Georgia Five Year Needs Assessment for the Maternal and Child Health Services Title V Block Grant

July 15, 2010

State of Georgia
Department of Community Health
Division of Public Health
Maternal and Child Health Program
MCH Services Title V Block Grant Five Year Needs Assessment

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INTRODUCTION

GEOGRAPHIC DESCRIPTION

Georgia is bordered on the south by Florida; on the east by the Atlantic Ocean and South Carolina; on the west by Alabama; and on the north by Tennessee and North Carolina. The highest point in Georgia is Brasstown Bald, 4,784 feet (1,458 m); the lowest point is sea level.(1) With an area of 59,425 square miles (153,909 km^2), Georgia is ranked 24th in size among the 50 US states. Georgia is the largest state east of the Mississippi River in terms of land area, although it is the fourth largest (after Michigan, Florida, and Wisconsin) in total area, a term which includes expanses of water which are part of state territory.(1)

DEMOGRAPHICS

Since 1990, Georgia's population has increased over 50 percent, moving it from the 11th to 9th largest state in the nation.(2) The state's growth comes from a combination of natural increase (i.e., births versus deaths) and domestic and international migration. The explosive increase experienced by the Sunbelt states, including Georgia, through the most of this decade slowed dramatically with the onset of the economic recession beginning in late 2007. Nevertheless, from July 2000 to July 2009, the state's population increased by 1.6 million, reaching a total population of 9,829,200.(2) While the rate of population growth has slowed, Georgia has remained among the fastest growing states in the nation, exceeded only by Texas, California, and North Carolina.(3) Georgia was 4th largest in terms of new residents and 9th largest in terms of percent gain.(3) Given this population gain, the state anticipates an increase of one more congressional seat following the outcome of the 2010 US Census.

Based on birth, deaths, and migration trends, the Governor's Office of Planning and Budget has estimated that Georgia's 2030 population will grow to 14.7 million, an increase of 4.6 million residents.(4) Although the growth rate for this period is projected to be lower than the very rapid growth of the 1990s, it is similar to that of the most recent decade. With this growth comes increasing demands on state and local government to provide necessary services, including health care.(5)

The result of this fundamental shift in Georgia's population has changed the state from a largely rural area with urban clusters to an urban state with rural areas. In the past 25 years, Georgia has been described in terms of "two Georgias" – 1) economically strong urban and 2) less economically advantaged rural. Over the last decade, however, the state's population has become segmented into four distinct groupings among Georgia's 159 counties.(6) These are:

- Urban – 14 counties that form the core centers for Georgia's 15 metropolitan statistical areas (MSAs)
- Suburban – 56 counties located in the 15 Georgia MSAs
- Rural growth – 30 rural counties with small core urban areas that serve as a stimulus for supporting the local economy
- Rural decline – 30 counties, almost all located in south Georgia, experiencing population declines

Georgia and Surrounding States

Office of Health Indicators for Planning (OHIP)
Epidemiology Branch
Division of Public Health
Georgia Department of Community Health

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Created: June 2010
Source: Division of Public Health
Projection: Georgia Statewide Lambert Conformal Conic

URBAN COUNTIES

The seven historical MSAs in Georgia are

- Atlanta (Fulton/DeKalb Counties)
- Columbus (Muscogee County)
- Albany (Dougherty County)
- Athens (Clarke County)
- Savannah (Chatham)
- Macon (Bibb County)
- Augusta (Richmond County).

Except for Athens, these MSAs focus around the state's older, well-established cities. These core areas are marked by well-developed urban infrastructures with upper and middle class areas as well as impoverished communities. While the core counties of Fulton and DeKalb in the Atlanta MSA and, to a lesser extent, Clarke County in the Athens MSA have continued to grow, the core counties in the other MSAs have evidenced population and economic declines as their central cores deteriorate, while surrounding suburban areas expand.

Based on the 2000 Census, seven new MSAs were designated in areas that were previously classified as rural. These MSAs are:

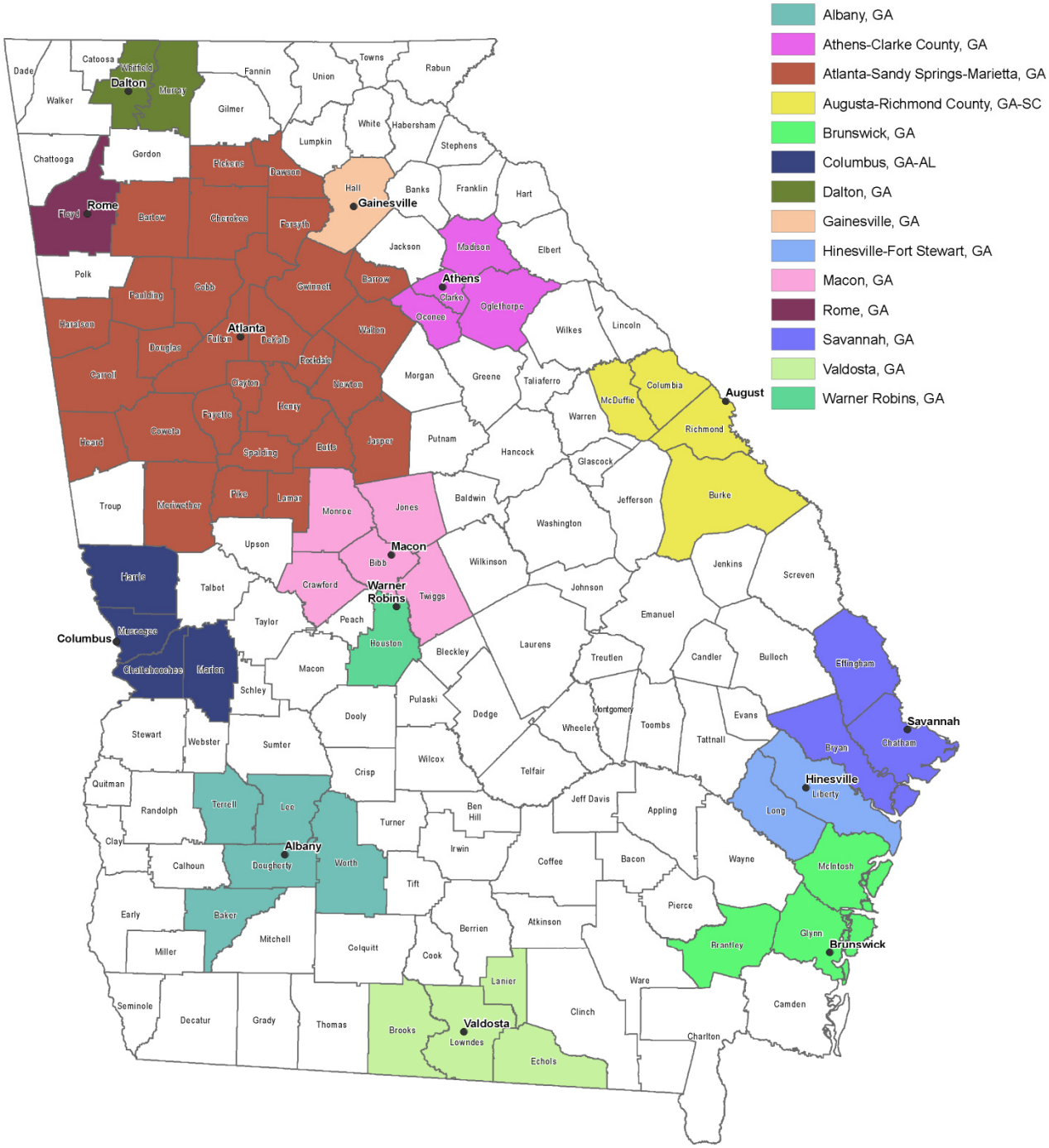
- Brunswick (Glynn County)
- Hinesville/Fort Stewart (Liberty County)
- Valdosta (Lowndes County)
- Warner-Robbins (Houston County)
- Dalton (Whitfield County)
- Gainesville (Hall County)
- Rome (Floyd County) in northern Georgia

With these designations, there is a contiguous urban area stretching from Chattanooga, Tennessee, through Atlanta into east-central Alabama and another contiguous urban area, with the exception of two counties, reaching from Augusta along the Savannah River down through Savannah and along the coast to Jacksonville, Florida. These MSAs are marked by their location along the interstate highway system, which was built in the 1970s.

SUBURBAN COUNTIES

The number of suburban counties in Georgia more than doubled from 27 to 56 in the decade between the 1990 Census and 2000 Census. Eight suburban counties were added as a result of the expansion of the Atlanta MSA; eight were included as expansions of the other historical MSAs; and the remaining 40 counties are part of the recently designated MSAs described above. All 56 of these counties were classified as rural until their re-designation. They obtained their status as metropolitan areas because more than one-quarter of their residents commute into the core or central city of the MSA to work.

Georgia's Metropolitan Statistical Areas



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The largest growth, both geographically and population-wise, occurred in the suburban areas surrounding Atlanta. Eight new counties were added. Only one, Dawson County, was north of the city. The remaining seven counties were all to the south and west. The designated Atlanta MSA extends into Alabama, with a size exceeding Massachusetts, the ninth smallest state in the US, and a combined income larger than 35 of the 50 states. Fifty-six percent of the entire state's population lives in the Atlanta MSA. Metro Atlanta now covers 14.5 percent of the state's area, resulting in a footprint that makes Atlanta the sixth largest MSA in the country. The Atlanta MSA ranks among the nation's largest ten metro areas in both population and area.

Population-wise, Fulton County remains the largest county in the state and the Atlanta MSA with 1,033,000 residents. Gwinnett has become the second largest county in the MSA with 880,000 people, and DeKalb County is now the third largest with 740,000 residents. The remaining two counties in the core Atlanta MSA are Cobb (715,000) and Clayton (276,000). While Gwinnett County has experienced the most significant growth, all five counties, except for Clayton, have seen population increases in the past five years. The greatest growth, however, has been experienced in the suburban counties surrounding the five core counties, Forsyth, Henry, Newton, and Paulding. These counties have consistently ranked among the twenty fastest growing counties in the US.(7)

Georgia Office of Planning and Budget projections suggest that all regions of the state and almost all counties are expected to grow over the next 20 years. Northern and coastal regions of the state are projected to experience fast paced growth. Metro Atlanta will remain the most densely populated part of the state, with two out of five Georgians living in the region.(8)

The emergence of issues traditionally associated with core urban areas has accompanied the state's population influx. Social problems such as juvenile crime, gangs, drug trafficking and use, and child and domestic abuse are increasing along with the need for basic infrastructure for education, health and child care services.

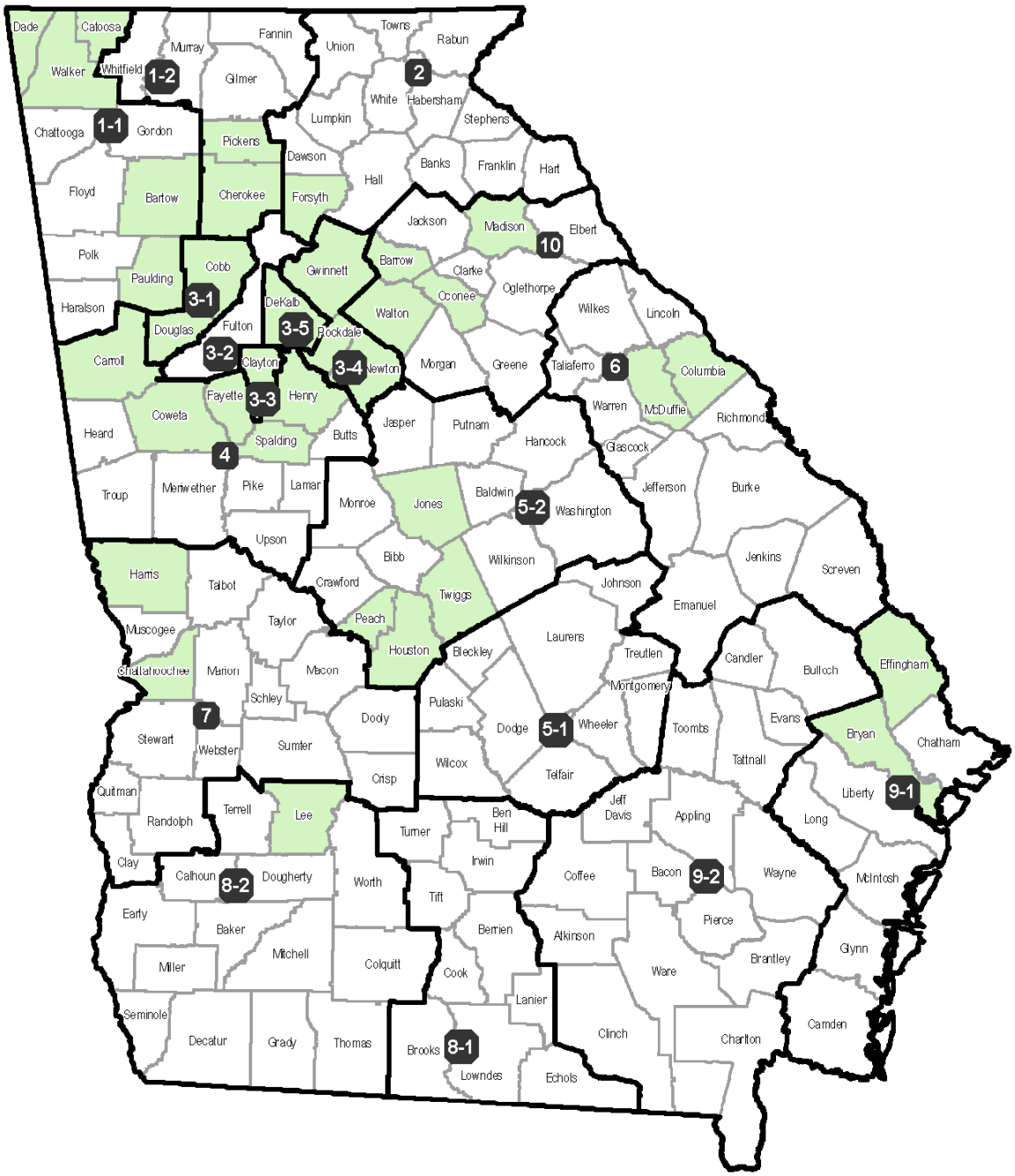
GROWING RURAL COUNTIES

These 30 non-metropolitan or rural areas are characterized by some type of physical landscape that makes them attractive places for tourists and/or retirees. Some of them are located near military centers or regional growth centers that can sustain or attract economic growth.

DECLINING RURAL COUNTIES

A population decline in these 30 counties has occurred during the past decade. These counties have lost population because of a lack of diversified economy, with downturns in the agriculture and timber industries, and the inability of the counties' small-scale economies to withstand the overall state and national recession.

Suburban Counties



1-1 Northwest Health District (Rome)
1-2 North Georgia Health District (Dalton)
2 North Health District (Gainesville)
3-1 Cobb/Douglas Health District
3-2 Fulton Health District
3-3 Clayton County Health District (Jonesboro)
3-4 East Metro Health District (Lawrenceville)
3-5 DeKalb Health District
4 LaGrange Health District
5-1 South Central Health District (Dublin)
5-2 North Central Health District (Macon)
6 East Central Health District (Augusta)
7 West Central Health District (Columbus)
8-1 South Health District (Valdosta)
8-2 Southwest Health District (Albany)
9-1 Coastal Health District (Savannah)
9-2 Southeast Health District (Waycross)
10 Northeast Health District (Athens)

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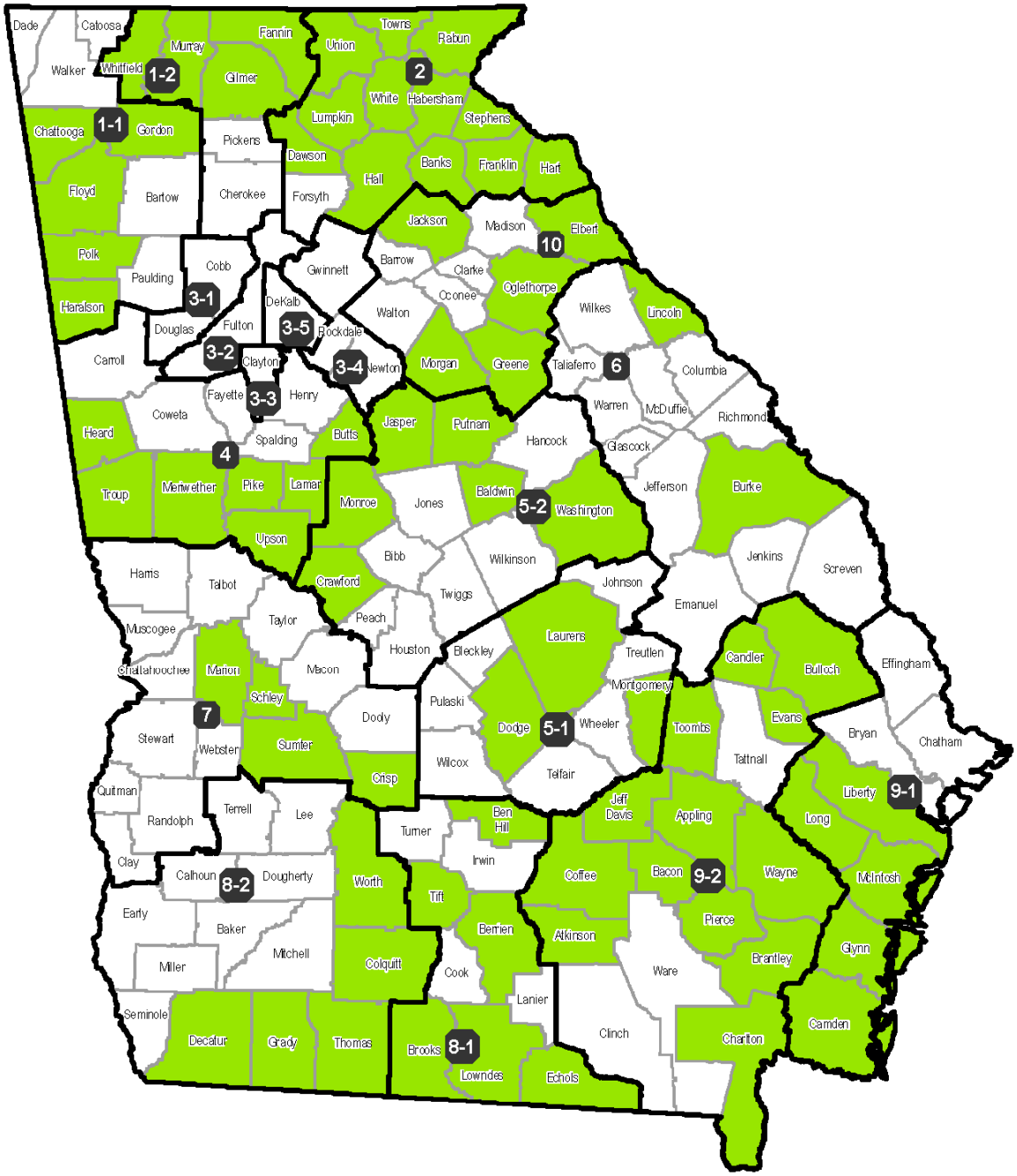
Growing Rural Counties



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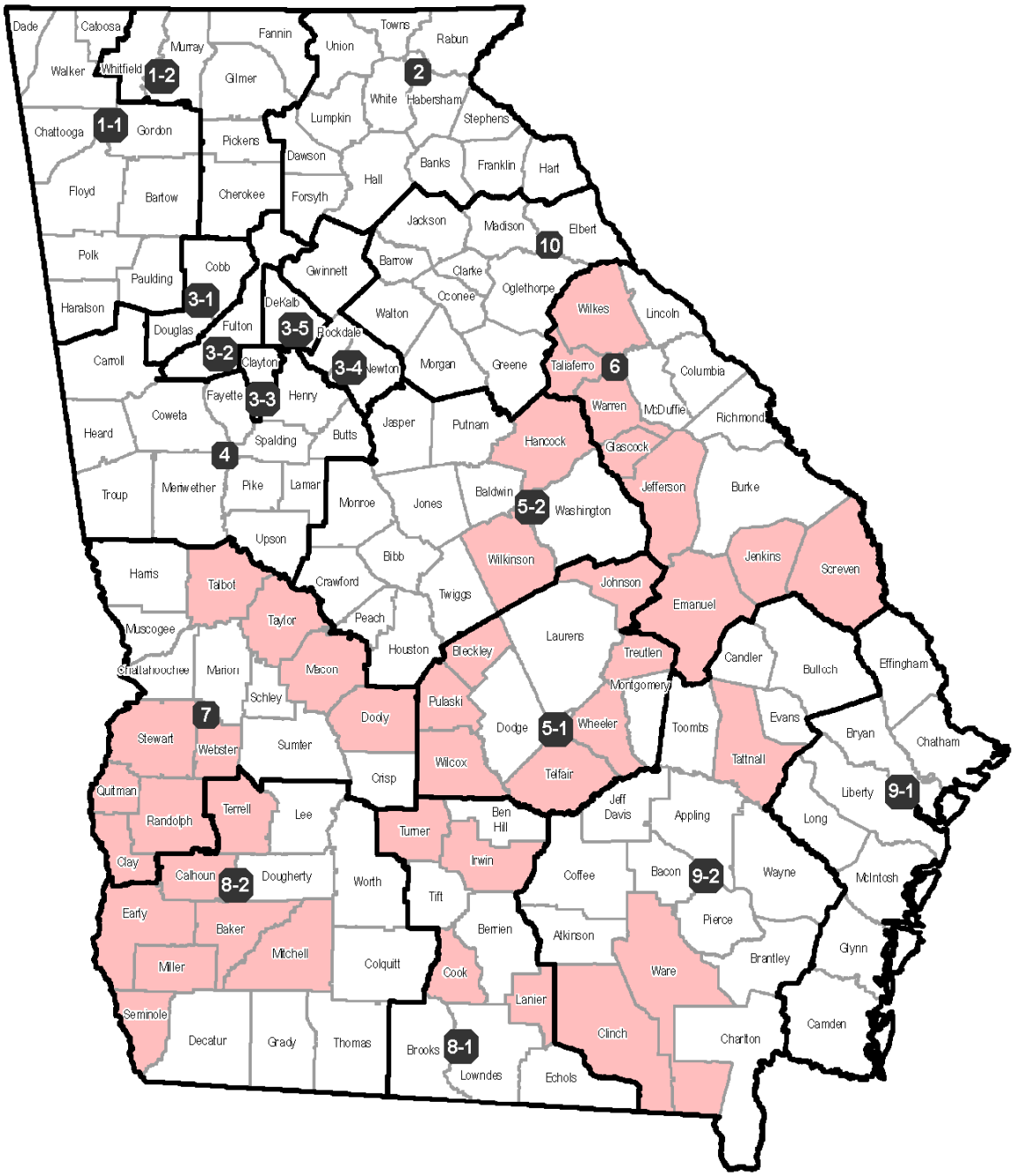
Declining Rural Counties



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10 Northeast Health District (Athens)

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Office of Health Indicators for Planning (OHIP)
Epidemiology Branch
Division of Public Health
Georgia Department of Community Health

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Created: June 2010
Source: Division of Public Health
Projection: Georgia Statewide Lambert Conformal Conic

GEORGIA'S POLITICAL FRAMEWORK

While population is a significant consideration in service and delivery planning, the political framework is also an important factor. With 159 counties, Georgia has the second highest number of any state. Four of these counties, all in the Atlanta MSA, have populations in excess of 700,000 (Fulton, Cobb, DeKalb and Gwinnett) with no other county in the state exceeding a population of 276,000. In addition to these four, there are 18 counties having populations of over 100,000, with 10 of these 18 counties located in the Atlanta MSA. The remaining 137 counties have fewer than 100,000 population with 87 of them having populations of less than 25,000 and 30 counties with a population of fewer than 10,000. Many counties, especially those with small tax bases that have been impacted by the economic recession that reduced local revenues and decreased state allocations, are challenged to support local services, such as health, education and social services.(6)

POPULATION CHARACTERISTICS

While population growth portrays one aspect of the recent trends in Georgia, underlying shifts in the composition and characteristics of the state's population illustrate further changes. The chart that follows highlights these changes.

Georgia Population Changes, 2000 through 2008, US Census Bureau

Population Characteristics	2000 Census		2006-2008 American Community Survey 3-Year Estimates	
	Number	Percent	Number	Percent
Age				
Under 5 years	595,150	7.3	723,818	7.6
5 to 9 years	615,584	7.5	686,550	7.2
10 to 14 years	607,759	7.4	680,016	7.2
15 to 19 years	596,277	7.3	696,423	7.3
20 to 24 years	592,196	7.2	652,645	6.9
25 to 44 years	2,652,764	32.4	2,806,671	29.5
45 years and older	2,526,723	30.9	2,771,331	34.4
Gender				
Male	4,027,113	49.2	4,676,016	49.2
Female	4,159,340	50.8	4,833,238	50.8
Race/Ethnicity				
White	5,327,281	65.1	5,911,318	62.2
Black/African American	2,349,542	28.7	2,824,572	29.7
Asian	173,170	2.1	266,911	2.8
American Indian/Alaska Native	21,737	0.3	23,504	0.2
Some other race	196,289	2.5	353,940	3.7
Two or more races	114,188	1.4	124,395	1.3
Hispanic/Latino	435,227	5.3	729,604	7.7

Georgia Population Changes, 2000 through 2008, US Census Bureau				
	2000 Census		2006-2008 American Community Survey 3-Year Estimates	
Population Characteristics	Number	Percent	Number	Percent
Place of Birth				
Born in US	7,519,654	91.9	8,530,425	89.7
Born in Georgia	4,735,652	57.8	5,292,707	55.7
Born in different state	2,784,002	34.0	3,237,717	34.0
Born outside of US	577,273	7.1	873,670	9.2
Foreign born, entered US since 2000	344,763	4.2	323,333	37.0
Language Spoken at Home				
English only	6,843,038	90.1	7,725,470	87.9
Language other than English	751,438	9.9	1,059,966	12.1
Household Type				
Family household with own children under 18	1,051,302	35.0	1,133,643	33.1
Married couple or family with own children under 18	732,734	24.4	756,178	22.1
Female household, no husband present, with own children under 18	258,006	8.6	306,036	8.9
Male household, no wife present, with own children under 18	60,562	2.0	71,429	2.1
Households with individuals under 18	1,174,114	39.1	1,270,845	37.1
Grandparents responsible for grandchildren in households with grandparent living in household	92,265	4.7	102,868	10.5
Educational Attainment				
Less than 9th grade	393,197	7.6	375,048	6.2
9th to 12th grade, no diploma	718,152	13.8	660,561	10.9
High school graduate	1,486,006	28.8	1,819,993	30.0
Some college/Associate's degree	1,328,432	25.6	1,180,782	19.5
Bachelor's degree	829,873	16.0	1,065,874	17.6
Graduate or professional degree	430,305	8.3	574,440	9.5
Percent high school graduate or greater		78.6		82.9
Percent bachelor's degree or higher		24.3		27.0

RACE/ETHNICITY

US Census data highlight the exceptional growth and increasing diversity of Georgia. Georgia ranks 3rd nationally, behind New York and Florida, in the number of Black people (2,864,431) and 3rd in the percentage of Black people (30.1 percent) in the overall population of the state, trailing Mississippi and Louisiana.(7)

Reflecting national trends, the number of Asians and Hispanics in Georgia have shown dramatic increases, which are projected to continue. Prior to the 1990s, almost all of the foreign born people living in Georgia were either migrant agricultural workers or a small nucleus of Southeast Asian people

and Mexican people in the core Atlanta area. With the booming economy in the early 1990s, these already settled residents, mostly men, formed the foundation for supportive communities that brought relatives, friends and neighbors to the state. Hispanic people, primarily Mexican people, are the most rapidly growing minority group (729,604) and now reside throughout Georgia. This growth impacts the provision of government and health, education, and human services in the state.(9) For example, the number of Hispanic children has risen dramatically in schools across the state. One impact of this has been an increased need for English as a second language classes and teachers who are bilingual. A policy brief by the Georgia State University Andrew Young School of Policy Studies on the economic implications of the state's increasing Hispanic population, both legal and undocumented, concluded that "Undeniably, the rapid increase in the Hispanic population and the numbers of undocumented workers in particular are associated with increased costs in terms of education, health care, and other government expenses. However, estimating the net effect must take into account short-term and long-term effects."(10) The study notes that the additional expenses related to immigrants can be a significant short-term burden to both individuals and society, but long-term gains can be positive.(10)

Until recently, Georgia's Asian population consisted of small numbers of Koreans and Chinese settling in the metro Atlanta area. Over the last 20 years, the number of Asians (266,911) has increased along with significant diversification. Large numbers have arrived from Southeast Asia – Vietnam, Philippines, Laos, Thailand, Cambodia, and from the India subcontinent. Many people from India and Pakistan settled in the state's metro areas. People from India now constitute the largest Asian population group (77,500) in the state.(10)

Driven by upheavals and economic conditions in their countries of origin, over the past five years waves of eastern European and African people also migrated to Georgia. In particular, African and Asian people displaced by famine and war have arrived as refugees from Ethiopia, Somalia, Eritea, and African people from other nations have arrived seeking economic opportunities. In 2008, Georgia accepted 2,824 refugees with the largest numbers coming from Iraq, Thailand, Cuba, Burma, Bhutan, Malaysia, and Nepal. The countries of origin of the refugees has changed dramatically in the last several years, requiring different language skills and cultural competencies to serve these groups.(11)

The Department of Homeland Security estimated that the percentage of unauthorized immigrants in Georgia increased 115 percent from 2000 to 2009, going from 220,000 to 480,000 persons.(9) Georgia now has the 6th largest number of unauthorized immigrants. While other states experienced a decline in unauthorized immigrants due to the economic situations, Georgia has been one of the few states to continue to see an increase in unauthorized immigrants.

AGE

Georgia's population continues to be younger compared to the US as a whole, ranking 5th in terms of the percentage with the largest population under 18 years of age (26.5 percent).(12) Of the state's population 724,000 were under the age of five, with another 1.37 million children school-age between five and 19 years of age. The median age of the population in Georgia was 34.8 years in 2008. (US Census: State Resident Population by Age) Of note, in 2008 following a national trend, the number of babies born in Georgia declined for the first time by almost a 1,000 births to 146,411.(13)

LANGUAGE PROFICIENCY

Of individuals five years of age or older living in Georgia in 2006-2008, twelve percent spoke a language other than English at home.(14) Statewide, about five percent of the state's public school students have limited proficiency in English, but school systems vary greatly, ranging from zero percent to 29 percent. Nine school systems in Georgia have ten percent or more of students who have limited English proficiency; another 29 systems have between five percent and nine percent.(15)

FAMILY HOUSEHOLD TYPE

According to the US Census Bureau, from 2006 through 2008, Georgia had 3.4 million households. Families accounted for 68 percent of these households, including married couple families (48 percent) and other families (19 percent).(16)

EDUCATIONAL ATTAINMENT

Georgia law requires that students attend a public or private school or a home study program from their sixth to sixteenth birthdays. Public kindergarten is available in every school system, but it is not mandatory. Georgia also provides a public pre-kindergarten program for children who are four years old on or before September 1 of each year. The program is administered by Bright from the Start: Georgia Department of Early Care and Learning (DECAL).(17)

In 2009, there were 205 school districts and 2,601 schools. Almost 191,000 children were enrolled in nursery school or preschool in 2008; 143,100 children in kindergarten; 1,092,700 in grades one through eight; and 551,200 youth in grades nine through twelve.(18) A National Association of State Boards of Education (NASBE) secondary school profile indicates that approximately 6 percent of the Georgia's secondary students (academic year 2007-2008) had limited English; 12 percent had disabilities, and 50 percent were from low income backgrounds. The average freshman graduate rate was 62 percent and the college enrollment rate was 69 percent.(19)

In 2006-2008, 83 percent of Georgians 25 years of age and older had at least graduated from high school; 27 percent had a bachelor's degree or higher; and 17 percent were high school dropouts who were not currently enrolled in school and had not graduated from high school.(19)

INCOME

Georgia's per capita income has been lower than the national average since 1997. However, the lower per capita income, a measure of well-being, has been offset until recently by the state's cost of living which has remained relatively low, enabling Georgia residents to "do more with the income they do earn."(15) Reflecting the economic downturn, the state's per capita personal income decreased from $34,612 in 2008 to $33,786 in 2009. Georgia ranks 39th among all states.(16)

EMPLOYMENT

Georgia continues to experience declining employment. In March 2010, Georgia had 3,807,500 jobs, down 3 percent (116,000 jobs) from March 2009. The state's March 2010 unemployment rate was a record 10.6 percent.(17) Reflecting the high unemployment rate, Georgia has the 7th highest foreclosure rate. In the first quarter of 2010, there were 39,911 foreclosure filings, a 30.5 percent increase over the fourth quarter of 2009 and 39.5 percent from the first quarter of 2009.(18)

Despite the continued rise in the state's unemployment rate, there are signs of improvement. The pace of new layoffs is slowing. Between 2009 and 2010, first-time claims for unemployment insurance decreased 28 percent from a year earlier, and modest job growth has been documented over two consecutive months (February and March 2010), suggesting that the worst of the recession may be over and the state's "fledgling recovery may be gaining traction."(19)

With the increase in the unemployment and foreclosure rates over the previous two years, the number of Georgians who receive Medicaid and food stamps increased substantially. Many of the new applicants for these services have never sought public assistance before but have lost their jobs and/or homes. Between December 2008 and December 2009, the state saw a 9 percent (57,282 new cases) increase in Medicaid cases and a 32 percent (156,777 new cases) jump in food stamp cases during that same time period.(20) The increased need for support places a strain on a state government that is already struggling to deal with huge revenue shortfalls.

POVERTY

In 2008, 19.3 percent (1,829,400) of Georgians were under 100 percent of the federal poverty level (FPL) compared to 18.3 percent nationally. An additional 6.2 percent (591,100) were between 100 and 133 percent of FPL (6.4 percent US) and 28.6 percent (2,711,800) were between 134 and 300 percent of FPL (28.9 percent US).(21). State residents living in non-metropolitan areas were more likely to experience poverty. Twenty-five percent of non-metro residents lived below the FPL in 2008 compared to 18 percent of persons living in metropolitan areas of the state. Disparities in poverty rates are also seen by race/ethnicity with 11.5 percent of White people living in poverty compared to 31.9 percent of Black people and 32.2 percent of Hispanic people.(21)

According to the National Center for Children in Poverty (NCCP), of Georgia's 1,402,694 families, with 2,484,182 children, 42 percent of these children lived in low-income (income below twice the FPL) families in 2008. In particular, young children (birth to age five) are likely to live in low-income families. Twenty-six percent of Georgia's young children (birth to age five) live in a low-income family with income less than 100 percent of FPL, 22 percent live in families with incomes 100-200 percent of FPL, and 52 percent live above low income in 2008.(22) Fifty-eight percent of the young children in low-income families lived with a single parent. Children living in minority families and children of foreign-born parents have a greater chance of living in a low-income family. Thirty percent of young white children lived in a low-income family in 2008 compared to 64 percent of young black children and 71 percent of young Hispanic children.(22)

CHILDREN IN FOSTER CARE

Approximately 8,000 Georgia children are in the state's foster care system. Children enter foster care either through the state's social service system to protect them against abuse or neglect or through the juvenile court system. Ten years ago, less than 10 percent of Georgia's foster children were placed in privately owned foster homes. Currently, about half (58 percent) of these children live in traditional foster homes, and a further breakdown is as follows: 16 percent in foster care with a relative other than a parent, 14 percent in group homes with treatment services, 5 percent in group homes without treatment services, 4 percent in a home with prospective adoptive parents, 2 percent at home under the supervision of a state case worker, and 1 percent in other settings. Many of the children have been diagnosed with mental illnesses, behavioral disorders, or both.(23) There are 336 licensed private foster care facilities in the state where neglected and abused children are placed. One hundred of these facilities receive direct state funding (more than $55 million in 2009).

HOMELESSNESS

On any given night, there are homeless men, women, and children sleeping in emergency shelters or transitional housing, cars, makeshift encampments, and on the street, or who are facing immediate loss of housing. The Georgia 2009 Report on Homelessness found that on a single night in January 2009, approximately 21,000 people were homeless in Georgia, a 20 percent higher estimate than in 2008.(24)

In addition to the unsheltered and sheltered homeless count provided by the 2009 Report on Homelessness, the Georgia Department of Education (DOE) reported that 15,700 students were homeless during the 2007-2008, an increase of 1,683 children from the previous school year.(24) Georgia ranks 49th in the number of homeless children (greater rank indicates more homeless children) according to a report from the National Center for Family Homelessness. The state's ranking reflects performance in four areas: child homelessness per capita (43rd), child well-being (41st), risk for child homelessness (48th), and state policy and planning (identified as inadequate).(25)

The Georgia Homeless Management Information System (HMIS) collects information on Georgia's homeless population. HMIS data indicates that 98,607 persons received homelessness prevention services in FY 2008. Eighty-eight percent of those receiving these services were individuals in families; 55 percent of the recipients were female. HMIS data also shows that statewide 15,870 people stayed in emergency shelters in State Fiscal Year (SFY) 2009 and 27,860 persons stayed in transitional housing. Forty-two percent of emergency shelter residents and 39 percent of transitional housing residents were female.(24)

In SFY 2009, over 4,100 adults and 4,450 children were provided with shelter through a Department of Human Services certified domestic violence agency. More than 3,500 additional victims of domestic violence were denied shelter during this time period because domestic violence shelter beds were full.(24)

JUVENILE DELINQUENCY

The Georgia Department of Juvenile Justice (DJJ) provides supervision, detention and a wide range of treatment and educational services for youths referred to the DJJ by the Juvenile Courts, and DJJ also

provides assistance or delinquency prevention services for at-risk youths through collaborative efforts with other public, private and community entities. Over 73,500 youths were served in 2008, including youths who were placed on probation, sentenced to short-term incarceration, or committed to the Department's custody by Juvenile Courts. The average length of stay was 218 days and the average daily population was 20,357.(26)

UNINSURANCE

Nearly one in four (24.6 percent) Georgians of working age was uninsured in 2008, before the full impact of the recession was felt.(31) Only four states (California, Texas, Florida, and New York) had more uninsured individuals than Georgia. The number of uninsured individuals would have been higher without the increase in public coverage of non-elderly individuals from 15.5 percent in 2000 to 19.9 percent in 2008.(32) Among the "young invincible," (adults ages 18 to 24) who are in prime child-bearing years, 40 percent of males and 34 percent of females were uninsured, an increase of almost 50 percent since 2000.(33)

Compared to White people under age 65, of whom 25.2 percent were uninsured, 66.2 percent of Hispanic people and 42.2 percent of Black people lack health insurance in Georgia.(34) Most uninsured Georgians (78.7 percent) are members of working families.(34) In total, it is estimated that there are now 1.7 million Georgians who do not have health insurance.(34) Care for these individuals is shifted to those who can pay, with doctors and hospitals charging third party payers more for the services provided for those with health insurance coverage, and in turn insurers are increasing the cost of premiums to pay for those shifted costs. The Center for American Progress has estimated that as a result of those costs passed on to consumers, Georgians paid an additional $330 for individual insurance premiums and $900 for family coverage premiums.(35)

Despite noted success in enrolling children into Georgia's Medicaid and PeachCare programs, 307,000 children are uninsured in Georgia. With one in nine children (12.1 percent) uninsured, Georgia ranks 5th in the nation in the number of uninsured children and 14th in the US for the percentage of children without health insurance. The vast majority of these children (86.2 percent) come from families where at least one parent works and over half (55.4 percent) live in two-parent households.(36) Almost three-quarters of the uninsured children live in families with low or moderate incomes, less than $40,000 for a family of four, an income within the current Medicaid and PeachCare eligibility range.(36)

Sixteen consecutive months of decline in state revenue have underscored the depth of Georgia's fiscal crisis. The SFY 2011 budget of $17.9 billion is $3.5 billion less than the SFY 2008 budget. One of the major approaches used to balance the SFY 2011 budget was initiation of a 1.45 percent fee on gross revenues (known as the 1.45 percent hospital bed tax) of 1.45 percent, which will enable Medicaid hospital, physician, and other provider reimbursement rates to remain stable.

A third of Georgia's overall state budget is used to buy medical services for public employees and the poor. Total state Medicaid expenditures are projected to be $1.7 billion in state fiscal year SFY 2011 (Note: low income Medicaid is $758,720,073 and Aged, Blind, Disabled is $916,469,015 for a total of $1,702,189,088. Low income Medicaid accounts for 37.8 percent of the DCH state fund budget and Aged, Blind, and Disabled is 45.7 percent. Information comes from June 10, 2010 presentation to the DCH Board.)

Georgia's health care and social assistance industry, the sixth-largest employment sector, is a major economic engine for the state. In 2008, the health care industry provided 381,000 jobs and contributed $24.6 billion to the state's Gross Domestic Product (GDP).(37)

EMERGING TRENDS

Although Georgia's economy has begun to show signs of recovery, economic experts suggest that the state's recovery will be slower than the rest of the nation because of its large number of businesses related to real estate and the construction industry and the impact of the financial crisis on Georgia's financial sector. It is anticipated that Georgia's economy will catch up with the nation's recovery mid-year 2011 with growth in transportation, education, retail, and hospitality industry jobs opening up by late 2010.(38) This growth will benefit from projected population increases. Recent US Census data (March 2010) indicated that Metro Atlanta's population is increasing at 1.6 percent and IHS Global Insight, an economic analysis organization, has predicted that Georgia will be among the five fastest growing states over the next five years.(39)

The 2010 General Assembly struggled to maintain basic state services in the face of declining state revenues. On April 29, 2010, the legislative session ended with the passage of a 2011 balanced budget of $17.8 billion. Legislators cut spending, increased or created dozens of state fees, and taxed hospital revenue. Education in particular was impacted by budget cuts with funding decreased by more than $600 million for schools and University System of Georgia universities and technical colleges.(40)

The 1.45 percent hospital bed tax is expected to raise $175 million as well as provide a match for additional federal Medicaid dollars. These dollars will be allocated to hospitals across the state with a high proportion of Medicaid patients. The full impact of the bed tax is not yet known, including to what degree the health care burden will increase for paying health care customers and insurance companies.(41)

The 2010 Georgia General Assembly also passed a proposed state constitutional amendment to fund an expanded trauma care network. If approved by the voters in November, 2010, it would impose an annual $10 fee on auto license tags to fund such services.

Georgia will elect a new governor in November 2010. S/he will face major issues including a shrinking state budget that must fund health programs, schools, parks, the state's prison system and a variety of other programs. Two years ago the budget was $21 billion; the SFY 2011 budget is $17.9 billion. Significant cuts have been made in all state programs along with staff furloughs and in some cases, increases in fees.

In addition, state finances this year were supported by more than $1 billion in federal stimulus money as well as millions of dollars in one-time funding or savings that will not be available next year. Even if Georgia's economy begins to show sustained recovery, it will take time for state government to make up lost financial ground. Georgia's new governor and the 2011 General Assembly that convenes in January 2011 will need to make difficult choices that will have impact on all state funded services, including Public Health and Maternal and Child Health.(42)

The full impact of the Health Reform legislation signed into law by President Obama in March 2010 is yet to be determined. "The law makes changes that affect health care quality, public health, the health care

workforce, and many other issues…"(43) Some reforms under the new law will take effect immediately; others will be phased in over the next four years. Beginning 2014, low-income Americans will be able to enroll in their state Medicaid program regardless of whether they have dependent children or a disability. In addition, children's coverage in Medicaid and CHIP is strengthened. CHIP is extended through Federal Fiscal Year (FFY) 2015 under existing rules; in 2016 states will receive a 23 percent increase in the portion of CHIP coverage paid for by the federal government. To receive federal funding, states will be required to maintain Medicaid and CHIP eligibility levels in place as of March 23, 2010, and they cannot enact any policies that make it more difficult to enroll in either program.

States will also be required to establish American Health Benefits Exchanges where eligible state citizens and small businesses can purchase health insurance. Individuals and families without health insurance who have incomes between 133 percent and 300 percent of the FPL will be eligible to receive a tax credit to defray the cost of coverage. Initially, private citizens will buy coverage through one exchange, and small businesses through another. Each state can elect to operate the exchanges directly or through a contracted entity.(43)

Establishment of the exchanges is expected to reduce the number of uninsured Americans (including 1.7 million Georgia residents) and expand coverage for many more citizens, such as those with pre-existing conditions. In addition to benefiting these individuals, increasing access to coverage may have an impact on the $1.7 billion in uncompensated care in Georgia, a health care burden that is frequently passed on to those with insurance.(44)

The new Health Reform legislation requires individuals to have a minimum level of insurance or pay a tax penalty, but it exempts people who would pay more than 8 percent of their income in premiums.(45) Some groups of individuals, however, will remain uninsured or under insured, including undocumented immigrants and younger people who may choose not to obtain coverage or cannot afford it. Beginning in 2014, eligible uninsured Americans must determine if they will buy at least minimum insurance coverage or if they will choose to pay a penalty of 1.95 percent or 1 percent of their taxable income, whichever is greater. The penalty will increase by 2016. However, key implementation decisions have not yet been made, including determination of minimum coverage standards (to be finalized by 2014) or reasonable premium costs. These decisions will have a significant impact on whether people choose to purchase insurance or pay a penalty. If they choose to wait to get coverage until they are sick, then costs may be driven up for those already participating in the system.(45)

The legislation also establishes a temporary high-risk pool to serve people who have lacked coverage during the six-month period prior to their application for pool coverage and who have pre-existing conditions. States can either choose to supplement an existing high-risk pool or other mechanism to serve the uninsured, establish a new one, or let HHS operate the pool. Georgia has decided not to establish a separate high-risk pool.

The new legislation also appropriates funding for consumer assistance and information; establishes a new internet portal through which residents in every state can learn about their insurance options; provides small business (25 or fewer full-time employees) with tax credits to help them pay premiums for employees' coverage; allows young adults to stay on their parents' group or individual insurance plans until age 26 years if the plans include coverage for dependent children, covers children's pre-existing conditions, and establishes appeals and patient protections.

It is estimated that by 2019, 1,170,000 Georgia citizens will gain health insurance coverage as result of the new health care reform.(46) Implementation of the health reform law will be complex and challenging, however. Over the next year, the federal Health and Human Services Administration (HHS) must begin to develop and issue the policies, regulation, procedures, and guidelines that will guide states in complying with the legislation. At the same time, states, including Georgia, must begin to assess the impact of the new law on health service delivery including the impact of expanding health coverage on hospital and provider capacity.(47)

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SECTION 1: PROCESS FOR CONDUCTING NEEDS ASSESSMENT

GOALS AND VISION

The Georgia MCH Program, which includes administration of funds provided to the state through the Title V Maternal and Child Health Services Block Grant, has undergone significant organizational and leadership change. In July 2009, the Division of Public Health, which includes the Georgia MCH Program, was organizationally relocated from the Department of Human Resources to the Department of Community Health. In addition to this organizational change, there have been significant leadership changes in the Division of Public Health, which included a new deputy director for programs and services (July 2009) and new director of the Division of Public Health (February 2010). In the Georgia MCH Program, the program director, who also serves as the Title V MCH director (January 2010), the Title V Children with Special Health Care Needs (CSHCN) director (June 2009), and director for the state's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) (November 2009) are all within twelve months of their start dates in their current positions. With these changes in programmatic leadership and direction, the Georgia Maternal and Child Health Program adopted a new mission and vision, which are:

> *Mission.* *To implement measurable and accountable services and programs that improve the health of women, infants, children, fathers, and families in Georgia.*
>
> *Vision.* *Through the implementation of evidence-based strategies and the use of program and surveillance data, identify and deliver public health information, direct services, and population-based interventions that have an impact on the health status of women, infants, children, fathers, and families in Georgia.*

These newly adopted mission and vision statements reflect the implementation of a new structural framework supporting data driven action. This structural framework emphasizes:

- more thorough analysis of existing data within Georgia
- expansion of data collection and surveillance activities to improve our understanding of health status within Georgia
- improved strategic planning, activity and plan development, and programmatic operations to improve health status driven by needs identified and supported by data analyses at the state level and among population and geographic subgroups
- increased program evaluation and monitoring to assess impact and return on investment

With these significant changes in the Georgia MCH Program framework and priorities, the vision for the 2010 Title V Maternal and Child Health Services Block Grant Needs Assessment is a document that will serve as a baseline for all future activities in MCH in Georgia and that will serve as a leverage point for sustaining existing collaborative relationships and seeding new collaborative relationships. The 2010 Georgia Title V Maternal and Child Health Services Block Grant Needs Assessment provides an opportunity to:

- conduct a thorough analysis of existing data
- collect information from stakeholders statewide to complement the existing quantitative data and identify emerging trend
- identify data gaps
- establish baselines for future activities in Georgia

Given the changes the Georgia MCH Program experienced through the previous two years, the 2010 Georgia Title V Maternal and Child Health Services Block Grant Needs Assessment presents an opportunity to gauge existing state capacity to address the needs identified through the analysis of quantitative and qualitative data. This information will help to guide staffing choices within the Georgia MCH Program, identify development needs, and prioritize the development of needed partnerships.

Through the 2010 Georgia Title V Maternal and Child Health Services Block Grant Needs Assessment, state priorities among women and infants, children, and children with special health care needs will be identified. These priorities will be reconciled with existing state resources and capacity, political feasibility, potential impact, measurability, and preventability to develop strategic plans and identify intervention points. Once strategic plans are developed and intervention points identified, statewide resources, including existing support and programs, will be catalogued to identify unique needs to ensure funding efficiency. This process will contribute to the development of the annual activity plans for the Title V national performance measures and state-developed performance measures and narratives for the health systems capacity indicators and health status indicators.

Building upon the meetings conducted as part of the 2010 Georgia Title V Maternal and Child Health Services Block Grant Needs Assessment, Georgia's MCH Program plans to host an annual stakeholders meeting to include consumers, representatives from families of children with special health care needs, health district and local health department staff, other state agencies, advocates, professional organizations, and statewide service organizations to assess annual progress on measures, review state priorities, review activity plans, identify activities in which others are willing to lead or participate, and provide general input for the annual Title V Maternal and Child Health Services Block Grant application. Through this annual meeting, a demand for updated data will be created through which the Georgia MCH Program can support the statewide transition to data driven action. The Georgia Division of Public Health maintains a user-friendly, Internet-based data analysis tool, Online Analytical Statistical Information System (OASIS), which will facilitate the production of the annual data updates.

LEADERSHIP

To conduct the 2010 Georgia Title V Maternal and Child Health Services Block Grant Needs Assessment, a Needs Assessment Workgroup (NAW) was formed. This group, which was led by the Georgia MCH Program Director, was tasked with the completion of Georgia's Title V Five-Year Needs Assessment. The NAW included the Director of the Capacity Building Section; the Deputy Director for the MCH Program; the Manager of the Children with Special Health Care Needs Unit, who is also the Title V CSHCN Director; the CDC Maternal and Child Health Epidemiologist assigned to Georgia; and other MCH and CSHCN staff and consultants. The NAW had limited ad hoc meetings beginning in October 2009. The primary focus of these initial NAW meetings was the development of a plan to ensure the involvement of families of children with special health care needs. With the arrival of new program leadership in January 2010, NAW meetings occurred more frequently either as a whole group or as smaller subgroups.

The NAW served as the day-to-day consulting team on all needs assessment activities to include information sharing, providing status updates on assigned activities, troubleshooting, and developing consensus on evolving issues. The major accomplishments and activities of the NAW follow.

- Building upon plans for engaging families of children with special health care needs, the NAW expanded the number of planned focus groups and developed a Gantt chart to guide the project and ensure all components identified in the federal guidance were addressed;
- To ensure standardization throughout the focus group process, the NAW developed a focus group guide (Appendix A). The focus group guide established protocols for data collection, focus group operation, and facilitator behavior. The focus group guide also provided context as to the purpose and need for the collection of qualitative data as part of the 2010 Needs Assessment.;
- The NAW was responsible for identifying quantitative data sets and selecting indicators to be included in the 2010 Needs Assessment;
- Following the collection and analysis of the qualitative and quantitative data, the NAW identified 54 needs that served as the frame for the selection of the state's top priority needs;
- The NAW developed an all employee survey to promote broad employee involvement in the needs assessment process;
- The NAW planned the Title V Priority Needs Selection Meeting to assemble maternal and child health stakeholders and families of children with special health care needs to assist the state in selecting the top priority needs and developed the tools used by participants to assess each need; and
- The NAW developed all state performance measures.

METHODOLOGY

The five year needs assessment provided Georgia an opportunity to formally reassess MCH services at a time of change and new leadership in the Division of Public Health and Maternal and Child Health Program. Given the leadership vision, the 2011 Title V Block Grant Application process provided a cornerstone for strategic planning and activity development to improve the health status of the maternal and child (MCH) population. A statewide design for stakeholder engagement in the needs assessment was key, and fully deployed. This wide view of the concerns of Georgia's community members, health care providers and advocates, coupled with extensive quantitative data, provides a sound basis for planning MCH services and system development for the future.

A list of key needs assessment activities follows.

- Review and analysis of quantitative data;
- Collection of current qualitative information on consumer and stakeholder views of the health care needs of women, children, infants, and children with special health care needs;
- Engagement of current and potential partners in providing input on health care priorities for women, children, infants and CSHCN through a day-long focus groups meeting specifically for representatives from statewide professional associations, advocacy organizations, academia, and service organizations;

- Collection of qualitative information on the needs and health care priorities of infants and young children through a focus group session with the steering committee of Georgia's Early Childhood Comprehensive System (ECCS);
- Needs assessment dialogues between the MCH Director and state agency leaders, resulting in new partnerships and activities;
- Engagement of physicians and District Health Directors in providing input on the ranking of health care needs of women, children, infants and CSHCN;
- Involvement of a group of consumers, stakeholders, MCH staff and public health leaders in selecting priorities in a two-day Title V Priority Needs Selection Meeting where data were discussed and priorities established; and
- Partnership building and engagement among MCH program leaders and staff through activity planning and work on performance measures.

STAKEHOLDER INVOLVEMENT

More than 180 stakeholders participated in 16 community-based focus groups conducted statewide to engage consumers, providers, and families of children with special health care needs including a separate focus group for representatives from statewide professional associations, advocacy organizations, local universities, and service organizations. A detailed description of the focus group process is provided in *Section 1. Process for Conducting the Needs Assessment* in the *Methods for Assessing the Three MCH Population Groups* subsection of this document beginning on page 26.

Stakeholders were also engaged in the selection of priority needs. Following the analyses of the quantitative and qualitative data, 54 needs were identified. Two surveys were conducted to determine if greater consensus could be reached on which of the 54 identified needs were most likely to be among the top priority needs in Georgia. On April 14, 2010, the Georgia district health directors; representatives from the Georgia Chapter of the American Academy of Pediatrics, Georgia Academy of Family Physicians, and Georgia Obstetric and Gynecological Society; and Division of Public Health staff working with MCH-related programs were administered a survey, as part of a broader meeting. The survey asked each respondent to identify the fifteen needs s/he believed to be most important among the list of 54 needs. There were 45 responses to this survey. This same survey was distributed to all Division of Public Health employees with the same instructions using SurveyMonkey®. This employee survey provided all Division of Public Health employees an opportunity to participate in the Title V 2010 Needs Assessment. The survey was available from May 14, 2010 through May 28, 2010. The survey was completed by 311 respondents. These surveys and how each was used in the selection of Georgia's priority needs were detailed in *Section 5. Selection of State Priority Needs* of this document beginning on page 342.

Through an online public comment period, stakeholder input was sought on the quantitative and qualitative data sections included in *Section 3. Strengths and Needs of the Maternal and Child Health Population Groups* of this document beginning on page 64, *Section 5. Selection of State Priority Needs* of this document beginning on page 342, and the FY11 activity plan for the 18 national performance measures included in the FY11 Title V MCH Services Block Grant application. A website was created with links to each of these three documents and a space in which comments could be provided. The website also included a question that allowed parents and family members of children with special health care needs to self-identify. Once the website was created, an e-mail was distributed on June 10, 2010 to a list of over 250 MCH stakeholders that included, but was not limited to, focus group participants who

provided e-mail addresses, professional societies, advocates, representatives from academic institutions, public health district staff, Division of Public Health leadership, and contractors. The e-mail requested that the recipients review the documents provided and share any feedback. Recipients were also asked to distribute the e-mail and link to the public comment site to distribution lists that they may have access to and/or post the link on their own website. When the public comment period closed on June 24, 2010, the public comment site received more than 500 unique page views and 43 individual comments were entered. Nine of these comments were from parents or family members of children with special health care needs. A list of all comments is included in Appendix B. A partial list of comments that specifically addresses stakeholder involvement follows.

- "The process of this task was handled in a professional and efficient manner. It was well organized and included many stakeholders from private and public agencies;"
- "I have been well informed during the phases of this assessment…I feel that the grant developers reached out to many groups for input in selecting the top ten priority needs for Georgia. The process was comprehensive and inclusive and the result impressive;"
- "I appreciate the very inclusive process used by MCH to help set priorities for Georgia;"
- "I was fortunate enough to participate in the workshop to select the top ten priority needs for Georgia. I am truly impressed with the new direction at the state office and am looking forward to making significant changes in the health outcomes of Georgia's maternal and child health population. The collaborations and partnerships that have been made and/or strengthened will be beneficial to Georgia's families…;"
- "I was impressed with the organization and method in which our groups worked to make these hard choices. It was two days of intense work…and I appreciate the leadership he has demonstrated pulling together the variety of interested parties to make the Title V FY11 Grant process meaningful and understandable;"
- "The process of development of the needs assessment has been dynamic and transparent;"
- "I appreciated the opportunity to participate in the needs assessment and public forum process. The attitude of inviting related organizations in the needs assessment process is definitely a step in the right direction. I feel the data yielded a more comprehensive view of what is needed and opened the door to partnerships and the ability to visualize common ground. I feel this process will yield greater rewards during the implementation process;"
- "It was very encouraging to take part in the Needs Assessment process for the Title V Block Grant this year. Given the short amount of time available, the process involved a wide variety of stakeholders. In addition, the selection process implemented during the Title V Priority Needs Selection Meeting provided a strategic method for selection resulting in (in my opinion) priority needs based on data, current political will in the state, and the ability to make an impact;" and
- "The Title V Application is well-written and extremely thorough. It is obvious that input was sought from consumers and providers alike. Families of children with special health care needs were invited to participate in the focus groups and stakeholders meetings to ensure they were not left out of the decision making process.

On June 3 and 4, 2010, the MCH Program convened stakeholders from throughout Georgia to participate in the Title V Priority Needs Selection Meeting. Stakeholders included representatives from non-profit organizations, providers, parents of children with special health care needs, academic institutions, and public health district staff. During the first day of the meeting, participants were asked

to assess 44 maternal and child health needs on five criteria using a standard tool. The evaluations provided by invitees on the first day of the meeting were compiled and the top priority needs were identified and discussed with the stakeholders. The role of stakeholders in this meeting is detailed in *Section 5. Selection of State Priority Needs* of this document beginning on page 342.

ENSURING AN ONGOING PROCESS

The next five-year needs assessment is due on July 15, 2015. Georgia Title V is committed to ensuring that data are collected to support the annual application and build toward the completion of the 2015 Needs Assessment. To this end, Georgia Title V plans to conduct annual focus groups with providers and stakeholders. These focus groups will investigate potential changes that may be attributable to the implementation of the annual activity plan. These focus groups will also monitor the changing health care environment in Georgia. The MCH Epidemiology Section will also establish a series of reports that will be completed on routine timelines. Reports may include a women's health report, PRAMS annual report, asthma prevalence report, adolescent pregnancy report, a child health report, and others. These reports will be designed to use the most recent data and be easily integrated into the 2015 Needs Assessment. In response to State Performance Measure 3 and the priority need *Improve the maternal and child health surveillance and evaluation infrastructure*, existing surveillance systems may be expanded by adding questions or increasing sample size to produce reliable point estimates at the sub-state level and new surveillance systems/sample surveys developed and implemented. This will generate new data and information to support activity plan changes.

The process of developing activities, implementing activities, monitoring priorities, and measuring impact will occur on a set schedule throughout the year. The monthly milestones that follow will be implemented beginning in FY11 and in each subsequent year.

July	Submit Title V MCH Services Block Grant application to the Health Resources and Services Administration to include annual report for the completed year, midyear report for present year, and plan for the upcoming year.
August	Participate in Title V MCH Services Block Grant application review in Atlanta, Georgia.
September	Assemble internal stakeholders to review activity plan for upcoming year including monitoring plan and expected outcome. Review plan to determine if any planned activity will require project management staff. Assign project management staff.
January	Work with internal partners to collect activity plan reports for the year that concluded on September 30 to post to website for public comment and for submission with annual application. Convene internal partners to discuss activity progress through the first quarter.
April	Convene internal partners to discuss activity progress through the second quarter. Collect mid-year activity plan reports to post to website for public comment and for submission with annual application.
May	Convene internal partners to discuss activity progress through eight months. Develop new activity plan to post to website and for submission with annual application.
July	Submit Title V MCH Services Block Grant application to the Health Resources and Services Administration to include annual report for the completed year, midyear report for present year, and plan for the upcoming year.

INTERFACE BETWEEN THE NEEDS ASSESSMENT AND APPLICATION

All national performance measures and federal outcome measures along with selected health status indicators and health system capacity indicators were analyzed as part of the needs assessment process. For each measure, trends over time were reported and data were stratified by age; race/ethnicity; maternal educational attainment, where appropriate; and sex, where appropriate. These analyses helped to inform activity plan development by identifying population groups or geographic areas in greatest need of intervention. For the national performance measures, a linear projection methodology was applied to trend data to provide estimates through 2014 to provide the annual performance measure objectives. In addition to the national performance measures and federal outcome measures along with selected health status indicators and health system capacity indicators analyzed as part of the 2010 Needs Assessment, other MCH-related indicators were also analyzed to provide a complete understanding of the health status of the MCH populations in Georgia.

METHODS FOR ASSESSING THE THREE MCH POPULATION GROUPS

QUANTITATIVE DATA

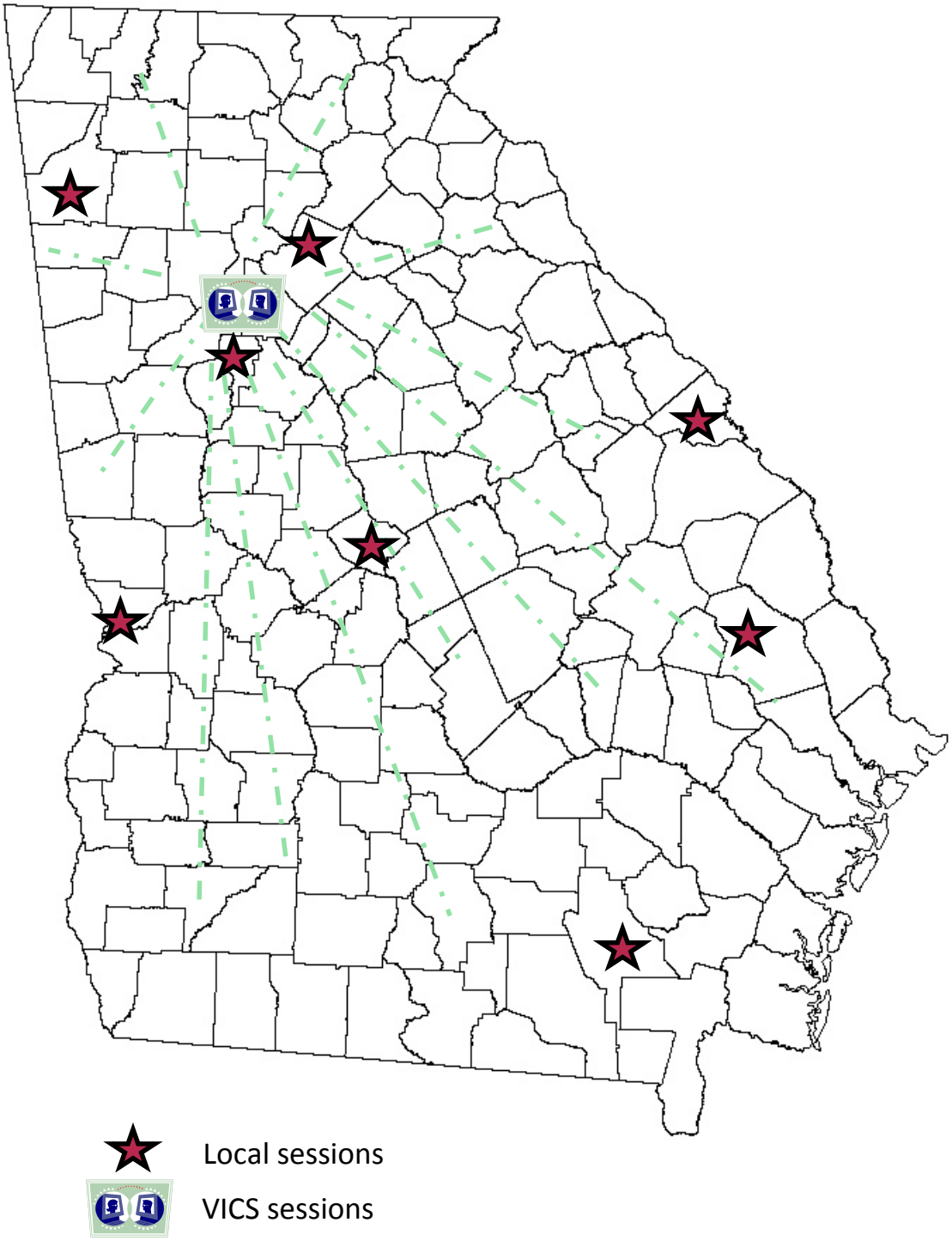
The quantitative data analyzed for the 2010 Needs Assessment represents the single most comprehensive report of the state of the health of MCH populations currently available in Georgia. More than ten unique sources of quantitative data were analyzed as part of the 2010 Needs Assessment. Trends over time were presented for all data sources for a period of time for which data were available and accessible. Where possible, data were stratified by age, race/ethnicity, maternal educational attainment, and/or sex; and maps were included that displayed point estimates for each of the public health districts. The compilation, review and analysis of quantitative data on existing health status indicators and performance measures were led by the CDC MCH Epidemiology Assignee and the MCH Program Director with contributions from the MCH Epidemiology Section staff.

QUALITATIVE DATA

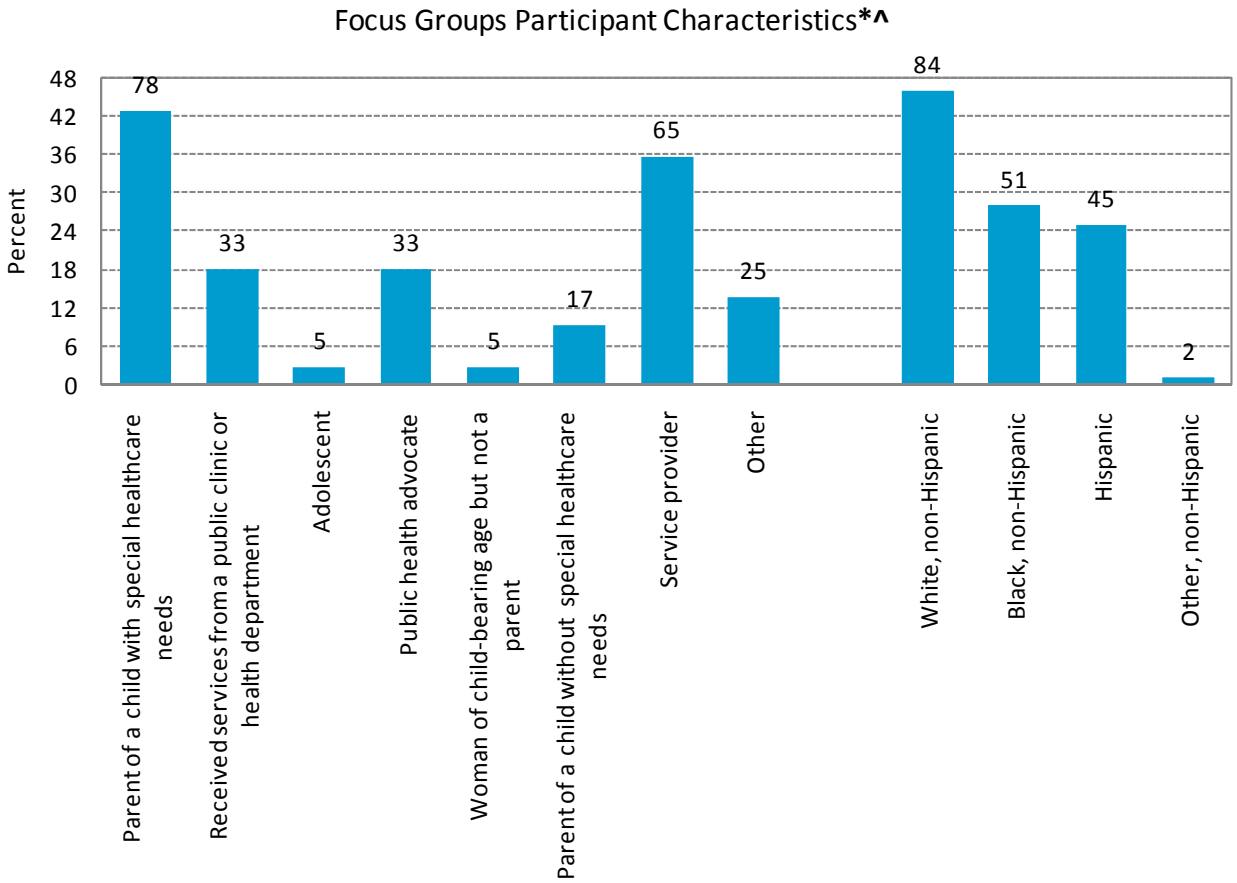
Engagement of a diverse community of MCH and CSHCN stakeholders statewide was the emphasis of the qualitative data collection strategy. Community-based focus groups were arranged and conducted in various locations in the state through a partnership effort of the MCH Program and the public health districts. Efforts were made to ensure a mix of parents/consumers and health care providers in the community. A positive response to outreach efforts to the Hispanic population in Georgia communities resulted in focus groups conducted in Spanish. Additional focus groups were conducted to ensure involvement of MCH internal stakeholders in Georgia's 18 public health districts through the use of VICS, the two-way video-conferencing system operated by DCH.

Statewide outreach to gain stakeholder and consumer input proved worthwhile. It added rich qualitative information on the health care needs of Georgia's women, children, infants, and CSHCN. When added to the vast amount of quantitative data, pictures of each population's needs became textured with personal, human perspectives. The inclusion of the information added insight into the identification of stakeholder priorities.

Title V Maternal and Child Health Block Grant Needs Assessment
Focus Group Locations



A total of 182 Georgia citizens were engaged through 16 needs assessment community focus groups. Thirty percent of the participants indicated that their primary source of health coverage was Medicaid and nearly 85 percent (n=154) were women. Parents of a child with special health care needs (n=78) and providers (n=65) were the most common characteristics among participants. More than half of all participants (n=98) were of a race/ethnicity other than White.



* Number listed at the top of each column is the number of respondents. Column height represents the percent selecting that answer.
^ Participants could select multiple descriptors of themselves, but only one race/ethnicity.

Each community-based focus group session lasted one and a half hours and was conducted by a two-person team. A value for data integrity was established early on by the Needs Assessment Team (NAT), and was carried out through use of a solid, structured protocol for administering the focus groups and in working with outputs of the focus group discussion. Consistency in the focus group process was ensured through the use of a comprehensive guide, *Focus Group Protocol Guide: Collecting Stakeholder and Consumer Input on Needs in the MCH and CSHCN Populations* (Appendix A).

A special focus group limited to representatives from statewide professional associations, advocacy organizations, academia, and service organizations diverted from the standard protocol. For this focus group, there were nine roundtables of stakeholders at which discussion focused on the health care needs of women, children, infants and CSHCN. A listing of the organizations participating in this focus group follows.

- American Academy of Pediatrics, Georgia chapter
- Annie E. Casey Foundation, Atlanta Civic Site
- Augusta Partnership for Children, Inc
- Babies Can't Wait Interagency Coordinating Council
- Brain and Spinal Cord Injury Trust Fund Commission
- Center for Black Women's Wellness
- Children's Health Care of Atlanta
- Georgia Hospital Association
- Emory University
  - School of Medicine
  - Genomics and Public Health Program
  - Rollins School of Public Health
- Hispanic Health Coalition of Georgia
- Enterprise Community Healthy Start
- Georgia Academy of Family Physicians
- Georgia Association on Young Children
- Georgia Association for Primary Health Care
- Georgia Breastfeeding Coalition
- Georgia Campaign for Adolescent Pregnancy Prevention
- Georgia Court Appointed Special Advocates, Inc.
- Georgia Coalition against Domestic Violence
- Georgia Council on Developmental Disabilities
- Georgia Department of Community Health, Division of Public Health
- Georgia Department of Education
- Georgia Family Connection Partnership
- Hands and Voices Coalition of Georgia
- Georgia Health Policy Center
- Georgia Obstetrical and Gynecological Society
- Georgia Organics
- Georgia Partnership Connection
- Georgia PTA
- Georgia Public Health Association
- Georgia State University
- Governor's Office of Highway Safety
- Healthy Mothers, Healthy Babies Coalition of Georgia
- Heart of Georgia Healthy Start Coalition
- March of Dimes, Georgia chapter
- Medical College of Georgia
- Parent to Parent of Georgia
- Prevent Blindness Georgia
- Prevent Child Abuse Georgia
- SAFE Kids of Georgia
- Voices for Georgia's Children

Another valuable source of perspective on the health care needs of infants and young children birth to five in Georgia is the steering committee of Georgia's Early Childhood Comprehensive System (ECCS). This intact advisory group was invited to contribute to the Title V needs assessment through a special focus group. Their responses were compiled and provided a rich data source which was included in the thematic analyses. A list of the organizations on the Georgia ECCS steering committee that contributed to the 2010 Needs Assessment focus group follows.

- Brain and Spinal Injury Trust Fund Commission
- Department of Early Care and Learning, Bright from the Start, parent representatives
- Center for Child Well-Being
- Centers for Disease Control and Prevention
- Children's Health Care Rehabilitation Services
- Georgia Academy of Family Physicians
- Georgia Department of Behavioral Health and Developmental Disabilities
- Georgia Department of Education
- Georgia Department of Human Services, Division of Family and Children's Services
- Georgia State University
- John Snow, Inc. (JSI)
- National Black Child Development Institute
- Nurse Family Partnership
- Office of Healthy Behaviors
- Parent to Parent of Georgia
- Prevent Child Abuse (PCA) Georgia
- Quality Care for Children
- Refugee Family Services
- Sheltering Arms, Early Education and Family Centers
- Smart Start Georgia
- Tender Care Clinic
- United Way, Metro Atlanta
- US Department of Health and Human Services, Health and Disabilities
- University of Georgia Cooperative Extension Service

DATA COLLECTION AND ANALYSIS

The two-person focus group team provided discussion facilitation and note-taking, using both a flip-chart visible to participants, as well as notepaper, detailing verbatim statements and discussion points. They independently documented their raw notes, juxtaposed and verified information collected, and produced a joint, structured debriefing document of raw data.

Work with the raw data from each focus group occurred over the course of several structured work sessions, wherein three-person teams conducted a thematic analysis of all of the information collected from MCH and CSHCN needs assessment focus groups. The teams compared and contrasted data from different focus group sources until the teams were satisfied that no new issues were arising. The qualitative data project manager/researcher then took the beginning themes around health care needs of each of the MCH populations produced by the teams and employed a content analysis, moving backwards and forwards between detailed thematic analyses conducted by three-person teams, on-site raw notes, and information from other qualitative sources. The output of that process was a list of

themes which was then presented to and tested out with MCH and CSHCN program leaders and the NAW.

The composition of the thematic analysis teams included the state epidemiologist, other epidemiologists, CSHCN Director, MCH staff and two external consultants. To further ensure data integrity, the thematic analysis teams were a mix of persons from on-site facilitation teams, NAW, and staff without direct involvement in data collection. The qualitative data project manager/researcher was an external consultant familiar with MCH programs and experienced with qualitative research methods.

METHODS FOR ASSESSING STATE CAPACITY

The NAW identified several strategies to assess the MCH capacity in Georgia. These were environmental scanning and key informant interviews. These methods were determined to be most effective in capturing maximum information for the internal and external environments that could provide the needed information to contribute to future strategic planning.

Environmental scanning is the acquisition and use of information about events, trends, and relationships in an organization's external environment, the knowledge of which would assist with the planning of an organization's future course of action. To the extent that an organization's ability to adapt to its outside environment is dependent on knowing and interpreting the external changes that are taking place, environmental scanning constitutes a primary mode of organizational learning. Environmental scanning includes both looking at information (viewing) and looking for information (searching). While the scan is a simple tool, it nevertheless helps to get a comprehensive view of the chief factors, helping to go beyond reacting to scattered observations. Environmental scanning was used primarily to assess the external health care system commonly associated with the direct and enabling levels of the MCH Pyramid of Health Services (Appendix C). The information acquired through this environmental scan provides a necessary baseline that will inform strategic planning so that the MCH Program and Division of Public Health can adapt and alter the health care environment in Georgia.

Key informant interviews are qualitative in-depth interviews with people who have specific knowledge of a specific topic. The purpose of key informant interviews is to collect information from people who have firsthand knowledge about a specific topic. These experts, with their particular knowledge and understanding, can provide insight in their areas of expertise including the problems and proposed solutions. Key informant interviews were used primarily to assess programs located in the Division of Public Health, but outside of the Maternal and Child Health Program. The goal of these interviews was to gather information on the program that included, but was not limited to, clients served, mission, and program requirements and parameters. These programs were associated with each level of MCH Pyramid of Health Services.

DATA SOURCES

The following data sources were used in the development of the 2010 Needs Assessment.

Note: There are several data sets that measure similar data points. Therefore, when interpreting data, it is important to note the source and the year of the data presented. Since most data points are based on sample surveys or projections, data points from different data sets are likely to be similar but not identical.

NATALITY FILES (1998 THROUGH 2007)

The Georgia final natality files are compiled by the Office of Vital Records and Office of Health Indicators for Planning. These files consist of all births that occur in Georgia for a given year. From all occurent births, resident births are identified. Unless specified, the natality files used for analysis here were limited to resident births. The natality files were used to track patterns in preterm deliveries, infant birth weight, use of prenatal care, and adolescent pregnancy.

MORTALITY FILES (1998 THROUGH 2007)

The Georgia final mortality files are compiled by the Office of Vital Records and Office of Health Indicators for Planning. These files consist of all deaths that occur in Georgia for a given year. From all occurent deaths, resident deaths are identified. Unless specified, the mortality files used for analysis here were limited to resident deaths. The mortality files were used to track leading causes of mortality among all age groups and age-specific mortality rates for varying causes of death and to calculate years of potential life lost.

Fetal deaths are defined as death before the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy. The death is indicated by the fact that after such separation, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. These deaths are captured in a separate file from the standard mortality file. In the 2010 Needs Assessment, the fetal death file is used to calculate feto-infant mortality rates, which are used in the perinatal periods of risk analysis, and perinatal mortality rates.

LINKED NATALITY-MORTALITY FILES (2006)

The Office of Health Indicators for Planning creates an annual linked natality-mortality file. This file is created by linking birth certificates to death certificates in a specified year and provides greater information than either file can provide alone. In the 2010 Needs Assessment this linked file was used to perform perinatal periods of risk analysis on fetal and infant deaths and to investigate the association between maternal educational attainment and infant death.

GEORGIA PREGNANCY RISK ASSESSMENT MONITORING SYSTEM (PRAMS)

PRAMS is a statewide, ongoing, population-based survey that collects information on women who give birth in Georgia. Georgia PRAMS supplements birth certificate data by collecting information on women's attitudes, experiences, and behaviors before, during, and after they deliver a live born infant.

Each month, a random sample of approximately 200 women is drawn from birth records and stratified by birth weight (low birth weight, normal birth weight) and race (black, other). Women are contacted by mail or telephone (for non-responders) within 2-6 months after delivery. Each mother's survey is linked to her infant's birth certificate. In the 2010 Needs Assessment, data from the 2004, 2005, and 2006 birth cohorts were reported. Aggregating data across these three years allows for district level point estimates.

GEORGIA BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM (BRFSS)

Georgia BRFSS is a state-based surveillance system, administered by the Division of Public Health in collaboration with the Centers for Disease Control and Prevention. BRFSS is a telephone survey of randomly selected Georgia adults (ages 18 years and older) to collect data on lifestyle risk factors that contribute to leading causes of death and chronic diseases. Questions allow for the monitoring of the Healthy People 2010 Objectives in smoking, obesity, high blood pressure, exercise, vaccinations, seat belt use, chronic conditions, negative health behaviors (e.g. smoking), and general overall well-being. Georgia BRFSS data also monitor patterns of physical and mental health status, access to health care, and utilization of health care services. Data may be examined by age, race, and educational attainment. Not all questions appear consistently on Georgia BFRSS. In the 2010 Needs Assessment, for some data points, Georgia BRFSS data were available from 1999 through 2008.

GEORGIA YOUTH RISK BEHAVIOR SURVEY (YRBS)

Georgia YRBS is a state-based surveillance system, administered by the Division of Public Health in collaboration with the Georgia Department of Education and Centers for Disease Control and Prevention. YRBS obtains information from a random sample of public high school students about the prevalence and age of initiation of various health risk behaviors such as tobacco use, physical activity, eating habits, alcohol and drug use, and behaviors that contribute to unintentional injuries and violence. A significant limitation of the Georgia YRBS is that it does not include questions about sexual activity, sexual debut, and safe sex practices. The absence of these data makes the interpretation of trends in adolescent pregnancy and birth more difficult and limits a key source of information for intervention planning. Georgia YRBS data are collected in odd years. In the 2010 Needs Assessment, Georgia YRBS data from 2003, 2005, and 2007 are reported.

NATIONAL SURVEY OF CHILDREN'S HEALTH (2003 AND 2007)

The National Survey of Children's Health is a national telephone survey funded by the Maternal and Child Health Bureau, Health Resources and Services Administration. The purpose of the survey is to estimate national and state-level prevalence for a variety of physical, emotional, and behavioral child health indicators in combination with information on the child's family context and neighborhood environment and to generate information about children, their families, and neighborhoods to help guide policymakers, advocates, and researchers. The survey was first conducted in 2003 and repeated in 2007.

The Georgia sample of the National Survey of Children's Health was collected and structured so that it is representative of all children in Georgia. The information gained from the data can be generalized to represent the entire population of children in Georgia. Although participants in the Georgia sample are

recruited from across the state, the data are not representative of smaller geographic units, such as at the county or city level. The data are also not appropriately sensitive to change for use in program evaluations. In the 2010 Needs Assessment, comparisons between data collected in 2003 and 2007 were made. Comparisons between HRSA Region IV and Georgia were also presented.

NATIONAL SURVEY OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS (2000/2001 AND 2005/2006)

The National Survey of Children with Special Health Care Needs (CSHCN) is a national telephone survey funded by the Maternal and Child Health Bureau, Health Resources and Services Administration. The purpose of the survey is to provide information about CSHCN in all 50 States and the District of Columbia. The survey was first conducted in 2000/2001 and repeated in 2005/2006. The questionnaire was altered between the two administrations. Survey questions include topics on access to services, medical home, transitional assistance, financial burden to family, and health insurance coverage.

The Georgia sample of the National Survey of Children with Special Health Care Needs was collected and structured so that it is representative of all children with special health care needs in Georgia. The information gained from the data can be generalized to represent the entire population of children with special health care needs in Georgia. Although participants in the Georgia sample of CSHCN are recruited from across the state, the data are not representative of smaller geographic units, such as at the county or city level. The data are also not appropriately sensitive to change for use in program evaluations. In the 2010 Needs Assessment, comparisons between data collected in 2000/2001 and 2005/2006 were made with notations when a change in the survey impacted analysis or interpretation. Comparisons between the US and Georgia were also presented.

EMERGENCY ROOM VISITS AND HOSPITALIZATIONS (2007)

The hospital discharge and emergency room (ER) visit databases provide population-based records for these two health service events. The data defining the cause of the admission or ER visit are captured in a series of diagnostic codes, the International Classification of Disease (ICD). There is a set of ICD codes which define the external cause of an injury. The codes distinguish between a broken leg caused by a fall and one resulting from a car crash. However, the hospital's reimbursement is based on the care required for a broken leg, regardless of the cause. There are concerns regarding both completeness and accuracy of the coding for injuries in the hospital discharge data. There are a set of ICD codes to define external causes for injuries (E-codes in ICD 9). The Office of Health Indicators for Planning searches all reported ICD codes for E-codes and, if found, assigns the underlying cause based on the E-code. In the 2010 Needs Assessment, these databases were used to determine leading causes of hospitalization and ER visits by age group.

NATIONAL IMMUNIZATION SURVEY (NIS)

NIS is sponsored by the National Center for Immunizations and Respiratory Diseases (NCIRD) and conducted jointly by NCIRD and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The NIS is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers to monitor childhood immunization coverage at the state level and in limited sub-state areas. In addition to data on childhood immunization, the NIS

provides valuable state-level data on breastfeeding. In the 2010 Needs Assessment, NIS data from 2000 through 2008 were reported depending on the data point of interest.

ONLINE ANALYTICAL STATISTICAL INFORMATION SYSTEM (OASIS)

While OASIS is a query tool used to access much of the data presented in the 2010 Needs Assessment, it is listed here as the source of population projections in Georgia. This tool provides access to Georgia population data from 1994 through 2008. In non-census years, OASIS provides post-censal estimates by age, sex, race/ethnicity, and public health district.

