medical Services) is a program that provides or arranges specialty medical services for children with chronic medical conditions in Georgia. This includes arranging and paying for services such as physical evaluations, tests, medical treatments and therapy. CMS also helps families coordinate care and transition to adult services for their children with special needs.

4. What has been your (or your family/friends') experience with the Children's Medical Services (CMS) program?

PROBE: What CMS services do you think are most helpful for families with a special needs child?
Nurse home visiting? Care coordination?

PROBE: Were there services you needed for your child that you couldn't get?

PROBE: What do you think are some reasons why someone might not use CMS services?

5. What other services could help a family get better care for their child with special needs?

Family Partnering in Decision Making (10-15 minutes)

We know families who have a child with special needs have to make a lot of medical and care decisions.

6. Which types of doctors/nurses/professionals listen to what you have to say about the care that your child needs?

PROBE: which professionals are best at considering your opinions for decision making?

7. What could be done to help professionals work better with your family to make decisions for your child together?

8. Thinking now about people who help you get non-medical services (WIC, transportation, education, etc.), which providers in the community really listen to what you have to say about what your child needs?

9. What suggestions do you have to help all professionals do a better job of working with your family to make care decisions for your child?

PROBE: trainings on working with families, create a form for parents to write down their opinions

Transitions to Adult Care (15-20 minutes)

We know that one of the hard issues for many families of special needs children is planning for transitions to adult care.

10. On a scale of 1-10 (10 being most sure), how sure are you that your child is able to live independently after his/her 18th birthday?

11. What are your biggest worries about your child's transition to adulthood?

PROBE: able to be/live independently? Pay the bills/get a job? Their education? Getting health care? Getting social services?

12. What are the biggest health care worries you have for your child's transition to adulthood?

PROBE: Your child's ability to make health care decisions on his/her own? Moving care from pediatric professionals to adult professionals? Getting good adult care?

13. Do you have someone who can help you/your child work through this transition process?

PROBE: If so, who? How have they helped you/your child? Have you developed a transition plan with this person?

PROBE: If you do not have someone to help you, what kind of help do you need?

14. Is there anything else you would like to add about the health care of your special needs child that we have not discussed today?

Thanks so much! This wraps up our focus group discussion for today. Do you have any questions for us, or anything that you would like to share? We appreciate your time and your comments. It has been very helpful.

Focus Group Guide

Ice Breaker (5 minutes)

Let's go around the room and do some introductions. If you feel comfortable, please share with the group the following information:

- What is your favorite treat or snack
- Name one thing you like to do for fun

Everyone should write their favorite snack on the name badge. They will be referred to by this "name" for the duration of the discussion.

Now we're going to start talking about school readiness and how to better serve families like yours.

School Readiness (5-8 minutes)

School readiness is the idea that all children start school ready to learn. This means that any health problems that make it difficult to learn have been found and addressed, that they have appropriate social and communication skills, that kids show early literacy skills (like knowing letters and understanding parts of a story) and that they have a general understanding of how the world works.

1. Tell us about your experiences with your child and his/her readiness for school. Did you feel he/she was ready to learn and succeed when he/she began school? Why or why not?
2. PROBE: What types of skills do you wish your child had more of in order to be better prepared for school?
PROBE: How do you think other parents could get help getting these services for their children?
3. What types of things did you do to help your child develop social and learning skills?
PROBES: Reading to them regularly, putting child in daycare/preK/Head Start, socializing your child with other children
4. What services related to school readiness would you like to have access to for your child/ren?
PROBES: Reading, math, socialization?

Health and School Readiness (5-8 minutes)

One area that we are very interested in is thinking about kids being healthy enough to succeed in school.

5. Can anyone tell us about a situation with your child (or a friend or family member's child) where not being healthy got in the way of them succeeding in school?
PROBE: Hearing/vision issues that made it hard for child to learn; dental issues that made it hard for the child to eat or the child was in pain; other?

6. For those kids, were they able to get services or help with what they needed for school readiness?
Why or why not?

Bright from the Start (5-10 minutes)

In Georgia, a lot of the school readiness services come from the Bright from the Start Program. This program includes helping families find childcare, including Head Start and Pre-K programs as well as nutrition services.

7. ~ By show of hands, how many of you have used any of these services from Bright from the Start or other community agencies?
PROBE: Which services have you used? Finding childcare? Pre-K?
PROBE: How did you learn about these services?

8. For those of you who have used childcare, Head Start, Pre K or nutrition services, what has been your experience?
PROBE: What did you like about this program?

PROBE: What didn't you like about the program?

PROBE: What can be improved about the program?

9. For those of you who haven't used any of these kinds of services, were you aware that they existed?
PROBE: IF so, why didn't you use these services?

PROBE: Have you used any of these services from a different program? If so, tell us about this program.

If you weren't aware of these services, we will provide more information for you at the end of today's focus group.

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PROBE: Did you have any difficulty getting these screenings for your kids?

PROBE: Where did you get the screenings? Private Doctor's office, health department, school clinic, dentist's office, other?

13. For those of you who did not get the screenings at the health department, if all of these screenings were available at your local health department, would you have used them?

PROBE: Why or why not?

Now I want to switch for a minute and talk to any of you who were not able to get these required screenings for your kids prior to enrolling your child in school.

14. Which types of screening were difficult for you to get for your child or did you not get at all? Why was it difficult to get these services?

PROBES: Unable to access a provider to get screening; didn't know it was required; too expensive; transportation difficulties; didn't know where to get screening.

Final Question (5 minutes)

15. Is there anything else you would like to tell us about how the health departments or other programs could help better prepare your kids or kids in your community for school?

Thanks so much! This wraps up our focus group discussion for today. Do you have any questions for us, or anything that you would like to share? We appreciate your time and your comments. It has been very helpful.

APPENDIX E. CRITERION DEFINITION SHEET

Criterion	Rationale	Description
Seriousness of the Issue	Consider the potential for this issue to result in severe disability and death in the state	1- Problem is not life-threatening or disabling to individuals or the community 2- Problem is not life threatening but is sometimes disabling 3- Problem can be moderately life threatening or disabling 4- Problem can be moderately life threatening, but there is strong likelihood of disability 5- Problem has high likelihood of death and disability
Health Equity	Consider the extent to which there are racial, socioeconomic or geographic disparities	1- There are no disparities 2- There are few disparities 3- There are moderate disparities with small gaps 4- There are some disparities with noticeable gaps 5- There are several disparities with significant gaps
Economic Impact	Consider the monetary costs to the state that result from the issue	1- Economic/societal cost is minimal 2- There are some costs to society if this issue is not addressed 3- There are moderate costs to society if the issue is not addressed 4- There are substantial increased costs if the issue is not addressed 5- There are great economic and societal costs if the issue is not addressed
Trend	Consider whether the issue is improving or worsening in Georgia	1- The issue rapidly improved in the past few years 2- The issue has improved some in the past few years 3- The issue has remained stable in the past few years 4- The issue has worsened some in the past few years 5- The issue has rapidly worsened in the past few years
Magnitude of the Problem	Consider how many people in the state are impacted	1- The issue affects very few people in the state 2- The issue affects some people in the state 3- The issue affects a moderate amount of people in the state 4- The issue affects many people in the state 5- The issue affects a great number of people in the state
Importance	Consider this need in light of the other needs	1= Not important 2= Somewhat important 3= Moderately important 4= Highly important 5= Essential to address