

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

Georgia

**FY 2019 Application/
FY 2017 Annual Report**

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I. General Requirements

I.A. Letter of Transmittal



J. Patrick O'Neal, M.D., Commissioner | Nathan Deal, Governor

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July 16, 2018

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Grantee Name: Georgia Department of Public Health
Grant Name: Maternal and Child Health Services Title V Block Grant
Grant Number: B04MC31480
Reference: Notification of Submittal

Dear Ms. Brower,

This is a letter of transmittal informing you that a grant application requesting funding for the FY 2019 Maternal and Child Health Services Title V Block Grant has been submitted from the Georgia Department of Public Health.

For questions related to the grant, please contact LaToya Osmani, Division of Health Promotion Director, as Jeannine Galloway is on leave until September 17, 2018. Ms. Osmani can be reached at 404-463-0791 or LaToya.Osmani@dph.ga.gov.

Sincerely,

A handwritten signature in blue ink that reads 'Jeannine Galloway'.

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

A handwritten signature in blue ink that reads 'Dionne Denson'.

Dionne Denson, CGFM, MSA
Deputy Commissioner
Chief Financial Officer
Georgia Department of Public Health

We Protect Lives

I.B. Face Sheet

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

I.C. Assurances and Certifications

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

I.D. Table of Contents

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

II. Logic Model

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

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Georgia Department of Public Health (DPH) Maternal and Child Health Section (MCH) located in the Division of Health Promotion administers the Maternal and Child Health Services Title V Block Grant. DPH is the lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a health perspective. In Georgia, public health functions have been shared by state and local governments. The unique public health landscape in Georgia includes 18 health districts comprised of one or more of 159 counties and county health departments. As the lead agency DPH provides and assures access to quality MCH services for mothers and children and provides and promotes family centered, community-based, coordinated systems of care.

DPH has developed goals, objectives and strategies to achieve positive health outcomes throughout the state focusing on the four priority areas set forth by the DPH Commissioner: early brain development, prescription drug program monitoring, cardiac care systems, and enterprise system modernization. As the number one priority for DPH, early brain development for children ages zero to three, impacts all MCH programs. In an effort to improve early brain development in Georgia's children, DPH convened a public-private partnership, the Brain Trust for Babies. In coordination with MCH programs and the Brain Trust for Babies, DPH helps to ensure that by 2020 every child in Georgia will achieve the promise of optimal brain development by age three.

DPH has worked to achieve national accreditation through the Public Health Accreditation Board (PHAB). The national accreditation program works to improve and protect the health of the public by advancing and transforming the quality and performance of health departments. DPH has completed the prerequisites, collected the required documentation, and implemented improvements as needed. DPH submitted its documentation for accreditation to the PHAB and is planning for the site visit in the fall of 2018.

Needs Assessment Summary

Georgia conducted a comprehensive needs assessment in 2015, examining both qualitative and quantitative data to better understand the needs and desired health outcomes of the state's MCH populations. Public health professionals and community partners worked across program areas to collaborate in evaluating the state's public health needs.

The 2015 MCH Needs Assessment illuminated emerging Priority Needs and informed the selection of Georgia's National Performance Measures (NPMs) and State Performance Measures (SPMs) for the project period. Data was collected in 16 of 18 public health districts. The assessment identified 34 health needs which 100 stakeholders subsequently reviewed and identified ten priority needs:

Priority Needs	
1. Prevent maternal mortality	6. Reduce suicide among adolescents
2. Increase access to family planning services	7. Improve systems of care for children and youth with special health care needs
3. Prevent infant mortality	8. Increase access to specialty care for CYSHCN
4. Promote developmental screenings among children	9. Reduce maternal substance use and
5. Promote physical activity among children	10. Promote oral health among all populations

In the current year, Priority Needs, NPMs and SPMs were reviewed. Preventing Suicide among Adolescents was removed as a Priority Need, for the upcoming year, as well as Bullying, a National Performance Measure, due to the Georgia Department of Education (DOE) serving as the primary lead around these efforts. Safe Sleep was added as a State Performance Measure to reduce the number of children under one year of age that die from a sleep-related cause. DPH initiated the Hospital Safe to Sleep Program to help ensure health providers implement and model safe sleep practices.

The 2015 Needs Assessment identified emergent and ongoing needs such as opioid use and Zika. Georgia has seen an increase in opioid use and the effects on children and families. Opioid misuse and abuse among women of childbearing age has led to an increase in Neonatal Abstinence Syndrome (NAS). In 2016, using ICD-9 and ICD-10 codes, 1,592 NAS cases out of 120,371 total hospital births were reported for a NAS rate of 13.23. With the emergence of the Zika virus in 2015, Georgia created a Zika Response Team within the Epidemiology Section of the DPH. This team consists of epidemiologists from the Acute Disease Epidemiology Section and the Maternal and Child Health Epidemiology Section. Several activities have been performed to maintain and enhance the surveillance of Zika-related health impacts. In the year ahead, Title V will expand its reach to serve the refugee population in Georgia to ensure that all mothers, children, and families have access to adequate health care services which will further improve the overall health outcomes in our communities.

DPH's success in improving health outcomes relies on leveraging extensive state-wide partnerships. In addition to maintaining close relationships with public health districts, MCH partners with over 100 external stakeholders including Georgia's Hospital Association, Georgia's American Academy of Pediatrics, Georgia's Academy of Family Physicians, and Georgia's Obstetrics and Gynecological Society. In addition, families and consumers are recognized as partners that the MCH section values as critical to making significant change in performance measures.

Population needs and priorities

State priorities were selected through the needs assessment process and cover each of the six health domains. Each of the state priorities are directed at addressing and eliminating disparities.

Women/Maternal Health: Due to the critical need to reduce maternal mortality the Title V Program focused on efforts to impact this need. In 2011 the maternal mortality rate (MMR) was 28.7 which on average was four times higher in Black, non-Hispanic women (39.1 deaths per 100,000 live births) than White, non-Hispanic women (9.6 deaths per 100,000 live births). These staggering rates and the underlying racial and ethnic disparities served as the impetus for creation of a statewide Maternal Mortality Review Committee (MMRC) in 2012 administered by the Georgia Obstetrical and Gynecology Society with funding provided by MCH. The committee reviews cases to determine causes of death, and provides recommendations for maternal mortality reduction. An initiative stemming from the committee's findings was the implementation of Alliance for Innovation and Maternal Health (AIM) Safety Bundles to prevent leading causes of maternal morbidity and mortality in birthing facilities. Georgia joined the National Alliance

for Innovation and Maternal Health initiative as an AIM state in 2017.

Perinatal/Infant Health: Infant mortality is the single leading indicator of the overall health and well-being of a population. In 2016, Georgia's infant mortality rate (IMR) per 1,000 live births was 7.4, compared to 5.6 in the Nation. In the 2015 Needs Assessment, stakeholders identified infant mortality and the need to reduce maternal substance use as state's priority needs. The major evidence-based strategies recommended nationally for addressing infant mortality are regionalized perinatal care, safe sleep initiatives, and improving breastfeeding rates. DPH continues to develop strong partnerships around the coordination of Regional Perinatal Centers (RPC) by providing information and education to delivering facilities, staff, and women to ensure they deliver at the appropriate facility in instances where mother and baby may require specialized care. In January, 2018 the Neonatal Subcommittee of the Georgia Perinatal Quality Collaborative (GaPQC) developed a baseline survey for birthing hospitals to determine current practices around NAS diagnosis and treatment. In April, 2018 the survey was made available to all birthing hospitals to explore gaps and opportunities for maternal interventions to impact birth outcomes. Increasing breastfeeding rates and eliminating sudden unexplained infant deaths are ongoing MCH initiatives which are integral parts of Georgia's strategic plan to reduce infant mortality. Georgia has 13 birthing hospitals who have received baby-friendly designation due to their commitment to creating a culture of breastfeeding, with seven additional hospitals actively working through the Georgia 5-STAR Hospital Initiative process to receive a baby friendly designation. The Georgia Safe to Sleep initiative has recruited 100% of the 79 birthing hospitals in the state and has provided guidance and instruction on how to implement a hospital-based safe to sleep program. In January 2017, 87.3% of hospitals reported having a safe infant sleep policy in place or in progress.

Child Health: Promoting developmental screenings and physical activity were priorities for child health in our 2015 statewide Needs Assessment. In 2017, the Children 1st (C1st) program facilitated over 64 developmental trainings on developmental screening, milestone trainings and the referral system to more than 1,200 staff from hospitals, public health programs, community organizations, daycare centers, head start programs and primary care offices. In addition, the program provided peer-to-peer education on the importance of developmental screening, the use of online Ages and Stages Questionnaire (ASQ), and accessing support through the child health referral system. Addressing obesity requires a multi-level approach, involving both policies and activities in schools. In a partnership with the Georgia DOE, MCH works intensively on obesity prevention in elementary and early learning school settings. These efforts include the Georgia School Health and Physical Education (SHAPE) Network, which provides trainings and resources for school district staff and administrators on incorporating physical activity into daily school activities. In 2017, the Power Up for 30 program, aims to increase physical activity before, during, and after the school day in schools across the state and includes participation from 881 active elementary schools.

Adolescent Health: MCH addresses risk and protective factors for children ages 8-17 at the local, regional and state levels and provides evidence based interventions and evidence informed strategies to employ for prevention of suicide. The Sexual Violence Prevention Program administers Step Up Step In (SUSI), an awareness campaign that addresses sexual bullying prevention and targets middle and high school students. Although Preventing Suicide Among Adolescents has been removed as a Priority Need, moving forward, DPH will support GA DOE in its efforts by continuing to serve on its coalition to support Injury Prevention and Adolescent Health activities. The Student Health and Physical Education (SHAPE) Network, also implements the Power Up for 30 program in Georgia middle schools to increase physical activity in seven pilot middle schools.

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

2017, 8,664 children and youth were served by the CMS program. During this time, 91% of transition age youth, ages 16 to 21, received education and support to transition from pediatric care to adult-centered health care. Approximately 988 CMS participants and families received transition planning, support and education by care coordinators. Telehealth technology is utilized to provide education and pediatric specialty care. The Parents as Partners Project enhances and further supports the system of care for CYSHCN. Currently, there are six Parents as Partners trained and supporting families with children and youth with special health care needs.

Cross-Cutting/Life Course: Oral health is a priority for the MCH section and a strategic focus to improving health outcomes for women, infants and children. The Oral Health program provides training to organizational stakeholders on oral health and provides services including fluoride varnish, dental sealants, prevention education and comprehensive restorative treatment. School-based prevention programs targeting high-risk children, teledentistry, and tobacco prevention programs to pregnant women are also provided.

Family Centered Services

The MCH section set a goal to expand family centered services across all MCH programs. Family and community partners are engaged in strategic planning, program development, quality improvement initiatives, and workforce development to assess and build capacity around family engagement. MCH host multiple committees and councils for which families, organizations and partners participate throughout the health districts. At the state level, MCH has one full time family engagement staff member who works with the Children and Youth with Special Health Care Needs program and provides guidance and technical assistance to all MCH programs.

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

Title V Block Grant funds complement MCH efforts supported by the state of Georgia. MCH programs strive to create federal, state, and community partnerships that support access to quality health care for mothers and children, especially with low incomes and/or limited availability of care due to the rural demographic of Georgia. Title V funding supports MCH efforts that seek to reduce infant and maternal mortality, the incidence of preventable diseases, and to improve the system of services for children and youth and to increase the number of children immunized. MCH programs strive to provide initiatives such as access to comprehensive prenatal, postnatal, and oral health care for women and children as well as promote and increase health assessments and follow-up diagnostic and treatment services. Title V funding helps support efforts to conduct data analyses and disseminate information from surveillance systems. Strategies and initiatives are created to promote improved maternal and child health and the public health mission in Georgia. Title V funds are utilized to meet specific needs that have been identified through the Five-Year Needs Assessment.

Title V Funding is provided to public health districts and other organizations, and supports the following programs:

- Babies Can't Wait
- Children 1st
- Children's Medical Services
- Data and Surveillance
- Family Planning
- Georgia SHAPE
- Injury Prevention
- Newborn Screening
- Oral Health
- Perinatal Health

III.A.3. MCH Success Story

Access to specialty care can be a challenge for children with Sickle Cell disease living in rural Georgia. To enhance access to medical services for underserved rural communities, DPH has implemented outreach and telemedicine clinics to extend health care services to subspecialists for children living outside of the two city centers where comprehensive sickle cell treatment is located. The Sickle Cell Telemedicine Program was established in 2016 through a partnership with Augusta University (AU), DPH Newborn Screening and the CMS program. The CMS program supports the pediatric outreach clinics by providing nursing staff and the clinic infrastructure, including telemedicine, for diagnostic and follow up care. The Sickle Cell Telemedicine Program, currently serving 97 children, provides care for CMS patients in five public health districts in rural areas of the state receiving hydroxyurea therapy as well as testing and genetic counseling for abnormal newborn screening results. The telemedicine clinics address workforce shortages, reduce travel burdens for both the patient and provider bridging the geographic gap. Telemedicine for the care of children living with Sickle Cell disease in rural communities has enhanced the current delivery of care system and facilitates improved health outcomes in cost effective ways. The collaborative efforts to create the Sickle Cell Telemedicine Program illustrates the federal-state Title V partnership in action.

III.B. Overview of the State

Georgia is a diverse state with a growing population, robust political landscape, and slow growing health care environment. The distinct health care environments in rural Georgia and the urban metropolitan area are a unique challenge for the Title V Program. The growing population amplifies challenges that arise from the political landscape, health care environment, economy and/or sociocultural context.

Geographic Description

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

Urban and Rural Counties

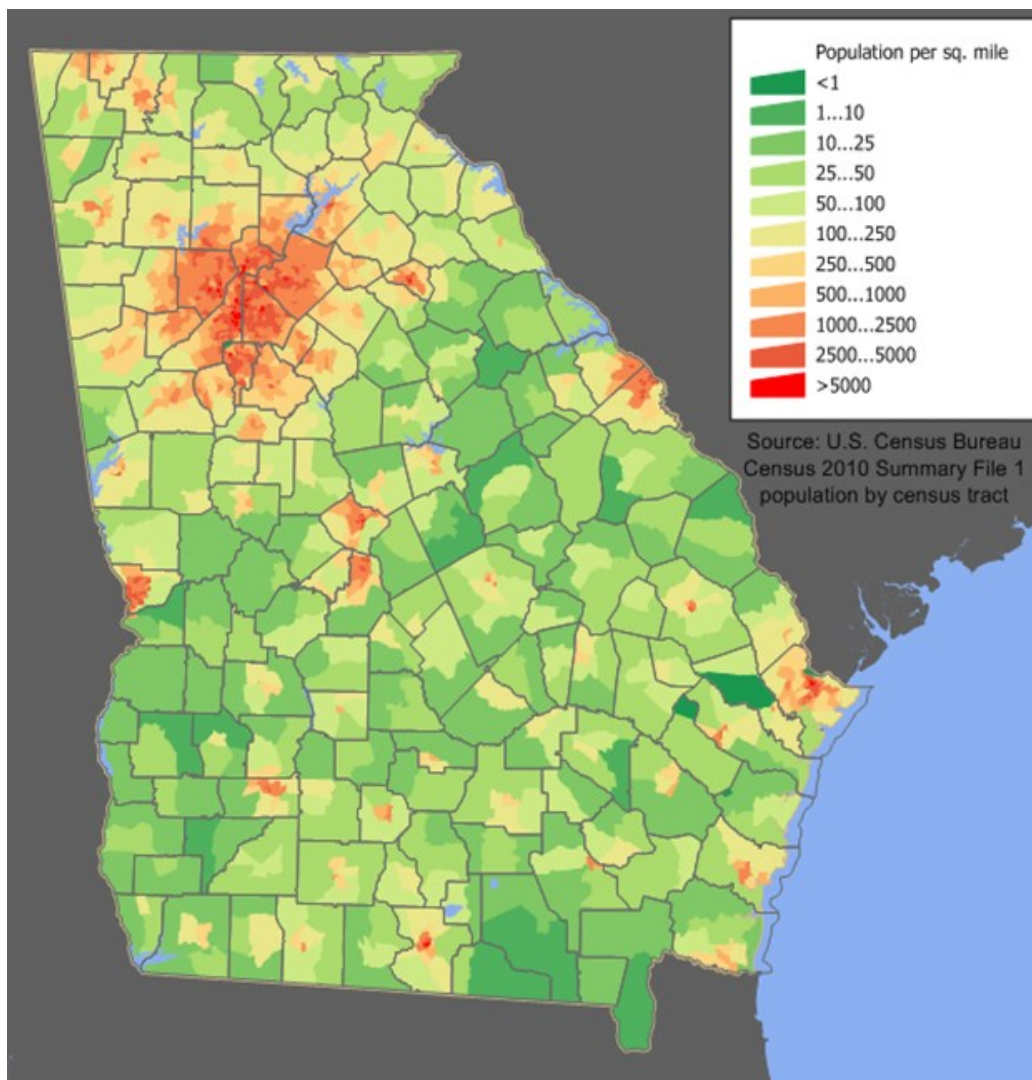
Of Georgia's 159 counties, there are both urban and rural located throughout the state. The Census Bureau defines two types of urban areas: urbanized areas of 50,000 people or more, and urban clusters between 2,500 people and 50,000 people. All other counties are considered rural. Of the 159 counties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

According to the 2010 census, the most recent census available, there are 15 Metropolitan Statistical Areas in Georgia⁴: Albany, Athens-Clarke County, Atlanta-Sandy Springs-Roswell, Augusta-Richmond County (GA-SC), Brunswick, Chattanooga (TN-GA), Columbus (GA-AL), Dalton, Gainesville, Hinesville, Macon, Rome, Savannah, Valdosta and Warner-Robins.

The increasing population and migration trends are resulting in certain rural areas that are experiencing growth in both economics and population while other rural areas are experiencing a decline. The largely rural makeup of the state provides many challenges, and opportunities, to offering adequate health and social services to all Georgia residents.

Due to the large number of counties being designated as rural, access to health care services is challenging, and as such it is essential for DPH to accommodate the needs of the rural population. DPH provides an alternative approach in meeting the needs of Georgia's rural citizens through innovative strategies such as telemedicine that increase access to health care services. The following map generated by the US Census Bureau based on population data for 2010 depicts the urbanized and non-urbanized areas in Georgia.

Figure 2: Urbanized areas in Georgia



Population

As of 2017, Georgia had an estimated population of 10.4 million people.¹⁸ It is ranked the 8th largest state with respect to population, based on 2015 estimates.¹⁷ Georgia is the 14th fastest growing state in the nation, with a 7.6% increase from 2010 to 2017,¹⁷ and is the 6th highest among states with the largest numeric population increase.¹⁷ It is estimated that Georgia's population will increase to 11.3 million by 2020.¹⁰ As with any population growth, there are increasing demands on state and local governments to provide necessary services, including health and social services.

Atlanta, the state capital, is the economic, cultural and demographic center of Georgia. It is the largest city in the state, with approximately 486,000 people living in the city in 2017. Atlanta is the ninth largest metro area in the nation with a 2016 population estimate for the Atlanta Metropolitan Statistical Area of 5,789,700. The population grew an estimation of 12.4% from 2010 to 2016, and is expected to continue to do so. Approximately 5.9% of residents are under five, 18.7% are under age 18 and 10.8% are over age 65. The city also has a high percentage of minorities, with 52.4% of residents identifying as Black or African American, 40.1% as White, 4.8% as Hispanic and 4.0% as Asian. Hispanics are the largest growing minority, with Asians following as a close second. Poverty is rampant in Atlanta, with approximately 1 in 4 Atlanta residents living below the federal poverty line as of 2011-2016, compared to 16% of the overall Georgia population.¹⁸

Race/Ethnicity

The racial distribution has shifted slightly from 2000 to 2010, although the majority of Georgians are still White or Black. The percentage of Georgians who are White decreased from 65.1% in 2000 to 59.7% in 2010. However, an increase was seen in the percentage who are Black. In 2010, 30.5% of Georgians were Black. The number of Hispanics in Georgia doubled between 2000 and 2010. The number of Asians nearly doubled, with the highest increases seen among Asian Indian, Korean and Vietnamese populations. Such a growth in diversity and population necessitates the availability of culturally-competent health care, education and human services.

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

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

Age and Gender

Georgia is a young state, with 25.7% of the population under 18 years of age, 38.2% between 18 and 44 years, 25.4% between 45 and 64 years and 10.7% over age 65.¹⁵ Georgia is ranked 4th highest for the percentage of the population under age 18. The median age in the state is 35.3.¹⁵ According to 2012-2016 estimates, 6.5% of Georgia's population is under 5 years old.¹⁹

Immigration

Georgia's population is continually evolving with the immigration of foreign-born individuals that add to the racially and ethnically diverse population of Georgia. The estimated percentage of immigration has stayed stable from 2010-2015. In 2015, it was estimated that 9.8% of the total population in Georgia are foreign-born. However, there has been an increase in naturalized citizens from 33.8% in 2010 to 40.5% in 2016.¹⁹ In 2016, twenty percent of children under the age of 18 are foreign-born or reside with at least one foreign-born parent.²⁰ The parent's region of origin can be broken up into 60% from Latin American, 22% from Asia, 11% from Africa, and 7% from Europe.²⁰ In 2011-

2016, an estimated 90% of children in immigrant families are U.S. citizens.²⁰

As of 2016, 40.2% of foreign-born residents identify as White, 17.1% identify as Black or African American and 26.4% as Asian.¹⁹ Of all racial categories 40.6% identify as Hispanic or of Latin origin.¹⁹ Forty-six percent of foreign-born residents are between ages 25 and 44.¹⁹ In 2016, 52.0% of foreign born residents were enrolled in college with 18.4% attaining some college or their associate's degree.¹⁹ In 2016, 55.5% of foreign-born residents fell below 200 percent of the poverty level.¹⁹

From 2000 to 2009, the Department of Homeland Security estimates that the number of unauthorized immigrants in Georgia increased by 115%, ranking Georgia as 6th among states with the largest number of undocumented immigrants.³⁴ However, data from 2009-2014 show a decline in unauthorized immigrants from Mexico following the end of the Great Recession. Georgia was among one of the six states to have a population decline of unauthorized immigration.³⁵ The unauthorized immigrant population in Georgia declined by 13% from 2007 to 2014.³⁶ This decrease may be the result of immigration laws enacted in Georgia in 2011.¹⁴

Language Proficiency

Over 13% of Georgia residents speak a language other than English.¹⁹ Of the other languages spoken, Spanish is the most commonly spoken language at approximately 8%. Both other Indo-European languages, Asian and Pacific Island languages, account for approximately 2.5%, and the remaining 1% of residents speaks another language. Of those that speak a language other than English, 41.2% speak English less than very well.¹⁹ These factors can have implications on the services offered to residents and may necessitate investment in interpretation and culturally competent approaches to health care delivery.

Family Household Type

Household structures in Georgia are very similar to what is seen across the rest of the United States. In 2010, 47.8% of Georgia households were composed of a husband and wife, with 21.1% of these households having children under the age of 18. Female headed households comprised of 15.8% of the population and 8.9% of these households contained children under the age of 18; 4.9% were male family households with 2.2% having children under the age of 18. Finally, 25.4% of households were one-person households, with 7.5% being 65 or older. The average household size was 2.6 and the average family size was 3.2.¹⁶

Educational Attainment

Public schools are the primary source of education in Georgia. In 2016, 63.8% of children attended a public nursery school and/or preschool while 36.2% attended a private nursery school and/or preschool. In 2016, 90.5% of students in Kindergarten to 12th grade were in public school and 9.5% were in private school.¹⁹

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

Between 2012 and 2016, more than 85% of Georgia residents over the age of 25 have a high school diploma, and 29.4% have a bachelor's degree or higher. The residents of Atlanta have slightly higher graduation rates. In Atlanta, 89.5% of people over the age of 25 are high school graduates and over 48% have a bachelor's degree or higher.¹⁸

Income

Georgia's per capita income was below the national average from 2012 to 2016 with a per capita income of \$26,678 relative to the U.S. average of \$29,829; at the same time, the state's poverty level was above the national average.¹⁸ While median Georgia household incomes (\$51,037 in 2016) have not recovered to 2008 levels

(\$55,027), the trend appears to be reversing with the largest increase from 2013 to 2014 (\$1,513).¹⁹

Table 2. Median Household Income in Georgia and the US, 2008-2016

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

Poverty

Poverty is more prevalent in Georgia than in many states across the nation. In 2016, 17.8% of Georgians were living below the poverty line, compared with 15.1% for the U.S. overall. Over eight percent were below 50% of the federal poverty level (FPL) and 22.9% were living at less than 125% of the FPL. About 1 in 4 children in Georgia under the age of 18 are in poverty as of 2013 an increase from 2009 where 1 in 5 children under the age of 18 were in poverty. Poverty disproportionately affects race and ethnicity in Georgia. The poverty status of Georgians living below the FPL based on race and ethnicity in 2016 was 13.1% of White, 25.8% of African-Americans, 28.0% of American Indian and Alaska Native, 13.2% of Asians, 27.1% of Native Hawaiian and Other Pacific Island, and 28.7% of Hispanics.¹⁹

Economy

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

Georgia has over 1200 miles of interstate highways which connect Georgia to neighboring states and the rest of the nation, and help move workers from their homes to places of employment in the major cities. Three of the interstate highways converge in Atlanta, making it, along with Hartsfield-Jackson Atlanta International Airport, the transportation hub of the southeast. Atlanta is one of only five cities in the nation to be served by three separate interstate highways. The construction of these interstate highways was instrumental in the booming growth of Atlanta in the latter part of the 20th century. The highways helped attract business, industry, and more transportation facilities to the Atlanta area.³⁹ These advantages have led to many global headquarters establishing headquarters in Atlanta including 17 Fortune 500 companies, 30 Fortune 1000 businesses and more than 450 Fortune 500 companies having a presence in the state.⁴²

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

Two of the interstate highways - I-85 and I-285 - are near Hartsfield-Jackson Atlanta International Airport. Hartfield-Jackson is one of the busiest airports in the nation. Business travelers and those visiting Georgia add enormous impact to Georgia's economy. Hartfield-Jackson also hosts the only Perishables Complex in the southeast - allowing

for rapid movement of agricultural products. In addition, Hartsfield-Jackson is home to the Georgia Foreign Trade Zone, where Georgia companies can produce products at reduced cost, facilitating trade and increasing the overall competitiveness of companies doing business in Georgia. Combining all aspects of Hartfield-Jackson's effect on the regional economy of Atlanta, Georgia, and the southeast, it generates \$23.5 billion on an annual basis. The deep-water seaports of Savannah and Brunswick are integral to Georgia's economy as they allow products to be sent via ship to all parts of the world, while allowing foreign products to come into Georgia. The port of Savannah handles approximately 80% of the material entering Georgia via ship, and is one of the fastest growing ports in the nation.³⁹

The film and television industry is another major industry adding to Georgia's economy. Georgia offers lucrative tax incentives for television and movies making the state a popular site for filming and production stimulating further growth. Total film and television spending in Georgia hit a record of \$2.7 billion in the fiscal year that ended in July 2017, up about one-third over the prior year, and about a tenfold increase from 2008, according to figures from the state Department of Economic Development.⁴⁰

Georgia has a rich, varied, and ongoing tradition of producing quality sports teams that enhance the economy. Atlanta is home to five professional sports franchises - the Braves (Major League Baseball), Hawks (National Basketball Association), Falcons (National Football League), Dream (Women's National Basketball Association), and Atlanta United (Major League Soccer). In addition, minor league franchises are hosted by several Georgia cities. Augusta, Georgia is home to the Masters - professional golf's most famous and prestigious event. Atlanta Motor Speedway hosts one of NASCAR's biggest races each Labor Day weekend. Sports provide an economic boost for the city and remain a key revenue-generator within the tourism industry.⁴¹

Employment

As of April 2018, Georgia's unemployment rate is 4.3% ranking it 32nd in the United States. The lowest unemployment rate is 2.0% in Hawaii. High unemployment rates may have serious implications on the burden of public health and the available resources for public and social services.²

Homelessness

The homelessness rate in Georgia decreased 25% from the year 2015 to 2017. The number of unsheltered homeless individuals continues to decline in Georgia with 36% of the state's overall homeless population being unsheltered. In 2015, 5,803 individuals were unsheltered and 7,987 were in transitional or emergency housing, compared to 3,692 unsheltered and 6,681 in transitional or emergency housing in 2017.⁷ Of the homeless population, approximately 7% are veterans and 10% are considered chronically homeless.⁷

Insurance Status

Six percent of Georgia's children are uninsured, making it the state with the 9th highest rate of uninsured children. Twelve percent of the total state's population is uninsured, ranking it 3rd highest in the nation.¹¹ Those that identify as Black and White have the highest percentage of being uninsured, 40% and 34%, respectively. Twenty-one percent of Hispanics are uninsured.¹¹ This is yet another disparity that further contributes to the delay in seeking health care, increased visits to the emergency room and poor health outcomes.

Health Reform

The Affordable Care Act, signed in 2010, went into effect in 2014. It is a state decision to participate in the Medicaid expansion or not, and as of 2018 Georgia will not expand. Approximately 480,912 Georgians acquired health insurance through the marketplace at the end of 2018 open enrollment.³ DPH will continue to adapt to the changing health care landscape to promote the health of women and children.

Emerging Issues

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

Although state revenue increased in the 2018 fiscal year, the Department of Community Health faced a budget decline. The 2019 budget directs \$2.57 billion to the Department of Community Health, not including money for agencies attached for administrative purposes – which is a \$85.7 million decline from the 2017 budget. The budget decline is mostly due to an increased rate for federal matching funds in the Medicare program. Approximately 95% of the general fund is spent on health care services for Medicaid and PeachCare patients.⁵

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

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

Title V Priorities

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

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

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

Objective 1.1: Childhood Obesity

Objective 1.2: Asthma

Objective 1.3: Infant Mortality

Objective 1.4: Cardio Metabolic Syndrome

Objective 1.5: Early Brain Development

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

Objective 2.1: Healthcare Access/Primary Care

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

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

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

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

III.C. Needs Assessment

FY 2019 Application/FY 2017 Annual Report Update

The MCH Section developed the MCH Family Consumer Partnership Strategic Plan in 2015 to engage families and increase family and consumer partnership across all MCH programs as part of its MCH Transformation 3.0. Family consumer partnership is a shared responsibility among each MCH program.

In the third year of the strategic plan, a gap analysis was conducted with the use of the “*Patient and Family Engagement: A Framework for Understanding the Elements and Development Interventions and Policies*,”³⁶ as a model to compare MCH’s desired performance against actual performance at both the state and local district levels. The model seeks to create a pathway toward better-quality health care, more-efficient care, and improved population health. The framework has three levels of engagement: direct care, organizational design and governance, and policy making. Within these three levels, there is a continuum of engagement that moves from consultation to involvement, then partnership and shared leadership.

Introduction

Family engagement or family-centered care has shown to improve health outcomes for children with and without special healthcare needs. In recent years, there have been changes to the Title V MCH Services Block Grant to strengthen the focus on family engagement and create more requirements for engaging families within MCH and CYSHCN program planning and assessment.³⁷

The purpose of this study aims to assess the measures that MCH programs utilized to support family engagement. Results will assist MCH programs in identifying areas of improvement and enhancement of family engagement throughout the state of Georgia.

Methods

To analyze family engagement data a mixed-method approach was used to critically assess how DPH employees support family engagement activities and evaluation factors that may contribute to family’s abilities to engage with MCH programs. The mixed-method approach is used to emphasize the techniques or methods of collecting and analyzing data⁴³ from the use of quantitative and qualitative methods, not assessing the assumption of worldviews related to family engagement. The first technique used in-person and telephone interviews with key informants through snowball sampling of state and district program staff members from Children’s Medical Services (CMS) and Oral Health. The second technique used SurveyMonkey to administer the *Title V: Family Engagement Survey (FES)* through a convenience sampling of state and district MCH participants/staff members who attended the 2018 Second Annual MCH Conference in Athens, GA from May 1-3, 2018. The FES was sent to all MCH employees through an invitation from the Title V program staff to be completed by June 1, 2018. The aim for the second-round convenience sampling was to increase response rates of the online survey and to capture responses from those who did not have an opportunity to complete the survey during the conference and/or were unable to attend the conference.

Participants

Participants self-identified as state, district staff (including MCH administration and DPH related department members) and external partners who have contracts with MCH programs (n=216). All participants voluntarily

consented to in-person, over the phone and/or responded to an online or paper survey (*Title V: Family Engagement Survey*). Participants came from the following top three districts: Dekalb (n=29), Southwest (n=17), and East Central (n=15). MCH programs with highest participation were: CMS (n=34), Children First and First Care (n=24) and Women's Health (n=21). For this study, participants who self-identified their work in Child Health, Women's Health, and Oral Health were included in final analysis on levels of engagement, whereas individuals who self-identified their work exclusive of the mentioned MCH programs and external partners were excluded in the analysis of program specific assessment of levels of engagement but included in total numbers of levels of engagement.

Analysis

Key Informant Interviews

Twenty-two key informant interviews were conducted with three state and eight district program staff from the CMS and Oral Health programs. The interviews consisted of six questions regarding current activities about family engagement. The program staff gave verbal consent to the participation and recording of the interview. The interviews with state staff were conducted in-person while telephone interviews were conducted with district staff. Carmen's et al. family engagement framework (Figure 1) was used as a guide to create thematic codes for a codebook (Supporting Document #03- FE Interview Codebook). The key informant interviews were manually transcribed into Microsoft Word then uploaded into Nvivo 11 Pro to filter and extract passages for each thematic code.

Title V: Family Engagement Survey (FES)

The online survey resulted in a total of 194 responses. The survey consisted of 22-questions (including of two 6-point Likert scales and one open-ended question requesting participant feedback and/or suggestions on family engagement). The questions of the FES are centered on two themes: the continuum of engagement and factors influencing engagement.³⁶ Analysis of data from the online survey, utilized output analytic tools within SurveyMonkey which summarized individual responses and trends. Further analysis used Microsoft Excel to filter out responses by program and grouped questions accordingly to individual responses.

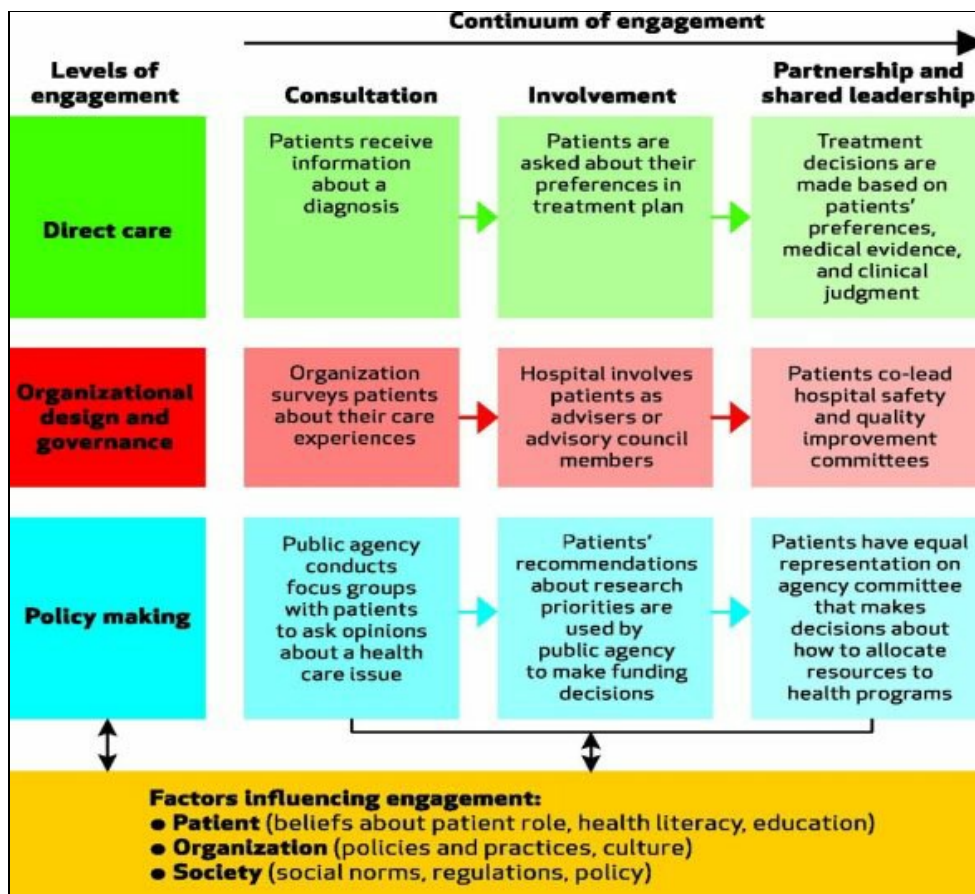


Figure 1: Carmen et al. (2013) multidimensional framework³⁶ for patient and family engagement in health and health care

Results

Key Informant Interviews

The CMS and Oral Health programs are depicted at various levels of engagement from the direct care setting to incorporating patient and family engagement into organizational design, governance, and policy making. Figure 2 displays the results of the key informant interviews based on family engagement activities by program. The greatest reported level of engagement within CMS and Oral Health programs was direct care (n=100). Within the direct care continuum, the highest level of engagement can be found at the consultation level with patient/families receiving education about a diagnosis from both programs (n=114). Oral Health narrated examples of providing patient education (n=67) through existing state programs (i.e., Head Start) whereas CMS provides patient education (n=47) by means of literature, resources, and referrals to specialty/support services. State CMS staff discussed instances of integrating families' values and experiences in the organizational design and governance of the program (n=10); however, the same could not be said among district CMS staff (n=0). Mentions of family involvement decreased throughout the continuum of engagement categories as the level of engagement increased. There were low levels of engagement on the policy making level among all the interviewees. The state staff from both programs gave 1-3 instances of patient/family involvement on the lower end of the continuum related to policy making. There were no references to the higher end of the continuum in the organizational design and governance or policy making levels from all participants.

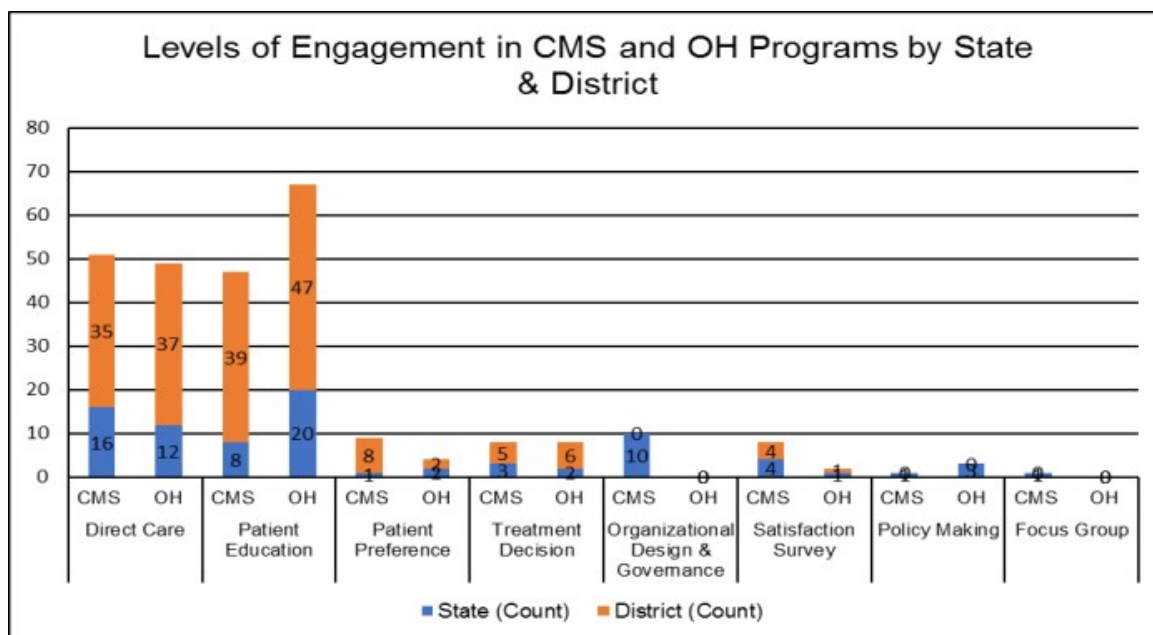


Figure 2: Count of family engagement activities in Children’s Medical Services (CMS) and Oral Health (OH) Programs by State and District staff

Figure 3 displays the factors influencing engagement within CMS and Oral Health programs at the state and district levels. CMS staff acknowledged belief of patient role, other patient factors (e.g. too busy/no time) and being a vulnerable population as influencing factor. The Oral Health program staff collectively identified health literacy, social norms about dental care, and other patient factors (e.g. patient compliance) affect the willingness of the patients and families to engage.

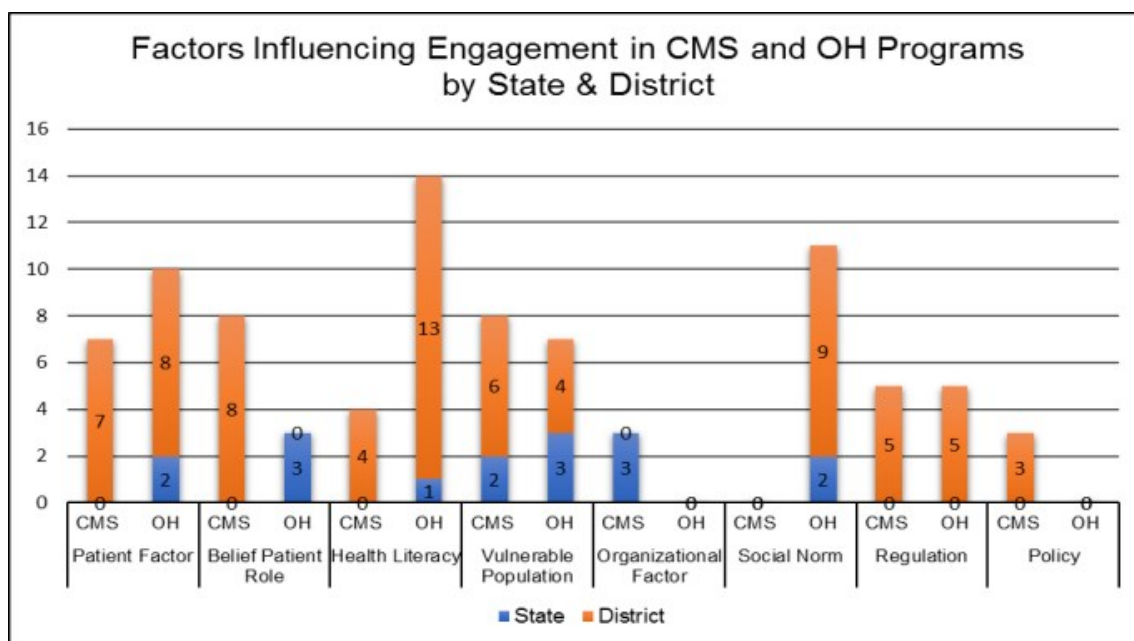


Figure 3: Count of factors influencing family engagement activities in Children’s Medical Services (CMS) and Oral Health (OH) Programs by State and District staff

To assess how MCH employees engaged with families within the past 12 months based on the three continuum of engagement categories: direct care, organizational design and governance, and policy making found that most engaged families very often and/or always (Figure 4). In the category of direct care, all respondents (n=194) were more likely to always agree with the following statements: families received information about a diagnosis (n=83), family(ies) are asked about their preferences in care/treatment (n=88), and treatment decisions are made based on families' preferences, medical evidence, and clinical judgment (n=105). Among the organizational design and governance category, responses from participants had higher variance in how often individuals engage families from rarely, sometimes, very often, always, and don't know/not applicable. For instance, respondents were equally split on their perception on their organization/department surveys families about their care experience (rarely=18; sometimes=40; very often=44; always=44; and don't know/not applicable=37) versus the higher number of don't know/not applicable on the question of my organization involves families as advisers or advisory council members (don't know/not applicable=69). Respondents were more likely to cite sometimes (n=47) to how often the organization uses interactive web-based resources to engage families. Within the category of policy making, most of all respondents were less familiar with ways their organization engaged families on policy making activities.

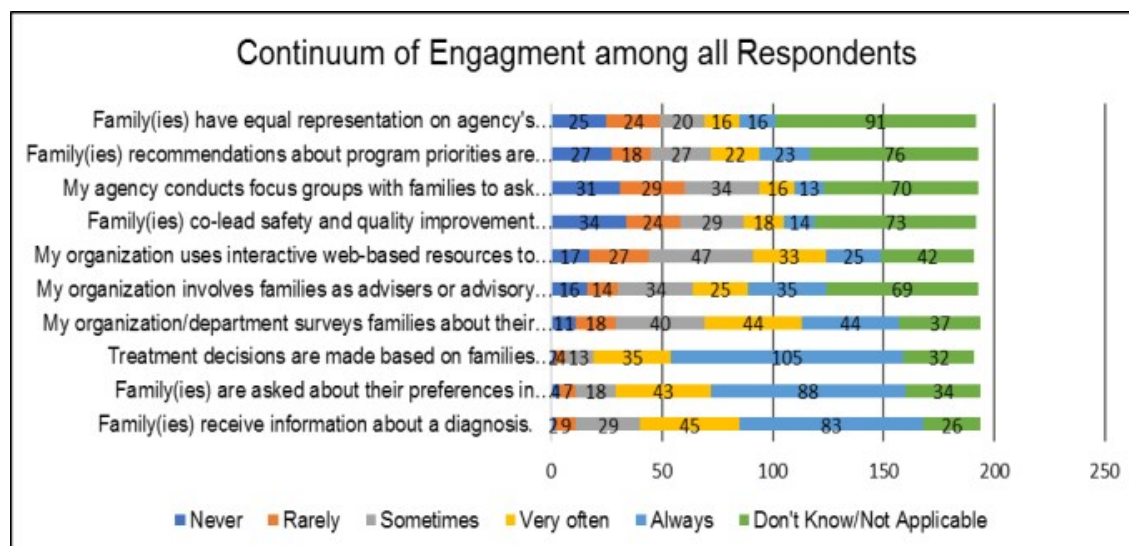


Figure 4: Chart taken from SurveyMonkey analysis excel file. Displays the total number of respondents for **levels of engagement** (N=194).

Descriptive analysis found that the majority of MCH programs had greater engagement with families or patients in direct care levels versus organizational design and governance levels. The survey found that respondents from MCH programs who provide higher number of services to families had greater levels of engagement in direct care and higher response rates. Figure 5 found Child Health programs had greater engagement with families as it relates to direct care than organizational design and governance and policy making.