PEDIATRIC NUTRITION SURVEILLANCE SYSTEM (PEDNSS)

PedNSS is a child-based public health surveillance system that describes the nutritional status of low-income US children who attend federally-funded maternal and child health and nutrition programs. PedNSS provides data on the prevalence and trends of nutrition-related indicators. In the 2010 Needs Assessment, PedNSS data from 1999 through 2008 were used to measure rates of overweight and obesity among WIC participants ages two to five years.

GEORGIA COMPREHENSIVE CANCER REGISTRY (GCCR)

GCCR is a statewide, population-based cancer registry collecting all cancer cases diagnosed among Georgia residents since January 1, 1995. This information furthers our understanding of cancer and is used to develop strategies and policies for prevention, control, and treatment. The availability of this data at the state level allows health researchers to analyze geographic, racial, and other differences that provide clues that point to risk factors. This data also helps in determining where early detection, educational, or other programs should be directed. In the 2010 Needs Assessment, data from the GCCR were used to measure cervical cancer incidence and mortality from 2000 through 2007.

CURRENT POPULATION SURVEY (CPS)

The CPS is a monthly survey of about 50,000 households conducted by the Bureau of the Census for the Bureau of Labor Statistics. The CPS is the primary source of information on the labor force characteristics of the US population. The sample is scientifically selected to represent the civilian non-institutional population. Respondents are interviewed to obtain information about the employment status of each member of the household 15 years of age and older. The sample provides estimates for the nation as a whole and serves as part of model-based estimates for individual states and other geographic areas. Estimates obtained from the CPS include employment, unemployment, earnings, hours of work, and other indicators. They are available by a variety of demographic characteristics including age, sex, race, marital status, and educational attainment. Supplemental questions to produce estimates on a variety of topics including school enrollment, income, previous work experience, health, employee benefits, and work schedules are also often added to the regular CPS questionnaire. In the 2010 Needs Assessment, the CPS was used to produce estimates of health insurance status among children from 2002 through 2008.

INFECTIOUS DISEASE SURVEILLANCE DATA COLLECTED THROUGH THE DIVISION OF PUBLIC HEALTH

Surveillance data on Chlamydia, gonorrhea, and HIV were supplied by the Infectious Disease and Immunization Program, Division of Public Health.

PUBLISHED REPORTS

Three reports were used in the development of the 2010 Needs Assessment. A listing of these reports follows.

- Refocus (www.thegcha.org). In an effort to increase knowledge and awareness about physical health issues affecting children statewide, Georgia Children's Health Alliance and the Division of Public Health developed the *Refocus* report. The purpose of the report is to describe the health of Georgia's infants, children, and adolescents and to discuss the quality and availability of child health data;
- SSI Recipients by State and County, 2009 (www.ssa.gov/policy/docs/statcomps/ssi_sc/). This report provides the number of SSI recipients under the age of 18 receiving SSI benefits; and
- Protective Services Data System Annual Report, 2007 (www.dfcs.dhr.georgia.gov/DHR-DFCS/DHR-DFCS-publication/PSDS_CY2007_Report.pdf). This report includes data from the Division of Family and Children Services pertaining to reports and substantiated cases of abuse and neglect.

LINKAGES BETWEEN ASSESSMENT, CAPACITY, AND PRIORITIES

With the changes in leadership throughout the Division of Public Health, there is an ongoing review of state capacity to provide those services identified as critical to the public's health. The 2010 Needs Assessment identified those critical services for the MCH population.

The analyses of the qualitative and quantitative identified programmatic opportunities to impact and improve the health of the Georgia MCH population and intervention points. Programmatic leadership throughout the Division of Public Health convened to develop the FY11 activity plan and ensured that activities were created that leveraged these identified opportunities. The priority needs identified through the 2010 Needs Assessment were examined for alignment with national performance measures and incorporated into activity plans where appropriate. Priority needs that did not align with NPM activity plans were addressed through the development of state performance measures and associated activity plans.

To support the implementation of the FY11 and future activity plans, quarterly meetings will be established to monitor the progress toward completing activities, explore and recommend opportunities for collaboration, reduce duplication of services, and leverage existing funding streams. It is expected that subcommittees to allow interested participants to explore and discuss topics in greater detail will develop from the quarterly meetings. The MCH Program will facilitate opportunities for the coordination and integration of resources throughout the Division of Public Health to ensure that adequate and appropriate resources are available to address critical services and health care needs

necessary to improve the health status of Georgia's MCH population and to monitor spending of Title V funded programs to ensure the appropriate use of allocated funds.

DISSEMINATION

The 2010 Needs Assessment was designed to provide data with the appropriate depth to inform action. This included subgroup analyses and, when possible, public health district-specific data. The 2010 Needs Assessment draws from multiple data sources, several of which do not produce annual reports, to provide a comprehensive assessment of the state of maternal and child health in Georgia. Furthermore, the 2010 Needs Assessment is unique in the qualitative data presented alongside the quantitative data. The varying levels of data presented along with the qualitative data differentiate the 2010 Needs Assessment from other reports. The data presented in the 2010 Needs Assessment will drive funding and strategic planning decisions for the MCH Program. For the 2010 Georgia Title V Maternal and Child Health Services Block Grant Five-Year Needs Assessment to serve as a catalyst to support the statewide transition to data driven action, broad dissemination to internal and external stakeholders statewide is a priority for the Georgia MCH Program.

The completed 2010 Needs Assessment will be posted to the MCH Program website and printed copies will be distributed to DPH senior leadership staff and all district health directors. Each health district will have an opportunity to meet with the Georgia MCH Program Director to discuss the findings, make suggestions for additional indicators, comment on the approach, and present ideas based on the findings. Additionally, the Georgia MCH Program will work with communications, design, and layout experts to use the quantitative and qualitative data presented in the 2010 Needs Assessment to produce a report on the state of maternal and child health in Georgia. The MCH Program will develop a communications plan and host an official release of this report for internal and external stakeholders and media.

STRENGTHS AND WEAKNESSES

STRENGTHS

- **Broad stakeholder involvement.** As detailed throughout the 2010 Needs Assessment, ensuring broad stakeholder involvement was a priority of the NAW. Multiple opportunities were provided for input into the needs assessment process that included participation in statewide focus groups, participation in the selection of the top priority needs, and public input on selections from the 2010 Needs Assessment. While stakeholder involvement in previous Title V MCH Services Block Grant applications from Georgia has been limited and no public comments have been received, a public comment website was created for the 2010 Needs Assessment and FY11 application that received 537 unique page views. Through this public comment website, 43 comments were entered by stakeholders, of which nine were from parents or family members of children with special health care needs.

- **Commitment to involving parents and families of children with special health care needs.** Involving parents and families of children with special health care needs was a priority for the NAW. Significant effort was made to ensure that parents and families of children with special health care needs were included in the statewide focus groups. With this effort, 43 percent of

all focus group participants identified themselves as parents and families of children with special health care needs. The focus group for representatives from statewide professional associations, advocacy organizations, academia, and service organizations included organizations representing children with special health care needs including the Brain and Spinal Cord Injury Trust Fund Commission, Georgia Council on Developmental Disabilities, Prevent Blindness Georgia, and Parent to Parent of Georgia. Parents and families of children with special health care needs were also included in the selection of priority needs and provided nine comments through the public comment website.

- **Standardized focus group process and procedures.** A standard focus group guide was developed to increase the quality of the qualitative data collected through the statewide focus groups. All focus groups adhered to the protocols detailed in this guide, which contributed to increased standardization between focus groups, established data collection and processing protocols, and reduced facilitator affect/bias.

- **Depth and scope of the data analyzed.** The 2010 Needs Assessment is the most comprehensive report on the health and health behaviors of women, infants, children, and children with special health care needs available in Georgia. The data were also presented in a manner to ensure availability for advocates, program planners, and policy makers as well as epidemiologists and academics.

- **Internal stakeholder engagement.** The success of the Title V MCH Services Block Grant is dependent on strong collaborative relationships with internal and external partners. There were several opportunities to engage Division of Public Health leadership throughout the 2010 Needs Assessment and Title V MCH Services Block Grant FY11 Application process. This included involving leadership in the selection of priority needs and in a process for joint activity plan development for the national and state performance measures. In addition to engaging Division of Public Health leadership, an employee survey was distributed to allow all Division of Public Health staff an opportunity to have input into the 2010 Needs Assessment.

- **Leveraged 2010 Needs Assessment opportunity to establish new vision for MCH Program.** During the twelve months prior to the submission of the Title V MCH Services Block Grant FY11 Application, the MCH Program and Division of Public Health experienced leadership and organizational changes. With new leadership for Georgia Title V and the MCH Program, the 2010 Needs Assessment was used as a platform to share a new vision for Georgia Title V and the MCH Program. Through this platform, there is increased awareness and understanding of the Title V MCH Services Block Grant and its role in sustaining and developing MCH infrastructure throughout Georgia and improved recognition of the MCH Program as an active partner in the Georgia MCH community.

WEAKNESSES

- **Time limitations and organizational change.** Due to organizational and leadership changes within Georgia, significant work on the 2010 Needs Assessment was not initiated until January 2010. This limited the time available for each phase of the needs assessment process (data analysis, examining capacity, setting priorities, setting targets, identifying activities) and several

phases were conducted simultaneously. This did not allow for a complete synthesis of the findings from one phase of the needs assessment process before progressing to the next phase.

- **Limited scope of quantitative data analyzed.** The limited diversity in the data analyzed is a weakness of the 2010 Needs Assessment. The data analyzed for the 2010 Needs Assessment were limited to those data sets for which the Division of Public Health had established access for primary data analyses. While these data allowed for a thorough analysis of health needs, there are gaps that may have been addressed through other data sources. Examples of data that were not included in the 2010 Needs Assessment are Medicaid claims data, education data, data from the Crash Outcome Data Evaluation System, and data from Early Head Start.

    - Corrective Action. In Georgia, there is no single listing of all data sets available for analysis within the Division of Public Health or statewide. Having an inventory of data sets with clear contact information and instructions for analyzing the data will increase awareness of data sets throughout the maternal and child health community and promote improved use. The Georgia MCH Program will convene a Data and Research Committee that will assess the current data infrastructure in Georgia to create an inventory of all available data sets and identify existing data gaps. The inventory will be posted to the Georgia MCH Program website. To address identified data gaps, the Data and Research Committee will develop an action plan to develop further the data infrastructure in Georgia.

- **Limited membership in the Needs Assessment Workgroup.** While the NAW implemented a team approach and ensured broad inclusion in the focus group process, membership on the actual NAW was limited to Georgia MCH Program staff.

    - Corrective Action. In the years subsequent to the 2010 Needs Assessment, the NAW will transform into the Title V Steering Committee and continue to meet monthly. While the Title V Steering Committee will continue to be internal to the MCH Program, to complement the Title V Steering Committee, the Maternal, Infant, and Child Advisory Group will be created. This group will meet quarterly to provide input on MCH activities including ongoing needs assessment activities and annual application. The purpose of the Maternal, Infant, and Child Advisory Group will be to identify resources, ensure maximization of effort across the Division of Public Health, promote increased collaboration with governmental and non-governmental partners, solicit requests for funding, and ensure all relevant MCH activities are captured and reported.

- **Development of the state performance measures.** The state performance measures were developed by the NAW without public comment or input from external stakeholders. While the state performance measures were all directly related to state priority needs that were determined with significant public input, increased input and a more collaborative developmental process was needed.

- **Limited scope of CSHCN data.** The only source of quantitative data available for the CSHCN population was the National Survey of Children with Special Health Care Needs 2000/2001 and 2005/2006. Increased and more recent surveillance is needed to improve our understanding of this population.

- Corrective Action. The Title V CSHCN Director will collaborate with the MCH Epidemiology Section staff to implement increased surveillance activities among CSHCN populations enrolled in MCH programs, specifically the Children's Medical Services Program and Babies Can't Wait Program. Improved collaboration with Family Voices and Georgia's Association of Maternal and Child Health Programs (AMCHP) Family Representative may provide increased access to parents and family members of CSHCN throughout Georgia who may be willing to participate in surveys and other surveillance activities.

- **Routine qualitative analysis techniques and data collection.** Collection of the focus group data and analysis could have been enhanced with the implementation of advanced qualitative data analysis techniques. The data collection and analysis process implemented in the 2010 Needs Assessment included the use of two-person teams that provided discussion facilitation and note-taking, using both a flip-chart visible to participants, as well as notepaper, detailing verbatim statements and discussion points. Each team member independently documented his/her raw notes, juxtaposed and verified information collected, and produced a joint, structured debriefing document of raw data. While this process was effective, recording and transcribing all sessions and using qualitative statistical software may have aided in the identification of themes and increased the scientific rigor of the analysis of the qualitative data collected.

- **Limited involvement from other state agencies.** Due to the limited time available to complete the 2010 Needs Assessment, the NAW focused on including consumers, providers, and other non-governmental stakeholders. This choice limited the opportunities to engage other state agencies. A focus group for staff from various state agencies was planned, but was not feasible given prevailing timelines.

  - Corrective Action. While there may be existing collaboration between the MCH Program and other state agencies among working-level staff, there has been limited collaboration at a strategic, leadership level and limited awareness of the Title V MCH Services Block Grant. The MCH Program is working on developing improved relationships with state agencies, divisions, and programs. The planned Maternal, Infant, and Child Advisory Group will include representatives from state agencies that serve children and families.

SECTION 2: PARTNERSHIP BUILDING AND COLLABORATION EFFORTS

Throughout Georgia there are numerous statewide and local efforts that share the common goal of improving the health outcomes among MCH populations. The MCH Program staff recognize that it must ensure and promote the need for collaborative efforts to be inclusive, for consistent and constant communication, and to maximize limited resources to their fullest potential. To this end, stakeholders were engaged throughout the needs assessment process. To ensure the involvement of family members of children with special health care needs, the MCH Program used its newly identified AMCHP family representative who is employed at Georgia Parent to Parent to recruit parents and family members and disseminate key information. Stakeholder involvement in the 2010 Needs Assessment is discussed throughout this document. Specifically, stakeholder involvement is discussed in:

- *Section 1. Process for Conducting the Needs Assessment* in the *Stakeholder Involvement* subsection beginning on page 23 of this document
- *Section 1. Process for Conducting the Needs Assessment* in the *Qualitative Data* subsection beginning on page 26 of this document
- *Section 5. Selection of State Priority Needs* in the *Methodologies for Ranking/Selecting Priorities* beginning on page 342 of this document

With the number of opportunities and breadth of stakeholder involvement, the 2010 Needs Assessment sets a tone of openness, transparency, and collaboration for the MCH Program during the next five year Title V cycle (2011 through 2015). The approval of stakeholders throughout Georgia is seen in the number of participants in the statewide focus groups, unique page views for the public comment website, the number of comments received, and attendance at the Title V Priority Needs Selection Meeting. The involvement of stakeholders strengthened the quality of the 2010 Needs Assessment and the FY11 Title V MCH Services Block Grant application. Success for the MCH Program and Georgia Title V will only be achieved with continued and expanding stakeholder involvement through improved partnership and collaboration. It is expected that opportunities for input and stakeholder involvement will be a routine part of the annual application as well as the next five year needs assessment.

This section describes selected partnerships throughout Georgia. A more inclusive table is included in Appendix D. The roles that several of the organizations identified in this section have had in the 2010 Needs Assessment or with the MCH Program also have been discussed elsewhere in this document.

STATE AND LOCAL MCH PROGRAMS

Service delivery in the state's public health system is carried out by 159 county boards of health. These boards of health are combined into 18 district units, ranging from one to 16 counties in size, and they are overseen administratively by a district office that provides management services and programmatic support. A map of the 18 public health districts can be found on page 296. Each district is led by a physician district health director who reports to the state office of the DCH Division of Public Health. The county boards of health are the local maternal and child health programs in Georgia and work with community partners in their counties around issues of common concern. Approximately 97 percent of the county health departments' funding (approximately $70 million) comes from the state in the form of general grants-in-aid (GIA).

Given the organization of public health in Georgia, there is a strong relationship between the Georgia MCH Program and local MCH programs. Through the development of the 2010 Needs Assessment, district health directors and district staff were routinely engaged to ensure that their voices were represented. The Georgia MCH Program is dedicated to ensuring a strong relationship with the district health directors and local MCH programs and broadening partnerships to include strategic planning and initiative development.

OTHER HRSA PROGRAMS

There are several HRSA-funded programs in Georgia with which the MCH Program currently collaborates. A description of these HRSA-funded programs and the relationship each has with the MCH Program follows.

EARLY CHILDHOOD: COMMUNITY-BASED SERVICE SYSTEMS

The MCH Program serves as the grantee for Georgia's three-year Early Childhood Comprehensive Systems (ECCS) Initiative. The ECCS Initiative has worked to act as a catalyst for action among state agencies and key stakeholders to facilitate collaboration among organizations to create a system that supports the health, safety, and well-being of the state's young children birth to age five. During the project period, ECCS is continuing efforts to strengthen state partnerships around ECCS principles and elements and to improve the lives of young children and their families. Initiative activities are guided by a State Team composed of a diverse group of public and private early childhood partners.

HEALTHY START – ELIMINATING RACIAL/ETHNIC DISPARITIES

Georgia has four Healthy Start sites: Atlanta Healthy Start, Augusta Partnership for Children, Enterprise Community Healthy Start, and Heart of Georgia Healthy Start. A collaborative relationship exists between the HRSA funded Healthy Start projects throughout Georgia and the MCH Program. The Healthy Start projects in Georgia have a unique community perspective offering strategic planning and information gathering for shared MCH goals in Georgia. The MCH Program, Georgia's Title V Program, provides a letter of support each year for the Healthy Start grant applications as well as the Community Doula Project. The MCH Program has also identified a liaison to work with Georgia's Healthy Start sites. Representatives from the Georgia Healthy Start sites participated in several phases of the 2010 Needs Assessment.

TRAUMATIC BRAIN INJURY PREVENTION AND ADVOCACY

The Georgia Advocacy Office serves as the grantee of this four-year grant. The project addresses the difficulties of persons with Traumatic Brain Injuries (TBI) in being safe, securing civil rights, residing in more integrated settings, and receiving treatment of neurobehavioral symptoms. An MCH Program staff member attends the Brain and Spinal Injury Trust Fund Commission and is a member of the Child and Youth Subcommittee of the Commission.

HEMOPHILIA TREATMENT CENTERS

Hemophilia of Georgia, Inc. (HOG) is the grantee of the multi-year (10/1/1990 to 5/31/2011) Region IV South Regional Hemophilia Program. The purpose of the program is to promote access to integrated and family-centered services for individuals with bleeding disorders in Region IV South. HOG is a recipient of approximately $2 million in funds from the Division of Public Health to supplement the activities funded through HRSA.

UNIVERSAL NEWBORN HEARING SCREENING

The Georgia Department of Community Health is the grantee for this three-year grant, which is administered by the MCH Program. Guided by the Georgia UNHSI Workgroup, the project is developing standardized protocols to educate parents about follow-up rescreens and reduce the state's lost to follow-up rate for infants who fail their initial hearing screen at birth.

MCH RESEARCH

Emory University Preventive Medicine Program received three-year funding to promote women's receipt of family and preconception health services as part of primary health care in order to reduce the proportion of pregnancies that are unintended and the proportion of women who enter pregnancy with modifiable risks for adverse outcomes. The study is pilot-testing and refining a preconception toolkit to facilitate women's receipt of appropriate family planning and evidence-based preconception care strategies. The MCH Perinatal and Family Planning staff worked with the Project Director, Dr. Anne Lang Dunlap, during the development and dissemination of the toolkit. The Emory University Preventive Medicine Program recently received HRSA funding for its new maternal-child health track in general preventive medicine and public health. The project, which will tentatively begin in July 2010, pays the salary of a medical resident to do applied public health activities in maternal-child health during the practicum year of their training. A candidate has been identified. The resident will help operationalize and implement preconception care and interconception care through local health departments and the Medicaid CMOs, and work on activities related to the "Reducing Low Birth Weight" initiative.

HEALTHY BEHAVIORS IN WOMEN

The Medical College of Georgia (MCG) Health, Inc. is the grantee of this three-year grant. The After Baby Fitness Challenge, led by the Augusta Regional Perinatal Center, which is funded by the MCH Program, in conjunction with input from community leaders and consumers, is a component of the established Enterprise Community Healthy Start. Using best practice activities of community partnerships, outreach, education, and case management, the program augments positive family support with professional support of case managers, provides group nutrition education, encourages exercise, and increases cooperation and collaboration among community social, health, and education providers and agencies.

SICKLE CELL NEWBORN SCREENING

The Sickle Cell Foundation of Georgia, Inc. (SCFG) serves as the grantee for this multi-year project (9/30/2003 to 5/31/2011). The project purpose is to advance the SCFG's (1) service model by honing its ability to manage data sets and (2) community-based outreach programs for families with newborns and children with special health care needs. The MCH Newborn Screening Unit has a sub-contractual relationship with the Sickle Cell Foundation of Georgia, Inc. This funding supports their efforts to provide notification, counseling, education and extended family testing to families of newborns identified with sickle cell trait via newborn screening.

FAMILY PROFESSIONAL PARTNERSHIP/CSHCN FAMILY TO FAMILY HEALTH INFORMATION CENTERS

Parent to Parent of Georgia serves as the Family to Family for Healthy Choices (F2F) grantee. Parent to Parent of Georgia has received an extension of the project period. F2F is designed to improve the ability of Georgia families to access health services, advocacy, and community supports. Primary services are built into four Levels of Capacity. At all levels, parents receive the training and information they need to build partnerships with health professionals and then create successful collaborative health delivery models that can help reduce barriers for a productive and independent future. Sherry Richardson, the F2F Project Director, participated in the Georgia MCH Program's five-year MCH needs assessment, helping with the planning and implementation of focus groups with families of children with special needs. Two of the focus groups were conducted with Spanish speaking families. Ms. Richardson attended the 2010 AMCHP conference as a Family Scholar. Parent to Parent holds the contract for the central directory for BCW.

EMSC STATE PARTNERSHIP GRANTS

The Georgia Department of Community Health serves as the grantee for Georgia's three year EMS-C Program. In Georgia, much work remains to be done to ensure the accessibility and timeliness of pre-hospital services for the children of Georgia. The EMS-C Program provides emergency personnel with education materials and instructor resources, and builds capacities to support statewide collaborative training efforts through regional Emergency Medical Services (EMS) offices, advisory councils, and training institutes in areas lacking resources where children are at greatest risk for traumatic injury. Through improved collaboration with the Georgia Injury Prevention Program, it is expected that the relationship between EMS and Georgia Title V will improve. In previous years, Georgia Title V has provided funding for equipment purchases to aid in treating pediatric trauma.

OTHER PROGRAMS WITHIN THE DIVISION OF PUBLIC HEALTH

There has been significant organizational and staff change in the Division of Public Health. In July 2009, the Division of Public Health was moved from the Department of Human Resources to the Department of Community Health. This change was accompanied by a new public health director, new deputy director of public health services and programs, and new program directors for three of seven programs in public health. These changes created an opportunity to strengthen existing partnerships and renew those partnerships that were no longer as active.

In addition to the MCH Program, the Division of Public Health includes Health Promotion and Disease Prevention Program, Infectious Disease and Immunizations Program, Environmental Health Program, Epidemiology Program, the Georgia Public Health Laboratory, and State Vital Records Office. Each DPH program and service has responsibilities that interrelate with MCH activities, requiring strong working relationships. A description of each program and the intersection between these other Division of Public Health programs and the MCH Program follows.

HEALTH PROMOTION AND DISEASE PREVENTION (HPDP) PROGRAM

HPDP implements population-based programs and services aimed at reducing disease risks, promoting healthy youth development, targeting unhealthy behaviors, providing access to early detection and treatment services, and improving management of chronic diseases. Targeted risk behaviors include smoking, physical inactivity, unhealthy eating, lack of preventive health care, sexual violence, and reducing risky behaviors in youth. HPDP's Office of Cancer Screening and Treatment includes the Georgia Breast and Cervical Cancer Program, Cancer State Aid Program, and breast and cervical cancer treatment for eligible women through the Women's Health Medicaid Program. Office of Chronic Disease Prevention and Wellness programs and services include comprehensive tobacco use prevention activities including tobacco cessation services through the Georgia Tobacco Quit Line; population-based strategies to address chronic disease prevention and management; primary sexual violence prevention; health communication and education; primary prevention strategies to address obesity in children, youth, and adults; adolescent health and youth development; and community capacity building through the provision of technical assistance to community-based organizations to address chronic disease prevention, risk reduction, and positive youth development.

There are several intersection points between the HPDP Program and the Georgia MCH Program. The primary responsibility for adolescent health, including reducing adolescent pregnancy, is assigned to the HPDP Program. However, several programs within the Georgia MCH Program, including Title X, Title V, and WIC, share adolescent health promotion goals with the HPDP Program. Improved collaboration will allow programs to leverage existing funds and staff. The HPDP Program and the Georgia MCH Program will collaborate on the creation of a statewide adolescent health and pregnancy workgroup to define opportunities to improve adolescent health statewide. Obesity is another intersection point between the HPDP Program and the Georgia MCH Program. The HPDP Program has responsibility for administering grant-funded activities to reduce obesity throughout Georgia. Reducing obesity in Georgia is a goal shared by Georgia WIC. Through a collaborative relationship between Georgia WIC and the HPDP Program, several pilot projects will be initiated to promote improved nutrition and reduce obesity for women and infants receiving WIC benefits.

INFECTIOUS DISEASE AND IMMUNIZATION (IDI) PROGRAM

The IDI Program includes the HIV, STD, Tuberculosis (TB), and Immunization Units. The HIV Unit coordinates services through Georgia's HIV Care Ryan White Part B Program and HIV prevention. The STD Unit works to reduce morbidity associated with sexually transmitted disease in Georgia by preventing STDs and their complications in both the public and private sectors through coordinated, comprehensive statewide STD prevention; statewide STD screening; and surveillance of STDs. The TB Unit, which has legal responsibility for all TB clients in Georgia regardless of who provides the direct services, identifies and treats persons who have active TB disease; finds, screens, and treats contacts; and screens high-risk populations.

The work of the Immunization Unit is carried out through the efforts of trained state staff and through partnership and collaboration with medical organizations, other state agencies, and community coalitions. Vaccine financing is accomplished through the use of state and federal funds to provide vaccines for uninsured and under-insured children in Georgia and for certain adult populations. The Immunization Unit oversees the acquisition, distribution, and management of vaccines through the Vaccines for Children (VFC) Program, as well as vaccines acquired through state and other federal funding.

All health care providers are mandated by law to report to the Georgia Registry of Immunization Transactions and Services (GRITS) all immunizations given to persons of any age. They also can access this database to get updated information on their clients' immunization status. In addition to housing immunization records, GRITS allows providers to track their vaccine inventory, print the Georgia Certificate of Immunization and send reminder/recall notices to clients.

There are several intersection points between the IDI Program and the Georgia MCH Program. These include Chlamydia rates among women of child bearing age and adolescents and immunizations rates. Program leadership in the IDI Program and Georgia MCH Program are working to identify opportunities and strategies to lower Chlamydia rates. As a result of findings from the 2010 Needs Assessment, lower immunization rates among WIC participants were identified. As part of the activity plan for National Performance Measure 7 for FY11, Georgia WIC (a program of the Georgia MCH Program) and the IDI Program will collaborate to develop an intervention strategy and identify possible pilot sites for implementation.

ENVIRONMENTAL HEALTH (EH) PROGRAM

The EH Program provides primary prevention through a combination of surveillance, education, enforcement, and assessment programs designed to identify, prevent and abate environmental conditions that adversely impact human health. Programs include Chemical Hazards, Food Service, Land Use (On-Site Sewage), Swimming Pools, Tourist Accommodations, Well Water, and other programs (e.g., Mosquito-borne Viral Diseases, Indoor Air Quality Assistance). There has been limited collaboration between the EH Program and the Georgia MCH Program. However, with an increasing literature on the impact of environmental health on birth outcomes and women's health, there is significant potential for collaboration.

EPIDEMIOLOGY PROGRAM

While the MCH epidemiology function is assigned to the Georgia MCH Program, there are several opportunities for increased collaboration between the Epidemiology Program and the Georgia MCH Program.

The Epidemiology Program includes the Office of Health Indicators for Planning (OHIP). There are significant opportunities for OHIP to support data linkages and data set creation that can be used by the MCH Epidemiology Section in the Georgia MCH Program. OHIP has been and will continue to be a partner in the implementation of the Georgia State System Development Initiative grant. OHIP also includes a strong geographic information system (GIS) capacity. All of the maps presented in the 2010 Needs Assessment were produced by OHIP. Through improved collaboration and communication, the

Georgia MCH Program and OHIP seek to expand the use of GIS for program planning and decision making.

Also included in OHIP is the DPH's Online Analytical Statistical Information System (OASIS), a suite of interactive, web-based tools used to access standardized health. Through OASIS, program staff and stakeholders have access to indicators that are available by a variety of population, disease, and survey characteristics. Where applicable, data are available by age groups, race, ethnicity, sex (person), census tract, county, health district, legislative district, state (place), and year (time). OASIS plays an integral role in program planning, which includes determining target population areas, formulating financial plans, monitoring program effectiveness, program evaluation and reporting program outcomes. Continued investment in OASIS is needed to ensure it remains technologically updated and meets the changing needs of the Georgia MCH Program and its stakeholders.

The Epidemiology Program is also responsible for the administration of the Behavioral Risk Factor Surveillance System (BRFSS) and the Youth Risk Behavior Surveillance System (YRBSS). These are vital surveillance systems to understand the changing dynamics in two MCH populations – women and adolescents. The Epidemiology Program and Georgia MCH Program will work collaboratively to ensure that appropriate state-developed questions can be added to these surveys, that BRFSS can be used to measure preconception health throughout Georgia, and that each survey has adequate sample size to allow for thorough analyses of the collected data.

GEORGIA PUBLIC HEALTH LABORATORY (GPHL)

GPHL provides screening, diagnostic and reference laboratory services to Georgia citizens through county health departments, public health clinics, physicians, other clinical laboratories, hospitals and state agencies. GPHL's five broad areas of testing and support include: chemistry (Newborn Screening Unit, Lead Screening and Fluoride Testing), Emergency Preparedness (Biological/Chemical Terrorism and Molecular Biology Units), Facilities Support, Microbiology (Bacteriology, Microbial Immunology, Mycobacteriology/ Mycology, Parasitology, and Virology Units), and Operations. The collaboration between the Georgia MCH Program and the State Laboratory is limited to newborn screening. The State Laboratory tests all newborn screening blood spots for metabolic and genetic disorders. When follow-up is required based on a laboratory finding, this activity is the responsibility of the Georgia MCH Program.

STATE VITAL RECORDS OFFICE

The State Vital Records Office maintains Georgia vital records and events, which are defined as birth, death, fetal deaths (stillbirth), induced termination of pregnancy, marriage and divorce certificates and reports. The Georgia MCH Program relies on the Vital Record Program for data needed to track key MCH measures including, but not limited to, low birth weight, preterm birth, infant mortality, and adequacy of prenatal care. The Georgia MCH Program will provide support to the Vital Records Program to ensure accuracy of the data and timeliness of its availability.

INJURY PREVENTION (IP) PROGRAM

While the IP Program is administratively located in the Division of Emergency Preparedness, there still exists a strong relationship between the IP Program and the Georgia MCH Program. Each program recognizes that several Title V National Performance Measures address injury prevention. Furthermore, as demonstrated by the data collected as part of the 2010 Needs Assessment, unintentional injuries have a significant impact on the health of women, infants, and children throughout Georgia. The IP Program and Georgia MCH Program have collaborated by helping to ensure that paramedics have the appropriate tools to treat childhood injury, supporting training and the distribution of car safety seats to children and children with special health care needs, and supporting the distribution of fire alarms. It is through the IP Program that a new partnership is developing between Georgia Fatality Review and the Georgia MCH Program. The IP Program and Georgia MCH Program will continue to identify new and innovative opportunities for collaboration to reduce the impact of unintentional injuries in Georgia.

OTHER GOVERNMENT AGENCIES WITHIN THE STATE OF GEORGIA

Limited involvement of other government agencies within Georgia was noted as a weakness in the 2010 Needs Assessment (see page 40). While improved strategic collaboration and coordination is needed, MCH Program staff work with other government agencies on a daily basis. A description of each government agency with which MCH Program staff work and/or that address the needs of children and families follows.

GEORGIA'S CHILD FATALITY REVIEW PROGRAM

Georgia's Child Fatality Review Program (GCFR) was established in 1990 by statute. It is an independent program administered out of the Georgia Office of the Child Advocate. The mission of GCFR is to serve Georgia's children by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse cases and child fatality investigations, and monitoring the implementation and impact of the statewide child injury prevention plan in order to prevent and reduce incidents of child abuse and fatalities in the state. The program is funded by Children's Justice Act dollars and state general funds.

The GCFR State Team is comprised of 17 members, who meet quarterly to oversee the county child fatality review process, report to the governor annually on the incidence of child deaths, and recommend prevention measures based on the data. Georgia also has 159 local teams with seven mandated members that are directed to meet within 30 days of a child's death. The county coroner alerts the district attorney, who initiates the review. GCFR teams review all injury, SIDS, unexpected or unattended deaths to children who are less than 18 years old.

Standardized data reporting forms are completed for all reviews. State vital statistics are used to serve as a form of quality assurance to make sure that all appropriate deaths are being captured for review. The Division of Public Health aggregates and analyzes the data, which is used for an annual report to the community.

In 2009, GCFR was selected as one of five recipients of the CDC's SUIDI pilot project which focuses on improving infant death scene investigations and CFR reporting in a multi-disciplinary setting.

MCH Program staff collaborate with the GCFR and serve on committees, as appropriate. Planned activities with GCFR include a study on infant safety and possible support for staff.

GOVERNOR'S OFFICE FOR CHILDREN AND FAMILIES

The Governor's Office for Children and Families (GOCF) mission is to build capacity in communities to improve outcomes for Georgia's children, youth, and families. GOCF was created in 2008 to ensure that Georgians are using child welfare resources – funding, policy, and personnel – in a way that is targeted, consistent, and most effective. This initiative united the Children's Trust Fund Commission (CTFC), Children and Youth Coordinating Council (CYCC), Office of the Child Advocate, and Office of Child Fatality Review in the newly organized GOCF.

GOCF supports and strengthens families and improves outcomes for Georgia's children and youth through a community-based system of prevention and intervention services, known as Caring Communities for Children and Families. The Caring Communities system of care approach integrates care planning and management through partnerships with community organizations, children, youth, and families. Organizations work in partnership to develop a network in which children, youth and families can access the programs and services that meet their needs. Although system of care was developed to focus on children and youth with emotional disorders and their families, the model translates well into other target groups.

GOCF is leading Partnerships for Healthy Communities, an interagency collaborative project supported by the University of North Carolina at Chapel Hill's PREVENT Institute. In addition to GOCF, partner agencies include DFCS and Children's Health Care of Atlanta. Partnerships for Healthy Communities seeks to decrease the rate of physical abuse and abuse-related injuries in Georgia's children from infancy to three years of age. To accomplish this, Partnerships for Healthy Communities is assisting health-care providers -- including pediatricians, family practice physicians, and their staff -- in preventing, recognizing, and reporting physical and sexual abuse as well as neglect.

GOCF, in partnership with DECAL, leads Strengthening Families Georgia, an interagency collaborative project that seeks to create a child abuse and neglect prevention initiative that can help program developers, policymakers, and advocates embed effective prevention strategies into existing systems. The project uses the Strengthening Families assets-based framework of protective factors in all systems, programs, services, and activities supporting families with young children. Initiative goals focus on two results areas: 1) practice changes related to how agencies promote the protective factors framework with families, and 2) systems' changes that promote the framework by making changes at the system or organization/program level.

GOCF staff participate on the ECCS Steering Committee. GOCF is the lead agency for the Maternal, Infant, and Early Childhood Home Visiting Grant Program. The MCH Program will partner will GOCF on the direction and implementation of these funds and lead the needs assessment.

DEPARTMENT OF HUMAN SERVICES

The Department of Human Services (DHS) provides Georgia with customer-focused human services that promote child and adult protection, child welfare, stronger families, and self-sufficiency. DHS includes the Division of Family and Children Services (DFCS), the Division of Aging Services (DAS), the Division of Child Support Services (DCSS), the Office of Residential Child Care (RCC), and support offices. DFCS is responsible for investigating child abuse; finding foster homes for abused and neglected children; helping low income, out-of-work parents get back on their feet; assisting with childcare costs for low income parents who are working or in job training; and providing support services and programs to help troubled families. DFCS and DPH are working to identify and explore opportunities to better serve the children and families of Georgia. Each agency has identified 15 representatives who participated in a meeting on May 27, 2010 to identify collaborative opportunities. Collaboration goals include: 1) determining how DFCS and DPH can more efficiently serve the same customer; 2) identification of early intervention opportunities in the two organizations that could help avoid deep-end services; 3) identification of opportunities to conduct common marketing and provide information in a coordinated way; and 4) share customer, outcomes, and program and services data between the two organizations. Co-leads were identified at the May 27 meeting to move collaboration goals forward.

DEPARTMENT OF EDUCATION

The Department of Education (DOE) oversees public education throughout the state, ensuring that laws and regulations pertaining to education are followed and that state and federal money appropriated for education is properly allocated to the Georgia's 180 local school systems. DOE is comprised of five offices under the State Superintendent of Schools: the Office of Policy and External Affairs; Office of Standards, Instruction, and Assessment; Office of Education Support and Improvement; Office of Finance and Business Operations; and Office of Technology Services.

The Divisions for Special Education Services and Supports, located in Standards, Instructions, and Assessment, include programs and services that support local school districts in their efforts to provide special education and related services to students with disabilities. These services focus on enhancing student achievement and post-secondary outcomes through implementation of regional and statewide activities for students, families, educators, administrators, and other stakeholders. Targeted areas for services and supports include accessible instructional materials, assistive technology, curriculum access and alignment, dropout prevention, family engagement, least restrictive environment, positive behavior supports, and transition. Additional services include ensuring compliance with federal and state regulations for special education, collecting and analyzing data on education services and outcomes, providing guidance and oversight for federal and state special education funds, and coordinating resolution requirements as required by state and federal requirements.

DOE has a memorandum of agreement with the DCH that endorses and encourages joint health and human services and education planning and programming targeting reductions in teen pregnancy, substance abuse, school failure, and delinquency. In many parts of the state, strong relationships have been developed between local public health agencies and the schools. As the Part B IDEA lead agency, DOE works closely with Babies Can't Wait, the Part C IDEA program in Georgia, in the MCH Program to ensure that children are successfully transitioned between programs at 3 years of age. DOE staff also serve on the Babies Can't Wait Interagency Coordinating Council.

With the passage of House Bill 229 as part of the 2009 Georgia Legislative Session another collaborative opportunity was created. House Bill 220 requires local school systems to conduct an annual fitness assessment. The MCH Program and Health Promotion and Disease Prevention Program are partnering with DOE to implement the selected assessment tool at several pilot sites throughout Georgia and to fund pieces of the full implementation. The MCH Program hopes to ensure that data collected as a result of this legislation is used for epidemiologic research and enhanced surveillance of obesity and physical activity.

BRIGHT FROM THE START: THE DEPARTMENT OF EARLY CARE AND LEARNING

Bright from the Start: The Department of Early Care and Learning (DECAL) is responsible for meeting the child care and early education needs of Georgia's children and their families. DECAL oversees a wide range of programs focused on children ages birth to school age and their families. These programs include: 1) administering Georgia's Pre-K Program; 2) licensing and monitoring the state's center-based and home-based child care facilities (approximately 10,000); 3) overseeing the federal Child and Adult Care Food Program and the Summer Food Service Program; 4) maintaining the Standards of Care Program and Family Homes of Quality to help child care providers enhance their program quality; 5) housing the Head Start State Collaboration Office; 6) administering the federal Even Start dollars to promote family literacy; and 7) providing technical assistance, training, and support to families and child care providers who care for children with special needs.

DECAL collaborates with Head Start, Family Connection Partnership, the Department of Human Services Family and Children Services, DPH, and Smart Start Georgia to blend federal, state, and private dollars to enhance early care and education. DECAL and DPH have a memorandum of agreement for enhanced services to support early childhood health and development for children and youth. DECAL is implementing an Agency Accepted Trainer pilot program with other state agencies to provide for-credit-training for Georgia child care providers. The MCH Program has been identified as the first Agency Accepted Trainer. MCH Ages and Stages training opportunities have been posted on the DECAL website and local training will be initiated by summer 2010. In addition, DECAL staff serves on MCH's Early Childhood Comprehensive Systems (ECCS) Steering Committee and on ECCS subcommittees.

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

The Department of Behavioral Health and Developmental Disabilities (DBHDD) provides treatment and support services to people with mental illness and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD has five regions. Each region has a regional office, which is an extension of the DBHDD state office to the local area. The regional office oversees the network of state-supported DBHDD community and hospital services in the region.

Georgia's services for children and youth who are seriously emotionally disturbed (SED) focus on family support and intervention and preventing crises whenever possible. When crises do occur, public mental health services aim to serve the child in the home or close to home if possible, and to avoid hospitalization, which can be traumatic for young children. The services a child and family receives depends on a professional determination of level of need and the services and other community resources available. Services vary by region and may include: crisis services, outpatient services, community support services, intensive family intervention, and outdoor therapeutic programs. Current

child and adolescent mental health initiatives include Community Based Alternatives for Youth (CBAY) and KidsNet Georgia. The CBAY 1915(c) Waiver Home and Community-Based Services demonstration program uses a systems approach that targets youth served by multiple agencies, striving to coordinate, blend, and braid programs and funding to create a comprehensive behavioral system that ensures youth are placed in and remain in intensive residential treatment only when necessary and that a coordinated system of services at the community level is available.

DBHDD's KidsNet Georgia Project is designed to support the transformation of the state's child behavioral health system by strengthening and enhancing the capacity to develop, expand, and sustain behavioral health services across all child-serving agencies for children and adolescents experiencing SED and/or substance abuse and their families. The project is supported by two federal grants (Child and Adolescent State Infrastructure Grant and State Adolescent Coordination Grant). The First Lady's Children's Cabinet serves as the oversight body for the KidsNet Georgia Project. The Cabinet is comprised of state child-serving agency heads at the department and division levels and provides state level support and guidance for grant initiatives that support children, families, and communities. The DCH Commissioner serves on the Cabinet. The MCH Program is represented in the KidsNet Collaborative, the project's operational body which governs the project, and in several of KidsNet workgroups. MCH's ECCS Initiative has been integrated into the project as a subcommittee to help support efforts involving early childhood developmental screening and socio-emotional health. DBHDD staff, including the KidsNet Director, serves on the ECCS Steering Committee. DBHDD also is a member of the Georgia ECCS State Team. As a result of these collaborative activities, the KidsNet Part C Finance Committee has been moved to the ECCS Initiative as an ECCS Partnership Subcommittee work group.

DPH also works with DBHDD around a number of state and local level concerns that relate to the MCH population such as youth risk prevention and tobacco use prevention. A DBHDD Mental Health representative serves on the BCW Interagency Coordinating Council. DBHDD's Division of Addictive Diseases Office of Prevention Services provided Substance Abuse Mental Health Services Administrative block grant funding to help support the DPH's Healthy Families Georgia Mental Health Screening Project (HFG MHSP) which was implemented between October 1, 2008 and September 30, 2009. The project was designed to help decrease the risk of suicide in pregnant and parenting women with depression and address associated issues with mother/child attachment and positive parenting in mothers participating in Healthy Families Georgia programs.

DEPARTMENT OF JUVENILE JUSTICE

The Department of Juvenile Justice (DJJ) provides supervision, detention, a range of treatment and education services for youths referred by the Juvenile Courts, and assistance or delinquency prevention services for at-risk youth through collaborative efforts with other public, private, and community entities. Over 52,000 youth are served annually, including youth who are placed on probation, sentenced in short-term incarceration, or committed to DJJ's custody by Juvenile Courts. DJJ, Corrections, Pardons and Parole, and MCH work collaboratively to strengthen relationships and create a continuum of care for youth leaving the state's youth detention centers to address their need for community-based health and mental health services.

SELECTED NON-GOVERNMENTAL STAKEHOLDERS

The stakeholders listed below are primarily statewide service organizations, advocacy groups, and professional associations/societies. Representatives from several of these stakeholders participated in the focus group held specifically for statewide professional associations, advocacy organizations, academia, and service organizations (see page 28), the focus groups for the ECCS steering committee (see page 29), and/or the Title V Priority Needs Selection Meeting (see page 343). Stakeholders and their descriptions listed in *Section 4. MCH Program Capacity by Pyramid Level* in the *State Program Collaboration with Other State Agencies and Private Organizations* subsection beginning on page 335 of the document are not repeated here.

ANNIE E. CASEY FOUNDATION

Atlanta is one of three cities designated by the Annie E. Casey Foundation as a civic site, a place where the Foundation has a long-term commitment to improving the futures of at-risk children. Many of the most vulnerable families live in five of Atlanta's oldest neighborhoods located just south of Downtown, in Neighborhood Planning Unit V (NPU-V). These neighborhoods comprise a once-thriving African-American community that has experienced a great deal of property disinvestment, population decrease, and general economic decline over the past 30 years. To be a catalyst to strengthen families in NPU-V, the Annie E. Casey Foundation and the Atlanta Civic Site have been working to promote neighborhood-scale programs, policies, and activities that contribute to strong, family supporting neighborhoods. There is significant synergy between the maternal and child health goals of the Annie E. Casey Foundation and the MCH Program. Building upon this organization's participation in the 2010 Needs Assessment activities, increased future collaboration is expected.

CHILDREN'S HEALTH CARE OF ATLANTA

Children's Health Care of Atlanta (CHOA) cares for more than half a million patients annually and operates three children's hospitals in metro Atlanta (Egleston, Scottish Rite, and Hughes Spalding) and 16 neighborhood locations (including four Immediate Care Centers, one Primary Care Center, and the Marcus Autism Center). CHOA is the largest Medicaid provider in the state, serving eight out of ten pediatric inpatient Medicaid cases in Atlanta and four out of ten statewide.

Nationally recognized CHOA programs include the Aflac Cancer Center (including the Sickle Cell Disease and Hematology Programs), Children's Sibley Heart Center, Emergency Services, Neonatal Intensive Care Unit, Orthopedics, Pulmonary, and Transplant Services. Other programs include Asthma; Autism and Related Disorders; Brachial Plexus; the Child Protection Center; Craniofacial; Cystic Fibrosis; Critical Care; Dentistry; Diabetes; Gastroenterology, Hepatology and Nutrition; General Surgery; Genetics; Immediate Care; Nephrology; Neurosciences; Orthotics and Prosthetics; Otolaryngology; Pain Relief; Pulmonary; Radiology; Rehabilitation; Sleep Center; Sports Medicine; Surgery; Urology; and Wellness and Safety. In 2009, CHOA provided care for 282,856 unique patients from all 159 counties in Georgia.

EMORY UNIVERSITY SCHOOL OF MEDICINE DEPARTMENT OF HUMAN GENETICS

The Emory University School of Medicine Department of Human Genetics provides adult and pediatric consultation and management of genetic disease throughout metropolitan Atlanta and much of the state. It operates three state-of-the-art diagnostic laboratories dealing with cytogenetics, metabolic diseases, and molecular diagnostics. The Department has the largest National Institutes of Health (NIH)-funded programs in both Down syndrome and Fragile X syndrome research in the country. The Emory University School of Medicine Department of Human Genetics has a contractual relationship with the MCH Program and is vital to the success of the newborn screening program in Georgia.

FAMILY CONNECTION PARTNERSHIP

The Family Connection Partnership is a public/private partnership created by the State of Georgia and funders in the private sector to help communities address the serious challenges facing Georgia's children and families. The Partnership also serves as a resource to statewide agencies and organizations that work to improve the conditions of children and families. As a non-profit intermediary organization, the Partnership works closely with community, state, and national partners to provide training and technical assistance to Family Connection county collaboratives; enhances public awareness, understanding, communication, and commitment to improve results for children and families; and uses research and evaluation to promote effective practices and programs. Family Connection serves on the ECCS Steering Committee and on the ECCS Planning Committee.

GEORGIA BREASTFEEDING COALITION

The Georgia Breastfeeding Coalition seeks to improve the nutritional status and overall health of families in Georgia by working collaboratively to protect, promote, and support breastfeeding throughout Georgia communities, health care facilities, worksites, schools and faith-based organizations through legislation, policy, social marketing, outreach, and education. The Georgia Breastfeeding Coalition is expected to be a strong partner as the MCH Program seeks to increase breastfeeding in Georgia through the implementation of activities associated with National Performance Measure 11.

GEORGIA CAMPAIGN FOR ADOLESCENT PREGNANCY PREVENTION

The Georgia Campaign for Adolescent Pregnancy Prevention (G-CAPP) is the only non-profit state-level teen pregnancy prevention organization in Georgia solely dedicated to eliminating teen pregnancy. G-CAPP serves as an expert in teen pregnancy prevention and youth development in Georgia by replicating evidence-based programs for young people, building local capacity to implement effect strategies, and advocating for policies that support young people. G-CAPP provides training and technical assistance to youth-serving professionals on effective approaches to prevent teen pregnancy, translates and disseminates information to the public, and evaluates the effectiveness of its efforts, using process, impact, influence, and leverage measures. G-CAPP is expected to be a strong partner as the MCH Program seeks to reduce adolescent pregnancy and repeat adolescent pregnancy through the implementation of activities associated with National Performance Measure 8.

GEORGIA CHILDREN'S HEALTH ALLIANCE

The Georgia Children's Health Alliance (GCHA) is a statewide collaboration uniting public, private, not-for-profit, business sectors, and pediatric health experts to create healthier futures for Georgia children. Children's Health Care of Atlanta (CHOA), March of Dimes, and Prevent Child Abuse Georgia serve as the lead agencies for GCHA. In 2009, GCHA and DPH joined together to lead the development of the 2010 "REFOCUS on Child Health in Georgia" report. The purpose of the report, which was released in April 2010, is to: 1) establish a baseline showing where the health of Georgia's children is today and create a starting point for conversations about child health issues, and 2) highlight what data are missing or need improvement and to bring organizations together to work on filling those data gaps. The report not only highlights health issues facing Georgia, but also looks at obstacles to families, individuals, health professionals, and organizations that are looking to improve health outcomes for Georgia's children. In addition to the report, GCHA is leading the implementation of the SHAPE act to monitor and improve fitness among school children as well as supporting curriculum in child care centers that promote healthy eating and physical activity. GCHA is also supporting reduction in child abuse and neglect through parent interventions and evaluation of home visitation models. The MCH Program Director serves as a member of the GCHA cabinet.

GEORGIA PARENT TEACHER ASSOCIATION

The Georgia Parent Teacher Association (PTA) serves as a link between the national organization and membership within the state, serving as a resource for Georgia families and communities and as a strong advocate for the education and well-being of every child. The Georgia PTA represents over 330,000 members at the state legislature, state board of education, and other education and child-focused organizations; provides support and training for local PTAs through workshops and publications; and coordinates special projects to promote the welfare of Georgia's children and youth. The Georgia PTA participated in the focus group held specifically for statewide professional associations, advocacy organizations, academia, and service organizations.

GEORGIA POISON CENTER

The Georgia Poison Center, the official State poison center, operates a 24-hour poison emergency treatment information service, providing assistance and expertise in the medical diagnosis and management of human and animal poisonings. The Center provides free, timely advice and information to parents, child care providers, pharmacists, nurses, and doctors and plays a significant role in reducing the cost of treatment and the severity of poisonings where time is of the essence. The Center is also a training site for health care professionals and serves the state by coordinating outreach and education programs to increase awareness of poison prevention and first-aid.

GRADY HEALTH SYSTEM

The Grady Health System (GHS) is one of the largest public hospitals in the US and the only level-1 trauma center within a 100 mile radius of Atlanta. Grady provides primary care services at its Primary Care Center and eight Neighborhood Health Centers located around Fulton and DeKalb counties. Other GHS service centers include a Diabetes Center, Georgia Cancer Center for Excellence and Avon Foundation Breast Health Center, and 100 other subspecialty services. Grady houses Georgia's Poison

Center and 24-hour Rape Crisis and Advice Nurse lines. Its Infectious Disease Program was named one of the top three HIV/AIDS outpatient clinics in the country. The Georgia Comprehensive Sickle Cell Center at GHS provides preventative comprehensive primary care to the sickle cell population in northwest Georgia. Twenty-four hour emergency care is available to non-pregnant, non-trauma adults over age 16 years. Patients under 16 years are seen in the Hughes Spalding Children's Hospital emergency facility directly across the street. The Grady Health System has several contracts with the MCH Program to provide services that include, but are not limited to, newborn screening follow-up, family planning, and WIC.

HANDS AND VOICES – GEORGIA CHAPTER

Hands and Voices – Georgia Chapter is a parent-driven, non-profit organization providing families with children who are deaf or hearing impaired with the resources, networks, and information they need to improve communication access and educational outcomes for their children. Its outreach activities, parent/professional collaboration, and advocacy efforts are focused on enabling deaf and hearing impaired children to reach their highest potential.

HEALTHY MOTHERS, HEALTHY BABIES COALITION OF GEORGIA

Healthy Mothers, Healthy Babies Coalition of Georgia (HMHB) is a strong, statewide voice for improved access to health care and improved maternal and child health outcomes through a statewide network of grassroots advocates. HMHB operates the POWERLINE, Georgia's toll-free, bilingual helpline for health care referrals funded by the Maternal and Child Health Program of the Georgia Division of Public Health. The POWERLINE maintains a database of Georgia's low-cost and sliding-scale providers, free clinics, public health programs such as Babies Can't Wait, and community health services. They also refer callers to appropriate WIC Clinics and record reports of complaints or fraud.

HEALTHY START PROGRAMS

Healthy Start Programs are community-driven and located in the poorest neighborhoods in the United States. Every Healthy Start project has developed a consortium composed of neighborhood residents, clients, medical providers, social service agencies, faith representatives, and the business community. This ensures that not just Healthy Start, but the whole community is committed to fight to reduce infant mortality and low birth weight. Georgia Healthy Start programs include the August-Richmond County Partnership, Center for Black Women's Wellness Healthy Start, Enterprise Community Healthy Start, and Heart of Georgia Healthy Start.

MARCH OF DIMES GEORGIA CHAPTER

The March of Dimes Georgia Chapter (MOD) is dedicated to improving the health of Georgia's babies by preventing birth defects, premature birth and infant mortality. Georgia MOD is providing support for selected provider groups interested in moving from a traditional prenatal care model to a group prenatal care model using Centering Pregnancy as an option for their clients. This innovative model of prenatal care has been found to reduce premature births in a randomized clinical trial and has had other positive outcomes. Other Georgia MOD programs include A Champion for Babies and Moms, Smoking Cessation, the NICU Bedside Reading program, and Grand Rounds Professional Development for Health

Care Providers. Through the A Champion for Babies and Moms initiative, MOD is working with the Centers for Disease Control and Prevention (CDC) in reducing disparities in premature births by testing models of delivering preconception and prenatal education and services to minority clients, such as the Centering for Pregnancy model. The Georgia MOD Education Workgroup is helping DPH's Health Promotion and Disease Prevention program and the Tobacco Technical Assistance Consortium (TTAC) implement a strategic plan for tobacco cessation education. An integral part of the Georgia MOD NICU Family Support project is the Neonatal Intensive Care Unit (NICU) Bedside Reading Program. Through supplying hospitals with books to place in the NICU, the program allows parents to read to their baby in the NICU as well as to the baby's siblings. The annual Grand Rounds program provides continuing education for perinatal health care providers on topics relevant to Georgia MOD's mission: prevention of birth defects. To increase collaboration between the MCH Program and MOD, the MCH Program Director is participating on the Statewide Program Services Committee.

UNITED WAY OF METROPOLITAN ATLANTA

United Way of Metropolitan Atlanta serves 13 counties in the metro region. Staff and volunteers in the local offices in each of the 13 counties work on six goal areas to ensure the metropolitan Atlanta community thrives: 1) babies are born healthy; 2) children enter school ready to learn and graduate prepared for careers; 3) young people avoid risky behaviors; 4) families are self-sufficient; 5) people have access to primary health care; and 6) homeless people are housed within a year. United Way's 2-1-1 online database is the most comprehensive listing of programs and services in the metro Atlanta area. 2-1-1 referral specialists are also available by telephone to provide information on programs and services. United Way programs include Smart Start Georgia, the early learning division of United Way of Metropolitan Atlanta. Smart Start has joined forces with a coalition of early childhood advocates and professionals to implement four Early Reading First (ERF) grants throughout metro Atlanta. These programs focus on low-income, preschool children with risks for reading difficulties. Other Smart Start metro Atlanta programs include Born Learning, the Georgia Parents as Teachers Network, Parent Engagement, Play Smart and SPARK Georgia. Metro and statewide programs include Get Ready to Read and the Substitute Teacher Program.

VOICES FOR GEORGIA'S CHILDREN

Voices for Georgia's Children is an independent, non-profit organization whose mission is to substantially improve the state's low *Kids Count* child well-being ranking by engaging lawmakers and the public into building a sustained, comprehensive, long-term agenda to impact the lives of Georgia kids in five distinct areas: health, safety, education, connectedness, and employability. Through advocacy, original research, and analysis, Voices address three strategic priorities: 1) a long-term policy agenda for children, 2) expanding and educating leadership for children, and 3) building public will to improve child well-being.

PROFESSIONAL ASSOCIATIONS/SOCIETIES

GEORGIA ACADEMY OF FAMILY PHYSICIANS

The mission of the Georgia Academy of Family Physicians (GAFP) is to promote the health of the citizens of Georgia by advancing the specialty of Family Medicine through education, advocacy, and service to family physicians in the State of Georgia. GAFP committees include Education, Finance, Legislative, Membership, and Practice Management/Managed Care. GAFP provides its membership with up-to-date information about topics that concern family physicians and their patients (e.g., managed care, pending legislation); Continuing Medical Education credits; access to legal, pharmaceutical, managed care, and peer resources; and networking and professional development activities. GAFP has a contractual relationship with the MCH Program.

GEORGIA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS

The mission of the Georgia Chapter of the American Academy of Pediatrics (GA-AAP) is to: 1) improve the health and welfare of all infants, children, and adolescents in the State of Georgia; 2) study the scientific, educational, social, economic, and legislative aspects of medicine to secure and maintain the highest standards of practice in pediatrics; 3) promote excellence in pediatric care by organizing programs of post-graduate education; 4) unite qualified primary care pediatricians and pediatric medical and surgical subspecialists of the state into a representative organization for the advancement of the practice of pediatrics; and 5) further the policies and objectives of the American Academy of Pediatrics at the state and local level. GA-AAP committees include Adolescence, Children with Disabilities, Child Abuse and Neglect, Child Health Care Financing, Continuing Medical Education, Coding and Nomenclature, Bioethics, Emergency Medicine, Families and Professionalism, Genetics, Infectious Diseases, Early Childhood Adoption and Dependent Care, Environmental Health, Fetus and Newborn, Hospital Care, Nutrition, Public Relations, Reach Out and Read, School Health, Smoke Free, Poison and Injury Prevention, Practice Management and Managed Care, Psychosocial Health, Rural Health, Sports Medicine and Fitness, Subspecialty, and Young Physicians. Task forces include the Asthma, Bright Futures, Clinical Information Technology, Mental Health, Oral Health, and Quality Improvement. In partnership with the DPH MCH Program, GA-AAP is implementing EPIC (Educating Physicians In Their Communities) education programs that offer free interactive peer to peer education programs in Immunization and/or Breastfeeding. The collaboration between the GA-AAP and the MCH Program is formalized in a annual contract.

GEORGIA OBESTETRICS AND GYNECOLOGY SOCIETY

The Georgia Obstetrics and Gynecology Society's (GOGS) membership includes physicians who are eligible for membership in a county medical society and whose practice or teaching is limited to obstetrics or gynecology or have a major interest in such fields. The Society offers annual scientific meetings, informative newsletters, coding workshops specific to OB/GYNs, legislative advocacy, and liaison with national and state organizations. GOGS has participated throughout the 2010 Needs Assessment process and there are several opportunities for collaboration in the FY11 activity plan. If the MCH Program is to achieve its goals, the cooperation, support, and partnership of GOGS will be crucial. GOGS collaboration will be needed to achieve success for National Performance Measures 8, 15, 17, and 18 and State Performance Measures 2, 7, and 8.

GEORGIA RURAL WATER ASSOCIATION

The Georgia Rural Water Association (GRWA) is a non-profit organization representing rural water systems throughout the State of Georgia in regard to drinking water and wastewater needs. Of the nearly 6,000 water systems in Georgia, 90 percent serve 10,000 people or less. The GRWA mission is to offer assistance to these systems in their goal to provide clean, safe, healthy water to their communities. GRWA partners with the Oral Health Unit to provide training, technical assistance, and monitoring to water plant operators to achieve optimal fluoridation levels for all public, community water systems as mandated by Georgia law.

GEORGIA PUBLIC HEALTH ASSOCIATION

The Georgia Public Health Association (GPHA) is an association of individuals and organizations working to improve the public's health. GPHA's mission is to advocate for conditions in which all people and communities can be healthy; to promote the scientific foundation of public health practice and policy; and to assure a continuous voice broadly representing public health in Georgia.

GEORGIA ASSOCIATION ON YOUNG CHILDREN

The Georgia Association on Young Children (GAYC) encourages and supports healthy development in young children by increasing public awareness of the importance of early childhood education and improving the quality of programs for young children through learning opportunities for early childhood educators. GAYC efforts have included support of appropriate early learning standards and assessments for young children, accreditation of child care and early education programs, professional development opportunities for those who work with young children, early detection and support of children with special needs, and family support programs.

GEORGIA DENTAL ASSOCIATION

The Georgia Dental Association (GDA) is the state's professional dental association. Open to dentists licensed in the state of Georgia, GDA promotes and upholds the highest standards of dentistry and dental care for Georgians through education, advocacy, and professionalism. The GDA has been a long-term advocate in the state legislature to maintain funding for the dental public health program, increase access to dental care for low-income children and adults, and promote community water fluoridation. The GDA also partners annually with public health for specific programs such as "Give Kids a Smile Day" and "Special Smiles for the Special Olympics."

GEORGIA DENTAL HYGIENISTS' ASSOCIATION

The Georgia Dental Hygienists' Association (GDHA), the state's association of professional dental hygienists, uses emerging technologies, research, and evidence-based practices to empower and educate its membership for the enhancement of patient care and the advancement of the dental hygiene profession. GDHA is partnering with the Oral Health Unit to promote increased dental sealant application and work with district dental programs in sponsoring school-based dental sealant events.

GEORGIA HEAD START ASSOCIATION

The Georgia Head Start Association's membership includes the 30 organizations, including school systems, community action agencies, and universities that operate Head Start and Early Head Start programs in Georgia. Head Start services are provided to children and families in 157 out of 159 counties in Georgia. Georgia Head Start and Early Head Start programs provide comprehensive early childhood and family development services to children from birth to five-years-old, pregnant women, and families. Head Start agencies provide a range of individualized services in the areas of education and early childhood development; medical, dental, and mental health; nutrition; parent involvement and family support.

GEORGIA HOSPITAL ASSOCIATION

The Georgia Hospital Association (GHA) is a nonprofit trade association made up of member health systems, hospitals, and individuals in administrative and decision-making positions within those institutions. GHA serves 170 hospitals in Georgia. Its purpose is to promote the health and welfare of the public through the development of better hospital care for all of Georgia's citizens. Changes in the hospital environment and hospital policy have the potential to have a significant impact on the health of maternal and child health populations throughout Georgia. GHA will be a partner with which the MCH Program will work as it seeks to engage the hospital systems throughout Georgia to advance best practices and policy changes that may contribute to improved outcomes.

PARTNERSHIPS PROVIDING TECHNICAL SUPPORT

DISTANCE LEARNING AND TELEMEDICINE PROGRAM

The MCH Program collaborates with the state's Distance Learning and Telemedicine Program network to bring specialty health care to areas with limited access. Babies Can't Wait also utilizes telehealth technology.

EMORY UNIVERSITY ROLLINS SCHOOL OF PUBLIC HEALTH

The Emory University Rollins School of Public Health (RSPH) includes six academic departments (behavioral sciences and health education, biostatistics, environmental and occupational health, epidemiology, health policy and management, and global health) and hosts over 20 interdisciplinary centers. RSPH offers dual-degree programs with Emory's business, medical, nursing, and law schools. In addition, the schools of public health and medicine collaborate on many levels.

GEORGIA HEALTH POLICY CENTER

The Georgia Health Policy Center (GHPC), housed within Georgia State University's Andrew Young School of Policy Studies, provides evidence-based research, program development, and policy guidance. GHPC works locally, statewide, and nationally to improve health status at the community level, focusing on solutions to the toughest issues facing health care today including insurance coverage, long-term care, children's health, and the development of rural and urban health systems.

REGIONAL TRAINING CENTER FOR FAMILY PLANNING – TITLE X, REGION IV – CICATELLO ASSOCIATES, INC.

The Regional Training Center(RTC) for Family Planning – Title X -Region IV – Cicatelli Associates, Inc. (CAI) is located in Atlanta, Georgia and provides training, technical assistance, and regional conferences for all staff of the Department of Health and Human Services (DHHS) Title X funded family planning programs in Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee. CAI – RTC is a non-profit organization dedicated to enhancing the quality of health care and social services delivered to communities in need across Region IV. CAI – RTC offers expert training and capacity building assistance to help health and human service providers improve their services by confronting challenging health issues, reducing health disparities, eliminating stigma and discrimination, and tackling increasing needs with decreasing resources. The Georgia Family Planning Program providers receive training on educational needs identified by the providers of family planning services. In addition, technical assistance can be provided as identified by the program manager in conjunction with the providers, Office of Population Affairs (OPA) federal officer, and state's needs. During FY 2010, Georgia received technical assistance on how to make family planning clinics more efficient through a performance function activity.

UNIVERSITY OF GEORGIA COOPERATIVE EXTENSION SERVICE

The University of Georgia Cooperative Extension Service and its College of Agricultural and Environmental Sciences and the College of Family and Consumer Services reach more than 2 million Georgians through its education programs annually. The College of Family and Consumer Services provides research-based information on food preservation, parenting, housing, financial management, and healthy eating.

ADVISORY COUNCILS/COMMITTEES

ADVISORY COUNCIL FOR PUBLIC HEALTH

The Advisory Council for Public Health is responsible for providing assistance and guidance to DPH and DCH on all matters regarding public health programs. Eight council members, appointed by the governor, serve one to two year terms. The Advisory Council for Public Health received an update on the progress of the 2010 Needs Assessment and FY11 Title V MCH Services Block Grant application at its June meeting.

GEORGIA COMMISSION ON HEARING IMPAIRED AND DEAF PERSONS

The Georgia Commission on Hearing Impaired and Deaf Persons consists of seven members. At least two of the members must be hearing impaired persons, and the remaining five members of the commission are selected from among parents of children who are hearing impaired persons, persons who are involved with hearing impaired persons or programs, and representatives of private providers of services to hearing impaired persons. Each commission member serves for a three-year term. The Commission serves as the principal agency of the state to advocate on behalf of hearing impaired persons by working to ensure those persons have equal access to the services, programs, and opportunities available to others. It assists hearing impaired persons and parents of hearing impaired

persons who are students in advocating for equal access to services, programs, and opportunities; advises the Governor, General Assembly, and Commissioner of Community Health on the development of policies, programs, and services affecting hearing impaired persons, and on the use of appropriate federal and state moneys for such purposes; and creates a public awareness of the special needs and potential of hearing impaired persons.

GEORGIA EARLY CHILDHOOD COMPREHENSIVE SYSTEMS (ECCS) INITIATIVE STEERING COMMITTEE

The Georgia Early Childhood Comprehensive Systems (ECCS) Initiative Steering Committee is composed of key early childhood partners across the state. Funded by a grant from the federal Maternal and Child Health Bureau, Initiative activities include the development of two electronic survey tools to: 1) assess the current and potential contributions of existing ECCS partners related to each of the five ECCS component areas (medical and dental home, social emotional development of young children, early care and education, parenting education, and family support) and system capacity building potential and 2) identify public and private early childhood developmental screening practices and social-emotional program systems capacity at the local level. Partnerships have been developed with the Centers for Disease Control and Prevention (CDC) "Learn the Signs, Act Early" State Team and with KidsNet Georgia. A medical/dental home brochure is in the final stage of development to be used with families and non-medical early childhood case managers. A focus group was held specifically for the ECCS Steering Committee to ensure the needs of young children were well represented in the 2010 Needs Assessment.

GOVERNOR'S COUNCIL ON DEVELOPMENTAL DISABILITIES

The Governor's Council on Developmental Disabilities (DD Council) serves as an advisory body and provides broad policy advice and consultation to state agencies. A representative from the DD Council participates on the BCW Interagency Coordinating Council.

BABIES CAN'T WAIT INTERAGENCY COORDINATING COUNCIL

The Babies Can't Wait Interagency Coordinating Council (ICC) for Early Intervention, mandated under Part C of IDEA, is appointed by the governor to advise and assist DPH in planning, coordinating, and implementing a statewide system of early intervention services for children with or at risk for developmental delays. The council includes several required state agency partners and parents of children with disabilities.

NEWBORN GENETICS SCREENING ADVISORY COMMITTEE

The Newborn Genetics Screening Advisory Committee is comprised of representatives from various public and private organizations in the state who have a role within the system for screening, diagnosis, and intervention for metabolic and hemoglobin disorders. Involved organizations include the Georgia Chapter of the American Academy of Pediatrics, Georgia Chapter of the Academy of Family Physicians, Emory University Division of Medical Genetics, Medical College of Georgia, Grady Comprehensive Sickle Cell Center, Sickle Cell Foundation of Georgia, Inc., Georgia Hospital Association, Northside Hospital, and March of Dimes.

STATE COMMUNITY WATER FLUORIDATION ADVISORY COUNCIL

The State Community Water Fluoridation Advisory Council is composed of the State EPA Drinking Water Program Manager, and representatives from the Georgia Public Health Laboratory, GRWA, the Oral Health Unit, and the CDC National Fluoridation Engineer. The group meets quarterly to address emerging issues impacting the quality and breadth of the state water fluoridation program.

UNIVERSAL NEWBORN HEARING SCREENING AND INTERVENION (UNHSI) STAKEHOLDER'S GROUP

The Universal Newborn Hearing Screening and Intervention (UNHSI) Stakeholder's Group was initiated in April 2010. It is comprised of representatives from various public and private organizations in the state who have a role within the system for screening, diagnosis, and intervention for hearing loss. Involved organizations include Pediatric ENT of Atlanta (PENTA), Hands and Voices (Georgia Chapter), Auditory Verbal Center, Inc., Babies Can't Wait, Pediatrix, Georgia PINES, the Georgia Chapter of the American Academy of Pediatrics, and the Georgia Chapter of the Academy of Family Physicians.

SECTION 3: STRENGTHS AND NEEDS OF THE MATERNAL AND CHILD HEALTH POPULATION GROUPS

AN OVERVIEW OF HEALTH RANKINGS FOR GEORGIA

Health rankings can help state leaders understand problems in their state, serve as a reference point in determining how healthy the state is compared to others, provide a gauge to measure progress from year to year, raise awareness in the general community, and inform policymakers.

America's Health Rankings. America's Health Rankings is a joint effort of United Health Foundation, the American Public Health Association, and Partnership for Prevention (http://www.americashealthrankings.org/2009/). The purpose of the rankings is to promote public conversation concerning health and encourage action at the individual, local, state, and national level to improve the health of the population of the US. The America's Health Rankings report examines four groups of health determinants: 1) behaviors, 2) community and environment, 3) public and health policies, and 4) clinical care.

With a rank of 47th, Georgia falls in the ten states identified as having the weakest determinants. The other states include Mississippi, Nevada, Oklahoma, Texas, South Carolina, Louisiana, Alabama, Tennessee, and Arkansas. At 41st, Georgia also ranks in the bottom ten states with the weakest health outcomes along with Mississippi, Alabama, West Virginia, Kentucky, Louisiana, Tennessee, Oklahoma, Arkansas, and South Carolina. Comparisons of 2008 and 2009 rankings indicate that 14 states, including Georgia, experienced a decline. The state's overall ranking declining for the second year in a row, dropping from 41st in 2008 to 43rd the following year.

Two of Georgia's improvements in health indicators are a low prevalence of binge drinking (13.2 percent) and moderate per capita public health funding ($69). However, challenges include a low high school graduation rate (62.4 percent of ninth graders who graduate in four years), high incidence of infectious disease (24.6 cases per 100,000), high levels of air pollution (13.9 micrograms of fine particulate per cubic meter), and a high rate of uninsured population at 17.7 percent. The America's Health Ranking report notes that "Georgia ranked lower for health determinants than for health outcomes, indicating that overall healthiness may be declining over time."

State Scorecard on Health System Performance. The Commonwealth Fund Commission on a High Performance Health System ranks state health system performance over five dimensions: access, prevention and treatment, avoidable hospital use and costs, equity, and healthy lives (http://www.commonwealthfund.org/Content/Publications/Fund-Reports/2007/Jun/Aiming-Higher--Results-from-a-State-Scorecard-on-Health-System-Performance.aspx). Georgia's 2009 ranking is 38th, an improvement over its 2007 ranking of 44th. Within the dimensions, Georgia ranked 36th in access, 39th in prevention and treatment, 24th in avoidable hospital use and costs, 28th in equity, and 37th in healthy lives.

Kids Count. Each year the Annie E. Casey Foundation ranks US states on ten measures of child well-being (http://datacenter.kidscount.org). Georgia's overall rank in 2009 was 42nd, placing the state in the bottom ten states. Georgia performed worse than the national average in all but one of the ten indicators below.

Kids Count Key Indicators		
Key Indicator	Georgia Percent/Rate	US Percent/Rate
Percent low-birth weight babies (2006)	9.6%	8.3%
Infant mortality rate (deaths per 1,000 live births) (2006)	8.1	6.7
Child death rate (deaths per 100,00 children ages 1-14) (2006)	21.0	19.0
Teen death rate (deaths per 100,000 teens ages 15-19) (2006)	71.0	64.0
Teen birth rate (births per 1,000 females ages 15-19) (2006)	54.0	42.0
Percent of teens who are high school dropouts (ages 16-19 (2007)	8.0%	6.0%
Percent of teens not attending school and not working (ages 16-19) (2007)	11.0%	8.0%
Percent of children living in families where no parent has full-time, year-round employment (2007)	33.0%	33.0%
Percent of children living in poverty (< $21,027) for a family of two adults and two children in 2007	20.0%	18.0%
Percent of children in single-parent families (2007)	36.0%	32.0%

PREGNANT WOMEN, MOTHERS, AND WOMEN OF CHILD BEARING AGE

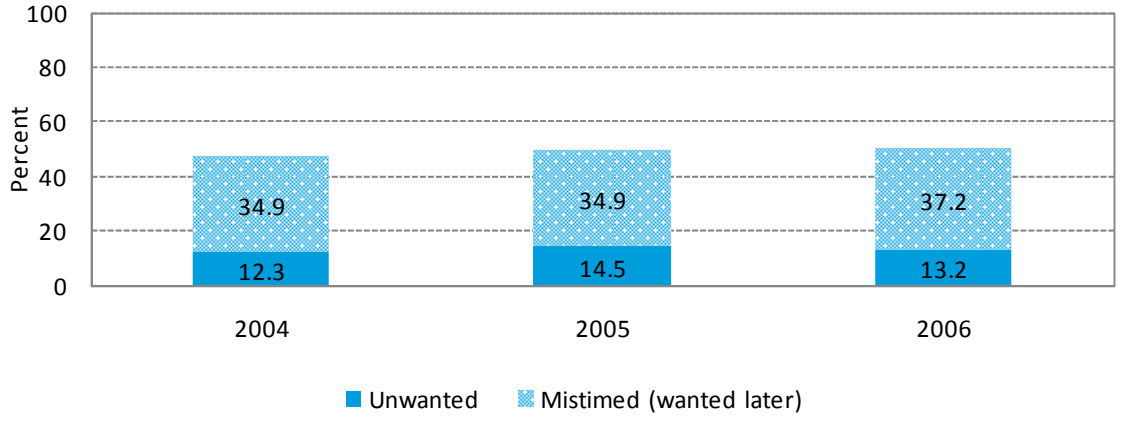
ANALYSIS OF QUANTITATIVE DATA

PREGNANT WOMEN

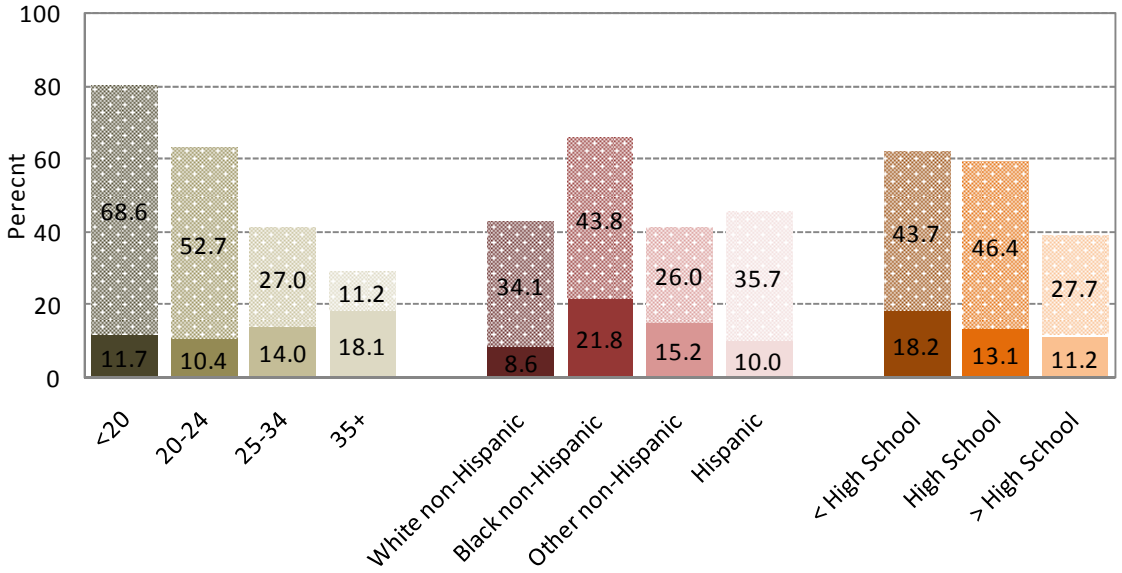
UNINTENDED PREGNANCY

The unintended pregnancy rate remained relatively constant between 2004 and 2006. In 2006, the percent of all births reported to be mistimed or unwanted exceeded 50 percent in Georgia. The *Healthy People 2010* objective is for unintended pregnancy not to exceed 30 percent. Among women under 20 years of age, approximately 80 percent of all births were either mistimed or unwanted. For Black women and women with a high school degree or less, approximately 60 percent of all births were mistimed or unwanted. Among Georgia's 18 public health districts, the percent of all births reported to be mistimed or unwanted exceeded 50 percent in eight public health districts, while this percent was less than 40 percent in only two public health districts.

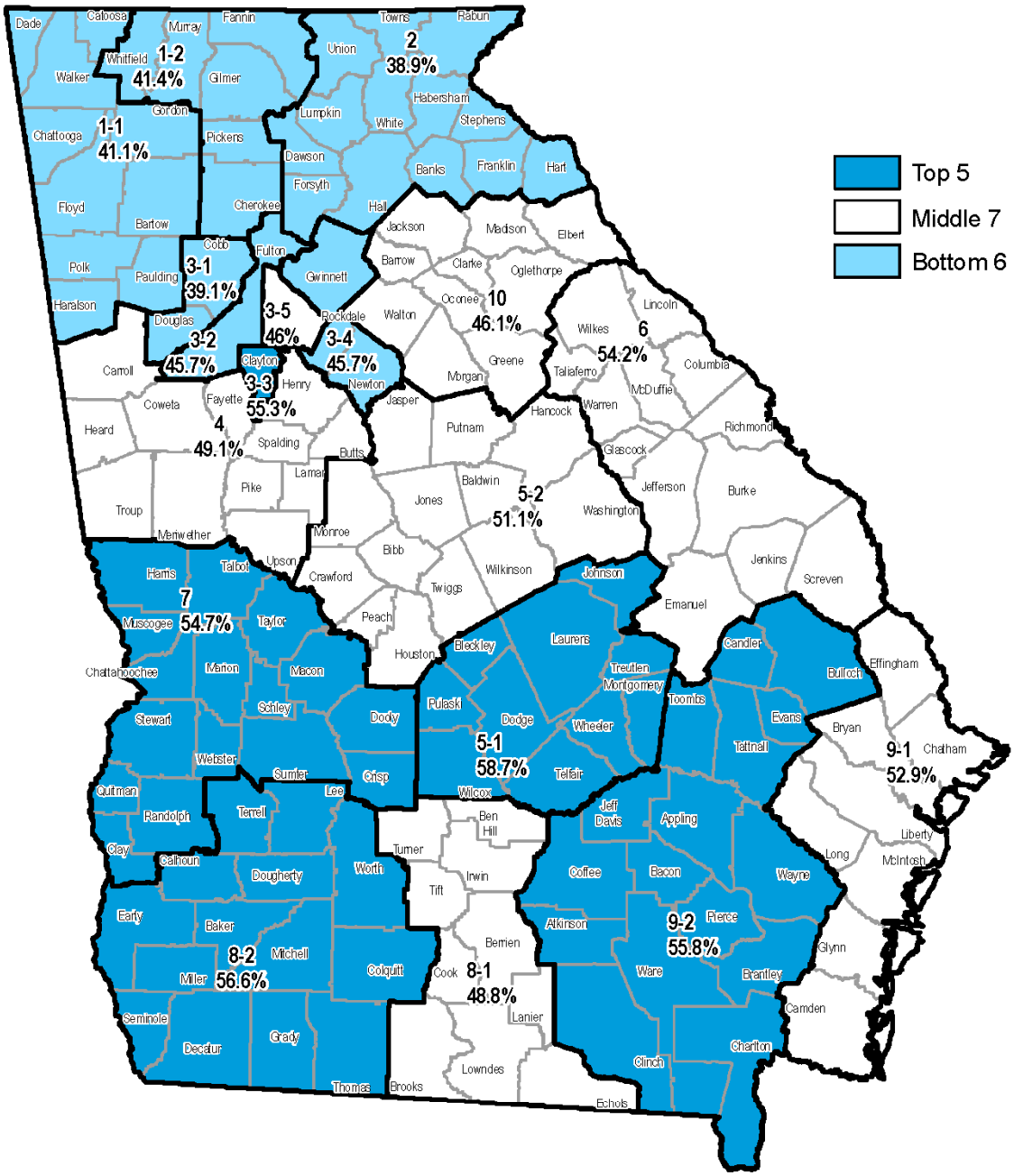
Percent of Births Reported to be Unintended by Year, Georgia, PRAMS 2004 through 2006



Percent of Births Reported to be Unintended by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



Percent of Births Reported to be Unintended by Public Health District, Georgia, PRAMS 2004 through 2006



1-1 Northwest Health District (Rome)
1-2 North Georgia Health District (Dalton)
2 North Health District (Gainesville)
3-1 Cobb/Douglas Health District
3-2 Fulton Health District
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3-4 East Metro Health District (Lawrenceville)
3-5 DeKalb Health District
4 LaGrange Health District
5-1 South Central Health District (Dublin)
5-2 North Central Health District (Macon)
6 East Central Health District (Augusta)
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9-1 Coastal Health District (Savannah)
9-2 Southeast Health District (Waycross)
10 Northeast Health District (Athens)

Office of Health Indicators for Planning (OHIP)
Epidemiology Branch
Division of Public Health
Georgia Department of Community Health

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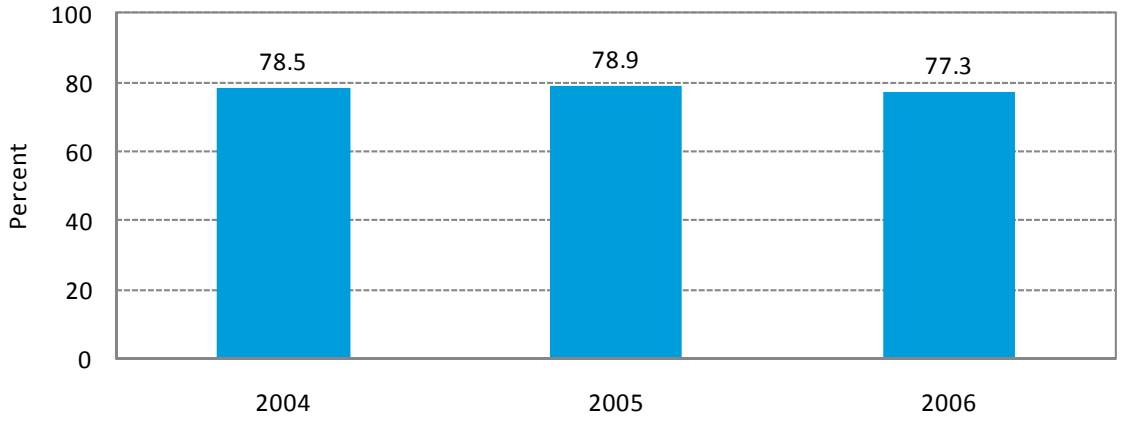
Created: June 2010
Source: Division of Public Health
Projection: Georgia Statewide Lambert Conformal Conic

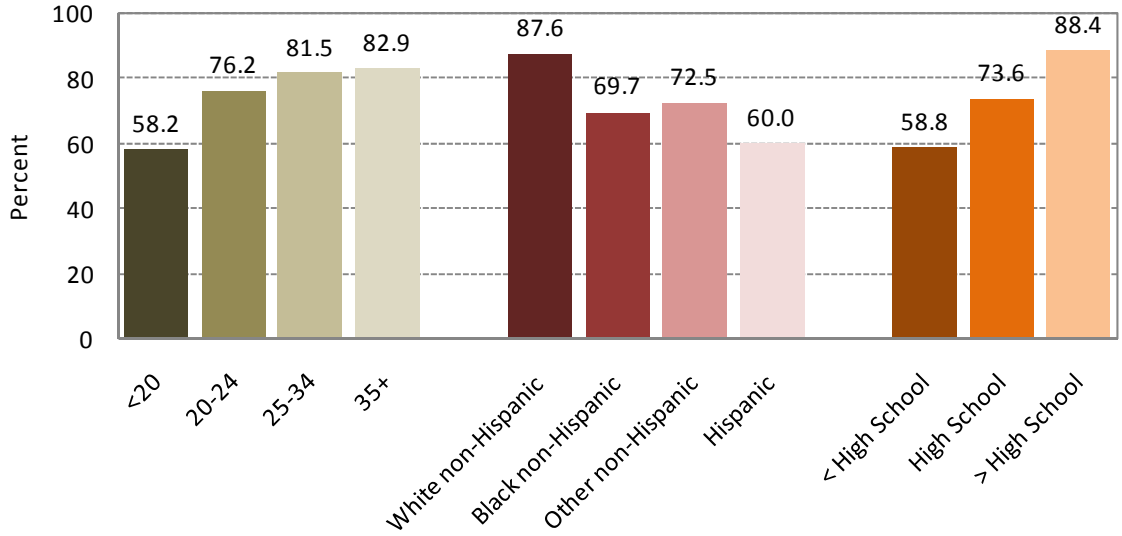
RECEIVING PRENATAL CARE IN THE FIRST TRIMESTER

The percent of women who received prenatal care in the first trimester remained consistent between 2004 and 2006. This indicator falls short of the *Healthy People 2010 objective* of 90 percent. Women with more than a high school diploma came closest to reaching the *Healthy People 2010 objective*. The percent of women who received prenatal care in the first trimester was less than 60 percent among women under the age of 20 years, Hispanic women, and women with less than a high school diploma. In half of Georgia's public health districts, between 80 percent and 89 percent of women received prenatal care in the first trimester. The Clayton Public Health District was the only district to have fewer than 75 percent of women receive prenatal care in the first trimester.

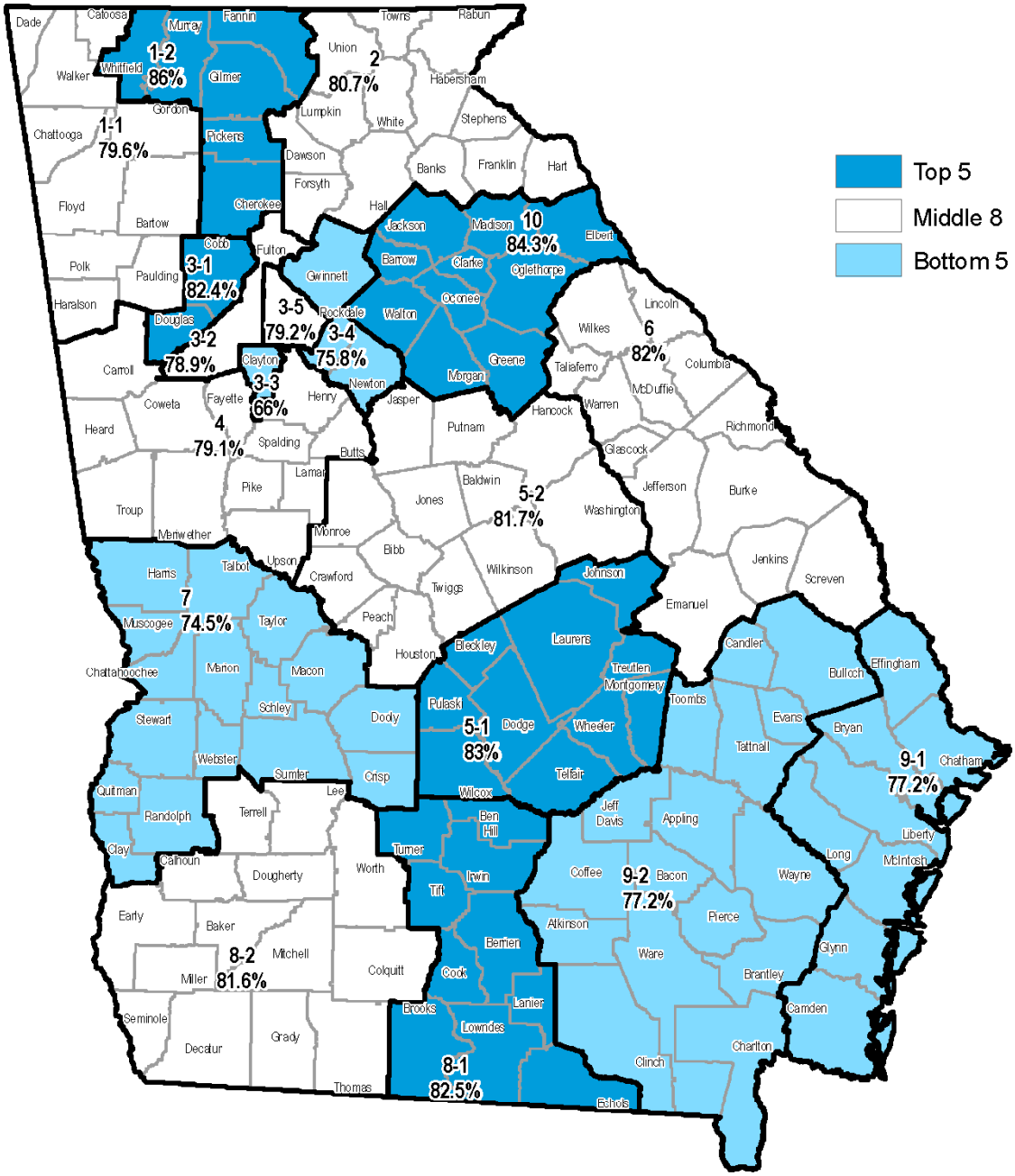
Percent of Mothers who Received First Trimester Prenatal Care by Year, Georgia, PRAMS 2004 through 2006



Percent of Mothers Who Received First Trimester Prenatal Care by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



Percent of Mothers Who Received First Trimester Prenatal Care by Public Health District, Georgia, PRAMS 2004 through 2006



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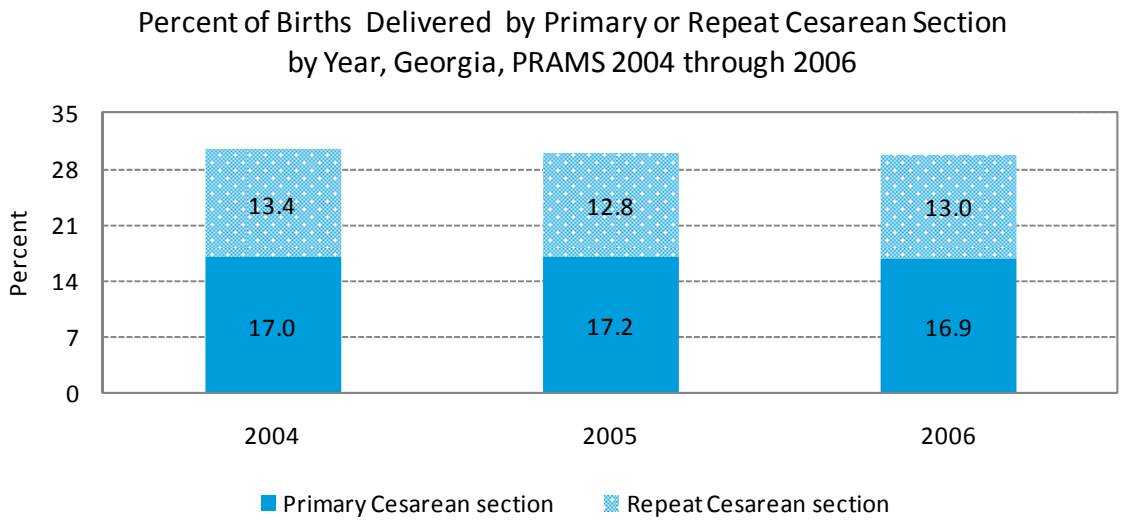
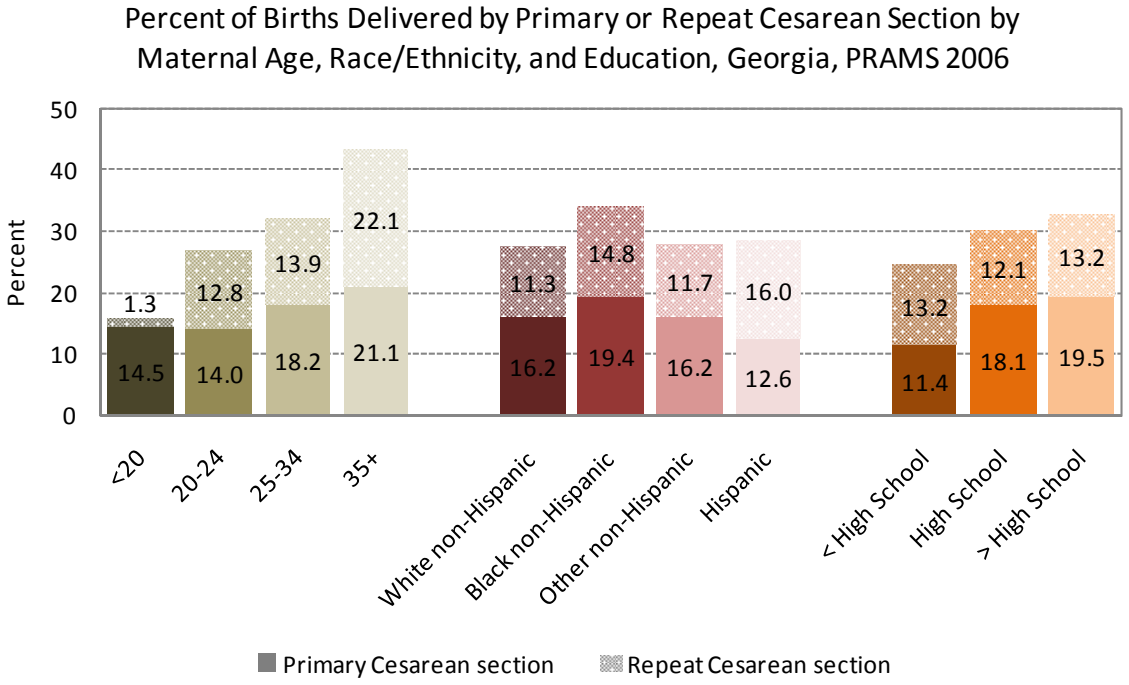
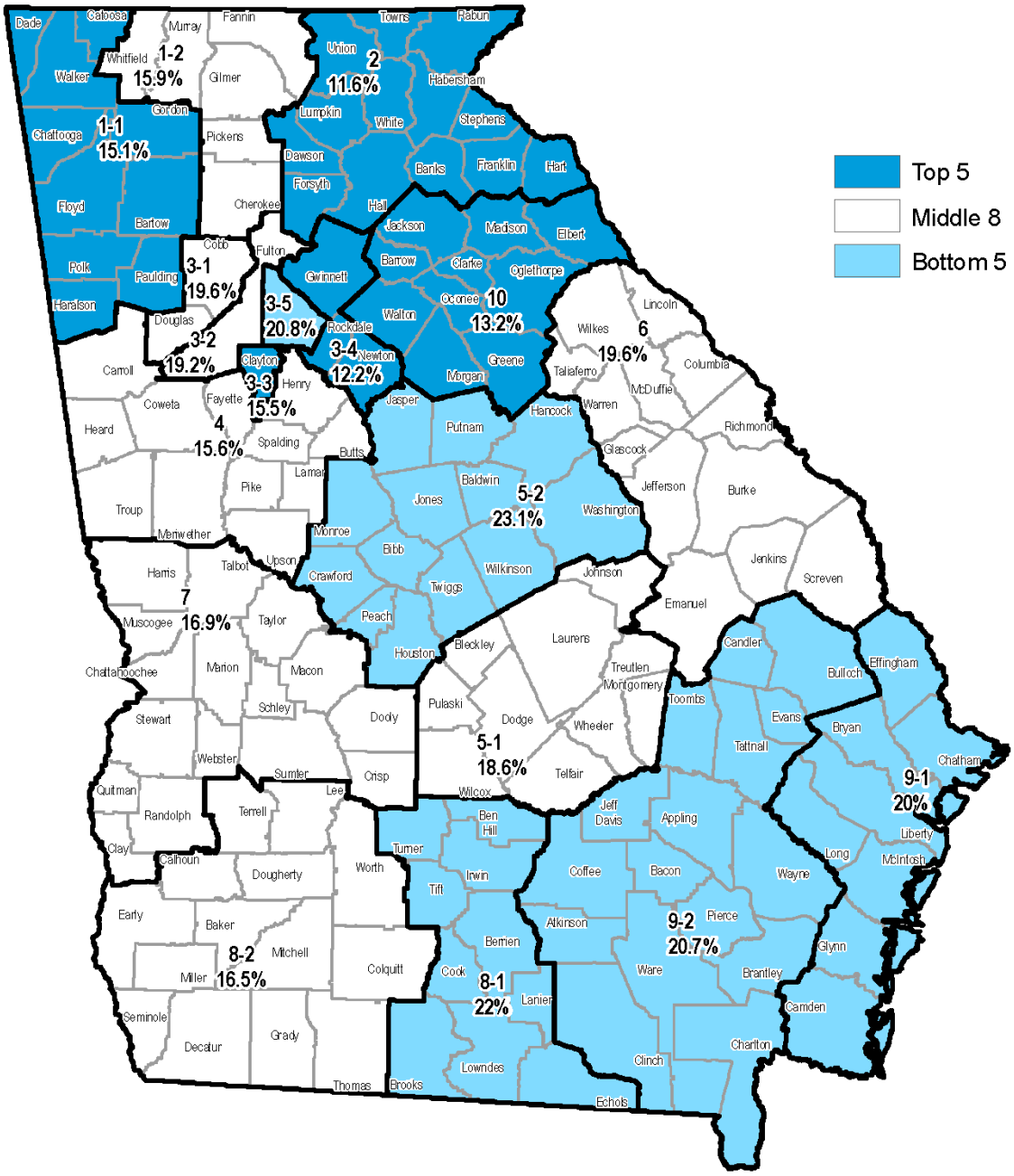
DELIVERIES BY CESAREAN SECTION

Approximately 30 percent of all deliveries in Georgia are by Cesarean section. This percent remained constant between 2004 through 2006. The percent of deliveries by Cesarean section was greater among Black women compared to women of other racial/ethnic groups. The percent of deliveries by Cesarean section exceeded 40 percent among women 35 years of age or older. Among Georgia's 18 public health districts, the percent of deliveries by Cesarean section ranged between 20.0 percent and 29.9 percent for nine public health districts and between 30.0 percent and 39.9 percent for eight public health districts. The percent of deliveries by Cesarean section exceeded 50 percent in the South Central Public Health District.





Percent of Births Delivered by Primary Cesarean Section by Public Health District, Georgia, PRAMS 2004 through 2006



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Deliveries by Cesarean Section and Infant Mortality

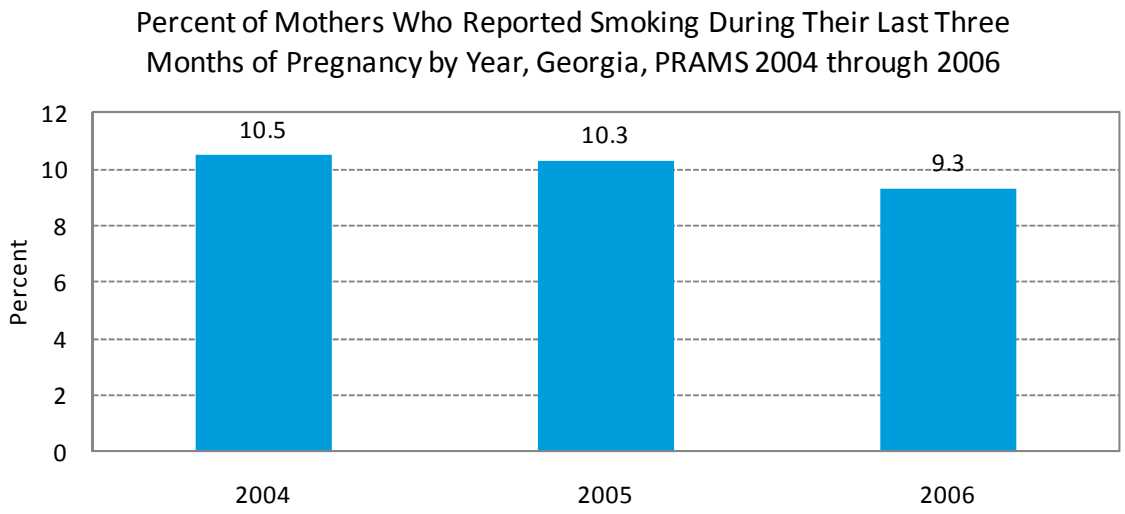
The below table examines infant death as an associated outcome with method of delivery. Deliveries via Cesarean section were associated with a lower infant mortality rate than vaginal delivery among infants less than 34 weeks gestational age. However, among all other groupings of gestational age, infant mortality rates were lower among vaginal deliveries or the rates were indistinguishable. Of particular note was the difference in infant mortality rates by delivery method in the 34 to 36 weeks gestational age grouping. The infant mortality rate among women who delivered vaginally was nearly 30 percent lower than the infant mortality rate among women who delivered via Cesarean section.

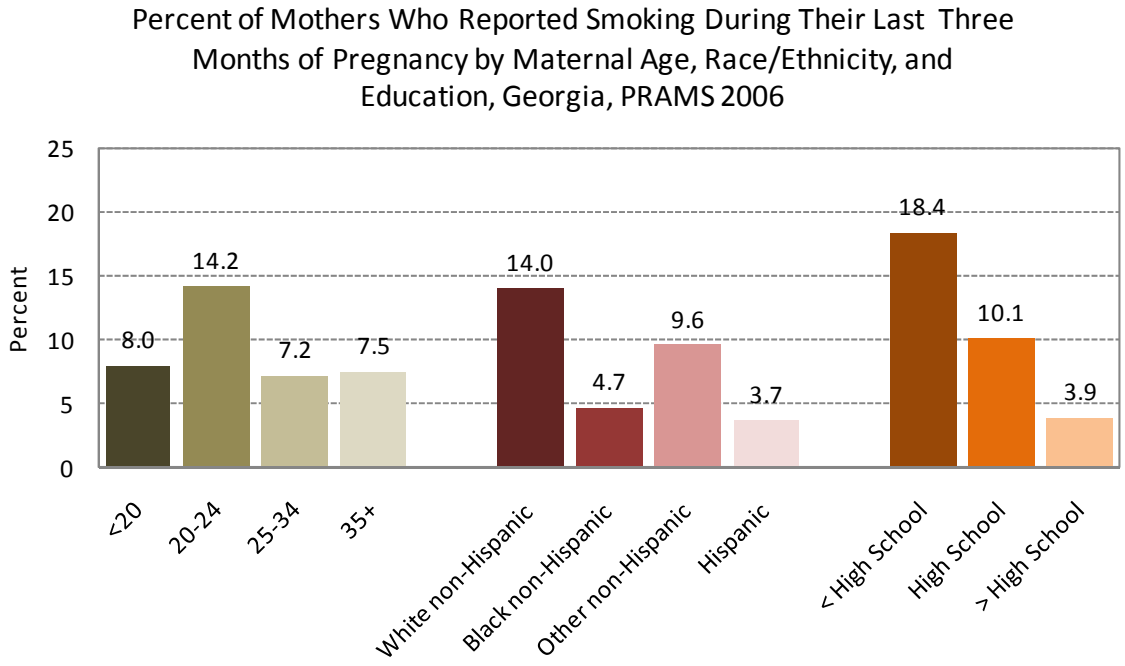
Infant Mortality by Method of Delivery and Gestational Age at Birth, Georgia, State Vital Records 2006									
Gestational Age	Vaginal		Cesarean section		Totals		Infant Mortality Rates		
	Infant Deaths	Live Births	Infant Deaths	Live Births	Infant Deaths	Live Births	Vaginal	Cesarean	Total
<34 wks	383	2,425	298	3,086	681	5,511	157.9	96.6	123.6
34-36 wks	65	9,243	62	6,253	127	15,496	7.0	9.9	8.2
< 37 wks	448	11,668	360	9,339	808	21,007	38.4	38.5	38.5
37+ wks	210	87,014	137	40,382	347	127,396	2.4	3.4	2.7
Total	658	98,682	497	49,721	1,155	148,403	6.7	10.0	7.8

Note: 2006 linked birth-death file was used in the analyses for this table.

SMOKED DURING THE LAST THREE MONTHS OF PREGNANCY

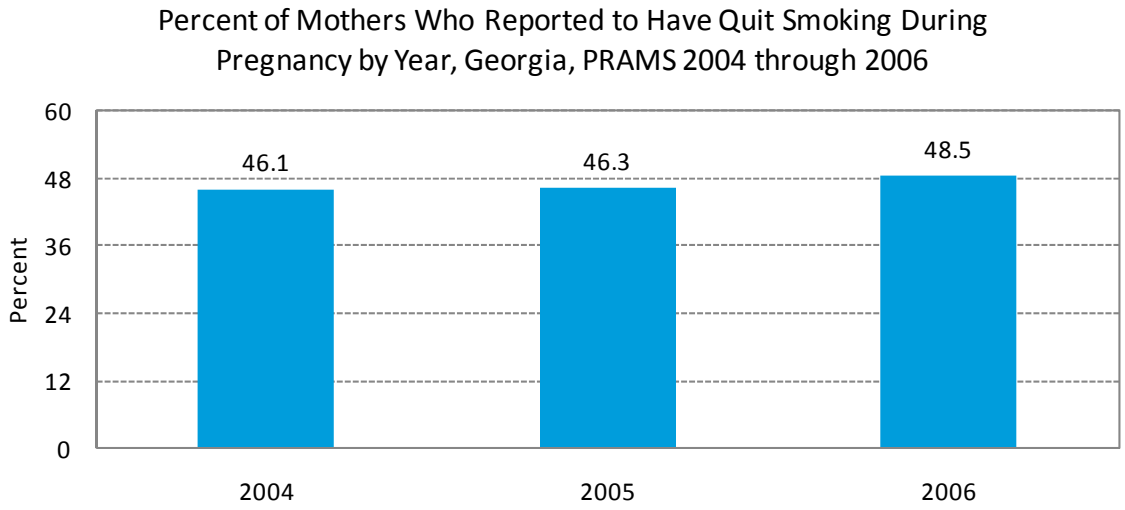
Approximately 10 percent of pregnant women reported smoking during their last three months of pregnancy. Rates of smoking during the last three months of pregnancy were greatest among White women and women with less than a high school diploma. Among Georgia's 18 public health districts, the rate of smoking in the last three months of pregnancy was less than 10 percent in five of the districts. In the Northwest Public Health District, the rate of smoking in the last three months of pregnancy was nearly 20 percent. Smoking in the third trimester of pregnancy was also elevated in the East Central Public Health District and LaGrange Public Health District.



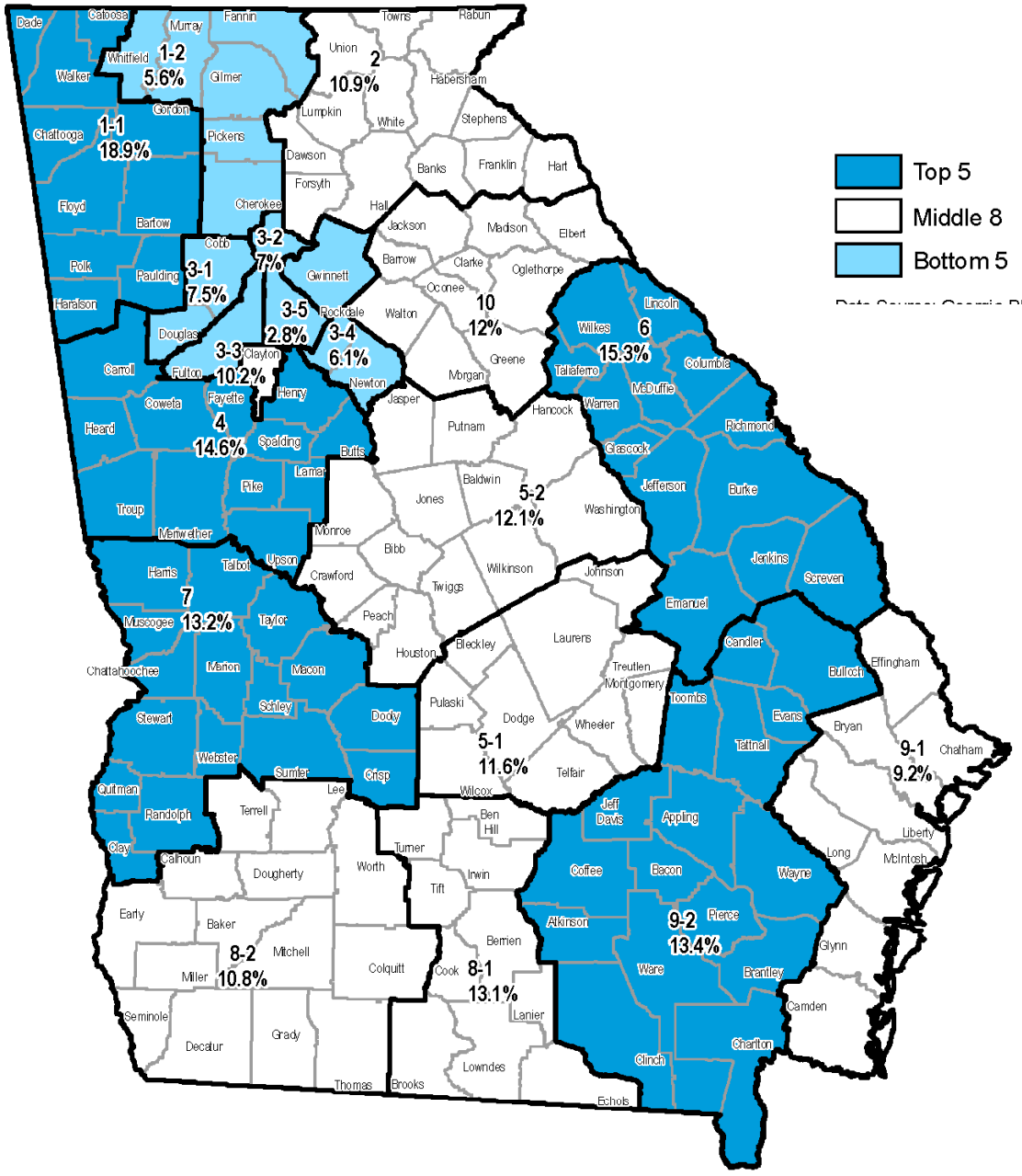


SMOKING CESSATION DURING PREGNANCY

Of all women who smoke while pregnant, nearly half quit during pregnancy. White women had the lowest cessation rates of any racial/ethnic group. Cessation rates were greatest among women with more than a high school diploma. While the cessation rate among mothers age 35 years and older may appear low, there was an inadequate number of cases for this estimate to be reliable. Among Georgia's 18 public health districts, three public health districts (North Georgia, East Metro, and DeKalb) had cessation rates in excess of 60 percent and an additional three public health districts (South Central, Southeast, Coastal) had cessation rates between 55 percent and 59.9 percent.



Percent of Mothers Who Reported Smoking During Their Last Three Months of Pregnancy by Public Health District, Georgia, PRAMS 2004 through 2006



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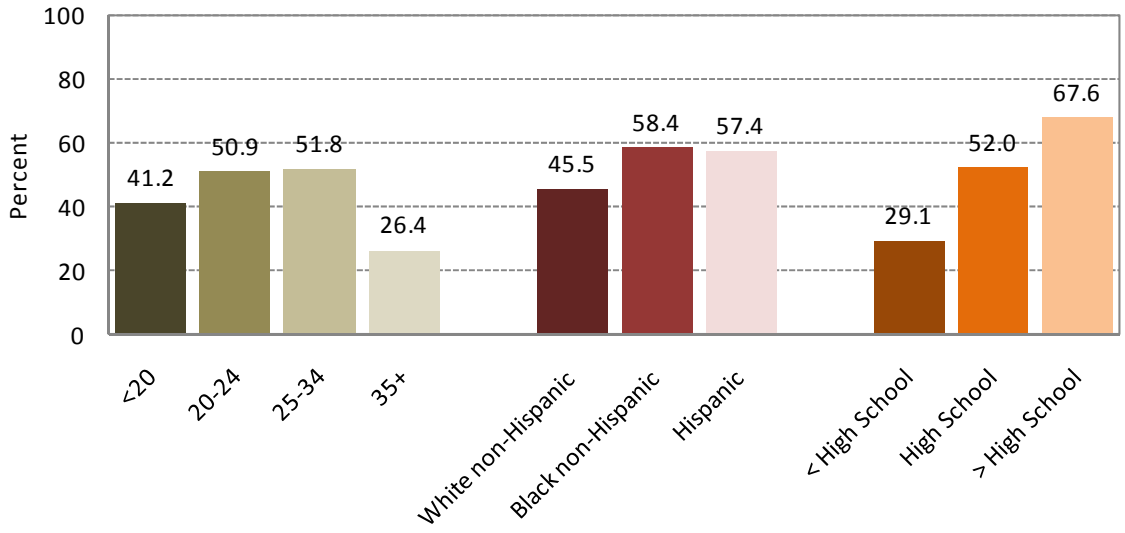
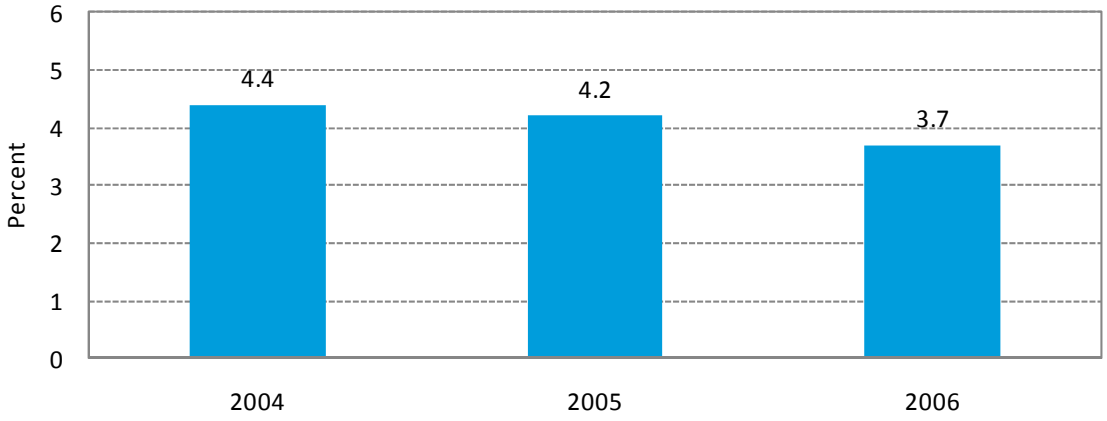
Percent of Mothers Who Reported to Have Quit Smoking During Pregnancy by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



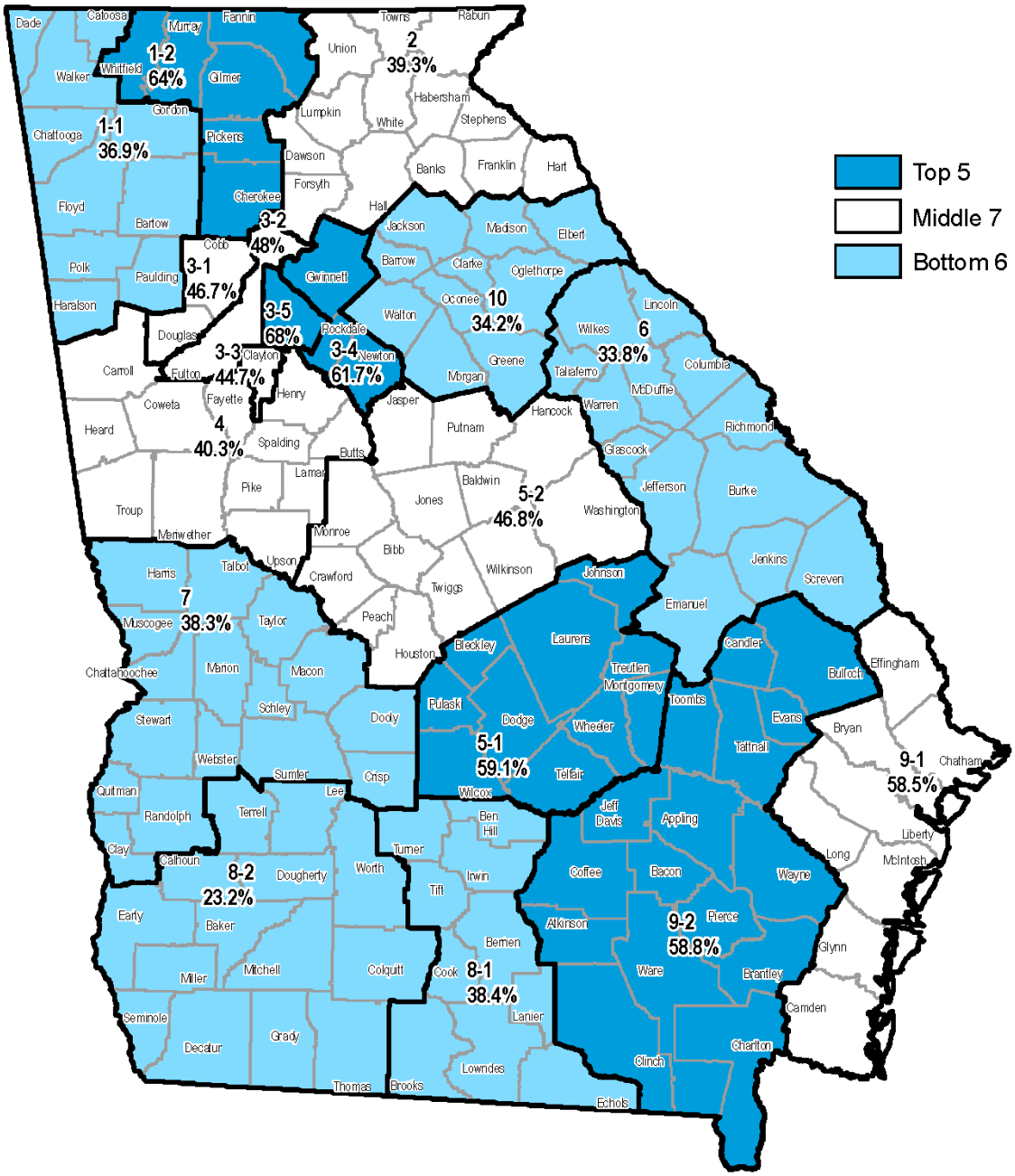
INTIMATE PARTNER VIOLENCE DURING PREGNANCY

Fewer than five percent of women who recently gave birth reported experiencing physical abuse during their pregnancy. Due to cell size limitations, subgroup analyses for this indicator were not possible.

Percent of Women Who Reported Experiencing Physical Abuse During Pregnancy, Georgia, PRAMS 2004 through 2006



Percent of Mothers Who Reported to Have Quit Smoking During Pregnancy by Public Health District, Georgia, PRAMS 2004 through 2006



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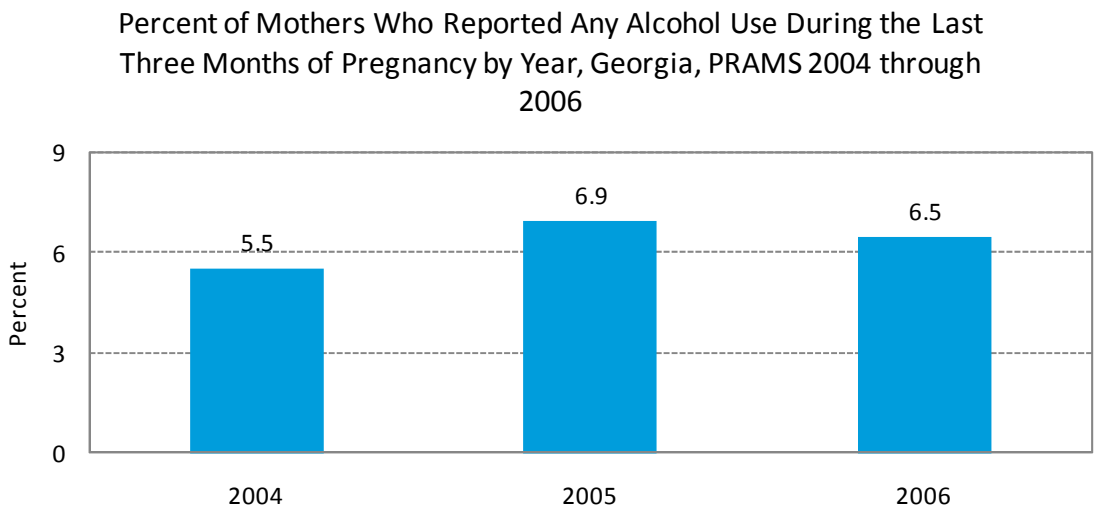
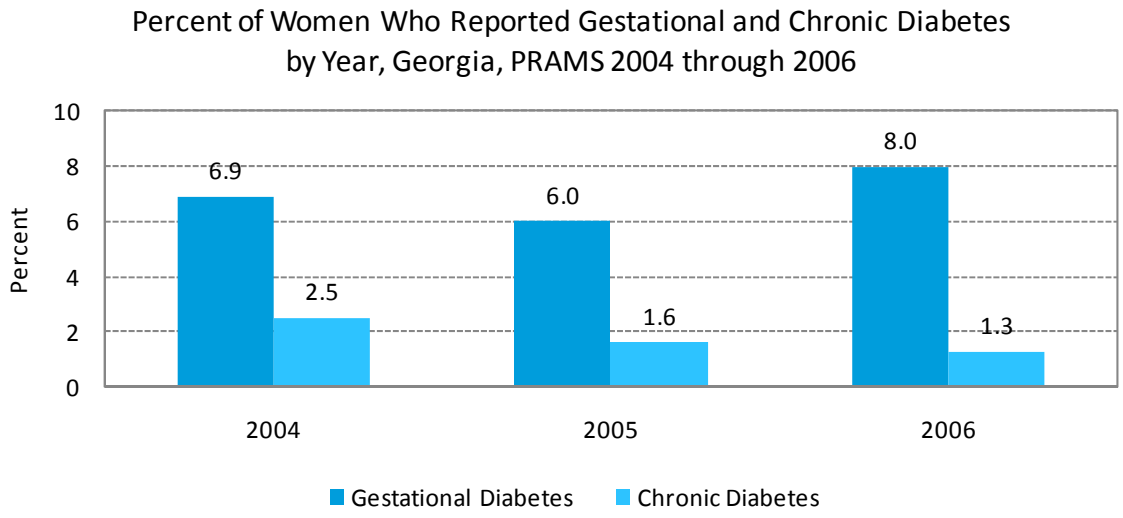
ALCOHOL USE DURING PREGNANCY

Fewer than seven percent of women who recently gave birth reported alcohol use in the last three months of their pregnancy. Due to cell size limitations, subgroup analyses for this indicator were not possible.



GESTATIONAL DIABETES AND CHRONIC DIABETES AMONG PREGNANT WOMEN

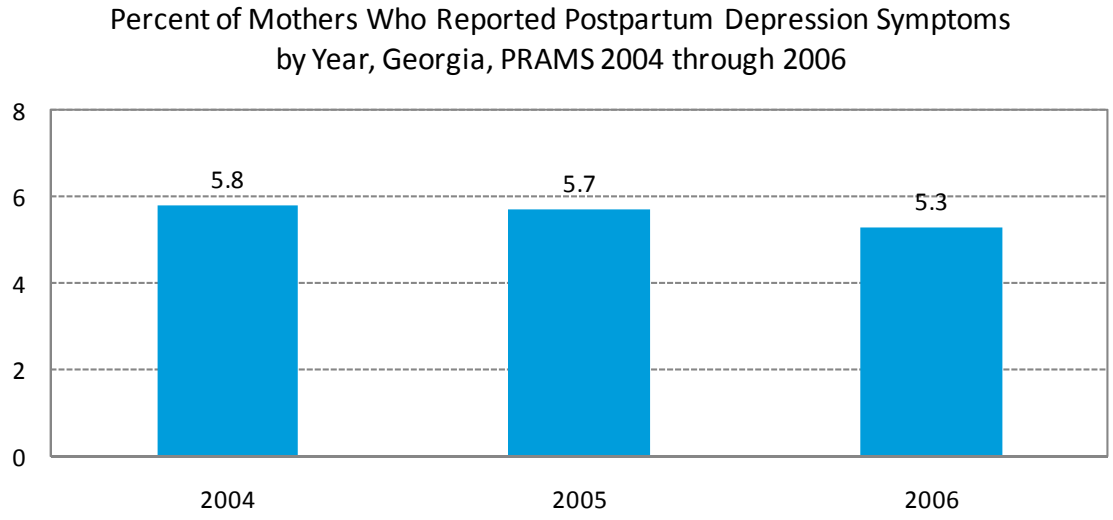
Among women who gave birth, the rate of chronic diabetes is lower than the *Healthy People 2010* objective of a clinically diagnosed diabetes rate of 2.5 percent. The prevalence of gestational diabetes ranged between 6.9 percent and 8.0 percent. In 2006, the prevalence of gestational diabetes exceeded 7.0 percent. In *Healthy People 2010*, gestational diabetes was included as a developmental measure. Therefore, a specific goal was not established.



MOTHERS

PERINATAL DEPRESSION

Approximately six percent of women who gave birth reported experiencing perinatal depression. This percent remained consistent between 2004 through 2006. Due to cell size limitations, subgroup analyses for this indicator were not possible.

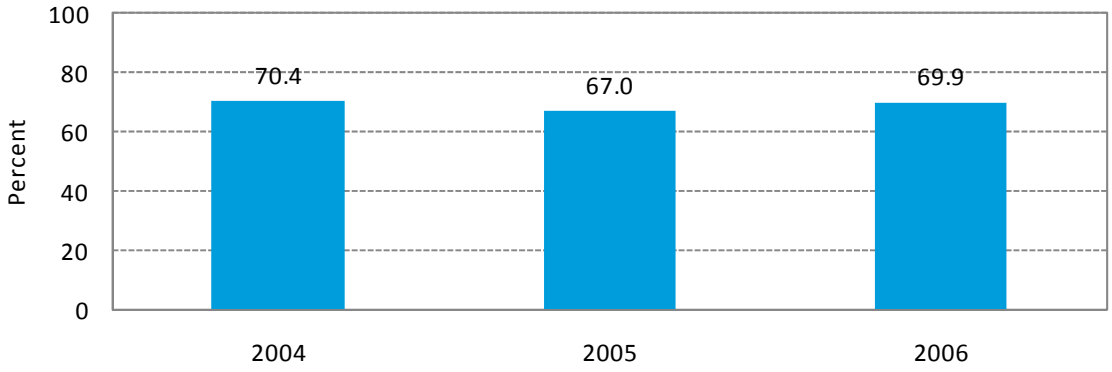


BREASTFEEDING

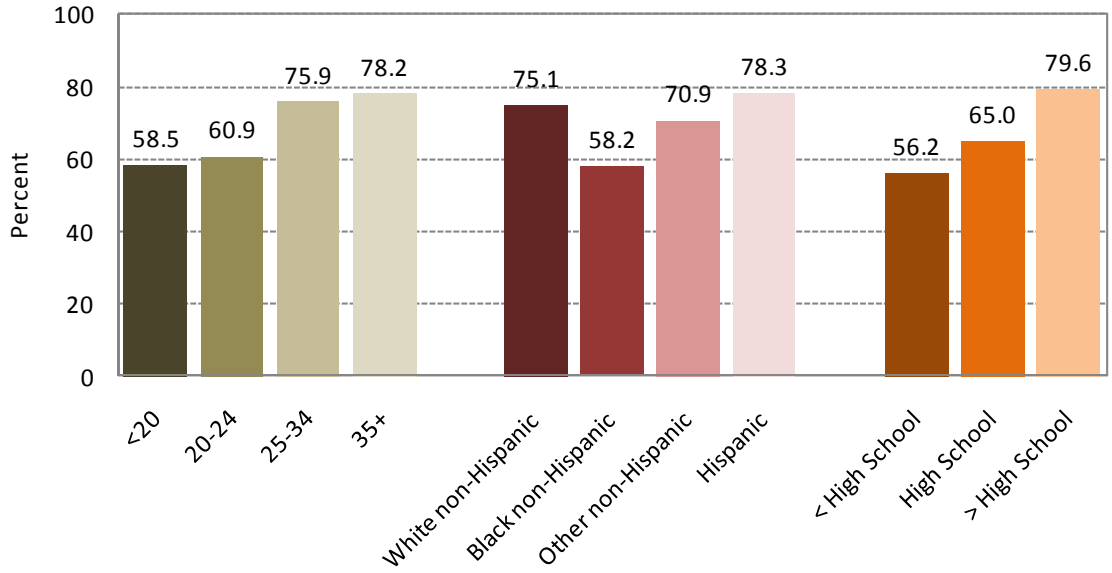
Ever Breastfed

The *Healthy People 2010* objective for infants receiving any breastmilk is 75 percent. The rate in Georgia is approximately 70 percent. Younger maternal age and lower maternal educational attainment were associated with lower rates of infants receiving any breastmilk. Infants receiving any breastmilk was 58.2 percent among Black mothers. The percent of infants receiving any breastmilk was more than 70 percent among all other racial/ethnic groups. Among Georgia's 18 public health districts, eight have rates of infants receiving any breastmilk that are less than 65 percent. The rate among the mothers in the West Central Georgia Public Health District was less than 45 percent.

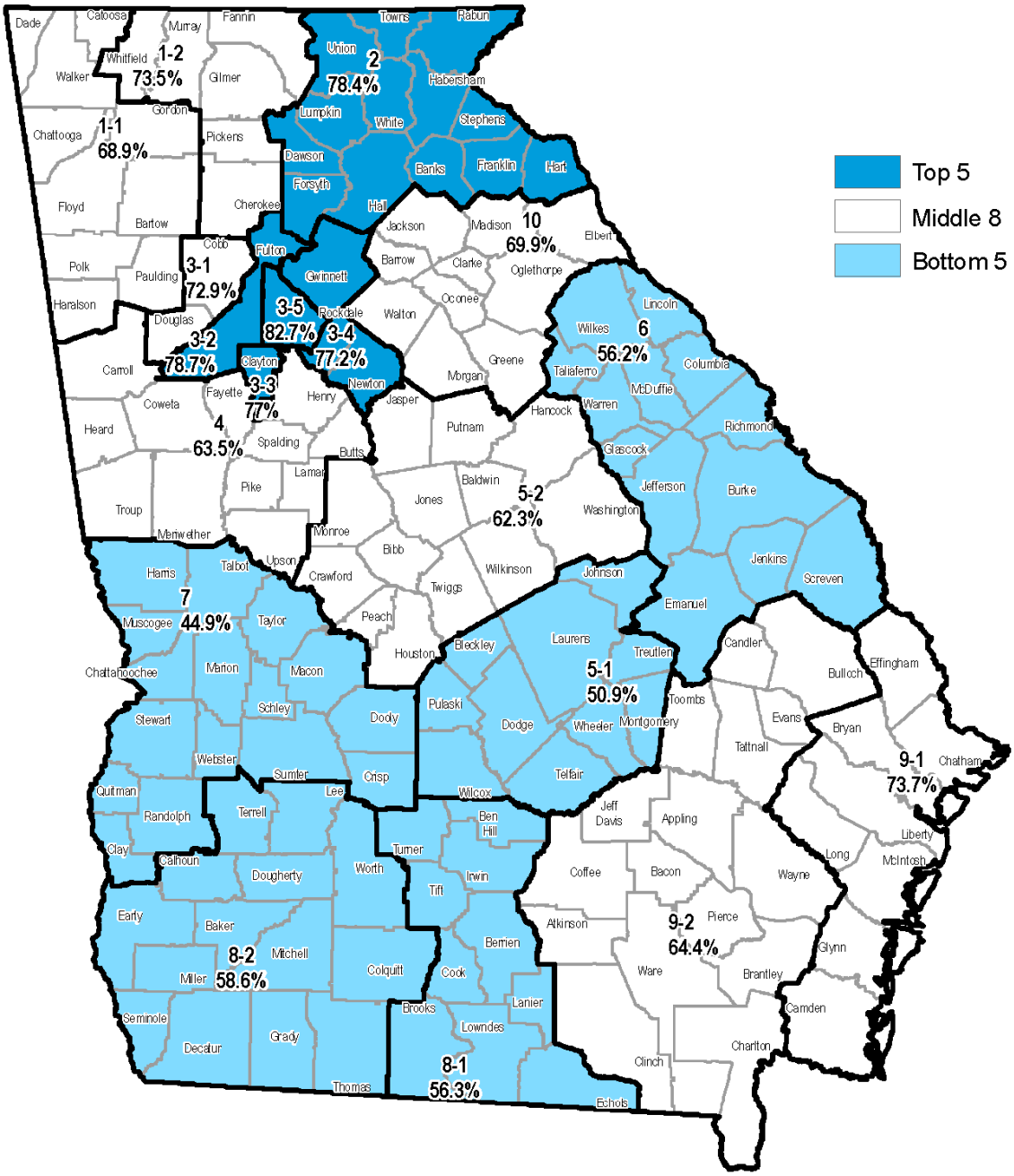
Percent of Mothers Who Reported Ever Breastfeeding Their Infant by Year, Georgia, PRAMS 2004 through 2006



Percent of Mothers Who Reported Ever Breastfeeding Their Infant by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



Percent of Mothers Who Reported Ever Breastfeeding Their Infant by Public Health District, Georgia, PRAMS 2004 through 2006



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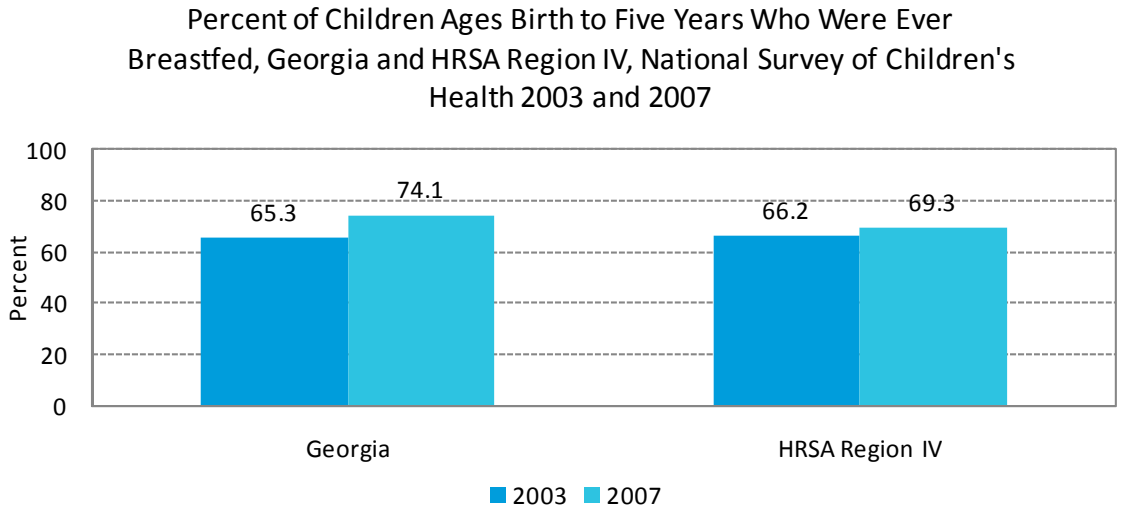
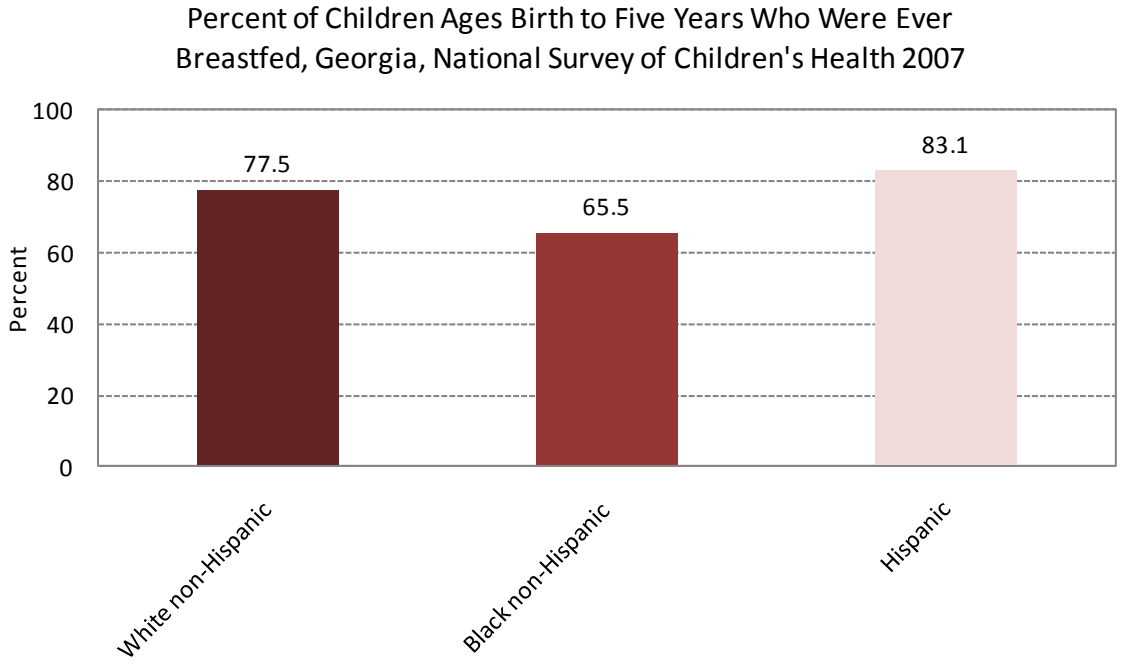
Ever Breastfed among Children Ages Birth to Five Years

The National Survey of Children's Health provided an estimate of ever breastfeeding among children birth to five years of age. There was a significant increase in the percent of children birth to five years of age ever breastfed between 2003 and 2007. The increase in Georgia was nearly double that of HRSA Region IV. As indicated in other surveillance surveys, the greatest rate of ever breastfeeding was among Hispanic children, while Black children had the lowest rate.

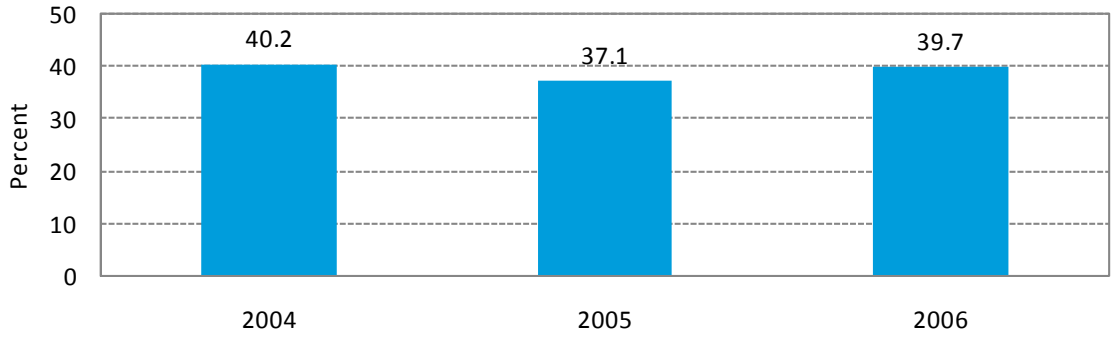




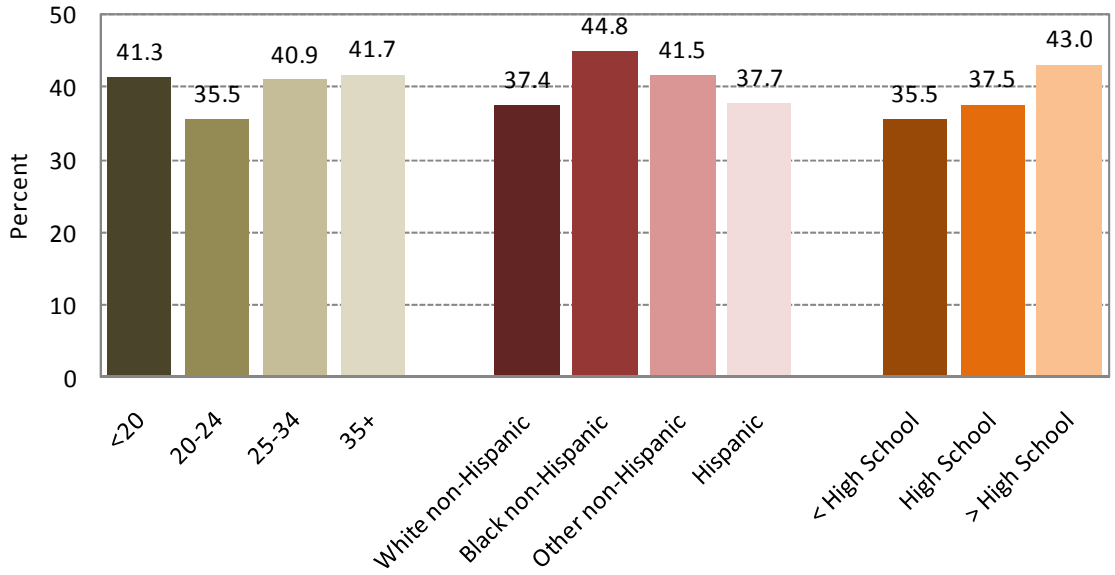
Exclusive Breastfeeding through Two Months of Age

Approximately 40 percent of mothers reported breastfeeding their infants for at least two months. Based on rates of receiving any breastmilk, this suggested that there are approximately a 43 percent decline in breastfeeding rates between delivery and an infant's first two months of life. Black mothers had the greatest rate of exclusive breastfeeding through two months of age. Among White mothers, there was a 100 percent difference between the rate of receiving any breastmilk and exclusive breastfeeding through two months. Among Georgia's 18 public health districts, the East Central Georgia Public Health District had the greatest percent of mothers exclusively breastfeeding at two months and the least decline between receiving any breastmilk and exclusive breastfeeding at two months.

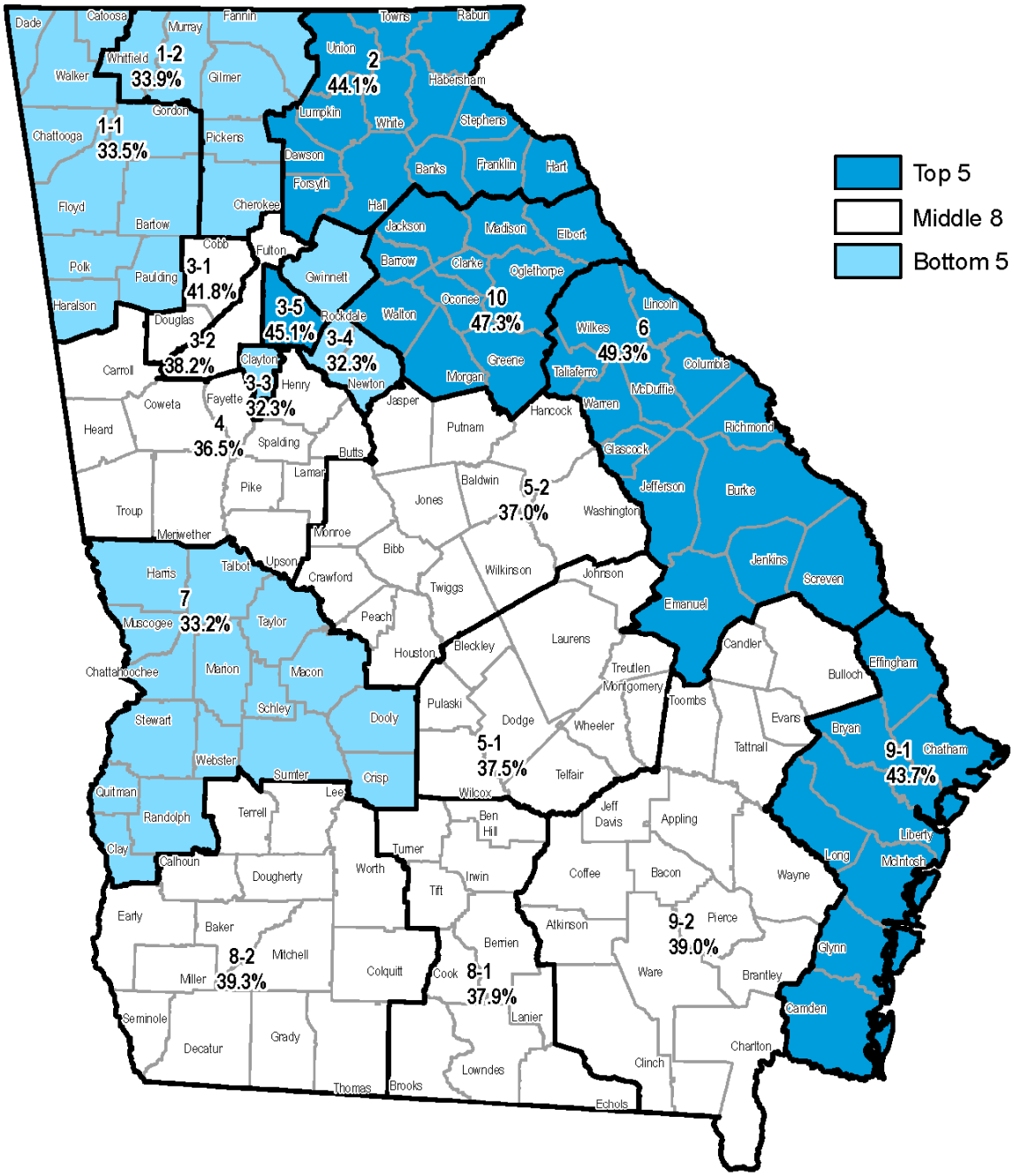
Percent of Mothers Who Reported Exclusively Breastfeeding Their Infants for at least Two Months by Year, Georgia, PRAMS 2004 through 2006



Percent of Mothers Who Reported Exclusively Breastfeeding Their Infants for at least Two Months by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



Percent of Mothers Who Reported Exclusively Breastfeeding Their Infants for at least Two Months by Public Health District, Georgia, PRAMS 2004 through 2006



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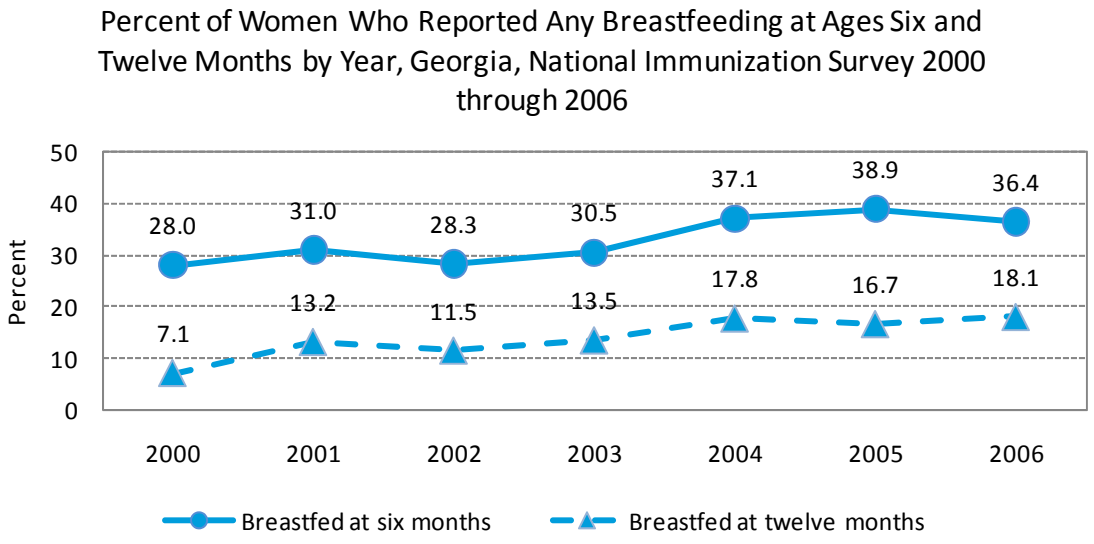
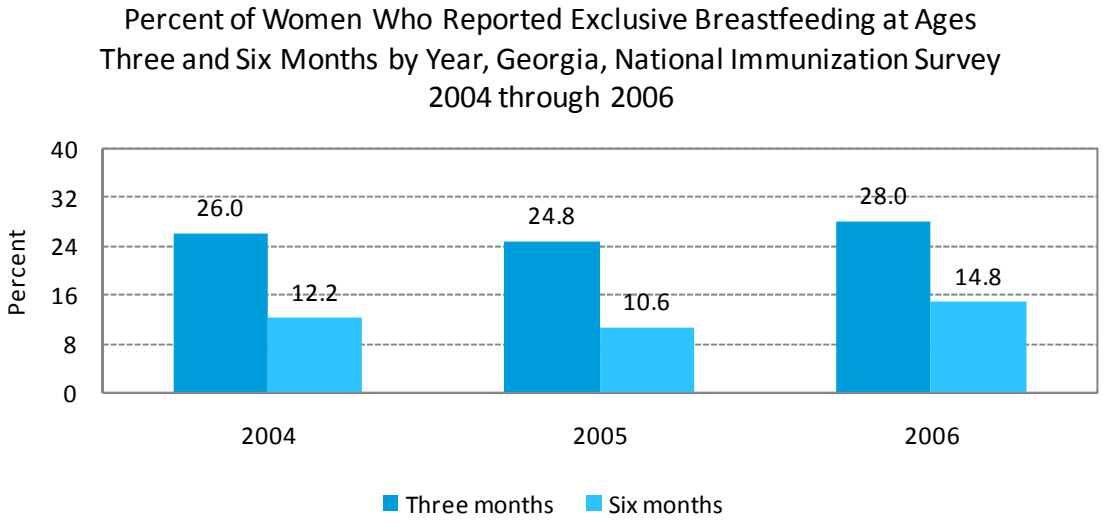
Any Breastfeeding through Six and Twelve Months of Age

Between 2000 and 2006, any breastfeeding at six months of age increased 30 percent, and any breastfeeding at twelve months of age increased 155 percent. However, despite these increases, rates in Georgia lagged behind nationwide rates of 43.4 percent at six months and 22.7 percent at twelve months.



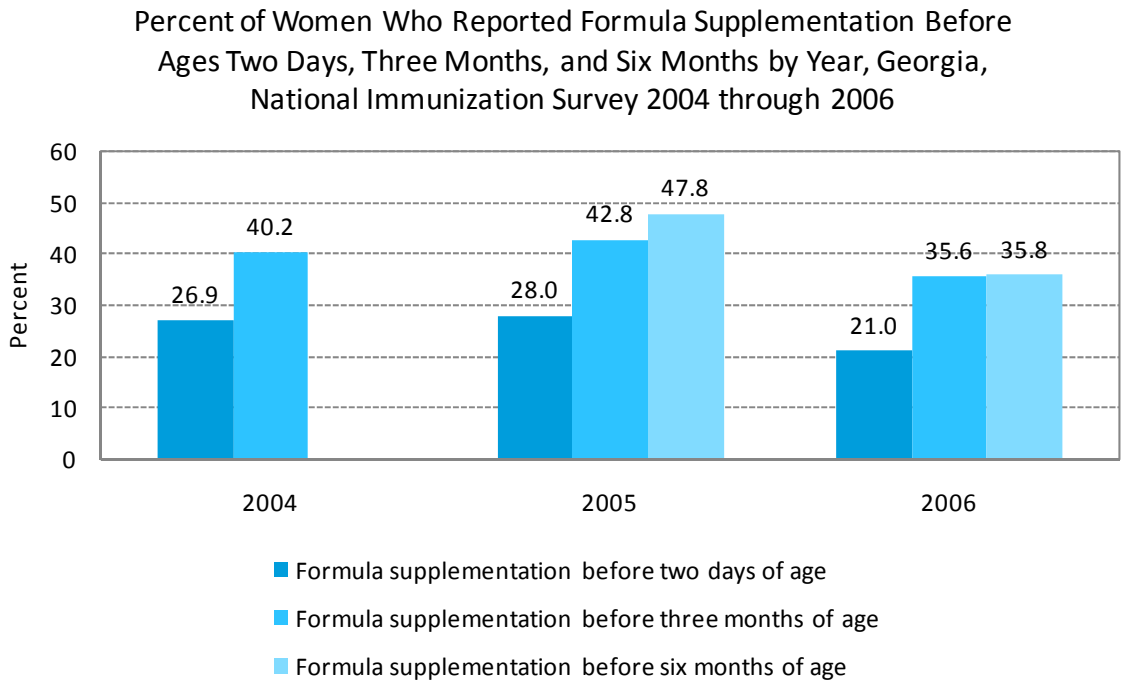
Exclusive Breastfeeding through Three and Six Months of Age

Rates for exclusive breastfeeding at three and six months of age remained relatively constant between 2004 and 2006. While the rate of exclusive breastfeeding at three months in Georgia in 2006 lags behind the national rate of 33.1 percent, the rate of exclusive breastfeeding at six months in Georgia exceeded the national rate of 13.6 percent.



Formula Supplementation

Rates of formula supplementation at two days, three months, and six months of age declined between 2005 and 2006. In 2006, rates of formula supplementation at two days, three months, and six months of age in Georgia were lower than rates at two days (25.6 percent), three months (37.9 percent), and six months of age (44.7 percent) nationwide.



Barriers to Initiation and Reasons for Breastfeeding Cessation

Not liking breastfeeding was the most commonly cited reason for not initiating breastfeeding. The percent of mothers citing this reason was more than double the next two most prevalent reasons cited. Limited milk supply and the belief that breastmilk was not satisfying their infant were the top two most commonly cited reasons for breastfeeding cessation.

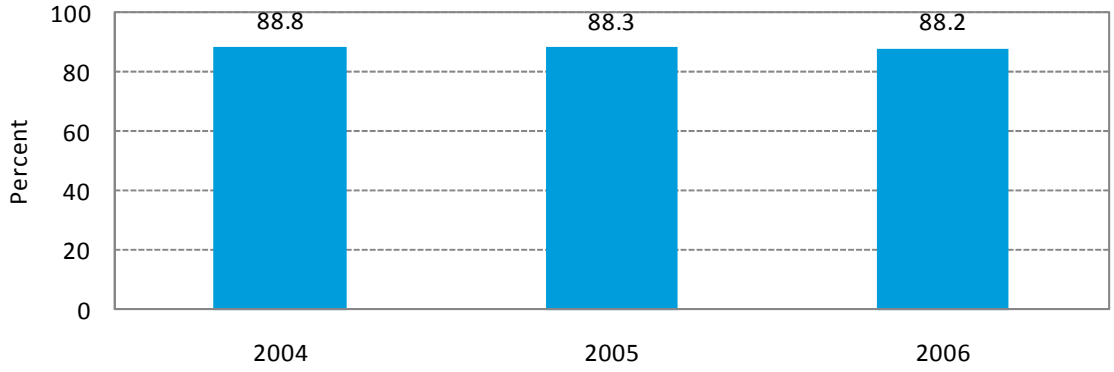
Barriers to Initiation of Breastfeeding and Reasons for Breastfeeding Cessation, Georgia, PRAMS 2006

Rank	Barriers to Initiation	Prevalence (%)	Reasons	Prevalence (%)
1	Did not like breastfeeding	51.7	Limited milk supply	39.8
2	Other barriers	20.9	Milk did not satisfy infant	37.9
3	Return to work or school	19.4	Difficulty nursing	25.5
4	Other children	17.3	Return to work or school	23.2
5	Mother too sick or on medication	11.9	Sore nipples Other reasons	20.0

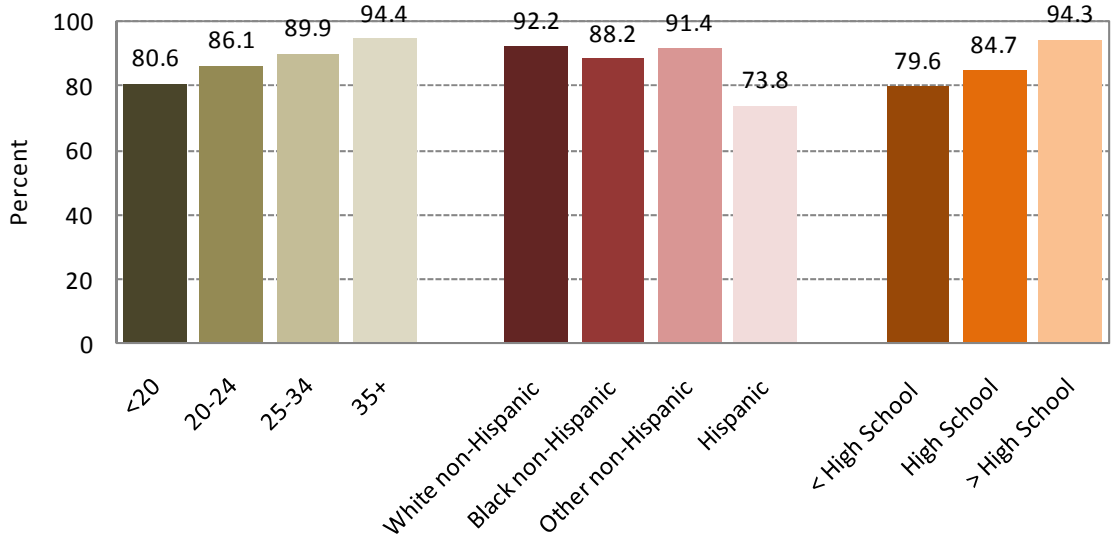
POSTPARTUM PROVIDER VISIT

Approximately 88 percent of women who gave birth received a postpartum provider visit. There was little variation in the percent of women who received a postpartum provider visit from 2004 through 2006. Maternal age and maternal education were positively associated with receiving a postpartum visit. Fewer than three-quarters of Hispanic women who gave birth completed a postpartum provide visit compared to at least 88 percent among women of other racial/ethnic groups. Among Georgia's 18 public health districts, the percent of women who received a postpartum provider visit ranged from 81.2 percent to 94.3 percent. Eight of the public health districts had more than 90 percent of women who gave birth receive a postpartum provider visit.

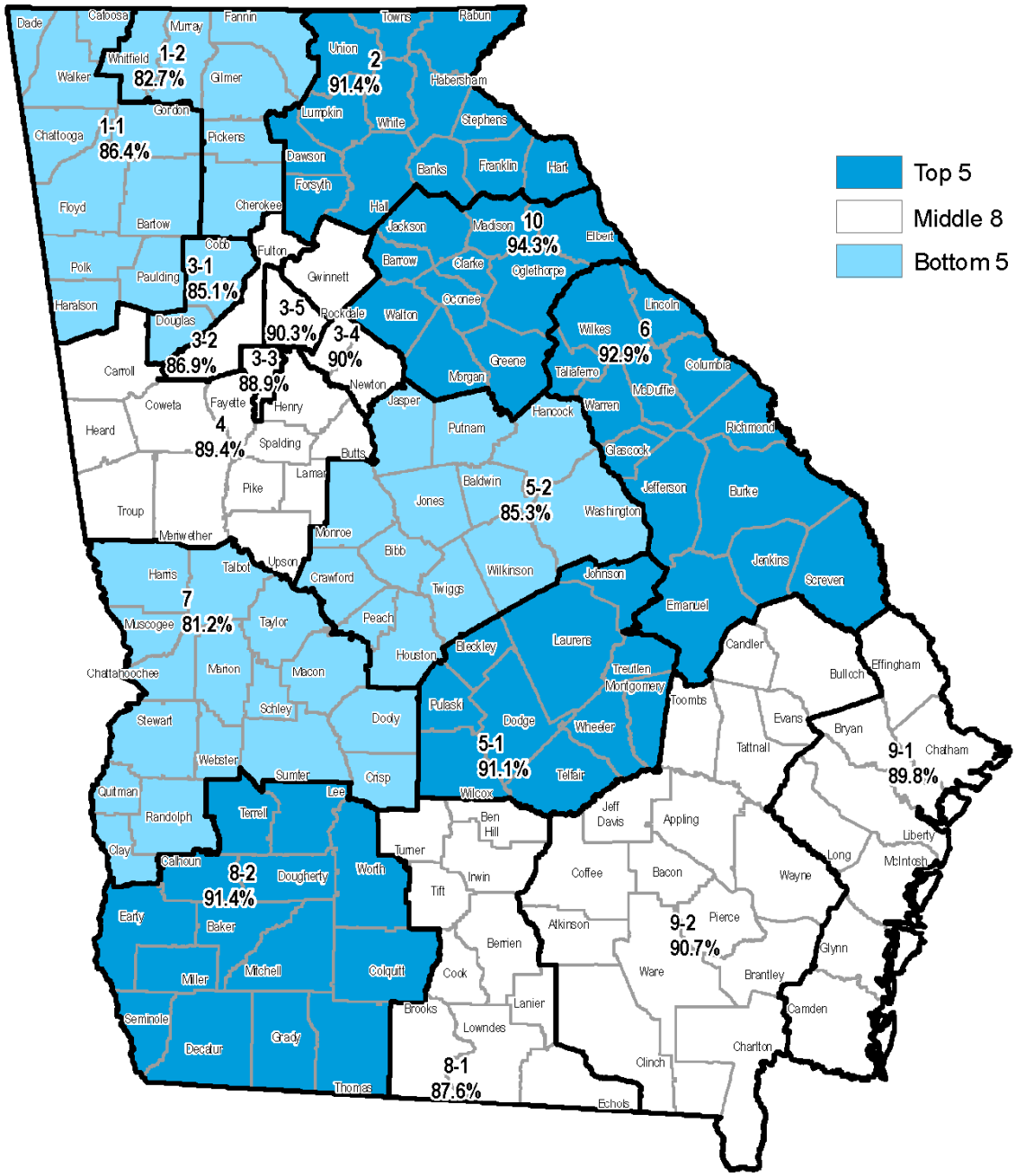
Percent of Mothers Who Reported Receiving a Postpartum Provider Visit by Year, Georgia, PRAMS 2004 through 2006



Percent of Mothers Who Reported Receiving a Postpartum Provider Visit by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



Percent of Mothers Who Reported Receiving a Postpartum Provider Visit by Public Health District, Georgia, PRAMS 2004 through 2006



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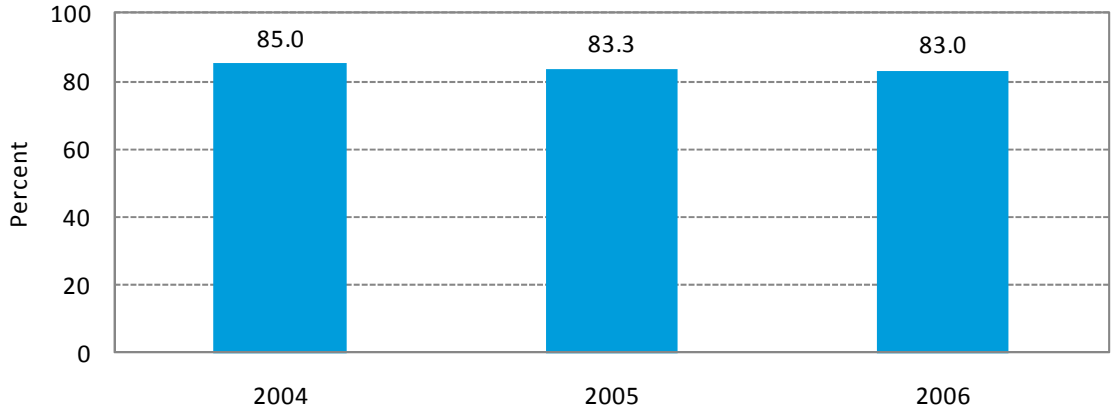
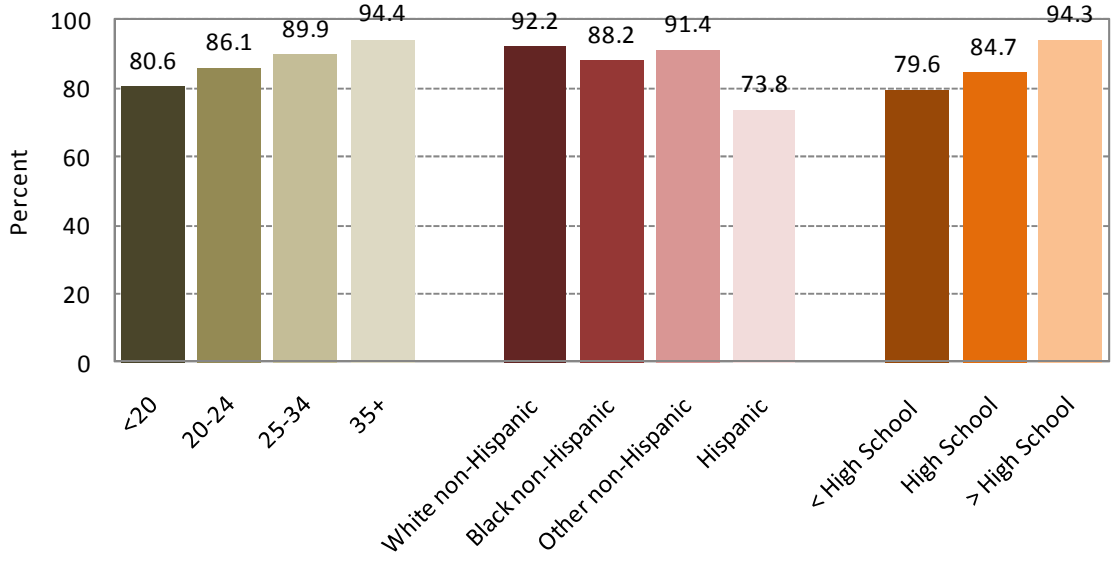
POSTPARTUM BIRTH CONTROL USE

Approximately 83 percent of women who gave birth used birth control postpartum. The *Healthy People 2010* objective is for all women of child bearing age to be using birth control. There was a positive association between maternal age and maternal education and using birth control postpartum. Less than three quarters of Hispanic women reported using birth control postpartum. Rates of using birth control postpartum were approximately 90 percent in all other racial/ethnic groups.

Percent of Mothers Who Reported Using Birth Control Postpartum by Year, Georgia, PRAMS 2004 through 2006



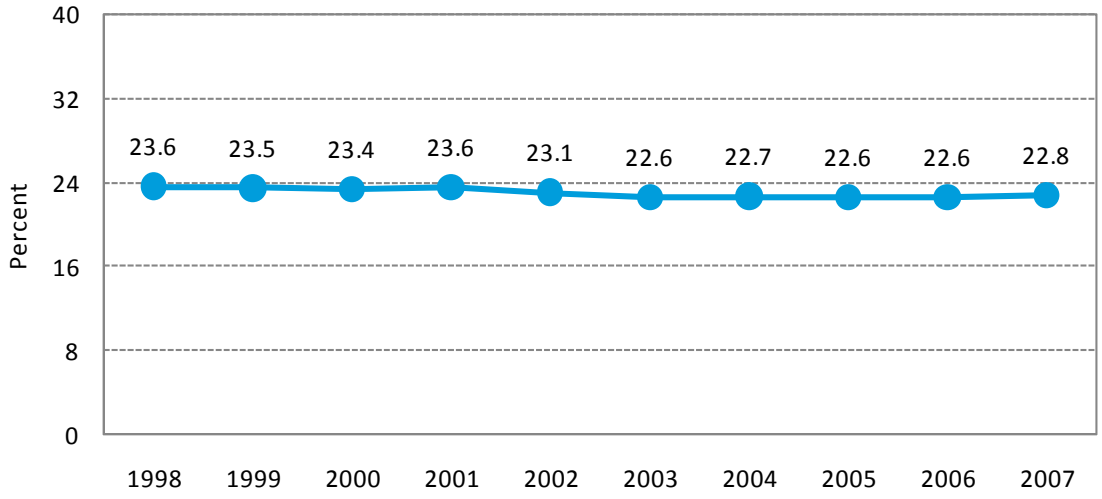
Percent of Mothers Who Reported Using Birth Control Postpartum by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



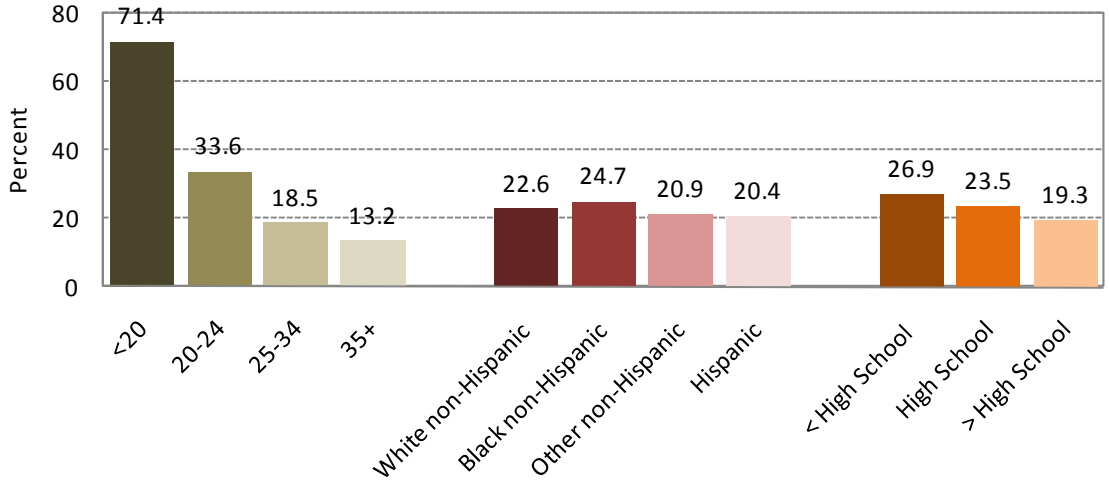
BIRTH SPACING

It is recommended to allow 24 months between births. Annually, about one fifth of all repeat births do not have adequate birth spacing. When stratifying by age, birth spacing appears to be a more significant issue among mothers under the age of 25 years.