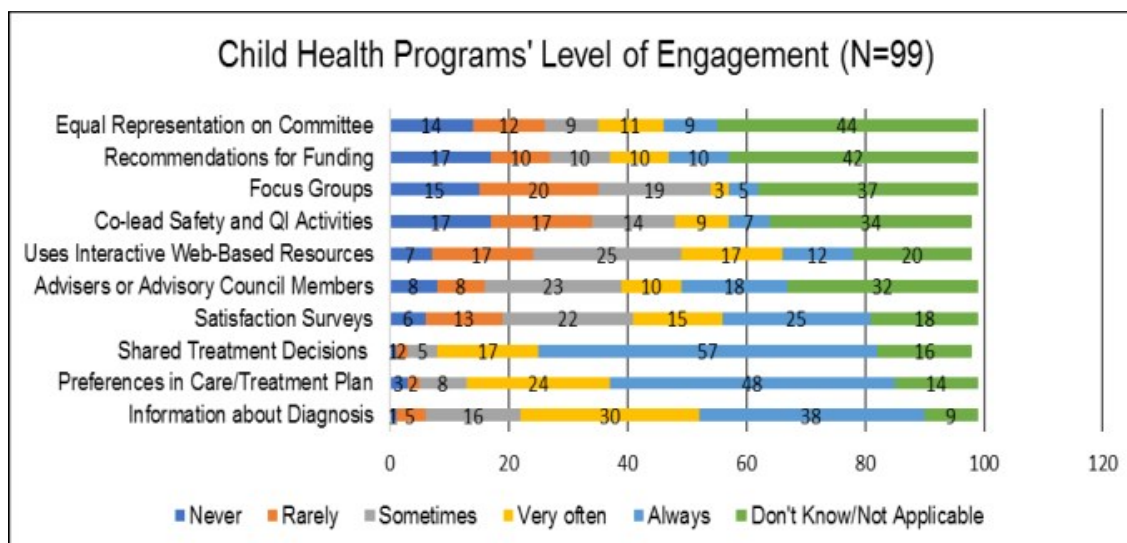


Figure 5: This chart was created from the Child Health Respondents worksheet. Respondents include Children First, CMS, NBS, EHDI, BCW, and Home Visiting (N=99).

Figure 6 shows the level of engagement among Women's Health respondents (including individuals who work in the areas of family planning, women's health, and perinatal case management (PCM)) were more likely to cite always in reference to direct care questions and had lower levels of engagement in policy making questions. The survey found that majority of respondents were not aware of ways to engage families on organizational design and governance. Figure 7 shows the levels of engagement among Oral Health respondents were more likely to cite always to questions related to direct care versus don't know/not applicable to questions related to organizational design and governance and policy making.

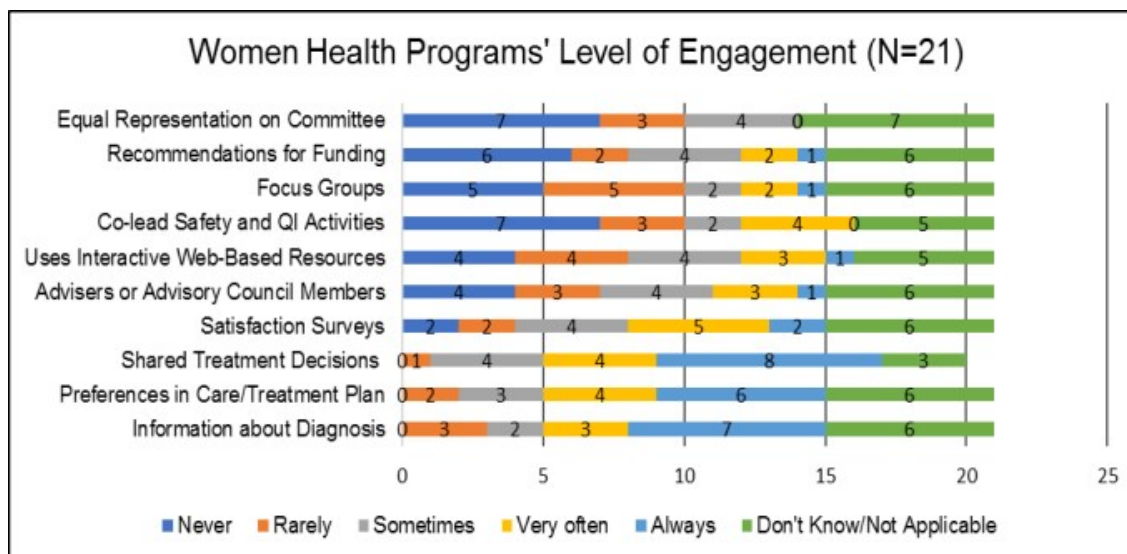


Figure 6: This chart was created from the Women's Health Respondents worksheet. Respondents include Family Planning and PCM (N=21).

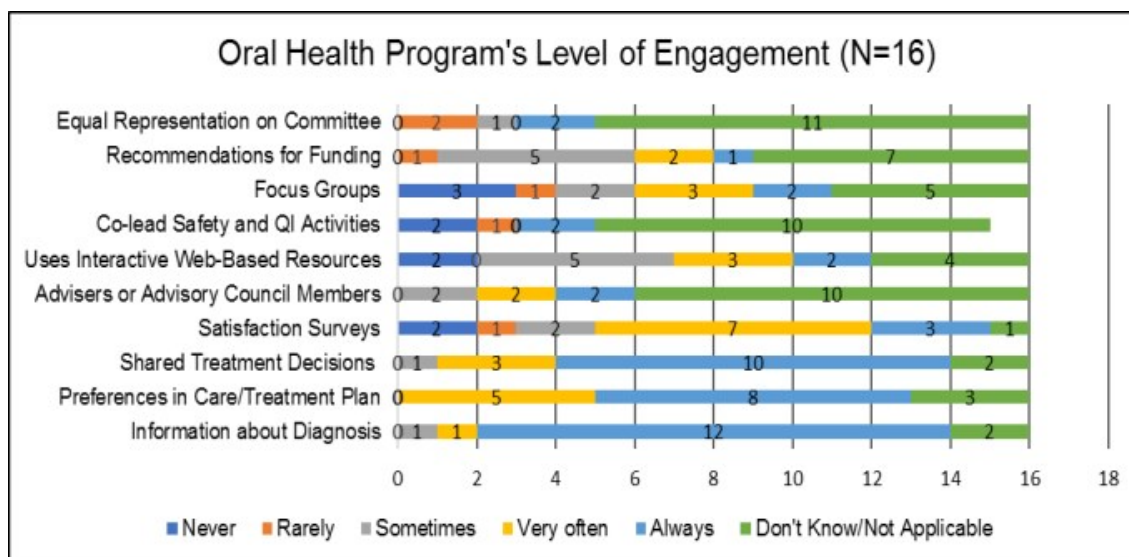


Figure 7: This chart was created from the Oral Health Respondents worksheet (N=16).

To assess factors that may or may not influence family engagement efforts among MCH employees based on three areas: the patient, the organization, and society. The majority of respondents from MCH programs agreed with the following factors: beliefs about the family's role, health literacy, my organization's policies and practices, family's culture, social norms, regulations, policy, practices, transportation, employment status, and taking time off from work influencing family engagement efforts (Figure 8). There were no found differences between MCH programs on the factors influencing family engagement except for how policy may or may not influence engagement (CH=44, WH=7, and OH=5).

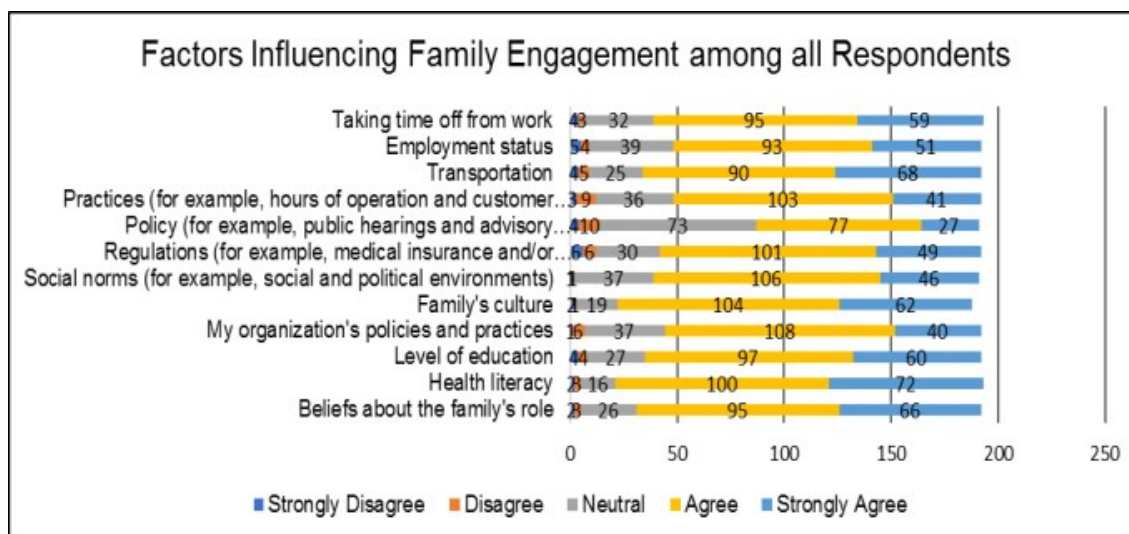


Figure 8: Chart taken from SurveyMonkey analysis excel file. Displays the total number of respondents for **factors that influence** family engagement (N=194).

Limitations

This study presented some limitations in sampling. Limitations in the convenience sampling of respondents for the *Title V: Family Engagement Survey* raised concerns related to response rate and potentially duplicated responses. Due to the low response rate of respondents who attended the Second Annual MCH Conference, internal leadership

determined the survey should be distributed out to all district staff members (including those individuals who attended the conference and those who did not) via e-mail blast to increase the response rate. The second push for survey responses may or may not have duplicated responses due to the inability to link all responses to contact information which was optional. In addition, individuals who participated in the key informant interviews may or may not have participated in the FES.

Conclusions

As part of the MCH Family Consumer Partnership Strategic Plan, a mixed-method approach was utilized to perform a gap analysis and program evaluation as to how DPH employees support family engagement activities and practices. In this study, family engagement among MCH employees was found to have the greatest engagement at direct care level on the continuum of engagement. Organizational design, governance and policy making are areas that need further improvement. The preliminary nature of this study has allowed MCH to determine strengths and weaknesses in how family engagement efforts are carried out by state and district employees. Future studies could incorporate greater rigor with a larger snowball sampling of state and district employees and the introduction of an annual Family Engagement Survey to evaluate trends in responses over time by program. This study gives a greater understanding of ongoing needs to improve family engagement and what factors contribute to the family's abilities to engage in MCH programs. Additionally, more work is needed to address communication to various stakeholder groups on the importance of family engagement and the benefits of family consumer partnerships within all MCH programs.

FY 2018 Application/FY 2016 Annual Report Update

On-Going Needs Assessment: Birth Injury

The Georgia Department of Public Health (DPH) Title V Program continuously receives information regarding MCH priorities, strategies and programs through dialogue with stakeholders and consumers, and program evaluation. Each year the Title V Program chooses one or two topic areas to formally investigate and include in the Title V block grant application.

In 2016, the Title V Program received a public comment from a parent, whose infant experienced a significant birth injury resulting in paralysis of an arm, regarding the lack of attention and coordination of services for infants who have experienced a birth injury. The parent's comment included a request to identify the significance of birth injuries and the feasibility of creating a surveillance system for birth injuries.

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

Introduction

Birth injuries, also known as birth traumas result from a physical injury a baby incurs during its' delivery.³² According to the Centers of Disease Control and Prevention (CDC) in 2014, the rate of infant mortality was 5.82 deaths per 1,000 live births. Birth injuries are a cause of infant death and account for approximately 5% of all infant mortalities in the United States in 2016.²⁷ Georgia alone had a total of 1,023 infant deaths in 2015, but specific data on causes related to birth injuries are unknown.

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

Methods

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

Results

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

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

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

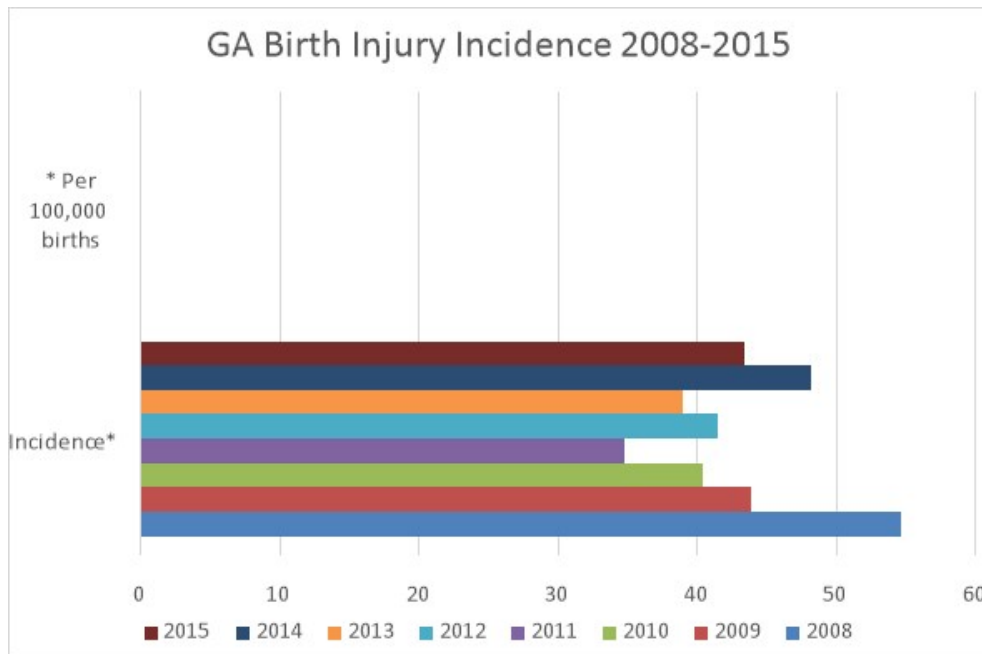
Characteristic	% (n)	Mean	Median
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Mother's Race			
White	66.96 (304)		
Black	25.33 (115)		
Asian	2.20 (10)		
Multiracial	3.74 (17)		
Mother's Ethnicity			
Hispanic	12.56 (57)		
Non-Hispanic	85.02 (386)		
Mother's Age		27.18±6.41	26
Mother's Education			
8th Grade or Less	3.52 (16)		
9 th -12 th Grade No Diploma	13.00 (59)		
High School Graduate or GED Obtained	29.74 (135)		
Some College or Higher	48.90 (222)		
Unknown	4.85 (22)		
Mother's Tobacco Use			
Yes	9.91 (45)		
No	90.09 (409)		
Insurance Type			
Medicaid Managed Care	1.98 (9)		
Blue Cross/Blue Shield	.22 (1)		
Tricare	4.85 (22)		
Medicaid	41.41 (188)		
Commercial Insurance	28.41 (129)		
Other Government Assistance	1.76 (8)		
Other	9.25 (42)		
Self Pay	4.85 (22)		
Unknown	7.27 (33)		
Birth Out of Hospital			
Yes	.66 (3)		
No	99.34 (451)		
Place of Birth			
Hospital	99.12 (450)		
Free Standing Birth Center	.22 (1)		
Residence (intended)	.22 (1)		
Residence (unintended)	.44 (2)		
Mother's First Birth			
Yes	43.61 (198)		
No	53.30 (242)		
Unknown	11.10 (5)		
Not Applicable	1.98 (9)		
Number of Prenatal Care Visits (of mothers who had at least one prenatal care visit)		11.83±5.55	12

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

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

* Per
100,000
births



Limitations

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

Conclusions

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

FY 2017 Application/FY 2015 Annual Report Update

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

The following reports were used for the Ongoing Needs Assessment:

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

Findings from 2015 Needs Assessment

Suicide

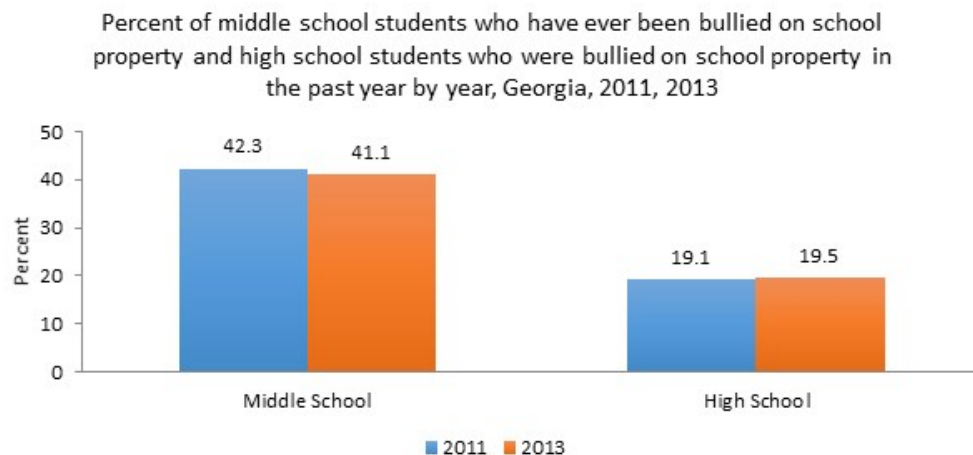
The adolescent suicide death rate increased from 3.2 in 2012 to 5.1 in 2013. From 2009-2013, the rate was 1.4 in those ages 10-14, 5.1 in those 15-17 and 8.2 in those 18-19. The rate was approximately twice as high among Non-Hispanic Whites (5.3) compared to Non-Hispanic Blacks (2.6) and Hispanics (2.7).

Bullying

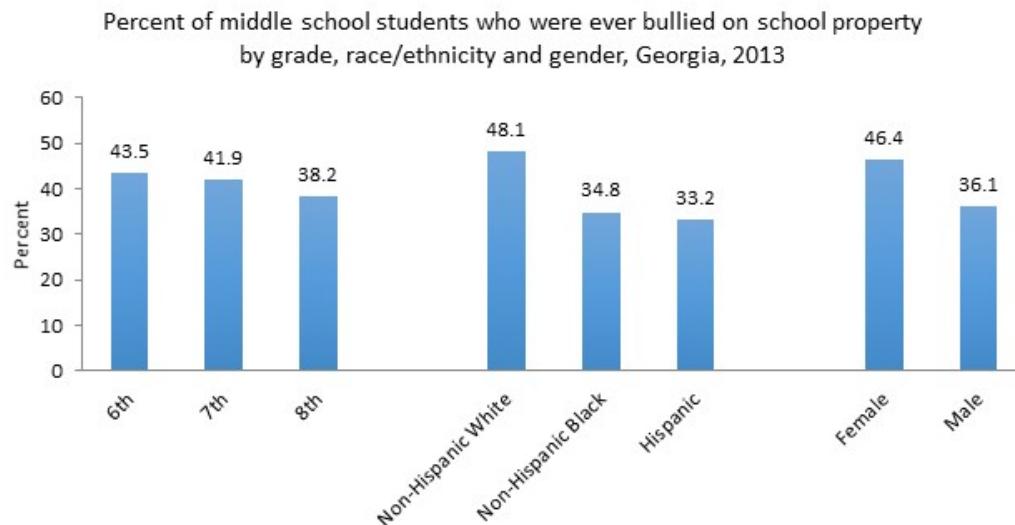
Just over 40 percent of Georgia's middle school students reported having ever been bullied on school property in 2011 and 2013. Among high school students during the same years, just over 19 percent were bullied on school property during the past year.

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

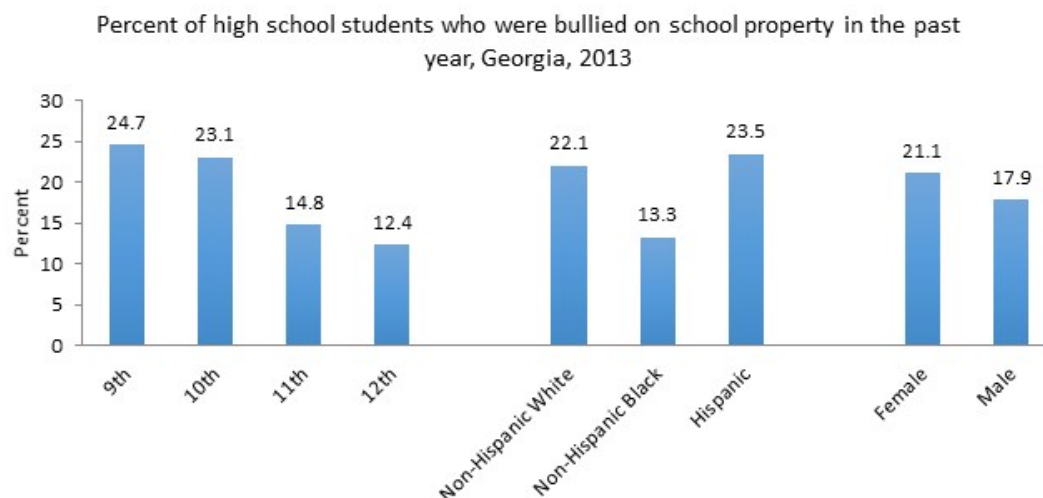
Bullying on school property during the past year was more prevalent among high school students in 9th and 10th grade (24.7 percent and 23.1 percent) compared to those in 11th and 12th grade (14.8 percent and 12.4 percent). Non-Hispanic Whites and Hispanics were bullied on school property in the past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



Source: YRBS



Source: YRBS



Source: YRBS

Victims and Bullies

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

Findings from 2016 Ongoing Needs Assessment

Suicide-Georgia Child Fatality Report

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

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

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

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

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

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

Strengths

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

Areas of Opportunity

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

Bullying- Evidence for Bullying Prevention in Georgia

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

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

Strengths

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

Areas of Opportunity

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

High Risk Groups – MMWR

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

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

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

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

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

Strengths

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

Areas of Opportunity

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

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

II.B.1. Process

Goals, Framework and Methodology Guiding Needs Assessment Process

Georgia's Title V Needs Assessment was conducted by the Maternal and Child Health (MCH) Office of Epidemiology within the Georgia Department of Public Health. MCH currently uses the following mission and vision to guide all programmatic efforts, including the Title V Needs Assessment:

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

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

The focus of MCH Epidemiology is to promote and improve the health and well-being of women, children and families by building data capacity at the state and local levels to effectively use information for public health actions.

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

The Needs Assessment was organized by six population health domains: maternal/women's health, perinatal health, children's health, adolescent health, children and youth with special health care needs (CYSHCN) and cross-cutting/life-course. Key steps for the needs assessment process are outlined in Figure 1.

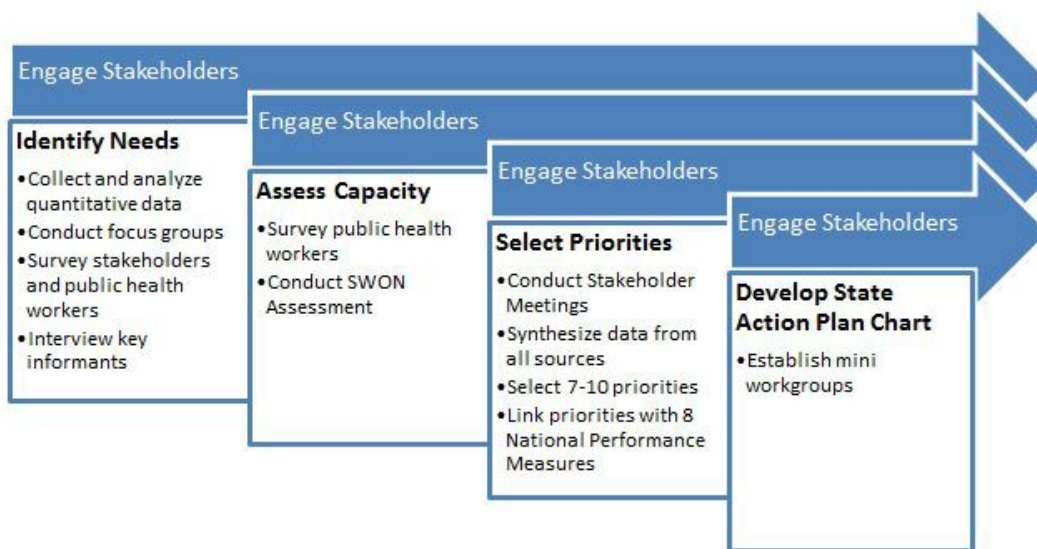


Figure 1. Georgia Title V Needs Assessment Process

Quantitative Methods

A thorough examination of the health status of women and children in Georgia was conducted by analyzing the most current information available by population domain. Trends over time were presented for all data where possible and information was stratified by relevant variables including age, race/ethnicity, education, income, gender, health insurance coverage and CYSHCN status. Comparisons with national averages and Healthy People 2020 objectives were made when possible to provide better context for the data provided. Due to a lack of current data regarding CYSHCN, projection analysis was applied to the 2009/10 National Survey of Children with Special Health Care Needs results. The following data sources were used:

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

- Water Fluoridation Reporting System

Focus Groups

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

Table 1. Needs Assessment Focus Groups by Location and Topic

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

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

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

MCH program and epidemiology staff reviewed all data from the quantitative and qualitative analysis in order to select the potential priority needs for the state for the population domains relevant to their work. Staff individually indicated their top needs based on the data reports and then a consensus was developed across all members. They were asked to primarily consider whether the data indicated an area of need, whether it was measurable, and whether MCH had the capacity and authority to address the need. A total of 34 priorities were selected and brought to stakeholders for prioritization.

Stakeholder prioritization occurred during two meetings. Meetings were held in Atlanta and Valdosta to encourage the participation of stakeholders in both North and South Georgia. A total of 100 stakeholders representing 38 organizations attended. Following group discussions, each stakeholder individually completed a prioritization tool. The tool was designed to rate each need on a scale of 1 to 5 based on the following criteria: seriousness of the issue, health equity, economic

impact, trend, magnitude of the problem and importance. Stakeholders provided key activities and strategies within each area of need to inform the development of the State Action Plan Chart.

The individual rating tools were analyzed across the two meetings to determine the highest rated priority needs in each domain. When determining priorities, the needs with the highest rating in each domain were considered first. The data and results from survey rankings were reviewed to assess consistency and confirm an area of need. Needs were then aligned with a NPM when possible (displayed in Table 2).

Table 2. Linkage between Priority Needs and National Performance Measures

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

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

II.B.2. Findings

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

II.B.2.a. MCH Population Needs

Maternal/Women's Health

Maternal Mortality

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

Preventive Visit

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

Family Planning

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

Low-Risk Cesarean Deliveries

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

Table 3. Maternal/Women's Health Qualitative Findings

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

Strengths and Needs

The data indicate areas where sub-groups of Georgia's population are achieving acceptable outcomes. The percentage of

women receiving a preventive visit in Georgia is higher than the national average. In Georgia, the percentage is highest among non-Hispanic Blacks and women with higher educational attainment. Younger women in Georgia undergo cesarean deliveries for a low-risk birth less often than older women.

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

Programmatic Efforts to be Continued

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

Areas of Opportunity

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

Perinatal Health

Infant Mortality

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

Perinatal Regionalization

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

Breastfeeding Initiation

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

Breastfeeding Exclusivity

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

Safe Sleep

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

Table 4. Perinatal Health Qualitative Findings

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

Strengths and Needs

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

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

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

Programmatic Efforts to be Continued

- The Georgia 5-STAR initiative has been highly successful in motivating hospitals to take steps toward becoming breastfeeding-friendly
- The March of Dimes banner program has been successful in reducing early elective deliveries
- The Safe to Sleep campaign continues to be promoted to change community norms regarding safe sleep environments

Areas of Opportunity

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

Child Health

Developmental Screening

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

Non-Fatal Injury

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

Physical Activity

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

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

Table 5. Child Health Qualitative Findings

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

Strengths and Needs

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

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

Programmatic Efforts to be Continued

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

Areas of Opportunity

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

Adolescent Health

Suicide

The adolescent suicide death rate increased from 3.2 in 2012 to 5.1 in 2013 (Figure 26). From 2009-2013, the rate was 1.4

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

Bullying

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

Physical Activity

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

Non-Fatal Injury

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

Preventive Visits

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

Table 6. Adolescent Health Qualitative Findings

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

Strengths and Needs

Georgia has seen success in reducing hospitalizations due to non-fatal injury. The rate has decreased over the previous five years. The prevalence of bullying and the increase in the suicide death rate indicates a need to address suicide, violence and bullying among adolescents. The overall percentages of adolescents performing recommended amounts of physical activity and receiving well-visits remain low.

Programmatic Efforts to be Continued

- Family planning clinics will continue to provide services to adolescents

Areas of Opportunity

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

Children and Youth with Special Health Care Needs (CYSHCN)

Transition to Adulthood

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

Medical Home

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

Table 7. CYSHCN Qualitative Findings

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

Strengths and Needs

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

Programmatic Efforts to be Continued

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

Areas of Opportunity

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

Cross-Cutting

Smoking during Pregnancy

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

Second Hand Smoke Exposure

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

Dental Visits during Pregnancy

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

Childhood Dental Visits

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

Health Insurance

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

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

Strengths and Needs

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

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

Programmatic Efforts to be Continued

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

Areas of Opportunity

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

II.B.2.b Title V Program Capacity

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

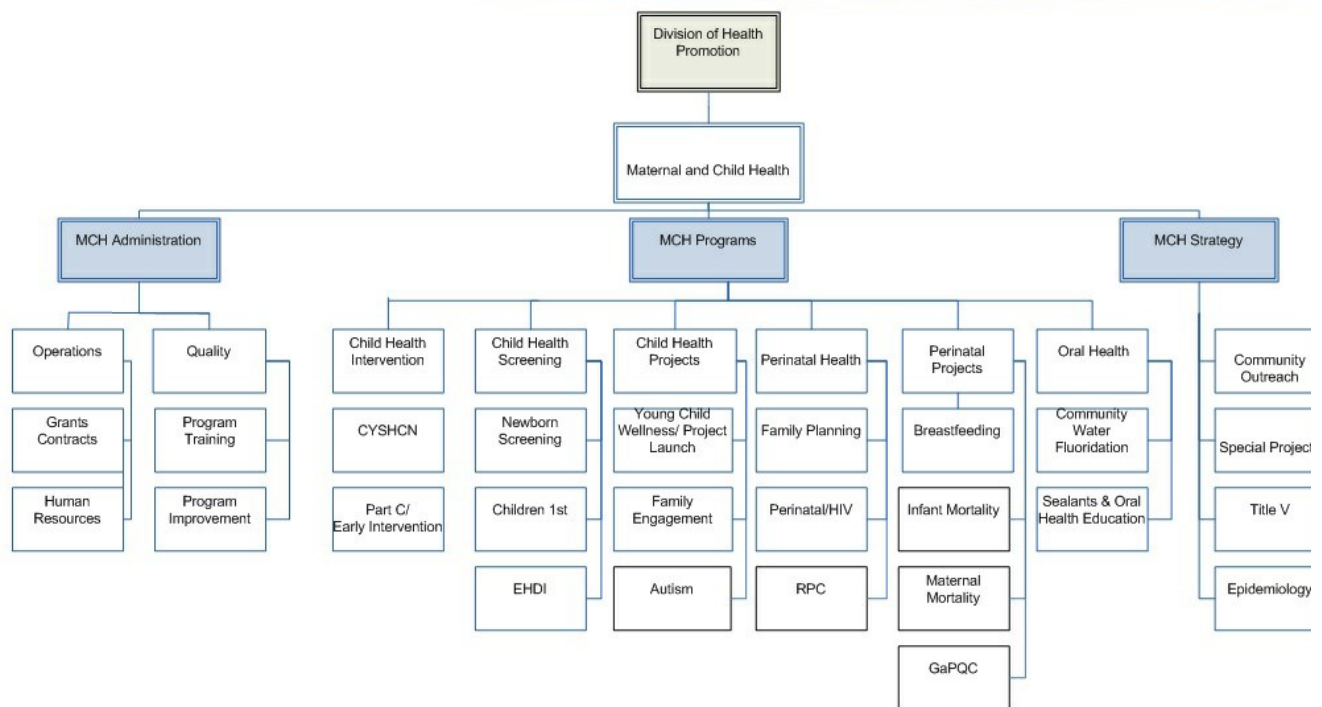
The Department of Public Health is the lead agency in preventing disease, injury and disability; promoting health and well-being; and preparing for and responding to disasters from a public health perspective. The agency's Commissioner reports directly to the Governor.

The Maternal and Child Health Section (MCH), located within the Division of Health Promotion, has primary responsibility for

administration of the Title V Block Grant. The MCH Director serves as the Title V Director. In 2014, MCH began a restructure to provide better coordination across programs. The restructure is expected to be completed by December 2015. There are three Offices within MCH: Office of Programs, Office of Strategy and Office of Administration. The Office of Programs includes the Perinatal Health Program, Perinatal Health Projects, Child Health Screening, Child Health Intervention (CYSHCN programs), Child Health Projects and Oral Health. The CYSHCN programs, Children's Medical Services and Babies Can't Wait, are both under the administration of the CYSHCN Director and Title V Director. The Office of Strategy is responsible for MCH Epidemiology, Community Outreach, Special Projects and activities to support the Title V application. The Office of Administration is responsible for Operations and Quality.



Division of Health Promotion Maternal and Child Health Section



August 18, 2015

Title V provides funding to Injury Prevention, located in Health Protection, and Georgia SHAPE, located in the Chronic Disease Prevention Section. The following list provides a description of all Title V funded programs.

Title V Funded Programs

Babies Can't Wait (BCW) provides a coordinated, comprehensive and integrated system of early intervention services for infants and toddlers birth to 3 as outlined by IDEA Part C.

Children First serves as the "Single Point of Entry" to a statewide collaborative system of public health prevention based

programs and services for children with poor health or developmental delays.

Children's Medical Services (CMS) ensures a community-based, coordinated, family focused, culturally appropriate, comprehensive system of quality specialty health care services available for Georgia's children with chronic medical conditions from birth to 21 years of age who live in low income households.

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

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

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

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

MCH Epidemiology (MCH EPI) supports data collection and analysis for all MCH programs and administers State Systems Development Initiative (SSDI), Early Hearing and Detection Intervention (EHDI) and Pregnancy Risk Assessment Monitoring System (PRAMS).

Newborn Screening (NBS) ensures that every newborn in Georgia has a specimen collected to screen for 28 inherited disorders that would otherwise cause significant morbidity or death.

Oral Health provides community water fluoridation, school-linked fluoride supplement programs for high-risk children, dental sealants and dental health education.

Perinatal Health assures pregnant women in Georgia have every opportunity access comprehensive perinatal health care services appropriate to meet their individual needs and supports outreach efforts at six Regional Perinatal Centers. Perinatal health also addresses infant mortality, maternal mortality and breastfeeding.

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

MCH currently has the capacity (structural resources, data systems, partnerships and competencies) to promote the health of all MCH populations. In each domain, MCH initiates partnerships with external organizations to ensure a statewide system of services that are comprehensive, community-based, coordinated and family centered.

Maternal/Women's Health

MCH uses Title V funds to provide services for women of reproductive age. Family planning clinics supported by Title V provide contraceptive counseling and preventive services. Cancer screenings and HPV vaccines are provided in the family planning clinics through a partnership with the Chronic Disease Prevention Section. MCH actively supports the Maternal Mortality Review Committee (MMRC) and will engage in various initiatives to promote maternal health, including the March of Dimes (MoD) Banner program to prevent early elective deliveries. MCH has epidemiology staff to support programmatic efforts. Data sources used are PRAMS, Vital Records, BRFSS and Family Planning program data. MCH also houses the data for the MMRC and identifies cases for review.

MCH has active partnerships with hospitals, private practice physicians, academic institutions, cancer and HIV screening agencies, the Chronic Disease Prevention Section, Healthy Mothers, Healthy Babies (HMHB), Georgia Obstetrical and Gynecological Society (GOGS) and March of Dimes (MoD) to ensure a comprehensive system of services for women of reproductive age in Georgia.

Perinatal Health

Title V staff supports newborn screening, breastfeeding initiatives, preterm birth initiatives, perinatal regionalization and the Safe to Sleep campaign to promote perinatal health. MCH also participates in the Georgia Perinatal Quality Collaborative (GaPQC) to implement quality improvement projects in participating hospitals. MCH also provides financial support towards the Baby LUV program and other pilot projects that target high-risk pregnancies. Title V supports epidemiology staff to collect and analyze data on perinatal health. The primary data sources used are Vital Records and PRAMS.

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

Child Health

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

To ensure a comprehensive system of services among children, MCH has active partnerships with the Chronic Disease Prevention Section, Department of Early Care and Learning (DECAL), Department of Education (DOE), academic institutions, GA Chapter of the American Academy of Pediatrics (GA-AAP), GA Academy of Family Physicians (GA-AFP), Marcus Autism and Emory Autism Center.

Adolescent Health

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

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

CYSHCN

MCH supports several programs to provide services to Georgia's CYSHCN. Children First acts as the point of entry for children with an identified special need. BCW provides services for children from birth to three. CMS is established and continues to provide on-going, comprehensive medical care for CYSHCN that are not eligible for state funded Medicaid and SCHIP programs. CMS promotes access to specialty care, care coordination, transition to adulthood and medical homes for CYSHCN. Epidemiologists support data collections for CMS. MCH has a data system that only captures youth enrolled in the CMS program at the public health district-level and does not have the data system to capture individual-level data. DPH is currently in the process to improve DPH data systems; however, this is a department initiative and will take approximately 5 years to complete.

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

Oral Health

MCH has Title V, CDC, state and private-donated funds to support oral health initiatives. MCH has access to oral health data through PRAMS, NSCH, CMS and 3rd Grade and Head Start Basic Screening Surveys. The Oral Health program does not have an Oral Health Epidemiologist; however, recruitment efforts are in progress to identify a qualified candidate.

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

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

MCH Leadership Staff

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

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

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

Valeria Newton-Lamb, MHSA is the Deputy Director of Administration. She has over 20 years of experience in health care

administration and managing large scale, complex operations for private and publicly funded organizations. Ms. Newton-Lamb is responsible for overseeing quality assurance and operations.

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

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

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

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

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

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

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

Strengths and Needs of Workforce

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

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

Cultural Competency

Several methods are used to ensure culturally competent approaches are used in service delivery across all programs. MCH EPI routinely collects and analyzes data by race/ethnicity and income to assess health equity and inform program activities. A bilingual interviewer is on PRAMS staff to ensure sufficient response rates from the Hispanic population. Focus groups and key informant interviews were conducted among Spanish speaking families for Title V and CMS.

MCH works closely with community leaders to plan service delivery programs, collaborate on grants and implement culturally competent services that meet the unique needs of populations. Specifically, NBS works with community groups to address strategies specific to needs of the sickle cell community. Injury Prevention goes to where the members of the minority groups are, such as temples, churches or local businesses in an effort to establish community ties.

In all MCH programs, services and/or educational materials are provided in English and Spanish. The Oral Health program has bilingual staff that will provide outreach education targeted to Hispanic children. Oral Health also participates in the Georgia Alliance for Health Literacy to offer health literacy resources. Georgia SHAPE travels to diverse populations to educate on various physical activity and nutrition efforts. BCW and NBS hire bilingual service coordinators to assist in coordinating services in their native language. The CMS program will arrange for the provision of oral language assistance, from language interpreter and translation services, in response to the needs of Limited English Proficiency (LEP) and Sensory Impaired (SI) individuals in both face-to-face and telephone encounters with CMS. Injury Prevention addresses cultural competency through partnering with the state Refugee Health Program and its case managers to address cultures and languages, such as Nepalese, Somali, Congolese, and Iraqi.

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

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

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

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

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

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

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

Other governmental agencies: MCH has strong relationships with the Department of Community Health, Department of Behavioral Health and Developmental Disabilities, the Division of Family and Children Services and the Department of Education.

Public health and health professional educational programs and universities: MCH frequently partners with Emory University, Rollins School of Public Health, Georgia State, University of Georgia, Valdosta State University and Georgia Regents University.

Others: MCH has a contractual relationship with six regional perinatal centers (RPC) to meet the needs of the perinatal regionalization system. The Georgia Obstetrical and Gynecological Society (GOGS) is contracted to administer the Maternal Mortality Review Committee. Relationships with Children's Health Care of Atlanta and Georgia Regents University will be critical to addressing transition, as these sites have transition clinics that DPH has assisted in establishing and promoting. Parent to Parent and GA-AAP are contracted to support services for CYSHCN. Emory University conducts follow-ups for the Newborn Screening program. MCH participates in three Collaborative Improvement and Innovation Networks (ColIN): Safe Sleep, Social Determinants of Health and Perinatal Regionalization.

Family/Consumer Partnerships

Nature and Substance

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

Diversity

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

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

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

Only family/consumer partnerships in CYSHCN receive compensation, although other programs are looking to expand this

service. Families that participate in the SICC are compensated for their travel expenses to attend meetings including child care if requested. Families are compensated if they provide clerical support for their LICC. The CMS Family Engagement Specialist receives salary and benefits. Parent Partners are paid hourly.

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

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

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

Impact of family/consumer partnership on programs and policies

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

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

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

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

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

III.D. Financial Narrative

	2015		2016	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$16,438,560	\$16,611,128	\$16,611,128	\$16,838,159
State Funds	\$92,757,286	\$91,825,080	\$98,513,369	\$96,689,064
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$157,349,758	\$141,371,383	\$132,713,617	\$141,206,672
Program Funds	\$3,771,854	\$9,133,504	\$7,652,922	\$8,319,821
SubTotal	\$270,317,458	\$258,941,095	\$255,491,036	\$263,053,716
Other Federal Funds	\$275,603,567	\$27,954,952	\$25,324,930	\$25,570,889
Total	\$545,921,025	\$286,896,047	\$280,815,966	\$288,624,605

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

	2019	
	Budgeted	Expended
Federal Allocation	\$17,154,058	
State Funds	\$112,090,944	
Local Funds	\$0	
Other Funds	\$164,161,576	
Program Funds	\$6,857,920	
SubTotal	\$300,264,498	
Other Federal Funds	\$33,901,215	
Total	\$334,165,713	

III.D.1. Expenditures

FY 2017 Annual Report Expenditures

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

The MCH Block Grant funding and expenditures for FY 2017 is based on actual expenditures and supported data. Expenditures are reported out of PeopleSoft Financials and Uniform Accounting System (UAS), to ensure compliance requirements are met such as:

- MCH Program Staff meets with local districts, to conduct monthly and quarterly calls to ensure districts are spending funds according to federal or state requirements.
- Funds allocated to the districts are based on Performance Measures and Allocation Formula Methods to ensure compliance requirements are met.
- Local Districts are required to submit quarterly reports to program managers to ensure oversight of expenditures.

The total FY 2017 Federal-State Title V Block Grant Partnership Annual Report Expended \$283,334,784 and the Georgia Maintenance of Effort (MOE) sustained the level of \$36,079,622 The FY 2017 State MCH Budget /Expenditure Grand Total is \$319,924,206. (See Form 2 lines 11).

The Federal MCH Block Grant funding was used to support the activities within the MCH programs. To provide services to public health prevention based programs, improving the health of women and infants, supporting the local coalitions, promoting developmental screenings among children, comprehensive oral health system of services, women of reproductive age, preterm birth initiatives, and conduct data analyses and disseminate information from surveillance systems. The Title V 30/30/10 requirement reflects FY 17 expended measures. The Federal MCH Block Grant expended \$16,870,802. Of this amount follows:

- Preventive and Primary Care for Children 30% requirement expended: \$5,148,881 (30.5%)
 - Children with Special Health Care Needs 30% requirement expended: \$8,174,839 (48.4%)
 - Title V Administrative Costs 10% requirement expended: \$731,954 (4.3%)
- (See Form 2 lines 1A-1C).

Expenditures for Federal MCH Title V Program Services are shown by types of MCH services listed below:

- Direct Services (Preventive and Primary care services, all pregnant women mothers, and infants up to age one), expended \$2,813,486 (16.7%)
- Enabling Services expended \$6,636,814 (39.3%)
- Public Health Services and System expended \$7,420,502 (44%)

The State MCH Funds expended \$110,765,452, exceeding the State required match of \$12,653,102 for FY 2017 MCH Federal Allocation of \$16,870,802. In addition to the required match for the MCH Block Grant - additional State Funds are used to support MCH programs and partnership activities in the MCH Population Domains: Women/Maternal Health, Child Health, Adolescent Health and Children with Special Health Care Needs. (See Form 2 line 3).

The Other Funds expended \$149,036,298, funds are used to support six Regional Perinatal Centers (RPC), to provide

advanced care for high risk mothers and infants. Georgia Newborn Screening (NBS) Program to ensure every newborn is screened for 28 heritable disorders in Georgia Partnership with Georgia Perinatal Quality Collaborative (GaPQC), to identify and implement new quality improvement activities. Partnership with Vaccines for Children (VFC) program, which is used to fund infants less than 1 and children 1-22. (See Form 2 line 5).

The Program Income expended \$6,662,232, this income is derived from Medicaid earnings, Private Insurance, Health Check earnings and Client Self Pay, for services provided to Pregnant and Postpartum Women, Preventive and Primary Care for Children and Reproductive Health Services to Women. The expenditures are tracked and monitored through the Uniform Accounting System (UAS) monthly. The UAS data reports are reviewed quarterly for annual reporting (See Form 2 line 6).

The Other Federal Funds expended \$36,589,423, this amount represents the variation of federal funds managed under the Title V Administrator. These funds are used to support the need of preventing, promoting and improving children and youth with special health care needs and pregnant women, mothers, and infants.

Other Federal Funds consist of:

- Temporary Assistance for Needy Families (TANF)
- Georgia Early Hearing Detection and Intervention (EHDI)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Preventive Health Services Block Grant (PHHS)
- Georgia State Sys Development Initiative (SSDI)
- Georgia's Project LAUNCH
- Infants and Toddlers with Disabilities
- Georgia Oral Health Prevention Program
- Maternal, Infant and Early Childhood Home Visiting Program
- Georgia STD AAPPS Project

III.D.2. Budget

FY 2019 Application Budget

The Georgia Department of Public Health has a system of accountability to monitor the allocation and expenditures of funds provided to local health districts. The department utilizes the computer program systems such as: PeopleSoft Financials and Uniform Accounting System (UAS), where state and local health districts' administrative personnel input budgets (funds that are allocated by programs such as Children with Special Health Care Needs) and expenditures. The Maternal and Child Health Section of the Georgia Department of Public Health administers audits, monitor programs quarterly and provide technical assistance when needed.