Among Women Who Had a Previous Birth, the Percent Whose First Birth Was Less than 24 Months Prior to the Current Delivery by Year, Georgia, State Vital Records 1998 through 2007



Among Women Who Had a Previous Birth, the Percent Whose First Birth Was Less than 24 Months Prior to the Current Delivery by Maternal Age, Race/Ethnicity, and Education, Georgia, State Vital Records 2007



LEADING CAUSES OF MORTALITY AMONG WOMEN AGES 18 TO 44

Among younger women (18 to 24 years of age), motor vehicle accidents and assault/homicide were the leading causes of death in 2007. These causes of death in this age group result in 5,161.5 years of potential life lost and 1,165.5 years of potential life lost, respectively. Among women 25 to 34 years of age, motor vehicle accidents remained the leading cause of death and was associated with an additional 3,731.0 years of potential life lost. However, assault/homicide falls to the sixth leading cause. For women 35 to 44 years of age, other heart disease and breast cancer are the top causes of mortality.

Top 10 Causes of Mortality among Women Ages 18 to 44 Years, Georgia, Hospital Discharge Data 2007

Ages 18 to 19 Year

Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	28	1,554.0
2	Assault (Homicide)	6	333.0
3	Accidental Poisoning and Exposure to Noxious Substances	4	222.0
4	Septicemia	3	166.5
5	Leukemia	2	111.0
6	Intentional Self-Harm (Suicide)	2	111.0
7	Sickle Cell Trait and Disease	1	55.5
8	Meningococcal Infection	1	55.5
9	Pneumonia	1	55.5
10	Other Heart Disease	1	55.5

Ages 20 to 24 Years

Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	65	3,607.5
2	Assault (Homicide)	15	832.5
3	Accidental Poisoning and Exposure to Noxious Substances	12	666.0
4	Intentional Self-Harm (Suicide)	12	666.0
5	Other Heart Disease	10	555.0
6	Septicemia	6	333.0
7	Human Immunodeficiency Virus (HIV) Disease	5	277.5
8	Pneumonia	4	222.0
9	Diseases of the Musculoskeletal System and Connective Tissue	4	222.0
10	Pregnancy, Childbirth and the Puerperium	3	166.5

Top 10 Causes of Mortality among Women Ages 18 to 44 Years, Georgia, Hospital Discharge Data 2007			
Ages 25 to 34 Years			
Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	82	3,731.0
2	Accidental Poisoning and Exposure to Noxious Substances	44	2,002.0
3	Human Immunodeficiency Virus (HIV) Disease	35	1,592.5
4	Other Heart Disease	33	1,501.5
5	Intentional Self-Harm (Suicide)	32	1,456.0
6	Assault (Homicide)	27	1,228.5
7	Malignant Neoplasm of the Breast	15	682.5
8	Nephritis, Nephrotic Syndrome and Nephrosis	14	637.0
9	Diabetes Mellitus	13	591.5
10	Cerebrovascular Disease	12	546.0
Ages 35 to 44 Years			
Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Other Heart Disease	87	3,088.5
2	Malignant Neoplasm of the Breast	79	2,804.5
3	Accidental Poisoning and Exposure to Noxious Substances	68	2,414.0
4	Motor Vehicle Accidents	64	2,272.0
5	Human Immunodeficiency Virus (HIV) Disease	63	2,236.5
6	Cerebrovascular Disease	46	1,633.0
7	Intentional Self-Harm (Suicide)	40	1,420.0
8	Malignant Neoplasms of the Trachea, Bronchus and Lung	34	1,207.0
9	Other Forms of Chronic Ischemic Heart Disease	34	1,207.0
10	Assault (Homicide)	32	1,136.0

*Age adjusted years of potential life lost before age 75 years.

LEADING CAUSES OF EMERGENCY ROOM VISITS AMONG WOMEN 18 TO 44 YEARS OF AGE

Though in varying order, the top four causes for emergency room visits were consistent across all age groups. Pregnancy, childbirth, and puerperium was the top cause for emergency room visits among women 18 to 34 years of age and the fourth leading cause for emergency room visits among women 35 to 44 years of age. Diseases of the muscuoskeletal system and connective tissues was the top cause for emergency room visits among women 35 to 44 years of age. While motor vehicle accidents and falls were not the top cause for emergency room visits among any age group, these causes resulted in 33,526 and 27,633 emergency room visits, respectively, in 2007.

Top 10 Causes for Emergency Room Visits among Women Ages 18 to 44 Years, Georgia, Hospital Discharge Data 2007		
Ages 18 to 19 Year		
Rank	Diagnosis	Count
1	Pregnancy, Childbirth and the Puerperium	11,181
2	Motor Vehicle Accidents	3,684
3	Diseases of the Musculoskeletal System and Connective Tissue	2,716
4	Falls	1,630
5	Unknown	844
6	Asthma	797
7	Assault (Homicide)	747
8	Infections of Kidney	637
9	Bronchitis and Chronic Unspecified	401
10	Intentional Self-Harm (Suicide)	242
Ages 20 to 24 Years		
Rank	Diagnosis	Count
1	Pregnancy, Childbirth and the Puerperium	30,065
2	Diseases of the Musculoskeletal System and Connective Tissue	8,691
3	Motor Vehicle Accidents	7,789
4	Falls	4,595
5	Unknown	2,257
6	Assault (Homicide)	2,127
7	Asthma	1,975
8	Infections of Kidney	1,448
9	Bronchitis and Chronic Unspecified	1,216
10	Sickle Cell Trait and Disease	888
Ages 25 to 34 Years		
Rank	Diagnosis	Count
1	Pregnancy, Childbirth and the Puerperium	29,980
2	Diseases of the Musculoskeletal System and Connective Tissue	21,991
3	Motor Vehicle Accidents	12,153
4	Falls	10,287
5	Unknown	4,381
6	Asthma	3,971
7	Assault (Homicide)	3,033
8	Bronchitis and Chronic Unspecified	2,527
9	Sickle Cell Trait and Disease	2,439
10	Infections of Kidney	2,036

Top 10 Causes for Emergency Room Visits among Women Ages 18 to 44 Years, Georgia, Hospital Discharge Data 2007		
Ages 35 to 44 Years		
Rank	Diagnosis	Count
1	Diseases of the Musculoskeletal System and Connective Tissue	26,232
2	Falls	11,121
3	Motor Vehicle Accidents	9,900
4	Pregnancy, Childbirth and the Puerperium	6,131
5	Unknown	4,467
6	Asthma	4,121
7	Bronchitis and Chronic Unspecified	3,159
8	Essential Hypertension and Hypertensive Renal Disease	3,086
9	Assault (Homicide)	2,087
10	Diabetes Mellitus	1,645

LEADING CAUSE OF HOSPITALIZATION AMONG WOMEN AGES 18 TO 44 YEARS

Motor vehicle accidents was a leading cause of hospitalization among women 18 to 19 years of age, 20 to 24 years of age, and 25 to 34 years of age. Motor vehicle accidents was a greater source of hospitalizations for women 18 to 19 years of age (rank 3) and 20 to 24 years of age (rank 2) compared to women 25 to 34 years of age (rank 9). While not in the top five causes of hospitalization among any age group, asthma was a top ten cause of hospitalization among all age groups except women 20 to 24 years of age. Diabetes mellitus was a leading cause of hospitalization among all age groups. Diabetes mellitus was a top five cause of hospitalization for all groups except women 35 to 44 years of age (rank 6).

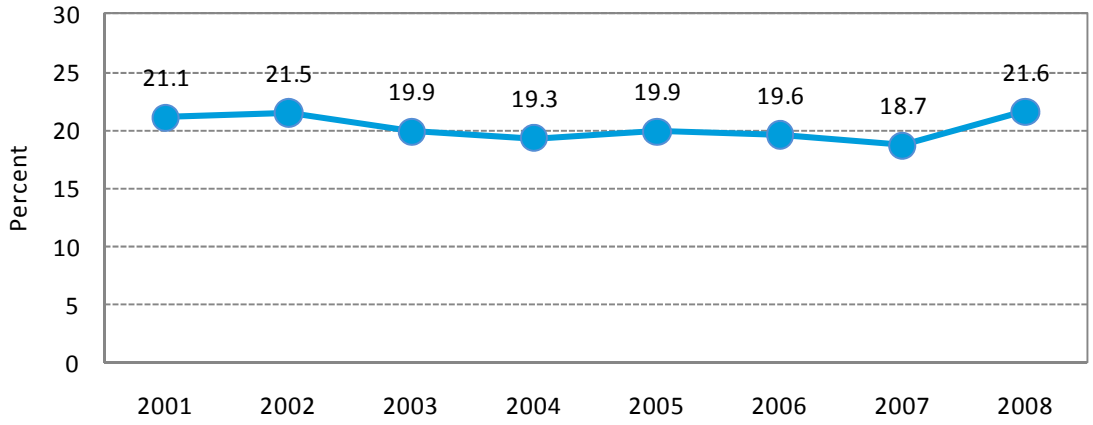
Top 10 Causes for Inpatient Hospitalization among Women Ages 18 to 44 Years, Georgia, Hospital Discharge Data 2007		
Ages 18 to 19 Year		
Rank	Diagnosis	Count
1	Pregnancy, Childbirth and the Puerperium	13,119
2	Diabetes Mellitus	169
3	Motor Vehicle Accidents	159
4	Infections of Kidney	114
5	Sickle Cell Trait and Disease	97
6	Unknown	88
7	Intentional Self-Harm (Suicide)	87
8	Diseases of the Musculoskeletal System and Connective Tissue	85
9	Pneumonia	57
10	Asthma	54

Top 10 Causes for Inpatient Hospitalization among Women Ages 18 to 44 Years, Georgia, Hospital Discharge Data 2007		
Ages 20 to 24 Years		
Rank	Diagnosis	Count
1	Pregnancy, Childbirth and the Puerperium	43,111
2	Motor Vehicle Accidents	366
3	Diabetes Mellitus	351
4	Sickle Cell Trait and Disease	338
5	Unknown	281
6	Diseases of the Musculoskeletal System and Connective Tissue	236
7	Infections of Kidney	218
8	Pneumonia	180
9	Intentional Self-Harm (Suicide)	170
10	Other Heart Disease	156
Ages 25 to 34 Years		
Rank	Diagnosis	Count
1	Pregnancy, Childbirth and the Puerperium	75,642
2	In Situ and Benign Neoplasms	1,203
3	Unknown	1,014
4	Diseases of the Musculoskeletal System and Connective Tissue	990
5	Diabetes Mellitus	894
6	Sickle Cell Trait and Disease	699
7	Other Heart Disease	585
8	Pneumonia	532
9	Motor Vehicle Accidents	480
10	Asthma	458
Ages 35 to 44 Years		
Rank	Diagnosis	Count
1	Pregnancy, Childbirth and the Puerperium	19,867
2	In Situ and Benign Neoplasms	4,245
3	Diseases of the Musculoskeletal System and Connective Tissue	2,344
4	Unknown	1,883
5	Other Heart Disease	1,281
6	Diabetes Mellitus	1,113
7	Pneumonia	996
8	Asthma	833
9	Essential Hypertension and Hypertensive Renal Disease	539
10	Intentional Self-Harm (Suicide)	517

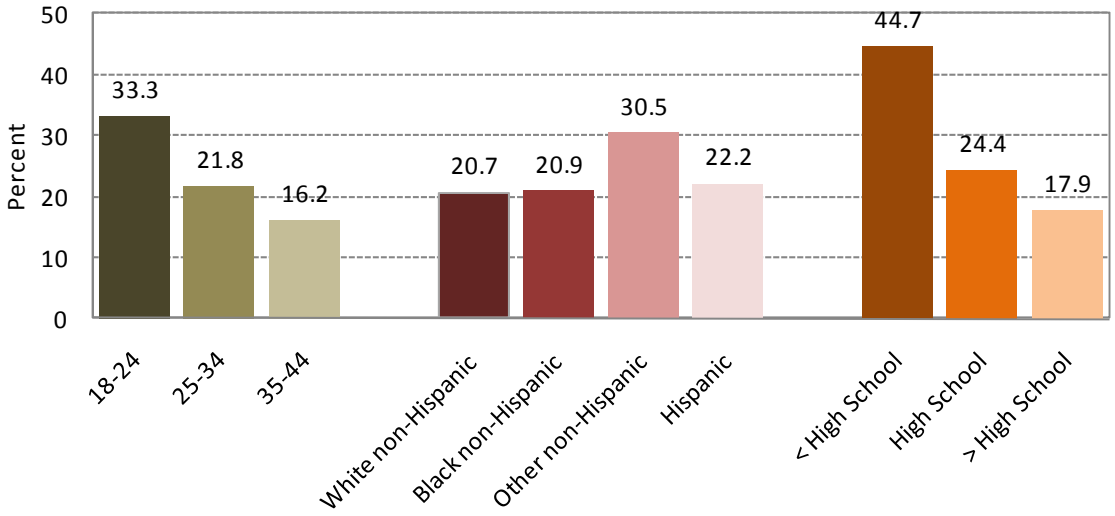
No Usual Source of Care

Between 2001 and 2007, there have been slight changes in the percent of women 18 to 44 years of age who reported no usual source of medical care. In 2008, the percent of women 18 to 44 years of age who reported no usual source of medical care increased by 15.5 percent. Younger age and less educational attainment were associated with a greater likelihood of reporting no usual source of medical care.

Percent of Women Ages 18 to 44 Years Who Reported No Usual Source of Medical Care by Year, Georgia, BRFSS 2001 through 2008



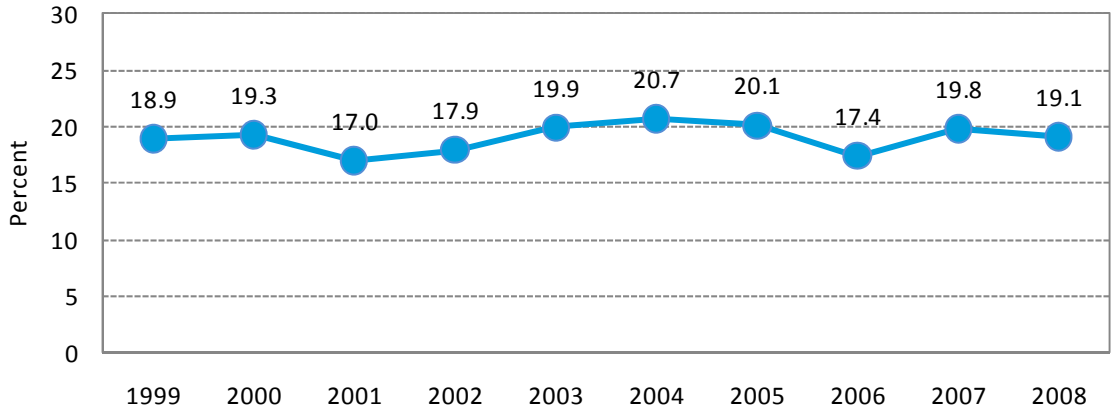
Percent of Women Ages 18 to 44 Years Who Reported No Usual Source of Medical Care by Maternal Age, Race/Ethnicity, and Education, Georgia, BRFSS 2008



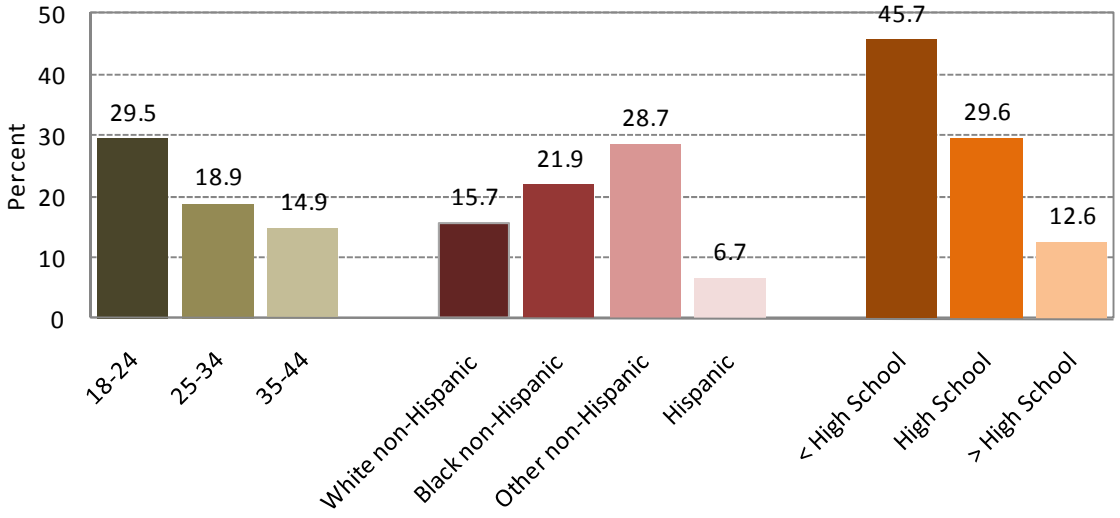
No Health Insurance

Between 1999 and 2008, approximately one fifth of women 18 to 44 years of age in Georgia reported no source of health insurance. Nearly half of all women 18 to 44 years of age who did not graduate high school reported no source of health insurance. Younger women had a greater likelihood of reporting no source of health insurance compared to older women.

Percent of Women Ages 18 to 44 Years Who Reported No Source of Health Insurance by Year, Georgia, BRFSS 1999 through 2008



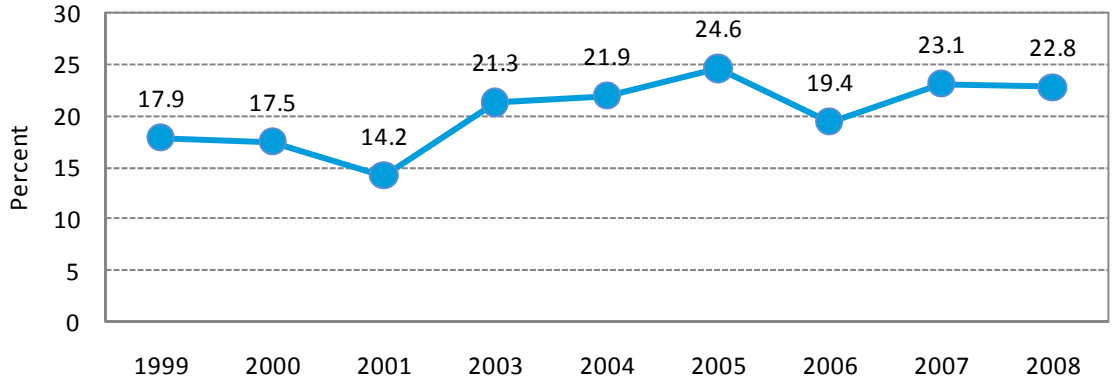
Percent of Women Ages 18 to 44 Years Who Reported No Source of Health Insurance by Maternal Age, Race/Ethnicity, and Education, Georgia, BRFSS 2008



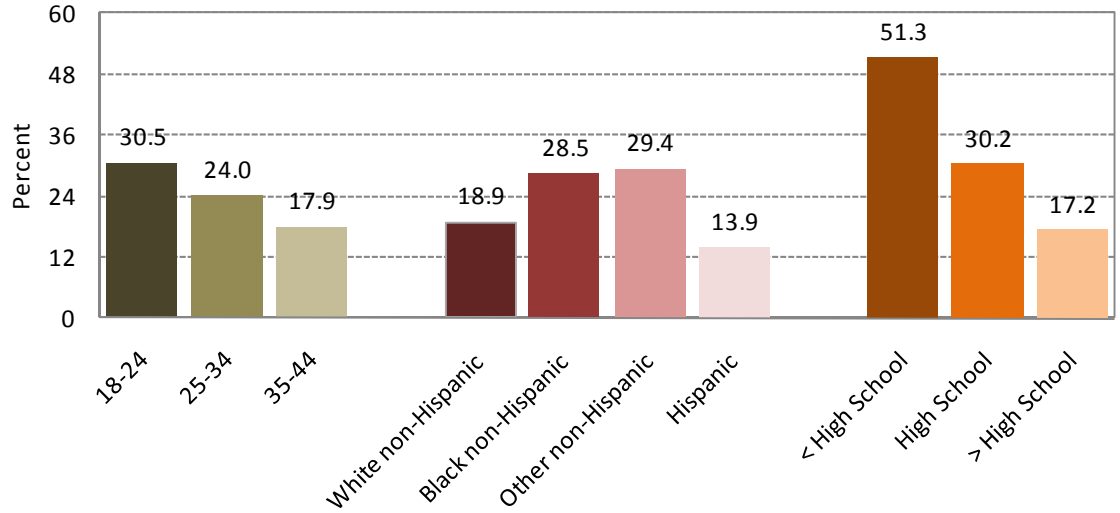
Did Not See a Physician Due to Financial Reasons

Between 1999 and 2008, on average, approximately one fifth of women 18 to 44 years of age in Georgia did not see a physician due to financial reasons. In three of the previous four years, the percent of women 18 to 44 years of age in Georgia had been higher than at any other point during the previous ten years. More than half of all women 18 to 44 years of age who did not graduate high school reported not seeing a physician due to financial reasons. Younger women had a greater likelihood of reporting not seeing a physician due to financial reasons compared to older women.

Percent of Women Ages 18 to 44 Years Who Reported Not Visiting a Physician Due to Financial Reasons by Year, Georgia, BRFSS 1999 through 2001 and 2003 through 2008



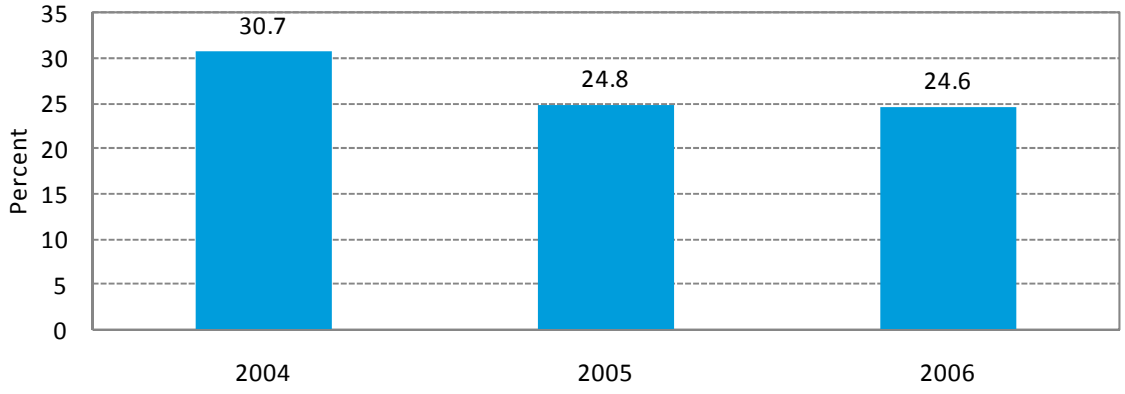
Percent of Women Ages 18 to 44 Years Who Reported Not Visiting a Physician Due to Financial Reasons by Maternal Age, Race/Ethnicity, and Education, Georgia, BRFSS 2008



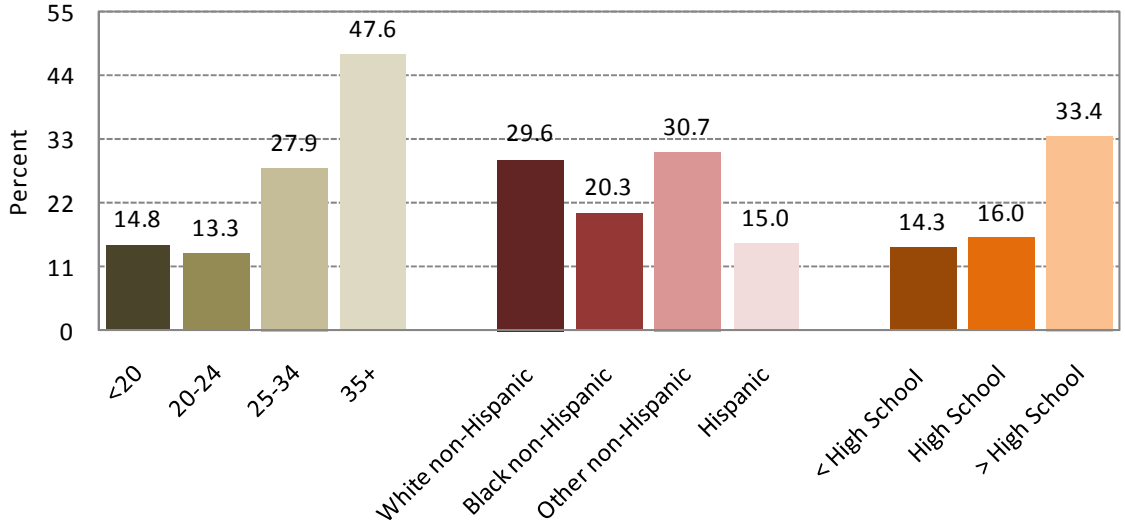
FOLIC ACID USE

The *Healthy People 2010* objective is for 80 percent of women of child bearing age to consume at least 400 µg of folic acid daily. However, among women who gave birth, less than 25 percent reported using folic acid every day in the month prior to conception. Women 35 years of age and older had the greatest rates of daily consumption, but this rate was still less than 50 percent. One third of women who had more than a high school education consumed daily folic acid the month prior to conception. Fewer than 20 percent of women less than 25 years of age, Hispanic women, and women with a high school diploma or less consumed daily folic acid in the month prior to conception. Among Georgia's 18 health districts, daily folic acid consumption ranged from 36.1 percent to 14.3 percent.

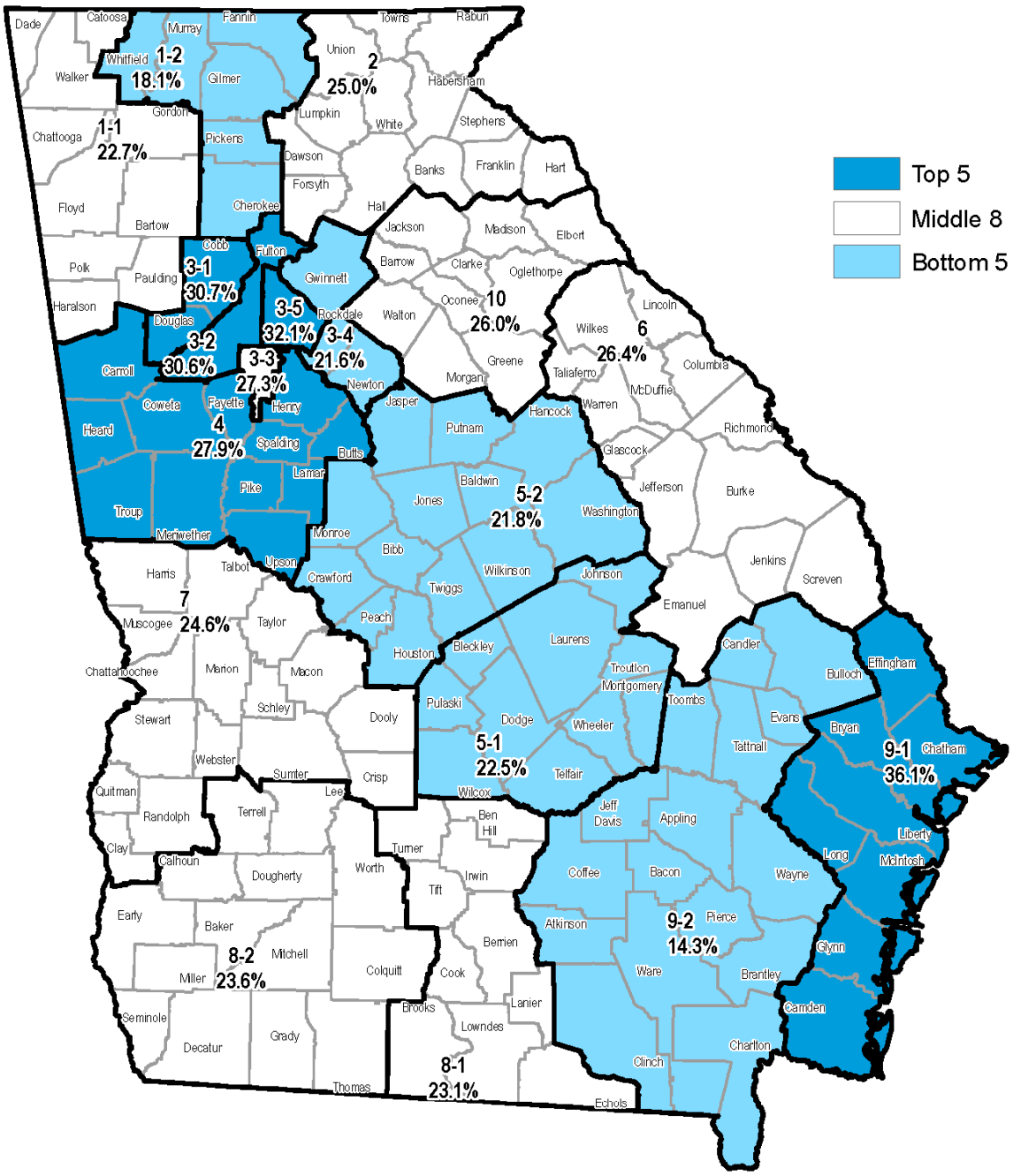
Percent of Mothers Who Reported Using Folic Acid Every Day in the Month Prior to Conception by Year, Georgia, PRAMS 2004 through 2006



Percent of Mothers Who Reported Using Folic Acid Every Day in the Month Prior to Conception by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



Percent of Mothers Who Reported Using Folic Acid Every Day in the Month Prior to Conception by Public Health District, Georgia, PRAMS 2004 through 2006



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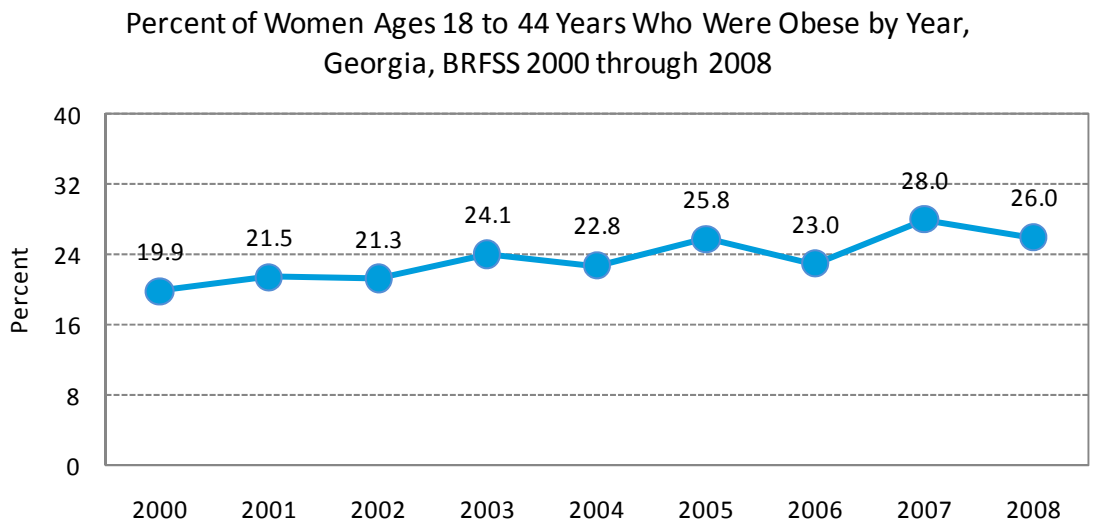
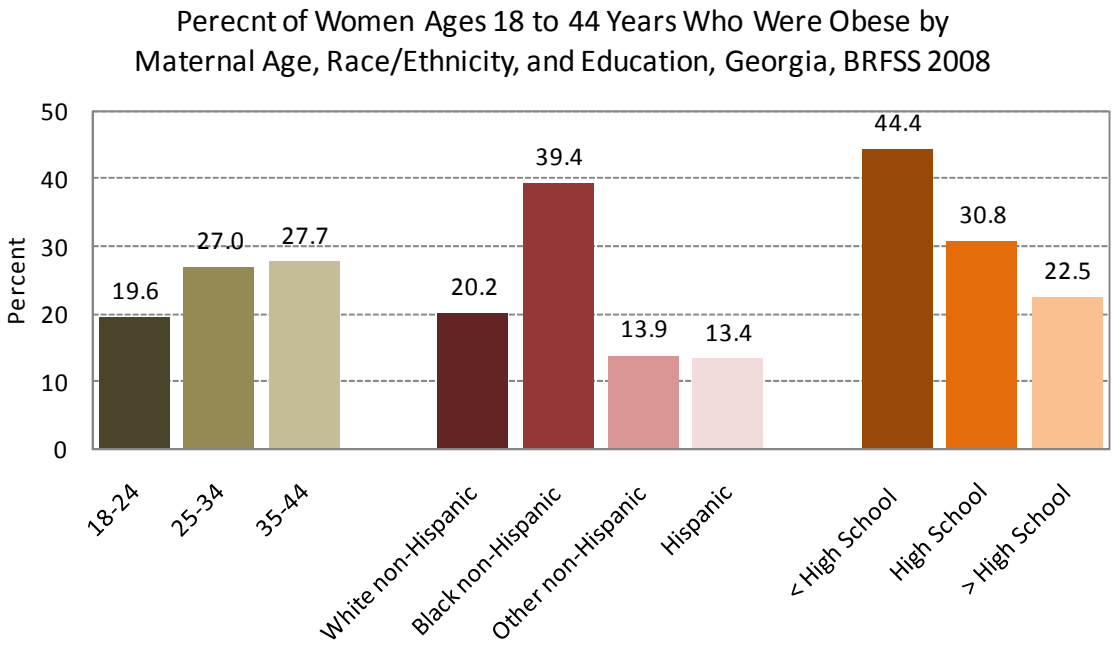
OBESITY

The rate of obesity among Georgia's women of child bearing age increased 30.7 percent between 1999 and 2008. Decreased educational attainment was associated with greater rates of obesity. More than 40 percent of women who did not graduate high school were obese and 30.8 percent of women who were high school graduates were obese. Nearly 40 percent of Black women were obese. The rate of obesity among Black women was nearly double that of White women and more than double that of Hispanic women.

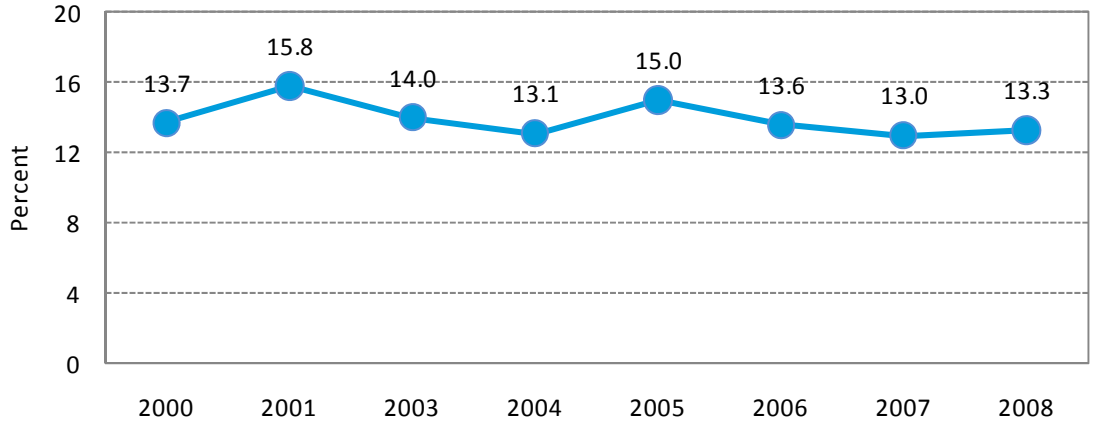




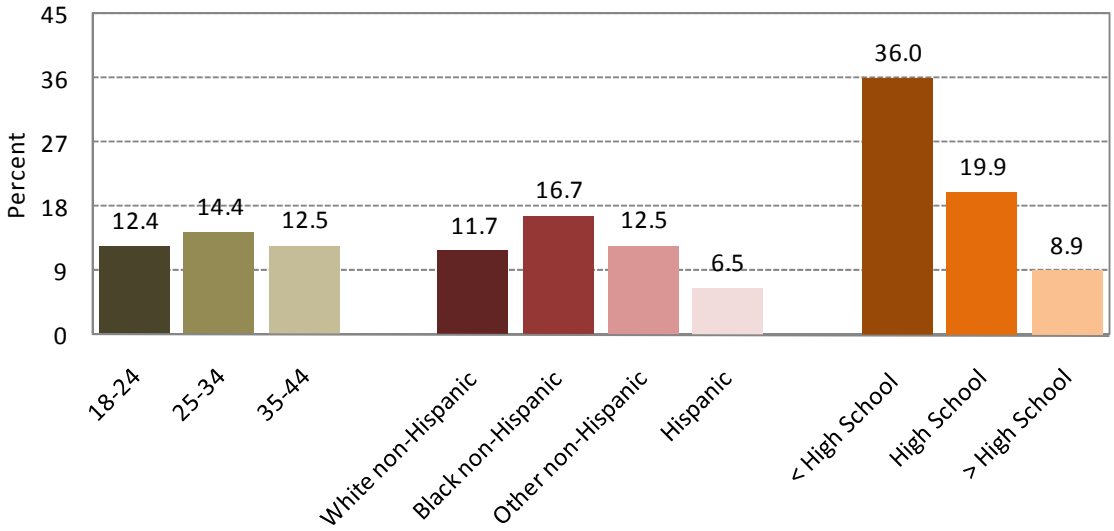
MENTAL HEALTH

Mental distress is defined as reporting one's mental health not to be good on 14 or more days in the past month. Using this definition, approximately 13 percent of women of child bearing age in Georgia experienced mental distress. There has been limited variation in this percent between 2000 and 2008. The rate of mental distress among Black women was greater than in other racial/ethnic groups. Women with less educational attainment had the greatest rates of mental distress. The percent of mental distress among women who did not graduate high school was three times that of the statewide percent.

Percent of Mental Distress among Women Ages 18 to 44 Years by Year, Georgia, BRFSS 2000 through 2008



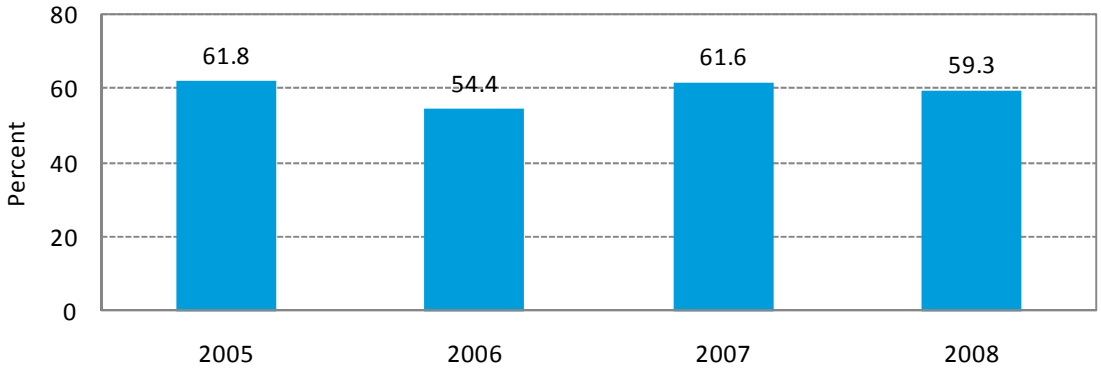
Percent of Mental Distress among Women Ages 18 to 44 Years by Maternal Age, Race/Ethnicity, and Education, Georgia, BRFSS 2008



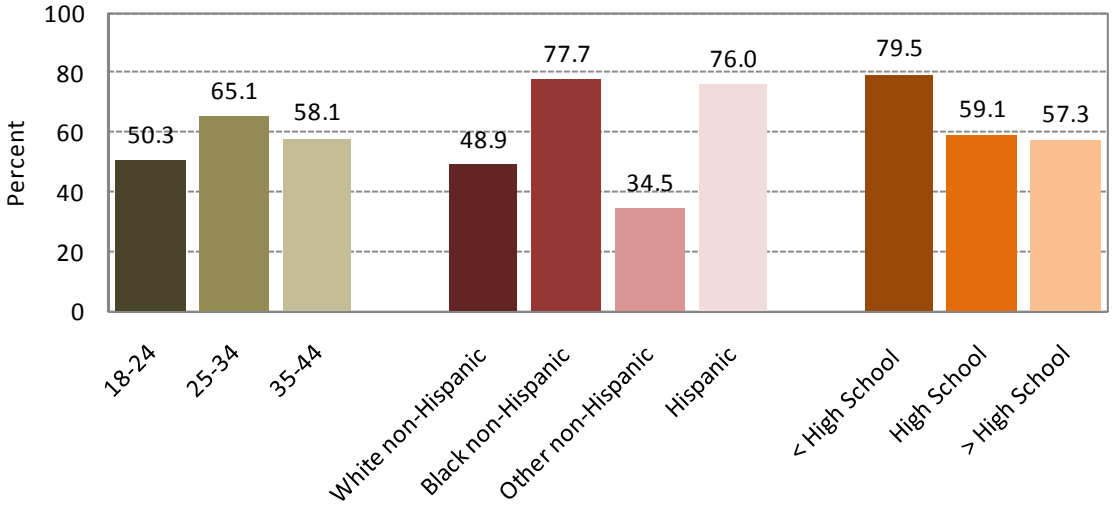
HIV Prevention

Approximately 60 percent of women of childbearing age in Georgia have been tested for HIV. However, there were significant disparities by age, race/ethnicity, and educational attainment. A greater percent of women over 25 years of age were tested as compared to women under 25 years of age. Testing rates among Black and Hispanic women were approximately 60 percent greater than the testing rate among White women. Women with less educational attainment had greater testing rates than women with greater educational attainment.

Percent of Women Ages 18 to 44 Years Who Reported Having Ever Taken an HIV Test by Year, Georgia, BRFSS 2005 through 2008



Percent of Women Ages 18 to 44 Years Who Reported Having Ever Taken an HIV Test by Maternal Age, Race/Ethnicity, and Education, Georgia, BRFSS 2008



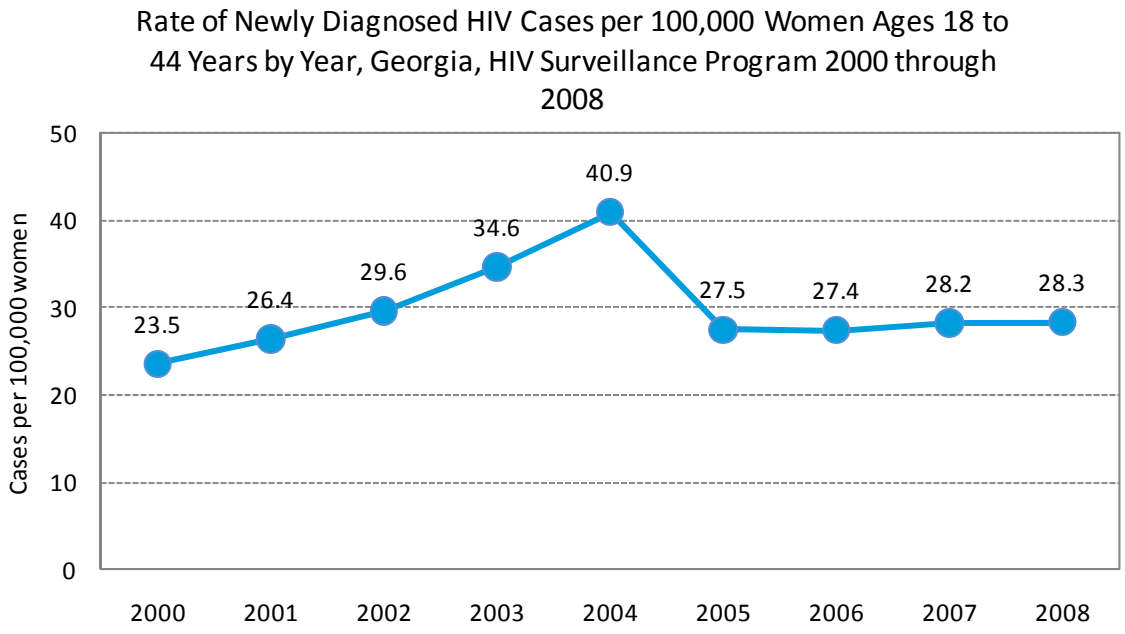
Newly Diagnosed Cases of HIV

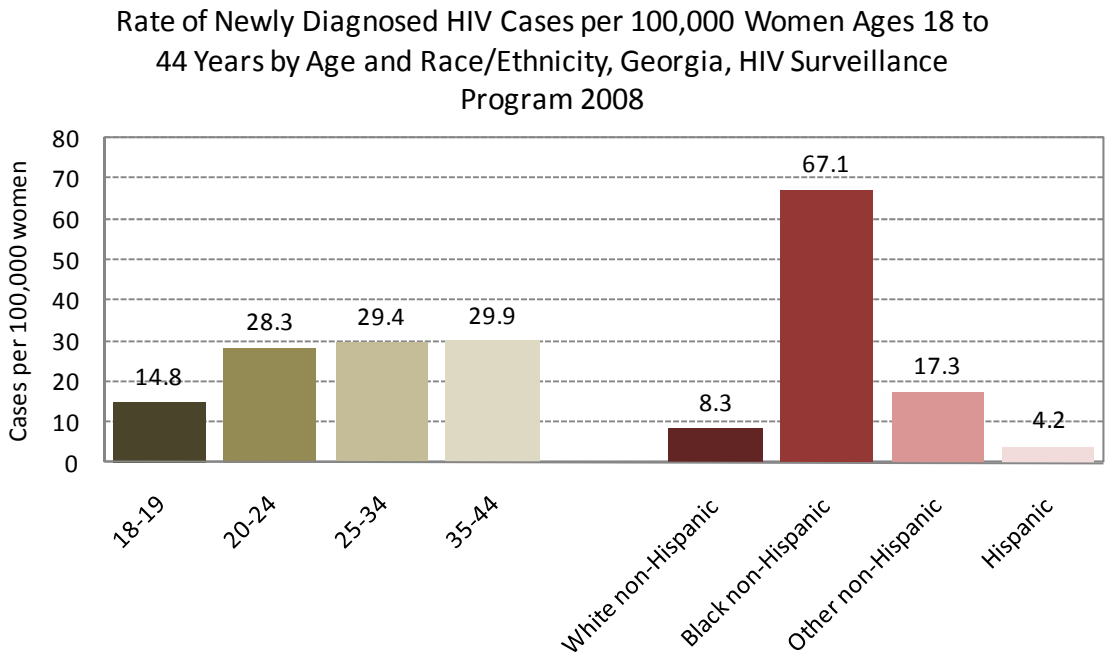
Between 2000 and 2008, the number of newly diagnosed HIV cases among women ages 18 to 44 years ranged between 407 (2000) and 736 (2004). Between 2000 and 2008, the rate of newly diagnosed cases of HIV exceeded 30 cases per 100,000 women 18 to 44 years of age in 2003 and 2004. This rate declined 32.5 percent between 2004 and 2005. This change was due to a change in process. In 2004, Georgia partnered with CDC to remove duplicate newly diagnosed cases of HIV. The results of this project were seen in the decline in the rate of newly diagnosed cases of HIV between 2004 and 2005. Data for 2005 through 2008 were a better representation of the number and rate of newly diagnosed HIV cases in Georgia.

The rate of newly diagnosed HIV cases was similar among women 20 to 24 years of age, 25 to 34 years of age, and 35 to 44 years of age. For women 18 to 19 years of age, the rate of newly diagnosed HIV cases was approximately half that of other age groups.

When stratifying by race/ethnicity, Black women accounted for 80.1 percent of all newly diagnosed HIV cases among women 18 to 44 years of age in 2008. The rate of newly diagnosed HIV cases among Black women was eight times greater than the rate among White, non-Hispanic women and four times greater than the rate among Hispanic women.

Among Georgia's 18 public health districts, cases in four public health districts (Clayton, Coastal Georgia, DeKalb, and Fulton) accounted for more than half of all newly diagnosed HIV cases among women 18 to 44 years of age throughout Georgia. The rate of newly diagnosed HIV cases among women 18 to 44 years of age exceeded 50 cases per 100,000 in the Clayton County Public Health District (67.9), the DeKalb County Public Health District (58.1), and the Fulton County Public Health District (52.9).





NEWLY DIAGNOSED SEXUALLY TRANSMITTED INFECTIONS

Between 1999 and 2008, the rate of newly diagnosed Chlamydia cases for women 18 to 44 years of age increased in all but three years. During this ten-year period, there was a 23 percent increase in the rate of newly diagnosed Chlamydia cases.

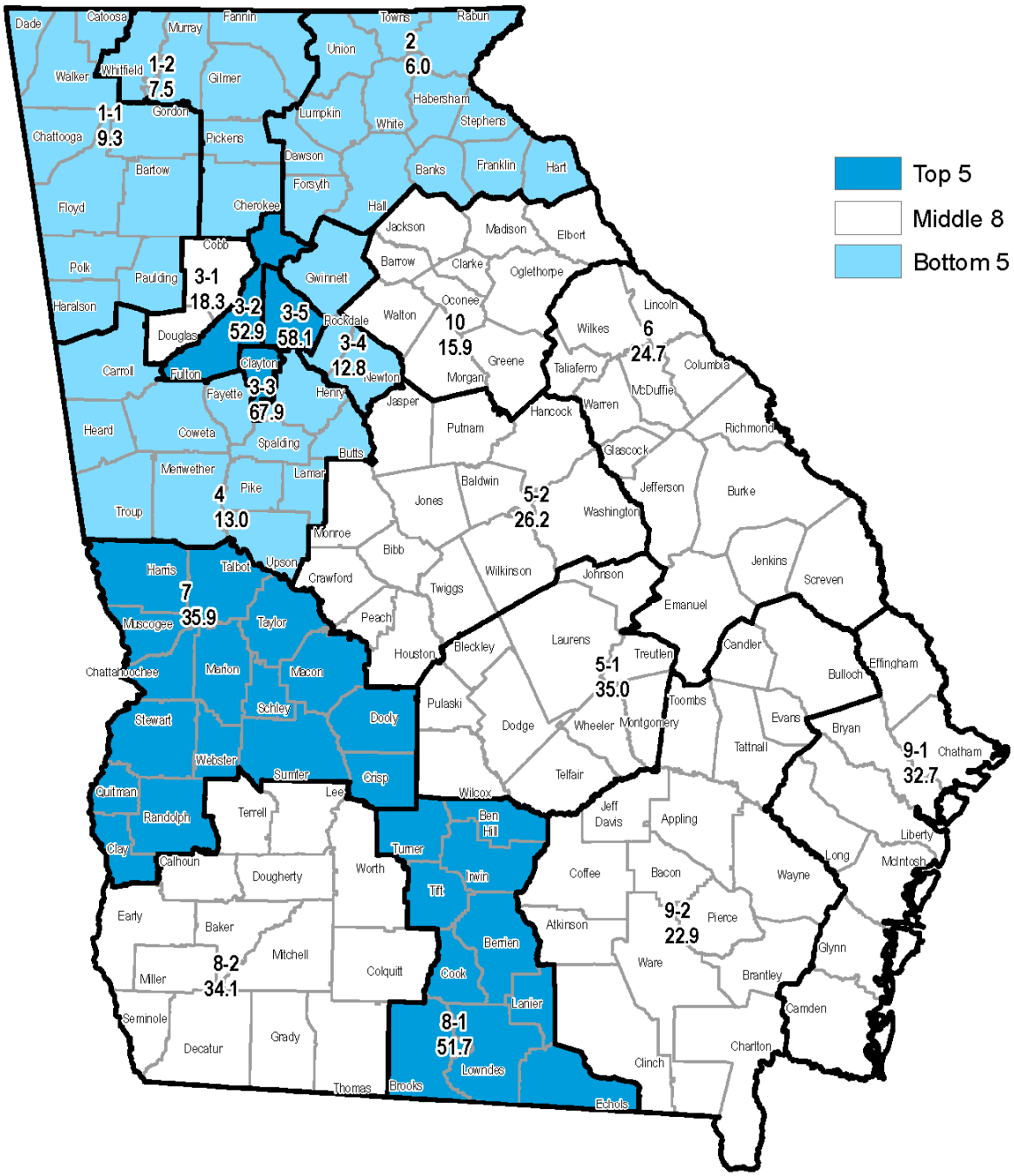
Between 1999 and 2008, rate of newly diagnosed gonorrhea cases for women 18 to 44 years of age decreased in all years except for one. During this ten-year period, there was a 17 percent decline in the rate of newly diagnosed gonorrhea cases.

Rates of newly diagnosed cases of Chlamydia and gonorrhea were greatest among younger women and Black women. For Chlamydia, the ratio of the newly diagnosed case rate among women 18 to 19 years of age and 25 to 34 years of age was six to one. The newly diagnosed case rate ratio was four to one when comparing women ages 20 to 24 years of age to women 25 to 34 years of age. These ratios were similar for gonorrhea.

Black women have the greatest rates of newly diagnosed cases of Chlamydia and gonorrhea. Racial/ethnic disparities persist for Chlamydia and gonorrhea, but are significantly larger for gonorrhea. For rates of newly diagnosed cases of Chlamydia and gonorrhea, the newly diagnosed case rate ratio of Black women to White women was nine to one and fifteen to one, respectively. The newly diagnosed case rate ratio of Black women to Hispanic women was four to one for Chlamydia and eleven to one for gonorrhea.

Among Georgia's 18 public health districts, the Southwest Health District and the West Central Health District had the greatest rates of newly diagnosed cases of Chlamydia and gonorrhea. These were the only two public health districts with rates of newly diagnosed cases of Chlamydia in excess of 2,000 cases per 100,000 women 18 to 44 years of age and rates of newly diagnosed cases of gonorrhea in

Rate of Newly Diagnosed HIV Cases per 100,000 Women Ages 18 to 44 Years by Public Health District, Georgia, HIV Surveillance Program 2008



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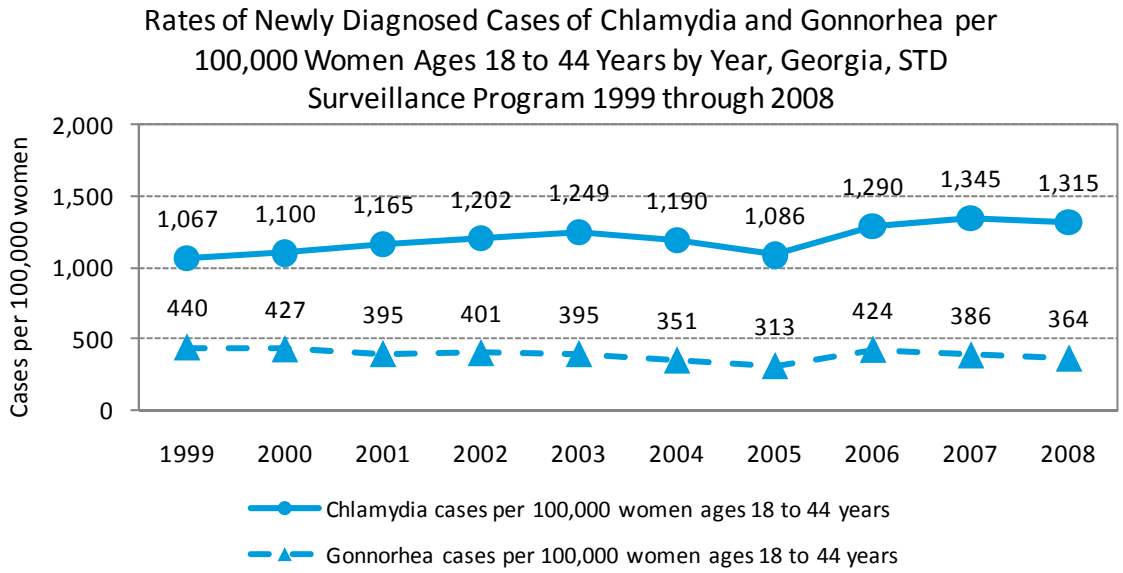
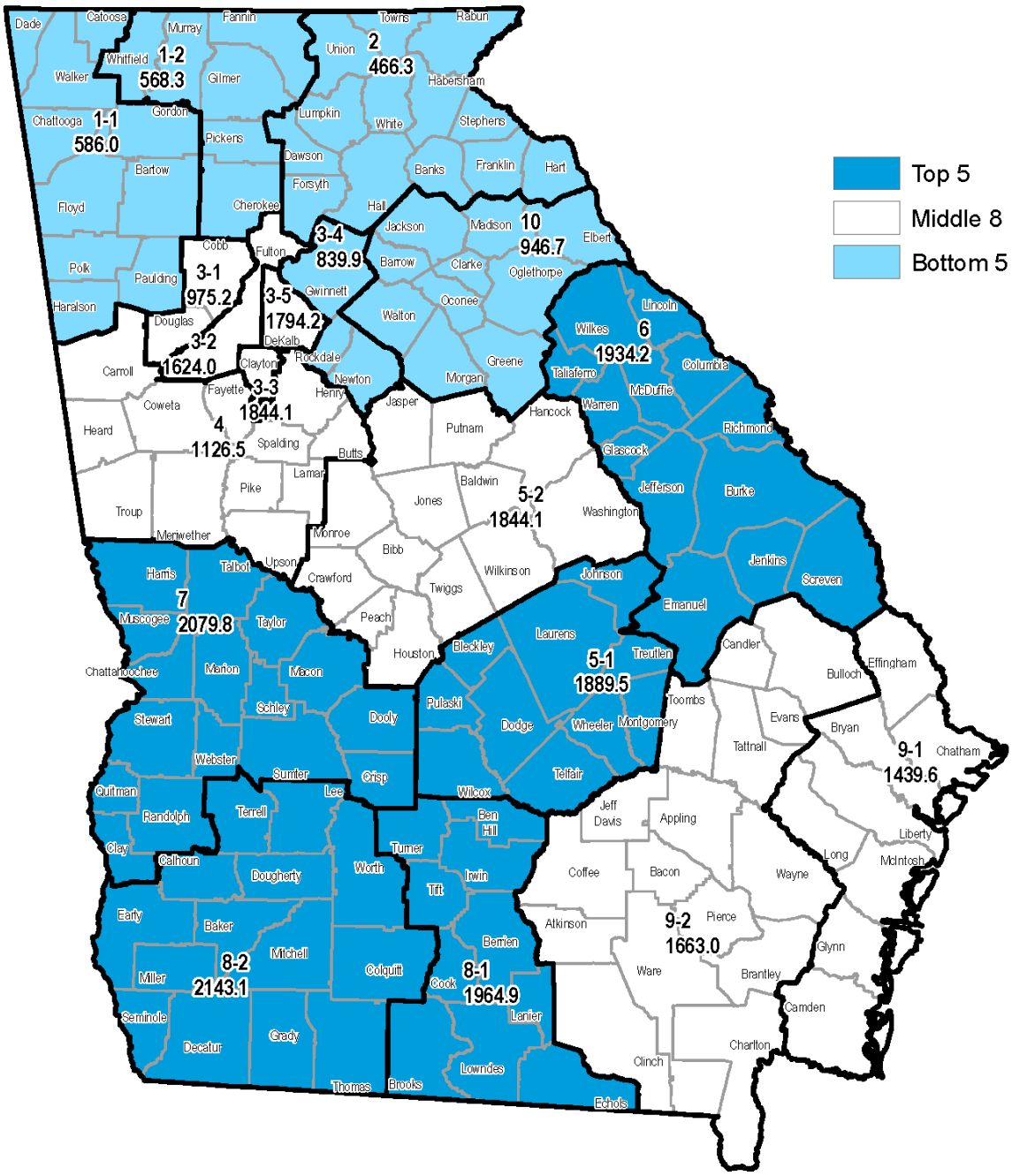
excess of 700 cases per 100,000 women 18 to 44 years of age. There were eight other public health districts with rates of newly diagnosed cases of Chlamydia in excess of 1,500 cases per 100,000 women 18 to 44 years of age and with rates of newly diagnosed cases of gonorrhea in excess of 500 cases per 100,000 women 18 to 44 years of age.

While data were available for newly diagnosed cases of primary syphilis, there have been fewer than 15 cases annually since 2002. Between 2002 and 2008, the rate of newly diagnosed cases of syphilis in Georgia among women 18 to 44 years of age did not exceed one case per 100,000 women.



Rate of Newly Diagnosed Cases of Chlamydia and Gonorrhea per 100,000 Women Ages 18 to 44 Years by Age and Race/Ethnicity, Georgia, 2008		
	Newly Diagnosed Chlamydia Cases per 100,000 Population	Newly Diagnosed Gonorrhea Cases per 100,000 Population
Age		
18-19	5,269	1,347
20-24	3,379	909
25-34	854	251
35-44	132	54
Race/ethnicity		
White non-Hispanic	151	31
Black non-Hispanic	1,320	476
Other non-Hispanic	91	25
Hispanic	325	43

Rate of Newly Diagnosed Cases of Chlamydia per 100,000 Women Ages 18 to 44 Years by Public Health District, Georgia, STD Surveillance Program, 2008



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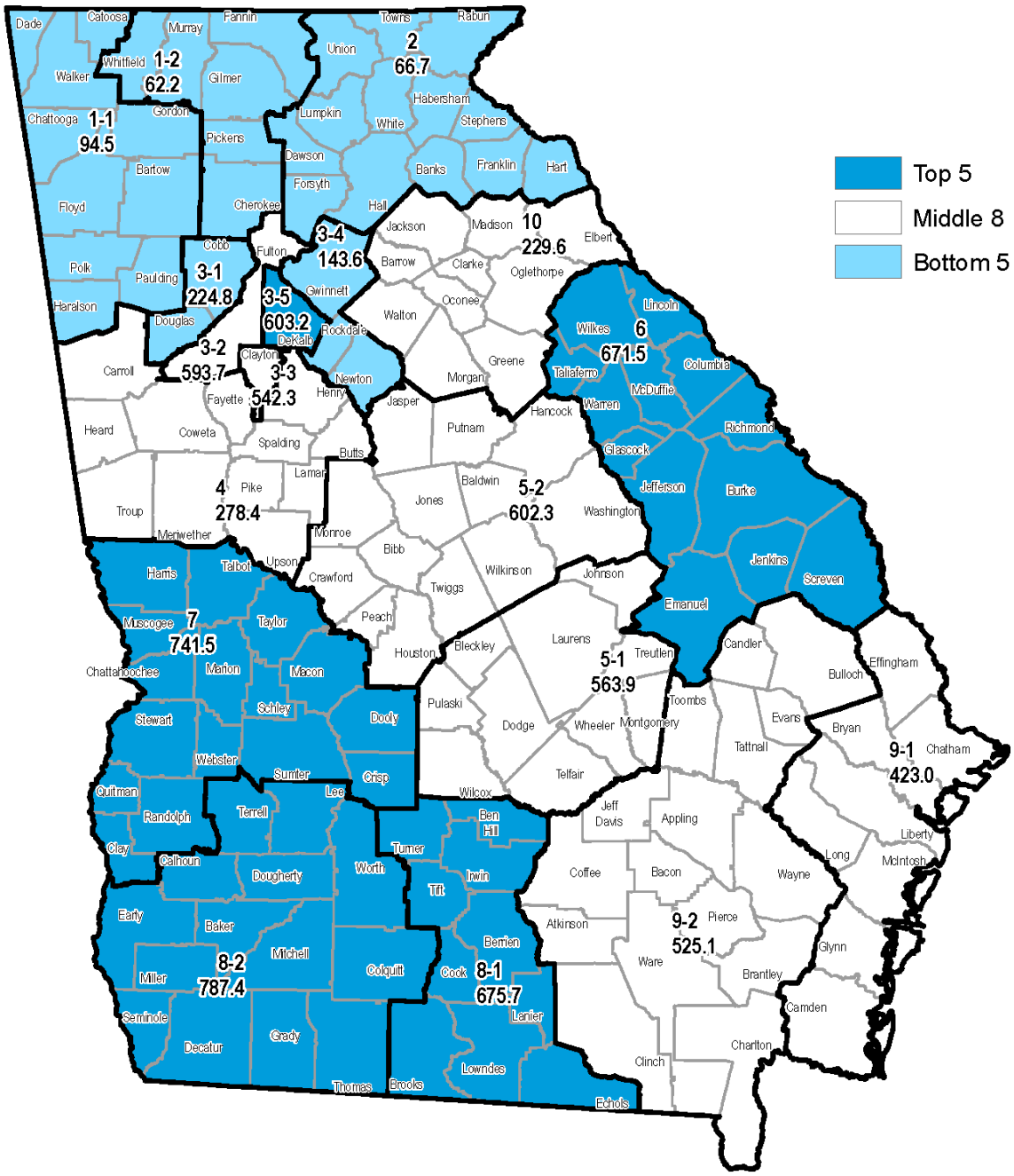
Rate of Newly Diagnosed Cases of Gonorrhea per 100,000 Women Ages 18 to 44 Years by Public Health District, Georgia, STD Surveillance Program, 2008



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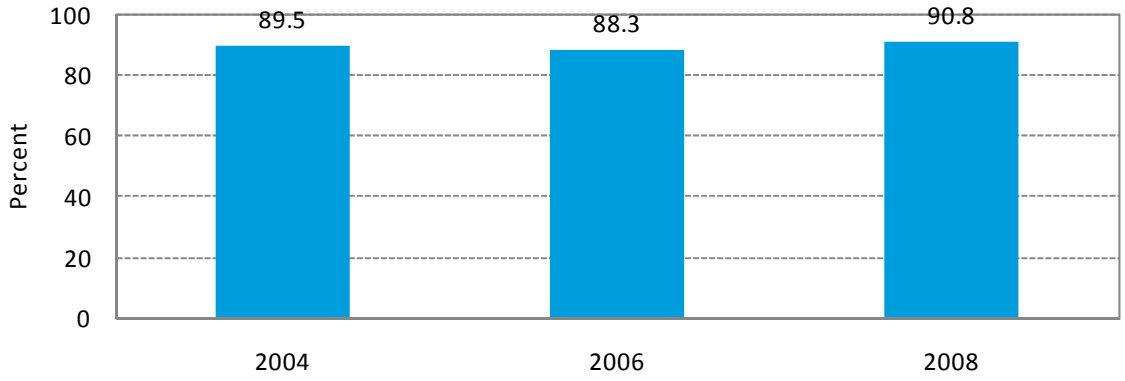
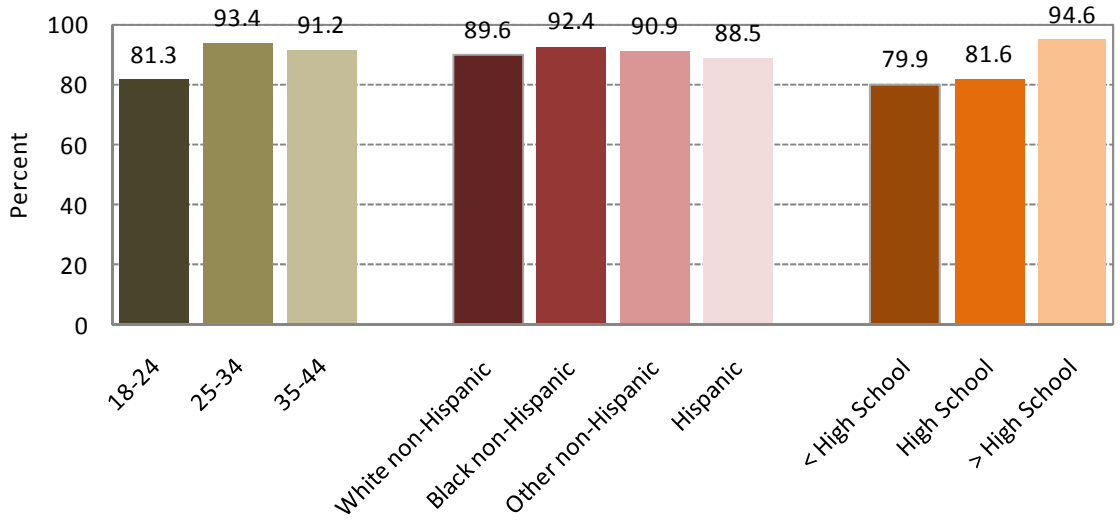
Pap Smears in the Previous Three Years

The *Healthy People 2010* objective is for women older than 18 years of age to have a pap smear in the preceding three years was 90 percent. This objective was exceeded in 2008 among women 18 to 44 years of age in Georgia. Younger women and women with a high school degree or less did not meet this objective. White and Hispanic women also did not meet this objective, short of the objective by two percentage points.

Percent of Women Ages 18 to 44 Years Who Reported a Pap Smear in the Preceding Three Years by Year, Georgia, BRFSS 2004, 2006, and 2008

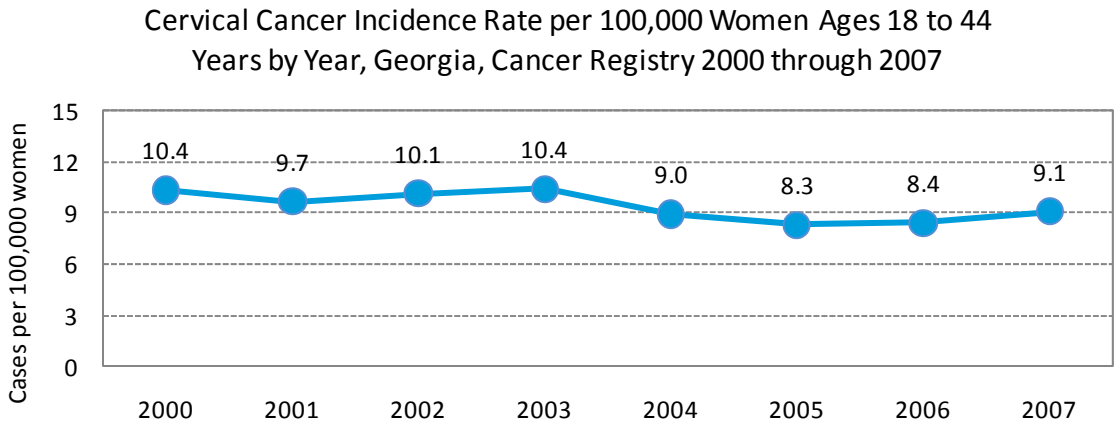


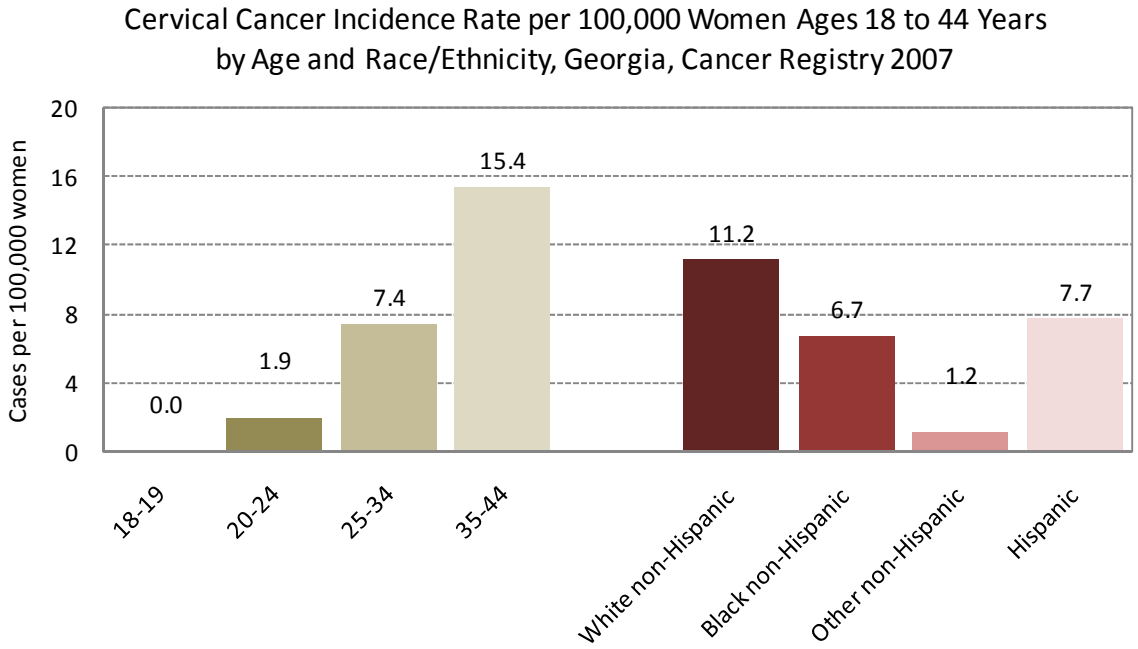
Percent of Women Ages 18 to 44 Years Who Reported a Pap Smear in the Preceding Three Years by Maternal Age, Race/Ethnicity, and Education, Georgia, BRFSS 2008



Cervical Cancer Incidence

There was limited variation in cervical cancer rates from 2000 through 2007. Cervical cancer incidence was greatest among women 35 to 44 years of age. White women have greater cervical cancer incidence rates compared to Black and Hispanic women.

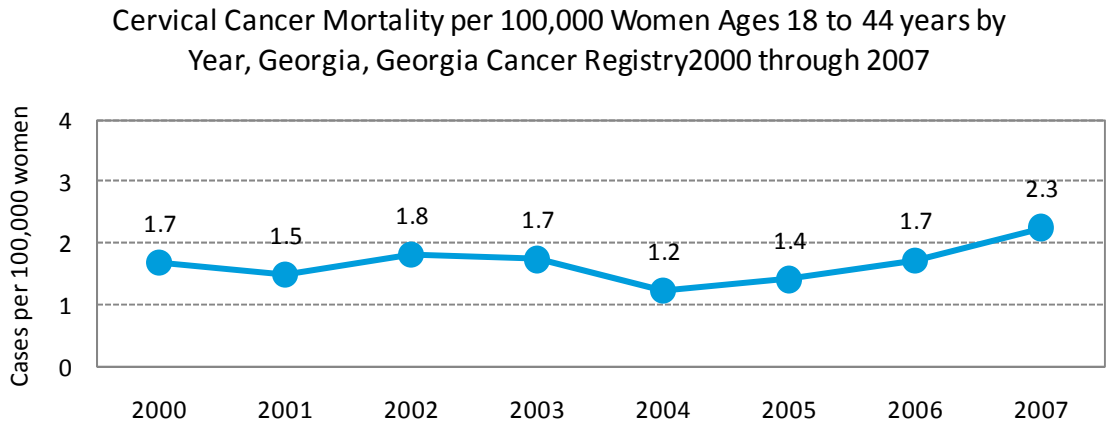




Cervical Cancer Mortality

Through 2006, the cervical cancer mortality rate among women 18 to 44 years of age in Georgia was below the *Healthy People 2010* objective for the female population of 2.0 deaths per 100,000 women. Following three consecutive years in which the cervical cancer mortality rate increased, the cervical cancer mortality rate was 2.3 deaths per 100,000 women 18 to 44 year of age. Cervical cancer mortality

was concentrated among women 35 to 44 years of age and occurred primarily among White women (data not shown). Cancer registry data do not include ethnicity.



QUALITATIVE THEMES FOR WOMEN FROM STATEWIDE FOCUS GROUPS

The qualitative data section is organized by theme. These themes were identified through analysis of the data collected through the focus groups. There is standard information provided for each theme that includes sections on *Quantification*, *Description of the Health Concern*, and *Ideas about What is Needed to Improve* the identified need.

The *Quantification* section provides information about the frequency with which the theme was identified.

After reviewing the notes collected during the focus groups, themes were identified by analysts based on the information recorded as part of the focus groups. The *Description of the Health Concern* section provides quotes and ideas communicated by focus group participants that were used in defining the theme. As frequently as possible, direct quotes from focus group participants are used.

The *Ideas about What is Needed to Improve* the identified need section captures focus group participant ideas about possible strategies and solutions to improve that theme.

In limited instances, along with the identified themes, a section has been included labeled *Other Health Concerns*. This section includes a list of health care concerns among a specific population that were not mentioned with adequate frequency to be considered a theme, but were important to document.

MENTAL HEALTH

QUANTIFICATION

Mental health is identified as a major health concern for women by four of nine MCH needs assessment community focus groups and five of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

The mental health of women is a major concern health concern in Georgia communities and among health care providers. Post-partum depression and substance abuse are perceived as associated health concerns among new mothers and pregnant women.

Various focus groups point out an increase in mental health problems in their communities. "We have seen an increase in mental health issues largely because of the state of the economy and lack of finances due to loss of job, spouse's job, or both."

"Addressing domestic abuse – huge in pregnant women. The red flags tie into mental health."

Part of the problem in communities is that there is not a good awareness of postpartum depression and "mental health in general and what to do about it."

The mental health of young girls is of special concern. "The mental health and emotional well being of young girls getting pregnant concerns me. They are troubled, depressed, and there are not enough resources in Richmond County."

The limited availability of mental health providers is a frequently cited concern of health care providers, public health employees and community members.

One South Georgia health care provider highlights the problem in her community. "We need more mental health services for pregnant women and postpartum mothers. It can be weeks before they receive needed mental health services. If you are dealing with postpartum depression, this is not adequate care."

There is additional concern that "access to mental health services is a problem for those who do not qualify for Medicaid and their insurance does not cover it."

Insurance company practices are seen as contributing to the problem. "Insurance companies are taking out coverage of mental health services. Their approach is 'let's medicate them.' It's easier than programs." Cutbacks in mental health services are also of major concern.

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE WOMEN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of women. Suggestions around mental health follow.

- Mental health referrals and care, including services for pregnant and postpartum women, are needed;
- As noted in several groups, there is stigma attached to receiving mental health services. One suggestion is to have "mental health services in the community and away from the clinic;"
- Some groups suggest that what is needed in their communities is "for doctors to address postpartum in women;"

- A physician in one community focus group cites the need for collaboration between mental health providers and OB's. "Prescribers don't want to prescribe medicines to pregnant women …Patients get caught in a circle then because they are referred to OB's who will not give psychiatric meds …There should be more collaboration between the two;" and
- "Psycho-social support, classes and support groups on postpartum depression are needed to improve the health of women." Suggestions for pregnant women include the use of "resource mothers" and "centering pregnancy programs" to improve health of women in the community. "Implement more centering pregnancy programs where a pregnant woman becomes part of a group of pregnant women who have their appointments at the same time. They talk about their diets, about their blood pressure and other health issues. Everything is done as a group with peers talking about the same issues."

PRENATAL CARE

QUANTIFICATION

Prenatal care is identified as a major health concern for women by four of nine MCH needs assessment community focus groups and five of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

A concern about prenatal care is that without it, as one health care provider states, "premature and low birth weight babies end up on my doorstep."

That women do not know the importance of prenatal care is a view forwarded in all of the focus groups that identified prenatal care as one of their communities' major health concerns. "They just go to the hospital and have the baby."

The concern about women accessing prenatal care is not only attributed to awareness of its importance. "Loss of health insurance has added an extra burden, as well as stress, to the pregnant woman wondering how she will pay for her pregnancy." As a consequence, "women are presenting themselves later for prenatal care, with many seeking assistance in their second trimester, and some not seeking prenatal care at all."

The concern that women are accessing prenatal care late is verbalized in other community focus groups as well.

Access issues that mothers and pregnant women are experiencing include the following.

- There is no public transportation in many parts of the state; multiple problems with Medicaid van logistics;
- Some counties do not have a physician; long driving distances to regional perinatal centers create barriers to care;
- There is a need for medical interpreters to ensure mutual understanding;
- Availability of providers "who are willing to care for women who are low income, not Medicaid eligible and at risk medically" is a problem in communities;

- "There is a lack of prenatal care for women who do not qualify for Medicaid." Women are "falling through the cracks" and not qualifying for assistance program. "You're poor but not poor enough;"
- "Affording health care if you are on the fence of eligibility for services" is a major concern. "If you work for the state, you can't get Peach Care...If one parent works, you make too much but don't have enough…It's almost better to stay home and not work;" and
- Insurance issues (cited as a problem by every group) affect many women and also hit hard high risk pregnant women "who need specialty care but do not have insurance to pay for needed services."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE WOMEN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of women. Suggestions around prenatal care follow.

- Health education is needed. "We need an outreach campaign to educate people about the importance of prenatal, postpartum and check-up care;"
- Perinatal programs are needed and access to perinatal care is a major concern;
- Several stakeholders forward suggestions for specific programs. "Revive essential services such as perinatal case management (PCM) and pregnancy related services (PRS);"
- Expansion of the Centering Pregnancy Program is also specifically suggested in several focus groups. Another suggestion is to incorporate dental component into prenatal and perinatal programs;
- Increased funding for prenatal care for women not eligible for Medicaid is suggested as needed to improve the physical and mental health of women; and
- "[One of our greatest needs] is to educate DFCS workers, the pubic and providers of programs like Temporary Medicaid and Women's Health Care Medicaid so they know that this type Medicaid, offered only at the health department, can help pregnant or medically-at-risk women get started with care immediately instead of waiting for their regular Medicaid application to be processed."

OBESITY

QUANTIFICATION

Obesity is identified as a major health concern for women by six of seven MCH needs assessment community focus groups and four of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

"Obesity is a huge problem in North Georgia. There is a struggle with inactivity and families don't try to work their way out of it."

Poor nutrition and eating choices and lack of exercise are often cited as the reasons there is a rise in obesity.

Obesity is a major health concern, especially given its impact on the early onset of chronic disease. "We are seeing more and more women, pregnant women and non-pregnant women, present to us who are overweight, many with untreated hypertension, diabetes, depression and poor state of health and nutrition."

Obesity is a major health concern given its impact on birth outcomes. Several community focus groups noted that "obesity has increased, creating greater risk with an increase in C-sections."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE WOMEN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of women. Suggestions around obesity follow.

- The most frequent suggestion is that there needs to be "increased public awareness around obesity and healthy lifestyles;"
- "The major food chains (grocery stores) don't locate themselves where problems are most severe - you mainly see fast food restaurants. They advertise things that are not healthy in poor neighborhoods. Society needs to do something to fix the problem;
- Family obesity counseling programs are needed; and
- "Women, infants and children in our area, including those on WIC, are very well fed – too well fed. Our district has many people who are overweight and who are not making good lifestyle and eating choices. We want to show public health as a leader in how to lead a healthy lifestyle."

NUTRITION

QUANTIFICATION

Poor nutrition is identified as a major health concern for women by four of nine MCH needs assessment community focus groups and five of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

A major health concern in one community is that there is no nutritional counseling for women with gestational diabetes.

Major health concerns for women are poor diet, lack of exercise and a rise in obesity.

Preconception health and diet is of specific concern in one focus group.

Poor products in grocery stores and at fast food chains are creating health concerns for women.

"The major food chains (grocery stores) don't locate themselves where problems are most severe – you mainly see fast food restaurants. They advertise things that are not healthy in poor neighborhoods."

A major health concern continues to be the lack of community support for breastfeeding and barriers such as what women on Medicaid experience when they seek coverage for a breast pump.

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE WOMEN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of women. Suggestions around nutrition follow.

- Family obesity counseling programs are needed;
- Increase preventative services for women;
- General well care is needed;
- "Teach parents a better way to feed their family. Teach classes on buying and cooking for low-income parents;" and
- "Provide education around health, life skills and healthy lifestyle."

ACCESS TO HEALTH CARE

QUANTIFICATION

Access to health care is identified as a major health concern for women by five of nine MCH needs assessment community focus groups and is the top priority for two of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

One non-governmental group noted "access to care" should 1) encompass prevention and management; 2) cover health throughout the lifespan; 3) be comprehensive and include wellness.
Consumers and providers point out specific access problems. Most frequently cited problems are related to health care provider availability, access to prenatal care; lack of transportation, insurance, consumer knowledge and attitude issues.

One of the most frequently raised concerns is health care provider availability.

- "I think a major health concern is the maldistribution of providers – some counties do not have a physician;"
- "There is a lack of referral sources and resources for low income and moderately low income women;"
- We need "more providers who are willing to care for women who are low income, not Medicaid eligible and at risk medically;"
- Specifically there are "access to mental health services issues for those who do not qualify for Medicaid and their insurance does not cover it;" and
- Mental health services are a problem. "There is limited access to mental health assistance and it's difficult knowing where to turn for help."

Access to prenatal care is a specific concern to health care providers/stakeholders. "We need better access to prenatal care. Premature and low birth weight babies end up on my doorstep – which filters to the child."

Lack of transportation is a problem –"getting to the actual places is a problem; a lot of young moms don't have cars or gas money."

- "Long driving distances to regional perinatal centers;"
- "Problems with Medicaid van logistics;" and
- Employment can be an obstacle to health care because getting off of work to go to the clinic can result in pay loss, if you are an hourly worker. It is especially problematic when they have to wait."

Six of nine groups brought up issues with insurance, specifically Medicaid coverage.

- Medicaid reimbursement
- Inadequate health insurance coverage

Consumer's lack of awareness of services and prenatal and postpartum care is of concern. There is also concern about access to interconception care.

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE WOMEN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of women. Suggestions around access to care follow.

- Provide medical interpreters to improve women's health care;
- Extend coverage for 24 months for women from end of pregnancy;
- A transportation fee assistance program "would help – something other than what Medicaid provides. Since the bus line is in jeopardy, they will have a hard time getting to the Health department since they will have to incur taxi expenses;"
- Improve Medicaid system and Medicaid eligibility determination;
- Implement the Medicaid waiver;
- Require cultural diversity training for staff;
- Put portable clinics into communities and serving rural areas; and
- Provide access to birth control.

FAMILY PLANNING

QUANTIFICATION

Family planning is identified as a major health concern for women by four of nine MCH needs assessment community focus group and six of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Family planning is a concern identified by many of the focus groups. Family planning to address pregnancy spacing and prevention is needed. Aspects highlighted as important: access to family planning education, access to birth control, and reproductive awareness.

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE WOMEN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of women. Suggestions around family planning follow.

- We need family planning, reproductive awareness and education;
- We need access to family planning including education and birth control;
- Teen clinics are needed to improve the health of young women;
- "Universal education for pregnancy prevention targeted for teens, men and the community" is needed;
- "Stronger programs to address teen pregnancy in the state" are needed; and
- "We need to bring back Family Planning Medicaid to help reduce the number of unwanted pregnancies, especially among our teens, those women who are medically at high risk, and those who desire not to have any more children."

CONSUMER KNOWLEDGE AND ATTITUDES

QUANTIFICATION

Consumer knowledge and attitude is identified as a major health concern for women by four of nine MCH needs assessment community focus groups and five of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

"The biggest concern or problem I see is that patients don't think they need care. We have a problem getting patients into the facility. There is a problem with how they see living life properly, or how they care about their health."

"My major concern is patients' understanding of their health responsibilities. Patients feel, "I don't care," and so getting them into a facility is a problem. We are dealing with the mental attitude around caring for self and family."

It's getting prenatal care [that is the challenge] – even in the public health clinic – it's a problem."

"We see a lot of women frustrated and don't know what to do – need more parenting classes."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE WOMEN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of women. Suggestions around consumer knowledge and attitude follow.

- "Universal education for pregnancy prevention targeted for teens, men and community" is needed;
- Provide "effective education which changes lifestyles and culture."
- Identify and communicate "what does the community have available? Some women are not aware of available services;"
- Implement family obesity counseling programs;
- "Implement more Centering Pregnancy programs where a pregnant woman becomes a part of a group of pregnant women who have their appointments at the same time;"
- Provide outreach;
- "Public education for all women on the importance of early screening, prenatal and postpartum care, and general well care" is needed;
- "Educating the community on the importance of access, what's out there and how to utilize it" is needed;
- Parent education on asthma symptoms, medications, and lifestyle is needed;
- There is an "increased need for moms to receive injury prevention education for their children;" and
- Lifespan health education and health promotion (healthy nutrition, healthy weight) is cited by four roundtables at the non-governmental provider and advocacy group focus group;

POSTPARTUM CARE

QUANTIFICATION

Postpartum care is identified as a major health concern for women by three of nine MCH needs assessment community focus groups and three of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Postpartum care is needed. Women do not have "awareness of postpartum depression and mental health in general, and what to do about it."

"Some women are not aware of available services and the importance of prenatal and postpartum care."

Stakeholders also communicated their "concern about lack of community support for breastfeeding."

Access to postpartum care is of concern. "Inadequate Medicaid coverage – limits on length of services after delivery" is a problem as is" lack of Medicaid coverage for breast pumps."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE WOMEN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of women. Suggestions around postpartum care follow.

- "Increase postpartum, depression services for low income and moderately low income women;"
- "Provide public education for all women on the importance of postpartum care;"
- We need "doctors to address postpartum depression in women;"
- "We need more mental health services for pregnant women and postpartum mothers. It can be weeks before they receive needed mental health services. If you are dealing with postpartum depression, this is not adequate care;" and
- Support groups are needed.

ADDITIONAL QUOTES

"We are seeing repeat pregnancies, some within the same year they gave birth. This may be due to the inability to pay for their birth control or the lack of education on spacing pregnancies."

"Lower middle class women need help…Why not a sliding fee?"

PERINATAL/MATERNAL CARE

QUANTIFICATION

Birth outcomes are identified as a major health concern for women by five of nine MCH needs assessment community focus groups and four of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

One Health Director said, "We looked at the health of the woman before she got pregnant. Women had poor health prior to pregnancy. Prematurity rates have not changed. . Infant mortality changed slightly, but still twice the state average. Very tiny babies born to women in poor health."

"Low birth weight is a persistent problem."

"A major concern is prematurity link with low socioeconomic status and few providers in the area (seen through geo-mapping)."

Infant mortality is major health concern. "Black community has a high infant mortality rate."

"As we worked on prematurity, we've developed a greater problem. Obesity and increased C-sections have created a problem."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE WOMEN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of women. Suggestions around birth outcomes follow.

- We need "adequate care for high risk mothers and babies;"
- We need "evidence-based strategies to reduce low birth weight, including strategies for metro and rural areas;"
- We need "mental health referrals and care, including services for pregnant and postpartum women;"
- A major concern is access to health care, affording health care if you are "on the fence" of eligibility for services. If you work for the state you can't get Peach Care. If one parent works, you make too much but don't have enough…You're poor but not poor enough;" and
- "Access to prenatal care is so important. Premature and low birth weight end up on my doorstep, which filters to the child."

INFRASTRUCTURE/SYSTEM ISSUES

QUANTIFICATION

Infrastructure/system issues are identified as a major health concern for women by six of nine MCH needs assessment community focus groups and all roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Public health model for comprehensive, coordinated response to address the physical and mental health of women is needed.

"A coherent and cohesive system which delivers a consistent message" is needed.

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE WOMEN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of women. Suggestions around infrastructure/system issues follow.

- Implement medical home for women;
- "You develop a cohesive, coordinated system for the best outcomes, for delivering the optimal health message;"
- Coordination of health care services between providers, agencies and the school is needed.. "We need a system and a person, a coordinator;"
- Centralized network is needed;
- "Involvement of more stakeholders in maternal health, including fathers, grandparents and extended families" is needed;
- Data and evaluation are noted aspects;

- "Using Children 1st system as the population-based framework and combined with newborn screening to assure early connection with community partners (includes home visitation)" is needed;
- Reaching underserved communities in a way that is sustainable is important;
- Customer service is noted as a problem. "Mothers feel discouraged to continue seeking women's services because of difficulties they've encountered while making appointments;"
- "An increase in "sense of personal responsibility and motivation" is needed; and
- A "concise and strategic marketing plan with access and ownership defined" is needed.

OTHER HEALTH CARE CONCERNS

The following is a list of health care concerns among women that were not mentioned with adequate frequency to be considered a theme, but are important to document.

- Medical interpreters/language barriers
- Drug and alcohol abuse
- Sexually transmitted diseases
- Domestic abuse
- Advanced maternal age
- Availability of healthy foods in grocery stores
- Undocumented mothers
- Employment
- Untreated chronic conditions such as hypertension and diabetes
- Availability of dental care

INFANTS (0 TO 365 DAYS OF AGE)

ANALYSIS OF QUANTITATIVE DATA

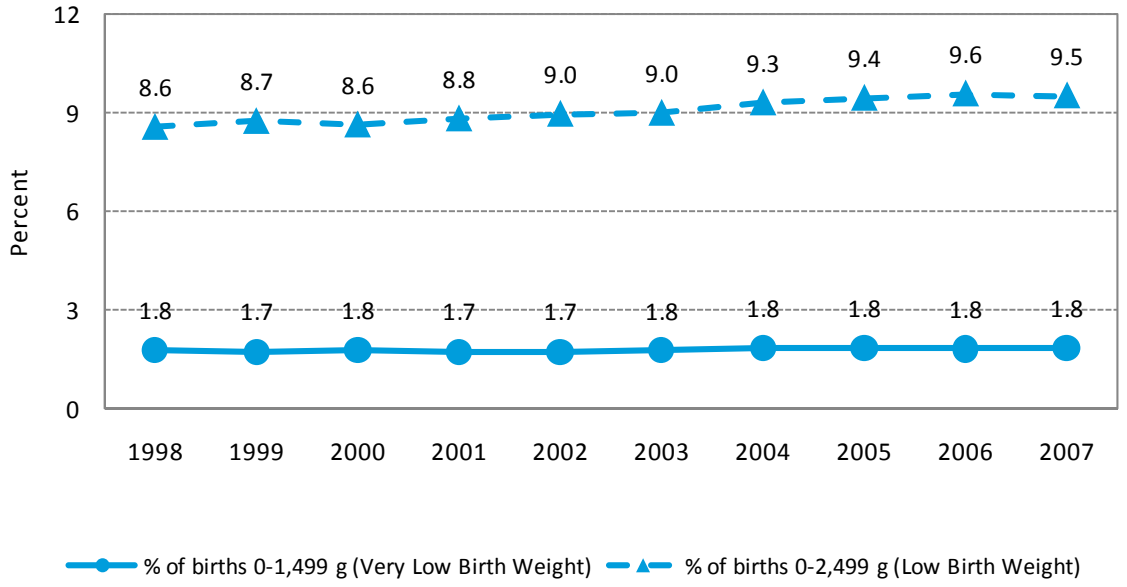
LOW BIRTH WEIGHT (LESS THAN 2,500 GRAMS) AND VERY LOW BIRTHWEIGHT (LESS THAN 1,500 GRAMS)

In 2007, the rates of low birth weight and very low birth weight in Georgia were approximately double the respective *Healthy People 2010* objectives. Though double the *Healthy People 2010* objective of 0.9 percent, the rate of infants born weighing less than 1,500 grams had remained consistent from 1998 through 2007. Conversely, the rate infants born weighting less than 2,500 grams increased by 10.5 percent over the same period of time.

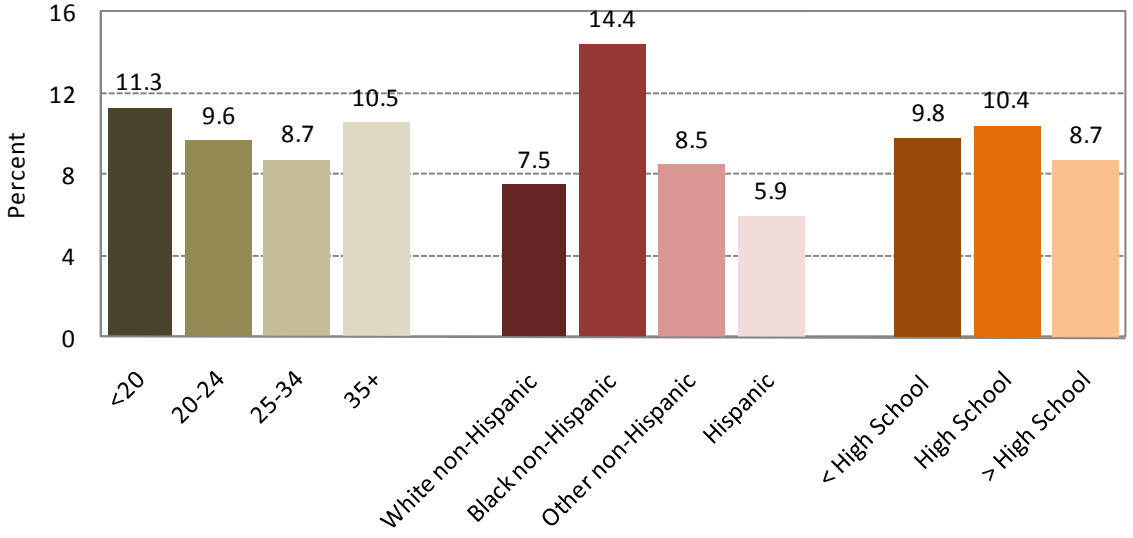
When stratifying by maternal age, race/ethnicity, and maternal education, low birth weight and very low birth weight had similar patterns. For both indicators, there was a U-shaped curve for maternal age. Women who had more than a high school education had a lower rate for each indicator than women with a high school degree or less. Also common to both low birth weight and very low birth weight was the elevated rate among Black infants. The rate of low birth weight among Black infants was nearly three times the *Healthy People 2010* objective and nearly four times the *Healthy People 2010* objective for very low birth weight. Hispanic infants had the lowest rates of low birth weight and very low birth weight.

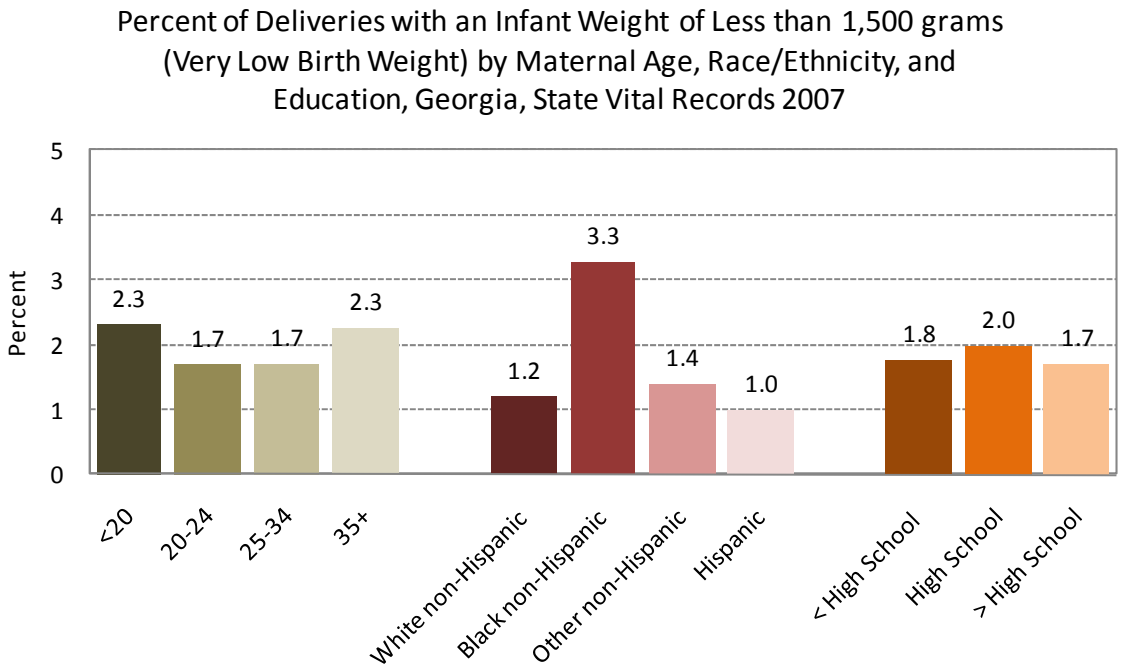
Among Georgia's 18 public health districts, four had rates of very low birth weight in excess of 2.0 percent. There were seven public health districts with rates of low birth weight in excess of 10.5 percent. Of these seven public health districts, four had rates of low birth weight in excess of 11.0 percent.

Percent of Deliveries with an Infant Weight of Less than 2,500 grams (Low Birth Weight) and Less than 1,500 grams (Very Low Birth Weight) by Year, Georgia, State Vital Records 1998 through 2007

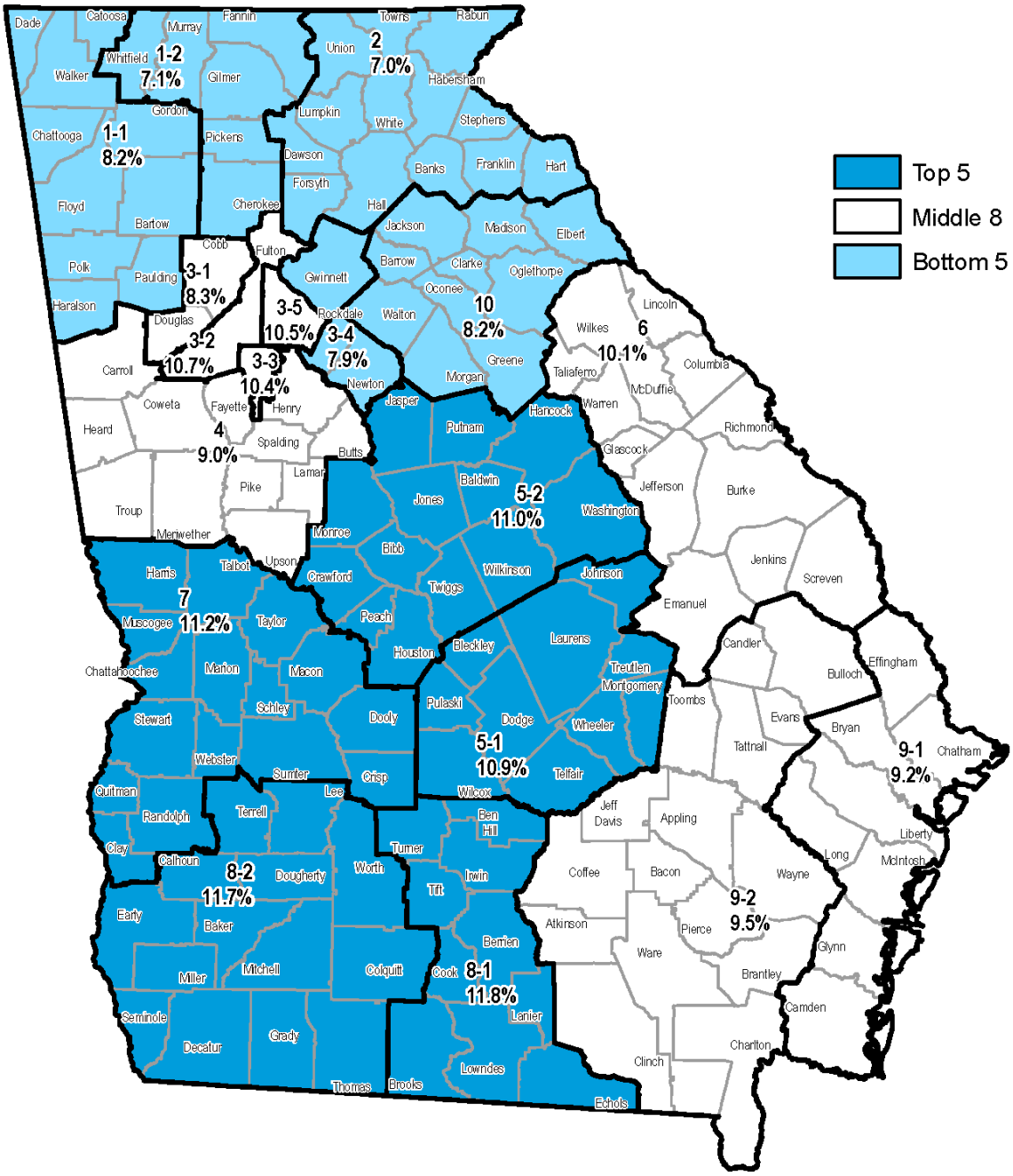


Percent of Deliveries with an Infant Weight of Less than 2,500 grams (Low Birth Weight) by Maternal Age, Race/Ethnicity, and Education, Georgia, State Vital Records 2007




Percent of Deliveries with an Infant Weight of Less than 1,500 grams (Very Low Birth Weight) by Maternal Age, Race/Ethnicity, and Education, Georgia, State Vital Records 2007
Percent
5
4
3
2
1
0
2.3
1.7
1.7
2.3
1.2
3.3
1.4
1.0
1.8
2.0
1.7
<20
20-24
25-34
35+
White non-Hispanic
Black non-Hispanic
Other non-Hispanic
Hispanic
< High School
High School
> High School

Percent of Deliveries with an Infant Weight of Less than 2,500 grams (Low Birth Weight) by Public Health District, Georgia, State Vital Records 2007



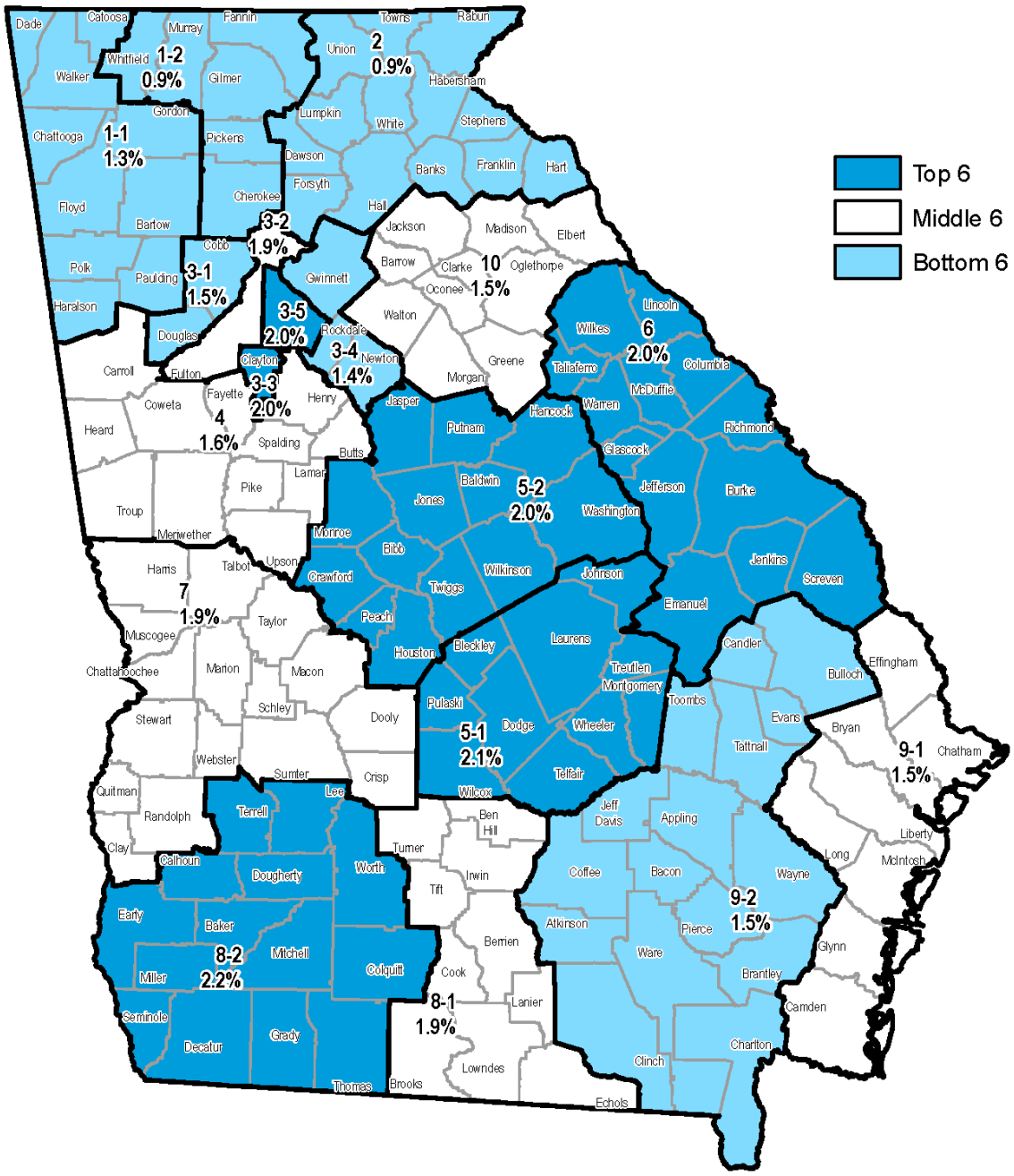
1-1 Northwest Health District (Rome)
1-2 North Georgia Health District (Dalton)
2 North Health District (Gainesville)
3-1 Cobb/Douglas Health District
3-2 Fulton Health District
3-3 Clayton County Health District (Jonesboro)
3-4 East Metro Health District (Lawrenceville)
3-5 DeKalb Health District
4 LaGrange Health District
5-1 South Central Health District (Dublin)
5-2 North Central Health District (Macon)
6 East Central Health District (Augusta)
7 West Central Health District (Columbus)
8-1 South Health District (Valdosta)
8-2 Southwest Health District (Albany)
9-1 Coastal Health District (Savannah)
9-2 Southeast Health District (Waycross)
10 Northeast Health District (Athens)

Office of Health Indicators for Planning (OHIP)
Epidemiology Branch
Division of Public Health
Georgia Department of Community Health

40 0 40 Miles

Created: July 2010
Source: Division of Public Health
Projection: Georgia Statewide Lambert Conformal Conic

Percent of Deliveries with an Infant Weight of Less than 1,500 grams (Very Low Birth Weight) by Public Health District, Georgia, State Vital Records 2007



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Georgia Department of Community Health

40 0 40 Miles

Created: July 2010
Source: Division of Public Health
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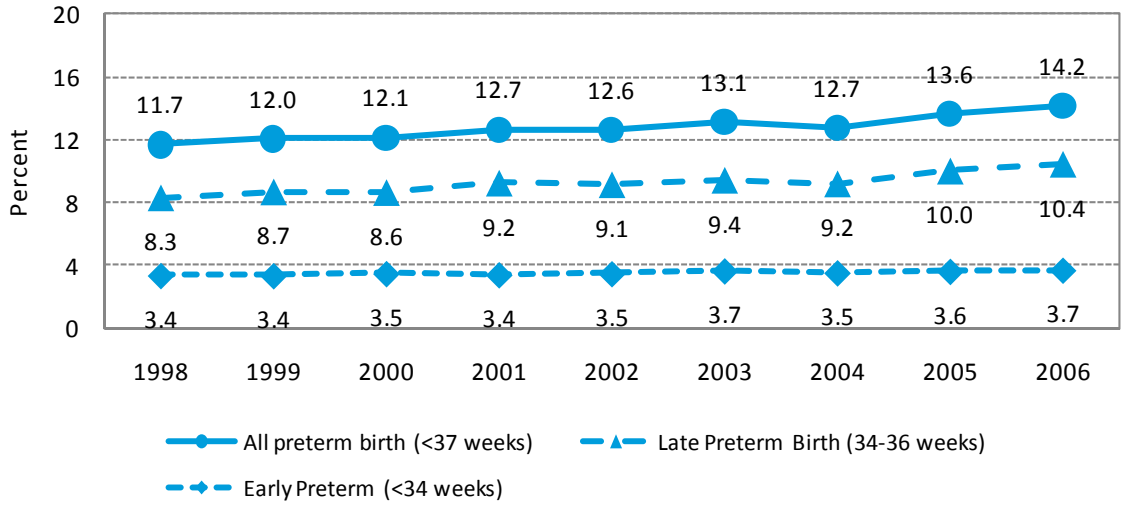
PRETERM BIRTH (PRIOR TO 37 WEEKS GESTATION)

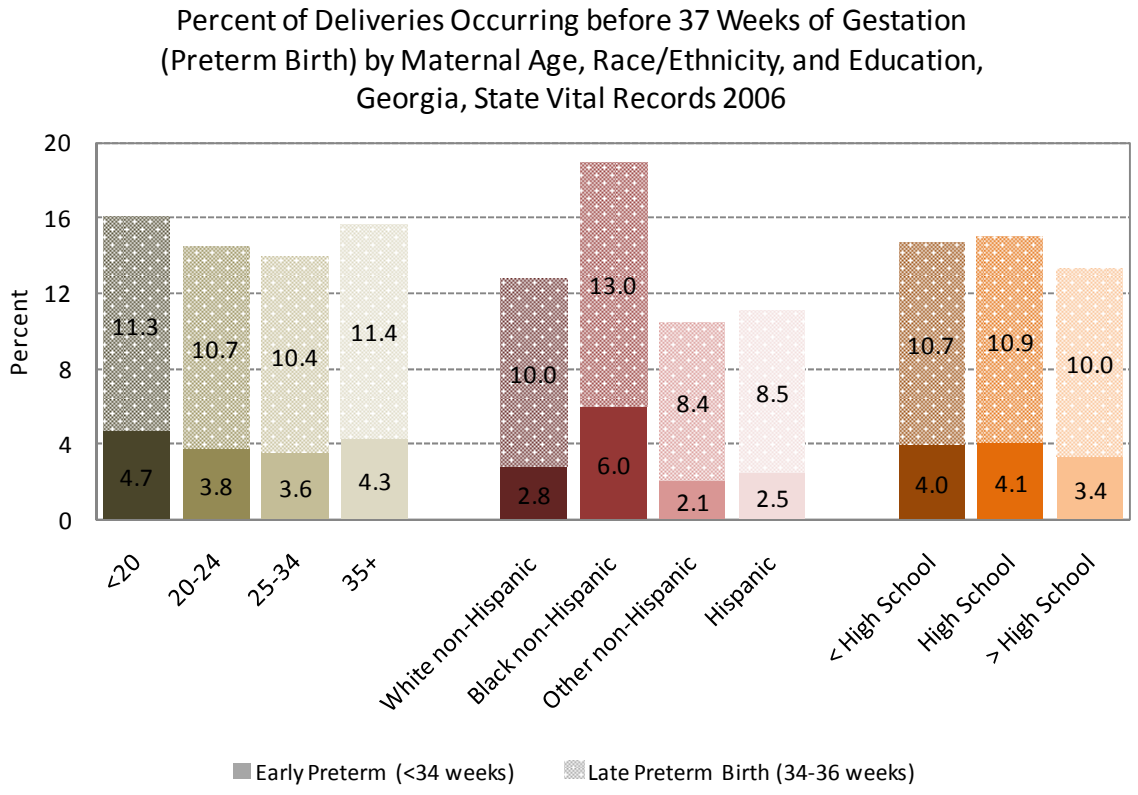
The *Healthy People 2010* objective for preterm birth was 7.6 percent. The rate in Georgia in 2006 was nearly twice this benchmark. The 21.4 percent increase from 1998 through 2006 occurred gradually with an annual increase of 2.4 percent. Only the change between 2004 and 2005 exceeded a 4.5 percent change. Late preterm birth (34 to 36 weeks gestation) appears to be driving the overall increase in the preterm birth rate.

There were limited variation in rates of preterm birth by maternal age and educational attainment. However, there was significant variation by race/ethnicity. Nearly one in five Black infants were born prior to their 37th week of gestation. The rate of early preterm birth was three times greater among Black women compared to other racial/ethnic groups.

Among Georgia's 18 public health districts, ten had preterm birth rates greater than 15.0 percent. The greatest preterm birth rates were found in the South Health District (19.0 percent), South Central Public Health District (18.7 percent), and Southwest Public Health District (17.3 percent).

Percent of Deliveries Occurring before 37 Weeks of Gestation (Preterm Birth) by Year, Georgia, State Vital Records 1998 through 2006



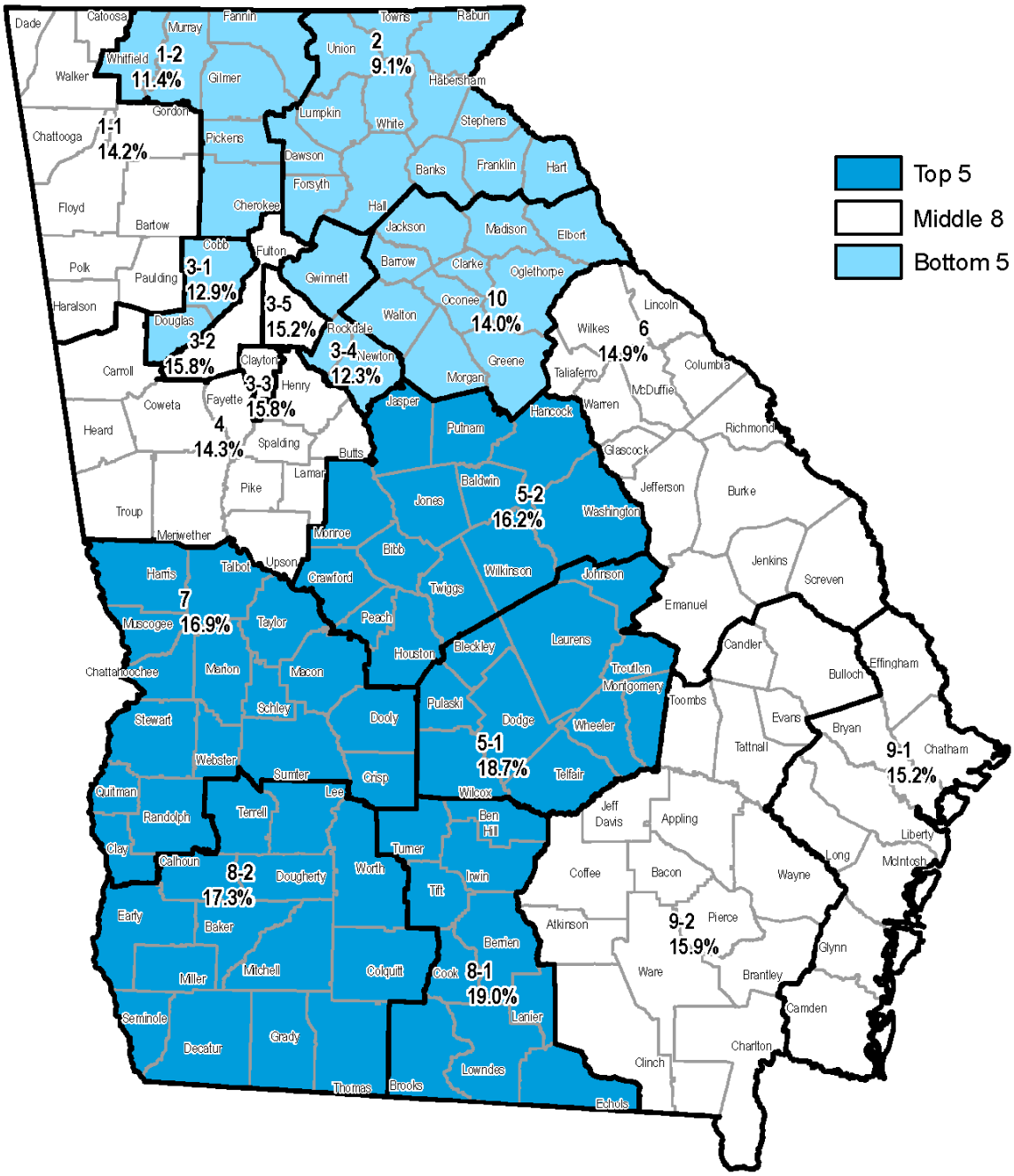


DELIVERY METHOD AND LATE PRETERM BIRTH

To test a possible explanation for the increase in late preterm birth described above, trends in Cesarean section and vaginal deliveries were explored. While primary and repeat Cesarean sections increased 31.1 percent and 77.1 percent, respectively, between 1994 through 2006, vaginal births declined 15.2 percent and vaginal births after Cesarean section delivery declined 65.0 percent.

Among women who delivered between 34 and 36 weeks gestation with low medical risk, the percent of deliveries via primary Cesarean section was 70.2 percent greater among women 25 to 34 years of age compared to women 20 to 24 years of age. The percent of deliveries via primary Cesarean section among women 35 years of age and older was nearly triple that of women with low medical risk 20 to 24 years of age.

Percent of Deliveries Occurring before 37 Weeks of Gestation (Preterm Birth) by Public Health District, Georgia, State Vital Records 2006



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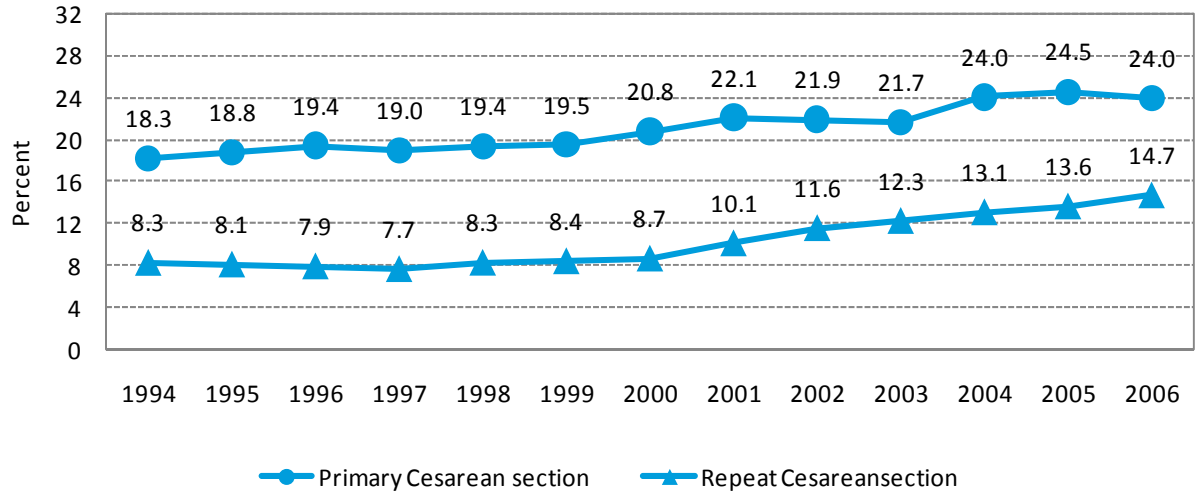
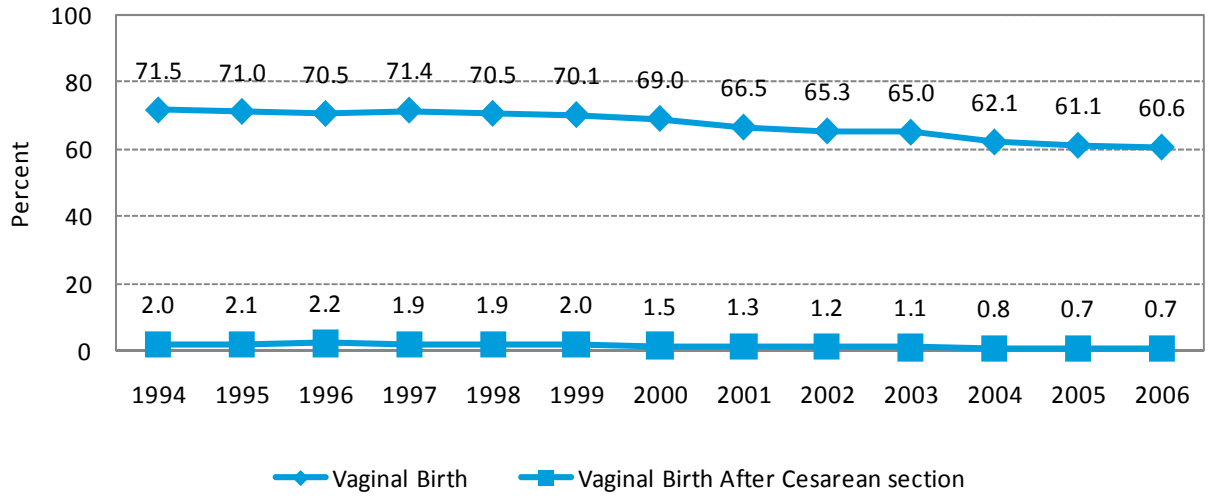
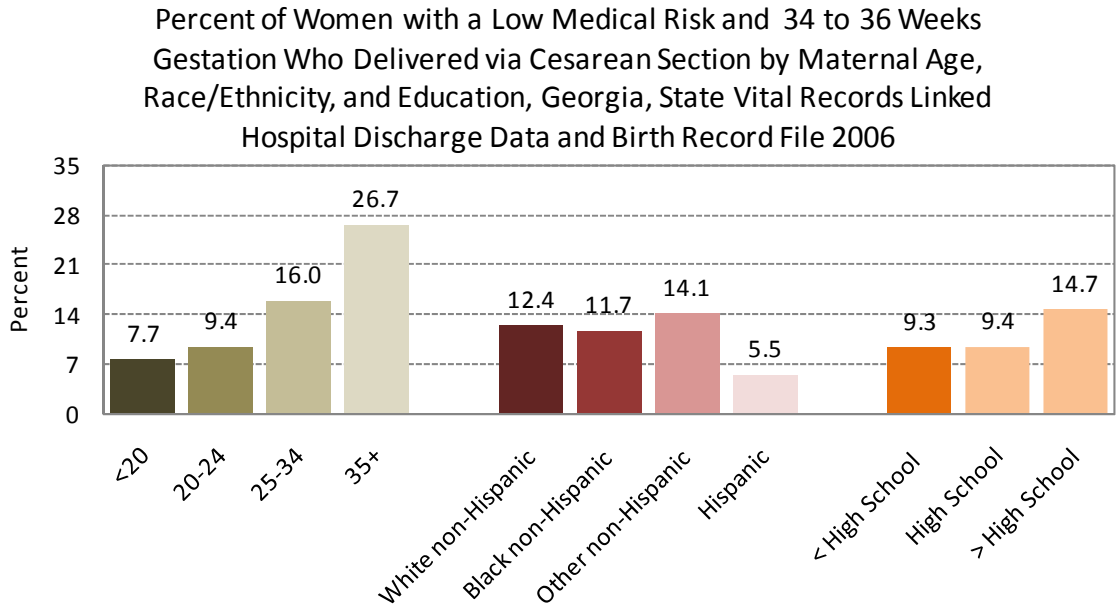
Percent of Primary and Repeat Cesearean Sections among Infants with a Gestational Age of 34 to 36 Weeks (Late Preterm) by Year, Georgia, State Vital Records 1994 through 2006



Percent of Vaginal Deliveries and Vaginal Births after Cesarean Sections among Infants with a Gestational Age of 34 to 36 Weeks (Late Preterm) by Year, Georgia, State Vital Records 1998 through 2007





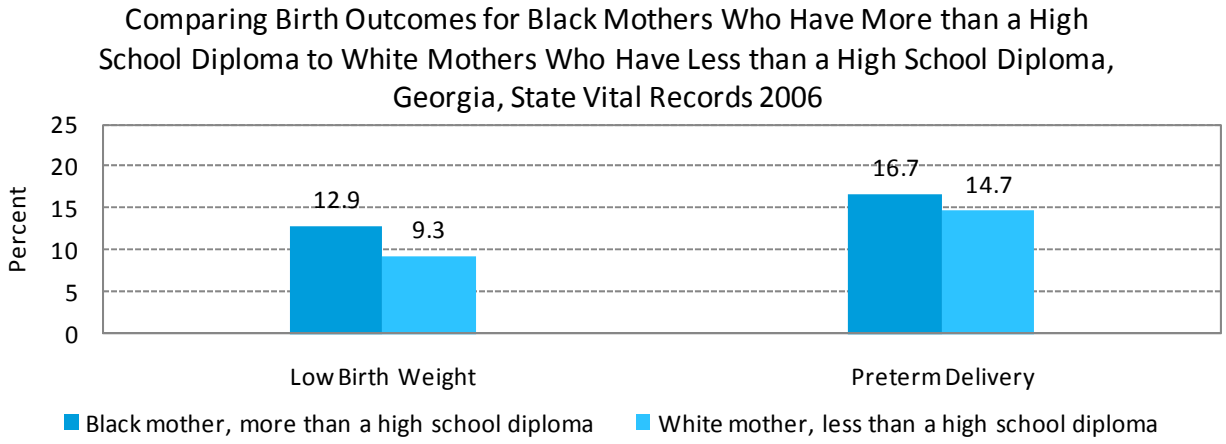
RACIAL DISPARITIES IN BIRTH OUTCOMES – AN ATYPICAL ANALYSIS

To help understand and quantify the depth of the racial disparities in birth outcomes in Georgia, three comparisons were made between the most advantaged group of Black mothers and infants and the least advantaged groups of White mothers and infants. These comparisons were:

- Black mothers with more than a high school education compared with White mothers who did not graduate from high school
- Black mothers who did not consume alcohol or smoke cigarettes during their pregnancies compared with White mothers who reported smoking cigarettes or consuming alcohol during their pregnancies
- Black mothers who received first trimester prenatal care compared with White mothers who received third trimester prenatal care or no prenatal care

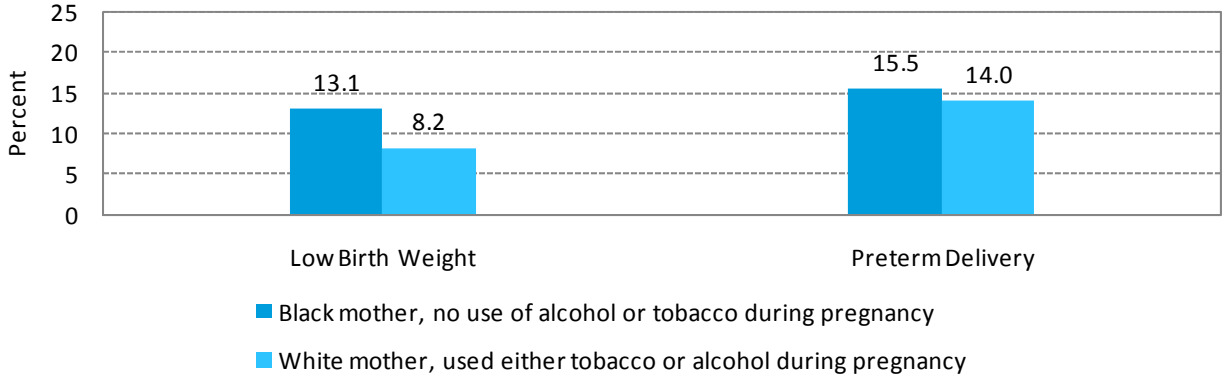
COMPARING BIRTH OUTCOMES BETWEEN BLACK MOTHERS WITH MORE THAN A HIGH SCHOOL DIPLOMA AND WHITE MOTHERS WITH LESS THAN A HIGH SCHOOL DIPLOMA

White mothers with less than a high school diploma had better birth outcomes compared to Black mothers with more than a high school diploma. The disparity between the groups was 27.9 percent for low birth weight and 13.6 percent for preterm birth.



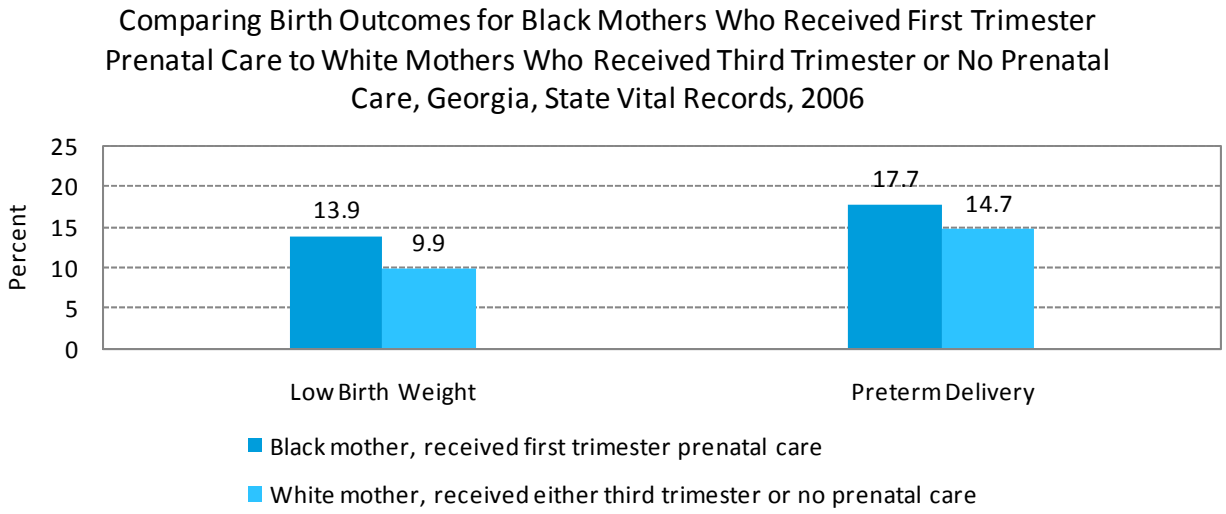
COMPARING BIRTH OUTCOMES BETWEEN BLACK MOTHERS WHO DID NOT SMOKE CIGARETTES OR CONSUME ALCOHOL DURING PREGNANCY AND WHITE MOTHERS WHO SMOKED CIGARGETTES AND/OR CONSUMED ALCOHOL DURING PREGNANCY

White mothers who reported smoking cigarettes and/or consuming alcohol during their pregnancy had better birth outcomes than Black mothers who reported remaining abstinent from cigarette smoking and consuming alcohol. The low birth weight rate for Black mothers who remained abstinent from tobacco and alcohol during pregnancy was 59.7 percent greater compared to the low birth weight rate among White mothers who used tobacco or alcohol consumption during pregnancy. While there is less of a disparity in the rate of preterm delivery, Black mothers who remained abstinent from tobacco and alcohol during pregnancy still had a greater rate than White mothers who did not abstain from either one or both substances.



COMPARING BIRTH OUTCOMES BETWEEN BLACK MOTHERS WHO RECEIVED FIRST TRIMESTER PRENATAL CARE AND WHITE MOTHERS WHO HAD THIRD TRIMESTER PRENATAL CARE OR NO PRENATAL CARE

Black mothers who received first trimester prenatal care had worse birth outcomes compared to White mothers who received third trimester prenatal care or no prenatal care. The percent of infants born weighing less than 2,500 grams was 28.8 percent lower among White mothers who received third trimester prenatal care or no prenatal care compared to Black mothers who received first trimester prenatal care. The preterm delivery rate was 20.4 percent lower.



INFANT MORTALITY

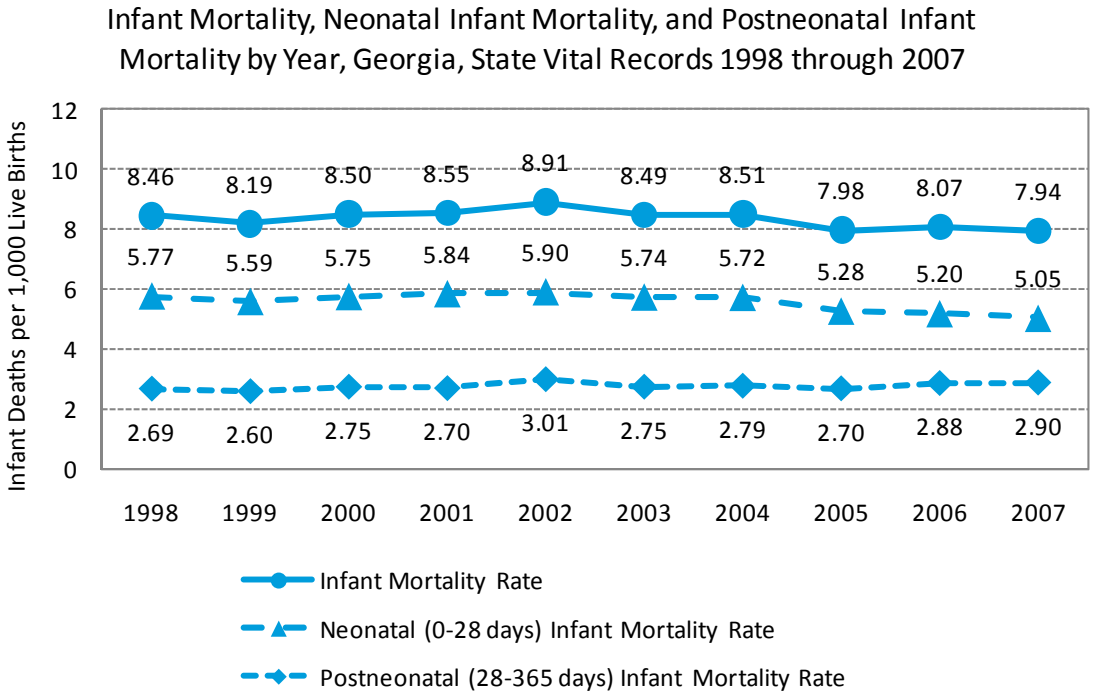
Infant mortality had little variation between 1998 through 2007. Infant mortality ranged from a high of 8.91 infant deaths per 1,000 live births (2002) to a low of 7.94 infant deaths per 1,000 live births (2007). These rates were significantly higher than the *Healthy People 2010* objective of 4.5 infant deaths per 1,000 live births.

Beginning with 2003, there has been a decline in the neonatal infant mortality rate. In 2002, the neonatal mortality rate was 5.90 infant deaths in the first 28 days of life per 1,000 live births, but this rate declined to 5.05 infant deaths in the first 28 days of life per 1,000 live births by 2007. However, the postneonatal infant mortality rate increased from 2006 to 2007. For both of these measures, Georgia did not meet the *Healthy People 2010* objectives of a neonatal infant mortality rate of 2.9 infant deaths in the first 28 days of life per 1,000 live births and a postneonatal infant mortality rate of 1.2 infant deaths between the 28th and 365th day of life per 1,000 live births.

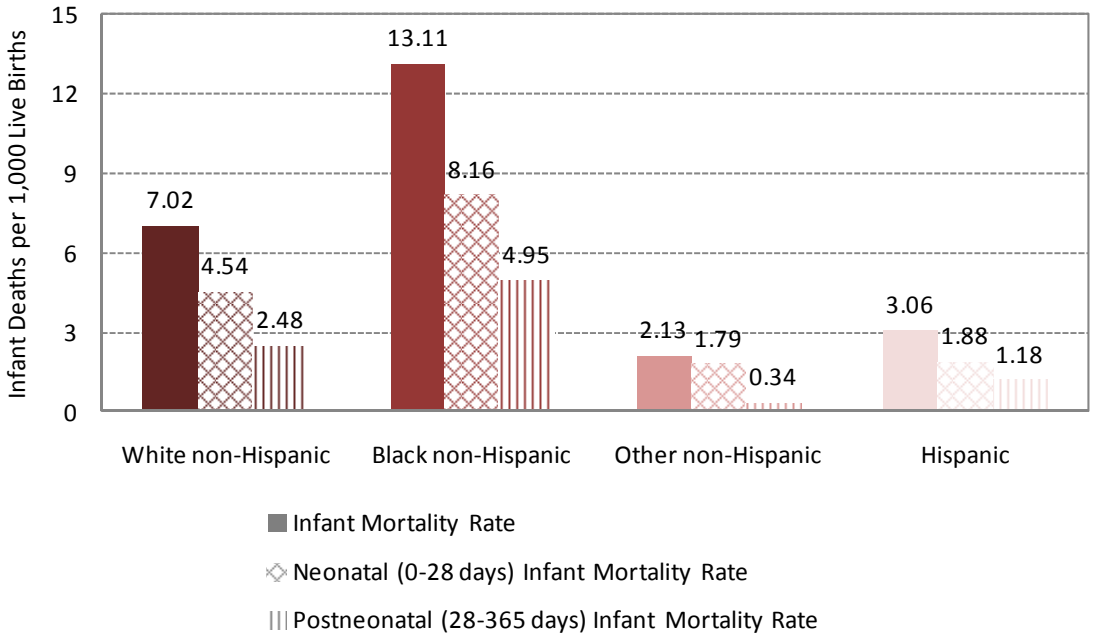
When examining infant mortality by race/ethnicity, Hispanic infants and infants of other race/ethnicity surpassed the *Healthy People 2010* objective for infant mortality, neonatal infant mortality, and postneonatal infant mortality. Among Black infants, the infant mortality rate was nearly 14 infant deaths per 1,000 live births, which was 191 percent higher than the *Healthy People 2010* objective. The infant mortality rate among White infants was more than double the infant mortality rate of Hispanic infants.

The linked birth-death record allowed for examination of the association between maternal educational attainment and maternal age and infant mortality. Younger maternal age and maternal educational attainment of a high school degree or less were both associated with greater infant mortality rates.

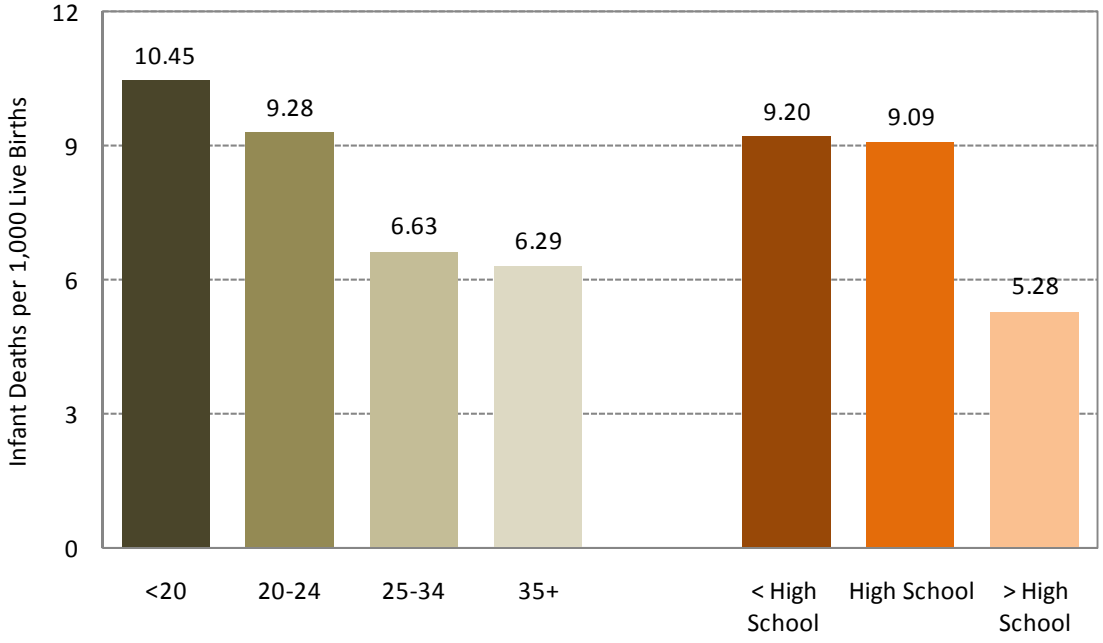
Nearly half of Georgia's 18 public health districts had an infant mortality rate in excess of nine infant deaths per 1,000 live births. Four of these eight public health districts had an infant mortality rate in excess of 11 infant deaths per 1,000 live births.



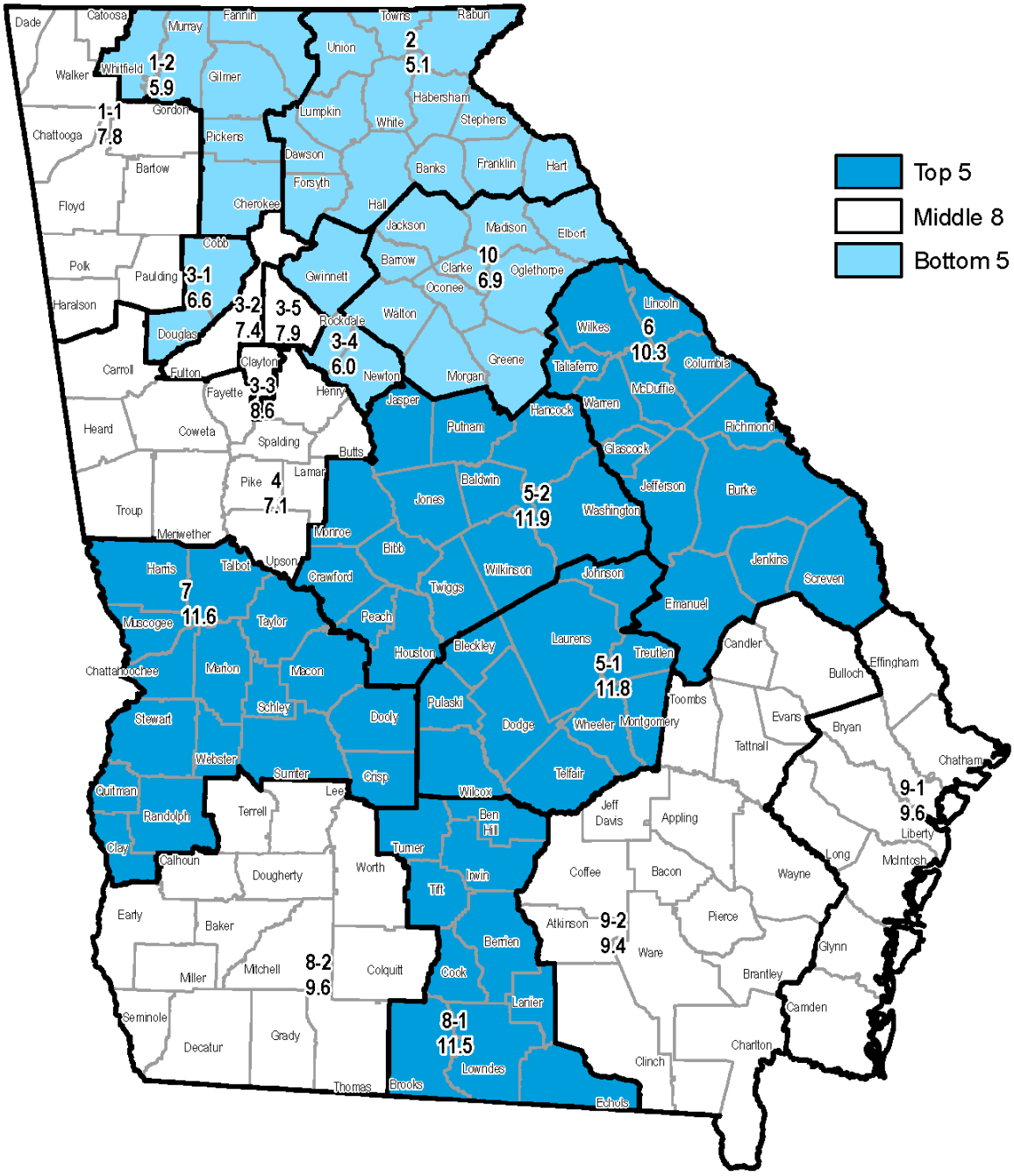
Infant Mortality, Neonatal Infant Mortality, and Postneonatal Infant Mortality by Race/Ethnicity, Georgia, State Vital Records 2007



Infant Mortality by Maternal Age and Educational Attainment, Georgia, State Vital Records Linked Birth-Death File 2006



Infant Mortality per 1,000 Live Births by Public Health District, Georgia, State Vital Records 2007



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EXCESSIVE INFANT DEATHS AND PERINATAL PERIODS OF RISK

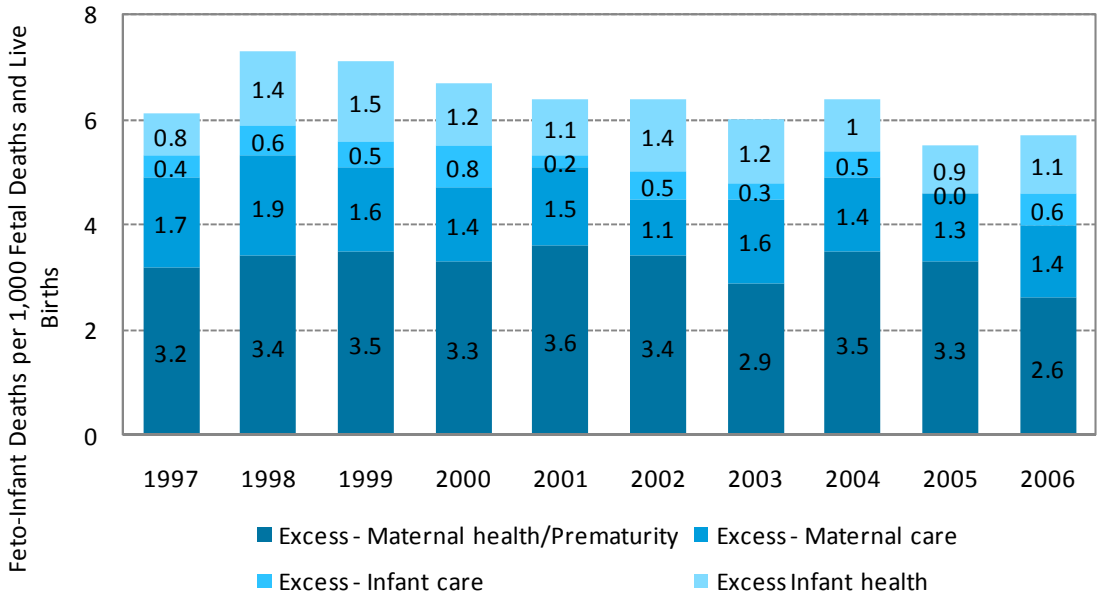
The Perinatal Periods of Risk (PPOR) framework allows for the calculation of excess death by subtracting the infant mortality of a selected subgroup from the feto-infant mortality rate (fetal deaths of at least 20 weeks gestational age and all infant deaths) in the general population. The reference group represents the lowest possible infant mortality in a defined area. It is hypothesized that the infant mortality rate in the reference group is attainable for all groups. For this analysis, the reference group included women who gave birth who were between the ages of 20 and 44 years, White, and had more than a high school education.

Using birth weight and age at death, the PPOR frameworks identified four cells into which infant mortality can be categorized.

- Maternal Health/Prematurity: any feto-infant death in which the infant weighed between 500 and 1,499 grams
- Maternal Care: any feto-infant death in which the infant weighed 1,500 grams or more and who was at least 20 weeks gestational age but was not delivered as a live birth
- Infant Care: any feto-infant death in which the infant weighed 1,500 grams or more and who died in the neonatal period
- Infant Health: any feto-infant death in which the infant weighed 1,500 grams or more and who died in the postneonatal period

Approximately half of all of Georgia's excess feto-infant deaths were attributed to maternal health/prematurity. This suggests activities and interventions that can have an impact on reducing the percent of infants weighing 500 to 1,499 grams regardless of the age at death. Such interventions include improving health behaviors for pregnant women, encouraging preconception health messaging, and improving perinatal systems of care to ensure appropriate care of high risk mothers and infants.

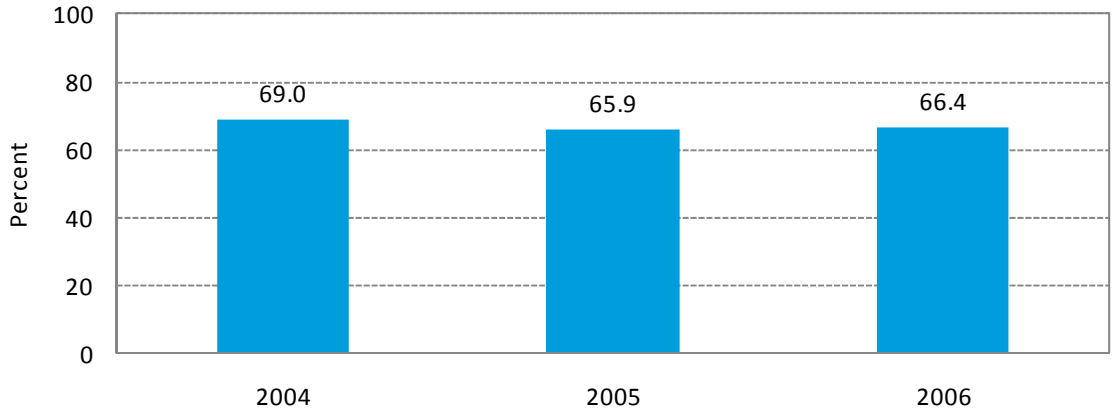
Excess Feto-Infant Deaths using the Perinatal Periods of Risk Framework, Georgia, State Vital Records Linked Birth-Death File 1997 through 2006



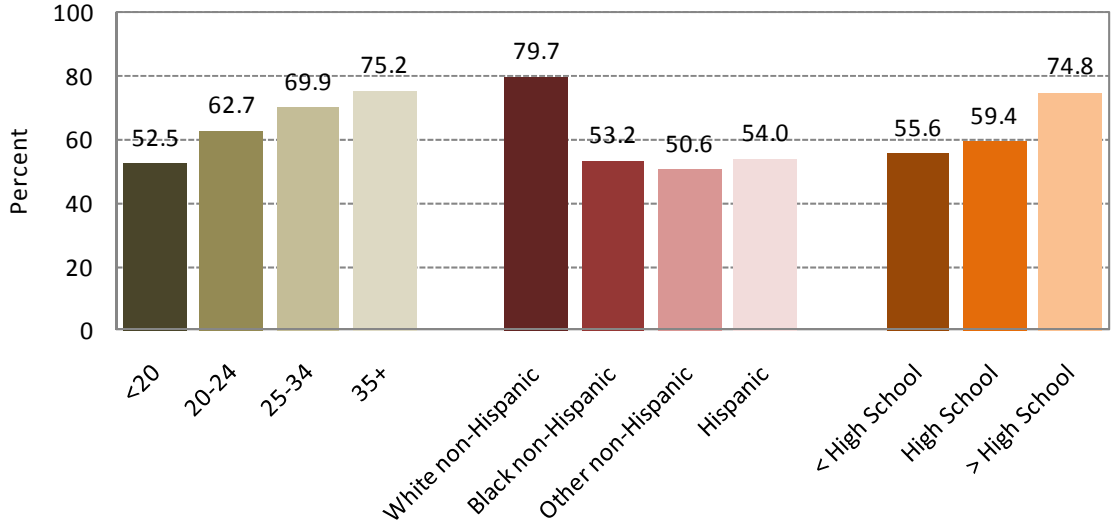
INFANT BEDSHARING

Between 60 and 70 percent of mothers reported never or infrequent infant bed sharing. The percent of mothers who never or infrequently bed share with their infants was positively associated with maternal age. While nearly 80 percent of White mothers reported never or infrequently bed sharing with their infants, this percent does not exceed 55 percent in any other racial/ethnic group. Mothers with more than a high school degree reported never or infrequent infant bed sharing compared to mothers with a high school degree or less education. Among Georgia's 18 public health districts, the North Georgia Public Health District had the greatest percent of mothers who never or infrequently bed share (84.3 percent). In two public health districts, Southeast Georgia and Clayton, fewer than 60 percent of mothers report never or infrequent infant bed sharing.

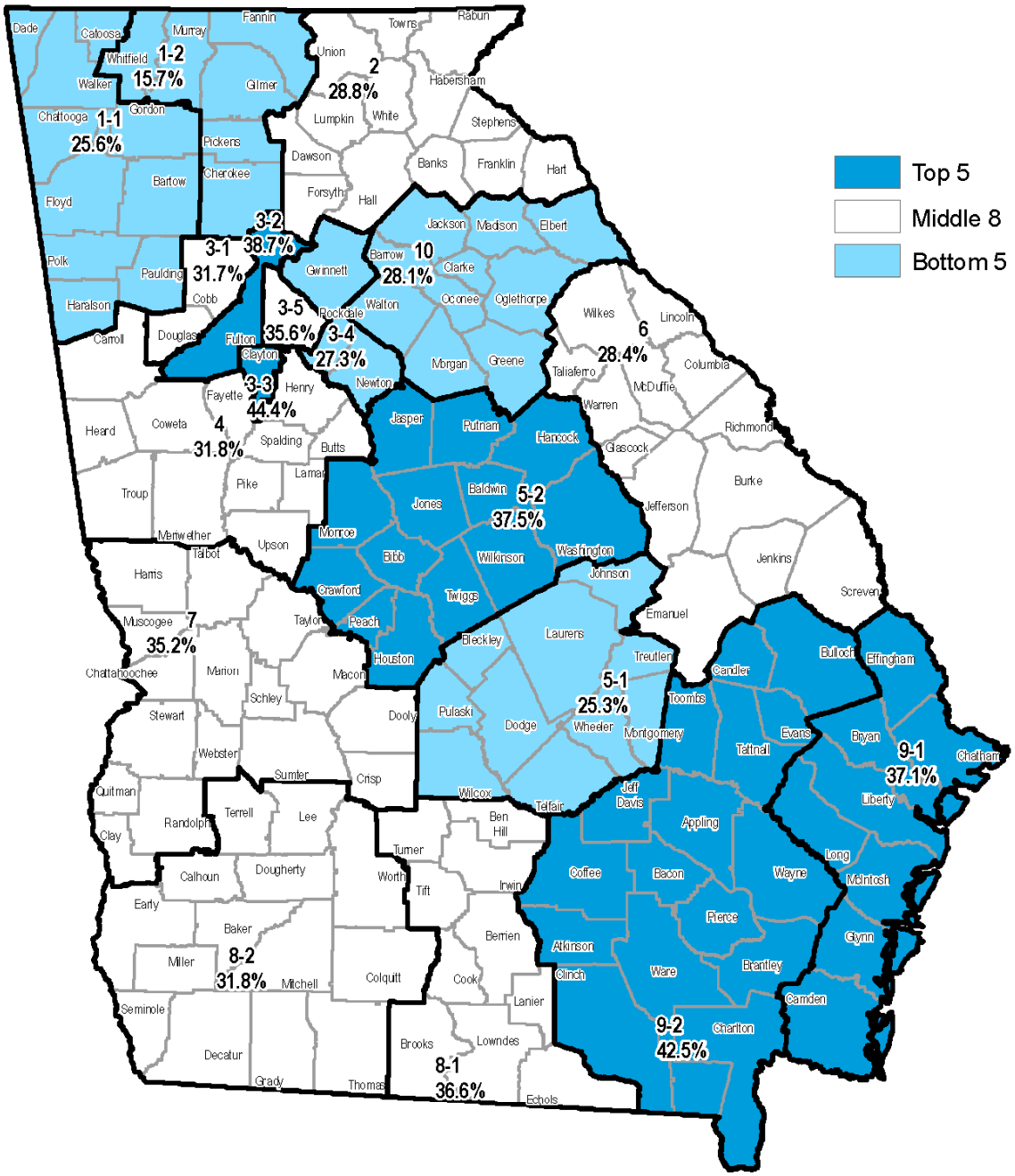
Percent of Mothers Who Reported that Their Infants Never, Rarely, or Sometimes Bedshare by Year, Georgia, PRAMS 2004 through 2006



Percent of Mothers Who Reported that Their Infants Never, Rarely, or Sometimes Bedshare by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



Percent of Mothers Who Reported that Their Infants Often or Always Bedshare by Public Health District, Georgia, PRAMS 2004 through 2006



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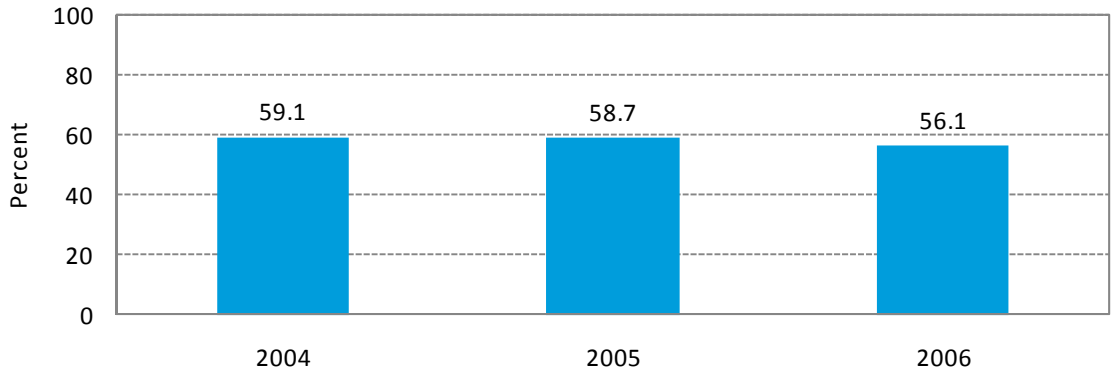
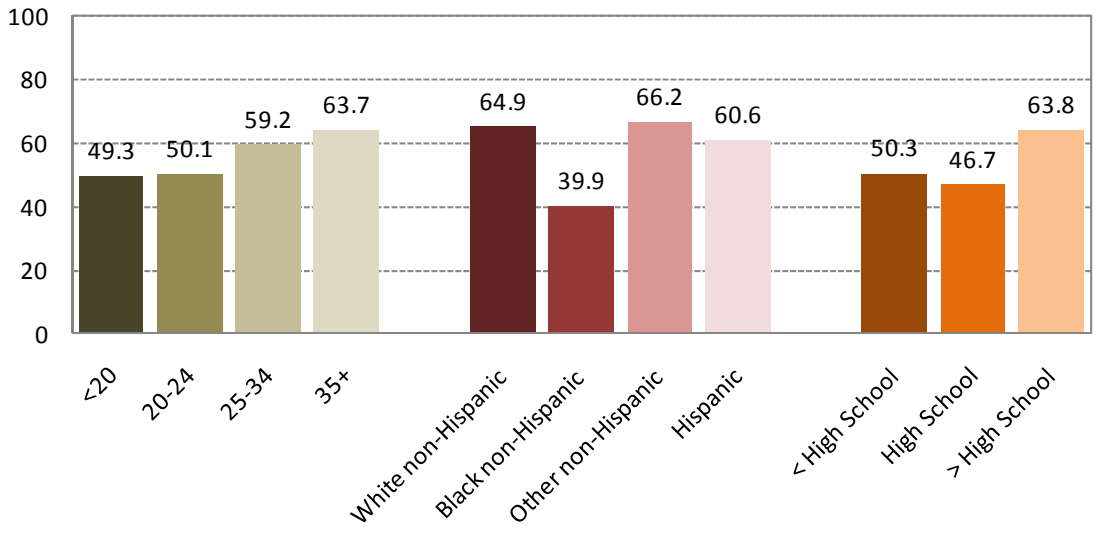
INFANTS PLACED ON THEIR BACKS TO SLEEP

The *Healthy People 2010* objective for infants being placed on their back to sleep is 70 percent. Fewer than 60 percent of mothers report that their infants were most often placed on their backs to sleep. Among White mothers, 64.9 percent report that their infants were most often placed on their backs to sleep, the greatest percent among any subgroup in 2006. Maternal age and educational attainment were positively associated with reporting infants were most often placed on their backs to sleep. Among Black mothers, less than 40 percent report that their infants were most often placed on their backs to sleep. Among Georgia's 18 public health districts, fewer than half of the mothers in South Central Georgia, West Central Georgia, and Southeast Georgia reported that their infants were most often placed on their backs to sleep. In another eight of the public health districts, this percent is above 50.0 percent but less than 60.0 percent.

Percent of Mothers Who Reported that Their Infants are Most Often Put on Their Backs to Sleep by Year, Georgia, PRAMS 2004 through 2006



Percent of Mothers Who Reported that Their Infants are Most Often Put on Their Backs to Sleep by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



INFANT INPATIENT HOSPITALIZATIONS

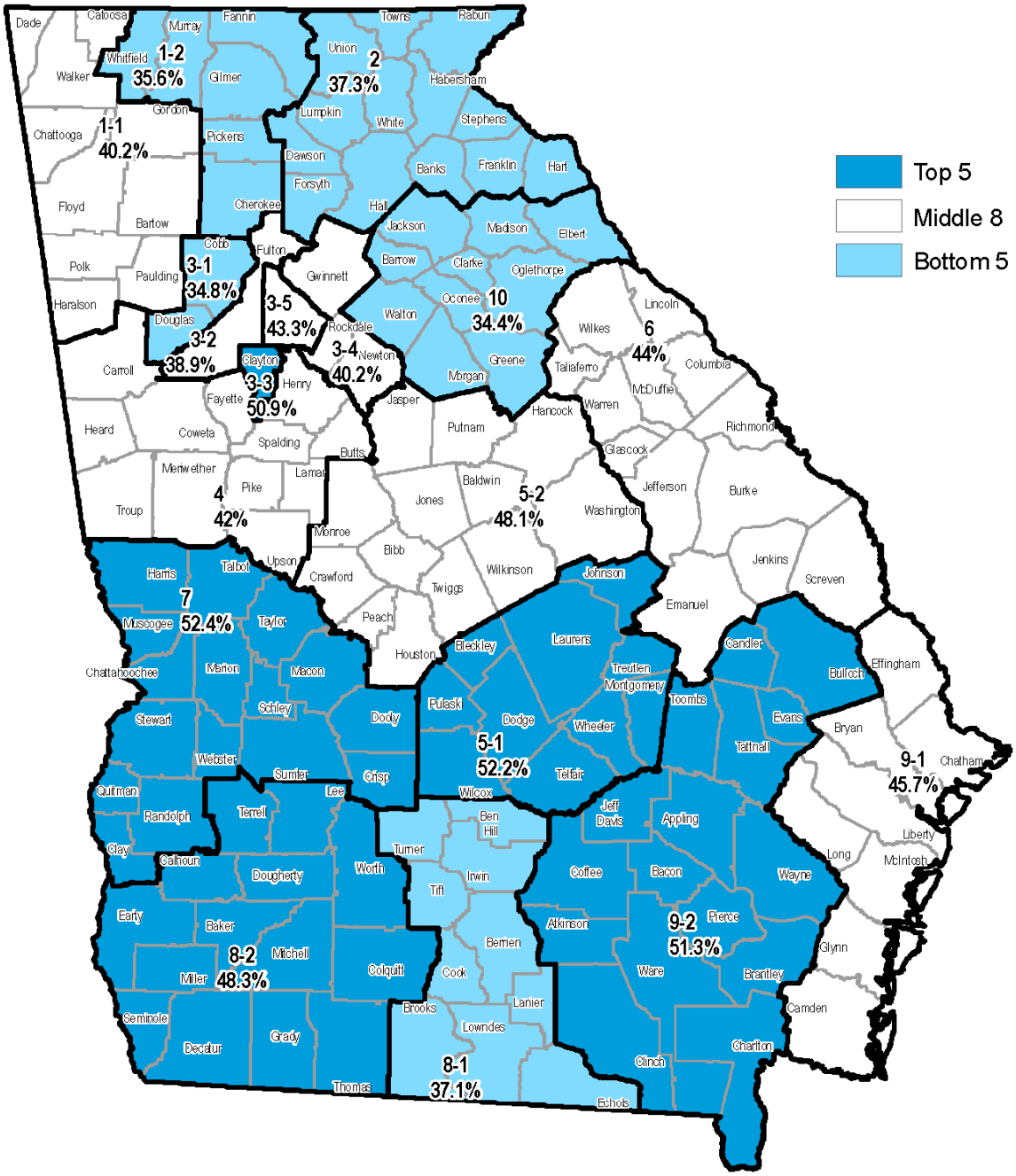
The top four diagnoses for infant hospitalization are pneumonia, disorders per short gestation and low birth weight, respiratory distress, and asthma. These four diagnoses were the same among infants when stratifying by race. Falls was among the top ten causes of hospitalization among all infants, White infants, and Black infants. Homicide was the eighth leading cause of inpatient hospitalization among Black infants.

Top 10 infant inpatient diagnoses (based on ICD codes) by Race, Georgia, Hospital Discharge Data 2007

Rank	Diagnosis – All Infants	Diagnosis – White Infants	Diagnosis – Black Infants
1	Pneumonia	Pneumonia	Pneumonia
2	Disorders Per Short Gestation and LBW, not elsewhere classified	Disorders Per Short Gestation and LBW, not elsewhere classified	Disorders Per Short Gestation and LBW, not elsewhere classified
3	Respiratory Distress of Newborn	Respiratory Distress of Newborn	Respiratory Distress of Newborn
4	Asthma	Asthma	Asthma
5	Septicemia	Infections of Kidney	Septicemia
6	Unknown	Septicemia	Unknown
7	Infections of Kidney	Unknown	Sickle Cell Trait and Disease
8	Congenital Malformations of the Nervous System	Congenital Malformations of the Nervous System	Assault (Homicide)
9	Falls	Falls	Congenital Malformations of the Nervous System
10	Sickle Cell Trait and Disease	Other Heart Disease	Falls

Note: Ethnicity is not recorded in hospital discharge data. People of Hispanic ethnicity are included among the White and Black infant columns.

Percent of Mothers Who Reported that Their Infants are Most Often Put on Their Sides or Stomachs to Sleep by Public Health District, Georgia, PRAMS 2004 through 2006



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INFANT EMERGENCY ROOM VISITS

Several of the emergency room diagnoses among the top ten in Georgia in 2007 are related to injury prevention, including the most frequent diagnosis, falls. Falls was the most frequent diagnosis among White and Black infants. Other unintentional injuries included in the top ten were motor vehicle accidents and poisoning are other accidental injuries included in the top ten most frequent emergency room diagnoses.

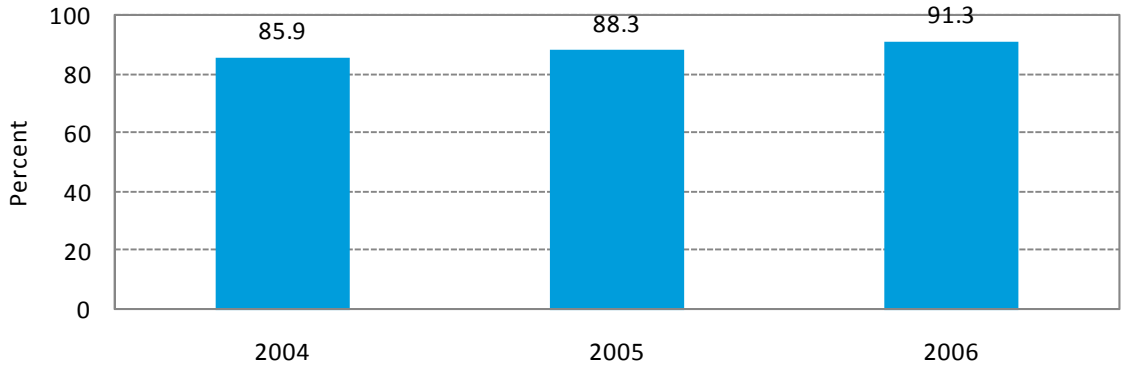
Top 10 Infant Emergency Room Diagnoses (based on ICD codes) by Race, Georgia, Hospital Discharge Data 2007

Rank	Diagnosis – All Infants	Diagnosis – White Infants	Diagnosis – Black Infants
1	Falls	Falls	Falls
2	Pneumonia	Pneumonia	Pneumonia
3	Asthma	Asthma	Asthma
4	Bronchitis and Chronic Unspecified	Bronchitis and Chronic Unspecified	Bronchitis and Chronic Unspecified
5	Infections Specific to the Perinatal Period	Infections Specific to the Perinatal Period	Infections Specific to the Perinatal Period
6	Diseases of the Musculoskeletal System and Connective Tissue	Accidental Poisoning and Exposure to Noxious Substances	Motor Vehicle Accidents
7	Accidental Poisoning and Exposure to Noxious Substances	Motor Vehicle Accidents	Other Heart Disease
8	Influenza	Diseases of the Musculoskeletal System and Connective Tissue	Diseases of the Musculoskeletal System and Connective Tissue
9	Motor Vehicle Accidents	Influenza	Influenza
10	Other Heart Disease	Other Heart Disease	Accidental Poisoning and Exposure to Noxious Substances

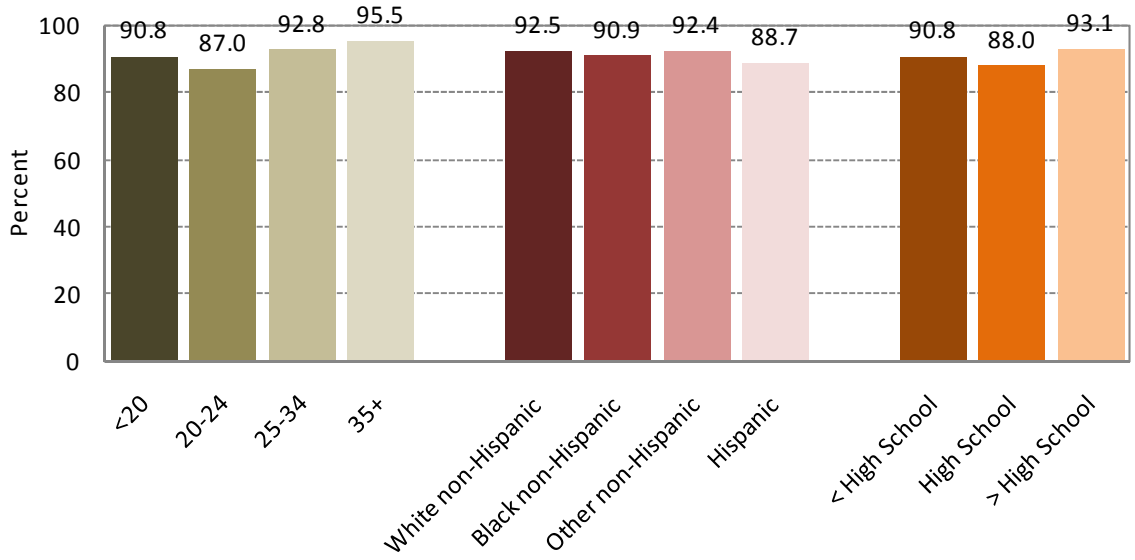
WELL INFANT CARE THROUGH ONE WEEK FOLLOWING DISCHARGE

In 2006, more than 90 percent of mothers reported that their infant received an infant examination within one week of hospital discharge. This percent increased in 2005 and 2006. Younger, less educated and Hispanic mothers were less likely to report that their infants received an infant examination within one week of hospital discharge.