The Maternal and Child Health total budget for FY 2019 is \$300,264,498. Of this amount, MCH expects to fund the FY 2019 budget from 5% Federal MCH Block Grant, 34% from State MCH Funds, 49% from Other Funds, 2% from Program Income and 10% from Other Federal Funds. Georgia's total Maintenance of Effort (MOE) from 1989 is \$36,079,622. As shown on Form 2, MCH effort far exceeds the match and MOE requirements. The total FY 2019 State MCH Budget Grand Total is \$334,165,713.

The required State Match for Georgia is \$12,865,543, which includes federal earmarked for Preventive and Primary Care for Children and Children with Special Health Care Needs.

For the FY 2019 Federal MCH Block Grant 30%-30%-10% requirement, \$6,213,920 (36.2%) is budgeted for Preventive and Primary Care for Children, \$6,452,729 (37.6%) is budgeted for Children with Special Health Care Needs, \$1,569,693 (9.2%) is budgeted for Title V Administrative Cost and the remainder (\$2,917,716) applies to Pregnant and All Others under the MCH Programs (See Form 2 1A-1C).

For FY 2019 Federal MCH Block Grant: (See Form 3b Federal)

- Direct Services is budgeted at \$2,293,064.
- Enabling Services is budgeted at \$7,266,532
- Public Health Services and Systems is budgeted at \$7,594,462

MCH Populations:

Pregnant Women: Title V is used in this area for Perinatal Health Services providing access to high-quality perinatal care to Georgians as we recognize that there is a direct relationship between perinatal birth outcomes and the quality of health care services. Neonatal Abstinence Syndrome (NAS) and Centering Pregnancy Services to decrease the rate of preterm and low weight babies, increase breastfeeding rates to lead to better pregnancy spacing in Georgia. The Home Visiting Program offers support and comprehensive services to at-risk families through home visits and group socialization experiences.

Infants Less Than 1 Year Old: Title V-leveraged services for this population include: Infant Mortality, Maternal Mortality, Neonatal Intensive Care Unit (NICU) Benefits and Administration - 6 tertiary centers statewide which provide clinical care and education services for high risk newborns, education and the prevention of Sudden Infant Death Syndrome (SIDS) and Other Infants Deaths (OID). Georgia Newborn Screening (NBS) Program and Epidemiology provides data and surveillance for MCH programs. Children 1st Program population-based system in the State of Georgia, designed to serve as an entry point into all public health services for children, birth – 5 years old.

Children 1-22 Years Old: Children1st facilitates early identification of at-risk children and links them with early interventions services, as well as other public health services and community based resources. The Oral Health Program contract with Richmond County Board of Health to provide dental services to mothers and children in the Augusta Health District and to provide training opportunities for pediatric dental residents in a mobile clinic environment. The Refugee Health Program protects the health of local, state, and national populations and to identify health issues that may need continued care over and beyond public health's capacity.

Children with Special Health Care Needs (CSHCN): Supports Genetic/Sickle and Children Medical Services provide care coordination and other needed medical/health services for eligible children and their families,

Federal MCH Block Grant Budget:

Federal Allocation Application Budget:	
MCH Program Measures	Budget Amount
Perinatal/Maternal Health	\$1,894,879
Infant Mortality	\$414,394
MCH Epidemiology	\$407,632
Home Visiting	\$1,338,740
Suicide Prevention	\$75,000
Child Health	\$970,830
Newborn Screening	\$2,598,913
Injury Prevention/Safe Sleep	\$550,000
Infant and Child Oral Health	\$881,248
Children with Special Health Care Needs	\$6,452,729
Administration Cost	\$1,569,693
Total Federal Allocation Budget	\$17,154,058

Other Federal Funds Budget:

Other Federal Grants	
MCH Grants	Grant Amount
Infants and Toddlers with Disabilities	\$14,642,342
Georgia Oral Health Prevention Program	\$570,000
Preventive Health Services Block Grant (PHHS)	\$630,000
Temporary Assistance for Needy Families (TANF)	\$9,153,768
Georgia's Project LAUNCH	776,398
Universal Newborn Hearing Screening	250,000
Maternal, Infant and Early Childhood Home Visiting Program	7,478,707
Georgia Early Hearing Detection and Intervention (EHDI)	200,000
Georgia's State-based Perinatal Quality Collaborative Project	200,000
Total Other Federal Budget	\$33,901,215

III.E. Five-Year State Action Plan

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

State: Georgia

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

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

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

Georgia's Title V Program is located within the Georgia Department of Public Health. Georgia operates a decentralized public health system with 18 district health departments serving 159 counties. The Title V MCH program is committed to providing a foundation for family and community health across the state and in improving quality health care services for Georgia's families.

Georgia utilizes multiple resources to design the state's Title V MCH program to address the 10 priority needs which includes a variety of evidence-based and evidence-informed strategies and increased healthcare access through telehealth. The life course perspective is used as a framework to conceptualize health and health disparities and guide improvements placing emphasis on early determinants of health and the need for integration within structural, social, and cultural contexts.

Georgia's Title V MCH program success to improve health outcomes relies on leveraging extensive state-wide partnerships. In addition to maintaining close relationships with public health districts, MCH partners with over 100 external stakeholders including Georgia's Hospital Association, Georgia's American Academy of Pediatrics, Georgia's Academy of Family Physicians, and Georgia's Obstetrics and Gynecological Society.

Families and consumers are also recognized as valued partners to making significant change in performance measures. Family centered care is a priority for MCH, identified through the needs assessment. Title V MCH aims to assess programmatic support of family engagement activities. To illustrate the value of family engagement the Title V Analyst presented a poster of this year's annual Needs Assessment on Family Engagement at the 2018 AMCHP Conference. The presentation illustrated the level of engagement for each part of the family engagement framework along with barriers influencing the programs/staff from engaging families in their work. Title V MCH continues to evaluate the level of engagement with families and develop strategies to enhance those efforts. To engage fathers and strengthen family partnerships, Georgia is participating in a pilot study of the first Pregnancy Risk Assessment Monitoring System (PRAMS) for Dads during the perinatal period. The study aims to begin the first surveillance system of new fathers, developing and piloting questions for PRAMS for fathers in Georgia. MCH Epidemiology is in the process of planning to finalize the PRAMS for Dads questionnaire using data approaches and methodology. Title V MCH recognizes that father involvement is related to improved outcomes in infants and children. Plans for the coming year include the development and implementation of a fatherhood program to strengthen father engagement.

Title V MCH programs develop and implement programs and initiatives that address the core functions of assessment, assurance and policy development. Program strategies are designed to increase awareness, provide services and promote behavior change to improve health outcomes among the MCH population, their families and/or providers working with women and children. Along with these efforts, Title V will continue developing partnerships, identifying new stakeholders and working toward collective impact through new and existing partnerships that support the goals of the Title V Block Grant.

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

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

The Health Promotion Administration Unit is responsible for MCH workforce development strategies that ensure recruitment and retention of qualified staff, training and professional development for employees and creative staffing structures that maximize funding resources. With the assistance of a human resources recruiter, MCH began utilizing the latest recruiting trends to address changing demographics and customer needs. This included prioritizing diversity, employing new tools in the interview process and using software (LinkedIn) for nationwide recruiting for highly qualified candidates. MCH, with 47 FTE's, has 95% of positions filled including all program director and manager positions. The MCH leadership staff is comprised of the following individuals:

LaToya Osmani, MPH serves as the Director of the Division of Health Promotion. She is responsible for providing leadership to the MCH Section, Supplemental Nutrition Program for Women, Infants, and Children (WIC), and Oral Health Program. She has over eighteen years of experience in public health ranging from the federal, local, non-profit, private and global arenas. In addition to her public health experience, she has several years of experience in informatics, business analysis and teaching public health.

Jeannine Galloway, MPH is the Maternal and Child Health Director. In her role she provides leadership and vision by working vertically and cross-functionally with department and division leadership in developing goals, objectives, and priorities to support the mission of the Georgia Department of Public Health. Ms. Galloway oversees women's health, early intervention, child health services, children with special healthcare needs, home visiting, autism initiative and the Title V Block Grant.

Paige Jones, LBSW is the Title V Program Senior Manager. Ms. Jones joined DPH in May 2018 and has over 26 years of maternal and child health experience developing, managing and directing both state and non-profit care coordination, managed care and home visiting programs, fatherhood initiatives and collective impact efforts.

Dianne Durrence, MPH, MSN, APRN is the Deputy Director of Women's Health. She has over 25 years of public health experience in clinical services and program management. Ms. Durrence oversees Women's Health which includes family planning and perinatal initiatives.

Ruben D. Brambila, MPH is the Deputy Director of Child Health Services. He has over 15 years of leadership and outreach experience, specifically focused on children, adolescents and families. Mr. Brambila is responsible for overseeing child health related programs and initiatives, including; Children's Medical Services, Newborn Screening Program, Early Hearing Detection Intervention (EHDI), Children First (C1st), and Help Me Grow.

Sharifa Peart, MPH is the Children and Youth with Special Health Care Needs (CYSHCN) Program Director and oversees the Children Medical Services Program. She has been with the DPH MCH Section since 2012 and has experience in health care transition, telemedicine expansion, care coordination, physician engagement, family satisfaction, and child health referral systems. Prior to her work with MCH, Ms. Peart directed the statewide hearing services program administered through a community based organization.

Lisa Pennington MS, MA, LPC is the Deputy Director of Early Intervention. She has over 26 years of Part C experience, conducting assessments and providing administrative guidance and oversight. Ms. Pennington also has direct service experience working in private practice providing behavioral health treatment services to children, adolescents and adults. Ms. Pennington oversees the Babies Can't Wait Program and the Georgia Autism Initiative.

Twanna Nelson is the Home Visiting Program Deputy Director at the Georgia Department of Public Health and

manages the overall direction and supervision of the *Maternal Infant and Early Child Home Visiting* (MIECHV) activities for the agency. She oversees Project LAUNCH, an initiative to promote the wellness of young children ages birth to 8 by addressing the physical, social, emotional, cognitive and behavioral aspects of their development in Muscogee County, Georgia.

Dr. Adam Barefoot DMD, MPH, is the Director of Oral Health for Department of Public Health for Georgia. He manages the State Oral Health Program including grants, contracts, budgeting, staffing, partnerships, and strategic programmatic objectives and activities. He helps facilitate oral health literacy awareness, education, school based oral health prevention programs, community fluoridation systems, oral health surveillance, and direct provision of clinical services through 18 state health districts.

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

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

The Division of Health Promotion instituted a new professional development policy designed to support professional development for program and support staff. The policy ensures that staff have a current database resource of relevant conferences, federal, state and local trainings and online professional development resources. The policy also seeks to provide equal opportunity to all staff by efficient use of financial resources to meet professional development needs. In an effort to have a greater reach and provide education, training, and staff development to staff and partners throughout the state, the MCH Section held its second annual MCH Conference from May 1-3, 2018 at the University of Georgia in Athens with 355 in attendance. The goals of the conference were to build synergy across programs, train on policies, protocols, state and federal requirements, give programmatic updates, and highlight district successes and best practices. The conference was divided into three primary tracks including child health, women's health and oral health. Topics included health equity, early brain development, opioid abuse, with an overarching theme of family engagement and cultural competency. Five sessions were devoted to Family Engagement. Conference survey results showed a high rate of satisfaction related to topics, venue and overall experience.

The Administration unit continues to use public health core competencies to assess workforce development needs and will focus on engaging staff in capacity building efforts with community partners. A work plan is in progress to develop a strategic initiative that will create stronger, more focused partnerships to increase community outreach and engagement.

In an effort to strengthen and enhance leadership skills, two MCH leaders submitted applications and were chosen for the New Director Leaders Cohort under the National Association of Maternal & Child Health Programs (AMCHP). The Children and Youth with Special Health Care Needs Program Director and the Director of Maternal and Child Health Epidemiology are participating in a 10-month program providing an opportunity to increase knowledge related to key MCH and leadership topics.

DPH's Applied Learning Program's efforts to bolster the future of the public health workforce were expanded. MCH currently has six interns who will receive Cultural Competency, Quality Improvement, Storyboard and Abstract Development, and Project Management training. DPH will continue to foster a learning environment and culture to support the Department's efforts to build a workforce capable for accomplishing the mission of public health as well as meet the mission of the Title V MCH Block Grant.

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

MCH has a long history of partnering with families, including those with CYSHCN, in program planning and decision-making at federal, state, and community levels. The MCH section values families' experiences and expertise, and are intentional in partnering with them to enhance MCH programs, policies and services. As with many states, the MCH section began its family partnership strategies in its Children's Medical Services and Babies Can't Wait - Early Intervention Programs, which serve CYSHCN. With MCH Transformation 3.0, the MCH section set a goal to expand family engagement and partnership across all MCH programs. Based upon this vision, the MCH section developed a strategic plan to increase family engagement, and incorporated a family engagement framework to evaluate family engagement on the state, local district, and community levels (see Table 1).

Family Engagement Vision, Strategic Plan, Framework

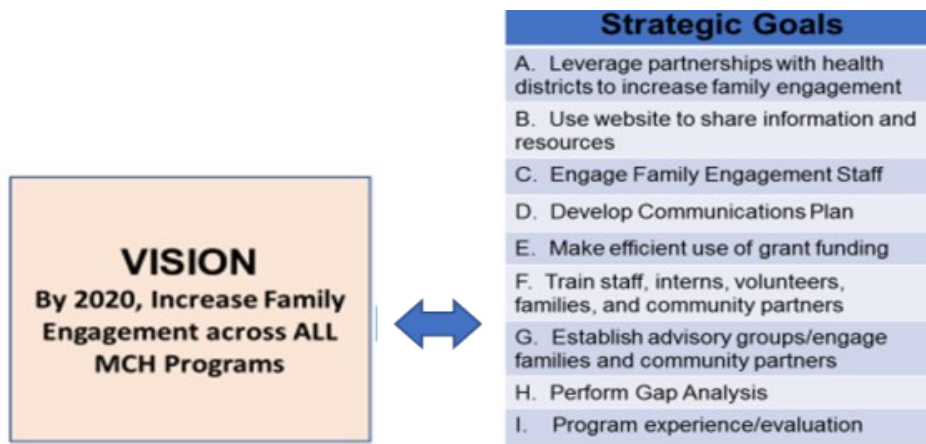


Table 1

MCH programs engage families and community partners in strategic planning, program development, quality improvement initiatives, block grant development and review, workforce development, training, policy-making, as members of advisory councils and community collaboratives, and as part-time and full-time staff.

MCH employs a family support coordinator that works directly with its CYSHCN programs. The Title V Team Lead provides consultative support to all MCH programs in developing and implementing their plans for family engagement, and serves as the Family Delegate to the Association of Maternal and Child Health Programs.

MCH also partners with federal and national partners, medical societies, hospital and healthcare systems, colleges and universities, community partners, other state agencies throughout DPH's 18 local health districts to support family leaders and family engagement at the local level. MCH collaborates with other MCH projects, state agencies and community partners to enhance and support their family engagement activities, i.e., Home Visiting, Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), Georgia Department of Education (DOE), Georgia Department of Early Care and Learning (DECAL), Georgia Department of Family and Children Services (DFCS), United Way, Children's Healthcare of Atlanta (CHOA), etc.

For the current year, the MCH section focused on supporting program directors as they worked to enhance family engagement in population domains. MCH made plans to assure state and district staff, MCH family leaders, interns, and community partners adhere to the same definition of family engagement and standards of cultural competency

and health equity in working with families. Approximately 300 participants received training on Title V, cultural competency, and health equity at MCH's second annual MCH conference. This strategy was incorporated to assure a "Culture of Family Engagement" throughout MCH populations at all levels.

A sample of training sessions for "Family Engagement Day" included:

- DBHDD Office of Children, Young Adults and Families
- Guardianship and Alternative Decision-Making Panel
- Family Resource Panel
- What is a Board-Certified Behavior Analyst (BCBS)?
- Helping Families with Emergency Preparedness
- Neurodevelopment Outcome of the High-Risk Infant: Supporting the Child and Family
- Georgia Hands and Voices – Family Engagement (D/HH)
- Helping Families Access High Quality Child Care
- Family Videos "From the Field"

In the coming year, MCH plans to continue spreading its "Culture of Family Engagement" philosophy amongst all MCH population domains. MCH will also continue to provide support to state and local district staff, and community partners as they implement family engagement strategies.

MCH programs will establish new family coalitions and advisory councils, educate families on MCH programs, collaborate with other state agencies and community partners on family engagement, cultural competency and health equity, and partner with families and family organizations on public policy initiatives.

MCH will continue its work to evaluate family engagement across the continuum, as well as evaluate family experience in its programs.

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

DPH is a Tier 2 site for the State Systems Development Initiative (SSDI) December 1, 2017-November 30, 2022. For the grant period, DPH proposed to build and expand state data capacity to support the Title V MCH Block Grant; develop and use data linkages among key MCH datasets; and enhance DPH surveillance systems that address the data needs related to emerging MCH issues, particularly infant health (e.g., NAS and Zika-related birth defects). Achieving the proposed objectives will enable Georgia to better measure multiple Title V minimum/Core Indicators. Proposed activities address most of the HRSA-identified Tier 2 program outcomes (HRSA-18-062). Through collaborative efforts of MCH and MCH Epidemiology (EPI), MCH aims to use SSDI funds to better guide policy and programmatic directions within MCH.

DPH's activities align with the primary purpose of SSDI to develop, enhance, and expand state and jurisdictional Title V MCH data capacity for needs assessment and performance measure reporting. By transitioning DPH Family Planning (FP) data to the State Electronic Notifiable Disease Surveillance System (SendSS), from stand-alone servers within DPH's Information Technology (IT) section, the data will be more accessible and timely to MCH EPI and program staff. MCH staff will be able to improve program evaluation activities as automated reports will be created within SendSS. An infant health EPI will be hired to support MCH EPI's capacity to conduct analyses specific to relevant Title V indicators. Analytic plans will be developed to better guide MCH programs. This will yield information that increases the ability of the program to assess, plan, implement, and/or evaluate efforts; without such plans and linkages critical information may remain inaccessible or unknown, particularly data pertaining to the Minimum/Core Dataset and MCH priority needs. MCH EPI staff responsible for implementing these data linkages will increase their capacity to perform data linkages through trainings. Establishing and maintaining surveillance systems relevant to emerging MCH issues and by performing data analyses for the corresponding programs, MCH EPI can deepen MCH's understanding of the burden and underlying dynamics of emerging MCH issues. This will guide the policy and programmatic direction. Prior to being awarded the current SSDI grant, DPH had ongoing surveillance efforts for NAS and birth defects related to the Zika virus. Improving both surveillance systems will enable MCH EPI to more effectively identify cases and guide programmatic decision.

To build and expand state data capacity to support Title V, the SSDI current funds are being used to facilitate direct access to women's health data, fund an EPI focused on infant-related morbidity and mortality, and create an analysis plan to meet Title V data needs. The Infant EPI has been successfully on-boarded and is performing infant health-related analyses that MCH EPI did not have the capacity to previously perform. A centralized information system has been developed to store DPH FP data that is easily downloaded for analysis and has several analyses available for programmatic staff to evaluate performance. Currently, the FP Portal allows for more timely access to the data, while making basic analyses available quickly for the non-EPI staff. Over the rest of the current fiscal year (FY), this centralized information system will be finalized with capacity to produce *ad hoc* reports. The periodicity of the data has already been increased, while the lag time for accessing and analyzing the Georgia Hospital Discharge Data (GHDD), a core MCH dataset, has decreased. MCH EPI is working on processing the quarterly data to perform surveillance on severe maternal morbidity for participating hospital facilities. This effort supports Georgia's Perinatal Quality Collaborative, which aims to reduce the burden of obstetric hemorrhage and severe hypertension among delivering women.

To meet the goal of advancing the development and utilization of linked information systems among MCH datasets, the SSDI fiscal year funds are being used to develop a plan to implement annual data linkages that fill existing gaps in the ability to assess indicators from the Minimum/Core dataset. By the end of the current FY, four priority data linkages will be identified and the MCH EPI staff will be trained to perform data linkages. As required by the SSDI grant, MCH EPI will report on the SSDI performance measure related to data access, periodicity, and lag time.

To meet the goal of supporting surveillance systems development that addresses the needs of emerging MCH issues, the SSDI current FY funds are being used to enhance NAS surveillance and expand Georgia's Birth Defects Registry (GBDR). Over the course of the first year of this project period, MCH EPI discussed an analysis plan for NAS data that would help guide policy and programmatic direction. The MCH EPI Unit has completed multiple data requests for internal and external stakeholders related to NAS. The code to produce the results of the analysis plan and the data requests was developed and implemented, while the results produced thus far have included interpretations to help programmatic decision making. By the end of the current FY, an annual NAS report will be submitted for clearance to be made available to the public. Regarding the expansion of the GBDR, multiple datasets have been linked together, (e.g., Birth Certificate, GBDR and Information System). Confirmed cases of birth defects have been connected into Georgia's early intervention referral program (C1st). Throughout the rest of the current budget year, the capacity to link confirmed cases of birth defects into early intervention services will be integrated into the electronic information system development. For the rest of the current FY, the ongoing development of the GBDR will result in multiple data linkages yet to be established. The GBDR will link Vital Records data (e.g., birth certificates, death certificates, and fetal death certificates), healthcare provider reported cases (e.g., facility-level line lists of suspected cases and direct reports), internal screening and surveillance systems (e.g., Newborn Screening Pulse Oximetry), Early Hearing Detection and Intervention, NAS, referral and medical services (e.g., C1st and CMS), electronic medical records, hospital discharge data, and data from the Centers for Disease Control and Prevention's (CDC) Metropolitan Atlanta Congenital Birth Defects Program. SSDI funds assist in the ongoing development of this electronic information system.

To further the goal of building and expanding state data capacity, modifications to the centralized information system housing Georgia FP data will be compiled and executed to assist in data-driven decision making in Title V-related MCH. In the second year of the project, the information system will be used to evaluate relevant women's health indicators.

In the upcoming year, the first data linkage will be performed. This data linkage will be chosen in collaboration with the MCH programmatic staff to ensure that the linkage and subsequent analyses can inform and/or guide programmatic direction. Appropriate documents will be created depending on programmatic needs.

Additionally, another NAS surveillance report will be created using up-to-date data, while continuous quality checks and resulting quality improvements will be performed. As part of the Infant EPI duties, they will work with the MCH programmatic staff to assist in understanding the burden of NAS.

Legal authority for the DPH to collect health information is provided in Chapter 31 of the Official Code of Georgia (O.C.G.A.). O.C.G.A. § 31-12-2. Under these authorities, DPH has deemed NAS to be notifiable conditions as of January 1, 2016. Similarly, Birth Defects were made a notifiable condition. House Bill 249: modified the Official Code of Georgia Section 31-12-2.

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

Georgia currently contracts with four managed care organizations to manage more than 1.3 million Medicaid and SCHIP low income adults and children. Children, youth, and young adults in foster care, those receiving Adoption Assistance, and a select group of children with Department of Juvenile Justice involvement are covered for their medical, dental and behavioral health needs through a single managed care organization. A small carve-out of the Aged, Blind and Disabled population is served through a fee-for-service arrangement and of those approximately 8,000 are served by Title V CYSHCN's program for care coordination services, health care transition preparation and planning and access to pediatric sub-specialists who partner with the program to serve families through on-site and telemedicine clinics in rural areas of Georgia.

Medicaid provides coverage to support pregnant women and women of reproductive age, as well as infrastructure funding. DPH and Medicaid partner with supplemental funding to provide six Regional Perinatal Centers (RPC) access to maternal and neonatal specialty care. The Planning for Healthy Babies (P4HB) covers family planning services for low income women ages 18 to 44, as well as limited primary care and dental services to those who have given birth to a very low birth weight (VLBW) baby. In 2018, the legislature provided funding to implement coverage of group prenatal care, a benefit which will be developed collaboratively with the input of DPH and other stakeholders.

Managed care for the Medicaid population has been in existence since 2006. Medicaid also provides long term care services to the elderly and individuals with disabilities in home and community based settings rather than institutional settings such as nursing homes, hospitals or intermediate care facilities. Georgia has five home and community-based services waiver programs. Waiver program services include assistance with daily living activities, facilitating the arrangement of medical or support services and services to relieve family caregivers. Waiver programs serve people who are elderly, physically disabled, have developmental or intellectual disability, or are medically fragile children.

The Governor, State Legislature, and state agencies have made a commitment to children with complex medical concerns and issues through state appropriations for children's Autism Spectrum Disorder (ASD) services and for behavioral/developmental services for children 0-6 years of age. In January 2015, the inclusion of Applied Behavior Analysis (ABA) therapy for children with ASD began for the State Health Benefit Plan and Georgia Board of Regents members. To ensure adequately trained professionals to provide quality diagnostic assessments, the Georgia Autism Assessment Collaborative (GAAC) was formed. GAAC is funded by DPH and implemented by the Emory Autism Center (EAC), with cooperation from the Georgia Psychological Association. GAAC is a collaborative aiming to build capacity of licensed psychologists in Georgia who provide diagnostic assessments with a focus on young children suspected of having an ASD. GAAC has acted as an ongoing learning collaborative, training 51 licensed psychologists in early assessment.

Effective January 2018, Medicaid provides adaptive behavioral services (ABS) coverage for individuals under the age of 21 with ASD. Pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, coverage is provided for an array of assessment and treatment services according to severity and based on medical necessity. Georgia is enrolling board certified behavioral analysts to provide ABS. DPH's Early Intervention program, Babies Can't Wait, is also expanding its scope of services for children birth to three years of age to include the provision of autism related services in 2018. Georgia became the 41st state to pass legislation (HB 429) providing coverage for ASD treatments. The law requires state-regulated private insurance companies operating in Georgia to provide coverage under group health insurance policies for habilitative and rehabilitative care, including ABA, counseling services and therapeutic services to children diagnosed with ASD.

Georgia uses the federally-run health insurance exchange and is divided into 16 geographic insurance markets. In 2016, there were seven insurers offering plans in Georgia which dropped to five in 2017. ³⁸ Georgia Health Insurance Marketplace enrollment dropped by 16 percent in 2017, but for 2018 coverage, enrollment only fell about 2.6 percent. There are approximately 480,912 people enrolled in coverage through the Georgia exchange. There are currently an estimated 240,000 people in the coverage gap in Georgia. According to the Kaiser Family Foundation October 2017 Issue Brief, the characteristics of the population that falls in the coverage gap for Georgia are 60% people of color, 78% adults without dependent children, 54% female and 62% in a working family. Assistance with navigating the state's complex health care system and social supports is provided by the Family to Family Health Information Center and Healthy Mothers Healthy Babies Coalition (HMHB) of Georgia. Georgia's Family to Family Health Information Center, named Parent to Parent of Georgia (P2P), provides support to more than 20,000 families with children with special needs each year.

DPH provides funding to P2P and HMHB to provide outreach, referrals, and support to Georgia families. P2P connects families by using volunteer families who are willing to assist other families through virtual support, support groups, and one-on-one matches to supporting parents. They also educate families by providing a Special Needs Database, group trainings across the state, and one-on-one assistance. P2P operates and maintains the Special Needs Database, trains volunteer parents across the state to become and participate as family leaders, conducts transition from pediatric to adult care workshops for parents and youth as well as administers the Parent as Partners project at seven site locations across the state. HMHB manages the C1st information and referral line receiving and making approximately 41,000 calls annually. HMHB partners with the Georgia Association for Primary Health Care, to provide education to families on health insurance, Affordable Care Act (ACA) plans, eligibility and directly enroll families in ACA plans through the Federal Healthcare Marketplace and the Planning for Healthy Babies Program.

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

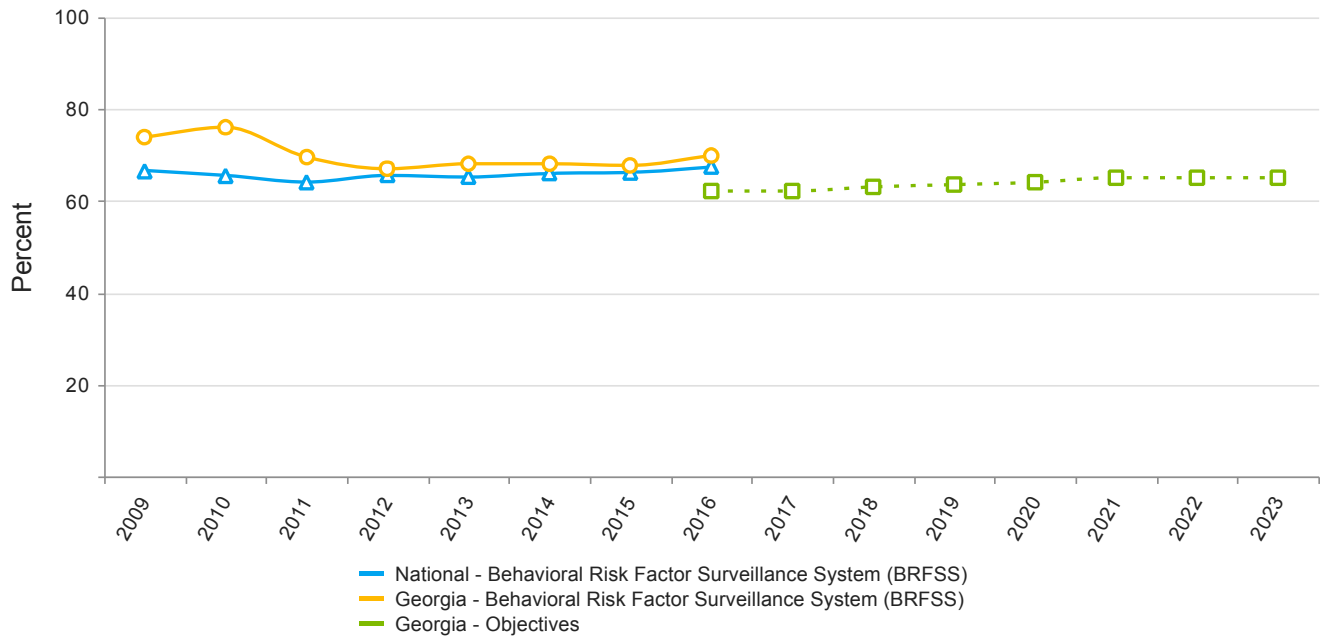
Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2015	172.8	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2012_2016	48.4	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2016	9.8 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2016	11.2 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2016	27.1 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	7.7	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	7.8	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	5.1	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.7	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	292.2	NPM 1
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy	PRAMS-2013	4.4 %	NPM 1
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births	SID-2015	2.8	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	13.3 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	90.3 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2016	23.6	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2013	9.2 %	NPM 1

National Performance Measures

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



Federally Available Data

Data Source: Behavioral Risk Factor Surveillance System (BRFSS)

	2016	2017
Annual Objective	62.1	62.1
Annual Indicator	67.7	69.7
Numerator	1,258,025	1,321,663
Denominator	1,857,538	1,895,900
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	63.0	63.5	64.0	65.0	65.0	65.0

Evidence-Based or –Informed Strategy Measures**ESM 1.3 - 1.3. Number of focus groups across the state that assess barriers to well-woman visits**

Measure Status:	Inactive - Replaced
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State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	1	0
Numerator		
Denominator		
Data Source	Title V On-Going Needs Assessment	Title V On-Going Needs Assessment
Data Source Year	2017	2017
Provisional or Final ?	Provisional	Provisional

ESM 1.4 - 1.4. Proportion of birthing hospitals that implement Alliance for Innovation on Maternal Health Bundles or approved quality improvement measures

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

State Provided Data	
	2017
Annual Objective	10
Annual Indicator	0
Numerator	
Denominator	
Data Source	GaPQC Data
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	25.0	30.0	50.0	60.0	85.0	85.0

ESM 1.5 - 1.5 Number of calls and clicks received from marketing campaign

Measure Status:	Active
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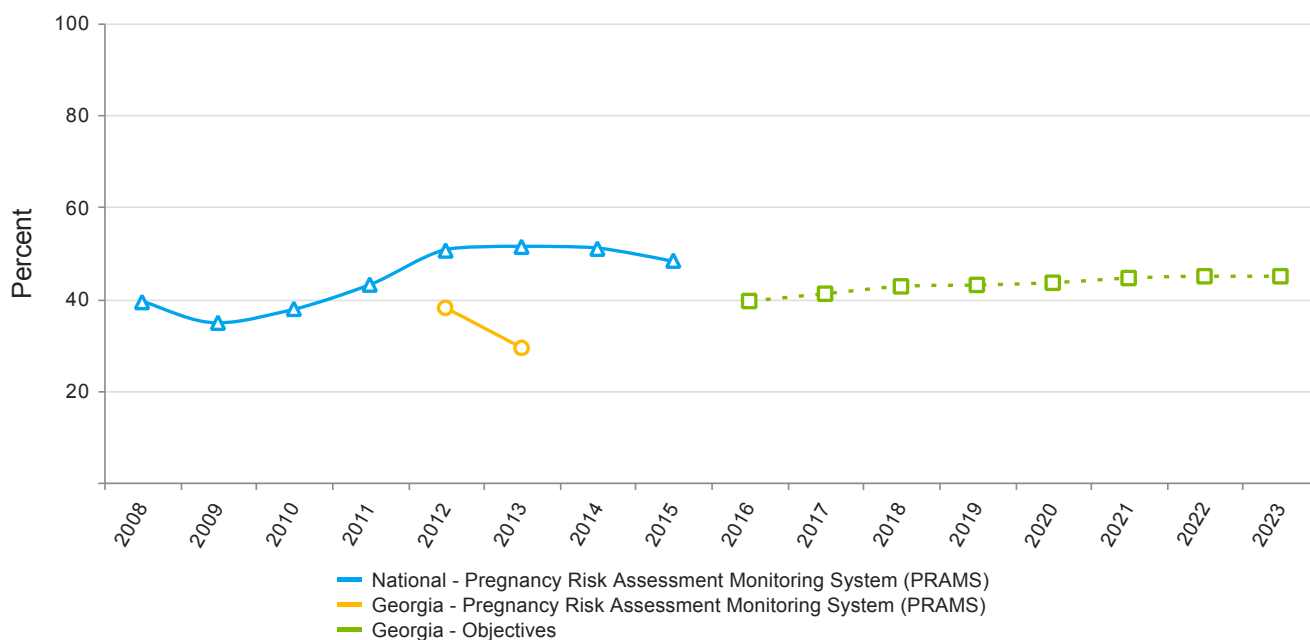
Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	5.0	10.0	15.0	20.0	25.0

ESM 1.6 - 1.6 Number of impressions based on media target audience

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	5,000,000.0	5,000,000.0	5,000,000.0	5,000,000.0	5,000,000.0

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



Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	2017
Annual Objective	39.5	41.1
Annual Indicator	29.3	29.3
Numerator	18,443	18,443
Denominator	63,060	63,060
Data Source	PRAMS	PRAMS
Data Source Year	2013	2013

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	42.7	43.0	43.5	44.5	44.9	44.9

Evidence-Based or –Informed Strategy Measures**ESM 13.1.1 - 11.1.1. Number of comprehensive webinars/presentations offered**

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		4
Annual Indicator	0	20
Numerator		
Denominator		
Data Source	Oral Health Program Data	Oral Health Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	8.0	12.0	16.0	20.0	20.0	20.0

State Performance Measures

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		11
Annual Indicator	16.6	16
Numerator	9,714	8,627
Denominator	58,434	54,076
Data Source	GFPP	GFPP
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	12.0	13.0	14.0	15.0	17.0	17.0

State Action Plan Table

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

Priority Need

Prevent maternal mortality

NPM

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

Objectives

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

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

Strategies

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

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

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

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

ESMs	Status
ESM 1.1 - 1.1.1. Number of public health districts with the Every Woman video in circulation	Inactive
ESM 1.2 - 1.2.1. Number of staff that have been trained on preconception health appraisals	Inactive
ESM 1.3 - 1.3. Number of focus groups across the state that assess barriers to well-woman visits	Inactive
ESM 1.4 - 1.4. Proportion of birthing hospitals that implement Alliance for Innovation on Maternal Health Bundles or approved quality improvement measures	Active
ESM 1.5 - 1.5 Number of calls and clicks received from marketing campaign	Active
ESM 1.6 - 1.6 Number of impressions based on media target audience	Active

NOMs
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations
NOM 3 - Maternal mortality rate per 100,000 live births
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)
NOM 5 - Percent of preterm births (<37 weeks)
NOM 6 - Percent of early term births (37, 38 weeks)
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths
NOM 9.1 - Infant mortality rate per 1,000 live births
NOM 9.2 - Neonatal mortality rate per 1,000 live births
NOM 9.3 - Post neonatal mortality rate per 1,000 live births
NOM 9.4 - Preterm-related mortality rate per 100,000 live births
NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy
NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

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

Priority Need

Promote oral health among all populations

NPM

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

Objectives

11.1. By 2020, develop a collaborative partnership working with women's health partners and the Chronic Disease Section to promote perinatal oral health

11.2. By 2020, develop an oral health resource database for CYSHCN

11.3. By 2020, increase the education and promotion activities regarding oral health among low-income Hispanic mothers and children from 0 to 8

Strategies

11.1.a. Partner with public health districts, private practices, dental hygiene programs (the Augusta University, Dental College of Georgia) to promote perinatal oral health screenings

11.1.b. Offer comprehensive educational webinars/presentations

11.2.a. Educate public health district oral health staff on special considerations and treatment needs for special needs patients

11.2.b. Determine data sources and begin collecting data to develop a special needs dental access database with location of practices serving special needs children and adults/special services offered, such as general anesthesia, orthodontics, insurance accepted and other specialties

11.3.a. Improve the Oral Health Education Initiative program to include culturally competent messages for low-income Hispanic children and adolescents

ESMs

Status

ESM 13.1.1 - 11.1.1. Number of comprehensive webinars/presentations offered

Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

State Action Plan Table (Georgia) - Women/Maternal Health - Entry 3

Priority Need

Improve access to family planning services

SPM

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

Objectives

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

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

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

Strategies

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

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

2.3.b. Increase inventory of LARCs in GFPP clinics

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

Women/Maternal Health - Annual Report

Priority Need: Prevent Maternal Mortality

NPM 1: Well-Woman Visits

During the reporting year, a statewide awareness campaign began development to promote preventive medical visits for women of reproductive age. Plans to market information about the availability of preventative services, i.e., family planning services at the local health departments were initiated.

Maternal Mortality Review Committee

The support of the Governor and the Georgia Legislature with the passage of SB 273, laid the foundation for the ability for the Georgia Maternal Mortality Review Committee (MMRC) to “identify pregnancy-associated deaths, review those caused by pregnancy complications and other selected deaths, and identify problems contributing to the deaths and interventions that may reduce these deaths” by providing legal protections for committee members and the review process, ensuring confidentiality of the review process and providing the committee with the necessary authority to collect data for case review. The MMRC met quarterly during the reporting year and reviewed maternal death cases for 2014.

NPM 3: Risk-appropriate Prenatal Care

Perinatal Regionalization

During the reporting period, the Women’s Health Program developed and implemented targeted marketing strategies to increase awareness of the Regional Perinatal Centers (RPC) with the goal of increasing utilization of perinatal regionalization with Level I and Level II birthing hospitals in the southernmost region of the state. Targeted marketing strategies included providing hand sanitizers, note pads and pens, and brochures that provided information on the management of popular high risk conditions (e.g. preeclampsia) as well as contact information of each medical director, per region. This strategy was used at the Georgia Ob/Gyn Society (GOGS) conference during the reporting period.

An additional five hospitals implemented the Preterm Labor Assessment Toolkits as their standard of care during the reporting period. A specialized workgroup was designed to revitalize the system of perinatal regionalization to include service delivery, data collection efforts and quality improvement initiatives.

Alliance for Innovation on Maternal Health (AIM) Bundles

The Alliance for Innovation on Maternal Health (AIM) program, under the auspices of the Council for Patient Safety in Women’s Health Care, collaborated with private and public programs and providers to improve implementation of preconception, postpartum and interconception women’s health care. DPH was awarded CDC funding September 30, 2017 to lead the Georgia Perinatal Quality Collaborative’s (GaPQC) initiative to implement the use of AIM hemorrhage and hypertension patient safety bundles in the state’s birthing hospitals. Georgia became an AIM state in October 2017.

Maternal safety bundles represent best practices for maternity care and are developed and endorsed by national multidisciplinary organizations. The maternal safety bundles include action measures for:

- Obstetrical Hemorrhage
- Severe Hypertension/Preeclampsia

- Prevention of Venous Thromboembolism
- Reduction of Low Risk Primary Cesarean Births/Support for Intended Vaginal Birth
- Reduction of Peripartum Racial Disparities
- Postpartum Care Access and Standards

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

In the reporting year, the Oral Health program served 955 pregnant women. Of the delivering women in 2014, per OASIS, 15.5% of low birth weight (LBW) infants were born to women living in rural counties. In an effort to reduce some of the contributing factors to LBW infants, education was provided to women of childbearing age about NAS and the need for good nutrition, prenatal care and dental care. Although Georgia Medicaid will reimburse dentists for comprehensive oral health services during pregnancy, only about 29.3% of pregnant mothers had routine teeth cleanings during pregnancy.

The Oral Health program offered Georgia Quitline and smoking cessation education in November and December 2016 to dental and medical colleagues in three rural counties. The risk factors contributing to LBW infants, the potential linkage of periodontal disease and preterm delivery, the dangers of smoking during pregnancy, and the need for prenatal dental care was discussed. Each course was attended by 30-45 dentists and dental hygienists.

The Oral Health program collaborated with Chronic Disease and the prenatal team to work on addressing grant performance measures: pregnant women who smoke and oral health providers reaching women concerning tobacco use during pregnancy, second hand smoke, and the risk factors for the developing fetus, mother and infant.

The Oral Health program presented at the Georgia Dental Hygienists' Association meeting in July 2017 on Oral Health and Tobacco in Pregnancy. In the Fall of 2017, four districts planned to offer education on tobacco/oral health/pregnancy risk factors with an emphasis on using Motivational Interviewing and the use of the Quit line in a dental practice.

Priority Need: Increase Access to Family Planning Services

SPM 1: Family Planning

During the reporting year, 58,596 women were served through DPH's Family Planning program with 17.55% of women, ages 15-44 using a Long Acting Reversible Contraceptive (LARC) compared to 14.80% in the previous year. The percentage of teens who used a LARC during the reporting year increased from 12.80% to 15.72%.

Family Planning provided leadership, guidance and resources to Georgia's 18 health districts in the development and provision of resources that increase the access of family planning services to Georgia's women offering comprehensive health care services designed to provide women with support to plan the birth of their children, reduce unintended pregnancies, determine effective birth control methods and improve the well-being of families statewide.

Other Women/Maternal Health Programs

Centering Pregnancy

In the reporting year, MCH collaborated with public health providers throughout the state providing information and

training about the CenteringPregnancy® evidence-based model of group healthcare that addresses the social determinants of health combining health assessment, interactive learning and community building to help support positive health behaviors and drive better health outcomes. MCH provided education, guidance, and support concerning program implementation beginning the expansion of Center Pregnancy. Two Centering Pregnancy sites were operational during this reporting period.

Perinatal Case Management

Perinatal Case Management (PCM) is a voluntary Medicaid program that is implemented in the local public health departments. PCM allows for a case manager to assist a pregnant woman with identifying her special needs and helps her gain access to medical, nutritional, social, psychosocial, educational and other services to improve health outcomes of mother and baby. During the reporting period, a PCM curriculum was developed and PCM services began implementation. Three PCM trainings occurred in August and September 2017. Following the three trainings, one health department included PCM services into their service delivery system.

Planning for Healthy Babies

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

Maternal and Child Health Information and Resource Center

In the reporting year, the Women's Health Program worked with the existing Maternal and Child Health Information and Resource Center that operates the MCH resource hotline and website to include resources and referrals to resources that identify and treat chronic illnesses such as IPC of P4HB, hypertension, heart disease, obesity, and diabetes.

Current Year Oct 2017-Sept 2018

Priority Need: Prevent Maternal Mortality

NPM 1: Well-Woman Visits

In the current year, the Women's Health program developed a preventive medical visit campaign. Meetings were held to develop messaging, marketing mode of delivery, and overall implementation strategy. The campaign is designed to launch in three phases each of which will cover various regions of the state. Depending on the regions, a mix of billboards, social media post or radio advertising may be utilized to reach the target population. Phase I was launched in March 2018 and Phase II is slated to launch in the fall of 2018.

Maternal Mortality Review Committee

The Maternal Mortality Review Committee (MMRC) met in December 2017 and March 2018 and continued review of 2014 maternal deaths. Review of 2014 cases will be completed in June 2018 and the 2014 MMRC Report is on target to be published by the end of 2018. Based on 2012 and 2013 MMRC findings, DPH submitted a white paper proposal to the 2018 legislative session for rural hospital funding to provide quality initiatives to impact leading causes of Maternal Mortality. DPH was awarded 2 million dollars to provide funding to 16 rural hospitals for quality

improvement initiatives beginning with implementation of patient care safety bundles for maternal hemorrhage. The 16 rural hospitals will join 23 additional hospitals already implementing the patient care safety bundles as part of DPH's GaPQC.

Challenges/Barriers: The time required for abstraction of many cases and limited number of abstractors presents a challenge for the MMRC.

NPM 3: Risk-Appropriate Perinatal Care

Perinatal Regionalization

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

Five of six RPC site visits have been completed. These site visits have served as mechanisms to assess the process of service delivery in each regional perinatal center; learn the strengths and opportunities of improvement of each region; foster collaboration and team building; and provide technical assistance in contract compliance.

House Bill 909-Creation of DPH Perinatal Facilities was signed into law and allows DPH to define and designate Perinatal Facilities in Georgia. The goal of this bill is to improve perinatal outcomes by providing more structure to risk appropriate care.

Challenges/barriers: Hospital acquisition by large healthcare organizations and growing numbers of specialty level of care in the metro area provides challenges to the regional system.

Alliance for Innovation on Maternal Health Bundles

During the fall of 2017 the structure, membership and initiatives of GaPQC were revised. Advisory Committee membership was updated and reflects inclusion of specialty providers and agencies focused on improving the health and outcomes of mothers and babies. Subcommittees were established for maternal, neonatal, data and operations. The Maternal Subcommittee is leading the work of AIM bundle implementation in birthing hospitals. In January 2018, a letter was sent to all 76 birthing hospitals in Georgia from the DPH Commissioner encouraging their participation in the AIM bundle initiative. In March 2018, enrollment packets and readiness assessment surveys were sent to 41 birthing hospitals that had expressed interest in participating in the AIM bundle initiative. Women's Health and GOGs staff are following up with those hospitals to reach the goal of enrolling at least 10 hospitals in the AIM hemorrhage bundle initiative by September 30, 2018.