Percent of Mothers Who Reported that Their Infant Received an Infant Examination within One Week of Discharge by Year, Georgia, PRAMS 2004 through 2006



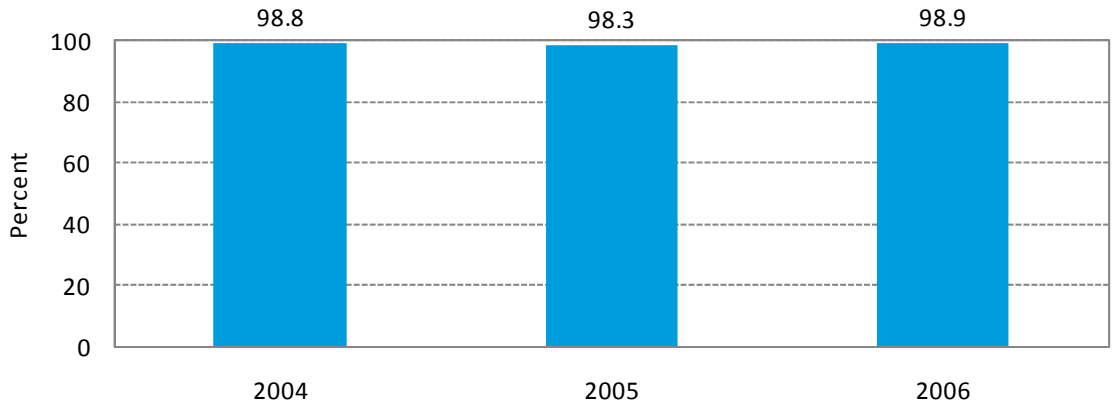
Percent of Mothers Who Reported that Their Infant Received an Infant Examination within One Week of Discharge by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



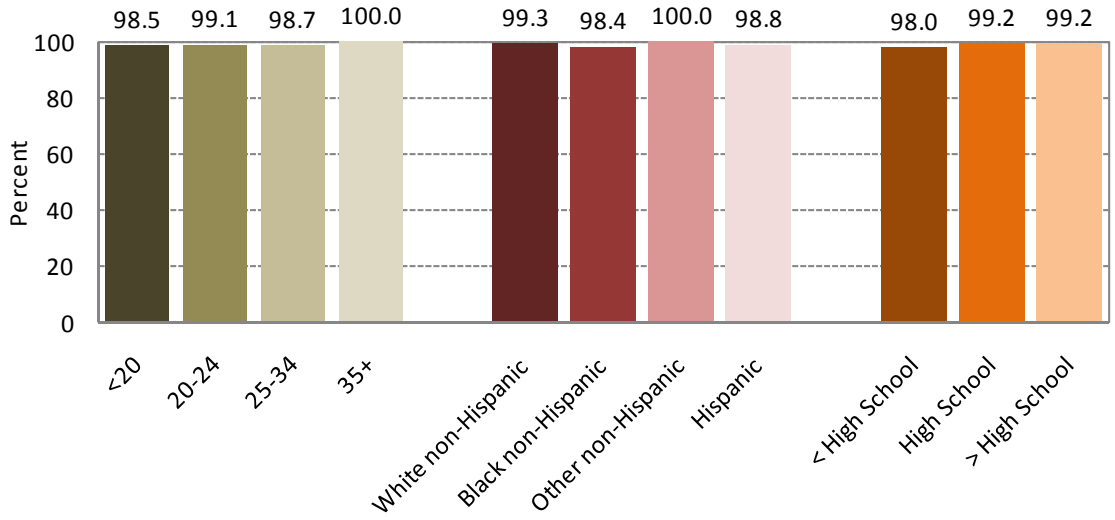
WELL INFANT CARE THROUGH ONE YEAR FOLLOWING DISCHARGE

More than 98 percent of mothers reported that their infant received a well infant examination. This indicator varies little by maternal age, race/ethnicity, or educational attainment.

Percent of Mothers Who Reported that Their Infant Received a Well Infant Examination by Year, Georgia, PRAMS 2004 through 2006



Percent of Mothers Who Reported that Their Infant Received a Well Infant Examination by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



QUALITATIVE THEMES FOR INFANTS FROM STATEWIDE FOCUS GROUPS

The qualitative data section is organized by theme. These themes were identified through analysis of the data collected through the focus groups. There is standard information provided for each theme that includes sections on *Quantification*, *Description of the Health Concern*, and *Ideas about What is Needed to Improve* the identified need.

The *Quantification* section provides information about the frequency with which the theme was identified.

After reviewing the notes collected during the focus groups, themes were identified by analysts based on the information recorded as part of the focus groups. The *Description of the Health Concern* section provides quotes and ideas communicated by focus group participants that were used in defining the theme. As frequently as possible, direct quotes from focus group participants are used.

The *Ideas about What is Needed to Improve* the identified need section captures focus group participant ideas about possible strategies and solutions to improve that theme.

In limited instances, along with the identified themes, a section has been included labeled *Other Health Concerns*. This section includes a list of health care concerns among a specific population that were not mentioned with adequate frequency to be considered a theme, but were important to document.

NUTRITION AND BREASTFEEDING

QUANTIFICATION

Nutrition and breastfeeding are identified as a major health concern for infants by the MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System, and seven of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Nutrition and breastfeeding issues appear to be a concern to stakeholders in communities and to many in the state's maternal and child health organizations.

A concern is that an "inadequate number of infants are breast fed." There is also concern about "the lack of breastfeeding becoming the norm." Some stakeholders forward the idea that inadequate or suboptimal (no breastfeeding) nutrition needs to be a priority for the state.

One stakeholder shared his view of what's contributing to the problem. "There is a huge disconnect sometime between health care providers and those encouraging breastfeeding so sometimes we lose a lot of our breast feeders. Women get two different messages."

Others point out the barriers to needed care; i.e., "inadequate Medicaid reimbursement for nutrition services for infants and children. "

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE INFANT HEALTH

MCH stakeholders identified various ideas on what is needed to improve the physical and mental health of infants. Suggestions around nutrition and breastfeeding follow.

- "Provide the breast-feeding support and breast-feeding education which is needed;"
- "Provide Resource Mothers to provide breast-feeding counseling and serve as mentors;" and
- "Consider use of family-centered care model (HIV model)."

NEED FOR IMPROVED BIRTH OUTCOMES

QUANTIFICATION

The need for improved outcomes (low birth weight, prematurity, infant mortality) is identified as a major health concern for infants by MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System and five of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Low birth weight is a major health concern and is forwarded as a suggested priority by half the group attending the non-governmental MCH provider and advocacy focus group.

Premature babies are also a health concern, noted by a third of the roundtables.

Infant mortality is a major health concern, noted in half the statewide focus groups.

"The Black community has a high infant mortality rate."

"There is a high percentage of infant deaths in Floyd County."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE INFANT HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of infants. Suggestions around improving birth outcomes follow.

- "Ensure appropriate medical home at birth, as defined by American Academy of Physicians (AAP);"
- "Be health outcome driven;"
- 'Provide primary prevention education at birth using community partners to begin early, using data and surveillance systems;"
- "Reduce infant mortality in term infants without lethal abnormalities to zero;" and
- "Fetal infant mortality review and perintal periods of risk analyses."

ADDITIONAL QUOTES

"We need a comprehensive approach to lowering infant mortality that includes case management, care coordination and advocacy for high risk women."

"Tie programs to outcomes, support the link to data, strong ties in public health between data, epidemiology to program people."

ACCESS TO SPECIALTY CARE

QUANTIFICATION

Access to specialty care is identified as a major health concern for infants by MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System, and seven of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Four roundtables independently concluded that "appropriate medical home at birth (as defined by AAP)" is one of their five major health concerns for Georgia's infants.

Stakeholders in community focus groups also expressed concerns about access to care, stating the needs in their communities as follows.

- Inadequate number of pediatricians
- Lack of access to specialty care
- "Gaping holes in specialists - no pediatric orthopedic, no pediatric neurologists"
- Lack of "accessible and affordable day care services"
- Problem with "transport of mothers and babies"
- Home visitation

A health care provider in one community focus group is especially concerned about resuscitation. "Hospitals are having difficulty in providing resuscitation for infants and newborns because community pediatricians are opting out."

The Early Childhood Comprehensive System steering committee identifies these barriers to zero-to-five-year-olds' health care and well-being:

- Insurance and Medicaid
- Geographic accessibility
- Availability of providers (e.g., specialty physicians)
- Access to caregivers
- Challenge for working parents to see providers during regular hours
- Transportation
- Information not getting to the population in a way that is usable

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE INFANT HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of infants. Suggestions around access to specialty care follow.

- "We need transportation coverage for infants in regional perinatal centers who are now stable and can receive a lower level of care at home;"
- "Increase access to child care services;"
- "Address the increased need for home visitation\promotion of Bright Futures;"
- "Ensure that the delivery of high-risk babies is at the appropriate hospitals;"
- "Improve access to board-certified pediatrician in rural areas;"
- "State needs to provide special incentives to attract subspecialists. There is a model for serving underserved areas;" and
- "Georgia needs to address the problems in southwest Georgia – offer incentives to specialty and subspecialty areas."

DEVELOPMENTAL SCREENING

QUANTIFICATION

Developmental screening is identified as a major health concern for infants by MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System, and six of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Developmental screening and follow-up is a top priority concern of half the roundtable groups. The concern is that infants "are not meeting developmental milestones."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE INFANT HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of infants. Suggestions around developmental screening follow.

- Developmental screening and early intervention (most often suggested)
- Screening for social emotional development and link to evidence-based service

QUALITY PARENTING

QUANTIFICATION

Quality parenting is identified as a major health concern for infants by MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System, and five of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

The health concern is that there is "lack of appropriate care for newborns due to mental/physical health of caretaker." Also "bonding/attachment" is needed and there is concern it is not occurring.

"Change in health-seeking behaviors for caretaker" is also forwarded as a priority which should be addressed.

Some stakeholders suggest that part of the problem is "not having a contact person in the community."

Family situations and challenges are of concern to the Early Childhood Comprehensive System steering committee and include the following.

- "Families are dealing with a host of issues, live a chaotic lifestyle and do a lot of juggling – best intentions go astray;"
- "Homelessness exists– families do not know how to get connected;" and
- "Parents may be feeling judged, may be feeling like a failure for needing help."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE INFANT HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of infants. Suggestions around quality parenting follow.

- Provide educational support/programs for caretaker;
- Provide new parent/family support (parenting skills, fatherhood support, mental health, developmental milestones);
- Provide comprehensive services to families; and
- Provide parent education on normal development, injury prevention, environmental issues and nutrition.

SAFETY/INJURY PREVENTION

QUANTIFICATION

Safety/injury prevention is identified as a major health concern for infants by MCH needs assessment community focus groups and five of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

There is concern among health care providers that "infants are experiencing trauma and injury." The safety concerns noted are environmental safety, cribs and car seats. A common observation in the community focus groups is that "we are concerned about parents not using car seats."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE INFANT HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of infants. Suggestions around safety/injury prevention follow.

- "Need to address injury prevention and environmental safety;"
- "Need educational classes on use of car seats;" and
- "We need education classes on the proper use of a car seat, and sleeping…We need more people offering classes in our community and more people to know about the classes."

INFRASTRUCTURE/SYSTEM ISSUES

QUANTIFICATION

Infrastructure / system issues are identified as a major health concern for infants by MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System, and 100 percent of the roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

A variety of infrastructure concerns emerged from stakeholder discussions at focus group sessions. Communication is specifically noted by half the roundtables at the non-governmental maternal and child health provider and advocacy groups; communication emerged from the Early Childhood Comprehensive System steering committee.

Another concern is the "lack of complete integrated child health record and adequate access."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE INFANT HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of infants. Suggestions around infrastructure/systems issues follow.

- "Improve interagency communication, collaboration;"
- "There is a need for health care coordination and collaboration;"
- "Build relationships with daycare providers in the community;"
- Specific suggestions for improved communication follow;
  - "Increase hands-on communication with families;"
  - "Provide education to public about the importance of regular health care and where to get it;"
  - "Provide education and outreach about insurance and the importance of preventative care;" and
- "Immunization registry needs to be maintained."

OTHER HEALTH CARE CONCERNS

The following is a list of health care concerns among women that were not mentioned with adequate frequency to be considered a theme, but are important to document.

- Immunizations
- Out-of-home placement support (foster care, developmental screen, unstable placement)
- Daycare
- Appropriate follow-up care for well baby checks during first year
- Primary prevention education at birth using community partners to begin early, using data and surveillance systems

CHILDREN 1 TO 21 YEARS OF AGE

ANALYSIS OF QUANTITATIVE DATA

LEADING CAUSES OF MORTALITY AMONG CHILDREN 1 TO 21 YEARS OF AGE

Motor vehicle accidents were the leading cause of child mortality in all age groups in 2007 accounting for 356 deaths among children 1 to 21 years of age. Deaths from motor vehicle crashes resulted in 20,598 years of potential life lost among children 1 through 21 years of age with 54.2 percent among children 18 to 21 years of age. Assault/homicide was the second leading cause of death among all age groups except children 1 to 5 years of age accounting for 174 deaths among children 1 to 21 years of age. Deaths from assault/homicide resulted in 6,858 years of potential life lost among children 1 through 21 years of age. Intentional self harm/suicide was the third leading cause of death among children 15 through 21 years of age and was associated with 3,441 years of potential life lost.

Top 10 Causes of Mortality among Children Ages 1 through 21 Years, Georgia, State Vital Records 2007			
Ages 1 to 5 Years			
Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	29	1,957.5
2	Accidental Drowning and Submersion	27	1,822.5
3	Assault (Homicide)	19	1,282.5
4	Other Heart Disease	9	607.5
5	Accidental Exposure to Smoke, Fire and Flames	5	337.5
6	Leukemia	5	337.5
7	Pneumonia	4	270.0
8	Septicemia	3	202.5
9	Malignant Neoplasms of Meninges, Brain, and other parts of CNS	3	202.5
10	Congenital Malformations of the Nervous System	3	202.5

Top 10 Causes of Mortality among Children Ages 1 through 21 Years, Georgia, State Vital Records 2007			
Ages 6 to 9 Years			
Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	9	607.5
2	Assault (Homicide)	8	540.0
3	Leukemia	7	472.5
4	Other Heart Disease	6	405.0
5	In Situ and Benign Neoplasms	4	270.0
6	Septicemia	3	202.5
7	Accidental Discharge of Firearms	3	202.5
8	Accidental Exposure to Smoke, Fire and Flames	2	135.0
9	Accidental Drowning and Submersion	2	135.0
10	Malignant Neoplasms of Meninges, Brain, and other parts of CNS	2	135.0
Ages 10 to 14 Years			
Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	32	2,160.0
2	Assault (Homicide)	8	540.0
3	Cerebrovascular Disease	6	405.0
4	Other Heart Disease	5	337.5
5	Leukemia	5	337.5
6	Intentional Self-Harm (Suicide)	3	202.5
7	Human Immunodeficiency Virus (HIV) Disease	3	202.5
8	Accidental Exposure to Smoke, Fire and Flames	3	202.5
9	Accidental Drowning and Submersion	3	202.5
10	Aortic Aneurysm and Dissection	2	135.0
Ages 15 to 17 Years			
Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	85	4,717.5
2	Assault (Homicide)	35	1,942.5
3	Intentional Self-Harm (Suicide)	16	888.0
4	Accidental Poisoning and Exposure to Noxious Substances	10	555.0
5	Other Heart Disease	7	388.5
6	Leukemia	5	277.5
7	Accidental Drowning and Submersion	5	277.5
8	Other Forms of Chronic Ischemic Heart Disease	3	166.5
9	Pregnancy, Childbirth and the Puerperium	3	166.5
10	Septicemia	2	111.0

Top 10 Causes of Mortality among Children Ages 1 through 21 Years, Georgia, State Vital Records 2007			
Ages 18 to 21 Years			
Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	201	11,155.5
2	Assault (Homicide)	104	5,772.0
3	Intentional Self-Harm (Suicide)	46	2,553.0
4	Accidental Poisoning and Exposure to Noxious Substances	36	1,998.0
5	Other Heart Disease	18	999.0
6	Accidental Drowning and Submersion	12	666.0
7	Leukemia	8	444.0
8	Falls	8	444.0
9	Human Immunodeficiency Virus (HIV) Disease	7	388.5
10	Cerebrovascular Disease	6	333.0

*Age adjusted years of potential life lost before age 75 years.

LEADING CAUSES OF EMERGENCY ROOM VISITS AMONG CHILDREN 1 TO 21 YEARS OF AGE

In 2007, falls and asthma were the leading causes of emergency rooms visits among children through 9 years of age and were present in the top ten causes among all age groups. Falls was the leading cause of emergency room visits up through age 14 years. Falls was the second leading cause of emergency room visits among children 15 to 17 years of age and the fourth leading cause of emergency room visits among children 18 to 21 years of age. Motor vehicle accidents was the leading cause of emergency room visits among children 15 to 17 years of age. The leading cause of emergency room visits among children 18 to 21 years and the fourth leading cause among children 15 to 17 years of age was pregnancy, childbirth, and the puerperium.

Top 10 Causes for Emergency Room Visits among Children Ages 1 through 21 Years, Georgia, Hospital Discharge Data 2007		
Ages 1 to 5 Year		
Rank	Diagnosis	Count
1	Falls	27,124
2	Asthma	10,796
3	Pneumonia	7,674
4	Unknown	4,213
5	Diseases of the Musculoskeletal System and Connective Tissue	3,319
6	Bronchitis and Chronic Unspecified	3,157
7	Accidental Poisoning and Exposure to Noxious Substances	2,582
8	Motor Vehicle Accidents	2,498
9	Influenza	903
10	Sickle Cell Trait and Disease	430

Top 10 Causes for Emergency Room Visits among Children Ages 1 through 21 Years, Georgia, Hospital Discharge Data 2007		
Ages 6 to 9 Years		
Rank	Diagnosis	Count
1	Falls	14,375
2	Asthma	6,362
3	Motor Vehicle Accidents	3,008
4	Diseases of the Musculoskeletal System and Connective Tissue	2,942
5	Unknown	1,990
6	Pneumonia	1,494
7	Bronchitis and Chronic Unspecified	994
8	Influenza	571
9	Assault (Homicide)	346
10	Sickle Cell Trait and Disease	253
Ages 10 to 14 Years		
Rank	Diagnosis	Count
1	Falls	16,984
2	Diseases of the Musculoskeletal System and Connective Tissue	5,771
3	Motor Vehicle Accidents	5,244
4	Asthma	4,761
5	Unknown	2,599
6	Assault (Homicide)	1,697
7	Bronchitis and Chronic Unspecified	849
8	Pneumonia	728
9	Influenza	388
10	Intentional Self-Harm (Suicide)	304
Ages 15 to 17 Years		
Rank	Diagnosis	Count
1	Motor Vehicle Accidents	7,398
2	Falls	7,106
3	Diseases of the Musculoskeletal System and Connective Tissue	5,456
4	Pregnancy, Childbirth, and the Puerperium	5,172
5	Assault (Homicide)	2,813
6	Asthma	2,129
7	Unknown	2,061
8	Intentional Self-Harm (Suicide)	738
9	Bronchitis and Chronic Unspecified	651
10	Infections of Kidney	492

Top 10 Causes for Emergency Room Visits among Children Ages 1 through 21 Years, Georgia, Hospital Discharge Data 2007		
Ages 18 to 21 Years		
Rank	Diagnosis	Count
1	Pregnancy, Childbirth, and the Puerperium	24,187
2	Motor Vehicle Accidents	13,498
3	Diseases of the Musculoskeletal System and Connective Tissue	10,076
4	Falls	7,103
5	Assault (Homicide)	4,339
6	Unknown	3,161
7	Asthma	2,898
8	Bronchitis and Chronic Unspecified	1,387
9	Infections of Kidney	1,293
10	Sickle Cell Trait and Disease	1,021

LEADING CAUSES OF HOSPITALIZATION AMONG CHILDREN 1 TO 21 YEARS OF AGE

Asthma and pneumonia were the top two causes of inpatient hospitalization among children 1 to 9 years of age. Among all age groups, sickle cell trait and disease were consistently among the top five causes of inpatient hospitalization. Asthma was a top three cause among children 1 to 14 years of age. Diabetes mellitus was a top five cause of inpatient hospitalization among children 6 through 21 years of age. Pregnancy, childbirth, and the puerperium was the leading cause of inpatient hospitalization for children 15 through 21 years of age. Among children 15 to 17 years of age, pregnancy, childbirth, and the puerperium accounted for 73.7 percent of all visits attributed to the top ten causes and 88.8 percent of all visits attributed to the top ten causes among children 18 to 21 years of age.

Top 10 Causes for Inpatient Hospitalization among Children Ages 1 through 21 Years, Georgia, Hospital Discharge Data 2007		
Ages 1 to 5 Year		
Rank	Diagnosis	Count
1	Pneumonia	2,014
2	Asthma	1,637
3	Unknown	400
4	Sickle Cell Trait and Disease	321
5	Falls	220
6	Diseases of the Musculoskeletal System and Connective Tissue	198
7	Infections of Kidney	158
8	Motor Vehicle Accidents	143
9	Accidental Poisoning and Exposure to Noxious Substances	126
10	Influenza	116

Top 10 Causes for Inpatient Hospitalization among Children Ages 1 through 21 Years, Georgia, Hospital Discharge Data 2007		
Ages 6 to 9 Years		
Rank	Diagnosis	Count
1	Asthma	846
2	Pneumonia	450
3	Sickle Cell Trait and Disease	223
4	Unknown	205
5	Diabetes Mellitus	181
6	Diseases of the Musculoskeletal System and Connective Tissue	179
7	Motor Vehicle Accidents	162
8	Falls	126
9	Infections of Kidney	73
10	Nephritis, Nephrotic Syndrome and Nephrosis	65
Ages 10 to 14 Years		
Rank	Diagnosis	Count
1	Asthma	481
2	Diseases of the Musculoskeletal System and Connective Tissue	422
3	Diabetes Mellitus	391
4	Pregnancy, Childbirth and the Puerperium	323
5	Sickle Cell Trait and Disease	306
6	Motor Vehicle Accidents	286
7	Unknown	251
8	Pneumonia	246
9	Falls	171
10	Infections of Kidney	74
Ages 15 to 17 Years		
Rank	Diagnosis	Count
1	Pregnancy, Childbirth and the Puerperium	6,283
2	Motor Vehicle Accidents	477
3	Diseases of the Musculoskeletal System and Connective Tissue	321
4	Sickle Cell Trait and Disease	315
5	Diabetes Mellitus	291
6	Unknown	245
7	Intentional Self-Harm (Suicide)	185
8	Pneumonia	160
9	Asthma	128
10	Falls	123

Top 10 Causes for Inpatient Hospitalization among Children Ages 1 through 21 Years, Georgia, Hospital Discharge Data 2007		
Ages 18 to 21 Years		
Rank	Diagnosis	Count
1	Pregnancy, Childbirth and the Puerperium	30,264
2	Motor Vehicle Accidents	972
3	Diabetes Mellitus	607
4	Sickle Cell Trait and Disease	485
5	Unknown	409
6	Diseases of the Musculoskeletal System and Connective Tissue	332
7	Intentional Self-Harm (Suicide)	306
8	Assault (Homicide)	264
9	Pneumonia	240
10	Infections of Kidney	221

HOMICIDE

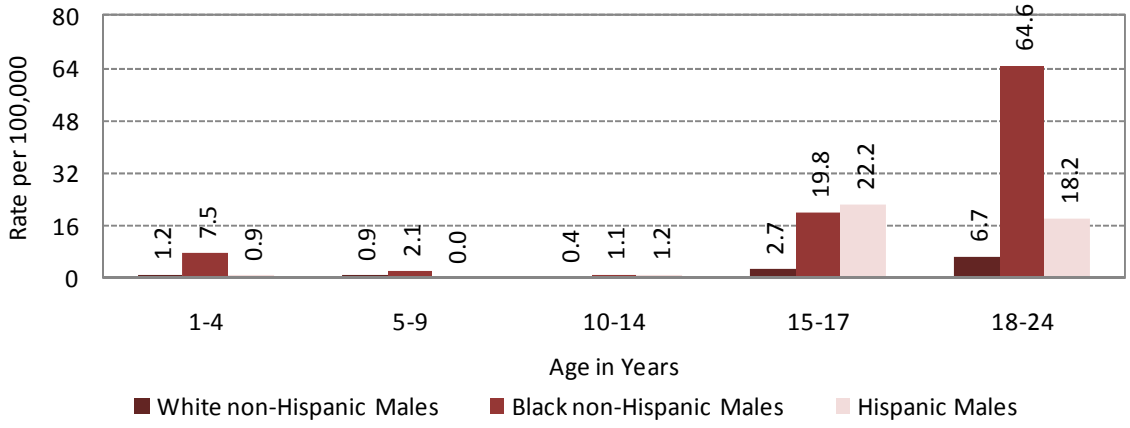
From 2002 through 2006, homicide rates declined. During this five-year period, Georgia experienced some of its lowest homicide rates. There was an increase in the homicide rate between 2006 and 2007 for each age group. In the ten years between 1998 and 2007, homicide rates in 2007 were either greater than most or all homicide rates from previous years.

Among children 1 to 4 years of age, the homicide rate was negligible among White and Hispanic children. However, among Black male children 1 to 4 years of age, the homicide rate was 733 percent greater than the homicide rate among Hispanic male children (the male group with the lowest rate). Among Black female children 1 to 4 years of age, the homicide rate was 1,005 percent greater than the rate among Hispanic female children (the female group with the lowest rates).

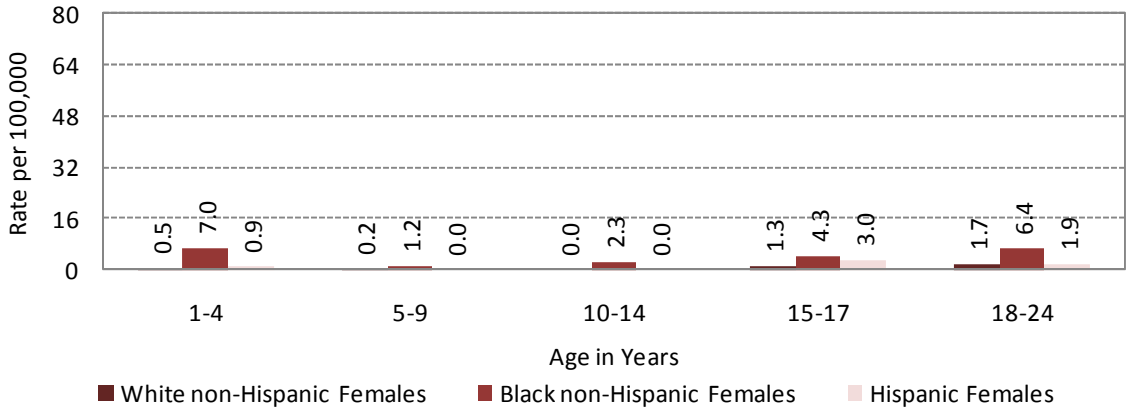
Homicide was concentrated among male children 15 through 21 years of age. Among children 15 to 17 years of age, homicide rates among Black and Hispanic children were similar. However, homicide rates in these groups were at least eight times greater than the homicide rate among White children in the same age group. Among children 18 to 21 years of age, the homicide rate among Black children was 864 percent greater than the homicide rate among White children in the same age group and 255 percent greater than the homicide rate among Hispanic children in the same age group.

Homicide Rates per 100,000 by Age, State Vital Records 1998 through 2007										
Age Group	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
1 to 4	2.4	2.8	3.2	5.6	2.9	3.6	4.3	2.7	2.9	3.1
5 to 9	0.3	1.5	1.1	0.8	0.2	0.6	1.6	0.6	0.6	1.3
10 to 14	1.4	1.4	2.1	1.3	1.1	2.3	0.5	0.8	0.3	1.2
15 to 17	9.6	7.7	7.4	5.9	8.0	5.2	5.3	5.2	5.5	8.7
18 to 21	17.2	17.4	18.0	18.4	17.7	15.2	11.9	12.5	16.4	18.6

Homicide Rates among **Males** by Age and Race/Ethnicity, Georgia, State Vital Records 2005 through 2007



Homicide Rates among **Females** by Age and Race/Ethnicity, Georgia, State Vital Records 2005 through 2007

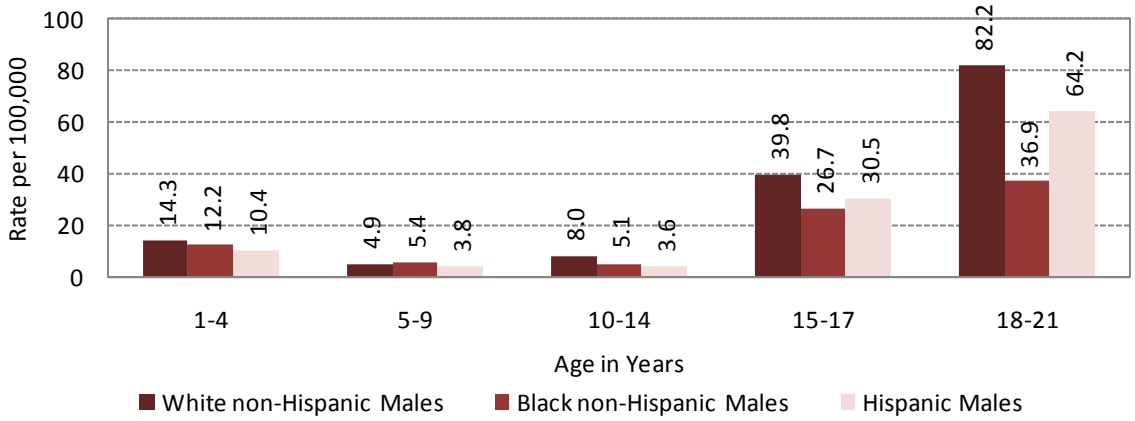


UNINTENTIONAL INJURY DEATHS

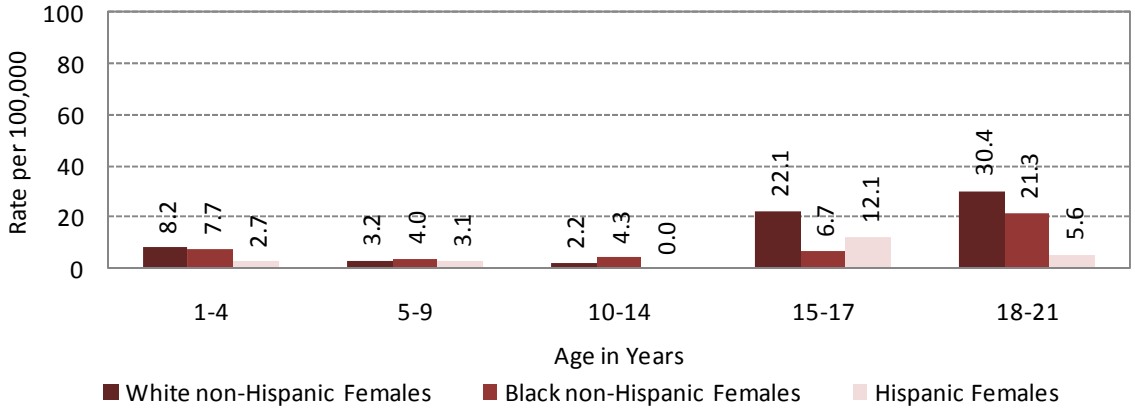
Unintentional injury mortality rates were greater among children 1 to 4 years of age, 15 to 17 years of age, and 18 to 21 years of age and lower among children 5 to 9 years of age and 10 to 14 years of age. Unintentional injury mortality rates among children 15 to 21 years of age were significantly higher than the rates in younger age groups. Mortality resulting from unintentional injury was more common among males than females. White children had the greatest rates of unintentional injury mortality in any age group. For males and females, Hispanic children ages 1 to 14 years of age consistently had the lowest unintentional injury mortality rates. However, among children over 15 years of age, Hispanic children had the lowest unintentional injury rates among female children 18 to 21 years of age only.

Unintentional Injury Mortality Rates per 100,000 by Age, State Vital Records 1998 through 2007										
Age Group	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
1 to 4	13.1	9.7	8.9	11.7	12.6	8.4	12.1	10.2	11.1	9.9
5 to 9	10.9	8.7	6.0	6.0	6.8	4.7	5.8	4.9	4.7	3.3
10 to 14	8.4	9.0	6.4	9.1	7.3	8.0	7.4	4.2	4.0	5.9
15 to 17	31.5	31.0	27.1	33.0	28.7	30.5	20.2	26.9	24.2	25.7
18 to 21	42.0	40.4	40.1	48.7	35.8	37.6	42.3	41.9	44.7	47.0

Unintentional Injury Mortality Rates among **Males** by Age and Race/Ethnicity, Georgia, State Vital Records 2005 through 2007



Unintentional Injury Mortality Rates among **Females** by Age and Race/Ethnicity, Georgia, State Vital Records 2005 through 2007



Drowning Mortality

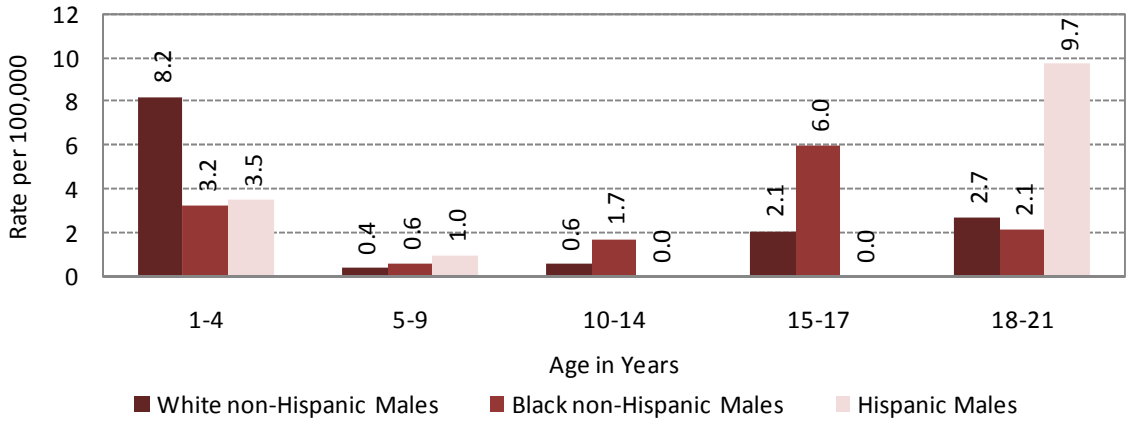
Drowning mortality rates fluctuated for children 1 to 4 years of age, 15 to 17 years of age, and 18 to 21 years of age. These rates declined among children 10 to 14 years of age and 15 to 17 years of age. Rates of drowning mortality were greatest among children 1 to 4 years of age. Among children 1 to 4 years of age, White children had the greatest drowning mortality rates. In this age group, drowning

mortality rates for White and Black male children were double the rates for White and Black female children. Among Hispanic children 1 to 4 years of age, the drowning mortality rate was 289 percent greater among males than females.

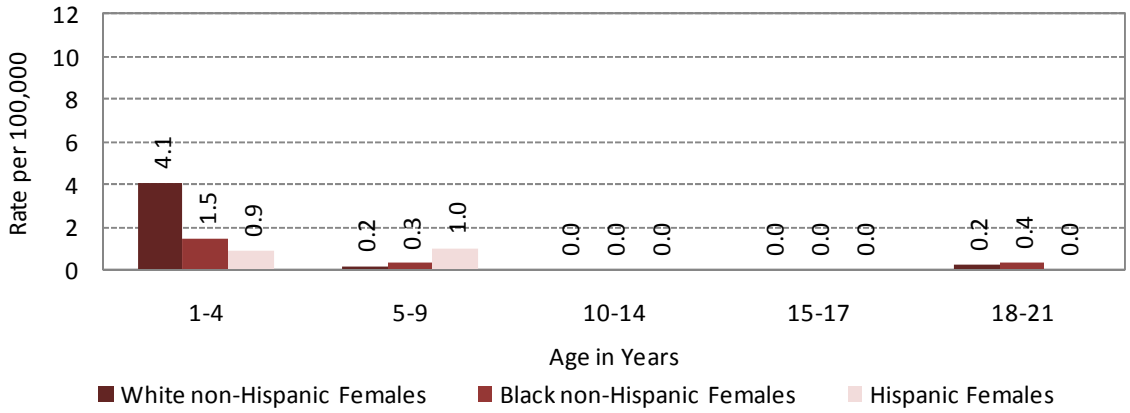
Except for children 1 to 4 years of age, there were few female deaths attributed to drowning. The same was not true for male children. Among children ages 15 to 17 years, drowning rates among Black children were three times that of White children. Among children ages 18 to 21 years of age, the drowning mortality rate was approximately four time greater among Hispanic male children than White or Black male children.

Drowning Mortality Rates per 100,000 by Age, State Vital Records 1998 through 2007										
Age Group	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
1 to 4	2.9	3.9	2.5	3.0	5.0	3.2	2.8	4.5	4.0	4.4
5 to 9	2.7	1.5	1.3	0.8	0.7	0.8	1.3	0.5	0.3	0.4
10 to 14	1.1	2.4	1.0	1.4	1.1	0.8	0.6	0.6	0.4	0.4
15 to 17	1.2	3.4	4.0	2.2	0.8	0.8	2.7	1.3	2.5	1.2
18 to 21	2.1	1.7	1.8	3.0	0.8	1.0	2.1	1.3	0.7	2.2

Drowning Mortality Rates among **Males** by Age and Race/Ethnicity, Georgia, State Vital Records 2005 through 2007



Drowning Mortality Rates among **Females** by Age and Race/Ethnicity, Georgia, State Vital Records 2005 through 2007



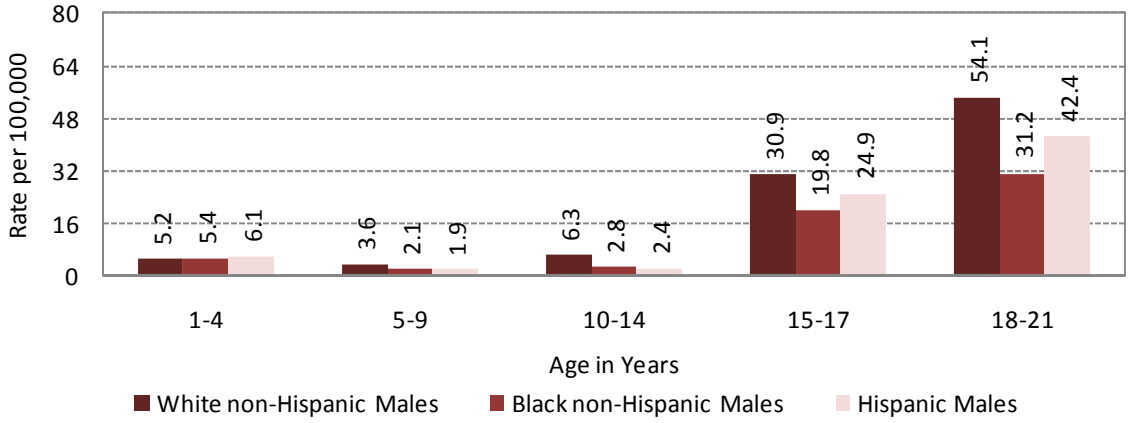
Motor Vehicle Accident Mortality

Motor vehicle accident mortality had a significantly greater impact on children ages 15 to 21 years than in younger children. Rates fluctuated among all age groups with no consistent pattern emerging. Male children had greater motor vehicle accident mortality rates than females. Regardless of gender, White children had greater motor vehicle mortality rates than Hispanic or Black children.

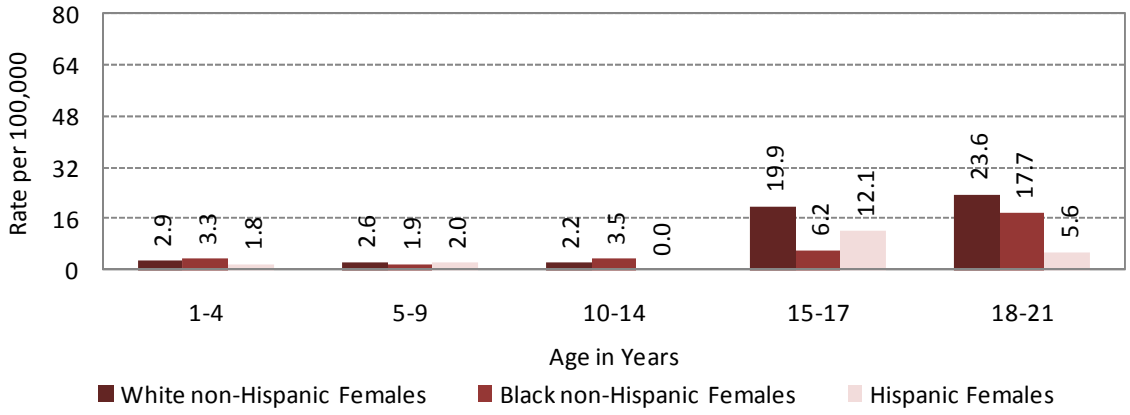
Motor Vehicle Accident Mortality Rates per 100,000 by Age, State Vital Records 1998 through 2007

Age Group	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
1 to 4	8.2	4.3	4.2	5.4	5.0	3.1	5.2	4.2	5.0	4.1
5 to 9	5.7	6.2	4.1	4.7	5.2	3.1	2.9	3.0	3.2	2.0
10 to 14	6.3	5.7	4.9	6.7	4.8	5.8	5.4	3.2	2.8	4.7
15 to 17	27.7	25.8	21.4	28.5	24.8	27.7	16.5	22.3	19.7	21.0
18 to 21	34.3	29.3	26.8	35.3	22.3	22.0	22.7	24.6	28.5	28.2

Motor Vehicle Accident Mortality Rates among **Males** by Age and Race/Ethnicity, Georgia, State Vital Records 2005 through 2007



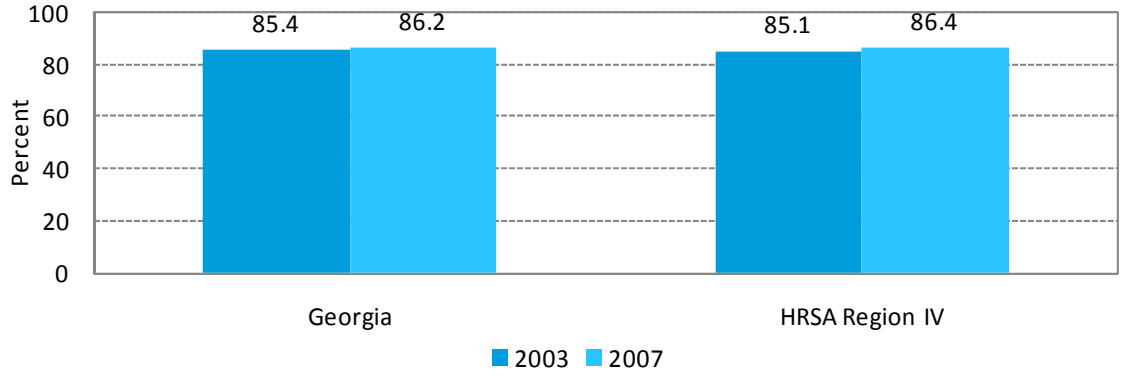
Motor Vehicle Accident Mortality Rates among **Females** by Age and Race/Ethnicity, Georgia, State Vital Records 2005 through 2007



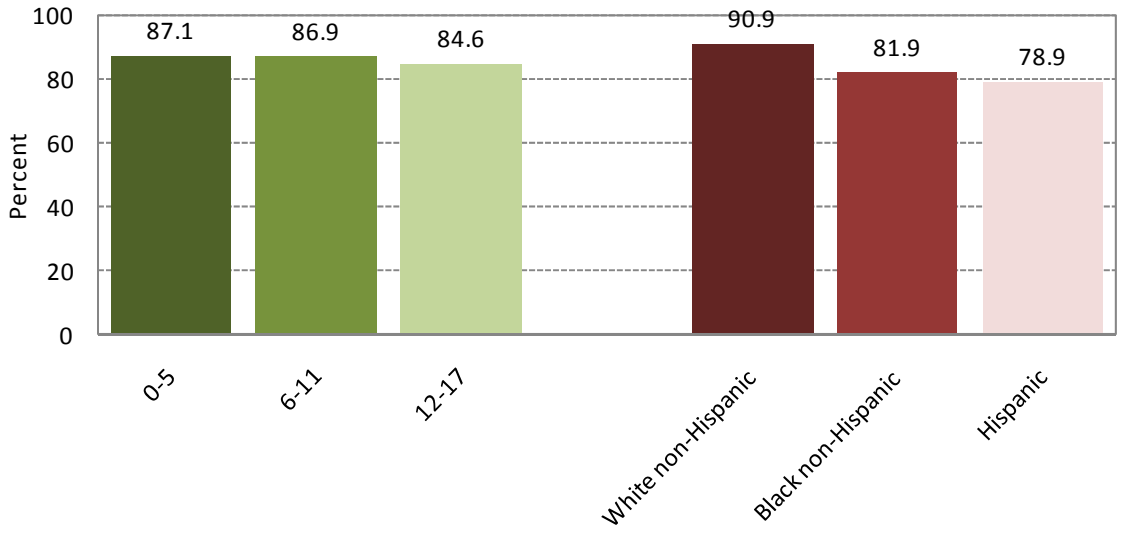
PHYSICAL HEALTH STATUS

More than 85 percent of children in Georgia and HRSA Region IV had very good or excellent health. There was slight change between 2003 and 2007. While there was little difference by age, a greater percent of White children reported very good or excellent health than did Black or Hispanic children. Less than 80 percent of Hispanic children reported very good or excellent health.

Percent of Children in Very Good or Excellent Physical Health, Georgia and HRSA Region IV, National Survey of Children's Health 2003 and 2007



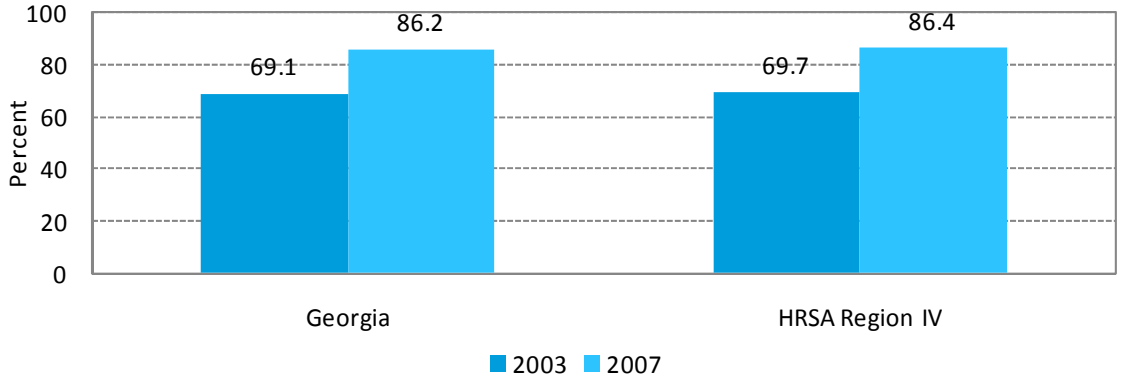
Percent of Children in Very Good or Excellent Physical Health, Georgia, National Survey of Children's Health 2007



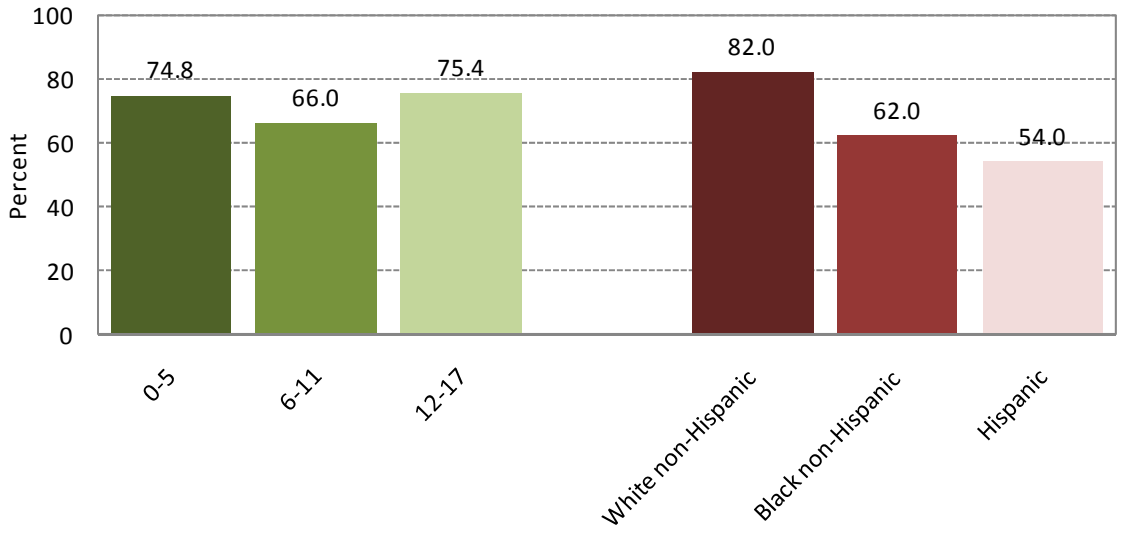
ORAL HEALTH STATUS

There has been an increase in the percent of children with very good or excellent oral health between 2003 and 2007 in Georgia. Georgia's rate and the increase were comparable to HRSA Region IV. The percent of children with very good or excellent oral health was lower among children 6 to 11 years of age compared to other age groups. There were significant differences in oral health status by race. While the percent of White children with very good or excellent health was in excess of 80 percent, this percent was 32.3 percent higher than the rate among Black children and 51.9 percent higher than the rate among Hispanic children.

Percent of Children in Very Good or Excellent Oral Health, Georgia and HRSA Region IV, National Survey of Children's Health 2003 and 2007



Percent of Children in Very Good or Excellent Oral Health, Georgia, National Survey of Children's Health 2007

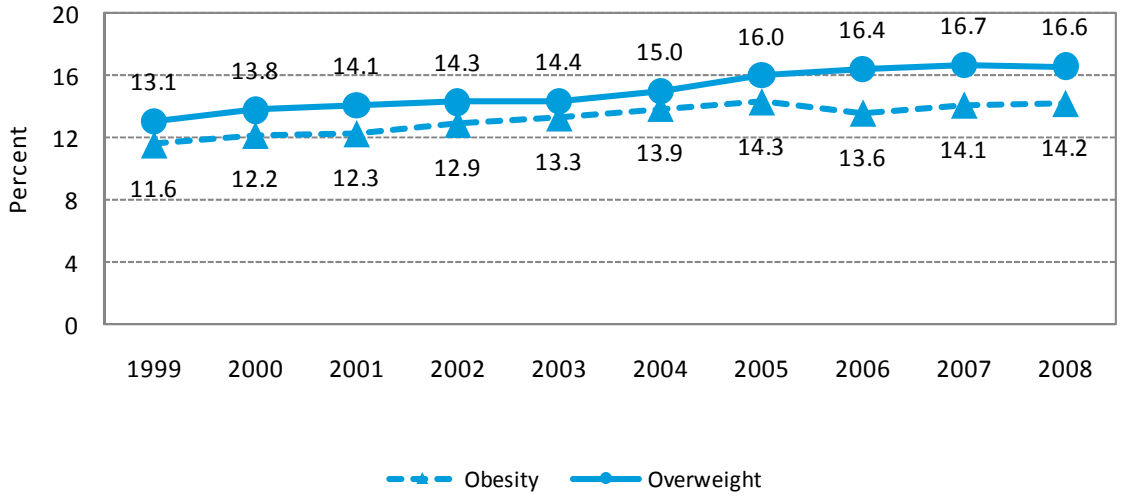


OVERWEIGHT AND OBESITY AMONG CHILDREN AGES 2 TO 5 YEARS ENROLLED IN WIC

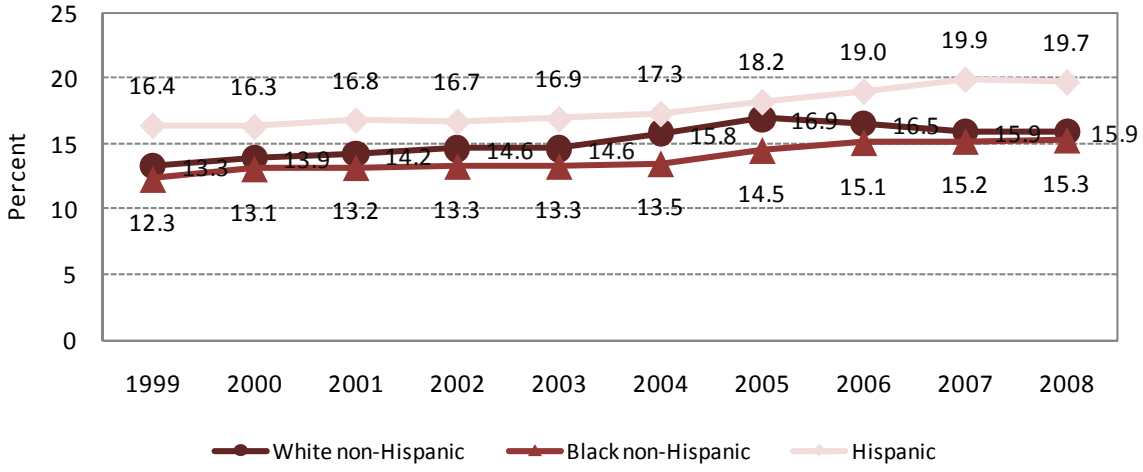
The percent of children 2 to 5 years of age enrolled in WIC who were overweight, which is defined among children as a BMI greater than the 85th percentile and less than the 95th percentile, increased 26.7 percent between 1998 and 2008. The increase in overweight was greatest among Black children 2 to 5 years of age enrolled in WIC. By 2008, nearly one in four Black children 2 to 5 years of age enrolled in WIC were overweight. While the increase was not as great among White and Hispanic children, increases among these groups were still approximately 20 percent.

Obesity, which is defined among children as a BMI in the 95th percentile or greater, increased 22.4 percent between 1998 and 2008 among children 2 to 5 years of age enrolled in WIC. This increase was greatest among White children followed by Hispanic children. By 2008, nearly one in five Hispanic children ages 2 to 5 years enrolled in WIC were obese.

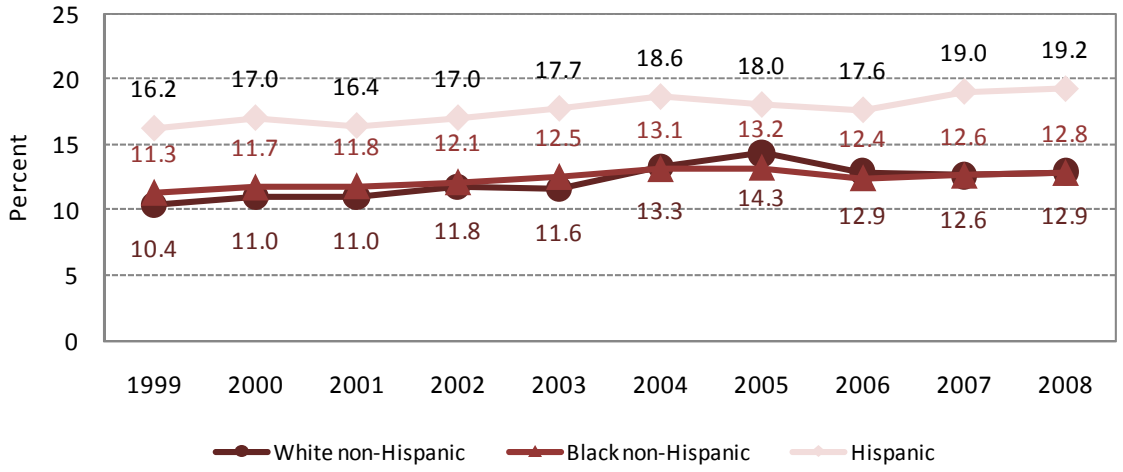
Preavelance of Overweight and Obesity among WIC Participants Ages Two to Five Years, Georgia, PedNSS 1999 through 2008



Preavelance of Obesity (Equal to or greater than the 95th percentile) among WIC Participants Ages Two to Five Years by Race/Ethnicity, Georgia, PedNSS 1999 through 2008



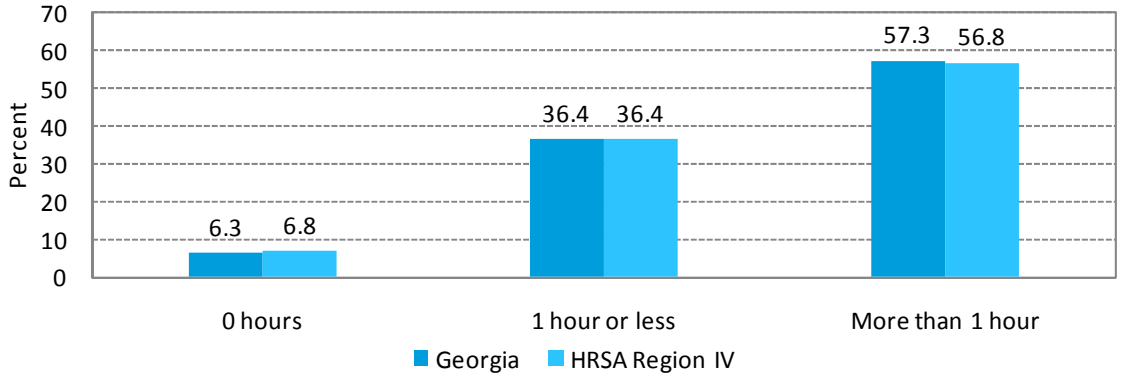
Preavelance of Overweight (85th to less than the 95th percentile) among WIC Participants Ages Two to Five Years by Race/Ethnicity, Georgia, PedNSS 1999 through 2008

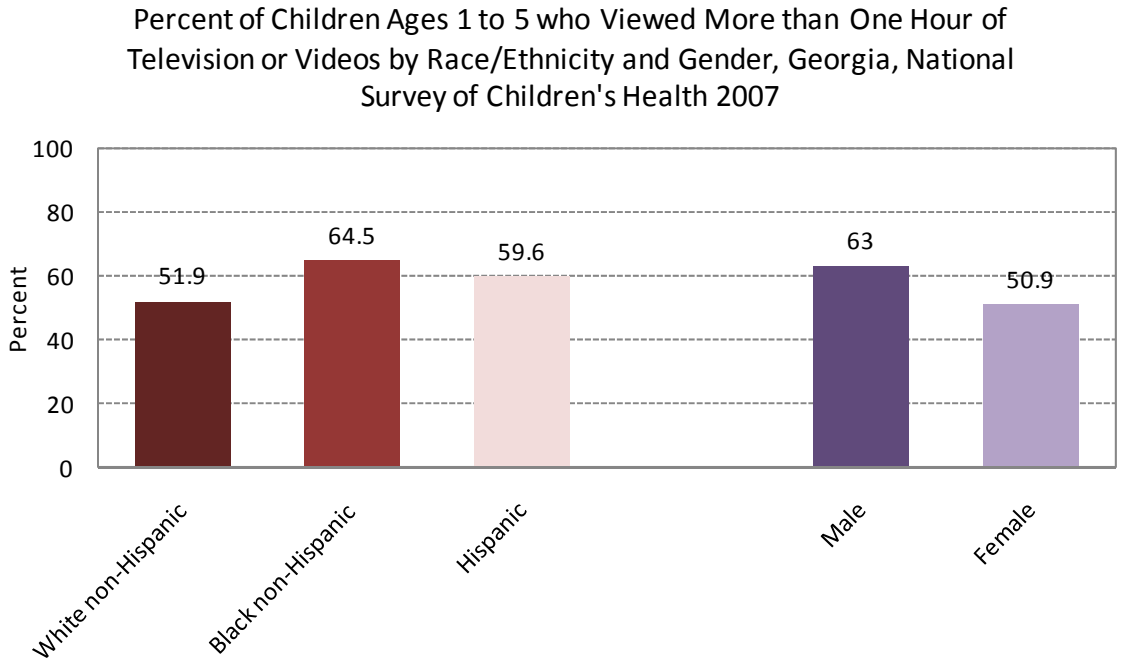


SCREEN TIME AMONG CHILDREN AGES 1 TO 5 YEARS

More than half of all children 1 to 5 years of age viewed television or videos more than one hour during a weekday in Georgia and HRSA Region IV. For Black children in Georgia, 64.5 percent viewed television or videos more than one hour during a weekday. The percent of male children who viewed television or videos more than one hour during a weekday was 23.8 percent greater than female children.

Television and Video Viewing among Children Ages 1 to 5 Years, Georgia and HRSA Region IV, National Survey of Children's Health 2007





ASTHMA HOSPITALIZATIONS AND EMERGENCY ROOM VISITS

INPATIENT HOSPITALIZATIONS

In 2007, there were 3,285 inpatient hospitalizations due to asthma. There has been minimal fluctuation in rates of inpatient hospitalization due to asthma by age over time. Throughout the ten year period of data presented, the greatest rates of inpatient hospitalization due to asthma were found among younger children 1 to 4 years of age and 5 to 9 years of age. Among younger children, the rate among children 1 to 4 years of age was double the rate among children 5 to 9 years of age. With the exception of children 1 to 4 years of age, Black children had the greatest rates of inpatient hospitalization due to asthma for all age groups. There were significant racial disparities in the rate of inpatient hospitalization due to asthma between Black and White children. The rate of inpatient hospitalization due to asthma was nearly four times greater among Black children 5 to 9 years of age and 10 to 14 years of age compared to White children of the same ages. Gender disparities were also found with rates greater among male children than female children.

Asthma Inpatient Hospital Discharges per 100,000 by Age, Hospital Discharge Data 1998 through 2007

Age Group	1999	2000	2001	2002	2003	2004	2005	2006	2007
1 to 4	3.39	3.22	3.66	3.82	3.70	3.88	3.34	2.62	2.34
5 to 9	1.46	1.41	1.31	1.71	1.66	1.78	1.97	1.49	1.60
10 to 14	0.95	0.90	0.87	0.76	0.80	0.82	0.89	0.67	0.71
15 to 17	0.46	0.46	0.50	0.51	0.47	0.40	0.43	0.32	0.32
18 to 21	0.42	0.39	0.34	0.34	0.40	0.37	0.35	0.26	0.36

Asthma Inpatient Hospital Discharges per 100,000 by Age, Race, and Gender, Hospital Discharge Data 2007					
Race	1 to 4	5 to 9	10 to 14	15 to 17	18 to 21
White	1.65	0.78	0.34	0.21	0.28
Black	3.22	3.06	1.32	0.49	0.52
Other	4.78	2.28	1.00	0.34	0.13
Ratio of Black to White	1.95	3.92	3.88	2.33	1.86
Gender	1 to 4	5 to 9	10 to 14	15 to 17	18 to 21
Male	2.92	1.93	0.84	0.32	0.29
Female	1.73	1.27	0.57	0.31	0.46

EMERGENCY ROOM VISITS

In 2007, there were 26,946 emergency room discharges due to asthma. The average daily emergency room discharges increased in each age group when comparing rates from 2002 and 2007. Among children 1 to 4 years of age and 5 to 9 years of age, more than 20 emergency room discharges daily in these age groups were due to asthma. Rates were significantly lower among children 10 to 14 years of age, 15 to 17 years of age, and 18 to 21 years of age. Black children had significantly greater average daily emergency room discharges than children of White or other race. The average daily emergency room discharges among Black children was consistently more than twice the average daily emergency room discharges among White children. Male children had greater average daily emergency room discharges through 14 years of age. Among older children, females had greater average daily emergency room discharges.

Average Daily Emergency Room Discharges by Age, Hospital Discharge Data 2002 through 2007						
Age Group	2002	2003	2004	2005	2006	2007
1 to 4	19.67	21.10	23.54	23.51	22.28	24.41
5 to 9	14.23	16.33	17.27	20.02	19.90	22.56
10 to 14	10.20	12.34	11.46	13.16	12.19	13.04
15 to 17	4.11	5.43	5.24	5.85	5.24	5.83
18 to 21	6.38	7.43	6.39	7.50	7.22	7.93

Average Daily Emergency Room Discharges by Age, Race, and Gender, Hospital Discharge Data 2007					
Race	1 to 4	5 to 9	10 to 14	15 to 17	18 to 21
White	7.14	5.45	3.20	1.61	2.75
Black	14.56	15.37	9.07	4.01	4.92
Other	2.72	1.74	0.77	0.21	0.26
Ratio of Black to White	2.03	2.82	2.83	2.49	1.80
Gender	1 to 4	5 to 9	10 to 14	15 to 17	18 to 21
Male	15.74	14.81	8.03	2.80	3.34
Female	8.67	7.75	5.00	3.03	4.59

ABUSE AND NEGLECT

SUBSTANTIATED CASES OF ABUSE AND NEGLECT

Child abuse and neglect have various negative effects on a child's health and well being. Victims often suffer physical injuries including cuts, bruises, burns, broken bones, and death. While most physical injuries will heal, if an injury is inflicted intentionally by an adult, the psychological effects can be devastating. In addition, abuse and neglect cause stress that can harm the development of the brain and immune system. As a result, children who are abused or neglected are also at higher risk for physical and mental health problems as adults.

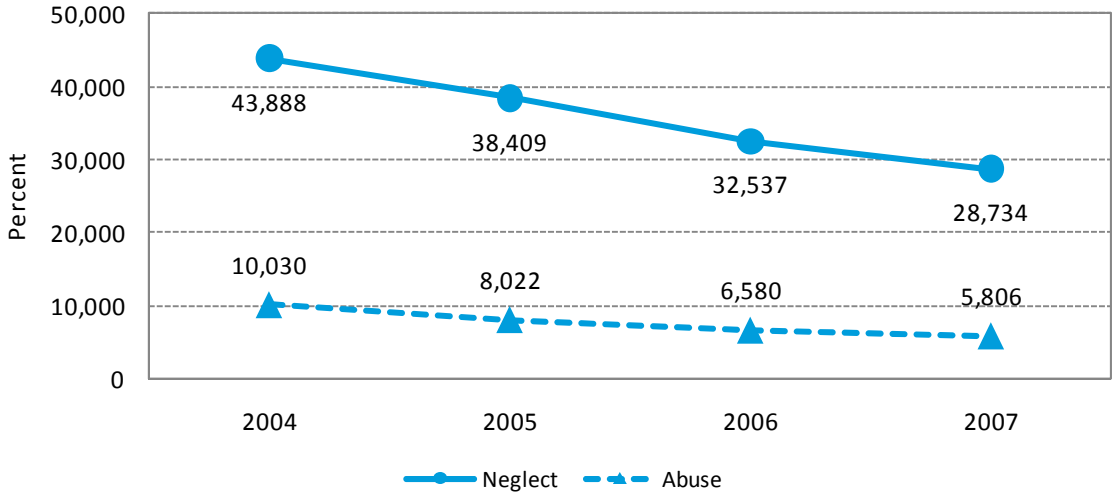
In 2007, 34,540 children were substantiated victims of child abuse and/or neglect of which 83 percent were neglect. The number of substantiated incidents presented here is conservative, as child abuse and neglect are typically underreported (a case is substantiated when the evidence supports the allegations of abuse or neglect). While everyone is encouraged to report suspected child abuse or neglect, Georgia law requires individuals in some professions to report suspected cases (O.C.G.A. § 19-7-5). Referred to as "mandated reporters," this includes any medical or health care personnel; anyone working in child care or school settings, including teachers, counselors, and administrators; and psychologists, professional counselors and social workers. In 2007, mandated reporters submitted 74 percent of the reports on child abuse and neglect that were substantiated.

There have been declines in the number of substantiated abuse and neglect cases between 2004 and 2007. Abuse cases declined 42.1 percent, and neglect cases declined 34.5 percent. Physical abuse accounted for more cases of abuse than sexual, emotional, and all other abuse combined. Declines in substantiated abuse and neglect may not necessarily indicate a real decline in the actual underlying number of abuse and neglect cases. Further investigation is needed to determine if this is a real decline or if other environmental factors such as policy or procedural change may explain this decline.

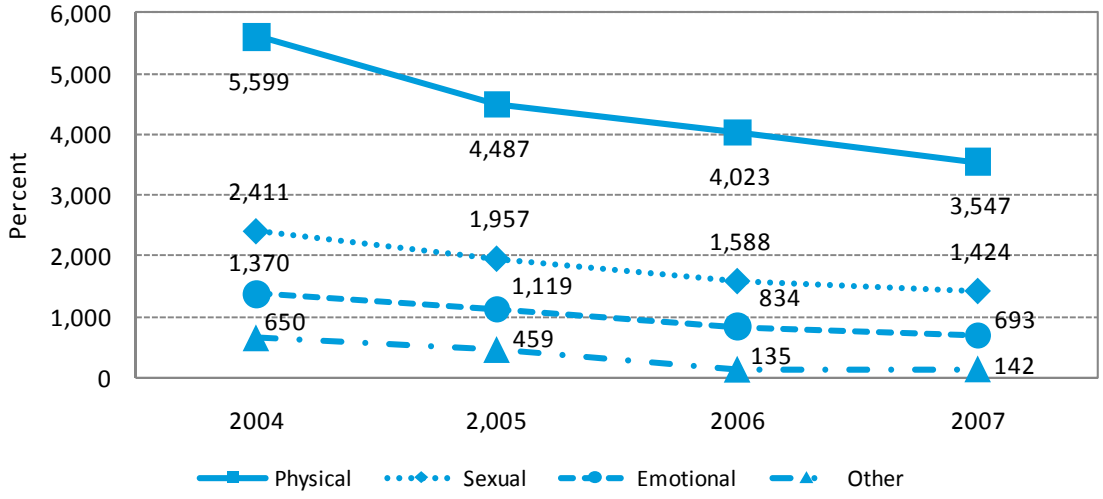
The risk of abuse or neglect was greater among Black children in Georgia. Among substantiated cases, the percentage of neglect cases was greater in younger children, and the percentage of abuse cases was greater in older children. Abuse and neglect are believed to be underreported for all ages, but are potentially a greater problem for younger children who have less exposure to possible reporters.

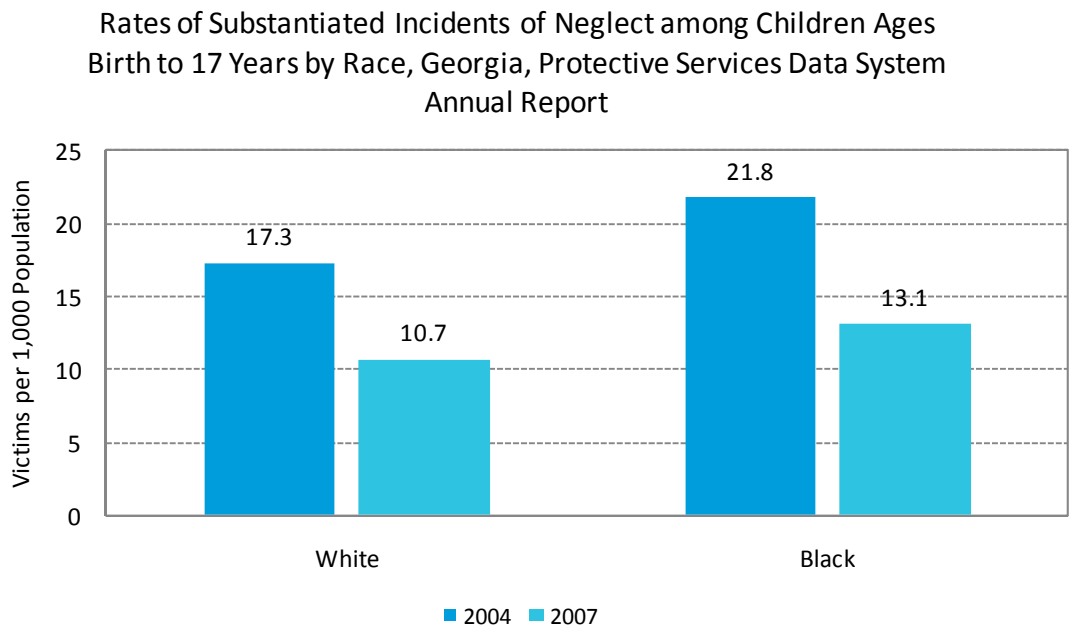
Note: Portions of the narrative in this section was taken from *Refocus*, a child health report prepared by the Georgia Children's Health Alliance.

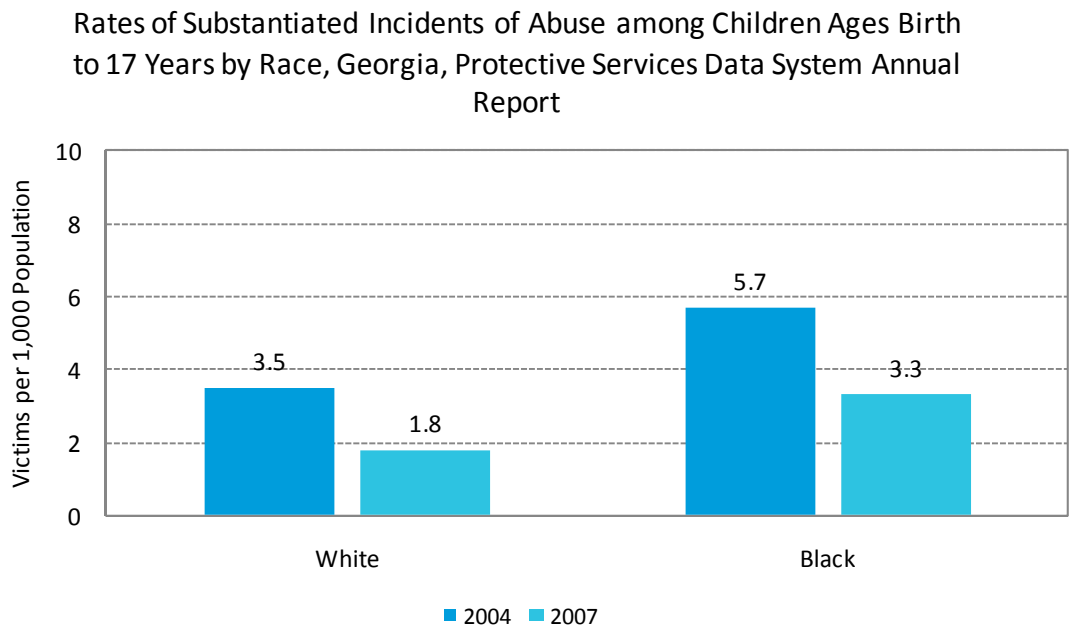
Substantiated Incidents of Abuse and Neglect among Children Ages Birth to 17 Years, Georgia, Protective Services Data System Annual Report

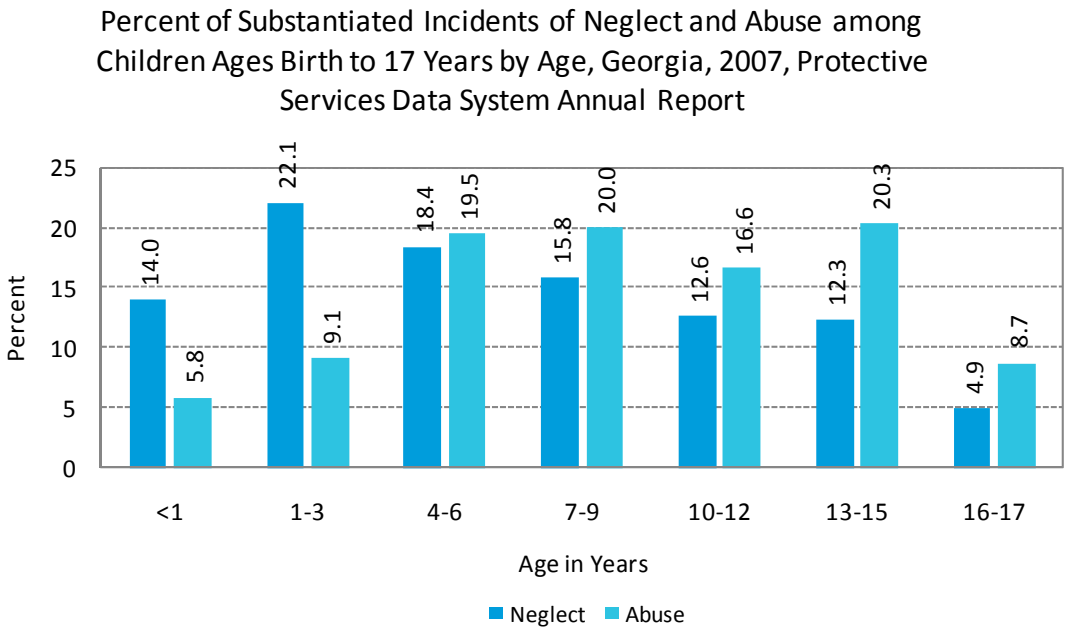


Substantiated Incidents of Abuse and Neglect among Children Ages Birth to 17 Years by Type of Abuse, Georgia, Protective Services Data System Annual Report




Rates of Substantiated Incidents of Neglect among Children Ages Birth to 17 Years by Race, Georgia, Protective Services Data System Annual Report
Victims per 1,000 Population
25
20
15
10
5
0
17.3
10.7
21.8
13.1
White
Black
2004
2007

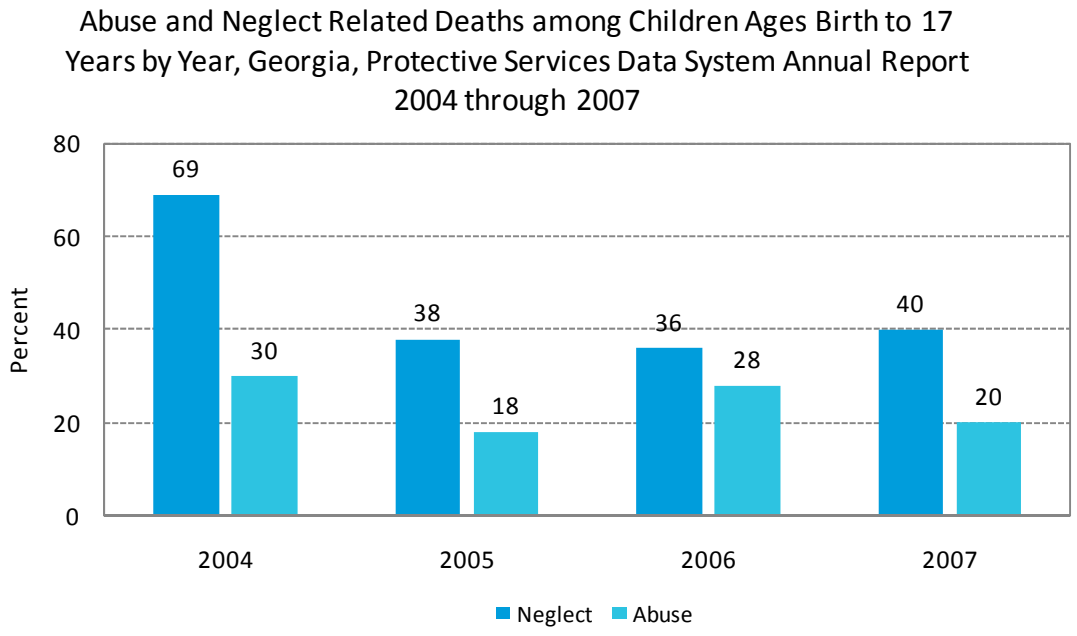

Rates of Substantiated Incidents of Abuse among Children Ages Birth to 17 Years by Race, Georgia, Protective Services Data System Annual Report
Victims per 1,000 Population
10
8
6
4
2
0
3.5
1.8
5.7
3.3
White
Black
2004
2007

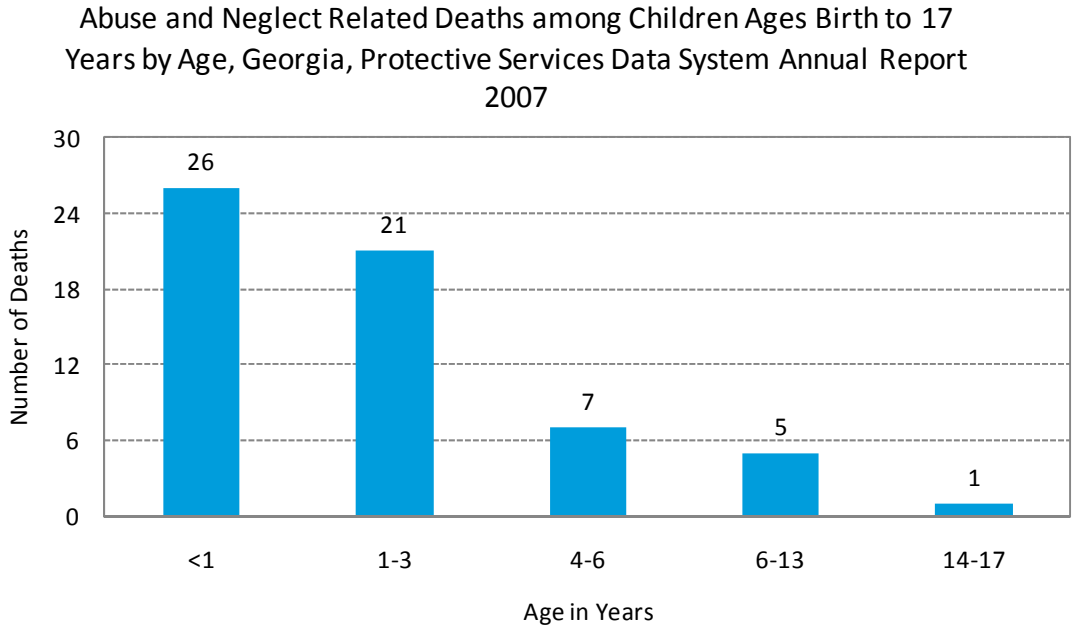


ABUSE AND NEGLECT MORTALITY

Between 2004 and 2007, there was an average of 60 deaths each year related to abuse and/or neglect. Deaths from neglect include those where a child was not adequately supervised and was injured, a child did not receive adequate nutrition, or a child's medical needs were not met. On average, neglect-related deaths outnumber abuse deaths by approximately two-to-one. While child abuse and neglect affect all age groups, children 3 years of age and younger were most likely to die from abuse or neglect.

Note: Portions of the narrative in this section was taken from *Refocus*, a child health report prepared by the Georgia Children's Health Alliance.

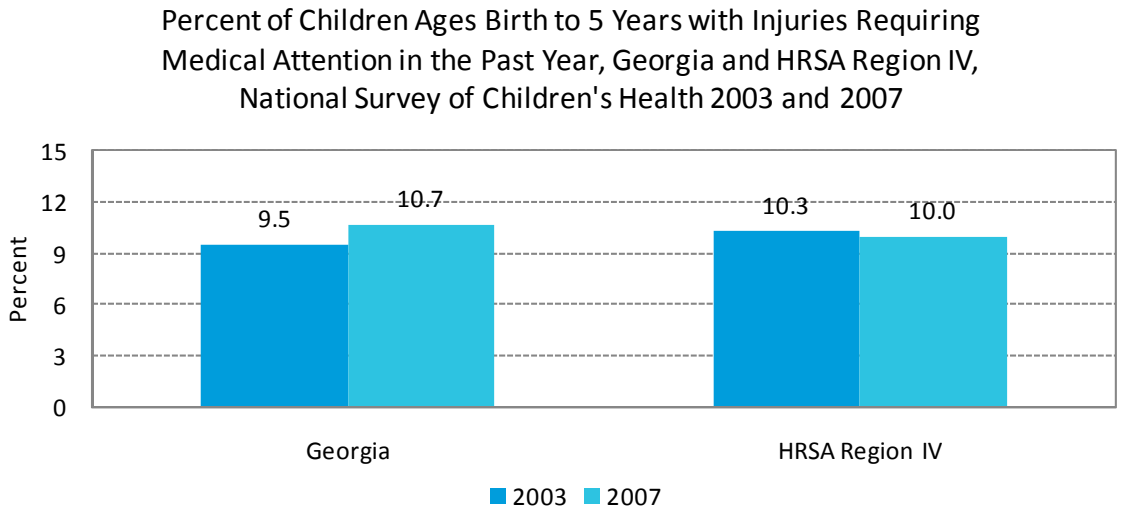


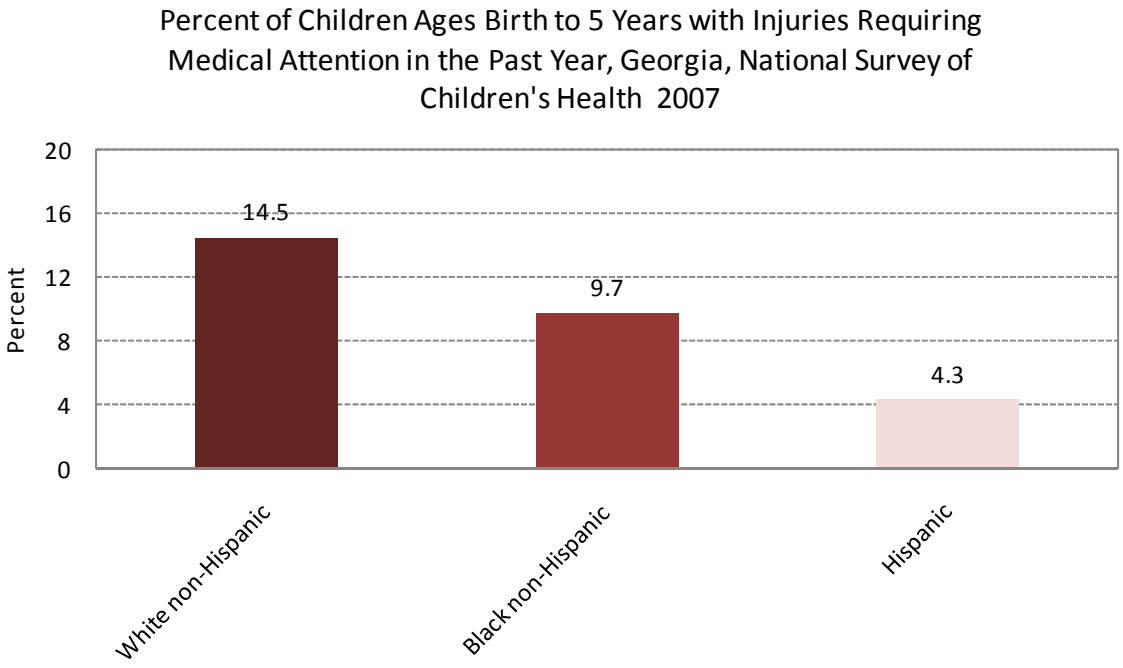


INJURIES REQUIRING MEDICAL ATTENTION

Approximately eleven percent of children birth to five years of age had an injury that required medical attention in 2007. This percent was slightly greater in 2007 than in 2003 and was comparable with states in HRSA Region IV. When stratifying by race/ethnicity, a greater percent of White children ages birth to 5 years reported experiencing an injury that required medical attention than did Black or Hispanic children in the same age group. While 4.3 percent of Hispanic children birth to 5 years of age reported having an injury that required medical attention, the lack of health insurance among this group

should be considered. This estimate may not reflect an absence of serious injury, but may reflect a lack of access to needed medical attention.

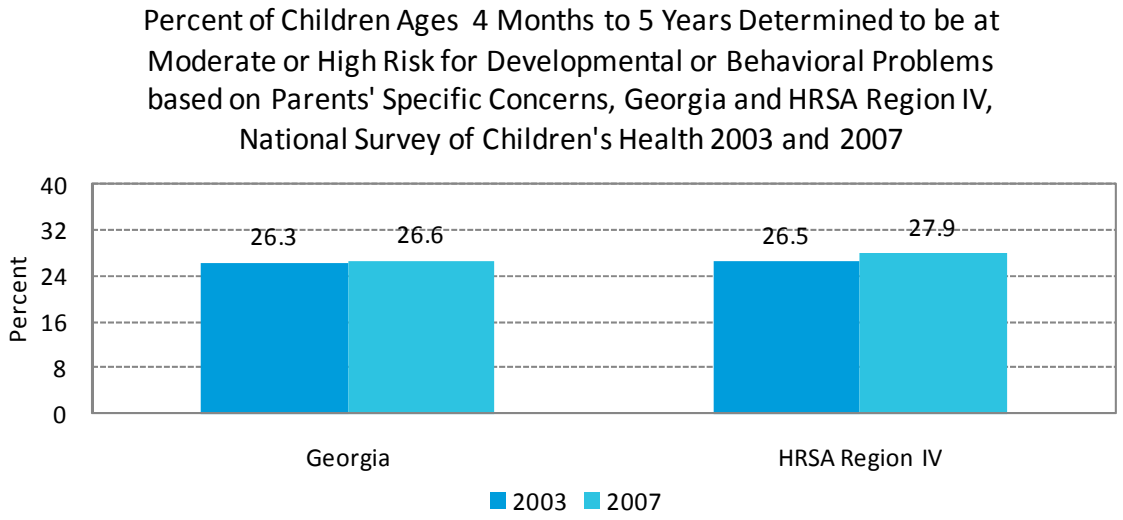


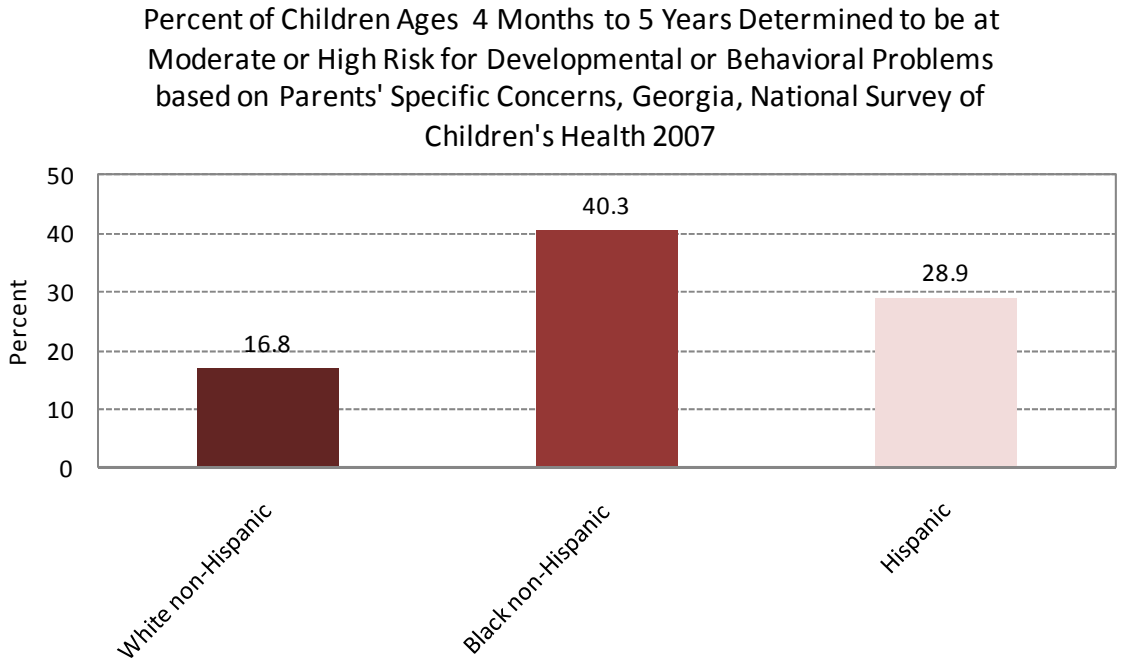


SOCIAL/EMOTIONAL DEVELOPMENT

RISK OF DEVELOPMENTAL OR BEHAVIORAL PROBLEMS

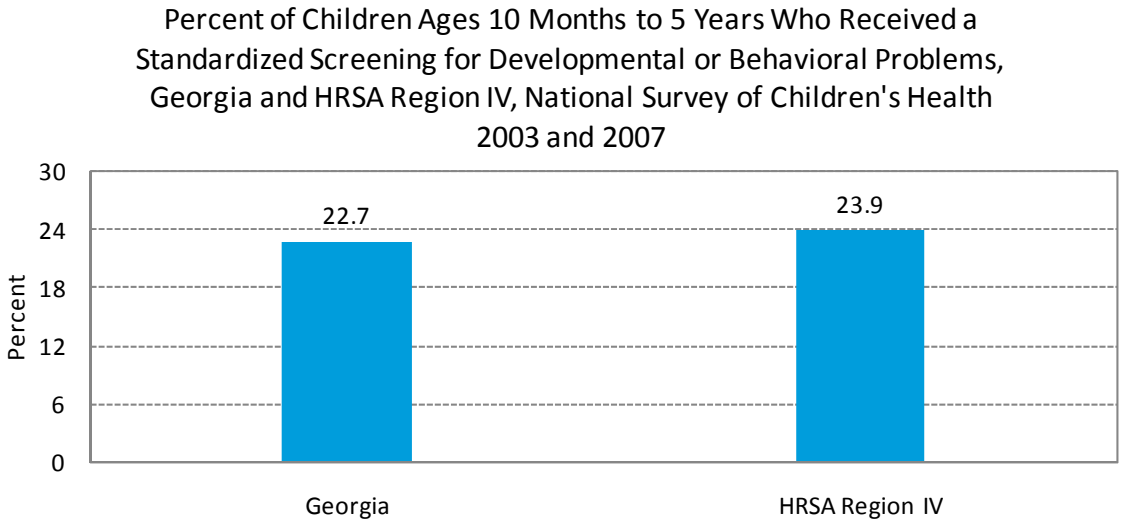
Approximately one quarter of children ages four months to five years were reported to be at moderate or high risk for developmental or behavioral problems. This percent was consistent between 2003 and 2007 and between Georgia and HRSA Region IV. The percent of children four months to five years of age were reported to be at moderate or high risk for developmental or behavioral problems was greater among Black children (40.3 percent) and Hispanic children (28.9 percent) than White children (16.8 percent).



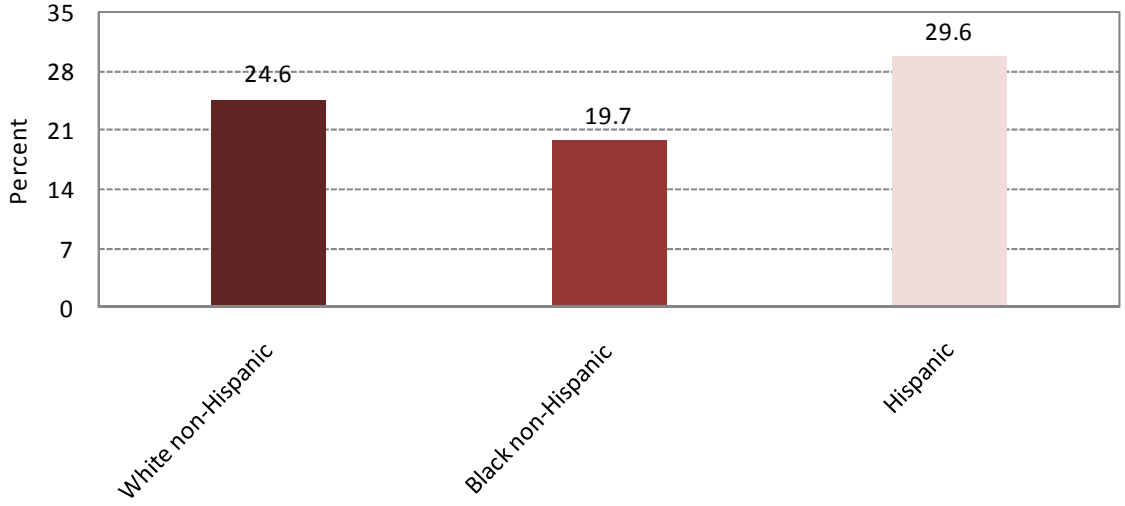


DEVELOPMENTAL SCREENING

The United States Department of Health and Human Services recommends developmental screening for all infants and young children as part of routine medical care. Key efforts include raising awareness and knowledge; improving developmental screening; changing systems to improve availability of early identification, diagnosis, and services; and monitoring the benefits, usage, and outcomes of early identification. Despite this recommendation, fewer than a quarter of Georgia children 10 months to 5 years of age reported receiving a standardized screening for developmental or behavioral problems. When stratifying by race/ethnicity, rates were greatest among Hispanic children, while less than one fifth of Black children received a standardized screening for developmental or behavioral problems.



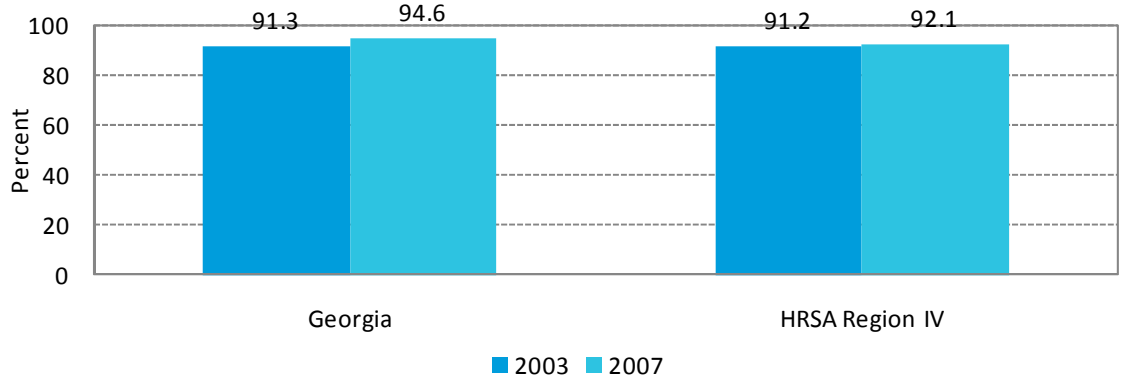
Percent of Children Ages 10 Months to 5 Years Who Received a Standardized Screening for Developmental or Behavioral Problems by Age and Race/Ethnicity, Georgia, National Survey of Children's Health 2007

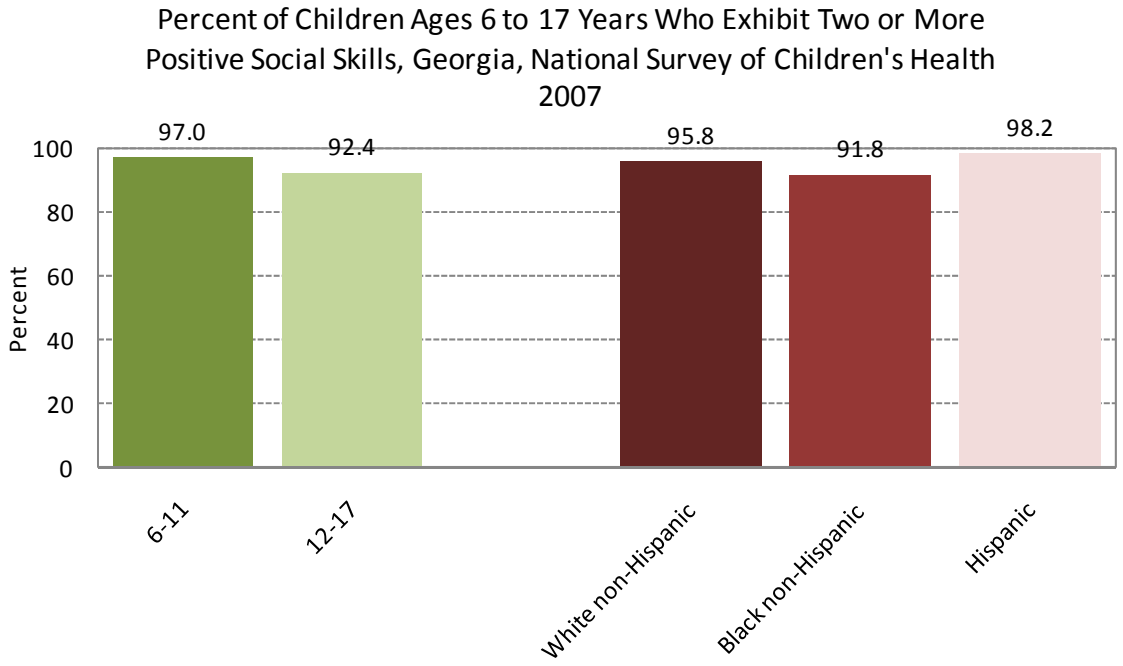


POSITIVE SOCIAL SKILLS

In Georgia in 2007, nearly 95 percent of children 6 to 17 years of age exhibited two or more positive social skills. This percent was greater than in 2003 and was greater than in HRSA Region IV in 2007. There is minimal variation by age and race/ethnicity with all groups exceeding 90 percent.

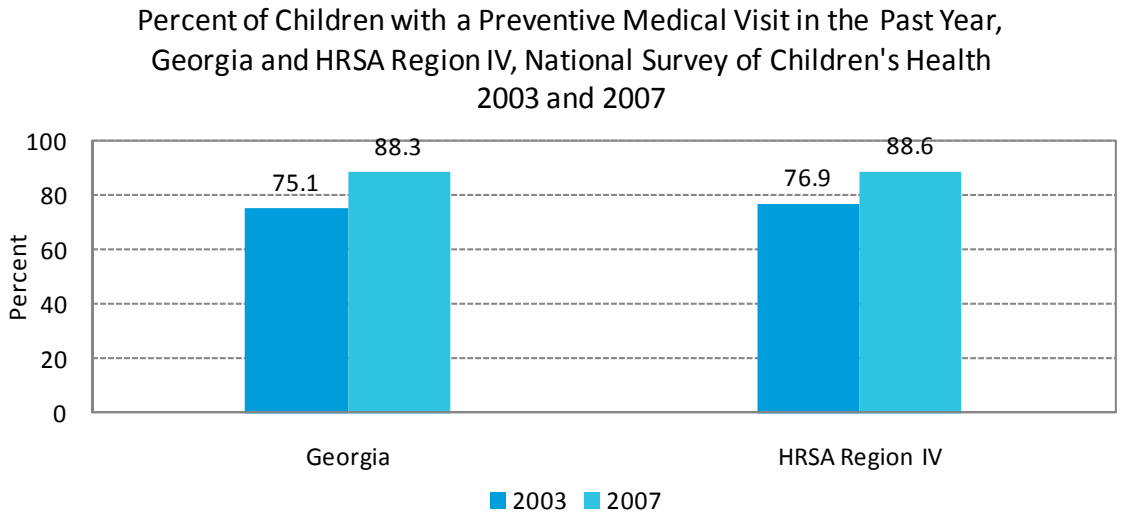
Percent of Children Ages 6 to 17 Years Who Exhibit Two or More Positive Social Skills, Georgia and HRSA Region IV, National Survey of Children's Health 2003 and 2007

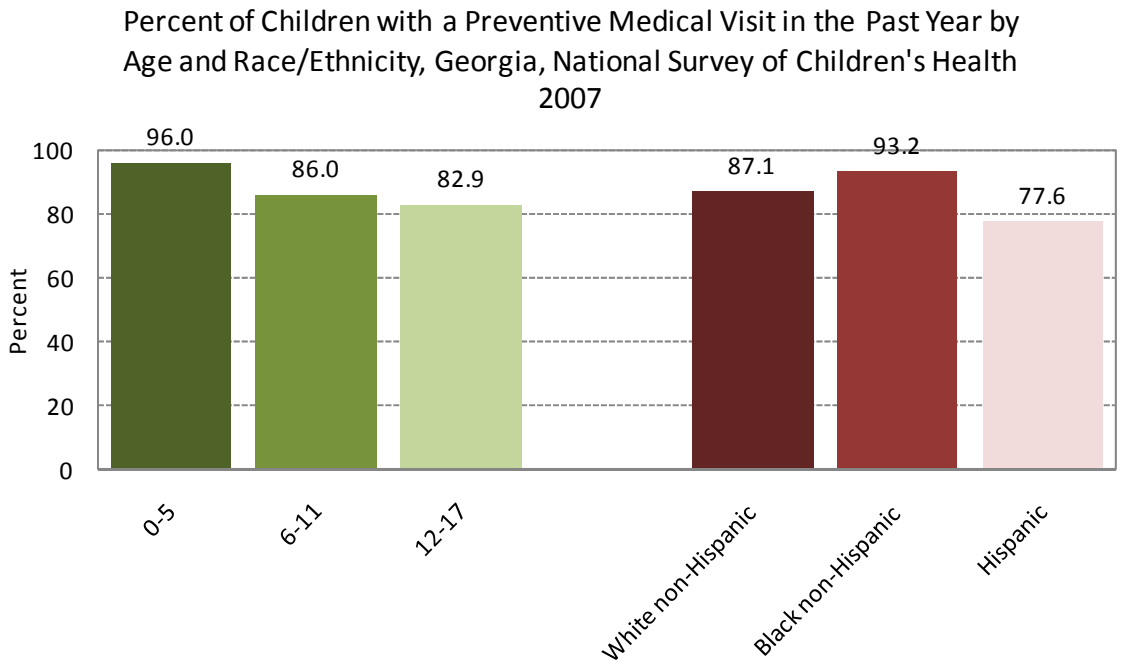




PREVENTIVE MEDICAL VISIT

The percent of children birth to 17 years of age who had a preventive medical visit increased between 2003 and 2007 in Georgia and in HRSA Region IV. In 2007, the percent of children birth to 17 years of age who had a preventive medical visit in Georgia was similar to that for HRSA Region IV. In Georgia, age was negatively associated with having had a preventive medical visit. While 96 percent of children ages birth to five years reported having had a preventive medical visit, this percent decreased by 10.4 percent among children 6 to 11 years of age and 13.7 percent among children 12 to 17 years of age. More than 90 percent of Black children reported having had a preventive medical visit compared to less than 80 percent among Hispanic children.



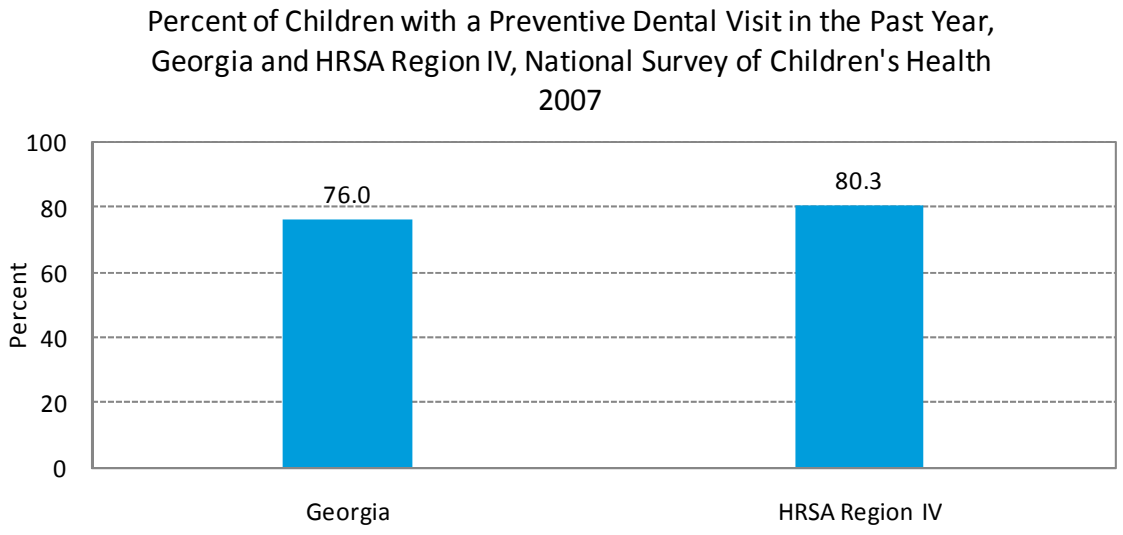


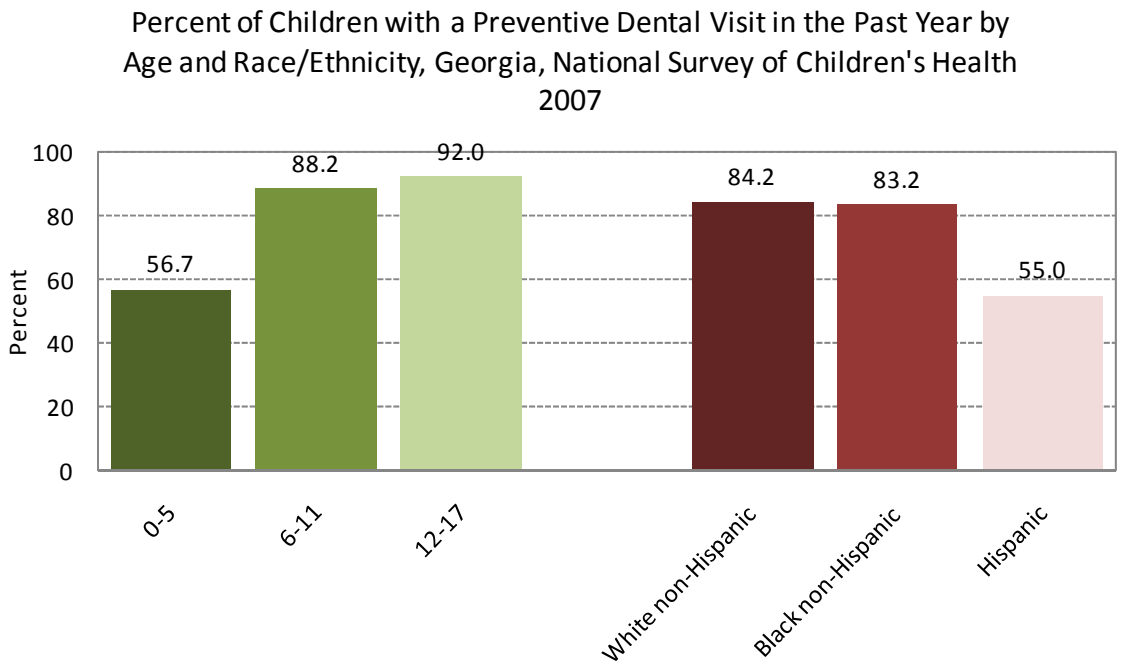
PREVENTIVE DENTAL VISIT

Three quarters of children birth to 17 years of age in Georgia reported having a preventive dental visit in the twelve months prior to completing the survey. This was four percentage points lower than the percent in HRSA Region IV. Fewer than 60 percent of children birth to 5 years of age reported having a preventive dental visit in the twelve months prior to completing the survey.

The percent of children birth to 5 years of age who had a preventive dental visit was more than 30 percentage points lower than the percent who had a preventive dental visit among children 6 to 11 years of age and 12 to 17 years of age. Given that pediatricians should be monitoring the oral health of young children and 96 percent of children ages birth to 5 years of age received preventive medical visits, the low rate of dental preventive visits may be due to respondents not recognizing the oral examination as part of the preventive medical visit or pediatricians may not be conducting this part of the examination.

The percent of Hispanic children who reported having had a preventive dental visit was 55 percent, which was 30 percentage points lower than the percent among White and Black children.





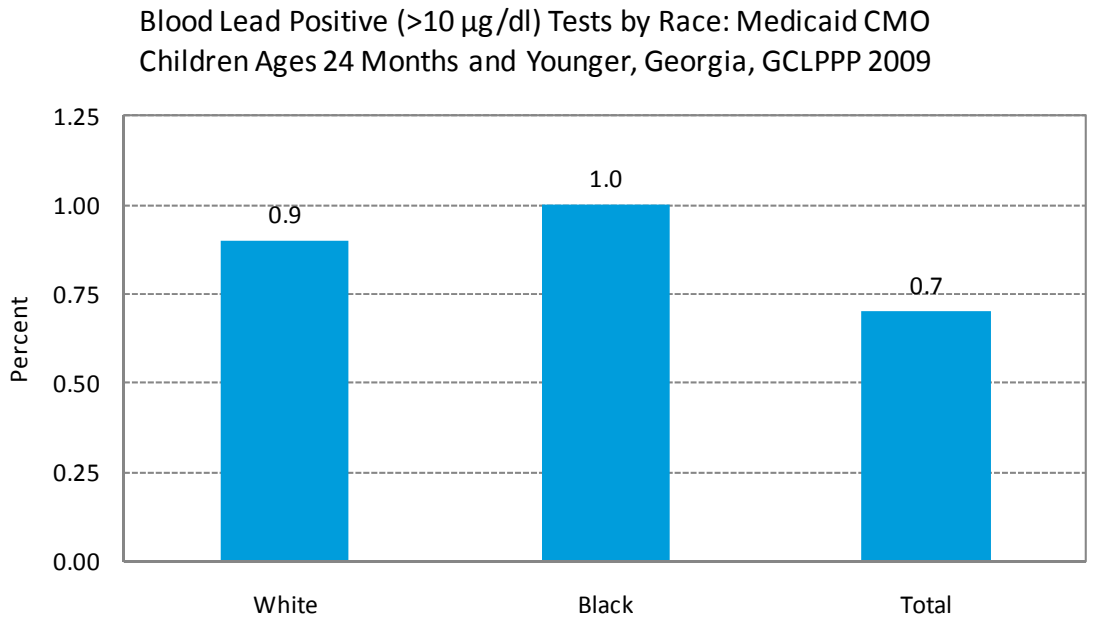
CHILDHOOD LEAD POISONING

While lead can be harmful to anyone, children under the age of 6 are at the greatest risk of being harmed by lead. Their bodies easily absorb lead, which can be harmful for the developing brain and other organs and systems. No amount of lead in a child's body is good, but blood lead levels greater than 10 micrograms per deciliter (µg/dL) require further evaluation. Consequences of lead poisoning include coma, convulsions, mental retardation, seizures, or death. Recent studies have also suggested an association between blood lead level and Attention Deficit Hyperactivity Disorder. Federal Medicaid regulations require that all children enrolled in Medicaid must receive a blood lead screening test at

ages 12 and 24 months. All children ages 36 to 72 months who have not previously been screened must also receive a blood lead test.

The Georgia Department of Community Health partners with private care management organizations (CMOs) to deliver health care services to Medicaid members. Out of a total of 37,033 tests in 2009, there were 257 reported blood lead tests with a blood lead level greater than 10 µg/dL. Of the tests with race identified in the report, Black children were slightly more likely than White children to have an elevated blood lead level. As of February, 2010 the Georgia Childhood Lead Poisoning Prevention Program reported there were 118,000 Medicaid CMO children under 2 years of age. The 37,000 children tested in 2009 indicated that only about one third of the eligible children were tested. Under-reporting of test results was possible.

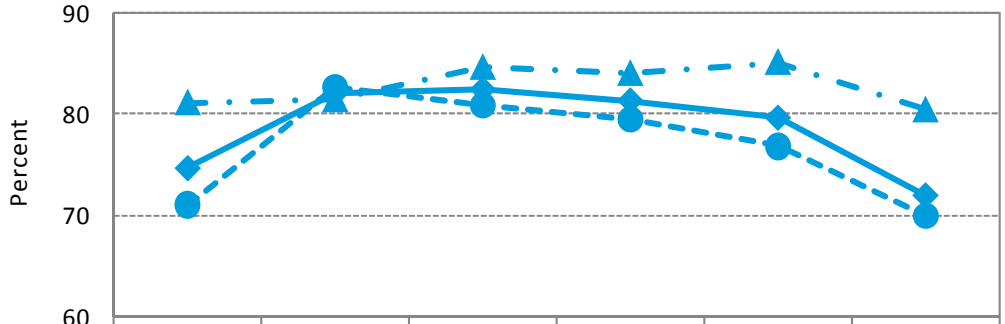
Note: Portions of the narrative in this section was taken from *Refocus*, a child health report prepared by the Georgia Children's Health Alliance.



CHILDHOOD IMMUNIZATIONS

Between 2004 and 2006, immunization coverage among children 19 to 35 months of age in Georgia exceeded 80 percent. However, by 2008, immunization coverage declined to 71.9 percent. Stratifying by participation in WIC revealed that WIC participants had a greater decline than did the non-WIC population. In 2008, immunization coverage among WIC participants declined to less than 70 percent. For each of the previous four years, the immunization coverage declined among WIC participants.

Estimated Vaccine Coverage, 4:3:1:3:3:1 Series, among Children Ages 19 to 35 Months, Georgia, National Immunization Survey 2003 through 2008

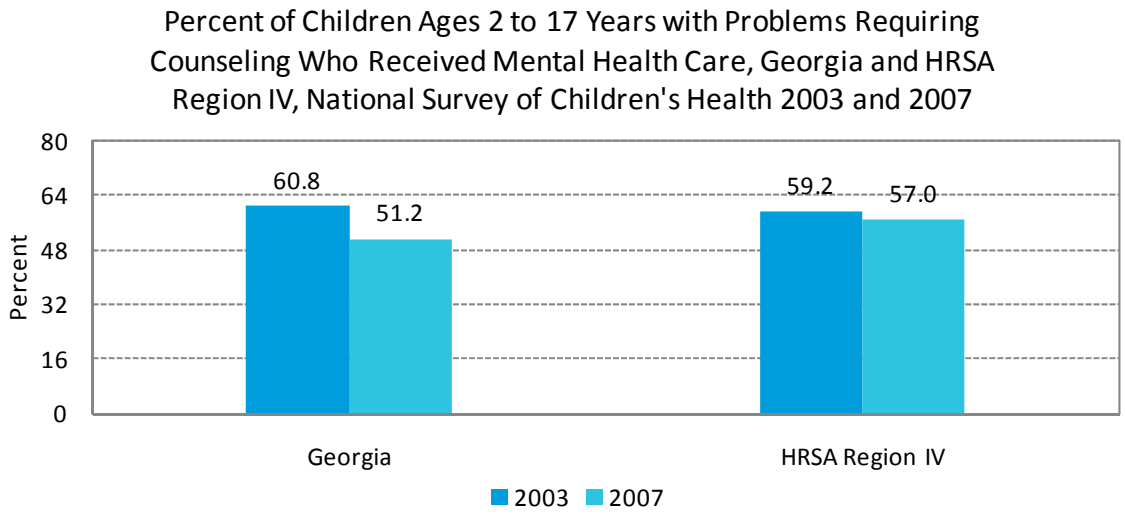


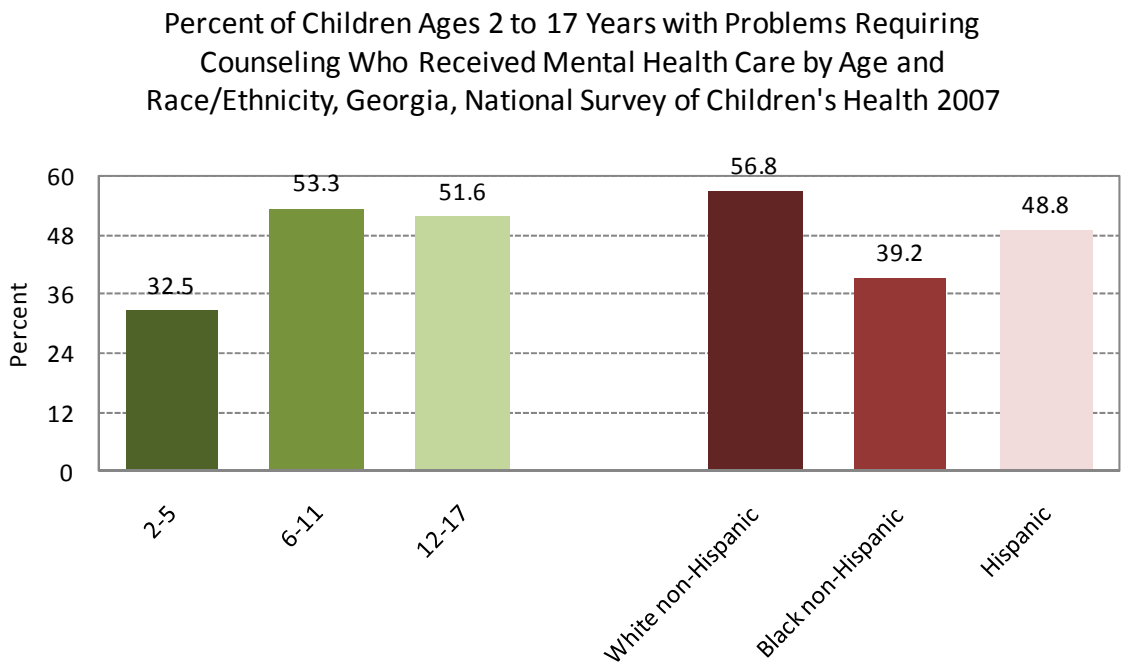
	2003	2004	2005	2006	2007	2008
Total	74.6	82.0	82.4	81.3	79.6	71.9
WIC	71.0	82.7	80.9	79.5	76.8	69.9
Non-WIC	81.1	81.4	84.6	84.0	85.1	80.4

Note: T he 4:3:1:3:3:1 series consists of 4 doses (or more) of diphtheria, tetanus toxoids, and pertussis (DTP) vaccines,diphtheria and tetanus toxoids (DT), or diphtheria, tetanus toxoids, and any acellular pertussis (DTaP) vaccines; 3 doses (or more) of poliovirus vaccines; 1 dose (or more) of any measles-containing vaccine; 3 doses (or more) of Haemophilus influenzae type b (Hib) vaccines; and 3 doses (or more) of hepatitis B vaccines and 1 or more doses of the varicella vaccine. This series of vaccines is typically completed by age 2.

AVAILABILITY AND ACCESS TO MENTAL HEALTH SERVICES

Mental health access declined in Georgia and in HRSA Region IV. The decline was greater in Georgia. In HRSA Region IV, the percent of children 2 to 17 years of age with problems requiring counseling who received mental health care declined 3.7 percent. This decline was 15.8 percent in Georgia. Less than one third of children 2 to 5 years of age with problems that require counseling received mental health care. The percent of Black children 2 to 17 years of age with problems that require counseling who received mental health care was 31.0 percent lower than the percent among White children.



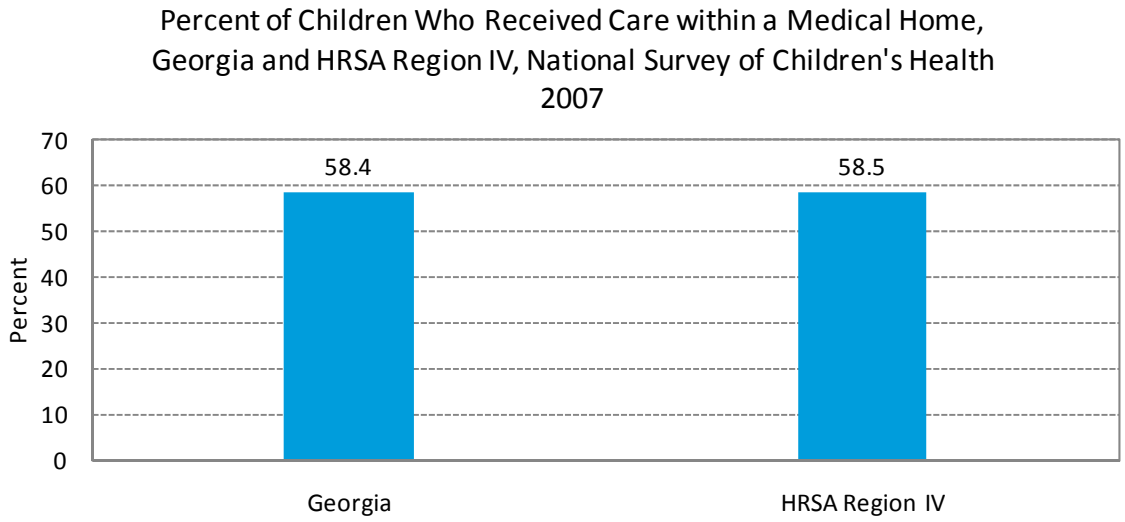


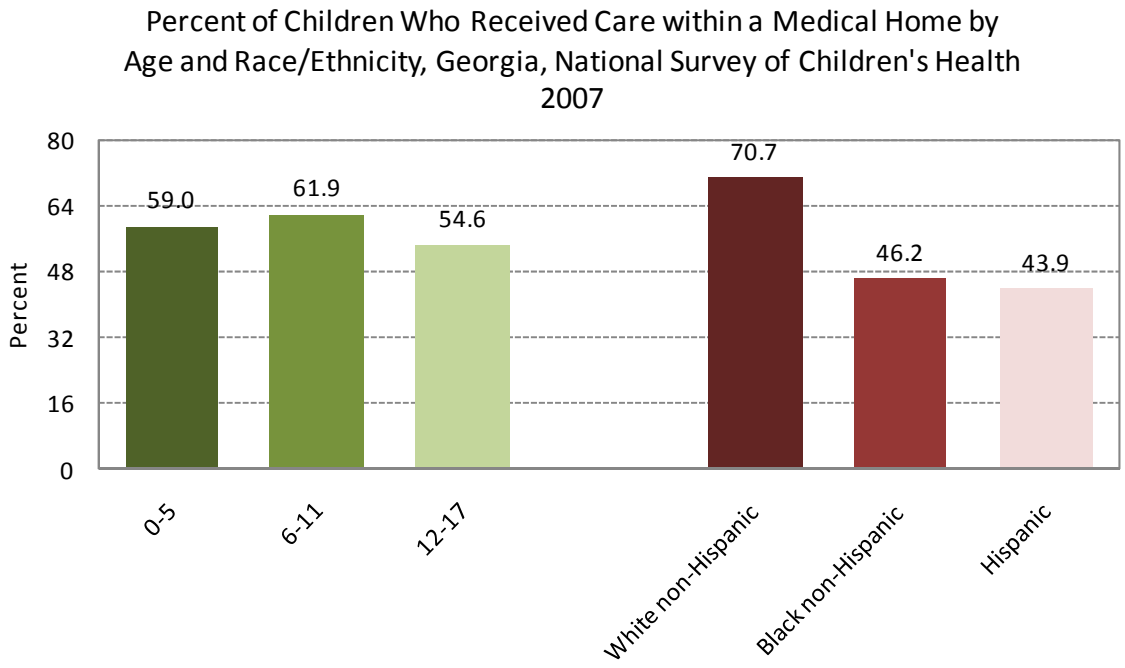
RECEIVING CARE IN A MEDICAL HOME

All children should receive medical care through a medical home. However, in Georgia and HRSA Region IV, about 58 percent of children received care that met the American Academy of Pediatrics' (AAP) definition of a medical home. Medical home refers to medical care for infants, children, and adolescents that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective. The medical home concept was first proposed by the AAP in a 1992 policy statement which was updated in 2002. The AAP definition of medical home emphasizes that a medical home is "not a building, house, or hospital, but rather an approach to providing continuous and

comprehensive primary pediatric care from infancy through young adulthood, with availability 24 hours a day, seven days a week, from a pediatrician or physician whom families trust."

In Georgia, there was a significant racial/ethnic disparity in the percent of children who received care that met the American Academy of Pediatrics' definition of a medical home. The percent among White children exceeded 70 percent, which was 53.0 percent greater than the percent who received care that met the American Academy of Pediatrics' definition of a medical home among Black children and 61.0 percent greater than the percent who received care that met the American Academy of Pediatrics' definition of a medical home among Hispanic children. In each of these groups, the percent of children who received care that met the American Academy of Pediatrics' definition of a medical home did not exceed 50 percent.

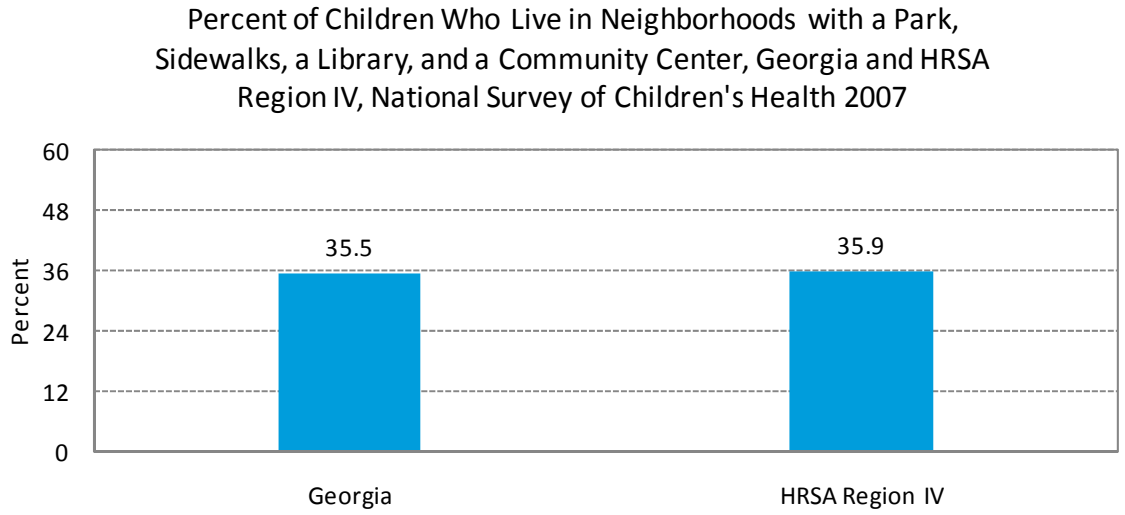


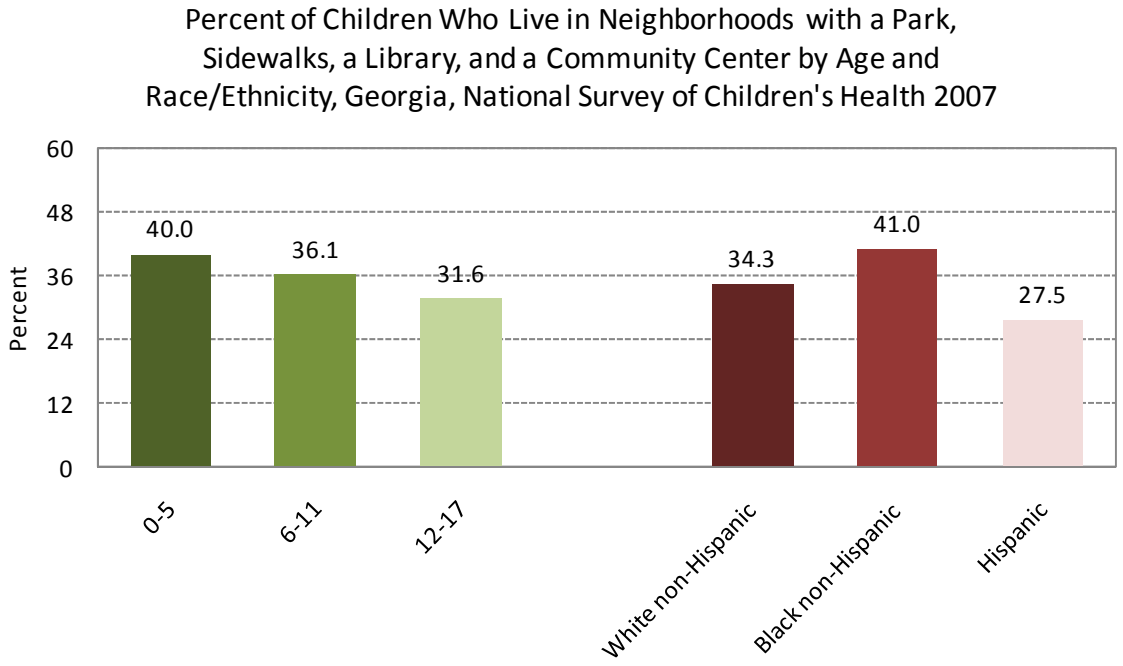


CHILD HEALTH AND THE BUILT ENVIRONMENT

COMMUNITY AMMENITIES

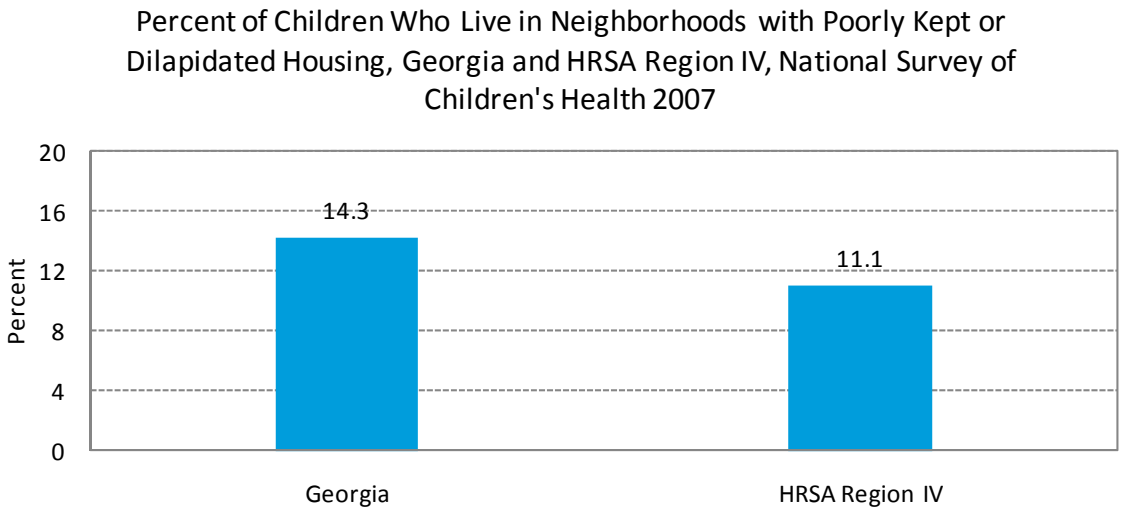
The percent of children who live in neighborhoods with a park, sidewalks, a library, and a community center was comparable between Georgia and HRSA Region IV. In Georgia, a lesser percentage of children 12 to 17 years of age reported living in neighborhoods with a park, sidewalks, a library, and a community center compared to younger children. A greater percent of Black children compared to White and Hispanic children reported living in neighborhoods with a park, sidewalks, a library, and a community center.

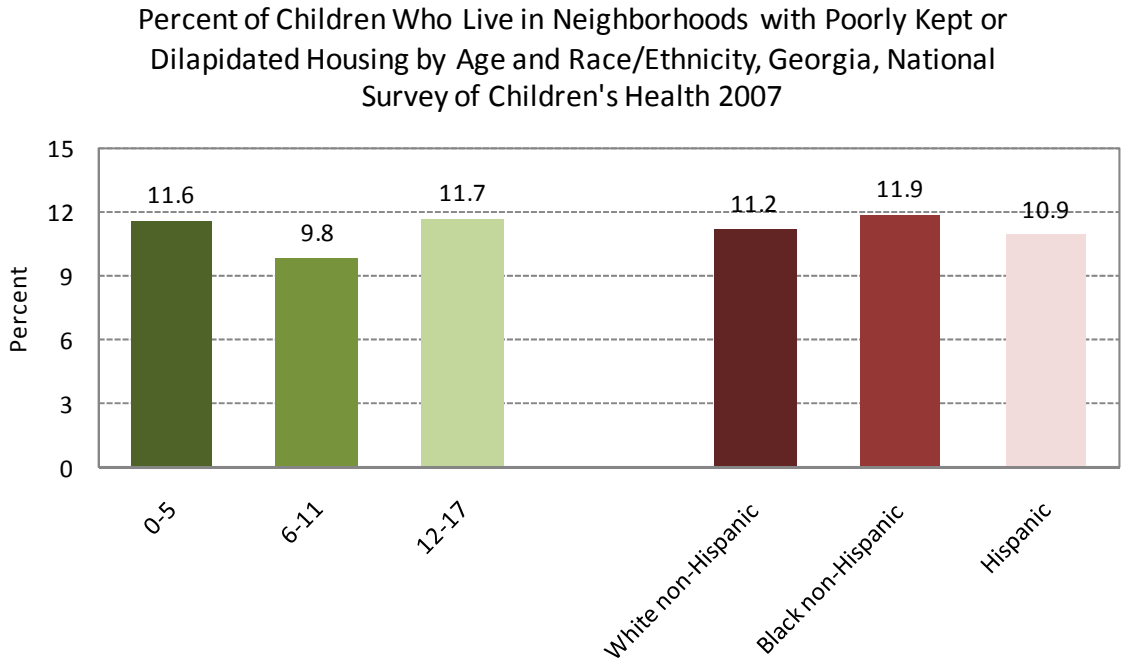




CHILDREN LIVING IN POOR OR DILAPIDATED HOUSING

The percent of children living in poor or dilapidated housing was greater in Georgia compared to HRSA Region IV. There was minimal variation in this indicator by age and race/ethnicity.

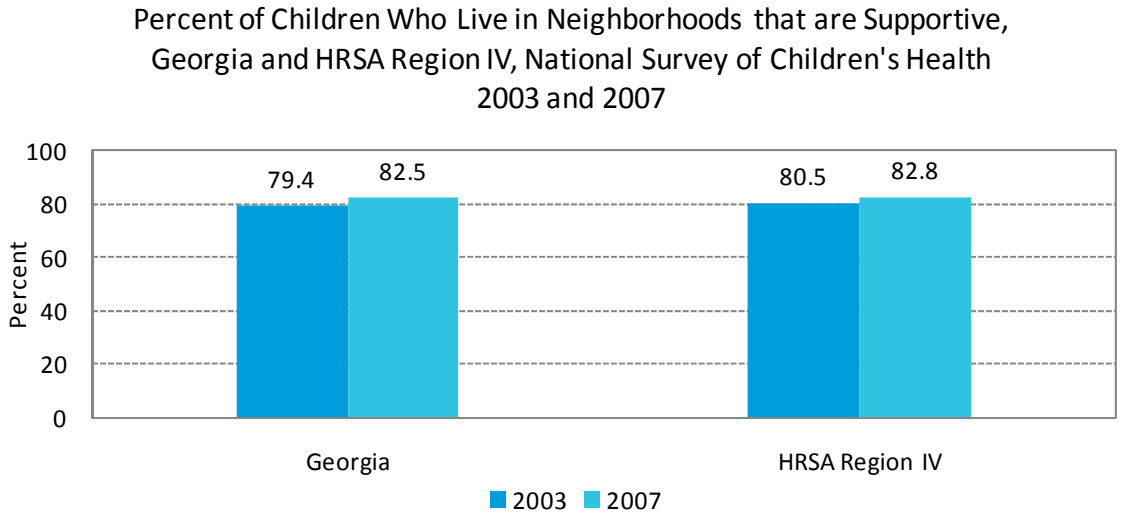


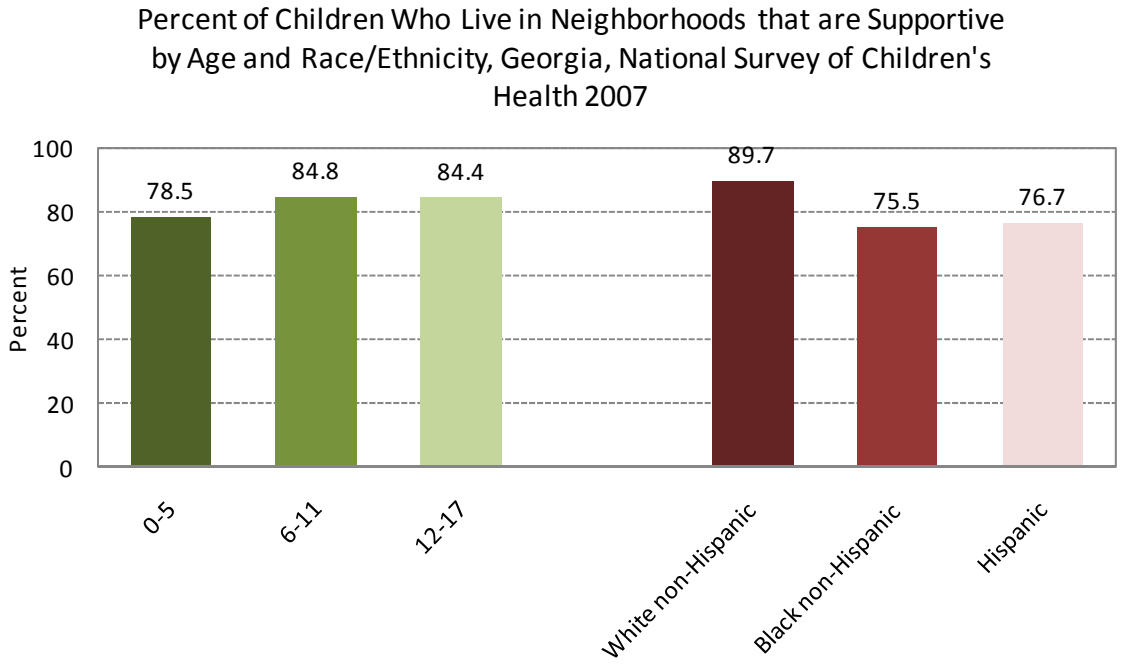


SUPPORTIVE NEIGHBORHOODS

Living in supportive neighborhoods was a measure of social capital that used four questions asked of all respondents: (1) whether people in the neighborhood help each other out, (2) whether people in the neighborhood look out for each others' children, (3) whether parents can count on people in their neighborhood, and (4) whether there are adults nearby that parents trust to help if their children get hurt or scared. Valid responses on at least three of these questions were required for scoring. Responses to the questions were assigned values and an average calculated for eligible cases. Children were grouped according to whether their mean score was above or below a threshold indicating no more than one response of "somewhat disagree" or "definitely disagree."

The percent of children who live in neighborhoods that were supportive was similar between Georgia and HRSA Region IV, and there has been limited variation between 2003 and 2007. While three quarters of Black and Hispanic children reported living in supportive neighborhoods, with nearly 90 percent of White children living in supportive neighborhoods, a racial disparity was present.

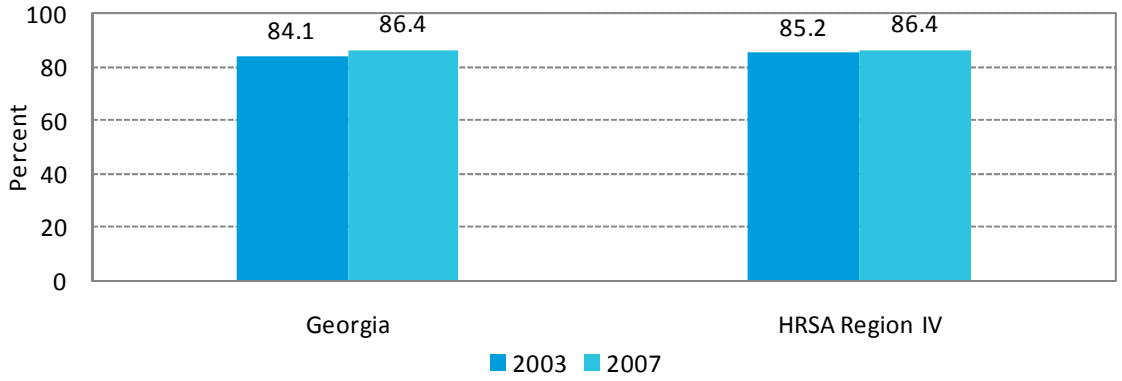




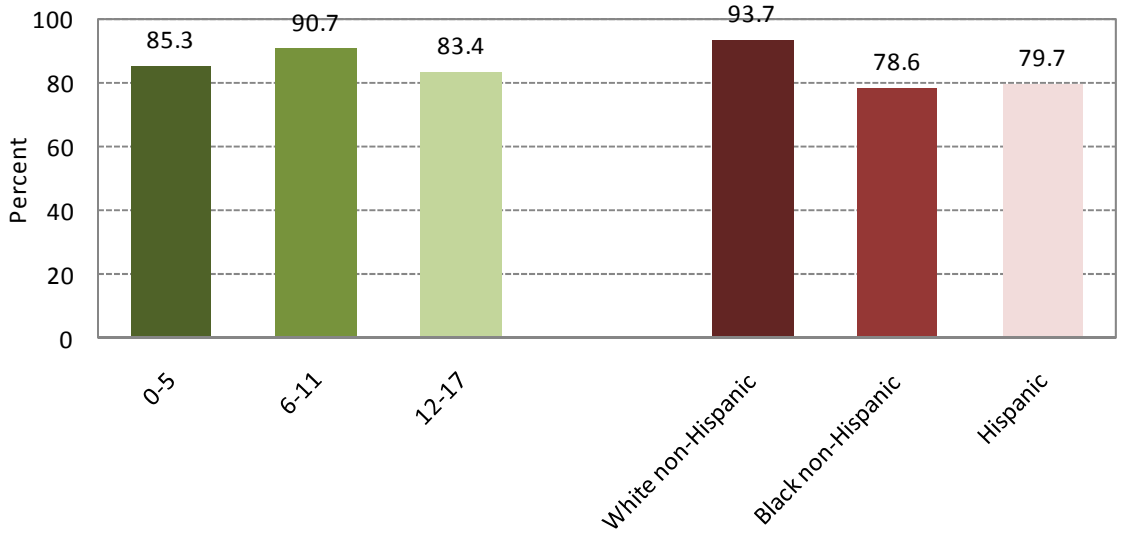
NEIGHBORHOOD SAFETY

The percent of children who live in neighborhoods that were usually or always safe was similar between Georgia and HRSA Region IV. There was limited variation between 2003 and 2007. While three quarters of Black and Hispanic children report living in neighborhoods that were usually or always safe, the percent of White children who live in neighborhoods that are usually or always safe was greater than 90 percent.

Percent of Children Who Live in Neighborhoods that are Usually or Always Safe, Georgia and HRSA Region IV, National Survey of Children's Health 2003 and 2007



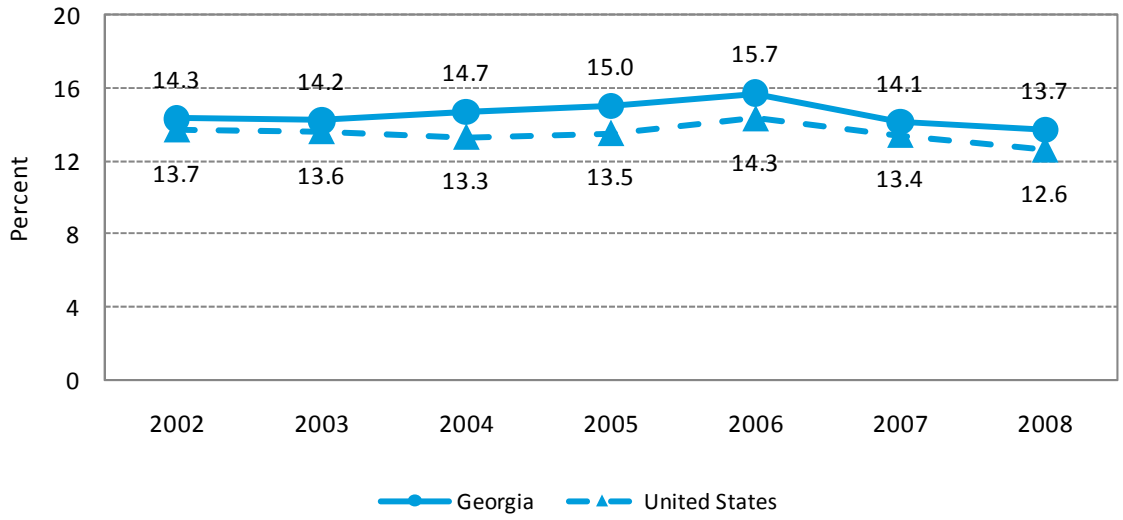
Percent of Children Who Live in Neighborhoods that are Usually or Always Safe by Age and Race/Ethnicity, Georgia, National Survey of Children's Health 2007



ESTIMATES FROM THE CURRENT POPULATION SURVEY

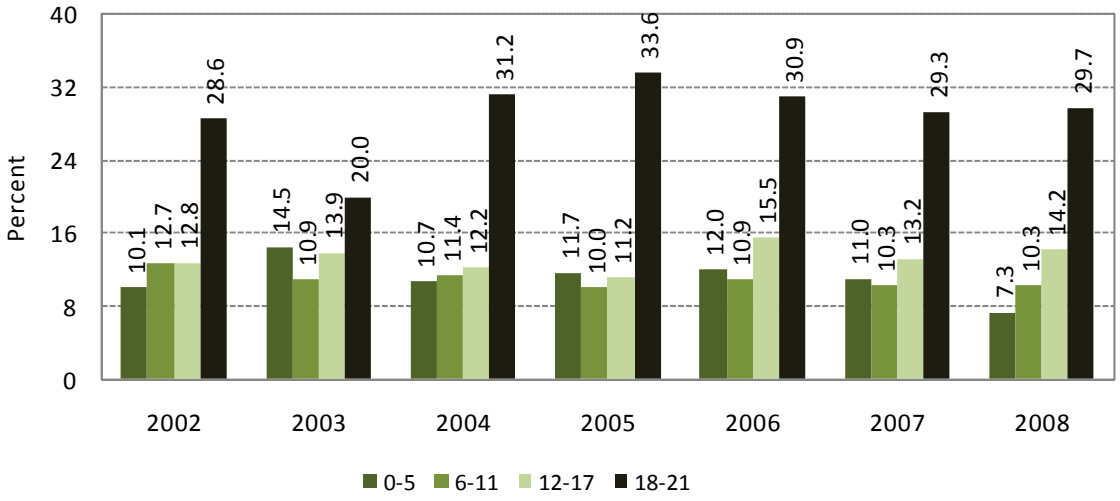
Georgia has had a consistently greater percent of uninsured children than the United States as a whole. Patterns in Georgia over time have been similar to those throughout the United States. Among all children birth through 21 years of age, children 18 to 21 years of age were the most likely to be uninsured with rates often double that of the next youngest age group. A greater percent of White children in Georgia were uninsured compared to the United States, but the opposite was true for Black children. The percent of Hispanic children in Georgia without health insurance was 36.4 percent greater than Hispanic children throughout the United States. Within Georgia, the percent of Hispanic children without health insurance was more than double the percent of White and Black children without health insurance.

Percent of Children Ages 0 through 21 Years without Health Insurance Coverage, Georgia and the United States, Current Population Survey - Annual Social and Economic Supplement 2002 through 2008



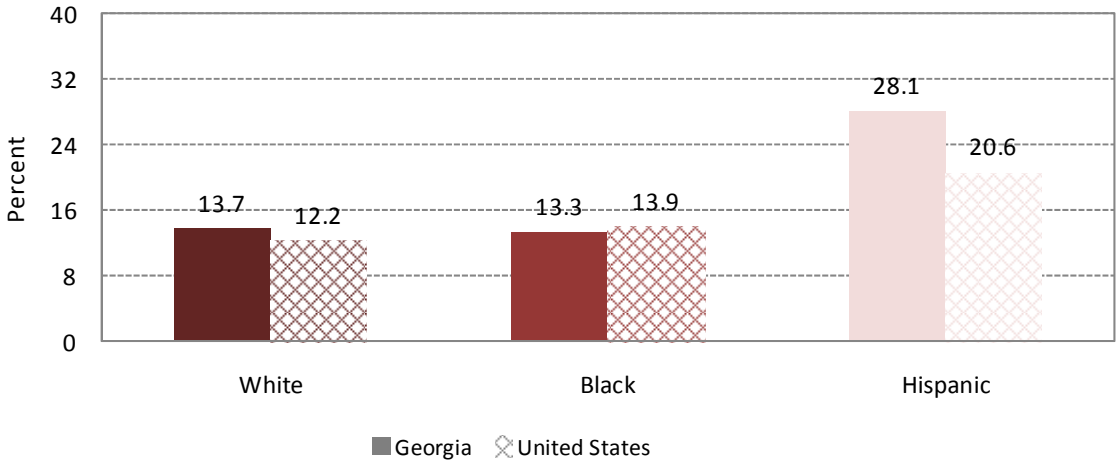
Note: Survey is from year following the estimate. For example, the 2004 estimate is from the 2005 survey.

Percent of Children Ages 0 through 21 Years without Health Insurance Coverage by Age Group, Georgia, Current Population Survey - Annual Social and Economic Supplement 2002 through 2008



Note: Survey is from year following the estimate. For example, the 2004 estimate is from the 2005 survey.

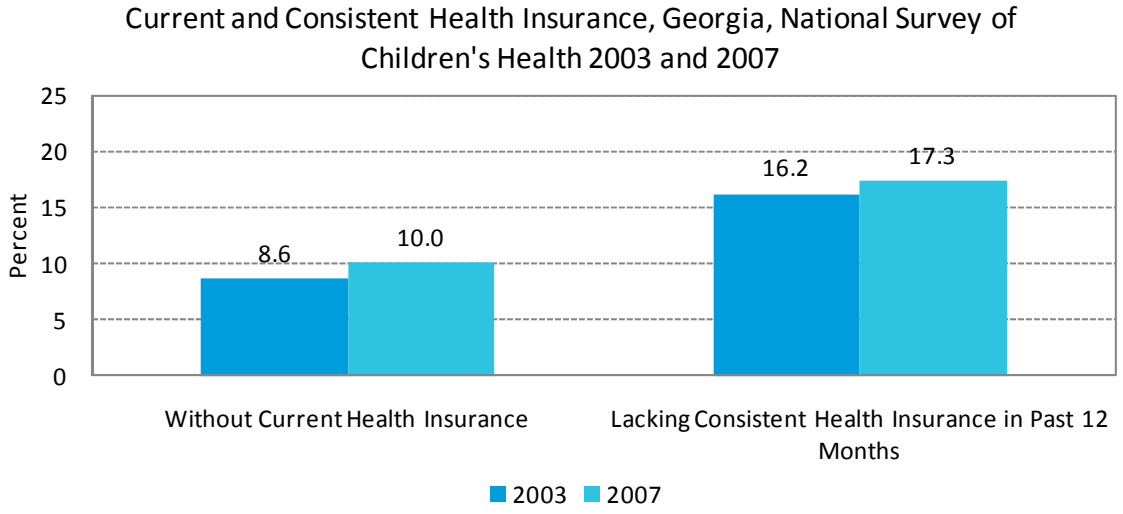
Percent of Children Ages 0 through 21 Years without Health Insurance Coverage by Race/Ethnicity, Georgia, Current Population Survey - Annual Social and Economic Supplement 2008

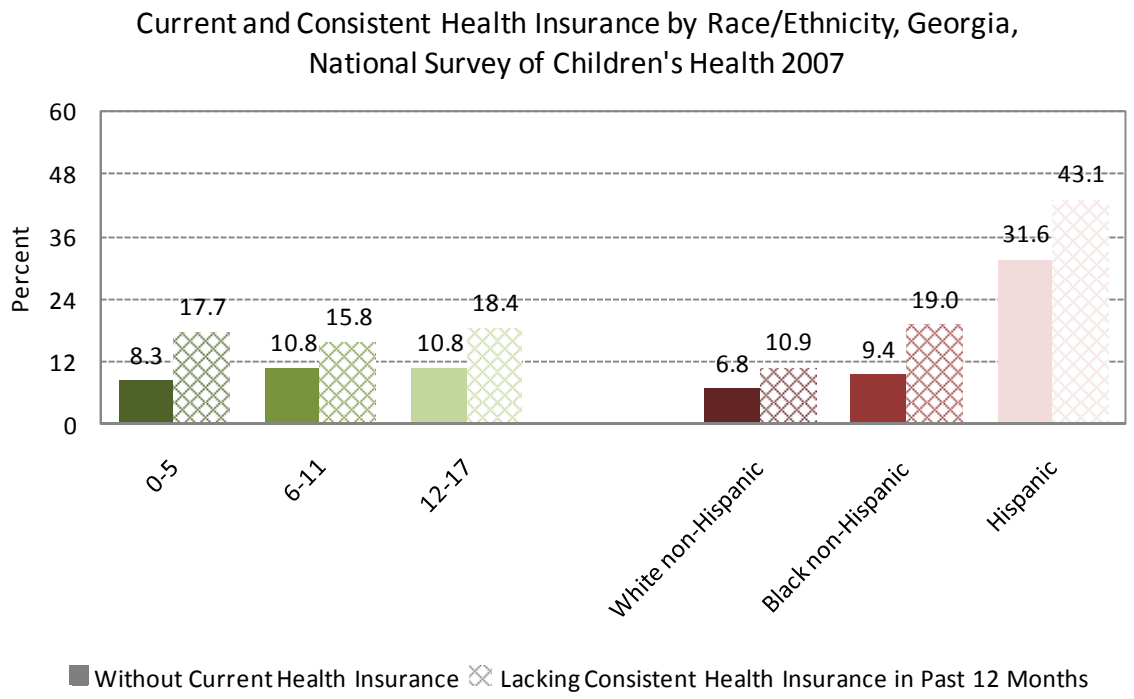


Note: Survey is from year following the estimate. For example, the 2004 estimate is from the 2005 survey.
Note: Race and ethnicity are not mutually exclusive as presented in this chart.

ESTIMATES FROM THE NATIONAL SURVEY OF CHILDREN'S HEALTH

Estimates of the percent of children without health insurance provided by the National Survey of Children's Health (2007) were comparable to the Current Population Survey estimates for 2007. The percent of children currently with health insurance is a measure that provides a snapshot of a particular instance in time and does not measure consistency of health insurance coverage. For most groups, the percent who lacked health insurance at any point during the twelve months prior to the survey was significantly greater than the percent that currently did not have health insurance. For children birth to 5 years of age, the percent of children who lacked health insurance at some point during the twelve months prior to the survey was more than double the percent of children currently uninsured. A similar relationship was found among Black children. Among Hispanic children, 43.1 percent lacked health insurance at some point during in the twelve months prior to the survey, which was 36.4 percent greater than the percent of children currently uninsured.





QUALITATIVE THEMES FOR CHILDREN FROM STATEWIDE FOCUS GROUPS

The qualitative data section is organized by theme. These themes were identified through analysis of the data collected through the focus groups. There is standard information provided for each theme that includes sections on *Quantification*, *Description of the Health Concern*, and *Ideas about What is Needed to Improve* the identified need.

The *Quantification* section provides information about the frequency with which the theme was identified.

After reviewing the notes collected during the focus groups, themes were identified by analysts based on the information recorded as part of the focus groups. The *Description of the Health Concern* section provides quotes and ideas communicated by focus group participants that were used in defining the theme. As frequently as possible, direct quotes from focus group participants are used.

The *Ideas about What is Needed to Improve* the identified need section captures focus group participant ideas about possible strategies and solutions to improve that theme.

In limited instances, along with the identified themes, a section has been included labeled *Other Health Concerns*. This section includes a list of health care concerns among a specific population that were not mentioned with adequate frequency to be considered a theme, but were important to document.

NUTRITION

QUANTIFICATION

Nutrition is identified as a major health concern for children by three of nine MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System (ECCS), and five of nine roundtables of stakeholders at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Stakeholders are concerned about children's diets and propose nutrition as a priority for Georgia in the upcoming years. "Lack of proper diets lead to health issues later on." "Kids are not getting enough food. Infants through high school age are not getting enough food."

Concerns about children's nutrition are sometimes attributed to "lack of understanding about healthy food choices and appropriate portion sizes." Pre-adolescent and adolescent lifestyles often include unhealthy eating along with other problematic behaviors such as smoking, drinking and lack of physical exercise.

Too, there is a "lack of ongoing education campaigns to promote nutrition and safety and to prevent smoking, alcohol and substance abuse (i.e. healthy lifestyle)."

Several specific concerns around nutritional services were forwarded by stakeholders.

- "Health Check recipients may not be keeping high risk nutritionist appointments;" and
- "Medicaid reimbursement for nutrition services for children" is inadequate.

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN'S HEALTH

Stakeholders of MCH services forward various ideas about what could improve the physical and mental health of children. Suggestions around nutrition follow.

- Improve health/wellness services;
- "The importance of a healthy lifestyle should be communicated, emphasizing importance of physical activity;"
- "We need a public education campaign on nutrition, emphasizing the importance of exercise, and health care…Unfortunately; we have lost the public education component as a result of budget cuts;"
- Enhance educational policies including a wellness program;
- "Provide disease and risk reduction health education including alcohol, drug, HIV, obesity, nutrition, physical fitness;" and
- "We are a fast food society. We know that fast food is not as healthy as home-cooked meals. We need to look at strategies to reduce behaviors, such as taxing fast food. Nutrition education is only good if client actually changes their behavior."

ACCESS TO HEALTH CARE

QUANTIFICATION

Access to health care is identified as a major health concern for children by five of nine MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System (ECCS), and three of nine roundtables of stakeholders at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

MCH stakeholders promote "preventative care" and "comprehensive services" as suggested priorities for Georgia's health care efforts. They are concerned that "access to health care (including mental health and dental health)" is a problem for some children.

"Lack of age-appropriate developmental and health (including mental health) screenings, follow-up and services" are aspects of the concern.

Stakeholders serving on Georgia's ECCS steering committee identify the following access issues and barriers to appropriate health care of children.

- Insurance and Medicaid issues
- Geographic accessibility
- Availability of providers (e.g., specialty physicians)
- Access to caregivers
- Parents working are challenged to see providers during regular hours
- Transportation
- Information is not getting to the population in a way that is usable
- Consumer's lack of awareness and/or knowledge

Transportation is of particular concern to every stakeholder focus group contributing to the needs assessment study, and has been discussed.

Availability of specialty providers is also of special note because of its pronounced impact on families seeking health care. Health Care providers shared some of their observations of the situation in the state today.

- "Outlying areas have a shortage of specialists. It places a tremendous burden on families to get specialty services;"
- "Lower part of the state has basically nothing when it comes to sub-specialties;" and
- "There are gaping holes in specialists - no pediatric orthopedic, no pediatric neurologist."

Insurance and Medicaid issues also pose challenges to children's access to health care.

"Gaps in insurance and coverage of services" for children appear to be of widespread concern. "Limited or lack of Medicaid coverage for Title V programs and services, and lack of continuous coverage under

Medicaid" are parts of the problem stakeholders cite, as well as "lack of adequate private health insurance coverage."

"For children who are not eligible for Medicaid, their only access to health care may be the emergency room and well child care checkups at the Public Health Department."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN'S HEALTH

Stakeholders of MCH services forward various ideas about what could improve the physical and mental health of children. Suggestions around access to health care follow.

- "We (existing programs and private physicians) need data and a more collaborative look at what we have and what we need;"
- "Increase access to child care services;"
- "Address the increased need for home visitation/promotion of Bright Futures;"
- "Interagency collaboration (DOE, DCH, DPH, DHS, DJJ, USDA, and Child Care)" is needed;
- Provide school-based health services – medical, behavioral;
- Ensure health coverage for the child through medical home;
- "Public health needs to look at where its niche is in the system;"
- "Stronger community-based programs" are needed;
- State needs to provide incentives to attract subspecialists – "there is a model for serving underserved areas;"
- "Fix the certification of need process;" and
- "[Physicians] need to know what each other does, and to make referrals."

LACK OF DEVELOPMENTAL OPPORTUNITIES

QUANTIFICATION

Lack of developmental opportunities is identified as a major health concern for children by three of nine MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System (ECCS), and two of nine roundtables of stakeholders at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

"The goal is age-appropriate opportunities for the child to be most productive citizens."

MCH stakeholders expressed concern that opportunities for children's physical and mental health are too limited.

"Foster development of optimal social, emotional and academic competence" is suggested as a top priority for children's health and education by four roundtable groups of stakeholders from non-governmental maternal and child health provider and advocacy organizations.

"Increase in the number of children being medicated for hyperactivity" is of great concern to several parents/stakeholders contributing to the community focus groups.

Developmental screening and follow-up is also forwarded as a top priority concern for half the roundtable groups of MCH stakeholders, as well as the steering committee of Georgia's ECCS. The concern is that young children "are not meeting developmental milestones."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN'S HEALTH

Stakeholders of MCH services forward various ideas about what could improve the physical and mental health of children. Suggestions around developmental opportunities follow.

- "Prevention and education are needed to improve the physical and mental health of children;"
- "Encourage physical activity in schools; build sidewalks and areas where kids can play;"
- "Educate children and families on healthy lifestyle – get up a public education campaign;"
- "Bring services (such as dental) to the schools;"
- "Coaching and self esteem classes K-12 are needed;"
- "At an early age, provide education on pregnancy;"
- Provide parenting classes;
- Provide developmental screening and early intervention;
- Provide screening for social emotional development and link child and family to evidence-based service; and
- "Before a child is medicated for hyperactivity the following must be considered: the classroom setting; teaching style methods; teacher training; the side effects of the medication."

UNHEALTHY BEHAVIOR/LIFESTYLES

QUANTIFICATION

Unhealthy behavior/lifestyle is identified as a major health concern for children by five of nine MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System (ECCS), and two of nine roundtables of stakeholders at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

MCH stakeholders have concerns about children's behavior and lifestyles, and their impact on health. They cite problems with "risky behaviors," injury and violence, the need for injury reduction and "safe environments for children."

The steering committee of Georgia's Early Childhood Comprehensive System (ECCS) specifically cites consumers' lack of awareness and/or knowledge as contributing to the problem and one of their top concerns for Georgia's children. "There is lack of awareness/knowledge of good health practices, when to see a doctor; and the importance of services."

Family situations and challenges can contribute to health practices as well. "Families are dealing with a host of issues; chaotic lifestyle and a lot of juggling. Best intentions go astray."

Other aspects of the health concern include "inadequate resources to assure healthy balance through growth and development" and "inadequate sex education and appropriate services from pre-school through high school."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN'S HEALTH

Stakeholders of MCH services forward various ideas about what could improve the physical and mental health of children. "Foster development of optimal social, emotional and academic competence" is suggested as a top priority by four roundtable groups.

Suggestions emerging from the focus groups around addressing unhealthy behaviors follow.

- Deliver innovative health education approaches for early childhood and continuous support for child and family unit;
- Improve educational outcomes;
- Provide health prevention/promotion starting at kindergarten and throughout life;
- Make early detection and screening a priority;
- Improve health and wellness services;
- Enhance educational policies including a wellness program;
- Provide ongoing education campaigns to promote healthy lifestyle;
- Provide disease and risk reduction health education; and
- Provide "age-appropriate health care throughout the spectrum – age-appropriate supervision, development of age-appropriate life skills – ages 1 – 21."

PARENT/CAREGIVER KNOLWEDGE AND FAMILY SUPPORT

QUANTIFICATION

Parent/caregiver knowledge and family support is identified as a major health concern for children by the MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System (ECCS), and of roundtables of stakeholders at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Parent/caretaker awareness and/or knowledge influence decisions about the direction of a child's health care. It is identified as a high-priority health concern because of its impact on children. "Lack of family support to rear healthy children" is stated by some health care providers as an adjunct concern.

Family situations and challenges are viewed to sometimes pose barriers to a child's access to health care. These are some of those barriers, according to MCH health care providers.

- Families are dealing with a host of issues, chaotic lifestyle, and a lot of juggling. "Best intentions go astray;"
- Homelessness – homeless families do not know how to get connected;
- Feeling judged, a failure for needing help, can make parent reluctant to acquire health care; and
- Not having a contact person in the community is a problem.

"Change in health-seeking behaviors" for caretakers may be required. One health care provider goes on to say, "When families are educated, they become self-sufficient and have better health outcomes."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of children. Suggestions around parent/caregiver knowledge and family support follow.

- "Educate public about the importance of regular health care and where to get it;"
- "Provide education and outreach about insurance and importance of preventative care;"
- "Increase hands-on communication with families;"
- "Parents need a support system – teach them about available resources; provide support group;"
- Community health infrastructure is needed;
- Improve the physical and mental health of caregivers throughout the lifespan;
- Enhance educational policies including a wellness program that is all-encompassing;"
- Interagency collaboration is needed; and
- Provide school-based health services – medical, behavioral.

OBESITY

QUANTIFICATION

Obesity is identified as a major health concern for children by four of nine MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System (ECCS), and one of the top five needs by five of nine roundtables of stakeholders at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Childhood obesity is a major health concern for stakeholders contributing to the needs assessment. Heard frequently is the concern about the "impact of obesity on the early onset of chronic health conditions."

The view that obesity is often "a family issue" was often heard.

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN'S HEALTH

MCH stakeholders forwarded various ideas on what is needed to improve the childhood obesity. Suggestions follow.

- Family obesity counseling programs are needed; and
- Address parent/consumer knowledge; promote healthy behaviors; promote physical activity.

SAFETY/INJURY PREVENTION

QUANTIFICATION

Safety/injury prevention is identified as a major health concern for children by four of nine MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System (ECCS), and two of nine roundtables of stakeholders at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

A health care provider in a central Georgia focus group notes, "Number one cause of death in children is accident injury." She goes on to say, "and so injury prevention is a major health concern."

Aspects of the concern typically highlighted by stakeholders include "engaging in risky behavior," "intentional and unintentional violence" and need for safe environments.

"Peer pressure among preteens around alcohol use, sexual activity, bullying, and violence" is occurring and some have observed "Increase in girls fighting in school."

Stakeholders in various community focus groups and also MCH provider/advocacy groups express concern about the lack of supervision of a child by an adult.

- "Supervision" is a health concern – [these are] latch key kids. Nowhere to go, which leads to gangs. No proper supervision for kids which leads into need for injury prevention;"
- "Lack of parental supervision is a problem. Parents are leaving it up to kids to take their medications;" and
- "Parents not following through with children's health care."

Other related and serious examples of the concerns expressed about children's safety include child neglect and "sexual abuse in the home."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN'S HEALTH

Stakeholders of MCH services forward various ideas about what could improve the physical and mental health of children. Suggestions around safety/injury prevention follow.

- "Increase counseling services to prevent child abuse and neglect;"
- "Need to address injury prevention and environmental safety;"
- "Parents have got to take responsibility for their children;"
- "Parenting classes are needed;"
- "Need to address injury prevention and environmental safety;" and
- "We need education classes on the proper use of a car seat, and sleeping…We need more people offering classes in our community and more people to know about the classes."