The Data Subcommittee was developed in the fall of 2017 and began an extensive data analysis process utilizing hospital discharge data to develop a perinatal data management system. The perinatal data system will be used to measure the impact AIM quality improvement initiatives have on severe maternal and mortality indicators like hemorrhage and hypertension.

Challenges: It is anticipated that rural birthing hospitals may lack sufficient staff to work on quality initiatives.

Priority Need: Promote Oral Health to All Populations

NPM 13: Preventive Dental Visit

In the current year, the Oral Health program partnered with DPH's Chronic Disease team for the Oral Health/Tobacco Program collaborative.

In April 2018, to assist in combating the opioid epidemic, the Oral Health program participated in the Opioid Taskforces Prescription Drug Monitoring Program (PDMP) work group to assess, evaluate and improve the PDMP registry for the state.

The Oral Health program participated on an advisory panel radio campaign through the DPH/Radio One Partnership. The campaign was developed in the DPH Sexually Transmitted Disease section to promote healthy pregnancies and the awareness of HIV transmission, congenital syphilis, and associated mandated clinical testing. The radio ads will play in Fulton, Cobb and Douglas counties in May-July 2018.

Priority Need: Increase Access to Family Planning Services

SPM 1: Family Planning

More Georgia women are planning their pregnancy which helps to insure healthier birth outcomes. Processes and procedures have been streamlined and training systems that support access to family planning and LARCs have been improved. Family Planning has a budget of 1.3 million dollars earmarked for the LARC project. Funds are used to purchase additional pharmaceuticals and provide support to districts to hire Advanced Practice Registered Nurses (APRN) to provide LARC related services.

In the current year, internal processes were streamlined to ensure districts have the ability to order drugs on an ongoing basis since the demand continues to increase. Changes and improvements to our Electronic Health Record (EHR) and data collection systems have increased efficiency in the clinics and data sharing respectively.

To meet training demands, week long Women's Health training courses were implemented to help insure nursing best practices. Nurses receive training on Breast and Pelvic exams, STD and Microscope best practices; a requirement to work under Women's Health protocols. Women's Health training courses are being provided seven times throughout the year. In previous years, these courses were provided less frequently.

Family Planning staff partnered with the University of California San Francisco Bixby Reproductive Health Center to provide LARC training to clinic staff. The training included medical and front line staff to improve capacity in providing education regarding providing the most reliable contraception. Counseling best practices were also emphasized as an integral component of the patient encounter. A LARC specialist training was designed to bring district leads together for peer-to-peer learning and garner knowledge to build capacity and sustainability in promoting access to family planning services.

The Family Planning Program began working on the development of a marketing campaign in 2017 to increase awareness of family planning options and services to women across the state. The campaign is designed to launch in three phases facilitating regional and district specific marketing and messaging to successfully reach the diverse populations throughout the various areas of the State. Phase I of the marketing campaign began in March 2018. The campaign includes billboards and radio messaging, depending on the area. Five media markets which included the cities of Albany, Augusta, Savannah, Valdosta, and Waycross were purchased for a :30 second radio message with women ages 18-49 as the media target audience. Current analytics from the media broker show that the estimated number of times the radio ads were heard by women ages 18-49 in four of the markets was 3,303,000. Waycross is an unrated market, therefore, not included in the total. However, there were a total of 224 :30-second radio spots aired on two Waycross stations.

Other Women/Maternal Health Programs

Centering Pregnancy

In the current year, MCH, in collaboration with the Centering Healthcare Institute, hosted five Centering Pregnancy information sessions in locations throughout Georgia's public health districts which have an increase in infant mortality rates and preterm births. Centering Pregnancy information sessions are a one day seminar to learn more about Centering Pregnancy's evidence-based, group care model and to understand what is needed for successful implementation and long term program sustainability. Those districts included District 2, District 3-3, District 3-5, District 4, District 6, District 7, District 8-2, District 9-1 and District 9-2.

MCH utilized the funding provided by the March of Dimes to allow staff from three Public Health Districts to attend the Basic Facilitators Workshop hosted by the Centering Healthcare Institute. This two-day workshop offered trainings to facilitative leadership through a variety of skill building and interactive activities.

The Georgia State Legislature passed the HB 684 to implement reimbursement for Centering Pregnancy programs. The funds were awarded to the Department of Community Health's (DCH) Medicaid programs.

Challenges/barriers: Challenges surrounding incorporating the Centering Pregnancy model are related to a lack of adequate space to host group prenatal care sessions in OB practices and county health departments. Lack of commitment from hospitals, district health directors, and private OB physicians to implement Centering Pregnancy at their facility presents a challenge, as does reimbursement issues related to providing the Centering Pregnancy program, however, with the passage of HB 684, barriers may be lessened. Billing/coding processes for enhanced reimbursement incentive from Caresource for Centering Pregnancy are being examined. County Health Departments do not have a medical provider as a Centering Pregnancy facilitator which presents a challenge for those health departments interested in implementing the model.

Perinatal Case Management

On March 1, 2017, the Department of Community Health, DPH, and Harris Solution launched the Visual HealthNet (VHN) Perinatal Case Management Module which is an automated process of transmitting documents between the Care Management Organizations (CMO) and the public health departments. A PCM curriculum was developed involving a one day interactive training provided to case managers in the Georgia Public Health Departments. The first PCM training was initiated on August 29, 2017. There have been nine trainings implemented thus far with more to occur throughout the state. DPH has increased the number of county health departments providing PCM services from 88 to 92. The projected target is to have 104 county health departments providing PCM services by September 2019.

Challenges/barriers: Several Georgia obstetricians have patients with identified CMO's which makes it difficult for the patient to be perinatally case managed through the health department system. The self-reporting monthly electronic data reporting system presents a need for an electronic data retrieval system. Decreased number of staff available to provide PCM services at the county health departments and communication between District IT and the Perinatal Case Managers at the county health departments also present challenges.

Planning for Healthy Babies

Planning for Healthy Babies (P4HB) is a family planning demonstration waiver program issued by the Georgia Department of Community Health (DCH) to assist the DPH in reducing the number of low birth weight (LBW) and very low birth weight (VLBW) infants in Georgia. Women who meet Medicaid eligibility criteria and/or have had a

VLBW baby may be eligible under the expansion policy to receive family planning services, Inter-pregnancy Care (IPC), Case Management, and/or Resource Mother. The program is intended to bridge health care for underinsured and uninsured women of high need. Efforts to increase enrollment into P4HB will continue with DCH and other partners.

Maternal and Child Health Information and Resource Center

In the current year, the Women's Health Program works with the existing Maternal and Child Health Information and Resource Center that operates the MCH resource hotline and website to include resources and referrals to resources that identify and treat chronic illnesses such as IPC of P4HB, hypertension, heart disease, obesity, and diabetes.

Family Engagement

Women's Health provides cultural competency training to clinicians working with teens in district teen clinics. Women's Health teen clinics are focused on the needs of teens, i.e., hours of operations, using teen-friendly language, etc. Teens are also often used in marketing campaigns for their peer groups.

Women's Health focuses on engaging pregnant women that participate in their Centering Pregnancy programs. Through facilitated discussions, these women act as peer-to-peer support through the prenatal, delivery, and postpartum periods.

Women/Maternal Health - Application Year

Priority Need: Prevent Maternal Mortality

NPM 1: Well-Women Visit

To promote preventive medical visits, the Women's Health Program will launch Phase III of the preventive medical visits, i.e., family planning marketing campaign, evaluate the process and outcomes of Phase I and Phase II, and plan future activities.

Maternal Mortality Review Committee

In the coming year, the MMRC will publish the 2014 MMRC Review and conduct quarterly case review of 2015 cases. Women's Health will support hospitals enrolled in quality improvement initiatives in implementation of patient care safety bundles for hemorrhage through technical assistance, monthly webinar meetings, and on-site training and guidance.

NPM 3: Risk Appropriate Perinatal Care

Perinatal Regionalization

In the coming year, Women's Health will continue annual site visits of each RPC and provide technical assistance for implementation of GAPQC quality improvement initiatives.

Alliance for Innovation on Maternal Health (AIM) Bundles

Women's Health will expand the use of AIM hemorrhage bundles into 10 additional birthing hospitals and AIM hypertension bundles into five birthing hospitals and will begin submitting perinatal data to AIM in the coming year.

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

In the coming year, through continued partnerships with public health districts, private practices, education at dental hygiene programs, and in partnership with the Augusta University College of Dental Medicine, the Oral Health Program intends to improve the percentage of pregnant women receiving an oral health visit. The Oral Health program will also continue to support, provide training, and educate providers on the health outcomes for pregnant women with poor oral health care and tobacco use. The Oral Health program will support four districts to train and educate providers on the health outcomes for pregnant women with poor oral healthcare and tobacco use, and processes for using the tobacco quit-line.

Priority Need: Increase Access to Family Planning Services

SPM 1: Family Planning

In the coming year, efforts to increase access to family planning will be developed. Some of the strategies planned include:

- Improve data sharing efforts by expanding the newly established data system that aggregates data from clinics. The system will be streamlined to allow enhanced report generation and data sharing to facilitate and monitor progress and troubleshoot issues more efficiently. Additional system improvements regarding data collection in the EHR systems will provide better efficiency in patient encounters and data transmission.
- Focused training of patient counselling on LARCs

Other Women/Maternal Health Programs

Centering Pregnancy

MCH will continue the quest to implement more CenteringPregnancy® group model prenatal care sites in DPH districts. Collaboration between MCH and the Centering Healthcare Institute to host a Centering Pregnancy Information Session and provide information to Obstetricians on the Centering Pregnancy program and its importance in improving health outcomes will take place in the coming year.

Perinatal Case Management (PCM)

In the coming year, PCM plans to continue the quest to provide PCM training and technical assistance to counties in implementation of PCM programs, establish better communication between DPH, county health departments and EMR partners with implementing the PCM Module, and improve communication between CMO's and DPH in their PCM reimbursement process. PCM plans to collaborate with EMR partners to develop a method of extracting data from the PCM Module for monthly reporting, percentages of Presumptive Eligibility and PCM enrollment.

Planning for Healthy Babies (P4HB)

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

Maternal and Child Health Information and Resource Center

In the coming year, the Women's Health Program will work with the existing Maternal and Child Health Information and Resource Center that operates the MCH resource hotline and website to include resources and referrals to resources that identify and treat chronic illnesses such as IPC of P4HB, hypertension, heart disease, obesity, and diabetes.

Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2015	7.7	NPM 3
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2015	7.8	NPM 3 NPM 4
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2015	5.1	NPM 3
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2015	2.7	NPM 4
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2015	292.2	NPM 3
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2015	129.4	NPM 4

National Performance Measures

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

Baseline Indicators and Annual Objectives

FAD for this measure is not available for the State.

State Provided Data		
	2016	2017
Annual Objective	81.8	80
Annual Indicator	80.9	82.6
Numerator	1,950	1,939
Denominator	2,409	2,347
Data Source	State Statistical File	State Statistical File
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	81.0	82.0	83.0	84.0	85.0	85.0

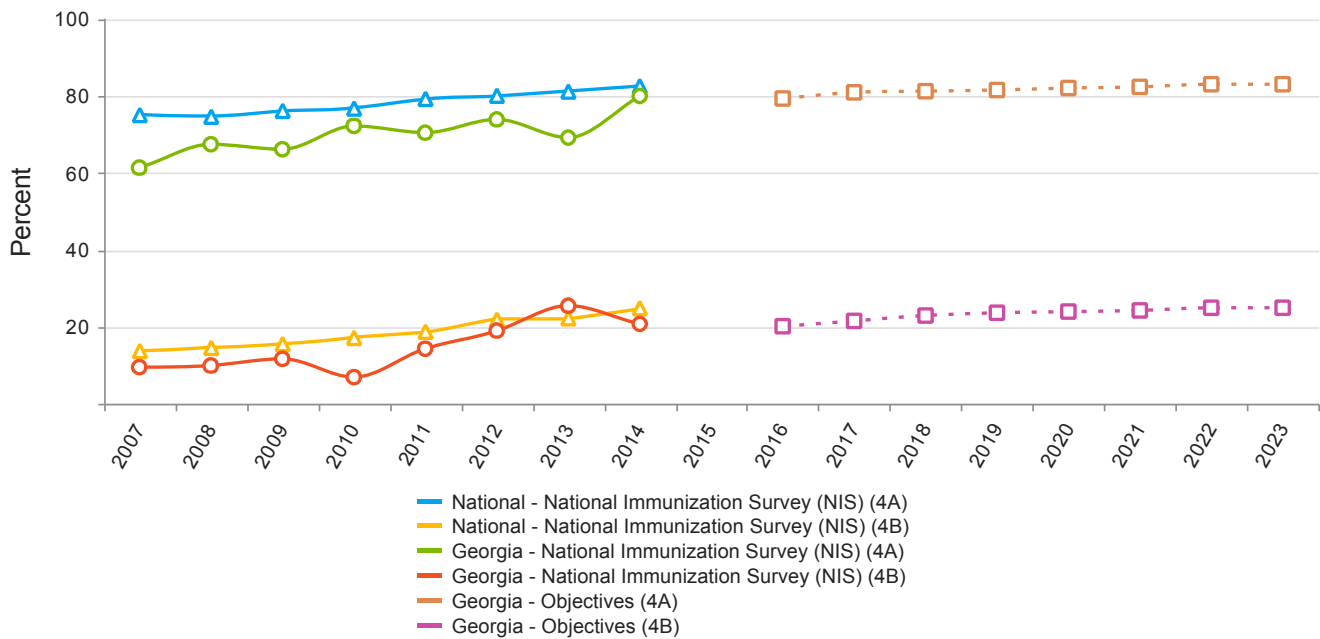
Evidence-Based or –Informed Strategy Measures**ESM 3.2 - 3.6.1. Proportion of Regional Perinatal Centers that receive a process evaluation**

Measure Status:	Active
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State Provided Data	
	2017
Annual Objective	6
Annual Indicator	6
Numerator	
Denominator	
Data Source	Womens Health Program Data
Data Source Year	2017
Provisional or Final ?	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	6.0	6.0	6.0	6.0	6.0	6.0

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	79.3	80.9
Annual Indicator	69.2	79.9
Numerator	80,818	100,061
Denominator	116,817	125,213
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	81.2	81.5	82.0	82.3	83.0	83.0

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	20.2	21.6
Annual Indicator	25.4	20.7
Numerator	29,130	25,611
Denominator	114,622	123,723
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	23.0	23.7	24.0	24.3	25.0	25.0

Evidence-Based or –Informed Strategy Measures**ESM 4.1 - 3.1.1 Number of birthing hospitals that participate in the 5-STAR Hospital Initiative**

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	39	40
Numerator		
Denominator		
Data Source	Womens Health Program Data	Womens Health Program Data
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	20.0	30.0	40.0	40.0	40.0

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

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

State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	2	3
Numerator		
Denominator		
Data Source	Womens Health Program Data	Womens Health Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	3.0	4.0	5.0	6.0	6.0	6.0

State Performance Measures

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		11
Annual Indicator	16.6	16
Numerator	9,714	8,627
Denominator	58,434	54,076
Data Source	GFPP	GFPP
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	12.0	13.0	14.0	15.0	17.0	17.0

SPM 3 - Rate of congenital syphilis.

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

State Provided Data		
	2016	2017
Annual Objective		13
Annual Indicator	17	13.1
Numerator	21	17
Denominator	123,292	129,563
Data Source	Projected Data from OASIS and SendSS, Births and C	SendSS
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	12.7	12.4	12.0	11.7	11.7	11.7

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

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

State Provided Data		
	2016	2017
Annual Objective		6.1
Annual Indicator	6.1	13.2
Numerator	735	1,592
Denominator	120,577	120,371
Data Source	Hospital Discharge Data, Vital Records	Hospital Discharge Data, Vital Records
Data Source Year	2015	2016
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	13.2	13.1	13.0	13.0	12.9	12.9

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

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

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	20.0	25.0	27.0	29.0	29.0

State Action Plan Table

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

Priority Need

Prevent infant mortality

NPM

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

Objectives

- 3.1. By 2020, increase the number of birthing hospitals participating in the Georgia 5-STAR Hospital Initiative to 40
- 3.2. By 2020, develop a partnership with WIC to conduct 1 training per year for public health workers on breastfeeding

Strategies

- 3.1.a. Recruit and train hospitals on the Georgia 5-STAR Hospital Initiative and the 10 Steps to successful breastfeeding.
- 3.1.b. Provide Train-the-Trainer opportunities for staff of hospitals participating in the Georgia 5-STAR Hospital Initiative.
- 3.1.c. Recognize hospitals for participating in and completing steps in the Georgia 5-STAR Hospital Initiative.
- 3.1.d. Work with community partners such as Georgia Academy of Pediatrics (GA-AAP), Georgia OB/GYN Society (GOGS), and other community partners to educate and train physicians, nurses, and other direct care providers on the importance of breastfeeding for mothers and babies
- 3.2.a. Continue to provide an education series to increase the breastfeeding knowledge base of public health employees throughout the state, including topics such as promoting the importance of breastfeeding, providing lactation support for working mothers, and other topics to support breastfeeding initiation and exclusivity at 6 months
- 3.2.b. Conduct a minimum of 4 VICS trainings annually for public health staff on topics developed through the breastfeeding education series

ESMs

Status

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

NOMs

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

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

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

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

Priority Need

Prevent infant mortality

NPM

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

Objectives

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

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

Strategies

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

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

ESMs

Status

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

Inactive

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

Active

NOMs

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

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

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

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

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

Priority Need

Decrease maternal substance use

SPM

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

Objectives

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

Strategies

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

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

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

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

Priority Need

Prevent infant mortality

SPM

SPM 3 - Rate of congenital syphilis.

Objectives

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

Strategies

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

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

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

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

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

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

Priority Need

Prevent infant mortality

SPM

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

Objectives

5.1. By 2020, 50% of birthing hospitals will have policies and education that adhere to the American Academy of Pediatrics (AAP) Safe Sleep guidelines

5.2. By 2020, 25% of NICU's, Pediatric Departments, and Children's hospitals will have policies an education that adhere to the American Academy of Pediatrics (AAP) safe Sleep guidelines

Strategies

Recruit birthing hospitals by providing staff with a step by step guide on implementing a Safe to Sleep Program

Provide in-person trainings to hospitals participating in the program

Provide participating hospitals with education resources for staff and caregivers on the safe infant sleep recommendations

Collect pre and post crib audits and policy statements from participating hospitals

Recognize hospitals for implementing a Safe to Sleep Program and policy

Perinatal/Infant Health - Annual Report

Priority Need: Prevent Infant Mortality

NPM 3: Risk-Appropriate Perinatal Care

Perinatal Regionalization

Perinatal regionalization is a strategy to improve maternal and perinatal outcomes by establishing systems designating where infants are born or transferred according to the level of care they need at birth. Regionalized systems assign hospitals risk-appropriate levels and ensure high-risk infants are born in facilities with appropriate technology and specialized health providers. During the reporting year, DPH worked to promote the regionalized system of care. Several committees were designated to focus on data collection, transportation, oversight and branding. The branding committee was responsible for outreach materials designed to promote knowledge of the regionalized system.

NPM 4: Breastfeeding

Breastfeeding

Georgia 5-STAR Hospital Initiative is a program that was implemented to encourage hospitals to take steps toward becoming breastfeeding-friendly and achieving the “Baby Friendly” designation. In the reporting year, Georgia 5-STAR recognized birthing hospitals for implementing evidence-based maternity care practices that promoted and supported breastfeeding with one star for every two steps implemented of the *Ten Steps to Successful Breastfeeding*, as defined by the World Health Organization (WHO) and Baby-Friendly USA. The Women’s Health Program provided educational workshops on the Ten Steps, as well as in-depth Train-the-Trainer workshops and webinars to nurses, lactation counselors and other providers throughout the state.

SPM 3: Rate of Congenital Syphilis

Congenital Syphilis

The Sexually Transmitted Disease (STD) Office’s mission is to prevent STDs by providing quality intervention strategies, programmatic support and education throughout the state. With a focus on congenital syphilis, the STD team worked to promote 1st and 3rd trimester testing for HIV and syphilis, as well as improve the data quality of congenital syphilis. The STD Office also worked to improve the identification of pregnant females with syphilis to ensure timely and appropriate treatment.

SPM 4: Neonatal Substance Abuse

Neonatal Abstinence Syndrome

Neonatal Abstinence Syndrome (NAS) became in a reportable condition in Georgia in January 2016. In the reporting year, Women’s Health provided oversight and management of the NAS surveillance process in close collaboration with MCH Epidemiology and birthing hospital staff. Cases were verified by MCH Epidemiology staff through review and confirmation of case indicators. Georgia’s case criteria for a confirmed case of NAS is: (1) presence of one or more clinical symptoms of NAS and/or (2) a positive infant substance test result.

In 2017, 935 NAS cases were reported and 754 NAS were confirmed.

Other Perinatal/Infant Health Programs

Newborn Screening

During the reporting year, the NBS program provided education to both parents and health care providers. The program made information available to parents in hospitals, providers' offices, and health departments prior to the completion of the newborn screening through informational brochures. The NBS program educated health care providers on the NBS system through the Georgia Newborn Screening Policy and Procedure Manual, which was provided in print to each birthing hospital and health district office and was also available electronically through the NBS website. The NBS Policy and Procedure Manual outlines the processes and regulations for specimen collection and submission, and reception of results. The NBS Clinical Coordinator provided technical assistance related to specimen collection and submission to hospitals, birthing facilities and primary care providers through telephone consultations and in-person trainings as needed.

The NBS program maintained the SendSS database through which each hospital accessed its NBS specimen report. The NBS system included provisions for children to receive therapies beyond the newborn period. In collaboration with Emory University, the NBS program provided medical foods and low-protein modified foods to children and adults who would otherwise be unable to access those treatment modalities due to cost. The NBS program supports works collaboratively with CMS and Augusta University to provide telehealth and outreach clinics for children and adults with Sickle Cell disease and other clinically significant hemoglobinopathies. The NBS program supported the Comprehensive Sickle Cell Center at Grady Memorial Hospital, a 24/7 comprehensive primary care center for adults with hemoglobinopathies. Additionally, the NBS program contracted with The Sickle Cell Foundation of Georgia, Inc. to provide Community Partners, which are responsible for completing a needs assessment, a transition assessment if appropriate, identifying medical homes, and providing resource referrals to clients with clinically significant hemoglobinopathies.

In May 2017, the Georgia state legislature passed HB 241 Cove's Law, providing a pathway for parents to access Krabbe screening at the option and cost of the parent(s).

Safe Sleep

The Georgia Safe to Sleep Campaign provided tools and resources that strengthened policy, provided consistent education to change infant sleep environments to prevent infant sleep-related deaths, empowered professionals to educate parents, empowered families to make informed decisions about infant sleep, and increased access to resources that support behaviors that protect infants from sleep-related deaths. MCH continued to work with participating birthing hospitals to meet the goals of the program. Recognition of hospitals who completed all aspects of the program continued on a quarterly basis.

Home Visiting

In the reporting year, the Home Visiting program gave pregnant women, children, and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn. Home visits were provided to 1,362 families which included 227 pregnant women. Postpartum depression screenings were provided to 80% of mothers who participated in home visiting programs within three months postpartum and 93% of mothers were screened for intimate partner violence within six months of program enrollment.

To promote breastfeeding, seven Certified Lactation Consultants (CLC) were added in seven communities. The CLCs promoted breastfeeding to six months postpartum and beyond to promote bonding and attachment with the mother.

The Home Visiting program implemented the HRSA Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program Innovation Grant, competitive funding awarded through HRSA for innovation, to promote professional

development in the field of home visiting. Innovation Activities focus on increasing the quality of the home visiting applicant pool by partnering with local colleges, collaborating with state partners to include evidence-based home visiting in the statewide early childhood Professional Development System, and providing continued opportunities for empowering the home visiting leadership through training opportunities to improve skills.

Current Year: Oct 2017 – Sept 2018

Priority Need: Prevent Maternal Mortality

NPM 3: Risk Appropriate Perinatal Care

Perinatal Regionalization

In the current year, there is increased communication with RPC stakeholders in an effort to strengthen the system of regionalization. Increased communication with data, education and budget/financial personnel from each RPC has fostered increased collaboration. Technical assistance has been provided in adherence to contract guidelines.

Five of six RPC site visits have been completed. These site visits have served as mechanisms to assess the process of service delivery in each regional perinatal center; learn the strengths and opportunities for improvement in each region; foster collaboration and team building; and provide technical assistance in contract compliance.

In the current year, RPC workgroups continue efforts to strengthen the system of perinatal regionalization. The branding committee was dissolved; however, committees continue to focus on data, transportation, and program oversight. Currently, a client brochure and a trifold brochure for physicians that detail the services of the RPCs are being designed. The client brochures will be placed in hospital waiting areas. The outreach materials will also be distributed during regional hospital site visits, conferences, and at community health fairs. The brochure can also be emailed or faxed.

NPM 4: Breastfeeding

Breastfeeding

In the current year, MCH worked to improve the Georgia 5-STAR Hospital Initiative infrastructure and functionality to include updating all programmatic materials, creation of marketing materials, identifying and improving barriers to success in achieving the 10 Steps to Successful Breastfeeding, and streamlining processes and procedures. Recruitment strategies to obtain and increase enrollment from all birthing hospitals statewide were developed. Efforts to enhance relationships with hospital staff have increased through in-person meetings introducing and supporting the program. MCH collaborated with the Georgia Hospital Association to introduce the program and raise awareness through webinar trainings. Webinar training sessions were conducted with participating hospitals to provide technical assistance on implementing the *10 Steps to Successful Breastfeeding*. Technical assistance by phone, emails, and in-person visits were provided. MCH continues to provide a plaque in recognition of a hospital's baby friendly status. In the current year, MCH also provides plaques to hospital who have completed one of the 10-Steps to Successful Breastfeeding to recognize hospitals who are making progress toward implementation. A star is placed on the plaque with each additional "step" that is completed.

Additional breastfeeding education was provided to increase provider and community knowledge of the importance and benefits of breastfeeding. In collaboration with the American Academy of Pediatrics, Georgia Chapter, DPH delivered the *Educating Physicians in Their Communities (EPIC)* breastfeeding program, a physician peer-to-peer training program that provides breastfeeding education to physician's offices, hospitals and residency programs,

and distributes information regarding access lactation support services in the community and free resources for patient education. MCH also partnered with WIC to provide breastfeeding educational trainings to all DPH staff including nurses, peer counselors, breastfeeding coordinators, nutritionists, and administrative staff.

SPM 3: Rate of Congenital Syphilis

Congenital Syphilis

During the reporting year, *Syphilis During Pregnancy* was added to Georgia's Notifiable Disease List. The promotion of 1st and 3rd trimester testing for HIV and syphilis have been underway. Efforts to provide education through trainings, community outreach, provider outreach, and district STD staff have been a priority. During the current year, MCH developed Congenital Syphilis Review Board Guidelines and launched a Congenital Syphilis Media Campaign. MCH also developed and disseminated a *Dear Colleague Letter* on congenital syphilis signed by the DPH Commissioner.

The following outreach and education activities were provided:

District Education

- Congenital Syphilis All Day Training for district staff (Feb 15, 2018)
- District Site Visits (CS was discussed)- Augusta (Nov 28, 2017)

Community Outreach World Changers Health Fair (April 21, 2018)

- Center for Black Women's Wellness Annual Health Fair (Nov 11, 2017)
- Fulton-Dekalb Health Summit (Oct 17, 2017)
- Latino Health Fair (Oct 14, 2017)

Provider Outreach

- Georgia Academy of Family Physicians Annual Meeting (Oct 25-28, 2017)
- Georgia Academy of Family Physicians Webinar on CS (April 25, 2018)

District STD staff

- HIV Linkage Coordinators
- Georgia Academy of Family Physicians
- Georgia OBGyn Society

Priority Need: Prevent Maternal Substance Use

SPM 4: Neonatal Substance Abuse

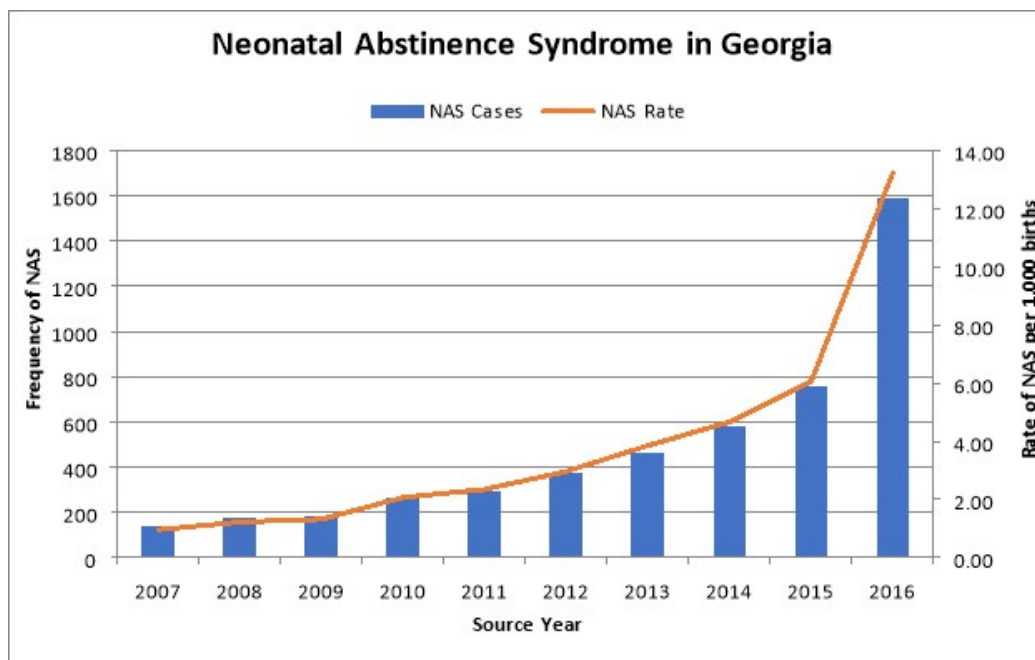
Neonatal Abstinence Syndrome

In January 2018, the Neonatal Subcommittee of the GaPQC began working on a quality initiative to impact the growing incidence of NAS. The committee developed a baseline survey for birthing hospitals to determine current practices around NAS diagnosis and treatment. The survey was piloted in 4 hospitals during March 2018 and was provided to all birthing hospitals in April 2018. NAS reporting data for 2017 was finalized in March 2018.

Surveillance continued to determine NAS rates. Hospital discharge data from 2007 to 2016 was used to determine the annual de-duplicated hospital discharge rate of NAS. Diagnosis was defined using ICD codes. For the last quarter of 2015 through 2016, (most current information available) the ICD10 codes P96.1 (neonatal withdrawal symptoms from maternal use of drugs of addiction) and P04.4 (newborn affected by maternal use of drugs of addiction) were used to diagnose NAS.

Using ICD-9 codes 779.5 and 760.72, and ICD-10 code P96.1 and P04.4

Source Year	NAS Cases	Total Hospital Births	NAS Rate
2007	140	146035	0.96
2008	175	142814	1.23
2009	181	137333	1.32
2010	263	127055	2.07
2011	296	126129	2.35
2012	373	125887	2.96
2013	466	120951	3.85
2014	580	124362	4.66
2015	757	124997	6.06
2016	1592	120371	13.23



Challenges/barriers: Although NAS is a reportable condition, hospital case reporting into SENDSS is lower than the number of cases identified through hospital discharge data.

Other Perinatal/Infant Health Programs

Newborn Screening

The Georgia Newborn Screening and Genetics Advisory Committee (NBSAC) is a multidisciplinary group of over 15 professional and consumer representatives with knowledge and expertise in NBS programs. On February 16th, 2018, the NBSAC convened a meeting to discuss, among other agenda items, whether to recommend three disorders for inclusion on the Georgia NBS panel. These conditions were nominated during the previous NBSAC meeting held in September 2017. Spinal Muscular Atrophy, which was recently nominated by the Secretary of the US Department of Health and Human Services for inclusion on the Recommended Uniform Screening Panel, was

nominated to the Georgia NBS panel during the February 16th NBSAC meeting as well. The NBSAC has established workgroups, including the long-term follow-up workgroup and the hemoglobin workgroup. The long-term follow-up workgroup met on October 3rd, 2017. The hemoglobin workgroup met on November 17th, 2017, February 2nd, 2018, and April 27th, 2018.

The NBS program worked with Emory University to hire a long-term follow-up coordinator for metabolic disorders. The long-term follow-up coordinator will create a subsection on the Emory NBS database to collect information on specific variables after a child is diagnosed with a NBS disorder. This will allow for longer-term tracking of NBS outcomes to enhance program evaluation and inform decision-making. The long-term follow-up workgroup, a subgroup of the NBSAC, discussed possible initiatives around this project during the October 3rd, 2017 meeting.

The NBS program has continued to collaborate with the Georgia Public Health Laboratory (GPHL) to develop policies, procedures, budgets, data exchange, evaluation, and education. In September 2017, GPHL completed a system update that allows hearing and Critical Congenital Heart Disease (CCHD) results to be fully integrated into the existing data entry system. Hearing and CCHD data is now entered at the same time, on the same module, and by the same clerk as the rest of the information on the NBS card unifying and streamlining all NBS information. Since that time, the NBS program has conducted ongoing training and technical assistance to GPHL data entry staff as well as project evaluation to ensure accuracy and efficiency of hearing and CCHD results entered into the NBS database.

The NBS program has conducted several educational activities aimed at increasing awareness around the NBS system for providers as well as improving specimen collection techniques. The NBS Clinical Coordinator traveled to Houston Medical Center on January 18, 2017 to provide in-person technical assistance on specimen collection, including an oral presentation and the supervision of several NBS collections. On March 7th, 2017, the medical foods program through Emory University, the Medical Nutrition Therapy for Prevention (MNT4P) program, presented a webinar to pediatric providers through the DPH's partnership with the Georgia Chapter of the American Academy of Pediatrics (GA AAP) to increase awareness of their services. The NBS program developed and mailed postcards to each birthing hospital and birthing center to report the number of babies each organization screened and identified in 2016. The NBS program also exhibited at the Georgia Academy of Family Physicians (GAFP) Annual Fall Meeting on February 26-28 and their Summer CME Meeting on June 14-17, 2018.

Zika Prevention

Arboviral

In July 2017, DPH's Zika testing guidelines were changed to match CDC's new recommendations. The changes made to the guidelines at that time are still in effect. Under these guidelines, only symptomatic patients are approved for Zika testing through GPHL. Exceptions include asymptomatic pregnant women who have a fetus with an anomaly and/or are uninsured. As a result of the change in guidelines, the number of patients approved for Zika testing at GPHL has significantly decreased. Since January 2016, Zika surveillance efforts in DPH epidemiology have identified 120 travel associated cases of Zika in Georgia citizens, with the last confirmed case identified in October 2017. To date, there has been no local transmission of Zika in the state of Georgia.

ZIKA

The Zika Pregnancy Registry (ZPR) Coordinator manages the investigation of pregnant women and infants identified to have laboratory evidence of Zika virus through Georgia Public Health Laboratory testing or commercial lab testing. Data is uploaded and reported monthly to the CDC US Zika Pregnancy Registry Team. As of May 2018, 17 women/infant pairs are enrolled in Georgia's Zika Pregnancy Registry. This included 3 transfer cases, and 1 fetal loss. To date, there are 2 live born infants with birth defects.

As of May 2018, 668 potentially Zika-associated birth defects cases have been identified and 488 records have been reviewed for 2016–2017 Georgia birth cohort. Of these, 155 infants (32%) have confirmed Zika-associated birth defects and an additional 144 (30%) had other general birth defects of interest to the Georgia Birth Defects Registry.

Potential cases were identified from three sources, including the ZAMS, and ZPR. Electronic birth certificates (eBCs) constituted the largest (73%) reporting source. However, birth defects reported on eBCs require confirmation through medical record review, per guidelines from CDC Zika Birth Defects Surveillance (CDC-ZBDS) and the National Birth Defects Prevention Network (NBDPN). Record requests involved mailing or faxing facilities, as well as calling facilities to ensure receipt of requests; determine which types of records are needed; and situate our efforts within the context of state and federal privacy laws. Through this effort, we have fostered relationships with these facilities, as well as drawn attention to the need for birth defects reporting, established a protocol for tracking records from initial requests through confirmation, referral to early intervention services, and reporting out to CDC.

The Zika Birth Defects epidemiologist (ZBDE) has been dedicated to this effort full-time since November 2016. The Zika Epidemiologist and the ZBDE have been collaborating to initiate medical record requests, review records for confirmation of reported birth defects, and abstract confirmed records since March 2017. In November 2017, an additional part-time epidemiologist was hired to conduct the record requests and build relationships with reporting facilities, as well as help review and abstract records. Once received, reviewed, and confirmed, the abstracted records were linked with confirmed cases from the Metropolitan Atlanta Congenital Defects Project (CDC-MACDP) and reported to CDC-ZBDS on a monthly basis.

Without these efforts, 299 infants with true birth defects, including 155 infants with Zika-associated birth defects, could have been missed. Zika birth defects surveillance has also given Georgia DPH the opportunity to develop a Birth Defects Registry. This registry will connect 17 reporting sources, including eBCs and ZAMS/ZPR; expedite referral of affected infants and their families to early intervention services; and facilitate standardized, timely, reporting and confirmation of birth defects statewide. Flexibility is inherent to the design of the registry and will greatly enhance Georgia's capacity to respond to emerging teratogens.

As of May 2018, 119 medical records were still outstanding for Zika-associated birth defects confirmation. A number of facilities receive record requests and/or send out records via mail only, which increases the amount of time needed to receive and fulfill requests as compared to facilities that have a designated fax line for medical record requests. In addition, facilities have provided conflicting information regarding the modes of receiving and fulfilling medical record requests, which further delays the overall Zika-associated birth defects surveillance effort. Nuanced language is sometimes needed to communicate exactly what information is being requested from a facility (e.g., "chart" instead of "record"). The combination of these issues has significantly delayed the confirmation of approximately 15% of the suspected Zika-associated birth defects cases.

Several facilities have refused to fulfill record requests on the basis of well-established privacy laws. Efforts have been made to redraft the medical record request forms to state the HIPPA privacy rule explicitly, in addition to providing germane state legislation, without adding unnecessary protected health information to the request. This was done to demonstrate that the request of medical records falls under the legal purview of the Georgia Department of Public Health. Once this education is provided and a second medical record request is sent, facilities generally comply with the request.

Challenges/Barriers: When the new Zika testing guidelines were adapted in July 2017, there was difficulty

disseminating the information to state partners and healthcare providers. Although the DPH website was updated to reflect the new guidelines, many providers had a difficult time understanding the changes and why they were made.

Newborn Screening-New Disorders

In May 2017, the Georgia state legislature passed a law to provide a pathway for parents to access Krabbe screening at the option and cost of the parent(s). In partnership with Emory University, the NBS program created an informational brochure that includes an overview of Krabbe disease, when and how to access screening on an optional basis, and NBS program contact information. The NBS program provided the Krabbe brochure to birthing hospitals, The Georgia Chapter of the American Academy of Pediatrics, The Georgia Academy of Family Physicians, Georgia Obstetrical and Gynecological Society, and public health district offices. These entities served as key partners in disseminating information about optional Krabbe screening to families.

During the reporting year, the NBS program facilitated NBSAC meetings and associated workgroup meetings. Four disorders, Pompe Disease, Mucopolysaccharidosis Type I (MPS I), X-linked Adrenoleukodystrophy (X-ALD), and Guanidinoacetate Methyltransferase (GAMT Deficiency) were nominated to the Georgia NBS panel at an NBSAC meeting on September 8th, 2017. Two workgroups were created at this meeting: one for Pompe, MPS I, and X-ALD, as these three disorders are included on the national RUSP, and one for GAMT Deficiency, which is included on the national RUSP at this time. Reports from the two workgroups covering all four disorders were presented at the NBSAC meeting on February 16th, 2018. The NBSAC voted to recommend Pompe, MPS I, and X-ALD for inclusion to the Georgia NBS panel with specific conditions. The Commissioner approved the inclusion of the three disorders to the Georgia screening panel in May 2018.

GPHL is collaborating with the Emory University Department of Human Genetics to conduct a pilot study on NBS for Spinal Muscular Atrophy (SMA). In collaboration with GA AAP, Emory University provided a webinar around the disorder as it relates to the pilot in Georgia. SMA was nominated to the Georgia NBS panel at the February 16th, 2018 NBSAC meeting. The nominating group presented information around incidence and treatment and the NBSAC voted to create a workgroup to review SMA with an emphasis on Georgia-specific data.

Safe Sleep

In the current year, all 79 birthing hospitals throughout the State of Georgia participate in the Safe Sleep Hospital Initiative. The Safe to Sleep Program provides quarterly recognition of birthing hospitals that have completed all parts of the Safe to Sleep hospital program. Efforts to track hospital submissions of requirements and ongoing trainings and follow up for staff will continue as well as the distribution of quarterly gown shipments, yearly safe sleep book shipments and twice a month bassinet shipments. To provide safe sleep education, MCH designed, developed and implemented the “floor talker” opportunity with 148 floor talkers sent to locations throughout Georgia with specific focus on the areas with the highest rates of sleep-related infant mortality from 2006-2016.

MCH presented on the topic of the Safe to Sleep Program to the American Public Health Associations Annual Meeting, GA Healthy Mothers Healthy Babies annual meeting, Prevent Child Abuse Rockdale meeting, Injury Prevention Research Center at Emory University, and at the Georgia Conference on Children and Families. The topic of merging breastfeeding and safe sleep messaging was presented on a national webinar. MCH launched a Quality Improvement Initiative at Children’s Healthcare of Atlanta to improve modeling of safe infant sleep for infants at their three campuses. MCH collaborated with the Department of Family and Children Services on their “community health educators” project designed to improve safe sleep education in areas of high infant mortality attributed to sleep-related causes. MCH contributed to the DPH Worksite Wellness program’s policy initiative around the employee lactation room and Baby at Work Program. MCH’s Safe to Sleep Program supports community partners by attending Emergency Medical Services for Children (ESMC) meetings, GA Injury Prevention advisory council meetings, Injury Prevention Research Center meetings at Emory University, and the Georgia DPH Breastfeeding

meetings. MCH also partnered with Vital Records to track distribution of materials and reporting from hospitals and presented a poster at the Association of Maternal Child Health Programs (AMCHP) conference on the Safe to Sleep program. The following three articles were published:

- Implementing a Statewide Safe to Sleep Hospital Initiative: Lessons Learned. R.Walcott, T. Salm Ward, T. Miller, P. Corso, L. Dawson
- A Statewide Hospital-Based Safe Infant Sleep Initiative: Measurement of Parental Knowledge and Behavior. R.Walcott, T. Salm Ward, T. Miller, P. Corso
- Evaluation of a Crib Distribution and Safe Sleep Educational Program to Reduce Risk of Sleep-Related Infant Death. T. Miller & T. Salm Ward

Challenges/Barriers: The ability to reach all of Georgia's counties presents a challenge due to the size of the state. It can be challenging to provide management and guidance in completing the safe sleep program to 78 birthing facilities with approximately 130,000 deliveries each year.

Home Visiting

In the current year, the Home Visiting program continues its commitment to implement evidence-based, comprehensive and community-based maternal and early childhood programs in Bartow, Bill Chatham, Clarke, Crisp, DeKalb, Fulton, Glynn, Gordon, Houston, Liberty, Lowndes, McDuffie, Muscogee, Richmond, Rockdale and Whitfield counties. Home Visiting programs currently include the Early Head Start-Home Based Option (EHS-HBO), Healthy Families Georgia (HFG), Nurse-Family Partnership (NFP) and Parents as Teachers (PAT).

DPH is working with Social Solutions to update the existing data system to the new ETO platform which is a robust system that provides the infrastructure and scalability needed to effectively manage the data, share information and track progress in a secure environment.

Family Engagement

Perinatal Health focuses on engaging families at MCH's Regional Perinatal Centers (RPCs). MCH requires each center to incorporate a perinatal bereavement policy, which defines the process used to support families experiencing and infant loss. Social workers and case managers are trained to provide support to mothers in preparation of and following an expected or unexpected infant loss.

Families that participate in RPC Developmental Clinics receive information and resources on developmental milestones and family support. MCH's Perinatal Health and CYSHCN programs partner to provide intensive support to families that participate in RPC Developmental Clinics.

Perinatal/Infant Health - Application Year

Priority Needs: Prevent Infant Mortality and Reduce Maternal Substance Use

NPM 3: Risk Appropriate Perinatal Care

Perinatal Regionalization

In the coming year, the Women's Health Program plans to continue annual site visits of each RPC and provide technical assistance for implementation of the Georgia Perinatal Quality Collaborative (GAPQC) quality improvement initiatives.

Targeted marketing strategies will continue through the placement of brochures in hospital waiting rooms, community health fairs and conferences. Efforts to promote awareness of the RPCs with the goal of increasing utilization will continue. Evaluation of possible measures such as the rate of VLBW born at the RPCs will potentially occur. In the coming year, the Women's Health Program plans to promote the implementation of the Preterm Labor Assessment Toolkit (PLAT), an evidence-based, quality improvement initiative created by the March of Dimes to standardize the assessment of preterm labor to facilitate prompt interventions to improve birth outcomes. PLAT implementation will focus on Level I and Level II birthing hospitals in the southernmost region of the state to quickly identify women presenting with preterm labor and initiate risk appropriate care.

NPM 4: Breast Feeding

Breastfeeding

In the coming year, the Women's Health Program will continue to support the 5-STAR Hospital Initiative and provide support to hospitals in completing the 10 steps to achieving Baby-Friendly designation. DPH and the Georgia Hospital Association (GHA) will continue to recognize hospitals with a star for every two of the *Ten Steps Completed to Successful Breastfeeding* that are implemented. MCH will continue work to recruit new hospitals into the program, provide training and technical assistance to participating hospitals to include mock assessments to provide feedback that will be useful in preparing hospitals for their Baby Friendly site visit.

In collaboration with the American Academy of Pediatrics-Georgia Chapter, MCH will continue to provide peer-to-peer breastfeeding training to providers throughout the state.

MCH plans to host a one-day Georgia 5-STAR Hospital Initiative Summit that will be used as a platform to publicly recognize hospitals that have made progress towards implementing the 10 steps. This summit will also provide the opportunity for hospitals to discuss any clinical updates, barriers to success, and best practices.

SPM 3: Congenital Syphilis

Congenital Syphilis

In the coming year, the STD Office will continue working with the identified team to focus on improving the accuracy and completeness of congenital syphilis data. The STD Office will also continue to improve efforts to identify pregnant females with syphilis to ensure timely and appropriate treatment.

SPM 4: Neonatal Substance Abuse

Neonatal Abstinence Syndrome

In the coming year, the Women's Health Program plans to continue implementation of a perinatal opioid advisory

group to explore gaps and opportunities for maternal interventions to impact birth outcomes. Educational and training for providers and the public will continue to be developed as needed.

SPM 5: Safe Sleep

Safe Sleep

In the coming year, the Georgia Safe to Sleep Campaign's Hospital Initiative will continue to work with the participating birthing hospitals to meet the goals of the program. Recognition of hospitals who complete all aspects of the program will continue a quarterly basis. Training and education will continue as needed and requested from hospital staff, home visitors, local health departments/WIC offices, first responders, social workers, and doulas. Information on infant crying, shaken baby syndrome, and grief resources will also be provided. Additionally, the program coordinator will also assist the Georgia Bureau of Investigation (GBI) by participating in the GA Safe Infant Sleep Coalition to pilot new ideas to facilitate infant and child safety. The quality improvement initiative to other pediatric departments and NICUs will continue.

Other Perinatal/Infant Health Programs

Newborn Screening

The NBS program will implement several quality improvement (QI) initiatives aimed at reducing the number of unsatisfactory specimens submitted to GPLH. These QI initiatives include a revised hospital report available through SendSS that includes each hospital's comparative values against national benchmarks, written educational materials outlining proper specimen collection techniques and timelines, and a NBS collection demonstration video that will be widely available to all specimen collectors.

In the coming year, the NBS program will continue to increase participation in the Georgia NBSAC. This will be done through the removal of inactive members as defined in the bylaws and the replacement of those members with engaged stakeholders of the NBS system. The program will continue to schedule meetings with adequate notice to encourage participation.

GPLH and the NBS program will collaborate to improve electronic transmission of results to providers. The goal is to increase access to electronic results and reduce the number of paper NBS results that are mailed to providers. This will also allow providers that were not listed as the provider of record on the NBS card to have easier access to their patients' NBS results.

In the coming year, the NBS program will increase family engagement. The NBS program will establish a consumer panel consisting of 5-10 parents of children with disorders diagnosed through NBS. This group will be a source of information for the program around education and outreach. They will provide feedback on the education strategies the NBS program has outlined for the coming year and provide input on the messaging developed by the NBS program and how it may be received by parents. The NBS program will also attend a baby fair within the state of Georgia. This is a new strategy to educate expecting parents about NBS prior to their child's birth. The NBS program will also help plan and participate in the second annual Newborn Screening Family Fun Day in collaboration with Emory University.

The NBS program will continue to make improvements to the NBS database through SendSS by frequently meeting with internal SendSS informational technology (IT) and epidemiology staff to discuss needed enhancements, build new requirements, and monitor the progress of any changes.

The NBS program will continue providing education to parents and providers. The NBS brochure given to parents

before their newborn receives a newborn screening will be revised to include a list of disorders included in the screening. The program will continue to partner with organizations that engage providers, such as GA AAP and GAFP, to participate in webinars, provide fax communications, professional development conferences, and grand rounds. On-site and telephone technical assistance to birthing hospitals will continue as needed.

Zika Prevention

The MCH Section will continue to support the Zika Prevention Team in the preparation for Zika response and prevention of perinatal Zika infection. The upcoming year will have several changes for the Zika surveillance effort. Funding for Zika surveillance as they relate to the Arboviral Epidemiology Team will be discontinued as of August 1, 2018. Zika surveillance will continue as it has been integrated into the case definition for the notifiable condition of all acute arboviral infections. There is uncertainty about surveillance activities after July 31, 2018 for the Zika Pregnancy Registry. The CDC will accept data submitted after March 31, 2018, but this data will not be counted as part of the national Zika response. Regarding Zika-associated birth defects, Georgia DPH is developing a statewide surveillance system for birth defects. This registry will connect 17 reporting sources and automate referral of affected infants and their families to early intervention services; and facilitate standardized, timely, reporting and confirmation of all birth defects statewide, including those associated with Zika. Flexibility is inherent to the design of the registry and will greatly enhanced Georgia's capacity to respond to emerging teratogens in the future.

Newborn Screening-New Disorders

The NBS program will continue to support the overall process of nominating conditions for inclusion on the Georgia NBS panel. The NBS program will provide information to groups and individuals that wish to nominate a disorder to the Georgia NBS panel. The NBS program will also continue to facilitate NBSAC meetings, including scheduling, compiling meeting minutes, sharing committee reports, and providing programmatic information as needed.

The NBS program will facilitate meetings for the workgroup created to review SMA. Throughout this process, the NBS program will establish a standardized outline and format for the review of a disorder for the Georgia NBS panel focusing on Georgia-specific information. The NBS program will collaborate with Emory University and GPHL on the SMA pilot through provider education, including a blast fax to members of the Georgia Chapter of the American Academy of Pediatrics.

The NBS program will also respond in accordance with the Commissioner's decision regarding the addition of Pompe, MPS I, and X-ALD to the Georgia NBS panel. The NBSAC will vote on whether to recommend GAMT deficiency for rejection or inclusion in the Georgia NBS panel.

Home Visiting

In the coming year, the Home Visiting Program plans to continue to move in the direction as suggested by DOE and Health and Human Services (HHS) to set a vision for stronger partnerships, collaboration, and coordination between awardees of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) and the Individuals with Disabilities Education Act, Part C Program (IDEA Part C Program). MIECHV and Part C Program staff meet regularly to discuss best practices and next steps necessary to ensure collaboration with programs and community partners.

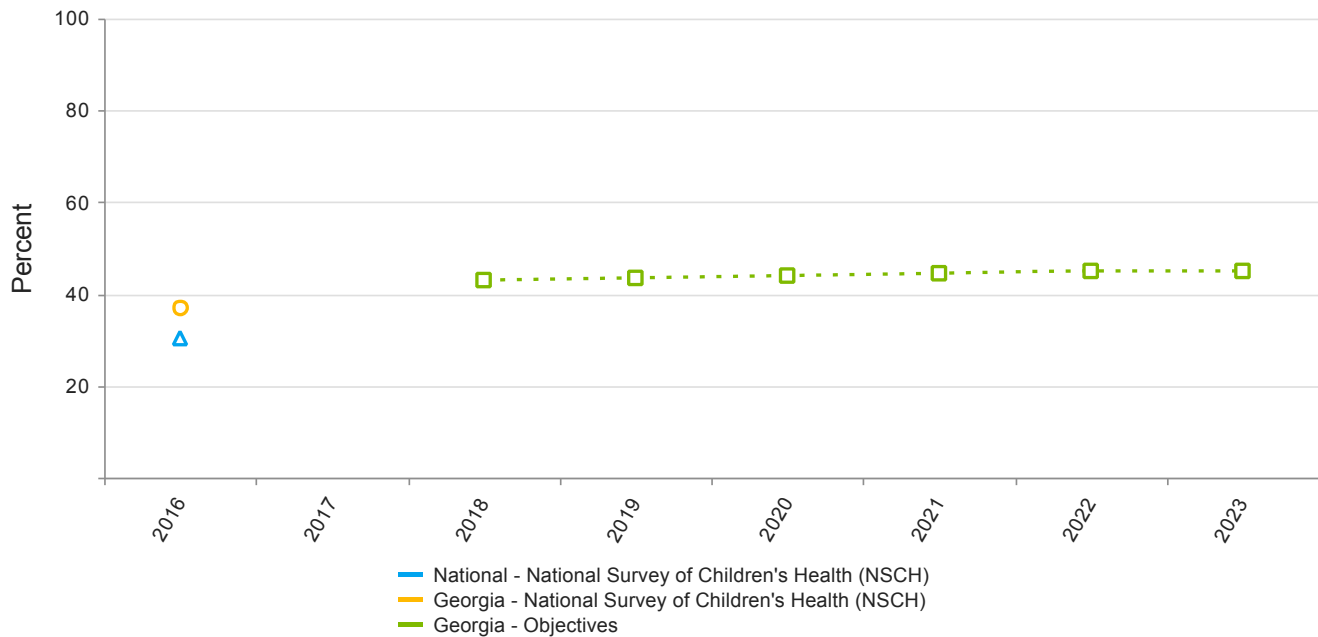
Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)	NSCH	Data Not Available	NPM 6
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016	13.3 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	90.3 %	NPM 6 NPM 8.1 NPM 13.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	18.6 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	13.0 %	NPM 8.1
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2013	12.7 %	NPM 8.1

National Performance Measures

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



Federally Available Data

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

	2016	2017
Annual Objective		
Annual Indicator		37.1
Numerator		104,456
Denominator		281,856
Data Source		NSCH
Data Source Year		2016

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

Annual Objectives

	2018	2019	2020	2021	2022	2023
Annual Objective	43.0	43.5	44.0	44.5	45.0	45.0

Evidence-Based or –Informed Strategy Measures**ESM 6.1 - 6.1.1. Number of public health districts using at least two developmental screening methods regularly**

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	8	8
Numerator		
Denominator		
Data Source	Children 1st Program Data	Children 1st Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	15.0	18.0	18.0	18.0	18.0

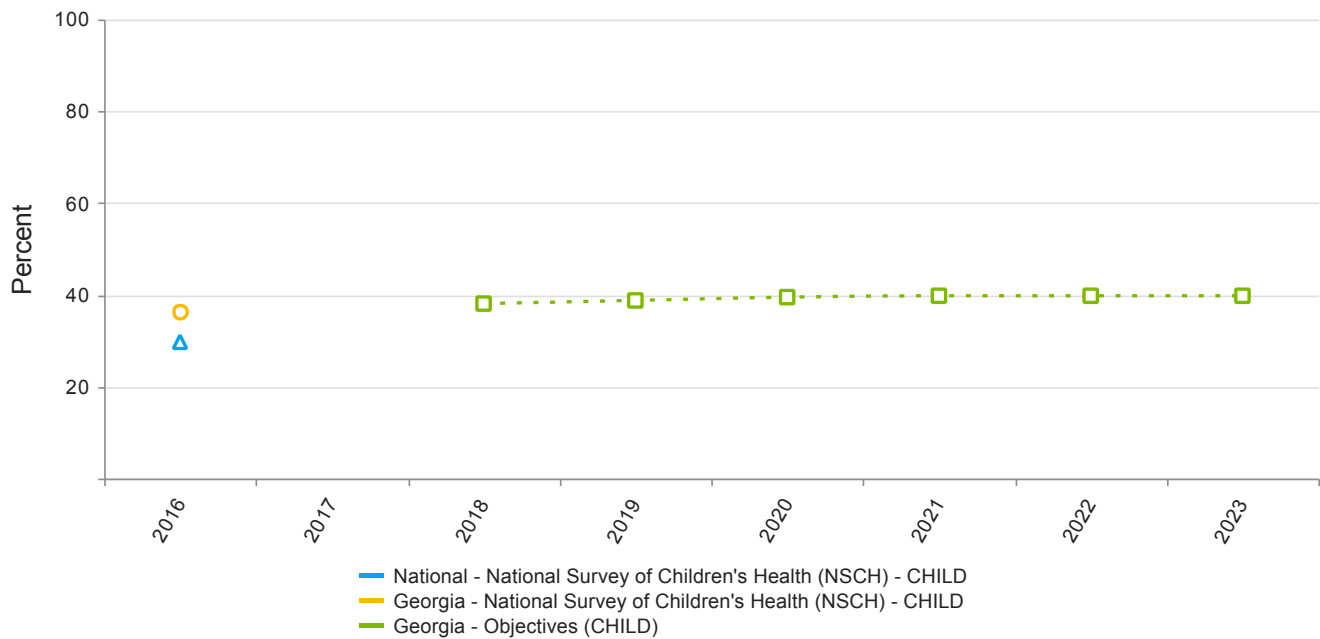
ESM 6.3 - 6.2.1. Number of formal training opportunities on developmental screening conducted in each public health district health districts each year

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	9	20
Numerator		
Denominator		
Data Source	Children 1st Program Data	Children 1st Program Data
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	14.0	26.0	30.0	36.0	38.0	38.0

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



Federally Available Data

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

	2016	2017
Annual Objective		
Annual Indicator		36.4
Numerator		301,002
Denominator		826,166
Data Source		NSCH-CHILD
Data Source Year		2016

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

Annual Objectives

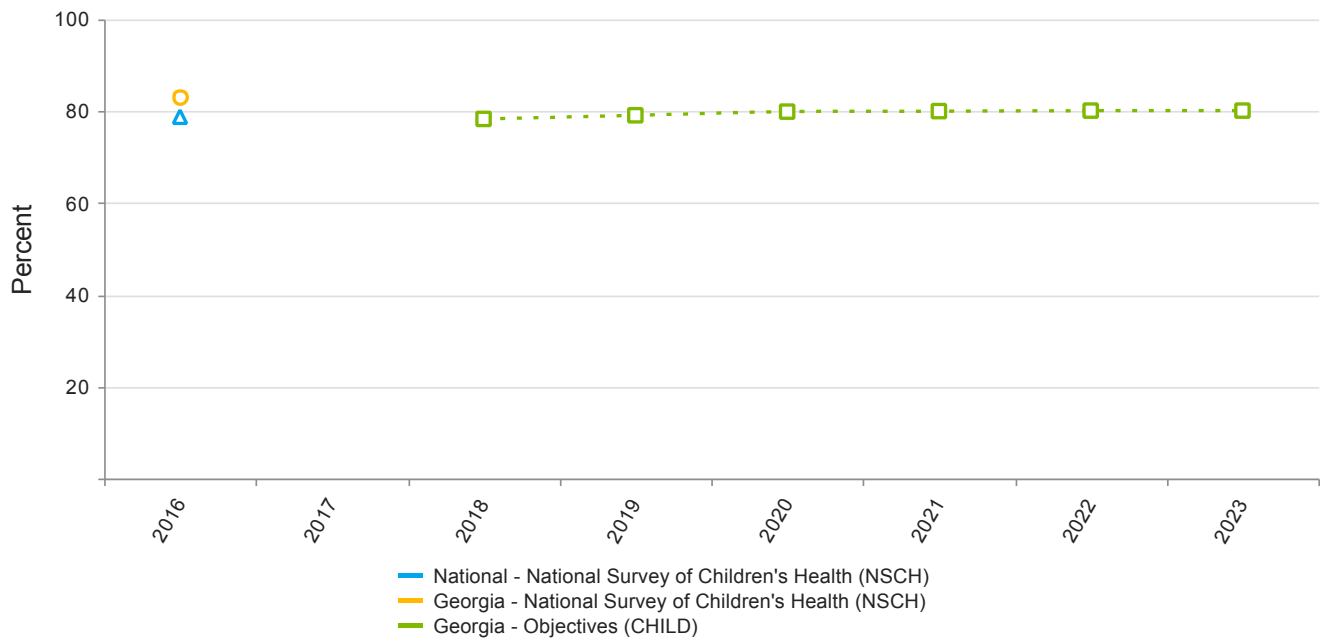
	2018	2019	2020	2021	2022	2023
Annual Objective	38.1	38.8	39.5	39.8	39.8	39.8

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Percent of children, in grades 1-12 enrolled in public school physical education class, who are in the Healthy Fitness Zone (HFZ) for Body Mass Index (BMI)

Measure Status:				Active	
Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	62.0	63.0	64.0	65.0	66.0

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



NPM 13.2 - Child Health

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		83.0
Numerator		1,968,896
Denominator		2,372,620
Data Source		NSCH
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	78.2	79.0	79.8	79.9	80.0	80.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - 11.1.2. Number of dentists, hygienists and staff educated on four specific dental services for individuals with special needs and the oral health connection and services

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	15	32
Numerator		
Denominator		
Data Source	Oral Health Program Data	Oral Health Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	20.0	30.0	40.0	40.0	40.0

State Action Plan Table

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

Priority Need

Promote developmental screenings among children

NPM

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

Objectives

6.1. By 2020, increase the number of partner agencies who are trained on developmental screening tools in the 18 public health districts from 0 to 20

6.2. By 2020, increase the number of early childhood providers in the 18 public health districts, from 0 to 20, who disseminate educational resources about developmental milestones and developmental screening to families.

Strategies

6.1.a. Convene a work group to recommend new, innovative, and effective screening methods (ie. phone, web-based, telephonic)

6.1.b. Identify two new partners per district who are able to administer developmental screens

6.1.c. Use a Train the Trainer model to train newly identified partners in each district on developmental screening tools

6.2.a. Partner with the Georgia American Academy of Pediatricians to disseminate educational resources to pediatric providers

6.2.b. Train public health district staff on developmental milestones and counseling skills to encourage parents to receive a formal developmental screen

6.2.c. Collaborate with early childhood stakeholders to disseminate Learn The Signs. Act Early, information to parents, to increase awareness of developmental milestones

6.2.d. Implement an evidence-informed child health information and referral system, to promote population developmental screening and referral for at-risk children

6.2.e. Collaborate with the Department of Family and Children Services, Women's Infants and Toddler, and Part C to disseminate information and provide training on monitoring developmental milestones.

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

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

Priority Need

Promote physical activity among children

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

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

Strategies

- 7.1.a. Implement and build sustainability for the Power Up for 30 (PU30) program that trains elementary school educators how to incorporate an extra 30 minutes of physical activity into the day (in addition to quality physical education class)
- 7.1.b. Implement a Middle School PU30 program in at least 10 middle schools
- 7.1.c. Implement a Pre-service teacher certificate program that trains educators to incorporate physical activity into the school day
- 7.1.d. Train at least 300 after school providers with PU30 program to incorporate physical activity into after school programs
- 7.1.e. Award at least 25 schools through the Georgia Shape Grantee program to increase physical activity and healthy nutrition efforts at the school level with mini grants and expert technical assistance
- 7.2.a. Collaborate with Department of Early Care and Learning (DECAL) to award at least 75 additional early learning centers that adhere to the 14 Quality Rated Nutrition and Physical Activity assessment items, whereby receiving the Quality Rated Georgia Shape recognition award
- 7.2.b. Collaborate with DECAL to train at least 30 early learning centers with the Growing Fit Kit curriculum, whereby guiding centers to create physical activity and healthy nutrition policy at the local level
- 7.3.a. Collaborate with Department of Education to increase the number of students that receive the Fitnessgram assessment through physical educator teacher training, afterschool provider training, and in-service teacher training(s)
- 7.4.a. All strategies listed above are in place to support this measure

ESMs	Status
ESM 8.1.1 - Percent of children, in grades 1-12 enrolled in public school physical education class, who are in the Healthy Fitness Zone (HFZ) for Body Mass Index (BMI)	Active

NOMs
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

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

Priority Need

Promote oral health among all populations

NPM

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

Objectives

11.1. By 2020, develop a collaborative partnership working with women's health partners and the Chronic Disease Section to promote perinatal oral health

11.2. By 2020, develop an oral health resource database for CYSHCN

11.3. By 2020, increase the education and promotion activities regarding oral health among low-income Hispanic mothers and children from 0 to 8

Strategies

11.1.a. Partner with public health districts, private practices, dental hygiene programs (the Augusta University, Dental College of Georgia) to promote perinatal oral health screenings

11.1.b. Offer comprehensive educational webinars/presentations

11.2.a. Educate public health district oral health staff on special considerations and treatment needs for special needs patients

11.2.b. Determine data sources and begin collecting data to develop a special needs dental access database with location of practices serving special needs children and adults/special services offered, such as general anesthesia, orthodontics, insurance accepted and other specialties

11.3.a. Improve the Oral Health Education Initiative program to include culturally competent messages for low-income Hispanic children and adolescents

ESMs

Status

ESM 13.2.1 - 11.1.2. Number of dentists, hygienists and staff educated on four specific dental services for individuals with special needs and the oral health connection and services

Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Child Health - Annual Report

Priority Need: Promote Developmental Screenings Among Children

NPM 6: Developmental Screening for Children

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

C1st remained the single point of entry for at risk children, and connected children and their families with public health programs, as well as other prevention based programs and services. C1st aimed to identify all children birth to five who are at risk for poor health and development. C1st is available in every county in Georgia and its system includes partnerships with; Department of Community Health (DCH), Department of Education (DOE), Department of Early Care and Learning (DECAL), Division of Family and Children Services (DFCS), primary care and specialty physicians, and DPH Home Visiting programs. C1st Coordinators utilized validated screening tools as a primary tool to identify children who, without early intervention, are at risk for poor developmental outcomes. Children with significant developmental delays were referred to intervention programs as quickly as possible to maximize the benefits of early intervention. Children who did not demonstrate significant delays during their developmental screening were monitored by the C1st program and received follow-up visits or phone calls in six month intervals. C1st Coordinators discussed the importance of developmental monitoring with families and often share the CDC's Learn the Signs. Act Early (LTSAE) materials with caregivers to enhance their understanding of age-appropriate developmental milestones along with a tool to track their child's development. C1st Coordinators communicated with pediatricians during monitoring activities to learn about any concerns the child's health care provider may have about his/her growth and development.

Priority Need: Promote Physical Activity Among Children

NPM 8: Physical Activity for Children and Adolescents

In the reporting year, Georgia SHAPE continued the management of statewide Fitnessgram "booster session" contracts with HealthMPowers (HMP) and the DOE. The contracts allowed DPH to train PE teachers to assess students effectively for fitness levels pertaining to Body Mass Index (BMI), aerobic capacity, flexibility, muscular strength and muscular endurance. Approximately 8-12 trainings a year are conducted through DOE or state PE/Health conferences (GAHPERD association) and the FG Certificate program which coordinates state recognition certificates for students that excel in FG components. The Governor, DPH Commissioner, DOE Superintendent all sign the Certificate. DPH sends about 110,000 to DOE to send to all schools in the state to recognize participation and student achievement.

During the reporting year, SHAPE reach was as follows:

- Fitnessgram and Power-up for 30: 180,038
- Growing Fit: 3196
- Early Feeding Program: 278 providers, reaching approximately 7,500 children
- WIC Live Trainings: 73 people, reaching approximately 8,200 children
- WIC Online Module: 265 completions
- School Nutrition: (Live and Online) 240 schools, reaching approximately 165,495 children

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

In the reporting year, approximately 13,000 school age children lacking an adequate source of fluoride received fluoride mouth rinse or fluoride varnish treatments in 2017.

Public Health Dental personnel placed more than 14,000 dental sealants on the permanent molars of Georgia children in 2017. The Sealant Coordinator also targeted Spanish speaking families at Hightower Elementary school where approximately 90% of the students are Hispanic and 94% of their students are in the free and reduced lunch (FRL) program. The Oral Health Program also participated in a book fair for parents and students providing education and outreach at Norcross Elementary School. The school is 86% on FRL.

The Oral Health program staff attended Family Physicians, OB/GYN and Pediatric conferences to promote the importance of oral health for their patients. In January 2017, an article for the Georgia Association of Family Physicians (AFP) was posted on their website encouraging practices to include the oral health assessment for all children and the fluoride varnish application for high risk children. In May 2017, an online webinar on fluoride varnish was presented on the Georgia Academy's website. Office trainings were offered for practices wanting hands-on training.

Public health dental hygienists teach school children the importance of proper brushing, flossing, and good nutrition for good dental health. More than 91,000 school children were reached in 2017.

Other Child Health Programs

Early Hearing Detection and Intervention (EHDI)

In the reporting year, EHDI maintained and supported a comprehensive, coordinated statewide screening and referral system. EHDI included screening for hearing loss on all newborns in the birthing hospital; referral of those who do not pass the hospital screening for rescreening; referral of those who do not pass the rescreening for diagnostic audiological evaluation; and linkage to appropriate intervention for babies diagnosed with hearing loss. EHDI coordinators conducted surveillance and managed follow-up contacts through the SendSS statewide database.

The EHDI program partnered with several external entities to improve follow-up services, outreach, resource referral, and education:

- Auditory-Verbal Center, Inc: EHDI contracts with the Auditory-Verbal Center, Inc. (AVC), which provides intervention services to children who are deaf or hard of hearing, manages the hearing aid loaner bank for families unable to acquire hearing aids, as well as provides an onsite audiologist to perform follow-up screening and diagnostic testing.
- Georgia PINES (Early Hearing Orientation Specialists): the EHDI program supports Early Hearing Orientation (EHO) Specialists through the Georgia Parent Infant Network for Educational Services (Georgia PINES) within the Department of Education, which is a non-Part C early intervention provider. The EHO Specialist visit is the initial visit a family receives after their child has been identified with a permanent hearing loss and serves to provide family support and introduce families to resources available as they begin intervention services.

- Georgia Hands & Voices: the EHDI program also funds Georgia Hands & Voices, a parent organization, to provide advocacy support and training to families through a program called ASTra. Georgia Hands & Voices also contracts with the EHDI program to support the Guide By Your side initiative, which is a program in which parent mentors provide support to parents of children diagnosed with hearing loss.
- Georgia PINES (Deaf Mentor Program): EHDI also supports the Deaf Mentor program through Georgia PINES to provide education, guidance, and support on Deaf Culture to more families with children that are deaf or hard of hearing (D/HH) in Georgia.

During the reporting year, the EHDI program continued to work on a long term follow up study and evaluation (100 Babies Project), which looks at long-term language outcomes of D/HH children in Georgia.

100 Babies

The 100 Babies Project is a long-term follow-up evaluation of early childhood outcomes for children who are diagnosed as deaf or hard of hearing (D/HH) through newborn hearing screening. 100 Babies partners with the DPH and the Georgia Pathway to Language and Literacy, a coalition of professionals, advocates, and parents who serve deaf and hard of hearing (D/HH) throughout the State of Georgia.

The goal of the 100 Babies project is to ensure grade level literacy by 3rd grade regardless of language used (spoken language and/or American Sign Language). The aims of the project are to identify system gaps and provide evidence-based solutions to improve outcomes. DPH collects language assessments and caregiver surveys from over 250 families participating in the project. Birth through third grade assessments and surveys include:

- Audiological information (hearing aids, cochlear implant, etc.)
- Access and enrollment of intervention services
- Language assessments
- Family survey (collected annually)

Data collection efforts continued to be collected from the project and analyzed to better understand the fitness of the EHDI and early intervention systems. DPH continued to enroll families into the 100 Babies Project and use project findings to improve outcomes for D/HH children in Georgia.

Brain Trust for Babies

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

The stated goal of the Early Brain Development initiative is to establish early brain development as a public health imperative, establish a common set of agreed upon metrics to determine success by age three (as many children do not enter a shared database system for measuring health and academic outcomes until they enter the educational

system) and to make sure that by 2020, every child in Georgia will achieve the promise for optimal brain development by age three.

Vision Screening

All children are required to have vision screening completed and documented on the Georgia state form 3300 prior to their initial entry into the Georgia school system.

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

Help Me Grow

Help Me Grow® (HMG) is a unique, comprehensive, and integrated statewide system designed to address the need for early identification of children at risk for developmental and/or behavioral problems, and then linkage to developmental and behavioral services and supports for children and their families.

During this reporting period, HMG worked to finalize its initial pre-implementation approach leading to its first phase of implementation. During pre-implementation, HMG focused its efforts on understanding and identifying key opportunities for developing a streamlined system. Through its collaboration with six of 18 Public Health Districts throughout the state during the Process Analysis Sessions, HMG was able to identify key and unique attributes across districts as opportunities for achieving successful outcomes.

Babies Can't Wait

Babies Can't Wait (BCW), also known as Part C, is an early intervention service to provide a coordinated, comprehensive and integrated system of service for infants and toddlers with special needs, birth to age three, and their families. This program provided early identification and screening of children with developmental delays and chronic health conditions by using a multidisciplinary evaluation and assessment to determine the scope of services needed. BCW coordinated services to assist the family in developing a plan to improve the developmental potential of infants and toddlers with these health conditions. Early Intervention allowed for support and resources to be built to assist family members and caretakers to enhance children's learning and development throughout everyday learning opportunities.

Home Visiting

During the reporting year, MCH continued to implement the Home Visiting program following the transfer of the program from the Department of Human Services to DPH the previous year.

The Home Visiting programs served 1,362 families through 17,279 home visits. Of those served, 1,313 were children.

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

During the reporting year, Project Launch provided outreach to area physicians to increase their knowledge of developmental screenings. Health fairs and meetings were held to promote the Project LAUNCH initiative utilizing new marketing materials. Project LAUNCH continued to partner with Children's Healthcare of Atlanta to provide training webinars on social emotional development and trauma, *Strengthening Families through Knowledge of Child Development* and other parent trainings. Through partnerships with New Horizons Community Service Board and Project AWARE, Project LAUNCH collaborated with the school system to screen all children in Pre-K and any child referred through age eight. Home Visitor training was enhanced during this period to include trauma informed

reflective skills training.

Immunizations

In the reporting year, Georgia Immunization Program (GIP) sought to increase immunization rates for all Georgians and decrease the incidence of vaccine-preventable diseases. GIP educated medical providers through partnerships and collaborations about the importance of protecting their patient population from vaccine preventable diseases, in accordance with the Advisory Committee for Immunization Practices (ACIP) recommended immunization schedule.

In addition, GIP worked to educate medical providers and laboratories about the importance of disease reporting, with a specific target population of prenatal care providers to increase the number of hepatitis B virus (HBV)-positive pregnant women identified in birth cohort 2018 by 2%, over the total from birth cohort 2017.

Child Occupancy Safety Program (COSP)

The mission of DPH is to protect the lives of all Georgians. Motor vehicle related injuries continue to be a leading cause of death for children under 14 years of age. The current method of child passenger safety (CPS) intervention through education, equipment distribution, enforcement, and policy change worked to increase child safety seat use and is an evidence-based approach listed in the Centers for Disease Control and Prevention's Guide to Community Preventive Services.

COSP has several initiatives focused on CPS education: Car seat Mini-Grant, Fire/EMS Outreach (including the Teddy Bear Sticker (TBS) Program), Hospital/Healthcare Training, Children with Special Healthcare Needs, and Law Enforcement Training, as well as Child Passenger Safety Technician (CPST) certification, recertification, and instructor development.

COSP, utilizing local partners, conducted monthly education classes to train caregivers on proper use and installation of child safety seats. After participating in the classroom education, caregivers were provided an appropriate child safety seat (either a convertible or a booster). The caregivers then demonstrated proper installation technique before leaving the event. This education and distribution program is known as the Mini-Grant program. In 2017, 132 counties either directly participated in or were covered by the Mini-Grant program. The Mini-Grant provided 2,509 monthly classes, trained 12,941 caregivers, and distributed 3,842 seats during FFY17.

In addition to the conventional seats distributed, COSP worked with families of children with special healthcare needs to evaluate transportation needs and issues. Evaluations were provided to 70 children and 11 seats were distributed. COSP staff previously developed a flow chart for use by Children's Medical Services and other field referrers to assist families through the process. Based on information received in the flow chart, many families have been able to receive seats through Medicaid funding, allowing COSP to transition to a funder of last resort.

Teddy Bear Stickers were placed on all car seats distributed to document the number of lives saved from injury and/or death due to program funded child safety seats. If a grant provided seat is involved in a crash, the caregiver may receive a replacement seat from the original issuing agency. In 2017, IPP staff received 31 Teddy Bear Sticker forms and replaced 31 seats.

Other trainings and presentations offered by IPP staff included:

- "You have the Power in Your Pen" – 5 classes, training 160 law enforcement officers
- Child Passenger Safety Technician course – 5 classes, training 70 attendees
- CPST recertification class for current CPSTs – 13 classes with 140 attendees
- "Transporting Children with Special Health Care Needs Training" – 2 classes with 38 attendees

- Keeping Kids Safe – 12 classes at 11 hospitals with 234 nurses trained
- Basic Child Passenger Safety Awareness course – 2 classes with 65 firefighters

Building on minority outreach efforts, the mini-grant training presentation and all training materials were translated with narration in Spanish. Additionally, a Spanish-English flipbook was developed to assist English speaking technicians when working with Spanish-speaking parents/caregivers. This flipbook was piloted with 12 counties in the reporting year. Training was provided to a total of 815 professionals and caregivers through DeKalb International Student Center, Telamon Transportation Training, World Relief Center, and the local Mini-Grant in Coffee County.

Current Year: Oct 2017 – Sept 2018

Priority Need: Promote Developmental Screenings Among Children

NPM 6: Developmental Screenings for Children

During the current year, the Children 1st (C1st) program continued to focus on developmental screening and monitoring and has had continued success in educating child serving programs about developmental screening. C1st received 28,477 appropriate referrals and C1st Coordinators facilitated 65 developmental screening, developmental milestones and the referral system trainings within the first six months of the year. These trainings provided participants with a wide range of focus areas including; developmental screening, developmental monitoring, and working with the child health referral system when developmental concerns are identified. More than 2,080 staff from hospitals, public health programs, community organizations, daycare centers, head start programs and primary care offices participated in these trainings. Twenty-one of the training opportunities focused on developmental screening using the Ages and Stages Questionnaires. More than 70 participants attended these trainings across four districts. Eight of the 21 trainings were facilitated using the train-the-trainer model. Implementation of this type of train-the-trainer model involved the use of local experts working with other agency staff on developmental screening. C1st also focused efforts on providing materials to families and community partners to support education to caregivers around developmental milestones. More than 2,700 Learn the Signs. Act Early (LTSAE) booklets and brochures were distributed across 20 events in a wide variety of settings including community outreach events, among community organizations, public health departments and during home visits. During the current year, C1st Coordinators attended over 108 outreach events and distributed over 12,620 pieces of literature around LTSAE, developmental milestones and DPH child health programs.

The C1st program has also worked closely with the Georgia Academy of Family Physicians (GAFP) and the Georgia Chapter of the American Academy of Pediatrics (GA AAP) to provide peer-to-peer education on the importance of developmental screening and accessing support through the child health referral system. Through collaboration with GAFP, Jennifer Zubler, M.D., a *Learn The Signs. Act Early* champion and Developmental & Behavioral Clinic Coordinator, presented on the importance of early identification of delays through developmental screening and surveillance during two grand rounds. Similarly, during GA AAP's summer conference, Ira Adams-Chapman, M.D., a well-known neonatologist presented to her peers on the developmental outcomes of high-risk infants, predictors of adverse developmental outcomes in early childhood and psychosocial support for parents and caregivers.

An additional approach that has been utilized to help increase early and frequent developmental screenings consists of expanding platforms through which developmental screening can be accessed. Nearly 45% (8) of Children 1st coordinators have employed multiple developmental screening methods. In total, 84% of all developmental screens were administered in-person, 10% were telephonic, 3% were administered via mail and 3% were administered via

e-mail. Providing all eighteen health districts with online web access to the Ages and Stages Developmental Screening tool (ASQ), represented a significant accomplishment during this reporting period. Online ASQ is a new advancement for the C1st program. This avenue helps increase opportunities families have to receive a developmental screening for their child. The C1st program can now offer developmental screenings in person, over the phone, via mail or through an online platform. C1st has recently started integrating web based screening into program operations and has already been received favorably by several districts.

C1st has also been successful in working more collaboratively with the Autism and Developmental Disabilities Program to implement Modified Checklist for Autism in Toddlers (MCHAT) screening within public health programs. The MCHAT is a parent-reported screening tool designed to identify toddlers, 16 -30 months, with risk factors for autism spectrum disorder and require further evaluation. C1st coordinators participated in training opportunities to learn how to administer MCHAT screening and where to refer based on the level of risk identified by the screening tool. The C1st program has also implemented program policies that minimize duplicate MCHAT screening. Prior to screening, C1st Coordinators contact pediatricians to learn if an MCHAT screening has recently been performed. If a child has recently received a screening, the C1st Coordinator will request a copy of the screening results rather than rescreen the child. The C1st Coordinator will then refer the child based on the level of risk identified by the screening tool.

Priority Need: Promote Physical Activity Among Children

NPM 8: Physical Activity for Children and Adolescents

In the current year, Georgia SHAPE continues to work toward increasing participation in the following programs for children 6-11 years of age:

- PU30 Elementary Program- To date, 881 active schools across the state participate with SHAPE providing TA and training components.
- PU30 Afterschool Program- DPH manages programs in partnership with HealthMPowers (HMP) and the Department of Family and Child Services (DFCS). This partnership allows funding for HMP to do trainings in all DFCS funded afterschool sites.

Other Physical Activity (PA) programs provided during the current year:

- Georgia Shape Grantee Program- A mini-grant program for schools allowing schools to choose what best practice interventions they want to introduce into the school environment. The program is provided technical assistance and funding through the partnership with Georgia State University (GSU). The program holds a summit and 25-26 schools attend annually to meet and receive two days of technical assistance. Twenty partners are invited to attend and share their resources with schools, as well as provide TA.
- Governor's Honor Roll- Schools (k-12) apply for the award online and are awarded a certificate signed by the Governor, DPH Commissioner, and the DOE Superintendent. In addition, they receive a banner for their school and an equipment package that promotes PA.
- Rise Up 159 Mini Grant Program- The Blank Foundation has awarded over \$240k to implement a Flag Football mini grant program. Shape works with the NFL, Falcons, and Blank Foundation on all aspects of program.
- Healthy Georgia Awards Program- Georgia Shape and the LT Governor's office co-host this large-scale event to acknowledge partners and participates.

Early Care programs:

- In the current year, SHAPE will host a Farm to Early Care Education (ECE) Summit. Georgia SHAPE held the first ECE summit in the country in 2014. Georgia Organics leads much of this work under a Shape contract. Shape built a statewide strategic map and programming that will be promoted statewide this year through additional funding from Kellogg. There are approximately 20 partners involved in the coalition facilitated by Georgia Shape and Georgia Organics.
- Georgia Shape Quality Rated Recognition- Recognition program through a partnership with DECAL and the QR assessment.

Nutrition Based Programs and Projects:

- Strong4Life (S4L) Cafeteria Program- DPH manages the S4L cafeteria project. based on Cornell's Smarter Lunchroom using behavioral economics as a framework. Dr. Janani Thapa at UGA is currently working with SHAPE on projects (Nutrition Survey, WIC workgroup).
- Statewide Nutrition Survey- Shape developed a survey to analyzed over 70% of the elementary school's physical activity environment. Shape is working to disseminate a statewide survey to 89 schools.
- Strong4Life Provider Training- Manages contracts with CHOA to provide providers (physicians, nurses, physician's assistants) with motivational interviewing (MI) tools and counseling techniques to help with goal setting based on the transtheoretical model to facilitate behavior changes.
- Strong4Life Early Feeding Provider Training- Providers are trained to utilize MI in working with parents and caregivers about early feeding best practices, developmental concerns, etc. Take home kits for providers to give to patients were created to be disseminated statewide.
- Strong4Life WIC Champions Program- WIC staff (100%) statewide have been trained using the Strong4Life Early Feeding Provider Training.
- Zipmilk- Georgia uses this platform to locate breastfeeding resources. The platform is updated by the Georgia Breastfeeding Coalition.

SHAPE cohosted the Southern Obesity Summit on October 1-3, 2017 with Texas Health.

In the current year, a peer reviewed Shape special supplement was included in Public Health Reports. The supplement showcased the available research. Dr. Satcher provided the forward, Emily Anne Vall, Jean O'Connor, Christine Greene and Katie Smith (and other outside partners) wrote commentary, and 12 researchers (many affiliated with the above stated projects) wrote articles. Published this November (search words: Georgia Shape Obesity Public Health Reports Satcher Vall).

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

In the current year, visits were made to several District Health Directors and county school boards to discuss the potential development of new school based sealant programs. The Oral Health program is exploring incorporating public health oral health programs into additional schools and investigating alternative strategies of utilizing early childcare centers and summer free and reduced lunch programs associated with schools.

Meetings were held with Georgia Dental College regarding potential future partnerships and an aligned mission to facilitate access to care and workforce distribution challenges in the state with new creative perspectives. The Oral Health program and Children's Health Care of Atlanta (CHOA) have discussed a potential pediatric dental residency

program to provide dental residents the opportunity to rotate through local DPH sites to gain clinical experience. A partnership opportunity was discussed with the Georgia Primary Care Association (GPCA) and their associated FQHCs.

Challenges/Barriers: The Oral Health Program is without an Epidemiologist; however, the position will post in July.

Other Child Health Programs

Early Hearing Detection and Intervention (EHDI)

Tele-audiology aims to increase access to specialty services by linking the audiologist to the patient through a video consultation, therefore decreasing the amount of travel time for the patient. The tele-audiology initiative is a partnership with the state EHDI program, the audiology department at Children's Healthcare of Atlanta (CHOA), and the Waycross Health Department. The tele-audiology clinic is held once a month and is used to perform diagnostic testing on babies that received a referral resulting from the hearing screen performed at the birthing hospital. At the inception of the clinic in June 2017, there were technical equipment issues that prevented accurate testing and clear interpretation of results. Since October 1st, 2017, EHDI program staff traveled to the Waycross Health Department for technical assistance, troubleshooting, and instrument validation, however, these efforts intermittently resolved the technical issues. In June of 2018, The CHOA audiologist traveled to Waycross, with validated equipment that would be used to test the infants schedule for clinic. The audiologist compared diagnostic results from the validated equipment with those from the teleaudiology equipment and found that the teleaudiology did not consistently provide reliable results. Identifying the root cause of the technical issues has positioned the clinic to become fully functional. The tele-audiology clinic will serve one to two patients per month.

The EHDI program continues to provide education to parents and providers. The program has updated, printed, and distributed the *Have You Heard* brochure to birthing hospitals via the district EHDI coordinators. This brochure is given to parents whose infants do not pass the newborn hearing screen in the hospital and also provides information on what to expect during the referral process. EHDI contracts with the Georgia Chapter of the American Academy of Pediatrics (GA AAP) and the Georgia Academy of Family Physicians (GaAFP) to provide education to health care providers across Georgia. State EHDI staff continue to provide technical assistance and training in-person and over the phone to district and hospital staff. The program continues to collaborate with Georgia PINES to train new Early Hearing Orientation (EHO) Specialists to conduct the initial visit to the family after a child is diagnosed with hearing loss. The development of training materials for EHO Specialists for the updated parent curriculum piloted in April 2017 will be completed this year.

With guidance from MCHB, the EHDI program established a learning community in Georgia. The learning community is a diverse group of stakeholders in the EHDI system that provide guidance to the program on best practices in service coordination and enrollment into early intervention. The initial visit with the learning community occurred in June of 2017 and additional calls and contacts were made in November 2017 and February 2018. The learning community is currently focused on reducing the time to diagnosis, improved quality of reporting, and increased enrollment in early intervention in one region of the state.

The EHDI program meets regularly with DPH Information Technology (IT) and epidemiology staff to evaluate the state hearing database, SendSS, and make improvements as needed. The program continues to increase awareness around the audiologist portal, an electronic interface where audiologists can enter diagnostic results directly into the SendSS database which is then linked to the child's existing record. The program is continuing process improvement around the automatic referral from SendSS to Georgia PINES for the EHOS visit after a provider reports a diagnosis in the database that was piloted last year.

The EHDI program participates in ongoing quality improvement (QI) activities. The program has ongoing webinar meetings with a representative from the National Center for Hearing Assessment and Management (NCHAM) to assess QI measures and identify areas for improvement. Since October 1, 2017, there have been four of these calls which occurred on the following dates: November 2, 2017, December 8, 2017, January , 2018, March 5, 2018 and April 27, 2018.

100 Babies Project

Early outcomes identified by the 100 Babies Project have highlighted areas for enhancing existing efforts. These areas include several areas along the continuum from identification of hearing loss, referral to early intervention, and school transition. In the current year, the EHDI program has worked to remove barriers to timely identification, reduce referral time into intervention, and promote the importance of an individualized education plan for school-aged children who are D/HH.

In the current year, improvements have been made with respect to the time it takes to refer to the EHO visit after identifying hearing loss. These improvements will likely result in more timely linkage to resources and services that will help families maximize learning and literacy for their children. In addition to improving the referral process to the EHO visit, the EHO visit format has been revised to simplify information provided to families, focus more on language development and its link to literacy, as well as the urgency of early intervention.

In the current year, unilateral hearing loss was added as a qualifying condition for the Georgia Part C program. This is a major success as it moves Georgia closer to having a true single point of entry model for early intervention for children with hearing loss.

The EHDI Program has strengthened its relationship with Georgia Hands and Voices as a strategy to support language and literacy goals both during early childhood and upon entry into school. Hands and Voices is a family support organization that provides unbiased support, resources, education and advocacy training to families with children who are D/HH. Trained Parent Guides work directly with families to reinforce the importance of early brain development and language acquisition for children who are D/HH. Parent Guides teach families how to work with their child's respective school system to ensure there is a continuation of resources and supports for children who are D/HH as they transition from early intervention to school based education.

Brain Trust for Babies

The activities of the Brain Trust are guided by the objectives of the strategic plan. Objectives 2, 3, 4, and 5 aim to improve development for children with hearing loss, autism and medical causes of developmental delay, as well as particularly achieve social and emotional outcomes for all children birth to three. MCH and the Title V program supports the Brain Trust by aligning goals within the Child Health Programs such as, Babies Can't Wait and Autism, Newborn Screening and Early Hearing Detection and Intervention, Children Medical Services, and Children 1st, with the objectives of the Brain Trust.

Program goals include: Ensuring that all children who are deaf or hard of hearing are on a path to third grade reading by ensuring screening of hearing loss by one month, diagnosis by three months, and appropriate intervention by six months; Achieving breakthrough outcomes for all children by building the self-regulation skills, executive functions and social-emotional health of the adults who care for them; and Ensuring that children in Georgia are screened for Autism and Developmental Delays by 36 months and connected to appropriate intervention.

A unique and innovative program supported by the Brain Trust is Talk With Me Baby. Talk With Me Baby is a public

action campaign aimed at coaching parents and caregivers on the primacy of language and language nutrition, or the rich language interactions between caregivers and infants, in the earliest stages of a child's development. A lack of early language exposure has lifelong consequences. Coaching caregivers to provide language nutrition to their children at an early age could drastically improve a child's lifelong trajectory. DPH has expanded its goal to reach three workforces by 2020. Currently, DPH and its various Talk With Me Baby partners are working to training 14 different workforces that interact with new and expectant families. The goal is to create an ecosystem around families where everyone who interacts with that family is coaching and modeling the skills of language nutrition.

Recently, the Brain Trust for Babies looked closely at HRSA National Survey for Children's Health and the newly-added Healthy and Ready to Learn measure. This measure looks at school readiness in four domains: early learning, physical well-being, social emotional health, and self-regulation. The Brain Trust's work aligns with these four domains and DPH and Brain Trust partners are working closely with HRSA and CDC on further defining measures of early brain development.

Vision Screening

During the current year, DPH state office staff revised the vision screening certification process local public health staff must follow to provide vision screens to children. The state office incorporated feedback from certified vision screeners at several health departments throughout the state in the revision process. The revised recertification process includes a vision screening protocol and a shortened vision screening procedures validation form.

Help Me Grow

In the current year, a comprehensive assessment of referral and intake strategies were finalized. The results of the assessments led to the development of the HMG Phase 1 Action Plan which includes five implementation goals. The five identified HMG goals include: (1) Increasing the number of children entering the child health referral system, (2) Increasing the timeliness and efficiency of children receiving child health services, (3) Improving the family and provider experience, (4) Increasing collaboration and coordination with special supplemental nutrition program for Women Infants and Children (WIC) to enhance partnerships, (5) Assessing internal and external partnerships to identify gaps in partner resources. With completion of the Phase I action plan, HMG is working with state programs and six public health districts to support goal implementation and associated activities.

Phase I recommendations/results are as follows:

- Development of a Centralized Calling System: building off the Children 1st program, HMG has initiated a process for an enhanced centralized call system. This system works primarily to streamline phone calls coming into the state DPH office into one single call line. This centralized system provides users with the opportunity to access multiple DPH services and programs through one central system. The system is currently in place at the state office and is being assessed as a strategy for increasing efficiency.
- Decrease *lost to follow up*: as a strategy to increase the number of children into the system, program leads are working with HMG to implement various strategies to decrease the number of children that are lost to follow up. Program leads have identified and will begin implementing trainings, technical support, and potential technological solutions to help meet this activity.
- Support telemedicine/telehealth: to help increase the reach of children and families throughout the state receiving public health services, HMG has worked with DPH's telemedicine/telehealth program to provide training and support for implementing local telehealth efforts.
- Enhancement of existing Quality Improvement efforts: HMG has currently taken inventory of existing quality improvement (QI) efforts taking place at our six HMG pilot sites and has worked with program leads to enhance current strategies to include goals listed under the HMG Phase I Action Plan.

- Increase referrals through bidirectional referral strategy with WIC: HMG worked closely with the WIC program to effectively capture children coming into either WIC or the Child Health referral system. A Memorandum of Understanding (MOU) was developed to help address potential barriers and increase referrals in both areas. This approach also focuses on reducing duplicate referrals that parents sometimes experience.
- Provide HMG pilot districts with family and provider resources: HMG provided pilot districts with links to various state-recommended resources which provide a rich library of services and supports for families and providers. Districts have included these resources as links on their respective websites.

Currently, internal quality improvement processes continue to evaluate and plan for program implementation. A baseline and post-test survey are being developed to provide analysis of the effectiveness of Phase I strategies. In addition, it is anticipated that Phase I program evaluation outcomes will improve existing strategies to proceed with the Phase II statewide implementation. Phase II will include the collective engagement of community partners.

Babies Can't Wait

In the current year, BCW completed the Annual Performance Reporting (APR) and submitted to the Office of Special Education Programs (OSEP) in February 2018.

The BCW Policy Manual was finalized in October 2017 and made available to the Health Districts.

New Category 1 conditions (*Severe Birth (perinatal) asphyxia; Shaken baby syndrome; Cleft lip and palate unrepaired; Congenital reduction deformities of the lower limb; Congenital reduction deformities of the upper limb; Down Syndrome, unspecified; Turner's Syndrome, unspecified; Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side; Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side; Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side; Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side; "Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side"; "Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side"*) have been added to the list of diagnosed conditions for program eligibility consideration.

A new Child Outcome Summary policy was implemented that specifies team composition and procedures for developing COS ratings, data entry into the BCW database as well as training requirements for practitioners who develop child outcome ratings.

The Early Childhood Technical Assistance (ECTA) Center and IDEA Early Childhood Data Systems (DaSy) online *Child Outcomes Summary (COS) Process* training module was added as planned to BCW's professional development website managed by Valdosta State University (VSU) effective July 1, 2017. All new providers are now required to complete the online COS training module within 60 days of hire or contract date.

A second cohort of Pyramid trainings was delivered to Service Coordinators and Special Instructors this year in the four SSIP implementation districts (Dalton, Columbus, Coastal, and Gwinnett) and a fifth district (Dublin) to implement evidence-based practices that will lead to improvements in the SiMR. The Master Cadre trainers in each SSIP implementation district conducted trainings with assistance and support provided by Georgia State University (GSU) staff. GSU staff and the Master Cadre from each SSIP implementation district were previously trained during Cohort 1 of Pyramid training.

In the current year, 16,852 children received BCW services.

Challenges/Barriers:

With referrals increasing each year, program costs increase without additional funds to meet the service delivery needs of the children and families enrolled in the program.

Home Visiting

In the current year, the Home Visiting program objectives included:

- 75% of families referred to home visiting will have a first face-to face contact within 14 days of referral to home visiting.
- 90% of families enrolled in home visiting will remain enrolled for longer than one month.
- 75% of families enrolled in home visiting will remain enrolled for longer than three months.
- 75% of expected home visiting will be completed.

During this period, four Georgia Parents as Teachers affiliates completed the comprehensive quality endorsement process and were recognized by the National PAT Office with the distinction of Blue Ribbon status. There are currently eight (8) Blue Ribbon sites in the State. Other Blue Ribbon Affiliates in Georgia include Community Partnership of Elbert County Family Support Services in Elberton, Parents as Teachers/Prevent Child Abuse Gordon County in Calhoun, Prevent Child Abuse Habersham, Inc. in Cornelia, and Twin Cedars Youth and Family Services, Inc. PAT in LaGrange.

Quality Improvement continues its focus on activities around recruitment and retention. The benefits of home visiting rely on at-risk families voluntarily enrolling and remaining engaged, both in their length of participation and the number of expected home visiting received.

Congress reauthorized the Maternal, Infant and Early Childhood Home Visiting (MIECHV) program for five-years at level-funding of \$400 million annually in the Bipartisan Budget Act of 2018.

Project LAUNCH

In the current year, Project Launch worked toward the achievement of the *Five Promotion and Prevention Strategies*:

1. Integration of Behavioral Health into Primary Care Settings

The Georgia Chapter of the American Academy of Pediatrics (GA AAP) assist Project LAUNCH GA in reaching physicians in the county by distributing Project LAUNCH GA marketing kits. The kits include marketing materials with the Project LAUNCH 8 clues and 5 Prevention and Promotion Strategies, and a guide from West Central Health District. The guide provides information regarding the services provided for young children and their families. In addition, Georgia American Academy of Pediatrics promoted Project LAUNCH at the *Georgia Pediatric Nurses & Practice Managers Fall 2017 Meeting*, October 13, 2017 and *Pediatrics on the Parkway*, November 2-4, 2017.

2. Enhanced Home Visiting with an Increased Focus on Social and Emotional Well-being

The Family Service Worker (Home Visitor) was hired, certified in the Healthy Families America curriculum and has maintained a full caseload while providing emotional support, crisis counseling, and psychosocial needs interviews for families with young children.

3. Mental Health Consultation in Early Care and Education

Several meetings during this time: Inter Coordination Collaboration meeting at Fort Benning, Hispanic Association Meeting (human trafficking panel), presented Project LAUNCH at the Department of Behavioral Health and Developmental Disabilities Regional Community Collaborative meeting, participated in the local LIPT (Local Interagency Planning Teams) meeting, which serves as a system of care meeting to improve family services. The Mental Health Consultant also attended the Department of Family and Child Services Community Stakeholder meeting regarding the State of Hope - sex trafficking, the strategic plan for the state in reference to child welfare, discussing the implementation of solution based casework, progress under Kenny A. Consent Decree, and potential changes in policy to improve child welfare issues.

4. Family Strengthening and Parent Skills Training

In attempts to sustain the work of Project LAUNCH GA beyond the SAMHSA funding period, efforts were successful in having the Parent Partner funded entirely through Children Medical Services & Babies Can't Wait fund. Additional links for families were made to the West Central Health District's Dental Clinic, Special Supplemental Nutrition Programs for Women, Infant and Children (known as WIC) and the Environmental Health departments; which will send mothers from WIC to Project LAUNCH for linkage and families to Environmental Health for homes with high lead levels.

5. Screening and Assessment in a Range of Child-serving Settings

The Mental Health Screeners and Mental Health Consultant completed parental contacts and referrals for Muscogee County School District universal screening process for 190 students in this reporting period. Families were also linked to wrap around services through direct referrals from counselors and school administration. Spanish speaking families were included in the review of the screening tool and were linked to resources. The Ages and Stages Questionnaire screening was completed in partnership with the West Central Health District First Care Nurse who also provided support to families to obtain Social and Emotional screening scheduled at their school. Project LAUNCH GA has continued partnership efforts with Project AWARE and the Muscogee County School District Director of Special Education to renew the existing renewed MOU between the school and Project LAUNCH GA. The Young Child Wellness Coordinator has met with the Mental Health Coordinator for Project AWARE, the Pre-K Director, and the Program Manager for Preschool Special Education Services to explore collaboration opportunities. The partnerships resulted in 702 completed questionnaires received between August and November (all nine schools reporting).

During the reporting period, the Project LAUNCH GA Leadership Team was selected as a participating team in the National Leadership Academy for the Public's Health (NLAPH), Cohort 7. The Academy is operated by the Center for Health Leadership and Practice (CHLP) and is funded by the Centers for Disease Control and Prevention (CDC). NLAPH is a national program focused on improving community health by working with collaborative, multi-sector leadership teams and training these teams through an applied, team-based, collaborative leadership development model. The vehicle for learning will be a team-identified Applied Health Leadership Project (AHLF) that ultimately advances the health of your community. The Leadership team will focus on sustaining Project LAUNCH GA and duplicating components across the state.

In an effort to increase accessibility in the area of telehealth/telemedicine in Muscogee County, Project LAUNCH GA was able to connect Columbus Regional Hospital to Children's Medical Services Genetic Clinic for an onsite visit to view telehealth equipment which resulted in a partnership discussion between the West Central Health District Director (YCWC Member) and the Chief of Pediatrics (YCWC member) regarding behavioral health and nephrology telehealth/telemedicine visits via Children's Healthcare of Atlanta for pediatric patients.

During this current year, Project LAUNCH provided Social-emotional Engagement-Knowledge and Skill Training

(SEE-KS) mentoring and coaching program to providers at Benning Hills Head Start Program through the Marcus Institute. This program was developed to assist early childhood teachers in learning different ways to foster engagement and promote student participation.

New partnerships were created to include the Columbus 2025 Initiative and Project LAUNCH GA are aligned to support the Cradle to Career (C2C) initiative, Success Ready; which strives to address the educational preparedness by increasing the number of students entering Pre-Kindergarten. The initiative was presented to the Local Child Wellness Council by Audrey Tillman, Executive VP/General Counsel, AFLAC. Since then, the Young Child Wellness Coordinator has attended the Annual Implementation meeting, serves on the Talented, Educated People Committee, and presented Project LAUNCH GA during the 2018

Child Occupant Safety Program (COSP)

In the current year, COSP expanded and is implementing a regional model approach. Eight additional staff members have been hired and each manage programmatic outreach within a local region with the bases being in Dalton, Athens, Atlanta, Macon, Augusta, Columbus, Albany, and Jesup. This modeling allows for more training coverage and outreach statewide.

Family Engagement

Newborn Screening (NBS) – provides training to families on newborn inheritable conditions. The program provides information to parents in hospitals, providers' offices, and health departments prior to the completion of the NBS through informational brochures. The NBS program contracts with The Sickle Cell Foundation of Georgia, Inc. to provide Community Health Workers, which are responsible for completing a needs assessment, a transition assessment if appropriate, identifying medical homes, and providing resource referrals to clients with clinically significant hemoglobinopathies.

The NBS program supports Emory University's Medical Nutrition Therapy for Prevention Camp for young women ages 12 and older. NBS also supports a Sickle Cell summer camp for children and youth.

<http://www.pkuii.org/wp-content/uploads/2017/02/2017-Emory-Metabolic-Camp-Brochure.pdf>

<http://sicklecellga.org/wp-content/uploads/2016/03/Camp-New-Hope-2017-Main-Flyer.jpg>

The Georgia Newborn Screening and Genetics Advisory Committee (NBSAC) provides guidance to the Georgia DPH regarding its statewide system for newborn screening and genetics. The NBSAC must include at least two parent representatives, and at least one representative from a community-based organization.

Children First (C1st) focuses its family engagement efforts around training and educating parents about early identification, developmental milestones and how to navigate public health programs and other community resources to best support their child's growth and development.

Early Detection Hearing Intervention (EDHI) supports families whose children are identified as deaf or hard of hearing (D/HH). EDHI helps families connect and enroll as early as possible into an intervention program. EDHI partners with the Georgia Hands & Voices to provide the Advocacy, Support, and Training (ASTra) program for parents and professionals to build their capacity to advocate for children and families in their community. EDHI also collaborates with the Georgia Hands & Voices Guide by Your Side initiative—a peer support program for parents of children identified as D/HH. EDHI also includes parents in training and programmatic decision-making.

EDHI continues to partner with Georgia DOE's Georgia PINES program to support their Deaf Mentor curriculum: a free, home-based service designed to help mentor, support, and teach families American Sign Language (ASL) and

Deaf Culture.

Project LAUNCH cohosts a state level council meeting alongside Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), and, also hosts a local Young Child Wellness Council (YCWC) meeting in Columbus, GA. Project LAUNCH is guided by a council whose mission is to improve coordination and collaboration across the systems that serve young children and their families. Family leaders are members of both the state level and local level councils.

A Project LAUNCH Parent Ambassador attended the National LAUNCH Family Leadership Summit in February 2018. The Summit provided a forum intended to build a national network to support the participation of families/parents in the strengthening of early childhood services and supports throughout the country. The Summit contributed to the goal of mobilizing and equipping family leaders to create and sustain a national early childhood family network.

Home Visiting is in its second year of a Continuous Quality Improvement (CQI) project which focuses on family engagement. The mission of Georgia's Home Visiting CQI plan is to facilitate the provision of high quality, evidence-based family support services to Georgia's at-risk families and children, prenatally and to age five.

Child Health - Application Year

Priority Need: Promote Developmental Screenings Among Children

NPM 6: Developmental Screening for Children

Developmental screening has remained a priority need for Georgia since 2015. This priority need will be addressed through promoting developmental screenings, increasing opportunities for developmental screening, and providing education and awareness to parents and health care providers about the importance of developmental monitoring and developmental screening.

In the coming year, the C1st program will continue to engage partners in developmental screening and monitoring. The Autism and Developmental Disabilities Program has recently partnered with the supplemental nutrition program, Women Infant and Children (WIC) to promote developmental milestones in WIC clinics. Through direct collaboration with this partnership, the C1st program will reinforce messaging to caregivers about developmental milestones and strengthen the referral process from WIC clinics to child health programs for children with an identified concern. C1st will work with WIC and the Autism and Developmental Disabilities Program to develop processes to help minimize duplication in developmental screening and referrals.

The C1st program will continue to work closely with medical societies such as Georgia Chapter of the American Academy of Pediatrics (GA AAP) and Georgia Academy of Family Physicians (GAFP) to facilitate peer to peer outreach and education to physicians around developmental screening and referral into the child health system. This messaging will become increasingly important as MCHAT screening within the C1st program increases and primary care providers are routinely contacted by C1st Coordinators to gather the most recent MCHAT screening results for children referred into the child health system.

C1st will continue the implementation of ASQ online and will track any increases in developmental screening as a result of the use of this online platform. The extent to which the online screening tool impacts continuous conversations with caregivers around child development and developmental concerns will also be assessed. The program will also monitor how the availability of online ASQ impacts screening and referral practices of partner agencies.

To support ongoing communication and education to caregivers, C1st Coordinators will take a two-step approach. C1st Coordinators will continue to disseminate LTSAE materials as a tool to educate families (and community partners that serve families) about child development and developmental monitoring. C1st Coordinators will also participate in various trainings to improve their capacity to effectively communicate with caregivers and deliver health education. One such training is motivational interviewing (MI) training. MI is a facilitative style of communication that encourages caregivers to take the lead in addressing the concerns they may have for their child and help to develop the solutions to any identified problems. This two-step approach provides caregivers with a baseline knowledge of child development, and empowers caregivers to express concerns they may have, and be equipped to develop a solution.

Priority Need: Promote Physical Activity Among Children

NPM 8: Physical Activity for Children and Adolescents

In the coming year, Georgia Shape will continue building a network of partners, agencies and athletic teams; including the Atlanta Falcons and the Atlanta Braves. DPH and DOE are committed to improving the health of

Georgia's young people by offering assistance and opportunity to achieve a greater level of overall fitness. Georgia Shape begins with a basic, benchmark measurement of fitness among students called Fitnessgram. The Fitnessgram tool used for Shape's annual standardized fitness assessment evaluates five different parts of health-related fitness, including aerobic capacity, muscular strength, muscular endurance, flexibility and body composition using objective criteria. It also generates reports providing valuable individual, school, and state-level data to empower parents, schools, and the community to best access the current health needs for children in Georgia. The report will be delivered confidentially to families and aggregate results are reported to create a true "snapshot" and highlight areas for improvement. In the coming year, Georgia Shape will continue to work with 120 partners to decrease childhood BMI measures while increasing childhood aerobic capacity measures and physical activity levels.

Priority Need: Promote Oral Health to All Populations

NPM 13: Preventive Dental Visit

The Oral Health program will continue its efforts to expand school-based programs helping to ensure that children are receiving adequate oral health services. Efforts to build future partnerships with federal, state, and local partners will continue regarding access to care and workforce distribution challenges in the state. The Oral Health program will continue to discuss potential dental residency programs to help facilitate the education of the future oral health workforce.

Other Child Health Programs

Early Hearing Detection and Intervention (EHDI)

For the application year, the EHDI program will continue to educate parents and providers around the EHDI system. EHDI program staff will attend a baby fair within the state of Georgia, which is a new strategy to educate parents about hearing screening prior to their child's birth. The program will work in collaboration with Georgia PINES to train EHO specialists on the updated parent curriculum using the training materials finalized in the current year. EHDI will continue to collaborate with GA AAP and GA FP to provide education around EHDI to health care providers. State EHDI staff will continue to provide technical assistance and training as needed to both hospital and district staff. EHDI will continue to collaborate with external partners. The contracts with Georgia Hands & Voices to support the ASTra program and the Guide By Your Side initiative will continue. The program will continue to fund Georgia PINES to provide the EHO Specialist visits and the Deaf Mentor program. The EHDI program will also continue to support the Auditory-Verbal Center, Inc. to provide the hearing loaner bank and an onsite audiologist.

The EHDI program will expand membership and scope of the learning community established in the current year. Membership will grow to include parents of children with hearing loss and diverse health care providers. The group will develop new objectives and the program will continue to consult this group for projects around best practices for early intervention and service coordination to increase participation and encourage engagement.

The EHDI program will continue to encourage QI projects at the district level. State-level QI efforts will be developed that focus on increasing the number of timely, complete, and accurate screen results that are reported to the program from local hospitals. Ongoing evaluation of QI measures and identification of areas of improvement will continue through the collaboration with NCHAM. EHDI will continue to collaborate with IT and epidemiology staff to make changes to the state database, SendSS, which will lead to improvements in data collection, program evaluation, and follow-up measures.

100 Babies Project

In the coming year, the 100 Babies Project will continue to enroll families in to the project. Evaluation outcomes of the project will continue to inform quality improvement strategies related to referral to and enrollment in early intervention.

Brain Trust for Babies

MCH and Early Brain Development will continue to work closely together to monitor shared goals and improve processes and strategies that achieve those goals during the application year.

In the fall of 2018, DPH plans to cohost a meeting with partners of the Brain Trust to bring together stakeholders for a discussion around developing activities. Additionally, DPH will continue to support the work of the Brain Trust to implement the strategies outlined in the strategic plan.

Vision

In the coming year, the state office will continue to assist in the completion, compilation, and assessment of documents for certification and recertification for vision screening for local health department staff.

Help Me Grow

Phase II plans to implement the program in all remaining public health districts in January 2019. Phase I pilot evaluation outcomes will inform Phase II statewide implementation and include the development of a statewide HMG Action Plan. HMG will work closely with the Help Me Grow® National Center and begin implementation of workgroups, including internal and external partners.

Babies Can't Wait

In the coming year, BCW will continue to serve children birth to three with developmental delay and category 1 chronic conditions. BCW will continue to focus on increasing provider capacity and will work to address strengths and challenges within the program redefining program infrastructure. A statewide QA/QI program that allows ongoing monitoring and review of program documentation and ensures timely and accurate recording will be implemented during the application year. BCW received \$1 million in program dollars during the legislative session to bring the BCW reimbursement rates in line with Medicaid rates for physical therapy, occupational therapy and speech therapy.

Home Visiting

In the coming year, the Home Visiting program will focus on quality improvement to help ensure retention in home visiting programs. One of the strategies to improve client retention will be training for home visiting staff. The Annual Georgia Home Visiting Institute will take place on August 28, 2018 which will address strategies to improve the quality and effectiveness of home visiting services, with an emphasis on supporting healthy infant/toddler development, parent-child relations, and developing skills necessary for establishing, building and enhancing relationships with families, thus improving program retention.

Plans to develop and implement a fatherhood program will continue. A Fatherhood Readiness Assessment is planned for the Fall 2018. The Home Visiting program will be working closely with the National Fatherhood Initiative through the upcoming project.

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

In the coming year, Project LAUNCH plans to continue efforts to achieve the Five Promotion and Prevention Strategies through the following action plans:

1. Integration of Behavioral Health into Primary Care Settings
 - Increase opportunities to partner with existing medical practices: to support their screening processes

- and linkage to mental health service providers in the area.
- Continue to provide Lunch & Learns to area physician offices to inform providers about the available Project LAUNCH GA services.
- Continue monthly calls with the Physician Advisory Committee.
- 2. Enhanced Home Visiting with an Increased Focus on Social and Emotional Well-being
 - The Project LAUNCH funded Family Support Worker (Home Visitor) will participate in specialized mental health trainings and activities.
- 3. Mental Health Consultation in Early Care and Education
 - Children's Mental Health Awareness activities are planned with community partners, such as the local community service board.
 - Carter Summit – School Based Mental Health initiative will feature Project LAUNCH Mental Health Consultation.
 - Continue to co-facilitate training sessions with the school teachers, counselors and staff on the tools necessary to promote a positive school climate through effective classroom behavior techniques.
- 4. Family Strengthening and Parent Skills Training
 - Provide the Parent Ambassador Group an opportunity to drive the next steps in this goal, supporting and facilitating as needed.
 - Align with Families and Schools Together (F.A.S.T.) to support evidenced based parent engagement program expansion.
 - Utilize the newly released SAMHSA Family Leadership Summit tools designed to strengthen family engagement.
- 5. Screening and Assessment in a Range of Child-serving Settings
 - Include screening tools in the 2018-2019 Pre-K registration packets with the goal of screening all Pre-K children enrolling in school. Families that complete the screening tool will be monitored every 90 days to ensure follow up and a completed referrals process. The plan is to explore how to sustain the screening processes long term utilizing champion partners to identify barriers and work through potential solutions throughout years 4 and 5.

Immunizations

In the application year, GIP will work to educate medical providers and laboratories about the importance of disease reporting, with a specific target population of prenatal care providers to increase the number of hepatitis B virus (HVB)-positive pregnant women identified in birth cohort 2018 by 2%, over the total from birth cohort 2017.

Child Occupant Safety Program (COSP)

In the coming year, Injury Prevention will continue to distribute child safety seats to children, including specialized child safety restraint systems for children with special health care needs. The number of lives saved will continue to be documented through Teddy Bear Stickers (TBS) placed on the child safety seats that are distributed.

Child passenger safety trainings to internal and external stakeholders will continue. Staff has developed online, modular trainings and has been utilizing non-traditional methods to conduct outreach with agencies, utilizing platforms like Zoom, Skype, and FreeConferenceCall.com. COSP will continue to offer a 16-hour Special Needs transportation program - "Safe Travel for All Children: Transporting Children with Special Health Care Needs."

Regional modeling will continue with additional Child Passenger Safety Technician certification courses added within each region.

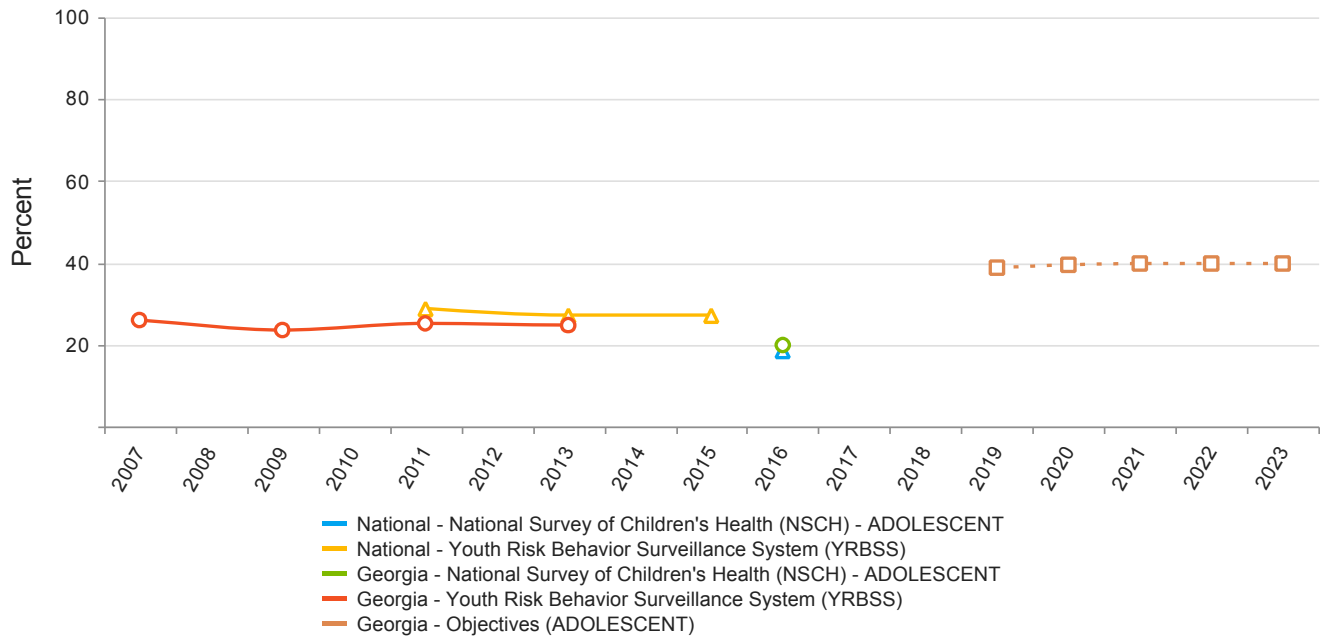
Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016	90.3 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	NSCH-2016	18.6 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	WIC-2014	13.0 %	NPM 8.2
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)	YRBSS-2013	12.7 %	NPM 8.2

National Performance Measures

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day Baseline Indicators and Annual Objectives



Federally Available Data

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

	2017
Annual Objective	
Annual Indicator	24.7
Numerator	107,932
Denominator	436,871
Data Source	YRBSS-ADOLESCENT
Data Source Year	2013

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT	
	2017
Annual Objective	
Annual Indicator	20.0
Numerator	186,178
Denominator	931,402
Data Source	NSCH-ADOLESCENT
Data Source Year	2016

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	38.8	39.5	39.8	39.8	39.8

Evidence-Based or –Informed Strategy Measures

ESM 8.2.1 - 7.1.1. Average HFZ measure (aerobic capacity) among students in grades 4-12

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		56
Annual Indicator	53.5	52.4
Numerator	380,890	379,767
Denominator	711,312	724,839
Data Source	DOE Fitnessgram	DOE Fitnessgram
Data Source Year	2016-2017	2017-2018
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	57.0	58.0	59.0	60.0	61.0	62.0

State Action Plan Table

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

Priority Need

Promote physical activity among children

NPM

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Objectives

7.1. By 2020, improve Aerobic Capacity (AC) HFZ measure for students in grades 4-12 by 1% each year for 4 years.

7.3. By 2020, increase Georgia's student population assessed via Fitnessgram assessment

7.4. By 2020, improve the Body Mass Index (BMI) HFZ measure for students in grades 1-12 by 1% each year for 4 years

7.5. By 2019, ensure 63% of males and 49% of females are inside the HFZ measure for AC

Strategies

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

7.1.b. Implement a Middle School PU30 program in at least 10 middle schools

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

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

7.1.e. Award at least 25 schools through the Georgia Shape Grantee program to increase physical activity and healthy nutrition efforts at the school level with mini grants and expert technical assistance

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

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

ESMs	Status
ESM 8.2.1 - 7.1.1. Average HFZ measure (aerobic capacity) among students in grades 4-12	Active

NOMs
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health
NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Adolescent Health - Annual Report

Priority Need: Prevent Suicide Among Adolescents

NPM 9: Bullying

Rape Prevention and Education

In the reporting year, surveillance of the issue through the death data and hospital discharge data for emergency room visits and inpatient hospital admissions related to suicide attempts and other mental illness were evaluated. As part of the Adolescent and School Health team, The Sexual Violence Prevention Program (SVPP) administered Step Up Step In (SUSI), an awareness campaign that addresses sexual bullying prevention and targets middle and high school students. Sexual bullying behavior includes sexual activity unwanted touching, name calling (sexual identity), sexual rumors, sexting, etc. in the Northwest, Coastal, East Metro, South, DeKalb, Cobb, and West Central public health districts.

Suicide Prevention

Primary prevention of suicide to address risk and protective factors at the local level, regional, and state levels continued in partnership with the Georgia Child Fatality Review (CFR) Panel.

Priority Need: Promote Physical Activity Among Children

NPM 8: Physical Activity for Children and Adolescents

In the reporting year, Georgia SHAPE continued the management of statewide Fitnessgram (FG) “booster session” contracts with HealthMPowers (HMP), a non-profit educational technical assistance provider with a national presence, and DOE. These contracts allow DPH to train PE teachers to assess students effectively for fitness levels pertaining to Body Mass Index (BMI), aerobic capacity, flexibility, muscular strength and muscular endurance. Approximately 8-12 trainings are conducted a year through DOE or state PE/Health conferences (GAHPERD association) and the FG Certificate program which coordinates state recognition certificates for students that excel in FG components. FG Certificates are sent to all schools in the state to recognize participation and student achievement.

Current Year: Oct 2017 – Sept 2018

Priority Need: Prevent Suicide Among Adolescents

NPM 9: Bullying

Rape Prevention and Education

Primary prevention of suicide to address risk and protective factors for children ages 8-17 continue during the current year. SUSI activities in participating schools include conducting a pledge drive for students, educators, staff, and administrators to keep their school safe from sexual bullying. Other activities include poster contests, poetry slams, student assemblies, parades, creating PSAs, lunch and learns and a variety of incentives for participants.

Suicide Prevention

DPH participates and supports several reports which have a specific focus on youth suicide. The CFR Panel, housed at the Georgia Bureau of Investigations (GBI) publishes an annual report. Because of an increase in suicide for the previous calendar year, the GBI in partnership with Voices for Georgia's Children, produced a series of PSA's

to be shared among state agencies, partners and other NGOs, <http://georgiavoices.org/blog/2018/02/07/suicide-prevention-psas/>. This has been shared with the state level CFR Panel members, (see report for list of panel members <https://www.ncfrp.org/cdr-programs/u-s-cdr-programs/spotlight-georgia/>). Most recently this was shared with the Georgia Injury Prevention Advisory Council on April 13, 2018.

Related legislation: HB 198: <http://www.gadoe.org/Curriculum-Instruction-and-Assessment/Curriculum-and-Instruction/Documents/HB%20198%20-%20Jason%20Flatt%20Act-Georgia.pdf>

Challenges/barriers:

Evolving research and promising practice, inconsistent funding, inconsistent strategies and approaches and continued stigma of mental illness, social services, suicide attempts and completions present challenges.

Priority Need: Promote Physical Activity Among Children

NPM 8: Physical Activity for Children and Adolescents

In the current year, SHAPE is working to increase physical activity measures for female adolescent populations through private funding in afterschool settings. In partnerships with DPH, DOE, and the Governor's office SHAPE continues to provide the following programs to children ages 12-17 years of age:

- PU30 Middle School Program- This program consists of seven pilot middle schools. Physical activity data is currently being collected and evaluated. Funding is available for approximately 40-50 more middle schools and a modified training will be offered statewide. During the 2017-2018 calendar year, one pilot school, an alternative school for students with previous behavioral issues removed from their zoned school, reported a 90% decline in behavior referrals after implementation.
- Middle School Girls Physical Activity Barriers and Facilitators project- Shape recently received an award for \$181k from the Blank Foundation to identify best practices and ethnographic information from adolescent females to inform organizations and partners of the large gender gap for aerobic capacity statewide between male and female students. Currently there is approximately a 10-percentage point difference between males and females. Spitfire Consultant Firm did online listening, branding best practices, participant interviews and Subject Matter Expert interviews to create a road map of the Georgia initiative collaboration and best practices to motivate and engage the middle school population, whereby hopefully closing the gender gap.
- Middle School girls PAL project (Physical Activity Leader)- Shape received seed money from the Blank Foundation to identify barriers and facilitators to female activity levels, forming a partnership between Georgia Shape, GSU and HMP.
- PU30 Pre-service teacher program- This program is managed through a partnership with the University of West GA (UWG). UWG developed a graduate certificate program for Early Education and Physical Education college majors with the help of HMP. Courses allow students to create educational opportunities for physical activity in the classroom. Upon graduation, a certificate is signed by the Governor, Dr. O'Neal, and the College President and is formalized on their college transcripts.

Family Engagement

Adolescent Health focuses on providing integrated and coordinated adolescent-centered services. Adolescent health also focuses on building the capacity of youth in their communities and helping them to become peer support to other youth. Adolescent Health youth participated in over 100 school and community-based trainings and events.

Adolescent Health - Application Year

Priority Need: Prevent Suicide Among Adolescents

NPM 9: Bullying

Adolescent suicide was identified as a priority need for Georgia in 2015 with a strategic focus on adolescent bullying. In the coming year, the Title V MCH program revised its state action plan to focus on strategies to address primary prevention efforts to reduce suicide and address risk and protective factors for children ages 8-17 at the local, regional and state levels. MCH will remove the Priority Need: Prevent Suicide among Adolescents and NPM 9 Bullying from its NPMs. Georgia DOE is the primary lead in preventing suicide among adolescents. In the coming year, DPH will continue to serve as a secondary conduit to preventing suicide among adolescents by continuing to serve on its coalition supporting these efforts. In addition, MCH will continue to support Injury Prevention and Adolescent Health activities that support suicide prevention efforts.

Rape Prevention and Education

SUSI will continue its efforts in the application year and will complete its fourth year of implementation in December 2018 partnering with 15 schools in six public health districts (Coastal, Northwest, DeKalb, East Metro, South, and West Central).

Suicide Prevention

In the coming year, the Suicide Prevention Program plans to execute a contract with the Suicide Prevention Action Network – Georgia (SPAN-GA). This contract will allow implementation of the Sources of Strength (SOS) wellness program within several of Georgia's middle and high schools. The overall goal of this evidence based strategy for suicide prevention is to utilize peer leaders and adult advisors to change peer social norms around help seeking, and allow youth to identify their own sources of strength to overcome obstacles. At least three middle and/or high schools will be recruited by SPAN-GA to implement SOS over year one of the proposed contract. While the intrapersonal and interpersonal needs of students will be addressed by school peer teams, awareness and education surrounding mental health and suicide will also take place through the engagement of community and family members.

Priority Need: Promote Physical Activity Among Children

NPM 8: Physical Activity for Children and Adolescents

In the coming year, Georgia Shape will continue building a network of partners, agencies and athletic teams to promote physical activity to adolescents ages 12-17 years of age. Georgia Shape will continue to work with 120 partners to decrease adolescent BMI measures while increasing aerobic capacity measures and physical activity levels. The PU30 Middle School Program, Middle School Girls Physical Activity Barriers and Facilitators project, Middle School Girls Physical Activity Leader (PAL) project, and PU30 Pre-service teacher program will continue.

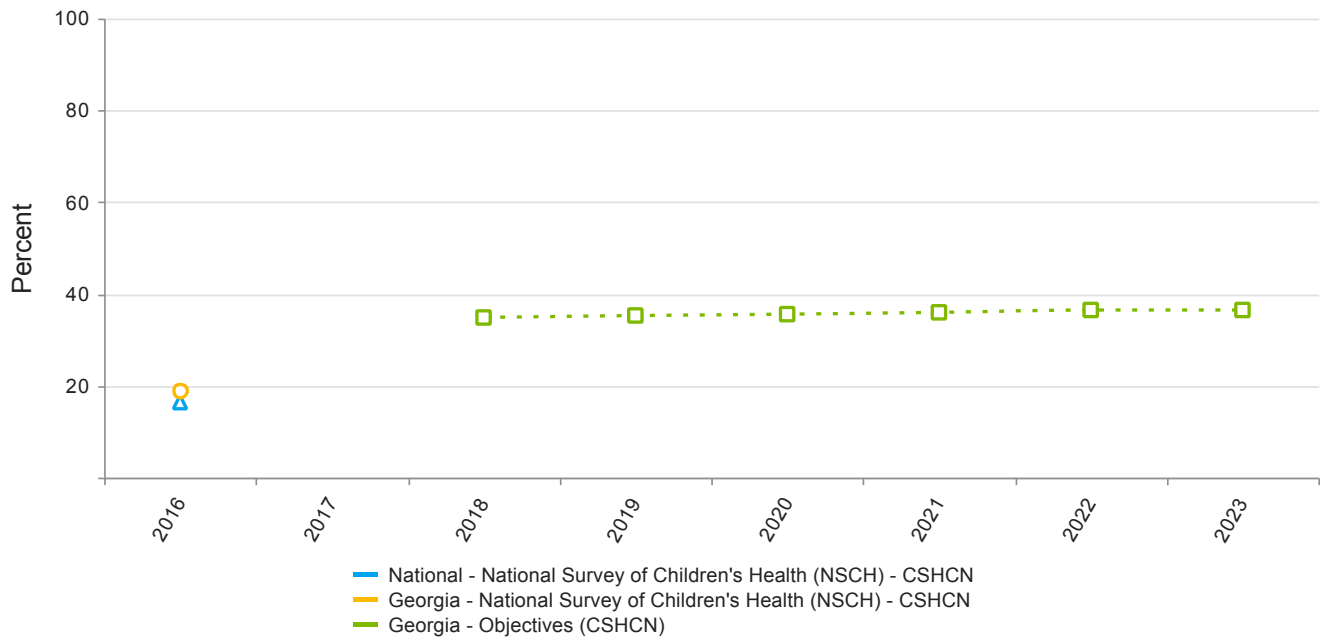
Children with Special Health Care Needs

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2016	13.8 %	NPM 12

National Performance Measures

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



NPM 12 - Children with Special Health Care Needs

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		19.0
Numerator		44,578
Denominator		234,699
Data Source		NSCH-CSHCN
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	34.9	35.3	35.6	36.0	36.5	36.5

Evidence-Based or –Informed Strategy Measures**ESM 12.1 - 9.1.1 Number of youth, families and professionals trained on health care transition**

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	250	434
Numerator		
Denominator		
Data Source	Children Medical Services	Children Medical Service
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	250.0	325.0	350.0	375.0	500.0	500.0

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Children Medical Services Program	Children Medical Services Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15.0	25.0	35.0	40.0	40.0	40.0

State Performance Measures

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		1.3
Annual Indicator	1.5	1.6
Numerator	704	781
Denominator	477,000	494,310
Data Source	CMS Program Data and Kids Count	CMS Program Data and Kids Count
Data Source Year	SFY 2016	SFY 2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1.5	1.7	1.9	2.0	2.0	2.0

State Action Plan Table

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

Priority Need

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

NPM

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

Objectives

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

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

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

Strategies

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

ESMs

Status

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

NOMs

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

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

Priority Need

Improve access to specialty care for CYSHCN

SPM

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

Objectives

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

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

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

Strategies

10.1.a. Provide comprehensive telehealth information to providers

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

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

10.2.b. Collaborate with the Department's Telehealth team and Waycross Health District to expand telemedicine sites

10.2.c. Expand the telemedicine provider network

10.2.d. Establish a telehealth stakeholder workgroup for CSHCN

10.2.e. Collaborate with the Department's EPI team to conduct a needs assessment and to develop a program evaluation plan

10.3.a. Utilize telehealth to improve care coordination efforts for CSHCN

10.3.b Utilize telehealth to improve access to audiological and speech therapy services for CSHCN

10.3.c Utilize telehealth to improve access to services for children and youth with sickle cell disease

Children with Special Health Care Needs - Annual Report

Priority Need: Improve Systems of Care for CYSHCN

NPM 12: Transition to Adult Care for All Children

Transition to adult care for youth and young adults is a National Performance Measure for the State of Georgia. The goal is to ensure an improvement in the percentage of youth and young adults who successfully transition from pediatric to adult health care services. Georgia's transition improvement efforts are focused on the families, youth and young adults as well as the pediatric and adult health care providers.

During the reporting year, the following strategies are used to drive the improvement process:

- Outreach and awareness activities geared towards youth, families and community stakeholders
- Training opportunities for health care professionals
- Implementation of health care transition protocols and standards in public and private health care settings

With implementation of the strategies outlined above, youth and young adults' successful transition should include:

- Transition education as early as 12 years of age
- Access to a variety of coaching and educational trainings to assist with independent health care skills
- Opportunities to take part in transition planning and preparation with their parent/caregiver(s)
- Seamless transfer to an adult primary care and specialty provider(s)
- Appropriate linkages to adult –focused community based resources and supports
- Access to adequate information for continued health coverage

Children's Medical Services (System of Care for CYSHCN)

Strengthening the system of care for youth and young adults transitioning from pediatric to adult care as well as for families with CYSHCN to access timely pediatric medical care in rural areas of the state are priority areas for the Children's Medical Services (CMS) program.

The CMS program partners with health care providers, state agencies and community based resources to coordinate health care services and supports for eligible CYSHCN and their families. Children and youth (ages 0-20) with eligible chronic medical conditions, and family income at or below 247% of the federal poverty level are served by CMS. In State Fiscal Year 2017 (July 2016-June 2017); 8,664 children and youth were served by the CMS program. During this time, 91% of transition age youth, ages 16 -21, received support to transition from pediatric to adult centered health care.

Continuity in medical care for CYSHCN is critical to achieving optimal outcomes for these children and preventing death. CMS serves as the payer of last resort for health care and medical expenses for families that do not qualify for the State's Medicaid, SCHIP programs, or, are without insurance during the time of CMS program enrollment. In addition to filling in the gap with health care coverage, CMS will also support CYSHCN and their families by coordinating appointments, identifying resources, assisting with social supports such as transportation and support groups with other families. Helping CYSHCN and their families feel confident about managing their health care needs and navigating through complex social issues is a very important goal for the CMS program.

For youth ages 16 and older, the care coordinator facilitates the transition process from pediatric to adult health care. Approximately 988 CMS program participants and their families received transition planning, support and education by care coordinators in SFY 2017. The care coordinator's role in the transition process is one of planner, facilitator and support to the adolescent and family. The coordinator assists with transitioning the youth from pediatric care to

physicians trained in adult medicine, ensuring that families and youth understand the health care systems available and learn to navigate services for adults with disabilities and chronic illnesses.

Pediatric specialty care clinics for children and youth living in rural counties in Georgia are offered where pediatric medical specialist's services are limited. The CMS program offers specialty clinics in nine public health districts and coordinates services with more than 30 specialty providers for face to face as well as telemedicine clinic visits. During SFY 2017, approximately 374 clinic days were offered, 98 of those provided via telemedicine, and 3,397 children and youth served via the specialty clinics. Specialty clinics types include endocrinology, nephrology, cardiac, chronic lung, genetics, hematology/sickle cell, orthopedic, hearing, neurology and cystic fibrosis.

CMS care coordinators frequently participate in a variety of outreach activities to assist with building partnerships with community stakeholders to effectively support families' wide range of medical and social needs and improving the timeliness of families accessing services. Some of the activities include participation in local Department of Family and Children Services community collaborative meetings held to share information on community resources. CMS program staff also provide asthma education for school nurses, university students and parent groups involved with summer asthma camps. Countless health fairs are attended to market and promote services to families and providers, including the Pigs N Peaches Market Fair in Kennesaw, GA and the Templo Bautista Hispana Health Fair in Warner Robins, GA.

Since the initiation of the project, there have been 11 Parents as Partners trained and supporting families with children and youth with special health care needs. The most frequent requests for assistance that come from parents include; community resources, early childhood services, education, parent and family support, and healthcare. The Parents as Partners have coordinated trainings for parents and professionals in the community. Parent to Parent (P2P) also maintains the Statewide Central Directory database and hotline, funded by the CMS and early intervention programs and houses approximately 6,000 resources. The Directory allows users to search for information and referral resources or one on one assistance over the phone for families of children ages birth to 26 years with developmental delays, disabilities and chronic health care conditions.

Health Care Transition Projects

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

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

In partnership with P2P, youth and parent/caregivers have access to annual workshops on preparing for the transition from pediatric to adult model of care. The curriculum used to facilitate these workshops are adapted from the Waisman Center and has accompanying workbooks for families and youth to document their transition goals as well as activities to help youth practice independent health care skills such as setting appointments, scheduling transportation and filling prescriptions. During this time, four workshops were provided with 65 attendees which represents about a 10% increase in attendees from the previous year.

To assist with efforts in educating the public on transition, the CMS program has a collection of transition materials specifically developed for families and youth. These materials are marketed at annual outreach events such as health fairs, expos, family nights and conferences. During the reporting year, more than 500 youth and parent booklets were distributed.

Training opportunities for health care professionals

Through continued partnerships with the Georgia Academy of Family Physicians and the Georgia Chapter of the

American Academy of Pediatrics, the CMS program can provide annual health care transition training opportunities to pediatricians, family physicians and pediatric nurse members. Trainings are offered via face to face encounters at the annual fall and summer conference meetings as well as via webinar. During this reporting period, there were five training opportunities provided with approximately 185 attendees.

The CMS program also utilized telehealth technology and hosted the live broadcast of the 18th Annual Chronic Illness and Disability Conference: Transition from Pediatric to Adult-based Care for public health district staff and community partners. This is the program's third year to participate and there were approximately 65 attendees who received continuing education credits. From this conference, the CMS program was introduced to the innovative transition program, "Good 2 Go," based in Toronto. Collaboration with the "Good 2 Go" program offered the opportunity to review their resource manual and supplemental documents. The Good 2 Go program's transition clinic flow sheet was used as a reference in creating a transition planning flow sheet for the CMS program.

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

The continued partnership with and funding for the Adult Disability Medical Home (ADMH) provides a vital resource to young adults with intellectual and developmental disabilities and their families. In SFY17, approximately 47 patients were seen by ADMH for transition services and supports. ADMH is housed within a family physician practice and transition clinics are supported by several disciplines, which includes: family physicians, behavioral analyst, clinical social worker, medical assistant and family/patient advocate.

During the reporting period, Dr. Clay, a leader in spearheading the Sickle Cell Transition Program, served as Physician Champion for health care transition and has participated in many training activities coordinated by the CMS program. In July 2017, Dr. Clay was invited to be a speaker at the 44th Annual Haitian Physician Abroad Conference at Decameron, Haiti. Her presentation was entitled: "Transition from Pediatric care to Adult Care in Patients with Sickle Cell Disease."

Priority Need: Promote Oral Health to All Populations

NPM 13: Preventive Dental Visits

The Oral Health program and Children's Medical Services partnered to identify dental offices serving children and youth with special healthcare needs and create a web-based referral resource (database). Data has been collected in six communities around the state on dental practices offering special needs services, Medicaid acceptance, general anesthesia and location. The data will be used to map the practices to facilitate easier access for families. The Oral Health program contacted the Georgia Academy of Pediatric Dentistry for a list of member dentists who treat special needs children. The Oral Health Team continued to provide education to public health district staff on special considerations and treatment needs for special needs patients.

SPM 2: Improve Access to Specialty Care for CYSHCN

In the reporting year, CMS partnered with health care providers and community-based resources to coordinate care for CYSHCN and their families. The Georgia Department of Public Health's (DPH) Office of Telehealth and Telemedicine, in partnership with county health departments, oversees a robust telehealth network which encompasses all 159 counties in the state. The telehealth and telemedicine programs aim to improve access to healthcare services, address workforce shortages, and reduce health disparities across Georgia.

The CMS program used telehealth and telemedicine to provide developmental and genetic services, asthma-

management, as well as endocrinology, nephrology, pediatric neurosurgery, pulmonology and sickle cell follow-up care. As the presentation/origination site, the CMS program was able to facilitate reimbursement with appropriate Medicaid telehealth billing codes.

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

Georgia Autism Initiative

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

Current Year: Oct 2017 – Sept 2018

Priority Need: Improve Systems of Care for CYSHCN

NPM 12: Transition to Adult Care for All Children

Children's Medical Services (System of Care for CYSHCN)

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

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

P2P continues to provide annual training workshops on preparing for the transition from pediatric to adult model of care for youth and families. With the increase in demand for this training from our care coordinators, the CMS program is in the process of increasing the number of workshops funded within the contract with P2P from four to six annual trainings.

Additional support and training opportunities are available to families from the Parents as Partners located across six public health districts and one private therapy provider office. Parents as Partners receive trainings on developing a health care transition plan for children and youth ages 14 and older as well as transition coaching strategies. During this time, the P2P transition pilot project in the Hall County area included the coordination of health care and vocational rehabilitation activities for families. The Parents as Partners supporting the Gainesville health district teamed up with the vocational rehabilitation transition coordinator to offer several transition education opportunities for families residing within the Hall County area.

The CMS program has also partnered with the Adult Disability Medical Home to provide an annual training to families on how to support the transition needs for youth and young adults with intellectual and developmental disabilities. This training will be held in June and more than 50 participants are expected to attend. Medical transition, educational transition, access to adult services and Medicaid waivers as well as long term support will be

discussed.

Through the CMS program's partnership with the Department's Newborn Screening program there is on-going collaboration with condition specific organizations to ensure transition planning is incorporated within their direct services. The Sickle Cell Foundation of Georgia utilizes community health workers to support outreach and coordination of care efforts for clients. Community health workers incorporate age appropriate transition planning and the foundation also incorporates transition education during the annual Camp New Hope activities for adolescents. Hemophilia of Georgia utilizes outreach nurses and social workers to address transition education and preparation with clients. During this time, there was also a teen retreat at Camp Jekyll where educational sessions were designed to help the teens with self-determination.

To support the families, youth and stakeholders with transition education and planning, the CMS program is in the final development phases of the "Georgia's Youth S.T.E.P.S. into Transition" tool kit. STEPS is an acronym that will help individuals remember how to address a successful transition and stands for:

1. START EARLY. Begin having conversations with your physicians about transition early
2. TALK. Begin talking with your parents and physician about transition and what it means for you
3. EDUCATE. Begin educating yourself about your specific condition
4. PLAN. Begin developing and creating a plan for your transition
5. SUPPORT. Begin creating a support system

The tool kit will include:

- My Must Have Paperwork for Transition
- Guardianship and Alternatives for Decision-Making Support
- My Health Report
- Differences in Pediatric and Adult Care
- Emergency Care Plan.
- "Taking Charge of My Healthcare. A Workbook for Youth," which includes additional resources, worksheets and scripts to help facilitate a successful transition from pediatric to adult healthcare.

The tool kit will be marketed to care coordination programs led by managed care organizations, condition specific organizations and parent organizations. The CMS program will also approach Department of Education to gauge their interests with utilizing the tool kit with their transition efforts during the Individualized Education Planning process.

Training opportunities for health care professionals

This year marks the third annual transition conference in partnership with the Georgia Chapter of the American Academy of Pediatrics. Each year, the planning committee consists of representatives from different health systems. This year's planning committee included Grady Health System, Wellstar Health System, Children's Healthcare of Atlanta and the Department of Public Health. *Resources for Transitioning Youth with Special Needs from Pediatrics to Adult Care* was this year's theme and was held in May 2018. This conference was designed to help family physicians, internists, OB/GYNs, pediatricians and clinical healthcare professionals to address issues surrounding transitioning youth with special health care needs from pediatric to adult care. Continuing medical education credits were provided with approximately 20 participants in attendance. Margaret McManus, MHS Co-Project-Director for Got Transitions was the guest speaker and discussed Directions and Innovations in Health Care Transition as well as Payment Strategies for Transition.

In the current year, the CMS program continues to also partner with the Georgia Academy of Family Physicians to

support health care transition activities, which include lecture presentation at their Fall and Summer meetings as well as live webinars. During this reporting period, the program worked with Got Transitions to provide a webinar on the Innovations in Transition from Pediatric to Adult Health Care presented by Patience White, MD, MA, Co-Project Director, Got Transition and Margaret McManus, MHS Co-Project Director, Got Transition to family physician members. The webinar was well attended with more than 20 participants.

Both medical societies have updated their websites to include health care transition information, resources and links to the Got Transition website.

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

During this reporting period, CMS began the process of revising the transition policies, programmatic forms and communication materials to improve the transition preparation and planning procedures for children and youth beginning at 12 years of age and their caregivers enrolled in the program. The CMS program utilized the Six Core Elements of Health Care Transition as a framework. The primary focus of the revisions were to ensure an enhanced transition process that is family and youth focused and developmentally age appropriate. The core goals of the revamped transition planning for the CMS program include:

- A. Increase the number of youth and young adults whose self-care skills are regularly assessed.
- B. Increase the number of youth and young adults with a developed plan of care that incorporates transition readiness goals and prepares youth for an adult model of care.
- C. Increase the number of youth and young adults that are transferred to an adult provider.
- D. Increase the number of youth and young adults and their parent/caregivers that report satisfaction with the CMS health care transition process.

Once the revised policies are rolled out and fully implemented, the CMS program will provide ongoing technical assistance to care coordinators responsible for leading this work to ensure commitment and reliability to this enhanced approach to transition preparation and planning.

SPM 2: Improve Access to Specialty Care for CYSNCN

In the current reporting period, CMS continues to expand clinical services to other areas of Georgia and enhance telemedicine services by leveraging existing partnerships with the medical community. During SFY15, there were only two local district (Waycross and Valdosta) CMS programs that offered telemedicine services for neurology, nephrology, pulmonology and endocrinology. In coordination with the Department's Telehealth team, the CMS program expanded services to eight local district (Athens, Valdosta, Albany, Columbus, Macon, Dublin, Cordele, and Waycross) CMS programs for patients needing sickle cell and genetic care.

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

During this reporting period, the CMS program and the Department's Telehealth team expanded the endocrinology telemedicine provider network to two network providers. Navicent Health Center which is the second-largest hospital in Georgia and serves central part of the state, became a provider for telemedicine services. Navicent currently supports one CMS district site with plans to expand to other sites.

Early Intervention Services

Babies Can't Wait

The BCW Policy Manual was finalized in October 2017 and made available to the Health Districts. New Category 1 conditions (Severe Birth (perinatal) asphyxia; Shaken baby syndrome; Cleft lip and palate unrepaired; Congenital reduction deformities of the lower limb; Congenital reduction deformities of the upper limb; Down Syndrome, unspecified; Turner's Syndrome, unspecified; Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side; Conductive hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side; Sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side; Sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side; "Mixed conductive and sensorineural hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side"; "Mixed conductive and sensorineural hearing loss, unilateral, left ear, with unrestricted hearing on the contralateral side") have been added to the list of diagnosed conditions for program eligibility consideration. A new Child Outcome Summary (COS) policy was implemented that specifies team composition and procedures for developing COS ratings, data entry into the BCW database as well as training requirements for practitioners who develop child outcome ratings. The Early Childhood Technical Assistance (ECTA) Center and IDEA Early Childhood Data Systems (DaSy) online COS Process training module was added as planned to BCW's professional development website managed by Valdosta State University (VSU) effective July 1, 2017. All new providers are now required to complete the online COS training module within 60 days of hire or contract date. A second cohort of Pyramid trainings was delivered to Service Coordinators and Special Instructors this year in the four State Systematic Improvement Plan (SSIP) implementation districts (Dalton, Columbus, Coastal, and Gwinnett) and a fifth district (Dublin) to implement evidence-based practices that will lead to improvements in the SiMR. The Master Cadre trainers in each SSIP implementation district conducted trainings with assistance and support provided by Georgia State University (GSU) staff. GSU staff and the Master Cadre from each SSIP implementation district were previously trained during Cohort 1 of Pyramid.

Georgia Autism Initiative

DPH has established a comprehensive statewide plan for autism spectrum disorder (ASD) early detection through screening, evaluation and intervention.

A. Professional Development and Capacity Building

In collaboration with Emory Autism Center (EAC), the department implemented a Board Certified Behavior Analyst (BCBA) Training and Supervision Program which allows children with ASD to receive behavioral support services from supervised trainees completing their filed hours required to become BCBA's. This initiative has provided field experience for approximately 12 professionals pursuing a behavioral health national certification. Approximately 200 children have received behavioral support services through this initiative.

B. Awareness and Early Identification

In collaboration with Marcus Autism Center (MAC), DPH has established Professional Learning Communities in three of five Child Health Regions where Resource Specialist lead monthly webinars on early identification and understanding signs of ASD. MAC also continues to provide one-on-one coaching and access to a 30-hour webinar course that includes five modules on early identification of ASD for select provider groups.

In collaboration with EAC, DPH has developed an online webinar for providers to receive training on the Modified Checklist for Autism in Toddlers – Revised Follow-Up (MCHAT-R/F). The MCHAT Training is a one-hour live webinar and focus how to identify "red flags" for ASD, how to administer the MCHAT – R/F with

children and how to discuss results with families. In May 2018, Qualified health care providers (QHCP) will undergo MCHAT-R Training and conduct the assessment with children enrolled in Babies Can't Wait (BCW) at recommended periodic intervals (18 and 24 months).

C. Diagnostic Evaluation

DPH has developed a memorandum of understanding (MOU) for the purpose of establishing formal partnership with Georgia Autism Assessment Collaborative (GAAC) professionals – psychologist trained to conduct diagnostic evaluations using a standardized tool, Autism Diagnostic Observation Schedule, Second Edition (ADOS-2). The MOU outlines standards and guidelines for GAAC professionals working throughout the 18 public health districts and serving as receptive referral sources.

- GAAC professionals associated with said MOU will adhere to the following
 - a) Conducting a diagnostic evaluation within 30 days of program referral.
 - b) Reporting diagnostic outcome to the program within 15 days of a completed diagnostic evaluation.

In January 2018, DPH established GAAC Early ID Specialty Clinics in five public health districts. Specialty Clinics will work together to establish, implement and evaluate standards and systems to provide timely accessible, quality evaluations of children suspected of having ASD by age three to facilitate meaningful supports in partnership with families and the community.

D. Behavioral Intervention

In June 2018, DPH will begin to identify 18 Board Certified Behavior Analyst (BCBA's) – at least one per Public Health District and up to 54 Registered Behavior Technicians (RBTs) – at least three per public health district.

E. Transition

To address adolescent to adulthood transition for youth with ASD, DPH and EAC has developed an Individualized Transition to Adulthood Plan (ITAP) Project that will be utilized by DPH, other educators and autism healthcare providers throughout Georgia. The Department has developed implementation models, best practices, materials and resources for educators and healthcare providers to offer services aimed at helping young people with autism spectrum disorder adopt a more independent and empowered lifestyle as they transition into adulthood. To help inform its development and improvement of the ITAP, an Individualized ITAP Advisory Board was established, consisting of key community stakeholders and experts.

EAC is implementing the current ITAP through services it is providing to at least 10 students between the ages of 14 and 22. The services include administering Transition Assessments, developing distinct ITAPs for each student and implementing ITAPs.

In 2017, legislation increased funds to establish an Adolescent to Adulthood Transition model to improve the outcome of adults with ASD.

Family Engagement

Babies Can't Wait district coordinators participated in over 200 local community events, which included health fairs, races, literacy events, social events, educational fairs, book drives, transition events, back-to-school events, preschool/daycare events, youth events, fall/spring festivals, support groups, and trainings/workshops.

Babies Can't Wait State/Local Interagency Coordinating Council(s) (SICC/LICCs) - The mission of the Georgia

SICC/LICCs for Early Intervention Programs is to advise and assist DPH and other agencies responsible for serving infants and toddlers, birth to age three with developmental delays and disabilities and their families, in providing an appropriate, family-centered, comprehensive service delivery system which promotes optimal child development and family functioning. Regular meetings of the council are held quarterly, and are open to the public. Family members are encouraged to attend. Travel expenses are covered.

Children Medical Services— CMS' Parents as Partners Project provides community level support for families of CYSHCN. The CMS program partners with Parent to Parent of Georgia (P2P), Georgia's Family to Family Health Information Center, to implement the Parents as Partners Project. The Parents Partners are themselves parents of CYSHCN. The Parents Partners are paid as part-time employees of P2P and support local district child health programs and private pediatric medical practices. Parents Partners provide information, resources, emotional support, and coordinate free training opportunities for parents served at their site.

Children with Special Health Care Needs - Application Year

Priority Need: Improve Systems of Care for CYSHCN

NPM 12: Transition to Adult Care for All Children

Children's Medical Services

In the coming year, the CMS program will continue to work with programs, state agencies, health systems, health plan, families, youth and stakeholders to enhance and expand the system of services for CYSHCN. Monitoring and documenting the implementation of the revised transition policies and procedures for the CMS program including youth and family satisfaction with transition planning is a priority. Documenting lessons learned from the CMS program care coordinators during the transition improvement process will help to offer recommendations and training opportunities to other programs and agencies providing care coordination services to adolescents 12 years of age and older. Ensuring that the Georgia's Youth S.T.E.P.S. into Transition tool kit is widely marketed and easily accessible for youth and health care professionals serving youth and providing educational opportunities on health care transition preparation and planning for staff coordinating the Individualized Education Plan activities for youth and families within target school district sites will continue in the coming year. Work will continue with school district parent mentors and transition coordinators to provide tools and resources for students and families.

Priority Need: Promote Oral Health to All Populations

NPM 13: Preventive Dental Visits

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

Priority Need: Improve Systems of Care for CYSHCN

SPM 2: Improve Access to Specialty Care for CYSHCN

Babies Can't Wait (BCW)

In the application year, BCW will continue to serve children birth to three with developmental delay and category 1 chronic conditions. BCW will continue to focus on increasing provider capacity and working on addressing strengths and challenges within the program and redefining the program infrastructure and areas to target for the upcoming year. A statewide QA/QI program that allows ongoing monitoring and review of program documentation and ensures timely and accurate recording will be implemented in the application year.

Autism

Qualified Health Care Professionals (QHCP) and paraprofessionals will receive MCHAT Training throughout May and June of 2018. QHCPs include BCW Service Coordinators, Children 1st (C1st) Coordinators or Developmental Specialist. Beginning in February 2018, trained professionals will implement ASD screening at the recommended 18 and 24 month intervals.

In the upcoming year, children zero to three enrolled in BCW will have access to comprehensive services that address ASD such as screening, diagnostic referral, behavioral evaluations and intervention. DPH is committed to ongoing professional development and capacity building, therefore, will continue contracting with certified behavioral

analyst to offer a quality standard of care.

Collaboration with internal and external partners has been vital to the Autism Initiative. DPH will maintain and establish partnerships with key stakeholders to leverage resources and expand access to care.

Cross-Cutting/Systems Building

Cross-Cutting/Systems Building - Annual Report

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

Promoting oral health among all populations was determined as a priority need through the 2015 Title V MCH Needs Assessment. The Title V MCH Section includes DPH's Oral Health program that oversees the agencies statewide oral disease prevention activities. The Oral Health program coordinates school-based oral health clinics, the state water fluoridation program, mobile oral health clinics, and co-leads coalitions, partnerships and stakeholder groups that promote oral health within Georgia. Dental (Oral) diseases are a major health concern affecting almost every person in Georgia. Dental caries and periodontal diseases have an economic and social cost and can result in serious systemic problems, pain, and suffering. Most oral diseases are preventable, and DPH's Oral Health program makes every effort to promote and implement preventive measures for all of Georgia's citizens. In the reporting year, the Oral Health Program served a total of 34,095 people.

Community Water Fluoridation

As of December 2014, 96% of Georgia's population using public water systems received fluoridated water. Water fluoridation has been shown to reduce dental decay by 20-40% in fluoridated communities, and results in a saving of \$20 in future dental expenditures for every \$1 invested in the Community Water Fluoridation Program.

Teledentistry

In the reporting year, the Waycross DPH Teledentistry program presented at a national meeting, *Case Studies of 6 Teledentistry Programs: Strategies to Increase Access to General and Specialty Dental Services* at the Center for Health Workforce Studies, School of Public Health University at Albany State University of New York. The report was published in December 2016.

Current Year: Oct 2017 – Sept 2018

Priority Need: Promote Oral Health Among All Populations

NPM 13: Preventive Dental Visit

Community Water Fluoridation Program

The Community Water Fluoridation program (CWF) in Georgia is mandated through state legislation requiring all public community water systems serving over 25 non-transient people to adjust their fluoride levels to the state mandated level. The Oral Health Program contracts with the Georgia Rural Water Association (GRWA) to monitor and train water plant operators on the safety, benefits, and value of CWF. Water systems with adjustable fluoride levels are required to monitor their fluoride level daily. Each month the Oral Health program monitors the water systems to ensure fluoridation levels are within the recommended range. The Oral Health program also leads the Georgia Fluoride Advisory Committee comprised of GRWA, Environmental Protection Division (EPD), Georgia Department of Natural Resources (DNR), Georgia Dental Association (GDA), Georgia Dental Hygienists' Association (GDHA) and DPH. The committee guides the development of policies and advises on the daily operations of the CWF program. Currently, almost 97% of Georgia residents on community water system enjoy the benefits of fluoridated water. The Oral Health program in collaboration with GRWA teaches six fluoridation training classes each year for water plant operators on the safety, benefits, and value of the Community Water. Eighteen trainings and presentations were provided during the current reporting year.

Teledentistry

In the current year, the Teledentistry programs operating in Waycross and Dublin are successful in reaching rural clients.

Family Engagement

Oral Health district coordinators provide outreach to families at the district level. Oral health partners with local schools, and local community organizations to engage and support families around oral health issues. Oral Health strategically partners with Georgia Head Start to deliver evidence-based family engagement strategies to families at the district level.

Georgia Oral Health Coalition (GOHC) The GOHC's mission is to increase access to dental care, prevent and reduce dental caries, periodontal disease, oral-facial trauma, and tobacco use, and detect oral cancer in early stages and reduce its incidence thus, improving oral health and quality of life for all Georgians. Family and community-based organizations are invited to participate in regional oral health coalition meetings and activities.

Oral Health partners with schools, colleges, faith-based organizations, WIC clinics, Special Olympics, senior citizen homes, and other community-based organizations to conduct oral health education and training sessions.

In the current year, Oral Health district staff reached approximately 2,500 families and students, and provided approximately 1,500 oral health supplies, i.e., toothbrushes, floss, toothpaste, and distributed approximately 1,000 flyers and brochures.

Cross-Cutting/Systems Building - Application Year

Priority Need: Promote Oral Health Across all Populations

NPM 13: Preventive Dental Visit

Oral health across all MCH populations will continue to be a priority in the coming year for the MCH section with a strategic focus on improving health outcomes for women, infants and children. In the coming year, the Oral Health program will also educate public health district oral health staff on the special considerations and treatment needs for special needs patients.

Community Water Fluoridation

The Fluoridation Specialist will provide six water operator fluoride trainings, participate in ASTDD fluoride committee conference calls each month, attend quarterly fluoride advisory committee meetings, and attend the DRWA Fall and Spring conferences.

Teledentistry

In the coming year, the Oral Health Program plans to expand Teledentistry to additional public health districts. A meeting will be held in August 2018 to discuss this opportunity and plan for the coming year.

III.F. Public Input

Public input was solicited from community members, stakeholders, and professional partners throughout the year.

The MCH Title V Block Grant 2019 Application and 2017 Annual Report was posted on the MCH Title V website. An announcement on how and where to make comment was sent to partners, stakeholders, community members, and District Health Directors. No responses were received prior to July 16, 2018.

Georgia's DPH website includes a MCH Title V web page informing viewers of the Federal-State Title V partnership. MCH posts the MCH Title V Block Grant Application and Annual Report on its website each year after submission of the block grant. MCH welcomes comments related to the MCH Title V Block Grant programs and invites the public to email comments directly to the MCH Title V program. Further, a link to a web-based survey soliciting input on the MCH Title V Block Grant is posted on the site.

As part of the current year's Needs Assessment on Family Engagement, MCH Title V sought input from district and state public health staff and external partners via in-person and web-based surveys and in-person and telephone interviews.

Input is also solicited throughout the year from parent support groups and agency partners who are affiliated with programs funded by the grant. For example, the Babies Can't Wait State Interagency Coordinating Council receives public comment during quarterly council meetings which are open to the public. The Oral Health Program's Fluoride Advisory Committee promotes communication and input through quarterly meetings between multiple stakeholders to help ensure that common issues related to community water fluoridation are discussed. The Oral Health program also seeks public input through conducting surveys to solicit input from stakeholders and program participants, most recently assessing the need for technical assistance in facilitating implementation of school-based/linked sealant programs. The Oral Health program also surveyed dental providers to evaluate the impact of House Bill 154, allowing licensed dental hygienist to provide preventive oral health services without direct supervision by a dentist, on district oral health programs and oral health services.

In the coming year, MCH will continue to develop and implement communication that increases visibility and strengthens outreach and utilization of MCH programs to the community.

III.G. Technical Assistance

Technical Assistance

Title V has an open request for technical assistance. The DPH Vital Records Office seeks to increase the knowledge and skills of the Vital Records office staff and to help expand capacity and grow partnerships with key stakeholders around infant mortality and fetal death data collection. The DPH Infant and Fetal Death Registration Quality Improvement (QI) Team enlist the assistance of an expert consultant to help develop and improve skills to conduct stakeholder interviews with infant and fetal death vital records data providers. TA will also be utilized to develop skills and competencies to improve the development of process maps and develop data quality improvement strategies. The desired outcomes of this TA are to improve the understanding of infant and fetal death data, improve data quality of key data fields used to evaluate Perinatal Periods of Risk (PPOR), such as gestational age, birth weight, and demographic data from the infant and fetal death records.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [2018 DPH-DCH MOU.pdf](#)

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [Glossary of Terms - Acronym List.pdf](#)

Supporting Document #02 - [FE Interview Codebook.pdf](#)

Supporting Document #03 - [References 7-5.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [Division of Health Promotion Org Chart 7-3.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Georgia

	FY19 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 17,154,058	
A. Preventive and Primary Care for Children	\$ 6,213,920	(36.2%)
B. Children with Special Health Care Needs	\$ 6,452,729	(37.6%)
C. Title V Administrative Costs	\$ 1,569,693	(9.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 14,236,342	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 112,090,944	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 164,161,576	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 6,857,920	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 283,110,440	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 36,079,622		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 300,264,498	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 33,901,215	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 334,165,713	

OTHER FEDERAL FUNDS	FY19 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 9,153,768
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 200,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 630,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 570,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement	\$ 200,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 7,478,707
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	\$ 776,398
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 14,642,342

	FY17 Annual Report Budgeted		FY17 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 17,267,095		\$ 16,870,802	
A. Preventive and Primary Care for Children	\$ 5,245,111	(30.4%)	\$ 5,148,881	(30.5%)
B. Children with Special Health Care Needs	\$ 8,604,406	(49.8%)	\$ 8,174,839	(48.4%)
C. Title V Administrative Costs	\$ 1,193,791	(6.9%)	\$ 731,954	(4.4%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 15,043,308		\$ 14,055,674	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 114,351,317		\$ 110,765,452	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 147,350,720		\$ 149,036,298	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 9,133,503		\$ 6,662,232	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 270,835,540		\$ 266,463,982	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 36,079,622				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 288,102,635		\$ 283,334,784	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 33,098,697		\$ 36,589,422	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 321,201,332		\$ 319,924,206	

OTHER FEDERAL FUNDS	FY17 Annual Report Budgeted	FY17 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Temporary Assistance for Needy Families (TANF)	\$ 9,153,768	\$ 9,153,768
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 155,000	\$ 122,606
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	\$ 400,000	\$ 272,286
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sexually Transmitted Diseases (STD) Prevention	\$ 3,615,632	\$ 3,615,632
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	\$ 310,600	\$ 330,908
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 1,089,366	\$ 7,410,490
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start	\$ 2,785,500	\$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 95,374	\$ 51,587
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 250,000
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH	\$ 798,586	\$ 961,155
US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)	\$ 14,311,871	\$ 14,311,871
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 133,000	\$ 109,119

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	1. FEDERAL ALLOCATION
	Fiscal Year:	2019
	Column Name:	Application Budgeted
	Field Note: The FY 2019 Federal Allocation was increased to reflect the new Home Visiting program and to increase the support of Centering Pregnancy.	
2.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2019
	Column Name:	Application Budgeted
	Field Note: The FY 2019 State MCH Funds received an increase of new funds in Georgia's State Appropriation Bill. The funds reflect Babies Can't Wait Occupational State, Maternal and Mortality, Sickle Cell Foundation and Early Brain Development.	
3.	Field Name:	5. OTHER FUNDS
	Fiscal Year:	2019
	Column Name:	Application Budgeted
	Field Note: For FY 2019 Immunization VFC program projected budget increase based on prior expenses and data.	
4.	Field Name:	1.FEDERAL ALLOCATION
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note: The final Notice of Award and Actual Expense amount reflects the FFR final report.	
5.	Field Name:	2. Subtotal of Lines 1A-C
	Fiscal Year:	2017
	Column Name:	Annual Report Expended

Field Note:

In Form 2: the subtotal amount reflects:

- A. Preventive and Primary Care for Children
- B. Children with Special Health Care Needs
- C. Title V Administrative Cost

6.	Field Name:	Federal Allocation, C. Title V Administrative Costs:
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	FY 2017 expenses reflects the administration activity of the program budget.
7.	Field Name:	3. STATE MCH FUNDS
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	In Form 2: State MCH Funds expenses decrease under Children 1-22 and All Others. This reflects the variance amount of \$3,585,865.
8.	Field Name:	5. OTHER FUNDS
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	In Form 2: Other Funds expenses increased in Infants <1 year and Children 1-22 years. This increase reflects the variance amount of 1,685,578.
9.	Field Name:	6. PROGRAM INCOME
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	FY 2017 Program Income decreased in Pregnant Women and Children 1-22 Years. This reflects the variance amount of \$2,471,271.
10.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant
	Fiscal Year:	2019
	Column Name:	Application Budgeted

	Field Note: In FY 2019 received an increase of funding. The Early Brain Development program was moved under the MCH program.
11.	Field Name: Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program
	Fiscal Year: 2019
	Column Name: Application Budgeted
	Field Note: The FY 2019 Oral Health Prevention Grant received an supplemental increase.
12.	Field Name: Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State-Based Perinatal Quality Collaboratives (PQCs) Cooperative Agreement
	Fiscal Year: 2019
	Column Name: Application Budgeted
	Field Note: In FY 2019 MCH received a 5 year new grant with CDC, to support the Georgia Perinatal Program.
13.	Field Name: Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants
	Fiscal Year: 2019
	Column Name: Application Budgeted
	Field Note: In FY 2019 MCH was awarded the MIECHV Formula Grant to support the Home Visiting Program.
14.	Field Name: Other Federal Funds, US Department of Education > Office of Special Education Programs > Early Identification and Intervention for Infants and Toddlers with Disabilities (Part C of IDEA)
	Fiscal Year: 2019
	Column Name: Application Budgeted
	Field Note: In FY 2019 MCH received an increase of funding from Infants and Toddlers to support the Babies Can't Wait Program.
15.	Field Name: Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Sexually Transmitted Diseases (STD) Prevention
	Fiscal Year: 2017

	Column Name:	Annual Report Expended
	Field Note:	STD Federal funds will no longer be administer under the Title V Leadership. Changes were made in FY 2017.
16.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	State Oral Health Prevention grant received supplemental funding for school. The final Notice of Award amount \$340,600.
17.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	In FY 2017 MCH received new funding for the Home Visiting Program.
18.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Healthy Start
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	In FY 2017 (DHHS) -Healthy Start expenses were not applicable during this budget period.
19.	Field Name:	Other Federal Funds, Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Project LAUNCH
	Fiscal Year:	2017
	Column Name:	Annual Report Expended
	Field Note:	In FY 2017 MCH received additional funding for the Project LAUNCH grant.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: Georgia

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	\$ 2,095,690	\$ 1,708,989
2. Infants < 1 year	\$ 822,026	\$ 732,241
3. Children 1 through 21 Years	\$ 6,213,920	\$ 5,148,881
4. CSHCN	\$ 6,452,729	\$ 8,174,839
5. All Others	\$ 0	\$ 373,898
Federal Total of Individuals Served	\$ 15,584,365	\$ 16,138,848

IB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Pregnant Women	\$ 24,142,984	\$ 21,528,771
2. Infants < 1 year	\$ 98,276,759	\$ 94,551,792
3. Children 1 through 21 Years	\$ 130,542,361	\$ 122,867,333
4. CSHCN	\$ 23,085,233	\$ 22,278,342
5. All Others	\$ 7,063,103	\$ 5,237,744
Non-Federal Total of Individuals Served	\$ 283,110,440	\$ 266,463,982
Federal State MCH Block Grant Partnership Total	\$ 298,694,805	\$ 282,602,830

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services
State: Georgia

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	\$ 2,293,064	\$ 2,813,486
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 218,361	\$ 227,389
B. Preventive and Primary Care Services for Children	\$ 784,157	\$ 182,797
C. Services for CSHCN	\$ 1,290,546	\$ 2,403,300
2. Enabling Services	\$ 7,266,532	\$ 6,636,814
3. Public Health Services and Systems	\$ 7,594,462	\$ 7,420,502
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 304,805
Physician/Office Services		\$ 59,032
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 69,032
Dental Care (Does Not Include Orthodontic Services)		\$ 457,485
Durable Medical Equipment and Supplies		\$ 290,048
Laboratory Services		\$ 65,323
Other		
Various Programs and Services		\$ 1,567,761
Direct Services Line 4 Expended Total		\$ 2,813,486
Federal Total	\$ 17,154,058	\$ 16,870,802

IIB. Non-Federal MCH Block Grant	FY19 Application Budgeted	FY17 Annual Report Expended
1. Direct Services	\$ 26,843,292	\$ 39,956,048
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 17,124,037	\$ 32,087,849
B. Preventive and Primary Care Services for Children	\$ 2,804,046	\$ 2,008,042
C. Services for CSHCN	\$ 6,915,209	\$ 5,860,157
2. Enabling Services	\$ 61,502,009	\$ 52,350,603
3. Public Health Services and Systems	\$ 194,765,139	\$ 174,157,331
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 457,207
Physician/Office Services		\$ 65,725
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 125,372
Dental Care (Does Not Include Orthodontic Services)		\$ 1,476,964
Durable Medical Equipment and Supplies		\$ 535,072
Laboratory Services		\$ 78,649
Other		
Various Programs and Services		\$ 37,217,059
Direct Services Line 4 Expended Total		\$ 39,956,048
Non-Federal Total	\$ 283,110,440	\$ 266,463,982

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	Field Name:	IIA. - Other - Various Programs and Services
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note: In Form 3b Line 4 Other (Various Programs and Services) Direct services is used to support MCH Programs and Grant –in Aid (District to County's). Various services are provided through programmatic activities to evaluate for testing procedures, Referrals, Monitoring, and Medical Diagnosis for normal/abnormal screenings etc.	
2.	Field Name:	IIB. - Other - Various Programs and Services
	Fiscal Year:	2019
	Column Name:	Annual Report Expended
	Field Note: In Form 3b Line 4 Other (Various Programs and Services) Direct services is used to support MCH Programs & Partnerships. Various services are provided through programmatic activities to evaluate for testing procedures, Referrals, Monitoring, and Medical Diagnosis for normal/abnormal screenings etc.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated
State: Georgia

Total Births by Occurrence: 130,199

Data Source Year: 2017

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Screen	(B) Aggregate Total Number Presumptive Positive Screens	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	121,232 (93.1%)	8,384	248	248 (100.0%)

Program Name(s)				
3-Hydroxy-3-methylglutaric aciduria	3-Methylcrotonyl-CoA carboxylase deficiency	Argininosuccinic aciduria	Biotinidase deficiency	Carnitine uptake defect/carnitine transport defect
Citrullinemia, type I	Classic galactosemia	Classic phenylketonuria	Congenital adrenal hyperplasia	Critical congenital heart disease
Cystic fibrosis	Glutaric acidemia type I	Hearing loss	Holocarboxylase synthase deficiency	Homocystinuria
Isovaleric acidemia	Long-chain L-3 hydroxyacyl-CoA dehydrogenase deficiency	Maple syrup urine disease	Medium-chain acyl-CoA dehydrogenase deficiency	Methylmalonic acidemia (cobalamin disorders)
Methylmalonic acidemia (methylmalonyl-CoA mutase)	Primary congenital hypothyroidism	Propionic acidemia	S, β -Thalassemia	S,C disease
S,S disease (Sickle cell anemia)	Severe combined immunodeficiencies	β -Ketothiolase deficiency	Trifunctional protein deficiency	Tyrosinemia, type I
Very long-chain acyl-CoA dehydrogenase deficiency				

2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Hearing	126,096 (96.8%)	1,804	183	177 (96.7%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Emory University, Augusta University, and Children's Healthcare of Atlanta are contracted to conduct short-term follow-up on abnormal NBS results. NBS short-term follow-up encompasses the time between receiving an abnormal result to the confirmation of a diagnosis. Each contractor utilizes a database to track newborns during the short-term follow-up process which included a minimum of 12 steps to locate and recall infants who screen positive for a condition identified by NBS. All diagnosed cases are referred to Children 1st, the single point of entry for public health services, which leads to an assessment to determine the newborn's eligibility for IDEA Part C, Babies Can't Wait, or Children and Youth With Special Health Care Needs Program, Children's Medical Services.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	Field Name:	Total Births by Occurrence
	Fiscal Year:	2017
	Column Name:	Total Births by Occurrence Notes
	Field Note:	This is a preliminary number.
2.	Field Name:	Core RUSP Conditions - Receiving At Least One Screen
	Fiscal Year:	2017
	Column Name:	Core RUSP Conditions
	Field Note:	Column A is determined by an algorithm to match newborn screens to vital records. The automatic match was 93% and 7% required manual matching. The position responsible for manual matching was vacant during the reporting year. The Georgia Public Health Laboratory tested around 130,000 blood samples in the reporting year.
3.	Field Name:	Core RUSP Conditions - Positive Screen
	Fiscal Year:	2017
	Column Name:	Core RUSP Conditions
	Field Note:	For CCHD, presumptive positive screens referred to documented outcome "Fail," regardless of pulse oximetry readings in hand and foot.
4.	Field Name:	Core RUSP Conditions - Confirmed Cases
	Fiscal Year:	2017
	Column Name:	Core RUSP Conditions
	Field Note:	Confirmed cases are provided through Emory Genetics Follow-up Program, Hemoglobin Follow-up Programs at Children's Healthcare of Atlanta (CHOA) and Augusta University Hospitals, Early Hearing Detection and Intervention (EHDI), and SendSS. This report was prepared on March 28th, 2018. Thus, it might be possible that later on some numbers would be added in confirmatory cases due to delayed/late diagnosis. Newborn Screening (NBS) program does not have a follow-up program to capture confirmed cases of critical congenital heart disease (CCHD) at present. However, Birth Defects Registry and NBS linkage would capture confirmed cases of CCHD and is under development.
5.	Field Name:	Core RUSP Conditions - Referred For Treatment
	Fiscal Year:	2017

	Column Name:	Core RUSP Conditions
	Field Note:	Emory Genetics refers and treats everyone confirms with metabolic/genetic disorders. CHOA, Augusta University Hospitals, and Sickle Cell Foundation provides referral services to all confirmed cases of hemoglobinopathies. EHDI provides referral services for confirmed cases of hearing loss. Newborn Screening (NBS) program does not have a follow-up program to capture confirmed cases of critical congenital heart disease (CCHD) at present. However, Birth Defects Registry and NBS linkage would capture confirmed cases of CCHD and is under development.
6.	Field Name:	Hearing - Receiving At Least One Screen
	Fiscal Year:	2017
	Column Name:	Other Newborn
	Field Note:	An aggregate hospital generated report is used to verify screening.
7.	Field Name:	Hearing - Confirmed Cases
	Fiscal Year:	2017
	Column Name:	Other Newborn
	Field Note:	Summary Report from SendSS was pulled on April 2018. These numbers are subjected to change due to late/delayed diagnosis, follow-up timeline, missed cases etc.
8.	Field Name:	Hearing - Referred For Treatment
	Fiscal Year:	2017
	Column Name:	Other Newborn
	Field Note:	Summary Report from SendSS was pulled on April 2018. These numbers are subjected to change due to late/delayed diagnosis, follow-up timeline, missed cases etc.

Data Alerts: None

Form 5a
Count of Individuals Served by Title V
State: Georgia

Annual Report Year 2017

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	14,353	51.0	2.0	44.0	3.0	0.0
2. Infants < 1 Year of Age	125,568	0.0	48.0	41.0	5.0	6.0
3. Children 1 through 21 Years of Age	1,522,850	20.0	2.0	50.0	7.0	21.0
3a. Children with Special Health Care Needs	8,664	78.0	4.0	8.0	10.0	0.0
4. Others	8,384	0.0	0.0	0.0	0.0	100.0
Total	1,671,155					

Form Notes for Form 5a:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2017
	Field Note:	Data Source: Hospital Discharge Data for October 2016-September 2017 births from Georgia Department of Public Health, Office of Vital Records. Retrieved March 29, 2018.
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2017
	Field Note:	Data Source: Data from SendSS Newborn. Self Pay patients included in # of uninsured infants. "Private/Other" includes Indian Health Services. CHIP includes TriCare, Medicaid, Other GOVT; Out of State Births excluded.
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2017
	Field Note:	Data Source: Data from Immunization data, Newborn Screening and Genetics program data, Oral Health program data, and Family Planning program data
4.	Field Name:	Children with Special Health Care Needs
	Fiscal Year:	2017
	Field Note:	Data Source: Children's Medical Services Quarterly Data for October 2016-September 2017. Retrieved June 6, 2018.
5.	Field Name:	Others
	Fiscal Year:	2017
	Field Note:	Data Source: SendSS Newborn Screening Program Data. Columns B- Data retrieved from GPLH on March 26th, 2018.

Data Alerts: None

Form 5b
Total Percentage of Populations Served by Title V
State: Georgia

Annual Report Year 2017

Populations Served by Title V	Total % Served
1. Pregnant Women	11
2. Infants < 1 Year of Age	96
3. Children 1 through 21 Years of Age	49
3a. Children with Special Health Care Needs	2
4. Others	6

Form Notes for Form 5b:

None

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women
	Fiscal Year:	2017
	Field Note:	Data Source: Family Planning program data, Immunizations program data, and Oral Health program data
2.	Field Name:	Infants Less Than One Year
	Fiscal Year:	2017
	Field Note:	Data Source: Newborn Screening and Genetics program data (this is not a duplicated count)
3.	Field Name:	Children 1 Through 21 Years of Age
	Fiscal Year:	2017
	Field Note:	Data Source: Newborn Screening and Genetics program data, Immunization program data, Oral Health program data, Children's Medical Service program data
4.	Field Name:	Children With Special Health Care Needs
	Fiscal Year:	2017
	Field Note:	Data Source: Children's Medical Service and National Survey of Children's Health (2016)
5.	Field Name:	Others
	Fiscal Year:	2017
	Field Note:	Data Source: Newborn Screening and Genetics program data (this is not a duplicated count)

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Georgia

Annual Report Year 2017

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	126,499	51,985	44,781	14,388	288	4,954	204	4,144	5,755
Title V Served	14,297	5,025	7,337	686	24	220	42	917	46
Eligible for Title XIX	61,969	18,201	28,450	8,858	73	1,206	86	2,296	2,799
2. Total Infants in State	128,105	53,469	42,332	20,278	307	5,181	155	6,383	0
Title V Served	121,808	52,003	42,906	15,915	223	5,151	152	2,760	2,698
Eligible for Title XIX	63,040	18,721	26,894	12,484	78	1,261	65	3,537	0

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	1. Total Deliveries in State
	Fiscal Year:	2017
	Column Name:	Total
	Field Note: Data Source: Provisional Hospital Discharge Data for October 2016-September 2017 from Georgia Department of Public Health, Office of Vital Records. Retrieved March 29, 2018.	
2.	Field Name:	1. Title V Served
	Fiscal Year:	2017
	Column Name:	Total
	Field Note: Data Source: Provisional Birth File for October 2016-September 2017 births from Georgia Department of Public Health, Office of Vital Records. Retrieved June 8, 2018 from SendSS-Newborn via Dynamic Reports.	
3.	Field Name:	1. Eligible for Title XIX
	Fiscal Year:	2017
	Column Name:	Total
	Field Note: Data Source: Provisional Birth File for October 2016-September 2017 births from Georgia Department of Public Health, Office of Vital Records. Retrieved June 8, 2018 from SendSS-Newborn via Dynamic Reports.	
4.	Field Name:	2. Total Infants in State
	Fiscal Year:	2017
	Column Name:	Total
	Field Note: Data Source: Projection based on Online Analytical Statistical Information System (OASIS), Population Web Query, Georgia Department of Public Health, Office of Health Indicators for Planning (OHIP). Http://oasis.state.ga.us/ . Accessed April 27, 2018.	
5.	Field Name:	2. Title V Served
	Fiscal Year:	2017
	Column Name:	Total

Field Note:

Data Source: October 2016-September 2017 Newborn Screening (Genetics, Hearing, and Critical Congenital Heart Defects) Records. Data query from the State Electronic Notifiable Disease Surveillance System, Georgia Depart of Public Health website. Retrieved June 11, 2018 from <https://sends.state.ga.us/>.

6.	Field Name:	2. Eligible for Title XIX
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Fiscal Year:	2017
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Column Name:	Total
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Field Note:

Data Source: Projection based on data in rows 7, 9, and 10.

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Georgia

A. State MCH Toll-Free Telephone Lines	2019 Application Year	2017 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(855) 707-8277	(855) 707-8277
2. State MCH Toll-Free "Hotline" Name	Maternal and Child Health Hotline	Maternal and Child Health Hotline
3. Name of Contact Person for State MCH "Hotline"	Paige Jones	Paige Jones
4. Contact Person's Telephone Number	(404) 656-4782	(404) 656-4782
5. Number of Calls Received on the State MCH "Hotline"		41,276

B. Other Appropriate Methods	2019 Application Year	2017 Annual Report Year
1. Other Toll-Free "Hotline" Names	Powerline (800) 300-9003	Powerline (800) 300-9003
2. Number of Calls on Other Toll-Free "Hotlines"		4,211
3. State Title V Program Website Address	https://dph.georgia.gov/MCH	https://dph.georgia.gov/MCH
4. Number of Hits to the State Title V Program Website		20,171
5. State Title V Social Media Websites	https://twitter.com/gadph https://facebook.com/gadph	https://twitter.com/gadph https://facebook.com/gadph
6. Number of Hits to the State Title V Program Social Media Websites		0

Form Notes for Form 7:

Title V Social Media activity is included in the overall social media thread of the Georgia Department of Public Health

Form 8
State MCH and CSHCN Directors Contact Information

State: Georgia

1. Title V Maternal and Child Health (MCH) Director

Name	Jeannine Galloway
Title	Maternal and Child Health Director
Address 1	2 Peachtree Street, NW
Address 2	
City/State/Zip	Atlanta / GA / 30303
Telephone	(404) 657-3147
Extension	
Email	jeannine.galloway@dph.ga.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Sharifa Peart
Title	Program Director, CYSHCN
Address 1	2 Peachtree Street, NW
Address 2	
City/State/Zip	Atlanta / GA / 30303
Telephone	(404) 657-2861
Extension	
Email	sharifa.peart@dph.ga.gov

3. State Family or Youth Leader (Optional)

Name	Sherry Richardson
Title	Title V Team Lead
Address 1	2 Peachtree Street, NW
Address 2	
City/State/Zip	Atlanta / GA / 30303
Telephone	(404) 651-7692
Extension	
Email	sherry.richardson@dph.ga.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Georgia

Application Year 2019

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

Form 9 State Priorities-Needs Assessment Year - Application Year 2016

No.	Priority Need	Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)	Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure
1.	Prevent maternal mortality	New	
2.	Improve access to family planning services	New	This priority need is not associated with a National Performance Measure. It will be addressed by a State Performance Measure developed in the 2017 Application.
3.	Prevent infant mortality	New	
4.	Promote developmental screenings among children	New	
5.	Promote physical activity among children	New	
6.	Reduce suicide among adolescents	New	
7.	Improve systems of care for children and youth with special health care needs	New	
8.	Promote oral health among all populations	New	

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10a
National Outcome Measures (NOMs)

State: Georgia

Form Notes for Form 10a NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	74.8 %	0.1 %	92,505	123,648
2015	74.9 % ⚡	0.1 % ⚡	84,535 ⚡	112,864 ⚡
2014	74.6 % ⚡	0.1 % ⚡	80,348 ⚡	107,749 ⚡
2013	73.6 % ⚡	0.1 % ⚡	80,053 ⚡	108,806 ⚡
2012	73.1 % ⚡	0.1 % ⚡	82,491 ⚡	112,902 ⚡
2011	72.0 % ⚡	0.1 % ⚡	79,004 ⚡	109,704 ⚡
2010	73.0 % ⚡	0.1 % ⚡	74,389 ⚡	101,886 ⚡
2009	73.0 % ⚡	0.1 % ⚡	73,094 ⚡	100,098 ⚡

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution


NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations**Data Source: HCUP - State Inpatient Databases (SID)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	172.8	4.3	1,615	93,486
2014	161.0	3.6	2,011	124,879
2013	163.4	3.7	2,013	123,209
2012	147.9	3.5	1,846	124,847
2011	142.6	3.4	1,812	127,067
2010	139.9	3.3	1,853	132,475
2009	138.7	3.2	1,863	134,368
2008	130.1	3.0	1,881	144,536

Legends: Indicator has a numerator ≤10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 2 - Notes:**

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2012_2016	48.4	2.7	315	651,420
2011_2015	46.2	2.7	302	653,787
2010_2014	39.3	2.5	258	656,330
2009_2013	30.8	2.2	205	666,761
2008_2012	23.5	1.9	161	684,616

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 3 - Notes:**

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	9.8 %	0.1 %	12,704	129,769
2015	9.5 %	0.1 %	12,464	131,326
2014	9.5 %	0.1 %	12,385	130,738
2013	9.5 %	0.1 %	12,064	127,627
2012	9.3 %	0.1 %	12,014	129,553
2011	9.4 %	0.1 %	12,333	131,791
2010	9.7 %	0.1 %	12,912	132,745
2009	9.4 %	0.1 %	13,190	140,396

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 4 - Notes:**

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	11.2 %	0.1 %	14,577	129,973
2015	10.8 %	0.1 %	14,133	131,349
2014	10.8 %	0.1 %	14,058	130,764
2013	10.7 %	0.1 %	13,665	128,164
2012	10.9 %	0.1 %	14,139	129,705
2011	11.0 %	0.1 %	14,473	131,865
2010	11.4 %	0.1 %	15,093	133,000
2009	11.3 %	0.1 %	15,859	140,367

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 5 - Notes:**

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	27.1 %	0.1 %	35,177	129,973
2015	26.8 %	0.1 %	35,183	131,349
2014	26.0 %	0.1 %	33,960	130,764
2013	26.1 %	0.1 %	33,440	128,164
2012	27.8 %	0.1 %	36,044	129,705
2011	28.5 %	0.1 %	37,579	131,865
2010	29.4 %	0.1 %	39,104	133,000
2009	31.1 %	0.1 %	43,614	140,367

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20, a confidence interval width >20%, or >10% missing data and should be interpreted with caution**NOM 6 - Notes:**

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016/Q2-2017/Q1	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	2.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	3.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	5.0 %			
2013/Q2-2014/Q1	7.0 %			

Legends: Indicator results were based on a shorter time period than required for reporting**NOM 7 - Notes:**

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.7	0.2	1,012	131,878
2014	7.2	0.2	946	131,369
2013	7.4	0.2	957	129,227
2012	6.6	0.2	867	130,753
2011	6.7	0.2	894	132,892
2010	6.3	0.2	843	134,409
2009	7.0	0.2	993	141,829


Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 8 - Notes:**

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	7.8	0.2	1,024	131,404
2014	7.5	0.2	985	130,946
2013	7.0	0.2	899	128,748
2012	6.2	0.2	812	130,280
2011	6.9	0.2	908	132,409
2010	6.3	0.2	849	133,947
2009	7.3	0.2	1,036	141,377

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.1 - Notes:**

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	5.1	0.2	666	131,404
2014	5.0	0.2	654	130,946
2013	4.8	0.2	619	128,748
2012	4.1	0.2	534	130,280
2011	4.3	0.2	570	132,409
2010	3.9	0.2	516	133,947
2009	4.9	0.2	696	141,377

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.2 - Notes:**

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.7	0.1	358	131,404
2014	2.5	0.1	331	130,946
2013	2.2	0.1	280	128,748
2012	2.1	0.1	278	130,280
2011	2.6	0.1	338	132,409
2010	2.5	0.1	333	133,947
2009	2.4	0.1	340	141,377

Legends:

- Indicator has a numerator <10 and is not reportable
- Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

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

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	292.2	14.9	384	131,404
2014	287.1	14.8	376	130,946
2013	282.0	14.8	363	128,748
2012	234.1	13.4	305	130,280
2011	216.8	12.8	287	132,409
2010	221.0	12.9	296	133,947
2009	258.2	13.5	365	141,377


Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.4 - Notes:**

None

Data Alerts: None

NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	129.4	9.9	170	131,404
2014	123.0	9.7	161	130,946
2013	105.6	9.1	136	128,748
2012	104.4	9.0	136	130,280
2011	125.4	9.7	166	132,409
2010	120.9	9.5	162	133,947
2009	96.9	8.3	137	141,377


Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 9.5 - Notes:**

None

Data Alerts: None

NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	4.4 %	1.1 %	2,852	64,607
2012	3.9 %	0.8 %	4,881	125,314
2011	6.2 %	1.1 %	7,842	127,353
2010	6.1 %	1.2 %	7,754	128,235
2009	5.1 %	1.1 %	6,938	134,961
2008	6.6 %	1.2 %	9,282	141,155
2007	4.9 %	1.2 %	7,094	144,786

Legends: Indicator has an unweighted denominator <30 and is not reportable Indicator has an unweighted denominator between 30 and 59 or has a confidence interval width that is inestimable or >20% and should be interpreted with caution**NOM 10 - Notes:**

None


Data Alerts: None


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

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	2.8	0.2	255	91,918
2014	2.9	0.2	358	122,387
2013	2.3	0.1	275	118,735
2012	1.8	0.1	218	123,712
2011	1.5	0.1	182	123,707
2010	1.2	0.1	157	128,527
2009	0.8	0.1	110	138,677
2008	0.7	0.1	103	144,048

Legends:

 Indicator has a numerator ≤10 and is not reportable

 Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

FAD Not Available for this measure.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

FAD Not Available for this measure.



NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	13.3 %	2.0 %	312,525	2,356,995
Legends:				
 Indicator has an unweighted denominator <30 and is not reportable				
 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	20.9	1.3	257	1,230,747
2015	21.0	1.3	259	1,234,835
2014	19.7	1.3	244	1,238,114
2013	21.9	1.3	271	1,240,503
2012	18.8	1.2	234	1,243,459
2011	20.2	1.3	251	1,245,086
2010	23.8	1.4	297	1,248,768
2009	22.4	1.3	279	1,247,044

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 15 - Notes:**

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	38.0	1.6	543	1,429,712
2015	36.5	1.6	518	1,418,744
2014	31.5	1.5	443	1,405,878
2013	33.6	1.6	470	1,400,810
2012	29.1	1.4	408	1,402,316
2011	32.6	1.5	456	1,398,831
2010	35.4	1.6	495	1,399,683
2009	31.8	1.5	444	1,396,065

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	14.3	0.8	302	2,118,795
2013_2015	13.8	0.8	289	2,098,804
2012_2014	12.4	0.8	260	2,091,081
2011_2013	13.0	0.8	272	2,095,858
2010_2012	13.3	0.8	281	2,110,591
2009_2011	13.2	0.8	280	2,123,186
2008_2010	14.9	0.8	318	2,129,778
2007_2009	18.8	0.9	398	2,114,902

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution


NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014_2016	8.1	0.6	172	2,118,795
2013_2015	7.9	0.6	166	2,098,804
2012_2014	6.8	0.6	143	2,091,081
2011_2013	6.7	0.6	141	2,095,858
2010_2012	6.0	0.5	126	2,110,591
2009_2011	6.1	0.5	129	2,123,186
2008_2010	6.1	0.5	130	2,129,778
2007_2009	5.4	0.5	114	2,114,902



Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 16.3 - Notes:**

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	19.8 %	2.0 %	494,310	2,497,183
Legends:				
 Indicator has an unweighted denominator <30 and is not reportable				
 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				



NOM 17.1 - Notes:

None

Data Alerts: None

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

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	13.8 %	3.1 %	67,972	494,310
Legends:  Indicator has an unweighted denominator <30 and is not reportable  Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	1.5 % ⚡	0.5 % ⚡	32,685 ⚡	2,165,278 ⚡
Legends: 🚩 Indicator has an unweighted denominator <30 and is not reportable ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				



NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	8.9 %	1.4 %	192,003	2,157,314
Legends:  Indicator has an unweighted denominator <30 and is not reportable  Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	41.1 % ⚡	7.1 % ⚡	112,671 ⚡	274,010 ⚡
Legends: 🚩 Indicator has an unweighted denominator <30 and is not reportable ⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				



NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	90.3 %	1.6 %	2,253,994	2,495,736
Legends:  Indicator has an unweighted denominator <30 and is not reportable  Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2014	13.0 %	0.1 %	12,165	93,386
2012	13.4 %	0.1 %	14,527	108,699
2010	14.4 %	0.1 %	15,122	104,959
2008	15.3 %	0.1 %	14,377	93,912

Legends:

🚩 Indicator has a denominator <50 or a relative standard error ≥30% and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	12.7 %	0.8 %		
2011	15.0 %	1.1 %		
2009	12.3 %	1.0 %		
2007	13.7 %	1.0 %		
2005	12.3 %	1.0 %		

Legends:

🚩 Indicator has an unweighted denominator <100 and is not reportable

⚡ Indicator has a confidence interval width >20% and should be interpreted with caution

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

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	18.6 %	3.3 %	207,930	1,118,321

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance**Data Source: American Community Survey (ACS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	6.4 %	0.3 %	161,540	2,511,414
2015	7.0 %	0.3 %	174,459	2,502,055
2014	7.5 %	0.3 %	187,590	2,490,299
2013	9.5 %	0.3 %	236,951	2,487,378
2012	8.9 %	0.4 %	221,352	2,490,232
2011	9.5 %	0.4 %	236,836	2,488,159
2010	9.8 %	0.3 %	245,304	2,492,676
2009	10.7 %	0.3 %	277,133	2,583,204

Legends: Indicator has an unweighted denominator <30 and is not reportable Indicator has a confidence interval width that is inestimable or >20% and should be interpreted with caution**NOM 21 - Notes:**

None


Data Alerts: None


NOM 22.1 - Percent of children, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3*:3:1:4)

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	77.3 %	3.1 %	145,534	188,384
2015	75.6 %	3.4 %	140,850	186,272
2014	74.0 %	3.9 %	142,195	192,050
2013	69.8 %	5.0 %	133,873	191,743
2012	74.7 %	3.5 %	146,814	196,476
2011	69.5 %	3.3 %	143,703	206,821
2010	49.6 %	3.5 %	108,443	218,575
2009	45.8 %	3.8 %	102,118	222,822

Legends:

 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

 Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2017	54.4 %	1.8 %	1,271,860	2,337,119
2015_2016	51.3 %	1.7 %	1,186,889	2,311,822
2014_2015	58.0 %	2.0 %	1,344,382	2,319,499
2013_2014	51.4 %	2.0 %	1,197,580	2,328,179
2012_2013	52.4 %	2.4 %	1,209,331	2,310,105
2011_2012	44.4 %	2.7 %	1,077,374	2,425,933
2010_2011	48.8 %	2.7 %	1,173,494	2,404,700
2009_2010	36.0 %	2.2 %	885,197	2,458,880

Legends:

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen (Female)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	77.0 %	3.7 %	270,782	351,797
2015	54.4 %	4.8 %	188,983	347,673
2014	65.4 %	4.6 %	225,530	344,809
2013	53.7 % ⚡	5.5 % ⚡	182,469 ⚡	339,975 ⚡
2012	52.3 % ⚡	5.5 % ⚡	175,971 ⚡	336,241 ⚡
2011	48.4 %	4.6 %	163,472	337,969
2010	43.5 %	4.0 %	141,115	324,413
2009	38.6 %	4.2 %	130,355	337,460

Legends:

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

Data Source: National Immunization Survey (NIS) - Teen (Male)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	58.0 %	4.8 %	211,239	364,007
2015	51.0 %	4.4 %	183,710	360,544
2014	41.2 %	4.6 %	148,198	359,724
2013	40.5 % ⚡	5.9 % ⚡	144,219 ⚡	356,096 ⚡
2012	19.5 %	4.3 %	68,607	352,408
2011	7.3 %	1.9 %	25,719	353,467

Legends:

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine**Data Source: National Immunization Survey (NIS) - Teen****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	92.8 %	1.8 %	664,117	715,804
2015	90.2 %	2.0 %	639,026	708,217
2014	86.1 %	2.4 %	606,772	704,533
2013	82.0 %	3.4 %	570,798	696,071
2012	80.5 %	3.1 %	554,543	688,649
2011	68.0 %	3.0 %	470,206	691,435
2010	62.2 %	3.0 %	412,380	662,735
2009	50.8 %	3.1 %	350,121	689,156

Legends: Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6 Estimates with 95% confidence interval half-widths > 10 might not be reliable**NOM 22.4 - Notes:**

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	91.4 %	1.8 %	654,281	715,804
2015	87.0 %	2.4 %	615,842	708,217
2014	74.9 %	3.1 %	527,722	704,533
2013	76.9 %	3.6 %	535,512	696,071
2012	73.1 %	3.5 %	503,360	688,649
2011	67.7 %	3.0 %	467,831	691,435
2010	63.5 %	2.9 %	420,582	662,735
2009	53.3 %	3.1 %	367,515	689,156

Legends:

🚩 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable


NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	23.6	0.3	8,248	350,110
2015	25.5	0.3	8,829	345,650
2014	28.4	0.3	9,661	340,458
2013	30.4	0.3	10,322	339,239
2012	33.7	0.3	11,488	341,282
2011	37.9	0.3	12,991	343,097
2010	41.5	0.4	14,378	346,765
2009	47.0	0.4	16,345	347,660

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 23 - Notes:**

None


Data Alerts: None


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

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2013	9.2 %	1.7 %	5,936	64,349
2012	8.1 %	1.1 %	10,035	124,724

Legends:

 Indicator has an unweighted denominator <30 and is not reportable

 Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% and should be interpreted with caution



NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year

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

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2016	5.6 %	1.4 %	139,440	2,483,820
Legends:				
 Indicator has an unweighted denominator <30 and is not reportable				
 Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution				

NOM 25 - Notes:

None

Data Alerts: None

Form 10a
National Performance Measures (NPMs)
State: Georgia

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

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2016	2017
Annual Objective	62.1	62.1
Annual Indicator	67.7	69.7
Numerator	1,258,025	1,321,663
Denominator	1,857,538	1,895,900
Data Source	BRFSS	BRFSS
Data Source Year	2015	2016

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	63.0	63.5	64.0	65.0	65.0	65.0

Field Level Notes for Form 10a NPMs:

None

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

FAD for this measure is not available for the State.

State Provided Data		
	2016	2017
Annual Objective	81.8	80
Annual Indicator	80.9	82.6
Numerator	1,950	1,939
Denominator	2,409	2,347
Data Source	State Statistical File	State Statistical File
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	81.0	82.0	83.0	84.0	85.0	85.0

Field Level Notes for Form 10a NPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data

Field Note:

Data Sources: OHIP - Final Birth Table, OASIS Final, and Vital Records Provisional Birth File

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	79.3	80.9
Annual Indicator	69.2	79.9
Numerator	80,818	100,061
Denominator	116,817	125,213
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	81.2	81.5	82.0	82.3	83.0	83.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: National Immunization Survey (NIS)		
	2016	2017
Annual Objective	20.2	21.6
Annual Indicator	25.4	20.7
Numerator	29,130	25,611
Denominator	114,622	123,723
Data Source	NIS	NIS
Data Source Year	2013	2014

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	23.0	23.7	24.0	24.3	25.0	25.0

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		37.1
Numerator		104,456
Denominator		281,856
Data Source		NSCH
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	43.0	43.5	44.0	44.5	45.0	45.0

Field Level Notes for Form 10a NPMs:

None

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CHILD		
	2016	2017
Annual Objective		
Annual Indicator		36.4
Numerator		301,002
Denominator		826,166
Data Source		NSCH-CHILD
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	38.1	38.8	39.5	39.8	39.8	39.8

Field Level Notes for Form 10a NPMs:

None

NPM 8.2 - Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day

Federally Available Data	
Data Source: Youth Risk Behavior Surveillance System (YRBSS)	
	2017
Annual Objective	
Annual Indicator	24.7
Numerator	107,932
Denominator	436,871
Data Source	YRBSS-ADOLESCENT
Data Source Year	2013

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - ADOLESCENT	
	2017
Annual Objective	
Annual Indicator	20.0
Numerator	186,178
Denominator	931,402
Data Source	NSCH-ADOLESCENT
Data Source Year	2016

Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	38.8	39.5	39.8	39.8	39.8

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - CSHCN		
	2016	2017
Annual Objective		
Annual Indicator		19.0
Numerator		44,578
Denominator		234,699
Data Source		NSCH-CSHCN
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	34.9	35.3	35.6	36.0	36.5	36.5

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)		
	2016	2017
Annual Objective	39.5	41.1
Annual Indicator	29.3	29.3
Numerator	18,443	18,443
Denominator	63,060	63,060
Data Source	PRAMS	PRAMS
Data Source Year	2013	2013


Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	42.7	43.0	43.5	44.5	44.9	44.9

Field Level Notes for Form 10a NPMs:

None

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

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH)		
	2016	2017
Annual Objective		
Annual Indicator		83.0
Numerator		1,968,896
Denominator		2,372,620
Data Source		NSCH
Data Source Year		2016

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

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	78.2	79.0	79.8	79.9	80.0	80.0

Field Level Notes for Form 10a NPMs:

None

Form 10a
State Performance Measures (SPMs)

State: Georgia

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

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

State Provided Data		
	2016	2017
Annual Objective		11
Annual Indicator	16.6	16
Numerator	9,714	8,627
Denominator	58,434	54,076
Data Source	GFPP	GFPP
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	12.0	13.0	14.0	15.0	17.0	17.0

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note: Data Source: Georgia Family Planning Program Data 2016 Projections	
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note: Data Source: Georgia Planning Program Data	

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

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

State Provided Data		
	2016	2017
Annual Objective		1.3
Annual Indicator	1.5	1.6
Numerator	704	781
Denominator	477,000	494,310
Data Source	CMS Program Data and Kids Count	CMS Program Data and Kids Count
Data Source Year	SFY 2016	SFY 2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	1.5	1.7	1.9	2.0	2.0	2.0

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Data Source: Children's Medical Services Program Data (Numerator), Kids Count (Denominator)
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Data Source: Children's Medical Services Program Data (Numerator), Kids Count (Denominator)

SPM 3 - Rate of congenital syphilis.

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

State Provided Data		
	2016	2017
Annual Objective		13
Annual Indicator	17	13.1
Numerator	21	17
Denominator	123,292	129,563
Data Source	Projected Data from OASIS and SendSS, Births and C	SendSS
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	12.7	12.4	12.0	11.7	11.7	11.7

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Data Source: State Electronic Notifiable Disease Surveillance System, Vital Records
2.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Data Source: State Electronic Notifiable Disease Surveillance System

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

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

State Provided Data		
	2016	2017
Annual Objective		6.1
Annual Indicator	6.1	13.2
Numerator	735	1,592
Denominator	120,577	120,371
Data Source	Hospital Discharge Data, Vital Records	Hospital Discharge Data, Vital Records
Data Source Year	2015	2016
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	13.2	13.1	13.0	13.0	12.9	12.9

Field Level Notes for Form 10a SPMs:

1.	Field Name:	2016
	Column Name:	State Provided Data

Field Note:

Data Source; OHIP Hospital Discharge Data, Vital Records

Method: The numerator is the number of infants younger than 1 year of age diagnosed with NAS in Georgia. Diagnosis was defined using ICD codes. For the first three quarters of 2015, NAS was indicated by ICD-9 codes of 779.5 (drug withdrawal syndrome in a newborn) and 760.72 (narcotics affecting fetus or newborn via placenta or breast milk). For the last quarter of 2015, the ICD-10 codes P96.1 (neonatal withdrawal symptoms from maternal use of drugs of addiction) and P04.4 (newborn affected by maternal use of drugs of addiction) were used. Iatrogenic cases were identified and removed from consideration using Stephen Patrick's methodology as described in "Neonatal Abstinence Syndrome and Associated Health Care Expenditures." The denominator is the total number of hospital births in Georgia.

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

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	20.0	25.0	27.0	29.0	29.0

Field Level Notes for Form 10a SPMs:

None

Form 10a
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Georgia

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

Measure Status:	Inactive - Replaced
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State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	1	0
Numerator		
Denominator		
Data Source	Title V On-Going Needs Assessment	Title V On-Going Needs Assessment
Data Source Year	2017	2017
Provisional or Final ?	Provisional	Provisional

Field Level Notes for Form 10a ESMs:

None

ESM 1.4 - 1.4. Proportion of birthing hospitals that implement Alliance for Innovation on Maternal Health Bundles or approved quality improvement measures

Measure Status:	Active
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State Provided Data	
	2017
Annual Objective	10
Annual Indicator	0
Numerator	
Denominator	
Data Source	GaPQC Data
Data Source Year	2017
Provisional or Final ?	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	25.0	30.0	50.0	60.0	85.0	85.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note:	Implementation of AIM Bundles in birthing hospitals started April 2018.

ESM 1.5 - 1.5 Number of calls and clicks received from marketing campaign

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	5.0	10.0	15.0	20.0	25.0

Field Level Notes for Form 10a ESMs:

None

ESM 1.6 - 1.6 Number of impressions based on media target audience

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	5,000,000.0	5,000,000.0	5,000,000.0	5,000,000.0	5,000,000.0

Field Level Notes for Form 10a ESMs:

None

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

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

State Provided Data	
	2017
Annual Objective	6
Annual Indicator	6
Numerator	
Denominator	
Data Source	Womens Health Program Data
Data Source Year	2017
Provisional or Final ?	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	6.0	6.0	6.0	6.0	6.0	6.0

Field Level Notes for Form 10a ESMs:

None

ESM 4.1 - 3.1.1 Number of birthing hospitals that participate in the 5-STAR Hospital Initiative

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

State Provided Data		
	2016	2017
Annual Objective		0
Annual Indicator	39	40
Numerator		
Denominator		
Data Source	Womens Health Program Data	Womens Health Program Data
Data Source Year	2016	2017
Provisional or Final ?	Provisional	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	20.0	30.0	40.0	40.0	40.0

Field Level Notes for Form 10a ESMs:

None

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

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

State Provided Data		
	2016	2017
Annual Objective		1
Annual Indicator	2	3
Numerator		
Denominator		
Data Source	Womens Health Program Data	Womens Health Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	3.0	4.0	5.0	6.0	6.0	6.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	8	8
Numerator		
Denominator		
Data Source	Children 1st Program Data	Children 1st Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	15.0	18.0	18.0	18.0	18.0

Field Level Notes for Form 10a ESMs:

1.	Field Name:	2016
	Column Name:	State Provided Data
	Field Note:	Georgia has 18 public health districts

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		2
Annual Indicator	9	20
Numerator		
Denominator		
Data Source	Children 1st Program Data	Children 1st Program Data
Data Source Year	FFY 2016	FFY 2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	14.0	26.0	30.0	36.0	38.0	38.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.1.1 - Percent of children, in grades 1-12 enrolled in public school physical education class, who are in the Healthy Fitness Zone (HFZ) for Body Mass Index (BMI)

Measure Status:	Active
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Annual Objectives					
	2019	2020	2021	2022	2023
Annual Objective	62.0	63.0	64.0	65.0	66.0

Field Level Notes for Form 10a ESMs:

None

ESM 8.2.1 - 7.1.1. Average HFZ measure (aerobic capacity) among students in grades 4-12

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		56
Annual Indicator	53.5	52.4
Numerator	380,890	379,767
Denominator	711,312	724,839
Data Source	DOE Fitnessgram	DOE Fitnessgram
Data Source Year	2016-2017	2017-2018
Provisional or Final ?	Final	Provisional

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	57.0	58.0	59.0	60.0	61.0	62.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		
Annual Indicator	250	434
Numerator		
Denominator		
Data Source	Children Medical Services	Children Medical Service
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	250.0	325.0	350.0	375.0	500.0	500.0

Field Level Notes for Form 10a ESMs:

None

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

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	0	0
Numerator		
Denominator		
Data Source	Children Medical Services Program	Children Medical Services Program
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	15.0	25.0	35.0	40.0	40.0	40.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.1.1 - 11.1.1. Number of comprehensive webinars/presentations offered

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		4
Annual Indicator	0	20
Numerator		
Denominator		
Data Source	Oral Health Program Data	Oral Health Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	8.0	12.0	16.0	20.0	20.0	20.0

Field Level Notes for Form 10a ESMs:

None

ESM 13.2.1 - 11.1.2. Number of dentists, hygienists and staff educated on four specific dental services for individuals with special needs and the oral health connection and services

Measure Status:	Active
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State Provided Data		
	2016	2017
Annual Objective		5
Annual Indicator	15	32
Numerator		
Denominator		
Data Source	Oral Health Program Data	Oral Health Program Data
Data Source Year	2016	2017
Provisional or Final ?	Final	Final

Annual Objectives						
	2018	2019	2020	2021	2022	2023
Annual Objective	10.0	20.0	30.0	40.0	40.0	40.0

Field Level Notes for Form 10a ESMs:

None

Form 10b
State Performance Measure (SPM) Detail Sheets

State: Georgia

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

Population Domain(s) – Women/Maternal Health, Perinatal/Infant Health

Measure Status:	Active	
Goal:	By 2020, Increase the percentage of women (ages 15-44) served in the Georgia Family Planning Program (GFPP) who use long-acting reversible contraceptives (LARC) from 11% to 15%.	
Definition:	Numerator:	Number of women ages 15-44 that used a LARC
	Denominator:	Total number of women ages 15-44 served in GFPP
	Unit Type:	Percentage
	Unit Number:	100
Healthy People 2020 Objective:	Related to Family Planning (FP) Objective 1: Increase the proportion of pregnancies that are intended	
Data Sources and Data Issues:	Data Source: Georgia Family Planning Program Clinic Data	
Significance:	<p>The availability of family planning services allows individuals to achieve desired birth spacing and family size, and contributes to improved health outcomes for infants, children, women, and families. In 2002, 51% of all pregnancies were intended in the U.S. In Georgia unplanned births increased in percentage from 52.6% to 54.8% between 2009 and 2011. According to the American College of Obstetricians and Gynecologists, intrauterine devices and contraceptive implants, long-acting reversible contraceptives (LARCs), are the most effective reversible contraceptives. The major advantage of LARCs compared with other reversible contraceptive methods is that they do not require ongoing effort on the part of the user for long-term and effective use, and return fertility quickly after removal.</p>	

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

Population Domain(s) – Children with Special Health Care Needs

Measure Status:	Active									
Goal:	By 2020, increase the rate of children and youth with special health care needs that have accessed their specialty health care visit through a telehealth clinic from 1.3 (per 1000 CYSHCN) to 2.0.									
Definition:	<table><tr><td>Numerator:</td><td>Number of children and youth that have seen a specialty provider within the last 12 months at the Children's Medical Services (CMS) Program telehealth clinic</td></tr><tr><td>Denominator:</td><td>Total number of children and youth with special health care needs</td></tr><tr><td>Unit Type:</td><td>Rate</td></tr><tr><td>Unit Number:</td><td>1,000</td></tr></table>		Numerator:	Number of children and youth that have seen a specialty provider within the last 12 months at the Children's Medical Services (CMS) Program telehealth clinic	Denominator:	Total number of children and youth with special health care needs	Unit Type:	Rate	Unit Number:	1,000
Numerator:	Number of children and youth that have seen a specialty provider within the last 12 months at the Children's Medical Services (CMS) Program telehealth clinic									
Denominator:	Total number of children and youth with special health care needs									
Unit Type:	Rate									
Unit Number:	1,000									
Healthy People 2020 Objective:	<p>Related to Maternal, Infant, and Child Health (MICH) Objective 31: Increase the proportion of children with special health care needs who receive their care in family-centered, comprehensive and coordinated systems</p> <p>Related to Access to Health Services (AHS) Objective 5.2: Increase the proportion of children and youth age 17 years and under who have a specific source of ongoing care</p>									
Data Sources and Data Issues:	Data Sources: Georgia Children's Medical Services Program Database, Kids Count Data Center									
Significance:	According to the American Telemedicine Association, telemedicine/telehealth has been used to bring health care services to patients in distant locations, improving access to patients in both rural and urban areas.Georgia's CSHCN families travel on average 300 miles round trip for specialty care visits. Often resulting in missed appointments, disruption in health care, missed school, and increased emergency room visits. Telehealth is a proven effective tool in providing specialty care services and care coordination to children with special health care needs.									

SPM 3 - Rate of congenital syphilis.**Population Domain(s) – Perinatal/Infant Health**

Measure Status:	Active	
Goal:	By 2020, decrease the rate of congenital syphilis from 13 (infants per 100,000 live births) to 11.7.	
Definition:	Numerator:	Number of infants born with congenital syphilis
	Denominator:	Total number of live births
	Unit Type:	Rate
	Unit Number:	100,000
Healthy People 2020 Objective:	Sexually Transmitted Diseases-Objective 8: Reduce congenital syphilis	
Data Sources and Data Issues:	Data Source: State Electronic Notifiable Disease Surveillance System (SendSS)	
Significance:	Congenital syphilis can cause miscarriage, stillbirth, deformed bones, meningitis, and nerve problems leading to blindness or deafness. The CDC considers Congenital Syphilis to be a winnable battle, partly because it can be prevented by testing the mother in the first and third trimesters and providing treatment at least 30 days before delivery. In 2014, Georgia ranked 12th in the U.S. for the congenital syphilis case rate (13 cases per 100,000 live births). There were 20 U.S. states with no congenital syphilis cases reported. Between 2010-2015, Georgia has had no less than 11 cases in a given year.	

SPM 4 - Rate of infants diagnosed with Neonatal Abstinence Syndrome (NAS).
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active	
Goal:	By 2020, decrease the rate of infants diagnosed as having NAS from 1.2 (per 1,000 live births) to 13.0.	
Definition:	Numerator:	Number of infants discharged with NAS
	Denominator:	Total number of live births
	Unit Type:	Rate
	Unit Number:	1,000
Healthy People 2020 Objective:	Related to Maternal, Infant, and Child Health (MICH) Objective 11: Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women	
Data Sources and Data Issues:	Data Source: Georgia Resident Hospital Discharge Data, Georgia Resident Births, State Electronic Notifiable Disease Surveillance System (SendSS)	
Significance:	There has been a significant increase in the prevalence of NAS, from 1.20 per 1,000 U.S. hospital births in 2000 to 3.39 per 1,000 U.S. hospital births in 2009. In Georgia, NAS increased from 2.07 per 1000 live births in 2010 to 13.23 per 1000 live births in 2016. A public health approach to NAS that includes averting maternal substance use and routine screening for unhealthy substance use in women at every health care visit will help increase the opportunities for primary prevention. Additionally, providing women with history of substance use connections to peer support and treatment/recovery services, as well as reducing barriers to family planning services, as well as reducing barriers to family planning services are critical prevention strategies. According to the Association of State and Territorial Health Officials (ASTHO), state health agencies play a key role in linking various resources and providers by tracking substance-exposed infants through screening, assessment, and service delivery.	

SPM 5 - Percent of birthing hospitals, NICUs, and Pediatric Departments with policies and education that adhere to the American Academy of Pediatrics (AAP) Safe Sleep guidelines
Population Domain(s) – Perinatal/Infant Health

Measure Status:	Active	
Goal:	By 2020, 25% of birthing hospitals, NICUs, and Pediatric Departments will have policies and education that adhere to the American Academy of Pediatrics (AAP) Safe Sleep guidelines	
Definition:	Numerator:	Number of birthing hospitals, NICUs, and Pediatric Departments that have policies and education adhere to the American Academy of Pediatrics (AAP) Safe Sleep guidelines
	Denominator:	Total number of birthing hospitals, NICUs, and Pediatric Departments
	Unit Type:	Percentage
	Unit Number:	100
Healthy People 2020 Objective:	MICH Objective 21: Increase the proportion of infants who are put to sleep on their backs	
Data Sources and Data Issues:	Safe Sleep Program Data	
Significance:	<p>The single most effective action that parents and caregivers can take to lower an infants risk of SIDS is to place the baby to sleep on his or her back for naps and at night. National Institute of Childhood and Human Development (NICHD) research has led to significant advances in our understanding of SIDS. For example, the current definition of SIDS resulted from an Institute-led conference of experts in infant mortality. In addition, the American Academy of Pediatrics Task Force on SIDS uses results from NICHD research as the basis for its safe sleep recommendations. Institute research informed the recommendation that the back sleep position carries the lowest risk of SIDS and that this sleep practice does not increase risks for other problems.</p>	

Form 10b
State Outcome Measure (SOM) Detail Sheets
State: Georgia

No State Outcome Measures were created by the State.

Form 10c
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Georgia

ESM 1.3 - 1.3. Number of focus groups across the state that assess barriers to well-woman visits
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Inactive - Replaced								
Goal:	Increase the number of focus groups across the state that assess barriers to well-woman visits from 0 to 8								
Definition:	<table border="1"> <tr> <td>Numerator:</td><td>Number of focus groups</td></tr> <tr> <td>Denominator:</td><td>Not applicable</td></tr> <tr> <td>Unit Type:</td><td>Count</td></tr> <tr> <td>Unit Number:</td><td>18</td></tr> </table>	Numerator:	Number of focus groups	Denominator:	Not applicable	Unit Type:	Count	Unit Number:	18
Numerator:	Number of focus groups								
Denominator:	Not applicable								
Unit Type:	Count								
Unit Number:	18								
Data Sources and Data Issues:	Data Source: Title V On-Going Needs Assessment								
Significance:	<p>A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.</p>								

ESM 1.4 - 1.4. Proportion of birthing hospitals that implement Alliance for Innovation on Maternal Health Bundles or approved quality improvement measures

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

Measure Status:	Active	
Goal:	Increase the proportion of birthing hospitals that implement the use of one of three AIM Bundles	
Definition:	Numerator:	Number of birthing hospitals implementing at least one of three AIM Bundles
	Denominator:	Number of birthing hospitals for year of reporting (number may fluctuate)
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Vital Records, GaPQC Data	
Significance:	Preventing maternal mortality is essential to improving the health of women in the state. Both quantitative and qualitative data examined in the needs assessment indicated the need to prevent maternal mortality in Georgia. Georgia's maternal mortality ratio increased from 11.5 (n=16) in 2004 to 43.6 (n=56) in 2013. Additionally, Georgia has been identified as among states with the highest maternal mortality ratio. Interviews with leaders in the field recommended this priority. Preventing maternal mortality was also a clear priority of stakeholders involved in the needs assessment. Maternal mortality was rated highest in the maternal/women's health domain at the stakeholder meetings and second overall.	

ESM 1.5 - 1.5 Number of calls and clicks received from marketing campaign

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

Measure Status:	Active									
Goal:	Increase the percentage of interactions, i.e., calls and clicks received from the marketing campaign									
Definition:	<table><tr><td>Numerator:</td><td>Sum of all calls and clicks</td></tr><tr><td>Denominator:</td><td>Number of women 18-49 within districts with marketing</td></tr><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table>		Numerator:	Sum of all calls and clicks	Denominator:	Number of women 18-49 within districts with marketing	Unit Type:	Percentage	Unit Number:	100
Numerator:	Sum of all calls and clicks									
Denominator:	Number of women 18-49 within districts with marketing									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Vendor analytics (Chemistry Atlanta)									
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women’s health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women’s preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.									

ESM 1.6 - 1.6 Number of impressions based on media target audience

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

Measure Status:	Active	
Goal:	Number of impressions (i.e., estimated number of times ad is seen by target population)	
Definition:	Numerator:	Total number of impressions based on media target audience (women 18-49) in districts with marketing
	Denominator:	Not Applicable
	Unit Type:	Count
	Unit Number:	9,000,000
Data Sources and Data Issues:	Vendor analytics (Chemistry Atlanta)	
Significance:	<p>A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes. The annual well-woman visit has been endorsed by the American College of Obstetrics and Gynecologists (ACOG) and was also identified among the women's preventive services required by the Affordable Care Act (ACA) to be covered by private insurance plans without cost-sharing.</p>	

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

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

Measure Status:	Active									
Goal:	Increase the proportion of RPCs that receive a process evaluation to ensure maintenance of subspecialty services and other components consistent with Level III designation from 0 to 6 each year for five years									
Definition:	<table><tr><td>Numerator:</td><td>Number of RPCs receiving one annual evaluation</td></tr><tr><td>Denominator:</td><td>Number of RPCs</td></tr><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr></table>		Numerator:	Number of RPCs receiving one annual evaluation	Denominator:	Number of RPCs	Unit Type:	Percentage	Unit Number:	100
Numerator:	Number of RPCs receiving one annual evaluation									
Denominator:	Number of RPCs									
Unit Type:	Percentage									
Unit Number:	100									
Data Sources and Data Issues:	Women's Health Program Data, Regional Perinatal Center Data									
Significance:	Very low birth weight infants (<1,500 grams or 3.25 pounds) are the most fragile newborns. Although they represented less than 2% of all births in 2010, VLBW infants accounted for 53% of all infant deaths, with a risk of death over 100 times higher than that of normal birth weight infants (≥2,500 grams or 5.5 pounds). VLBW infants are significantly more likely to survive and thrive when born in a facility with a level-III Neonatal Intensive Care Unit (NICU), a subspecialty facility equipped to handle high-risk neonates. In 2012, the AAP provided updated guidelines on the definitions of neonatal levels of care to include Level I (basic care), Level II (specialty care), and Levels III and IV (subspecialty intensive care) based on the availability of appropriate personnel, physical space, equipment, and organization. Given overwhelming evidence of improved outcomes, the AAP recommends that VLBW and/or very preterm infants (<32 weeks' gestation) be born in only level III or IV facilities. This measure is endorsed by the National Quality Forum (#0477).									

ESM 4.1 - 3.1.1 Number of birthing hospitals that participate in the 5-STAR Hospital Initiative

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

Measure Status:	Active	
Goal:	Increase the number of birthing hospitals that participate in the 5-STAR Hospital Initiative	
Definition:	Numerator:	Number of birthing hospitals participating in the 5-STAR Hospital Initiative
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	40
Data Sources and Data Issues:	Data Source: Women's Health 5-STAR Initiative Program Data	
Significance:	<p>The health effects of breastfeeding are well recognized. Breast milk is uniquely suited to the human infant’s nutritional needs and is a live substance with unparalleled properties that protect against a host of illnesses and diseases for both mothers and children. Breast milk promotes sensory and cognitive development, and protects the infant against infectious and chronic diseases. Exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhea or pneumonia, and helps for a quicker recovery during illness. These effects can be measured in resource-poor and affluent societies (Kramer M et al Promotion of Breastfeeding Intervention Trial (PROBIT): A randomized trial in the Republic of Belarus. Journal of the American Medical Association, 2001, 285(4): 413-420). The Baby-Friendly Hospital Initiative (BFHI) is a global program that was launched by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) in 1991 to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. Becoming a Baby-Friendly facility is a comprehensive, detailed and thorough journey toward excellence in providing evidence-based, maternity care with the goal of achieving optimal infant feeding outcomes and mother/baby bonding. It compels facilities to examine, challenge and modify longstanding policies and procedures. It requires training and skill building among all levels of staff. Georgia's 5-STAR Initiative models the Baby-Friendly Initiative encouraging 5 of the 10 steps towards a baby-friendly designation.</p>	

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

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

Measure Status:	Active	
Goal:	increase the number of Train-the-Trainer workshops conducted from 0 to 6	
Definition:	Numerator:	Number of Train-the-Trainer workshops conducted
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	6
Data Sources and Data Issues:	Data Source: Women's Health Program Data	
Significance:	<p>The health effects of breastfeeding are well recognized. Breast milk is uniquely suited to the human infant's nutritional needs and is a live substance with unparalleled properties that protect against a host of illnesses and diseases for both mothers and children. Breast milk promotes sensory and cognitive development, and protects the infant against infectious and chronic diseases. Exclusive breastfeeding reduces infant mortality due to common childhood illnesses such as diarrhea or pneumonia, and helps for a quicker recovery during illness. These effects can be measured in resource-poor and affluent societies (Kramer M et al Promotion of Breastfeeding Intervention Trial (PROBIT): A randomized trial in the Republic of Belarus. Journal of the American Medical Association, 2001, 285(4): 413-420). The Baby-Friendly Hospital Initiative (BFHI) is a global program that was launched by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) in 1991 to encourage and recognize hospitals and birthing centers that offer an optimal level of care for infant feeding and mother/baby bonding. Becoming a Baby-Friendly facility is a comprehensive, detailed and thorough journey toward excellence in providing evidence-based, maternity care with the goal of achieving optimal infant feeding outcomes and mother/baby bonding. It compels facilities to examine, challenge and modify longstanding policies and procedures. It requires training and skill building among all levels of staff. Georgia's 5-STAR Initiative models the Baby-Friendly Initiative encouraging 5 of the 10 steps towards a baby-friendly designation.</p>	

ESM 6.1 - 6.1.1. Number of public health districts using at least two developmental screening methods regularly
NPM 6 – Percent of children, ages 9 through 35 months, who received a developmental screening using a parent-completed screening tool in the past year

Measure Status:	Active	
Goal:	Increase the types of developmental screening methods that are regularly used in each public district from one to a minimum of two	
Definition:	Numerator:	Number of districts with at least two developmental screening methods being used regularly
	Denominator:	Number of public health districts
	Unit Type:	Count
	Unit Number:	20
Data Sources and Data Issues:	Data Source: Child Health Program Data	
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.	

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

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

Measure Status:	Active	
Goal:	Increase the number of formal training opportunities on developmental screening conducted in each public health district each year	
Definition:	Numerator:	Total number of formal training opportunities on developmental screening conducted in each public health district each year
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	45
Data Sources and Data Issues:	Data Source: Child Health Program Data	
Significance:	Early identification of developmental disorders is critical to the well-being of children and their families. It is an integral function of the primary care medical home. The percent of children with a developmental disorder has been increasing, yet overall screening rates have remained low. The American Academy of Pediatrics recommends screening tests begin at the nine month visit.	

ESM 8.1.1 - Percent of children, in grades 1-12 enrolled in public school physical education class, who are in the Healthy Fitness Zone (HFZ) for Body Mass Index (BMI)

NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active	
Goal:	Increase the percent of children, in grades 1-12 enrolled in public school physical education class, who are in the Healthy Fitness Zone (HFZ) for Body Mass Index (BMI)	
Definition:	Numerator:	Number of children enrolled in public school physical activity class, in grades 1-12, who are in the HFZ for BMI
	Denominator:	Total number of children enrolled in public school physical education class, in grades 1-12
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Data Source: Georgia SHAPE, DOE Fitnessgram	
Significance:	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.	

ESM 8.2.1 - 7.1.1. Average HFZ measure (aerobic capacity) among students in grades 4-12**NPM 8.2 – Percent of adolescents, ages 12 through 17 who are physically active at least 60 minutes per day**

Measure Status:	Active	
Goal:	Increase the average HFZ measure (aerobic capacity) among students in grades 4-12 by 4%	
Definition:	Numerator:	Aerobic capacity, HFZ measure (males and females), for students grades 4-12
	Denominator:	Total attempts (males and females) for students grades 4-12
	Unit Type:	Percentage
	Unit Number:	100
Data Sources and Data Issues:	Data Source: Georgia SHAPE	
Significance:	Regular physical activity can improve the health and quality of life of Americans of all ages, regardless of the presence of a chronic disease or disability. Physical activity in children and adolescents reduces the risk of early life risk factors for cardiovascular disease, hypertension, Type II diabetes, and osteoporosis. In addition to aerobic and muscle-strengthening activities, bone-strengthening activities are especially important for children and young adolescents because the majority of peak bone mass is obtained by the end of adolescence.	

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

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

Measure Status:	Active	
Goal:	Increase the number of youth, families and professionals trained on health care transition	
Definition:	Numerator:	Number of youth, families, professionals trained on health care transition
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	1,000
Data Sources and Data Issues:	Data Source: Children's Medical Services Program Data	
Significance:	Health care transition is the process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.	

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

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

Measure Status:	Active	
Goal:	Increase the number of pediatric and adult medical providers who have a health care transition policy within their practice	
Definition:	Numerator:	Number of pediatric and adult medical providers who have a health care transition policy within their practice
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	45
Data Sources and Data Issues:	Data Source: Children's Medical Services Program Data	
Significance:	Health care transition is the process of changing from a pediatric to an adult model of health care. The goal of transition is to optimize health and assist youth in reaching their full potential. To achieve this goal requires an organized transition process to support youth in acquiring independent health care skills, preparing for an adult model of care, and transferring to new providers without disruption in care.	

ESM 13.1.1 - 11.1.1. Number of comprehensive webinars/presentations offered
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active	
Goal:	Increase the number of comprehensive webinars/presentations offered to health professionals from 0 to 20	
Definition:	Numerator:	Number of comprehensive webinars/presentations offered
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	20
Data Sources and Data Issues:	Data Source: Oral Health Program Data	
Significance:	<p>Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.</p>	
	<p>Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children’s health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.</p>	
	<p>State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.</p>	

ESM 13.2.1 - 11.1.2. Number of dentists, hygienists and staff educated on four specific dental services for individuals with special needs and the oral health connection and services

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

Measure Status:	Active	
Goal:	Increase the number of dentists, hygienists and staff educated on four specific dental services for individuals with special needs and the oral health connection and services from 0 to 40	
Definition:	Numerator:	number of dentists, hygienists and staff educated on four specific dental services for individuals with special needs and the oral health connection and services
	Denominator:	Not applicable
	Unit Type:	Count
	Unit Number:	45
Data Sources and Data Issues:	Data Source: Oral Health Program Data	
Significance:	Oral health is a vital component of overall health. Access to oral health care, good oral hygiene, and adequate nutrition are essential component of oral health to help ensure that children, adolescents, and adults achieve and maintain oral health. People with limited access to preventive oral health services are at greater risk for oral diseases.	
	Oral health care remains the greatest unmet health need for children. Insufficient access to oral health care and effective preventive services affects children's health, education, and ability to prosper. Early dental visits teach children that oral health is important. Children who receive oral health care early in life are more likely to have a good attitude about oral health professionals and dental visits. Pregnant women who receive oral health care are more likely to take their children to get oral health care.	
	State Title V Maternal Child Health programs have long recognized the importance of improving the availability and quality of services to improve oral health for children and pregnant women. States monitor and guide service delivery to assure that all children have access to preventive oral health services. Strategies for promoting oral health include providing preventive interventions, such as dental sealants and use of fluoride, increasing the capacity of State oral health programs to provide preventive services, evaluating and improving methods of monitoring oral diseases and conditions, and increasing the number of community health centers with an oral health component.	

Form 11
Other State Data
State: Georgia

The Form 11 data are available for review via the link below.

[Form 11 Data](#)