SPECIAL ISSUES WITH CHILDREN IN FOSTER CARE

QUANTIFICATION

Special issues pertaining to children in foster care are identified as a major health concern for children by three of nine MCH needs assessment community focus groups.

DESCRIPTION OF HEALTH CONCERN

An emerging trend which health care providers in focus groups identify is the "increased number of children in foster care system, creating difficulties tracking these children and ensuring they receive needed physical and mental health services."

Special issues for children in foster care identified by the focus group participants follows.

- Lack of coordination of services and tracking system
- Lack of resources to address child abuse and neglect
- Shortage of foster homes in the community

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN'S HEALTH

Stakeholders of MCH services forward various ideas about what could improve the physical and mental health of children. Suggestions around addressing special issues of foster children follow.

- We need a "tracking system and other mechanisms to ensure children in foster care have a medical home and receive preventative, well care services, and mental health counseling;" and
- "[We need] long-term coordination with the foster care agencies to assist in tracking foster children who move."

INFRASTRUCTURE/SYSTEM ISSUES

QUANTIFICATION

Infrastructure/system issues are identified as a major health concern for children by all of the MCH needs assessment community focus groups, the steering committee of Georgia's Early Childhood Comprehensive System (ECCS), and all nine roundtables of stakeholders at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

A variety of infrastructure concerns emerged from stakeholder discussions at focus group sessions. Communication is specifically noted by half the roundtables at the non-governmental maternal and child health provider and advocacy groups; communication emerged as a priority need from the ECCS steering committee.

Other concerns cited by stakeholders include the following.

- "Lack of complete integrated child health record and adequate access;"
- "Emerging trends impacting delivery of care - change in family unit/dynamics;"
- "Recession is impacting care - number of new clients new to public health is growing fast;"
- Insufficient availability of interpreters and/or availability of health care agency employees who can communicate with Hispanic community;
- Need for improved/increased preventative services;
- "Insurance set-up is a problem;"
- Lack of care coordination in situations such as tube feeding and other nutritional disorders;
- Lack of parent leadership, care or concern;
- Lack of funding in the Division of Family and Children Services;
- Readability of information - not considerate of literacy level;
- Inability to communicate on a parent's level.
- Lack of one-stop shop; and
- "Lack of medical profession-WIC communication to fathers, especially those non-English speaking."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN'S HEALTH

Stakeholders of MCH services forward various ideas about what could improve the physical and mental health of children. Suggestions around infrastructure and system follow.

- "Community health infrastructure" is needed;
- "Need a good linkage system that includes Head Start, day care centers, and other providers so we can all better serve families;"
- "There is a need for health care coordination and collaboration;"
- "Take more of a systems approach to MCH;"
- "Improve interagency communication, collaboration;"
- "Visible accessible data across programs and services" is needed;
- "Drive needs assessment district/county level;"
- "Simplify delivery of services;"
- "Resolve Medicaid Care Management Organization (CMO) issues;"
- "Build capacity and provide training on best practices;"
- "Research alternative methods to provide support and services for families such as telemedicine;"
- "Flexibility in determining what is medically necessary" is needed;
- "Fund public education campaigns;"

- "Enhance education policies including a wellness program;"
- "Meet increased need for health department services. Increase staff, funding new technology, innovative service methodologies;"
- Provide "school-based health services – medical, behavioral;"
- "Utilize techs to maximize electronic medical record;"
- "Children 1st funding for entry/access point for all services, and strengthening Children 1st;"
- "Audits need to be done; attach reimbursement to adherence with a standard of care;"
- "Build relationships with daycare providers in the community;" and
- "Immunization registry needs to be maintained."

MENTAL HEALTH

QUANTIFICATION

Mental health is identified as a major health concern for children by four of nine statewide stakeholder/consumer focus groups and four of nine roundtables of stakeholders at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Mental health is identified as a major health concern for children. "Access to mental health services" is identified as a need in three community focus groups. There is concern about "number of providers out there who can afford to do care." Behavioral specialists are reportedly in short supply.

Developmental screening is seen as an associated aspect, forwarded as a priority by the steering committee of Georgia's ECCS.

Of special concern is the mental health of young girls. "There's peer pressure among pre-teens around alcohol use, sexual activity, bullying, violence." Several community focus group participants also noted that "we see an increase in girls fighting in school…The real world they see on TV is not the real world. "

Child health providers and advocates also brought up the need for universal developmental screening in talking about children's healthy development.

"Developmental screening and follow-up" is also forwarded as a top priority concern for half the roundtable groups of MCH stakeholders, as well as the steering committee of Georgia's ECCS. The concern is that children "are not meeting developmental milestones."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN'S HEALTH

Stakeholders of MCH services forward various ideas about what could improve the physical and mental health of children. Suggestions around mental health follows.

- "Age-appropriate development (mental health screening)" is needed;
- Improve "comprehensive medical and mental health availability;" and
- Address problems with "access to mental health care."

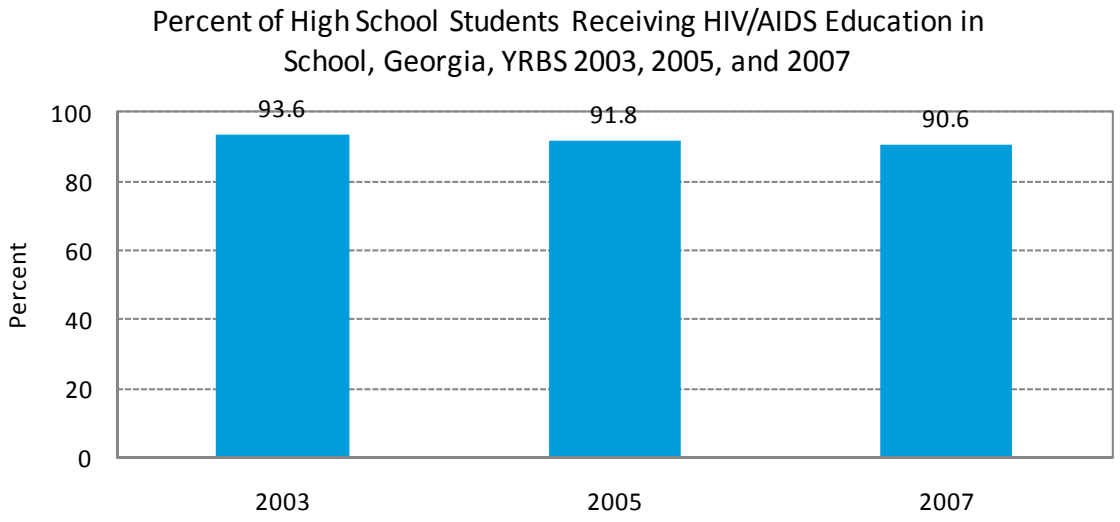
INDICATORS SPECIFIC TO ADOLESCENTS

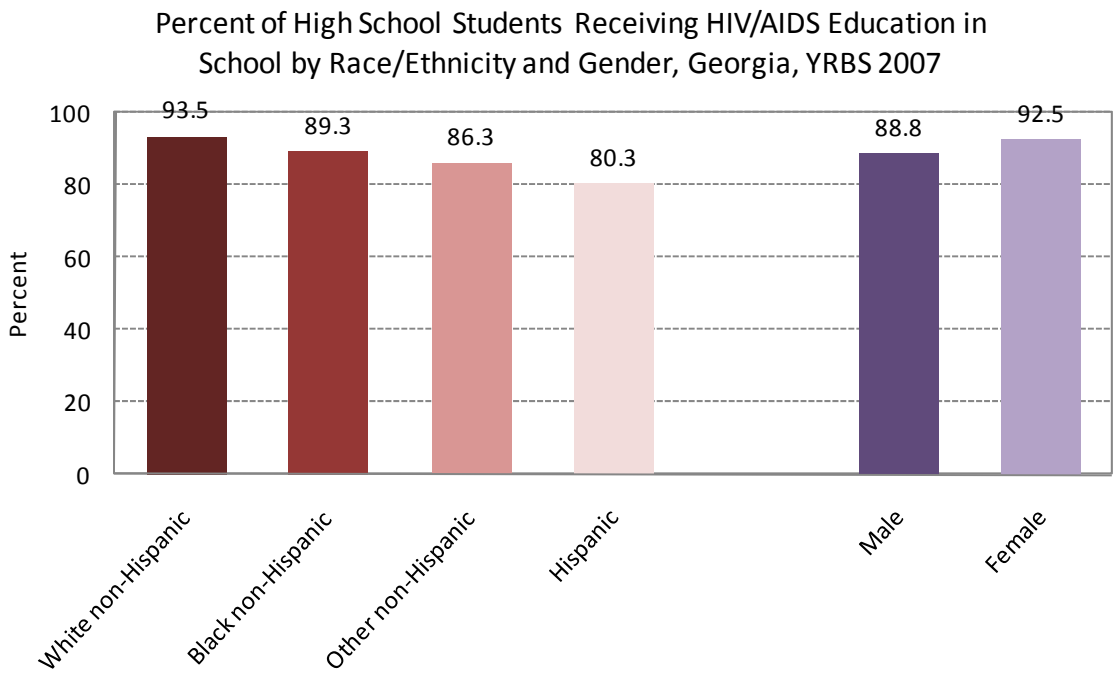
ANALYSIS OF QUANTITATIVE DATA

HUMAN IMMUNE DEFICIENCY VIRUS (HIV)

HIV PREVENTION EDUCATION AMONG HIGH SCHOOL STUDENTS

Approximately 90 percent of all high school students in Georgia reported receiving HIV/AIDS education in school. However, this percent declined in 2005 and 2007. White high school students were most likely to report receiving HIV/AIDS education. Among Hispanic high school students, 80.3 percent reported receiving HIV/AIDS education, which was 14.1 percent lower than the rate among White high school students. The prevalence of receiving HIV/AIDS education was four percentage points greater among female children compared to male children.

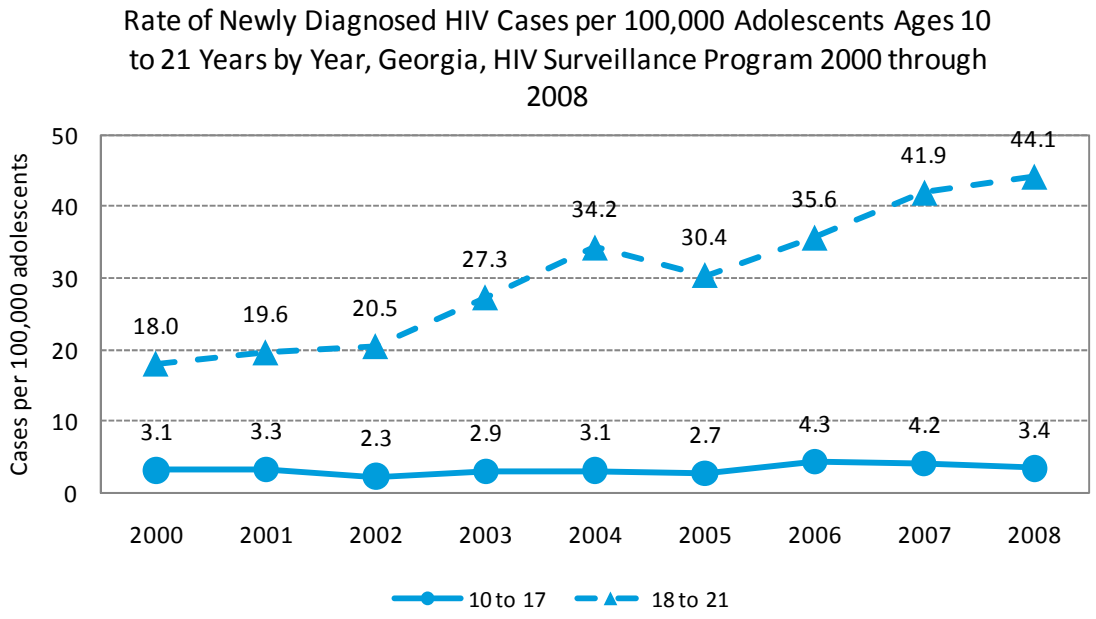


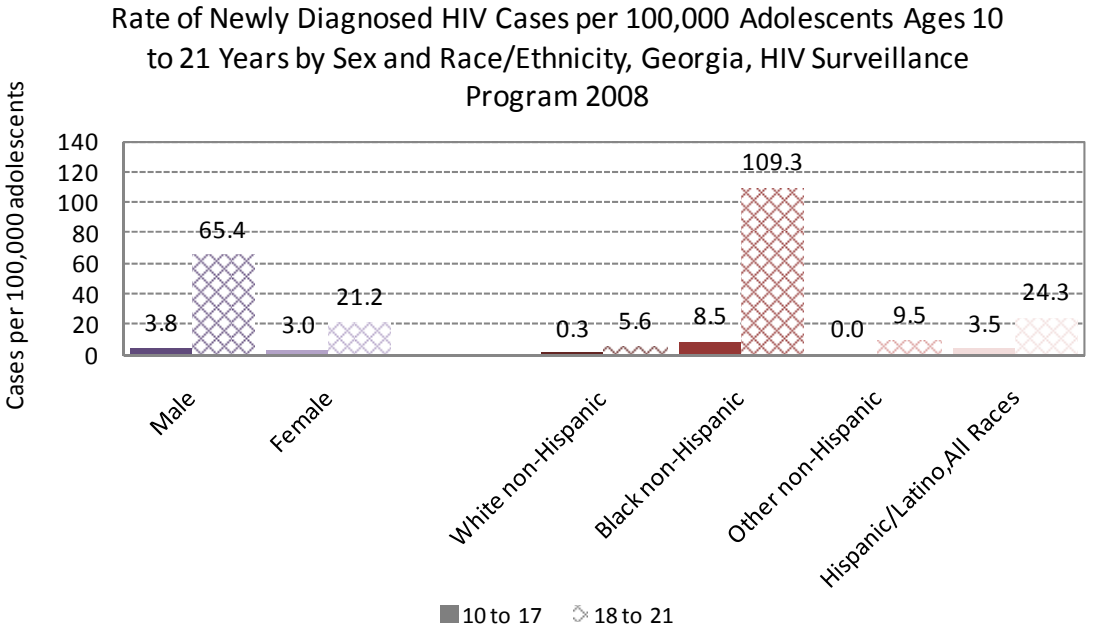


NEWLY DIAGNOSED HIV CASES AMONG ADOLESCENTS AGES 10 TO 21 YEARS

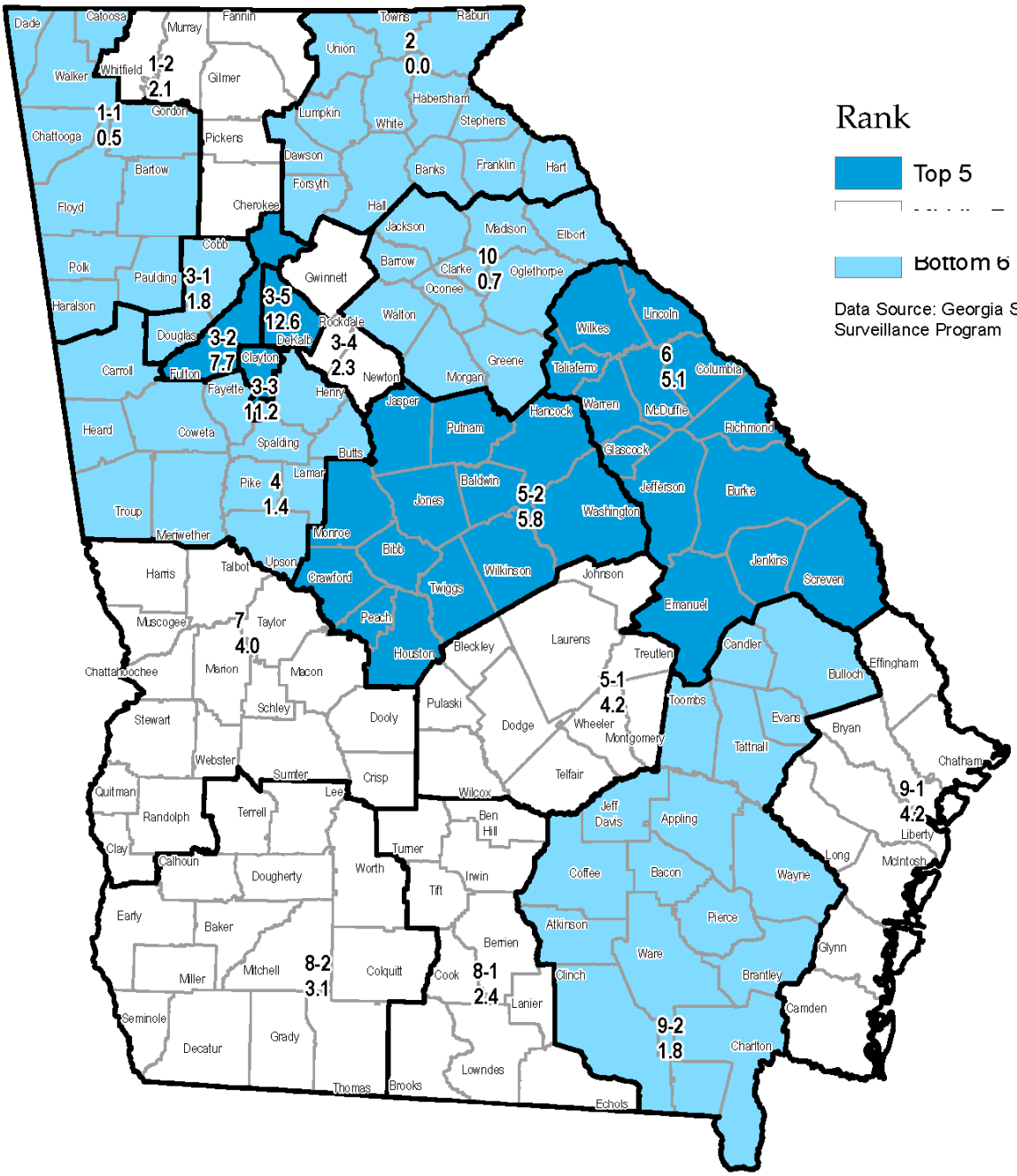
While the number of newly diagnosed HIV cases remained relatively consistent among adolescents 10 to 17 years of age, the number of newly diagnosed HIV cases increased each year from 2000 through 2008 among adolescents 18 to 21 years of age. The rate of newly diagnosed HIV cases among adolescents 10 to 17 years of age had limited variation between 2000 and 2008. However, the rate of newly diagnosed HIV cases among adolescents 18 to 21 years of age increased nearly 150 percent during the same time period.

Between 2006 and 2008, 40 percent of Georgia's newly diagnosed HIV cases among adolescents 10 to 17 years of age were in either the Fulton County Public Health District or the DeKalb County Public Health District. Fulton County Public Health District (148) and DeKalb County Public Health District (146) were also the only public health districts with more than 100 newly diagnosed HIV cases among adolescents 18 to 21 years of age. Clayton County Health District reported 48 newly diagnosed cases of HIV among adolescents 18 to 21 years of age, but had the greatest rate of newly diagnosed HIV cases in this group (110.2 cases per 100,000). Fulton County Public Health District had the second greatest rate of newly diagnosed HIV cases among adolescents 18 to 21 years of age (90.5 cases per 100,000).

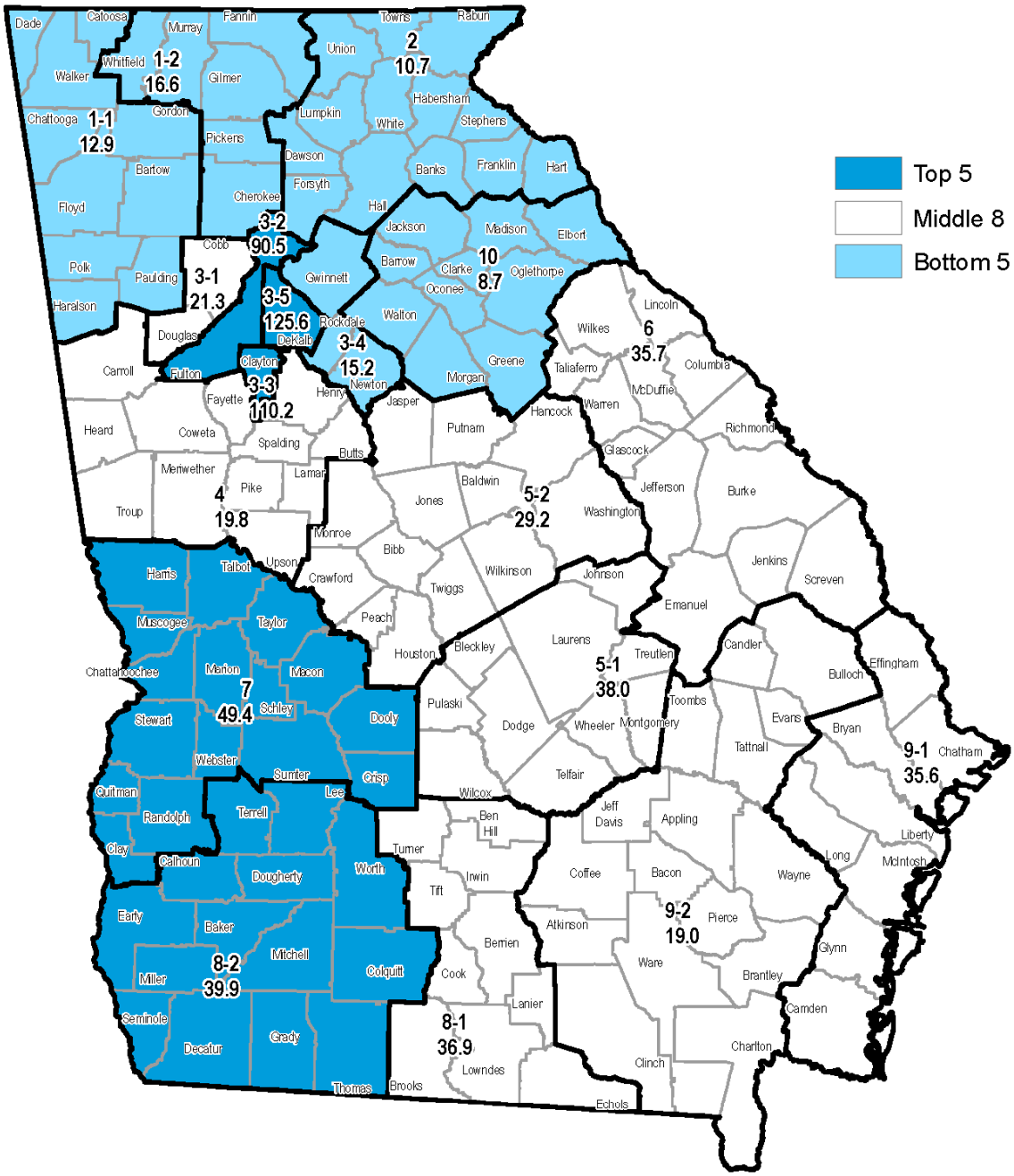

Rate of Newly Diagnosed HIV Cases per 100,000 Adolescents Ages 10 to 21 Years by Year, Georgia, HIV Surveillance Program 2000 through 2008
Cases per 100,000 adolescents
50
40
30
20
10
0
18.0
19.6
20.5
27.3
34.2
30.4
35.6
41.9
44.1
3.1
3.3
2.3
2.9
3.1
2.7
4.3
4.2
3.4
2000
2001
2002
2003
2004
2005
2006
2007
2008
10 to 17
18 to 21


Rate of Newly Diagnosed HIV Cases per 100,000 Adolescents Ages 10 to 21 Years by Sex and Race/Ethnicity, Georgia, HIV Surveillance Program 2008
Cases per 100,000 adolescents
140
120
100
80
60
40
20
0
3.8
65.4
3.0
21.2
0.3
5.6
8.5
109.3
0.0
9.5
3.5
24.3
Male
Female
White non-Hispanic
Black non-Hispanic
Other non-Hispanic
Hispanic/Latino,All Races
10 to 17
18 to 21

Rate of Newly Diagnosed HIV Cases per 100,000 Adolescents Ages 10 to 17 Years by Public Health District, Georgia, HIV Surveillance Program 2008



Rate of Newly Diagnosed HIV Cases per 100,000 Adolescents Ages 18 to 21 Years by Public Health District, Georgia, HIV Surveillance Program 2008



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Projection: Georgia Statewide
Lambert Conformal Conic

NEWLY DIAGNOSED SEXUALLY TRANSMITTED INFECTIONS AMONG ADOLESCENTS AGES 15 TO 21 YEARS

Between 1999 and 2008, the rate of newly diagnosed cases of Chlamydia among adolescents exceeded 2,000 cases per 100,000 adolescents in every year except 2005. The greatest the rates of newly diagnosed cases of Chlamydia were found in 2007 and 2008. Comparing 1999 to 2008, the rate of newly diagnosed cases of Chlamydia among adolescents increased 14.6 percent.

Between 1999 and 2008, the rate of newly diagnosed cases of gonorrhea among adolescents declined 39.8 percent. The rate of newly diagnosed cases of gonorrhea among adolescents has not exceeded 1,000 cases per 100,000 adolescents since 2001.

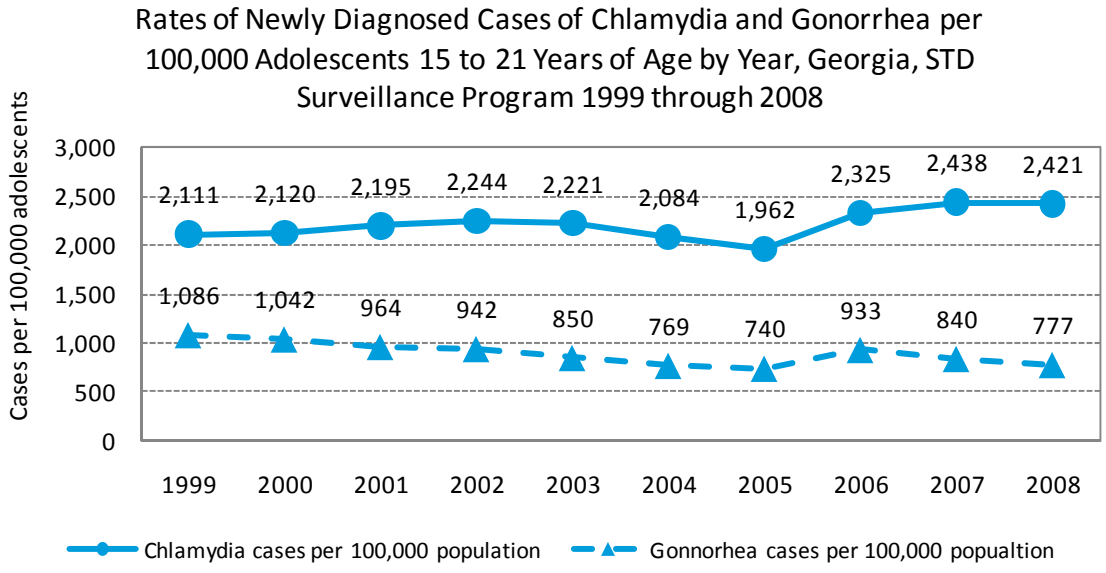
For both Chlamydia and gonorrhea, there were approximately double the numbers of newly diagnosed cases among adolescents 18 to 21 years of age as there were among adolescents 15 to 17 years of age. While adolescents 18 to 21 years of age account for the majority of newly diagnosed Chlamydia and gonorrhea cases among adolescents, the rate of newly diagnosed cases of Chlamydia among adolescents 15 to 17 years of age exceeds 1,500 cases per 100,000 adolescents and the rate of newly diagnosed cases of gonorrhea exceeds 500 cases per 100,000 adolescents.

Black adolescents had the greatest rates of newly diagnosed cases of Chlamydia and gonorrhea. Racial/ethnic disparities were found for Chlamydia and gonorrhea, but were significantly larger for gonorrhea. For the rates of newly diagnosed cases of Chlamydia and gonorrhea, the ratio of rates among Black adolescents to White adolescents was ten to one and twenty-three to one, respectively. The ratio of rates among Black adolescents to Hispanic adolescents was seven to one for newly diagnosed cases of Chlamydia and fourteen to one for newly diagnosed cases of gonorrhea.

Female adolescents had significantly greater rates of newly diagnosed cases of Chlamydia and gonorrhea compared to male adolescents. The ratio of the rate of newly diagnosed cases of Chlamydia among female adolescents to male adolescents was four to one. For gonorrhea, this ratio was two to one.

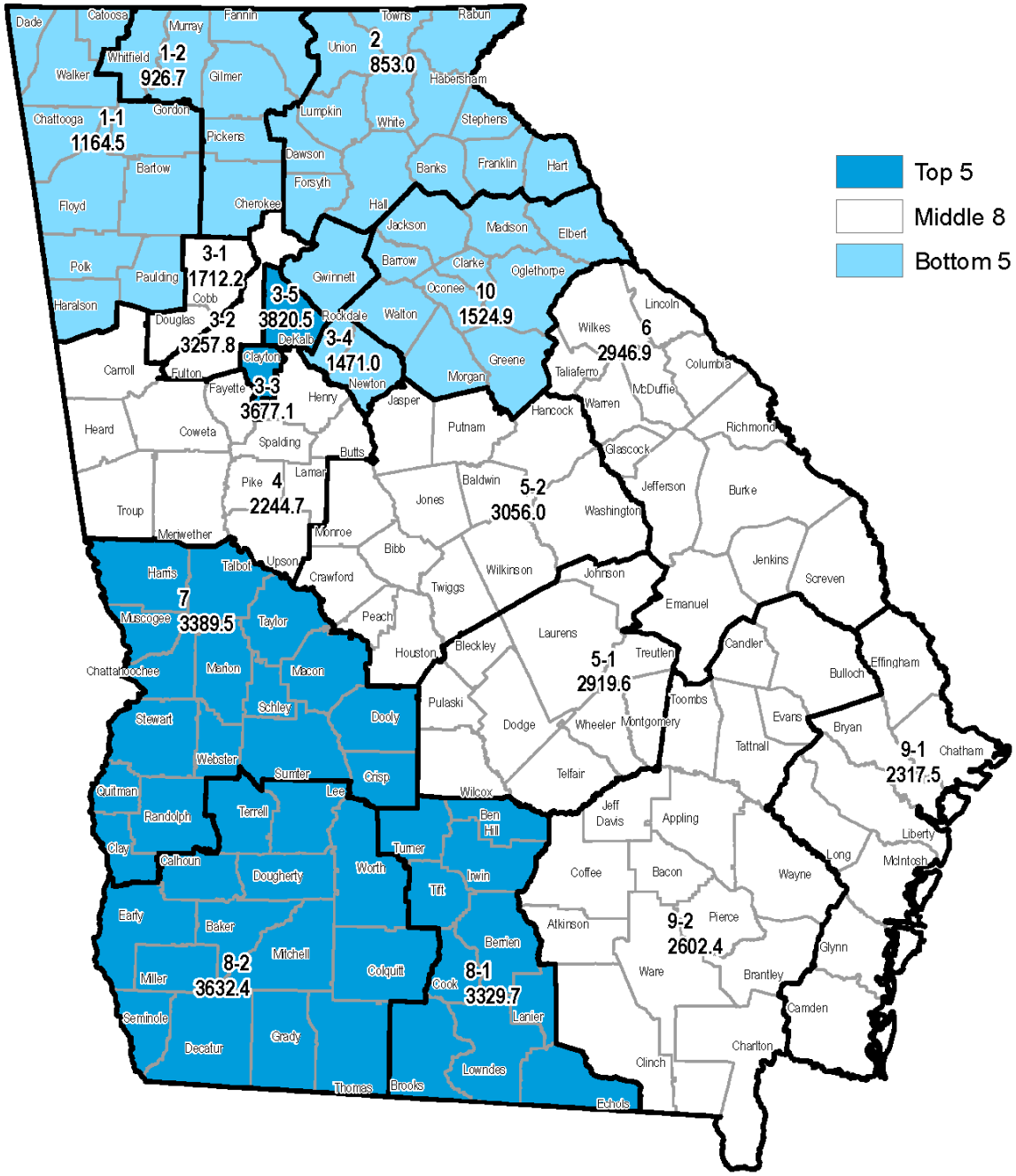
There were four newly diagnosed cases of Chlamydia among adolescent females for every one newly diagnosed case among male adolescents. Gender disparities were less for gonorrhea. For gonorrhea, the ratio of newly diagnosed cases among females to males was approximately two to one.

Newly diagnosed cases of primary syphilis doubled between 2007 and 2008 from 13 to 25 cases. In 2008, the rate of newly diagnosed cases of syphilis among adolescents 15 to 21 years of age was 2.6 cases per 100,000 adolescents.



Rates of Newly Diagnosed Cases of Chlamydia and Gonorrhea per 100,000 Adolescents 15 to 21 Years of Age by Age, Race/Ethnicity, and Sex, Georgia, STD Surveillance Program 2008		
	Chlamydia cases per 100,000 population	Gonorrhea cases per 100,000 population
Age		
15-17	1,720	512
18-21	2,943	975
Race/ethnicity		
White non-Hispanic	252	44
Black non-Hispanic	2,563	1,024
Other non-Hispanic	175	45
Hispanic	288	75
Sex		
Male	950	519
Female	3,947	1,042

Rates of Newly Diagnosed Cases of Chlamydia per 100,000 Adolescents 15 to 21 Years of Age by Public Health District, Georgia, STD Surveillance Program 2008



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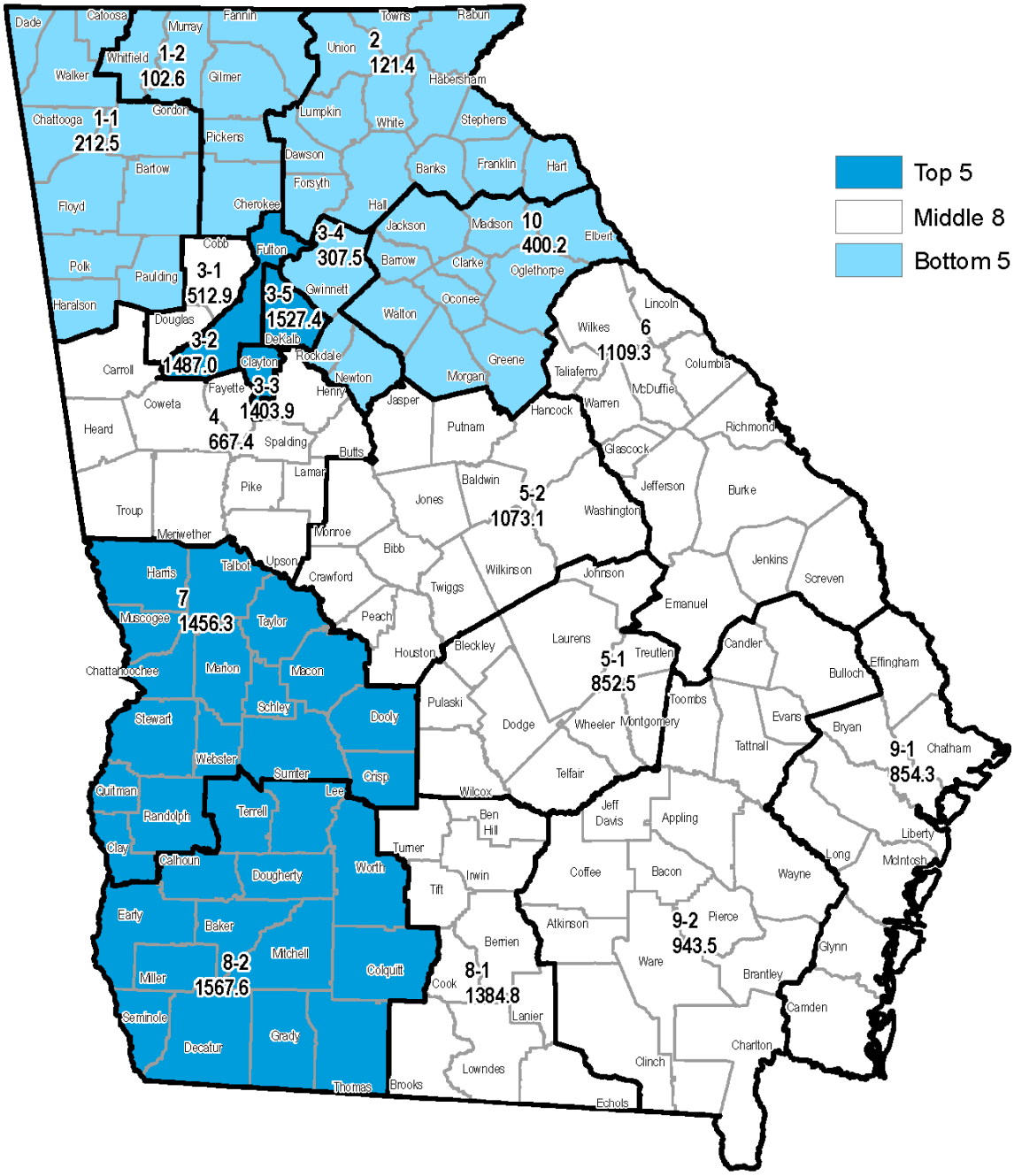
Rates of Newly Diagnosed Cases of Gonorrhea per 100,000 Adolescents 15 to 21 Years of Age by Public Health District, Georgia, STD Surveillance Program 2008



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BIRTHS AMONG ADOLESCENT FEMALES AGES 15 TO 19 YEARS

The adolescent (15 to 19 years of age) birth rate declined from 1999 through 2005, but increased in 2006 and 2007. Even with these increases, the overall decline in the adolescent birth rate in Georgia was 14.2 percent between 1998 and 2007.

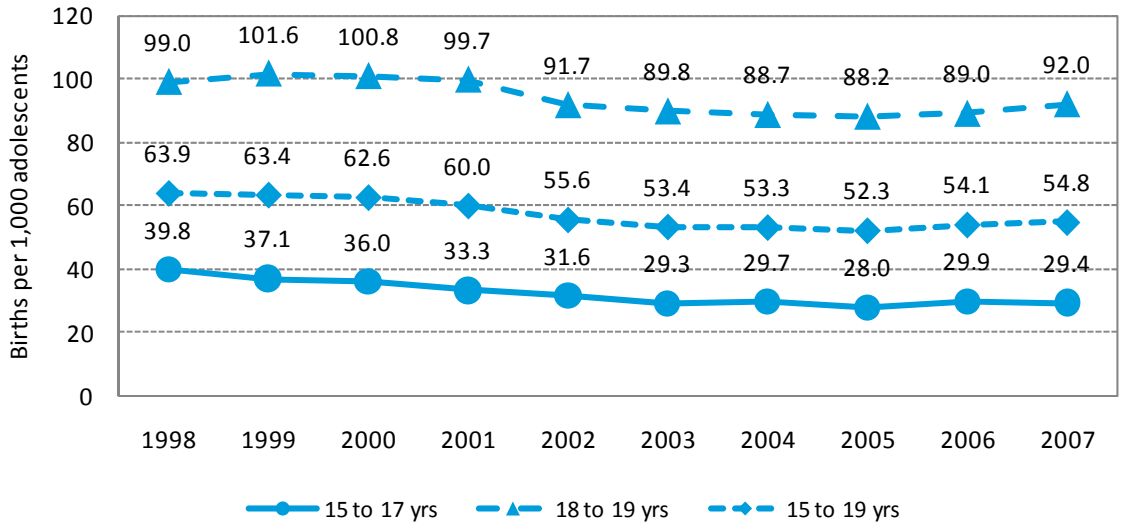
Among younger adolescents (15 to 17 years of age), there were declines in the birth rate from 1999 through 2003. From 2004 through 2007, the birth rate among younger adolescents fluctuated with no discernable pattern.

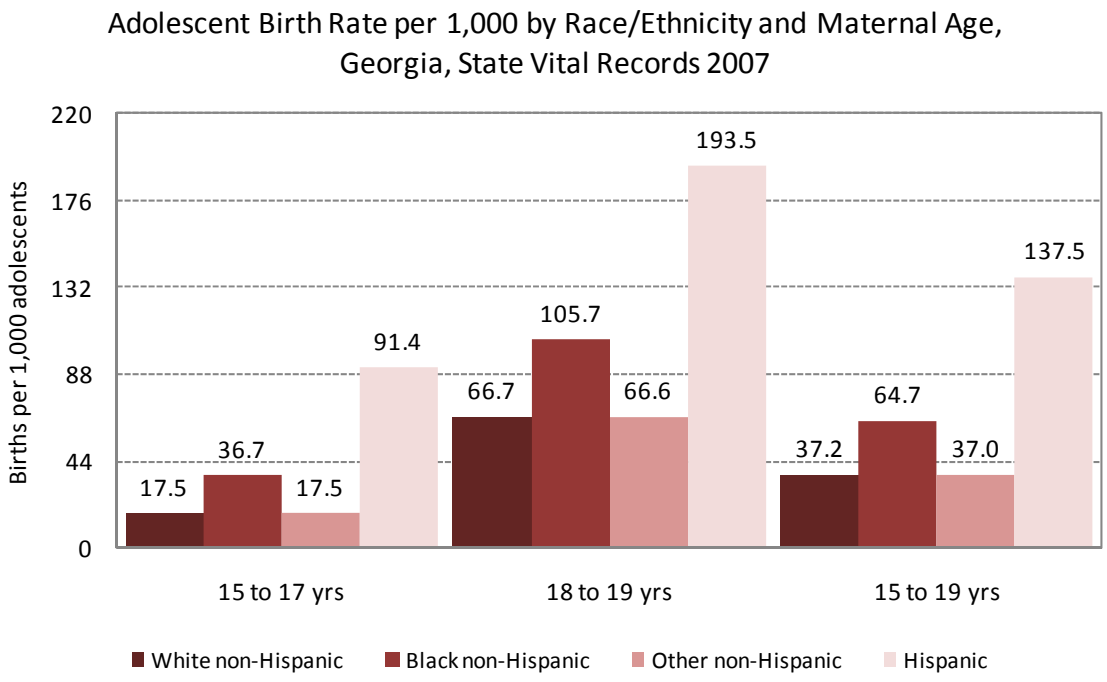
Among older adolescents (18 to 19 years of age), the birth rate declined from 2000 through 2005. The greatest decline occurred between 2001 and 2002 when the birth rate among older adolescents declined 8.0 percent. Among older adolescents, there was an increase in the birth rate from 2005 to 2006 and 2006 to 2007.

Regardless of age, Hispanic adolescents had the greatest adolescent birth rates among all racial/ethnic groups. Among adolescents 15 to 17 years of age, the birth rate among Hispanic adolescents was more than twice that of the next greatest group (Black adolescents, 36.7 births per 1,000 adolescents 15 to 17 years of age). Among adolescents 18 to 19 years of age, the birth rate among Hispanic adolescents was nearly 200 births per 1,000 adolescents 18 to 19 years of age.

Among Georgia's 18 public health districts, birth rates among adolescents 15 to 19 years of age exceeded 70 births per 1,000 adolescents 15 to 19 years of age in the South Public Health District, Southeast Public Health District, and Southwest Public Health District. In six of the 18 public health districts, the adolescent birth rate among this group was less than 50 births per 1,000 adolescents 15 to 19 years of age.

Adolescent Birth Rate per 1,000 by Year, Georgia, State Vital Records
1998 through 2007





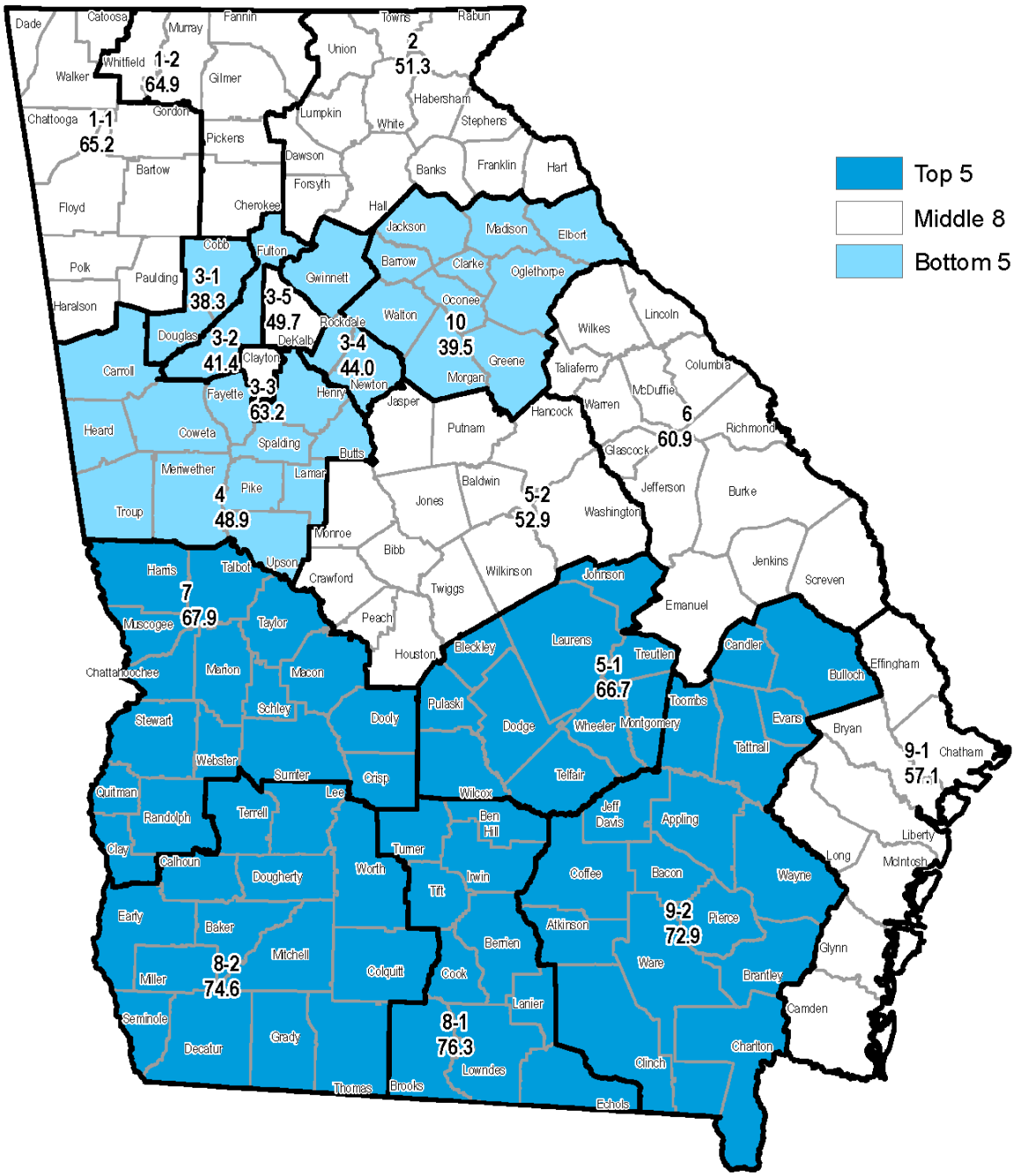
REPEAT BIRTHS AMONG ADOLESCENT FEMALES AGES 15 TO 19 YEARS

The rate of repeat adolescent birth declined in each year between 1998 and 2006. In 2007, the rate of repeat birth among adolescents 15 to 19 years of age increased. Among adolescents 15 to 17 years of age, the decline in the rate of repeat birth was 31.3 percent between 1998 and 2007. Among adolescents 18 to 19 years of age the decline was 23.4 percent. While this rate has declined, in 2007, there were 639 repeat births among adolescents 15 to 17 years of age and 3,114 repeat births among adolescents 18 to 19 years of age.

The greatest rate of repeat adolescent birth was found among Hispanic adolescents regardless of age. Among adolescents 15 to 17 years of age, the rate of repeat birth among Hispanic adolescents was ten times greater than the rate of repeat birth among White adolescents and more than three times greater than among Black adolescents. Among adolescents 18 to 19 years of age, the rate of repeat birth among Hispanic adolescents was more than double the rate of repeat birth among Black adolescents.

Among Georgia's 18 public health districts, the South Public Health District, Southeast Public Health District, and Southwest Public Health District each had rates of repeat birth among adolescents 15 to 19 years of age in excess of 4.5 per 1,000 adolescents 15 to 19 years of age. Examination of case counts revealed that a quarter of all cases of repeat birth among adolescents 15 to 17 years of age were found in DeKalb Public Health District, East Metro Public Health District, and Fulton Public Health District. Among adolescents 18 to 19 years of age, in addition to Fulton and East Metro Public Health Districts, the LaGrange Public Health District, Northwest Public Health District, and Southwest Public Health District each had more than 600 cases of repeat birth among adolescents 18 to 19 years of age.

Adolescent Birth Rate per 1,000 by Public Health District, Georgia, State Vital Records 2007



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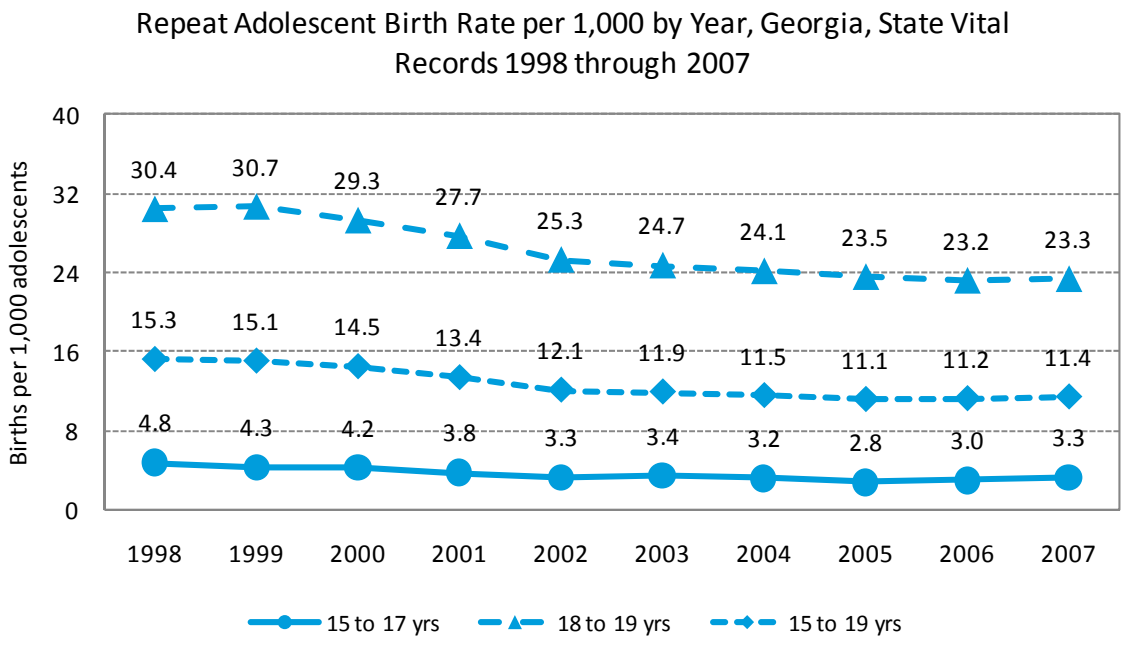
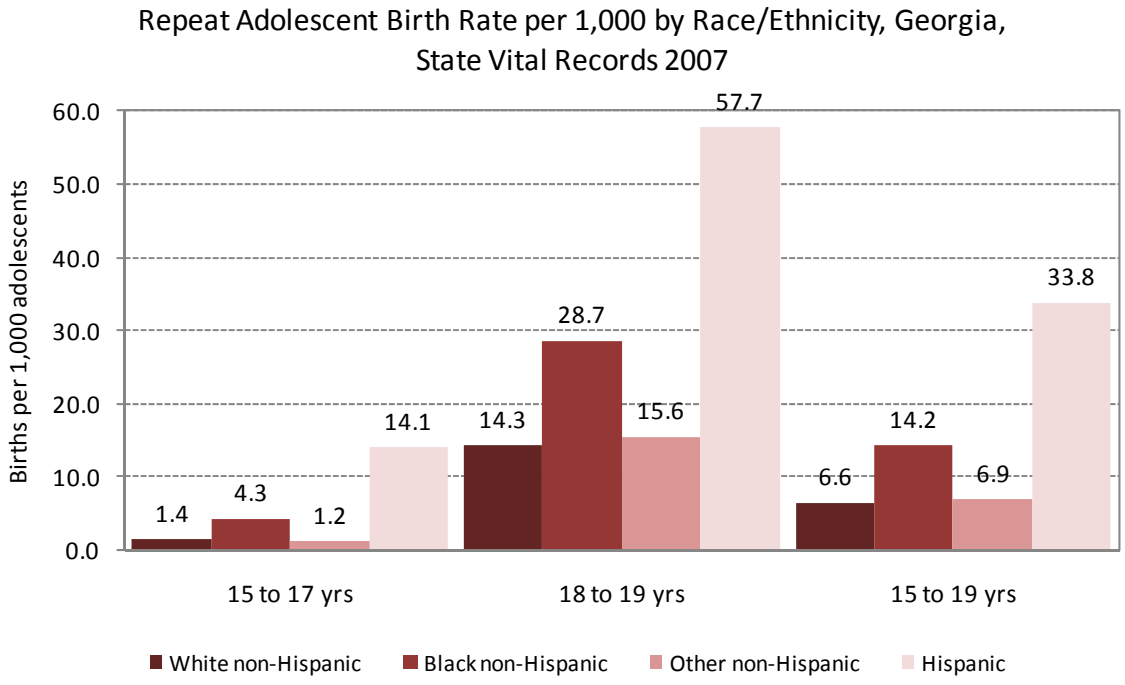
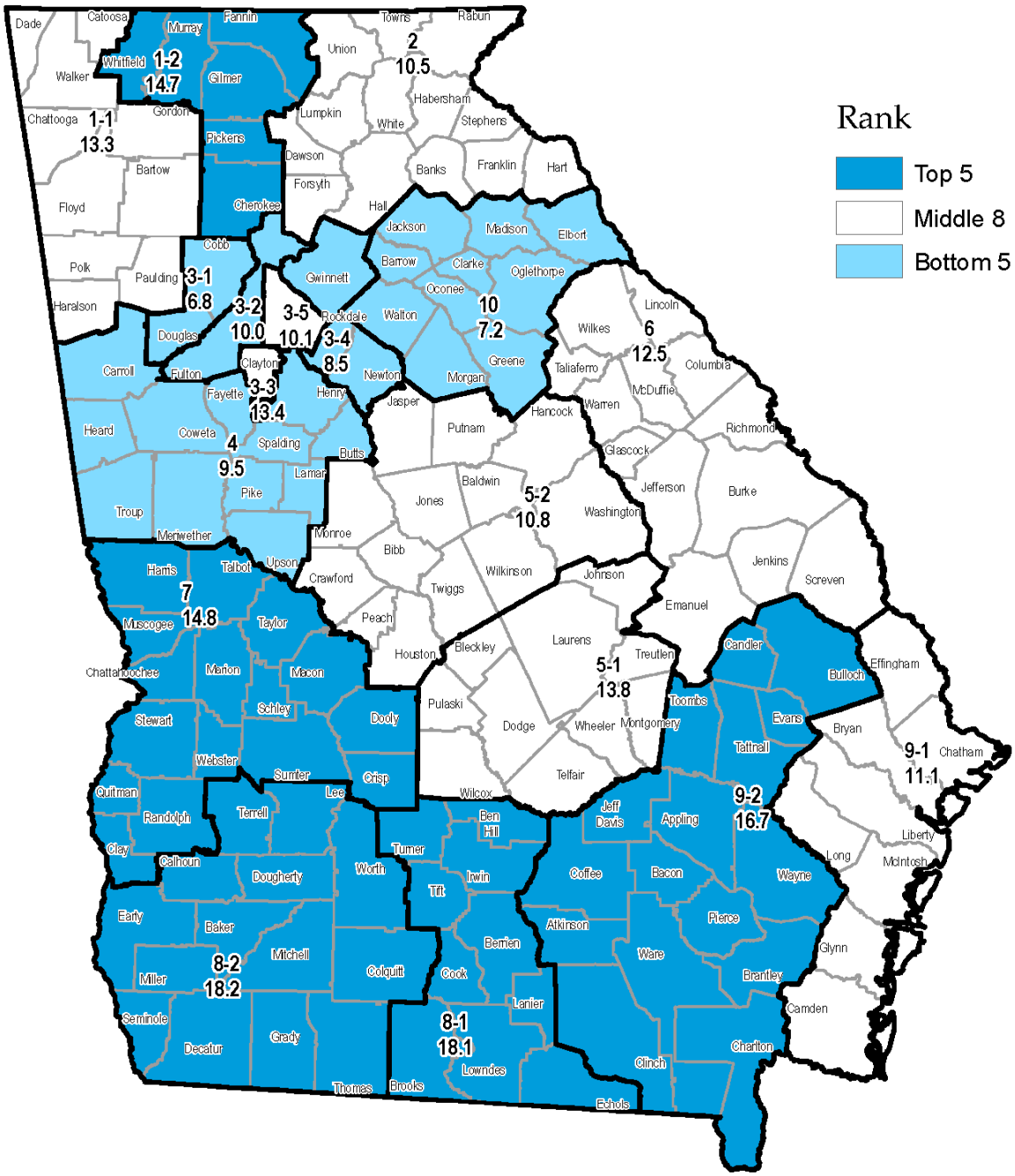

Repeat Adolescent Birth Rate per 1,000 by Year, Georgia, State Vital Records 1998 through 2007
Births per 1,000 adolescents
40
32
24
16
8
0
30.4
30.7
29.3
27.7
25.3
24.7
24.1
23.5
23.2
23.3
15.3
15.1
14.5
13.4
12.1
11.9
11.5
11.1
11.2
11.4
4.8
4.3
4.2
3.8
3.3
3.4
3.2
2.8
3.0
3.3
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
15 to 17 yrs
18 to 19 yrs
15 to 19 yrs


Repeat Adolescent Birth Rate per 1,000 by Race/Ethnicity, Georgia, State Vital Records 2007
Births per 1,000 adolescents
60.0
50.0
40.0
30.0
20.0
10.0
0.0
1.4
4.3
1.2
14.1
14.3
28.7
15.6
57.7
6.6
14.2
6.9
33.8
15 to 17 yrs
18 to 19 yrs
15 to 19 yrs
White non-Hispanic
Black non-Hispanic
Other non-Hispanic
Hispanic

Repeat Adolescent Birth Rate per 1,000 by Public Health District, Georgia, State Vital Records 2007



1-1 Northwest Health District (Rome)
1-2 North Georgia Health District (Dalton)
2 North Health District (Gainesville)
3-1 Cobb/Douglas Health District
3-2 Fulton Health District
3-3 Clayton County Health District (Jonesboro)
3-4 East Metro Health District (Lawrenceville)
3-5 DeKalb Health District
4 LaGrange Health District
5-1 South Central Health District (Dublin)
5-2 North Central Health District (Macon)
6 East Central Health District (Augusta)
7 West Central Health District (Columbus)
8-1 South Health District (Valdosta)
8-2 Southwest Health District (Albany)
9-1 Coastal Health District (Savannah)
9-2 Southeast Health District (Waycross)
10 Northeast Health District (Athens)

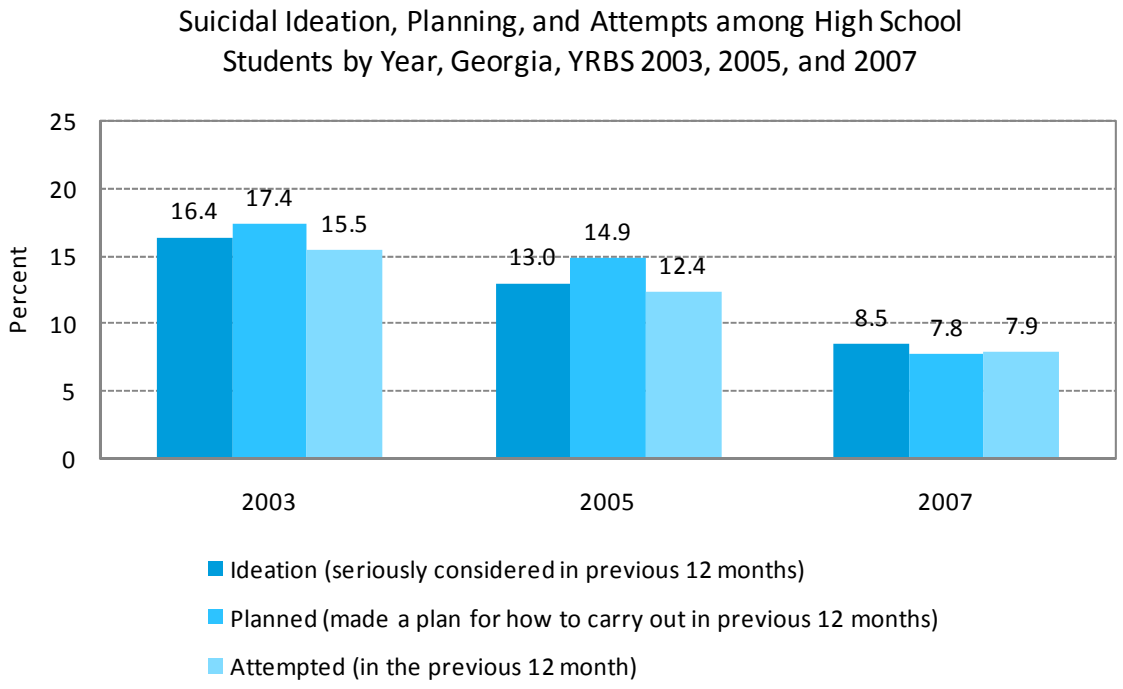
Office of Health Indicators for Planning (OHIP)
Epidemiology Branch
Division of Public Health
Georgia Department of Community Health

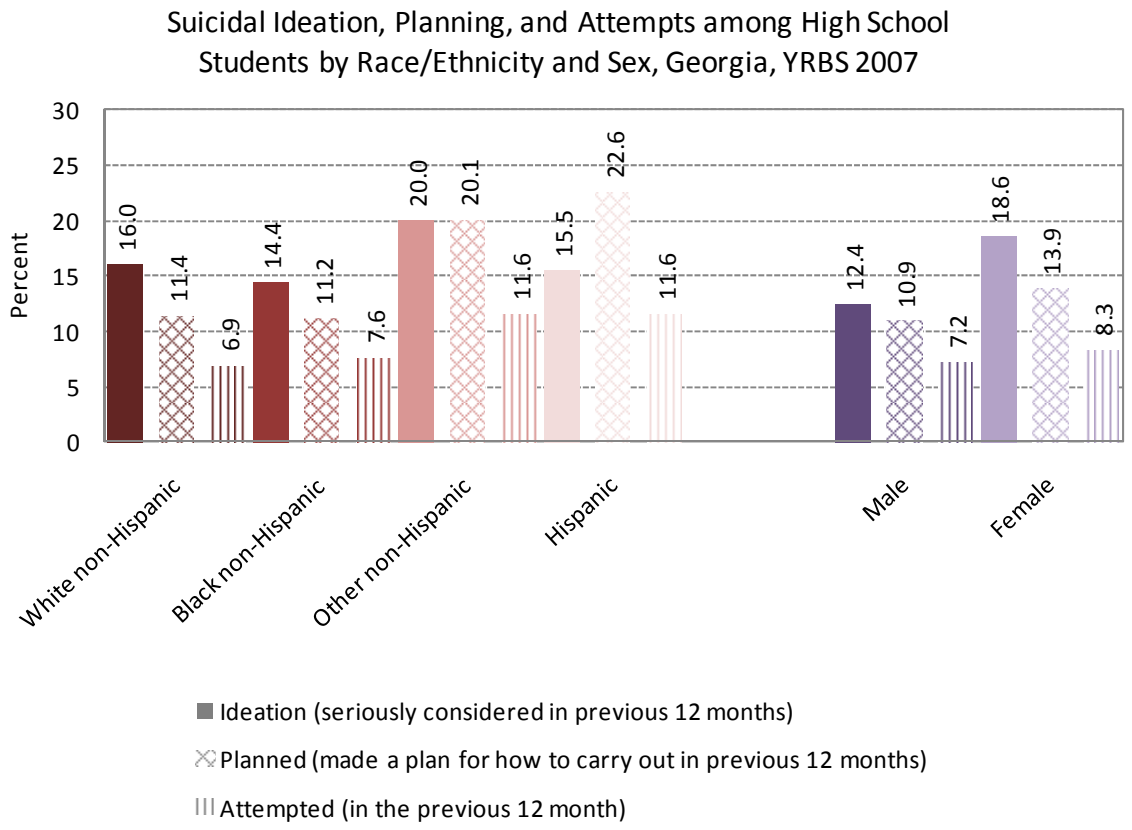
40 0 40 Miles

Created: July 2010
Source: Division of Public Health
Projection: Georgia Statewide Lambert Conformal Conic

SUICIDAL IDEATION, SUICIDE PLANNING, AND SUICIDE ATTEMPTS IN THE PAST TWELVE MONTHS AMONG HIGH SCHOOL STUDENTS

There was a decline in suicidal ideation, suicide planning, and suicide attempts in 2007 compared to 2003 and 2005. The decline from 2005 to 2007 replicated a decline, though not as large, between 2003 and 2005. Greater than one in five Hispanic high school students reported having made a plan for how to carry out a suicide in the previous twelve months and more than one in ten Hispanic high school students reported attempting suicide in the previous twelve months. These rates were greater than those reported among White and Black high school students. Female high school students had greater rates of ideation, planning, and attempting suicide compared to male high school students.



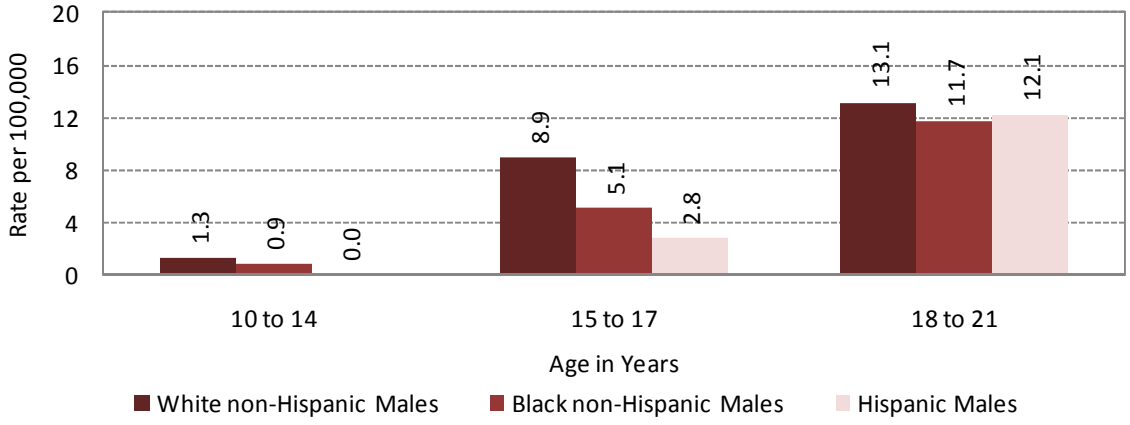


SUICIDE MORTALITY AMONG ADOLESCENTS 10 TO 21 YEARS OF AGE

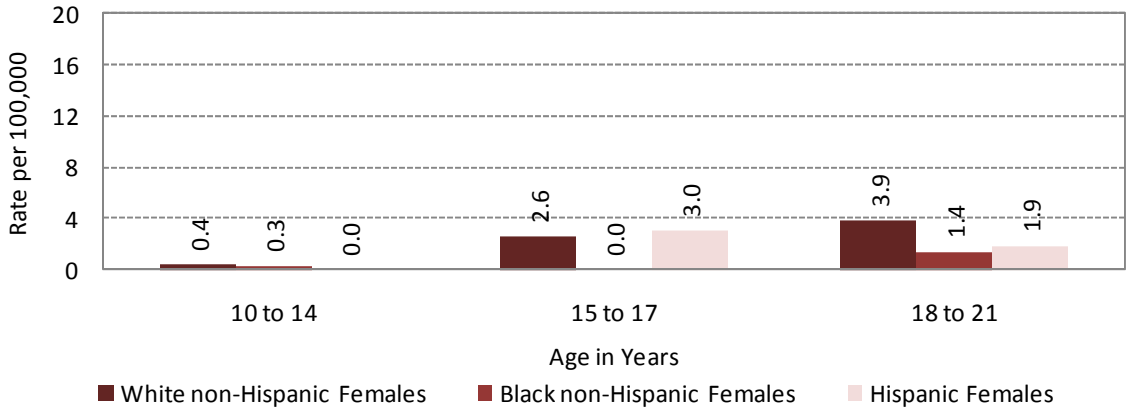
As noted earlier, in 2007, intentional self harm/suicide was the third leading cause of death among children 15 to 21 years of age. Suicide rates fluctuated between 1998 and 2007. Overall, suicide rates from 2002 through 2007 were generally lower than suicide rates between 1998 and 2001. The suicide rate among White children 15 to 17 years of age was greater than that among Black children 15 to 17 years of age and more than three times greater than the suicide rate among Hispanic children 15 to 17 years of age. While rates were similar between race/ethnic groups among children 18 to 21 years of age, the case counts are substantially different. Among children 18 to 21 years of age, there were 75 suicide deaths among children with White race/ethnicity. This compared to 37 suicide deaths among children with Black race/ethnicity and 11 suicide deaths among children with Hispanic race/ethnicity. Males had greater suicide rates than females for all age and racial/ethnic groups. Between 2005 and 2007, females accounted for 17 percent of all suicide deaths.

Suicide Rates per 100,000 by Age, State Vital Records 1998 through 2007										
Age Group	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
10 to 14	6.3	5.7	4.9	6.7	4.8	5.8	5.4	3.2	2.8	4.7
15 to 17	27.7	25.8	21.4	28.5	24.8	27.7	16.5	22.3	19.7	21.0
18 to 21	34.3	29.3	26.8	35.3	22.3	22.0	22.7	24.6	28.5	28.2

Suicide Rates among **Males** by Age and Race/Ethnicity, Georgia, State Vital Records 2005 through 2007



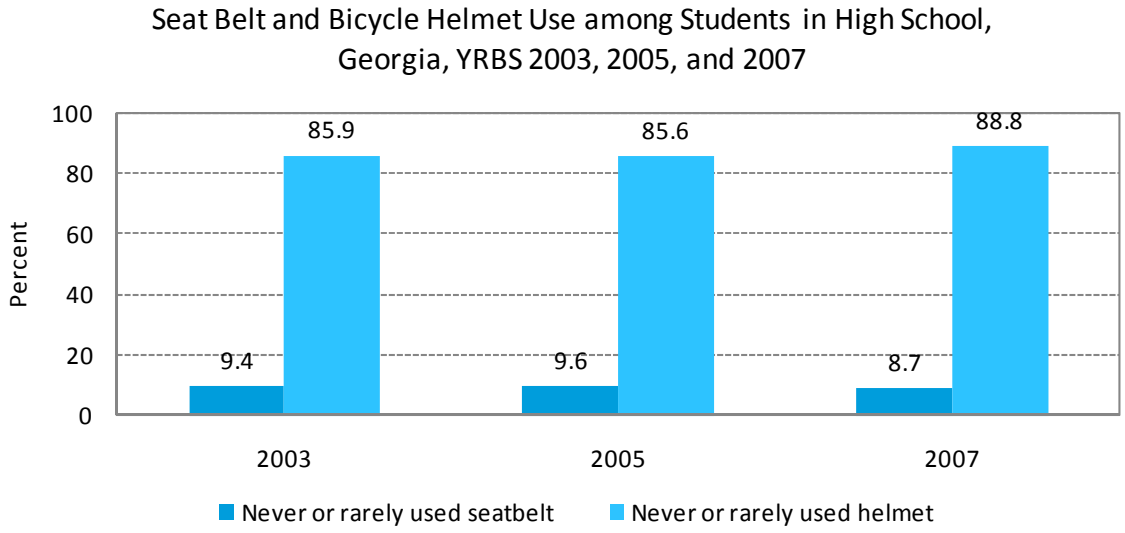
Suicide Rates among **Females** by Age and Race/Ethnicity, Georgia, State Vital Records 2005 through 2007

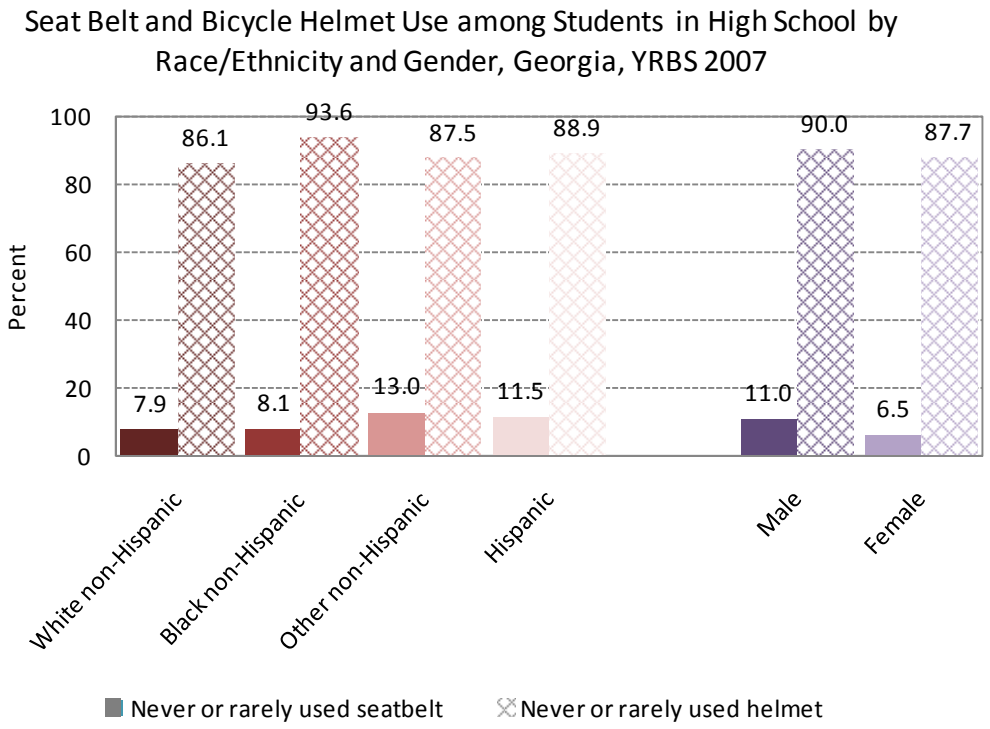


USE OF SAFETY DEVICES – SEAT BELTS AND HELMETS AMONG HIGH SCHOOL STUDENTS

Less than 10 percent of high school students reported either never or rarely using their seat belt. The percent of male high school students who either never or rarely used their seat belts was nearly double that of female high school students.

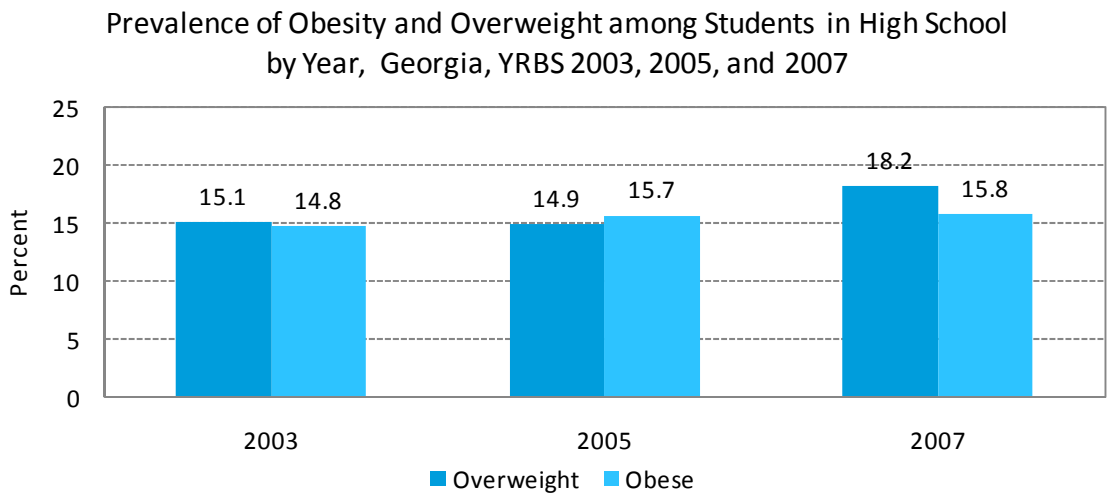
Unlike seat belt use, nearly 90 percent of high school students either never or rarely used bicycle helmets. The percent of high school students who either never or rarely used bicycle helmets exceeded 90 percent among Black high school students and male high school students.

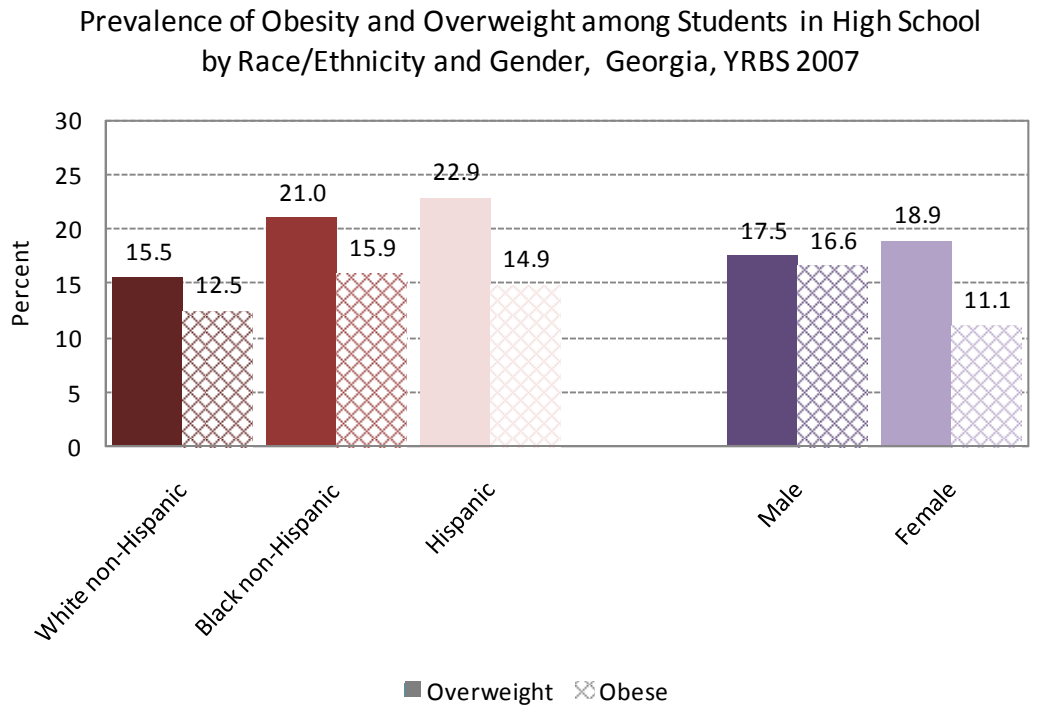




OBESITY AND OVERWEIGHT AMONG HIGH SCHOOL STUDENTS

In 2008, nearly one in five high school students in Georgia was overweight. This was approximately a three percentage point increase from previous years. Obesity rates have remained relatively constant between 2003 through 2007. Rates of overweight and obesity were greater among Black and Hispanic high school students compared to White high school students. The rate of overweight was greater among female high school students, but the rate of obesity was greater among male high school students.



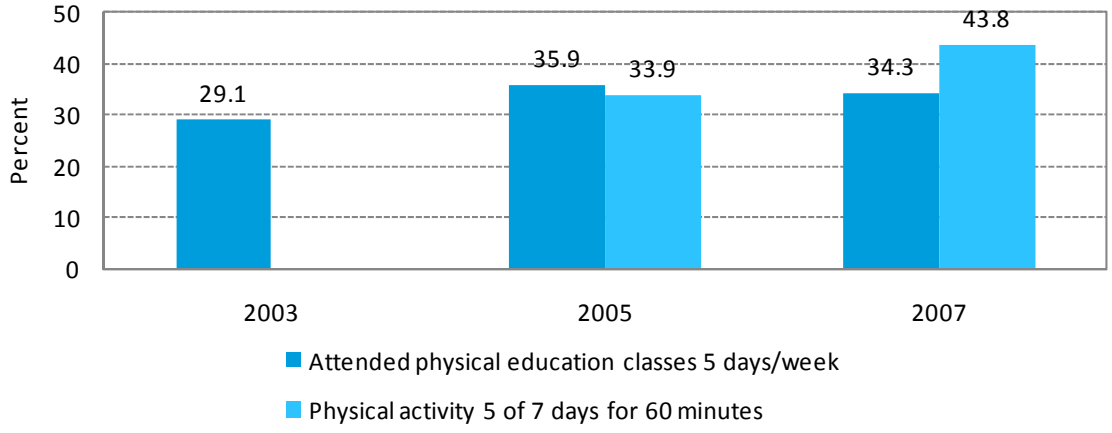


PHYSICAL ACTIVITY AMONG HIGH SCHOOL STUDENTS

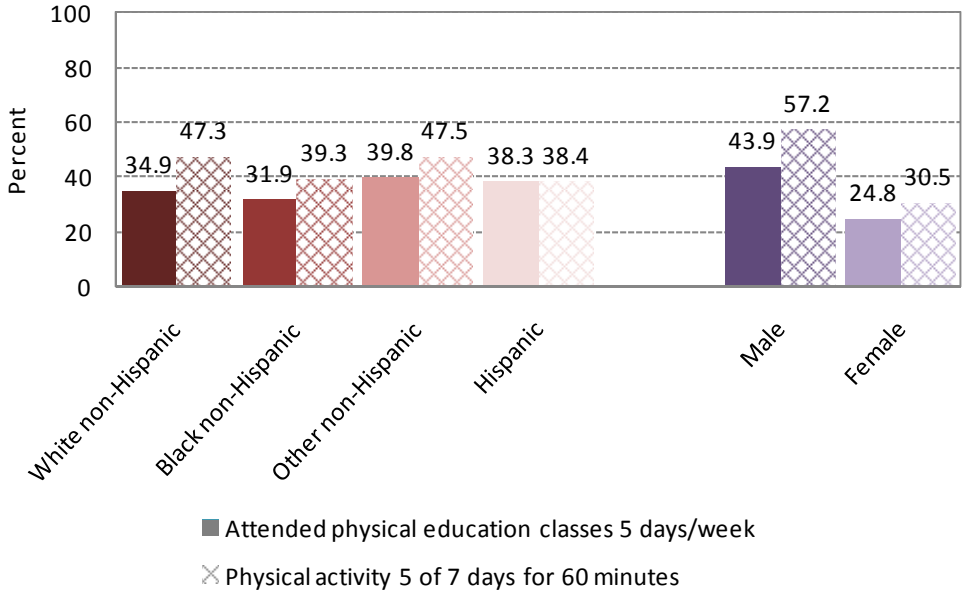
In 2005 and 2007, more than a third of high school students attended physical education class daily. However, while this was an increase from 2003, the *Healthy People 2010* objective for daily physical education class was 50 percent. While there was limited variation in daily physical education class attendance by race/ethnicity, the percent of male high school students attending physical education class daily was 77.0 percent greater than the same rate among female high school students.

The percent of high school students who participated in 60 minutes of physical activity on five of seven days in a week increased ten percentage points between 2005 and 2007. White high school students and high school students of other race/ethnicity had greater rates than Black or Hispanic high school students. The percent of male high school students participating in 60 minutes of physical activity on five of seven days in a week was 87.5 percent greater than among female high school students.

Physical Education Class Attendance and Physical Activity Prevalence among Students in High School, Georgia, YRBS 2003, 2005, and 2007



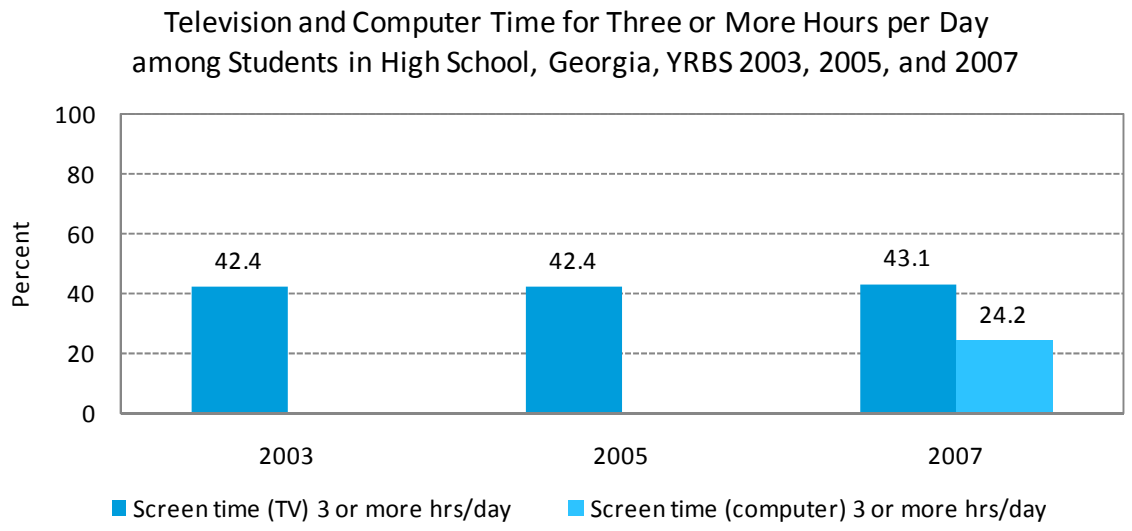
Physical Education Class Attendance and Physical Activity Prevalence among Students in High School by Race/Ethnicity and Gender, Georgia, YRBS 2007

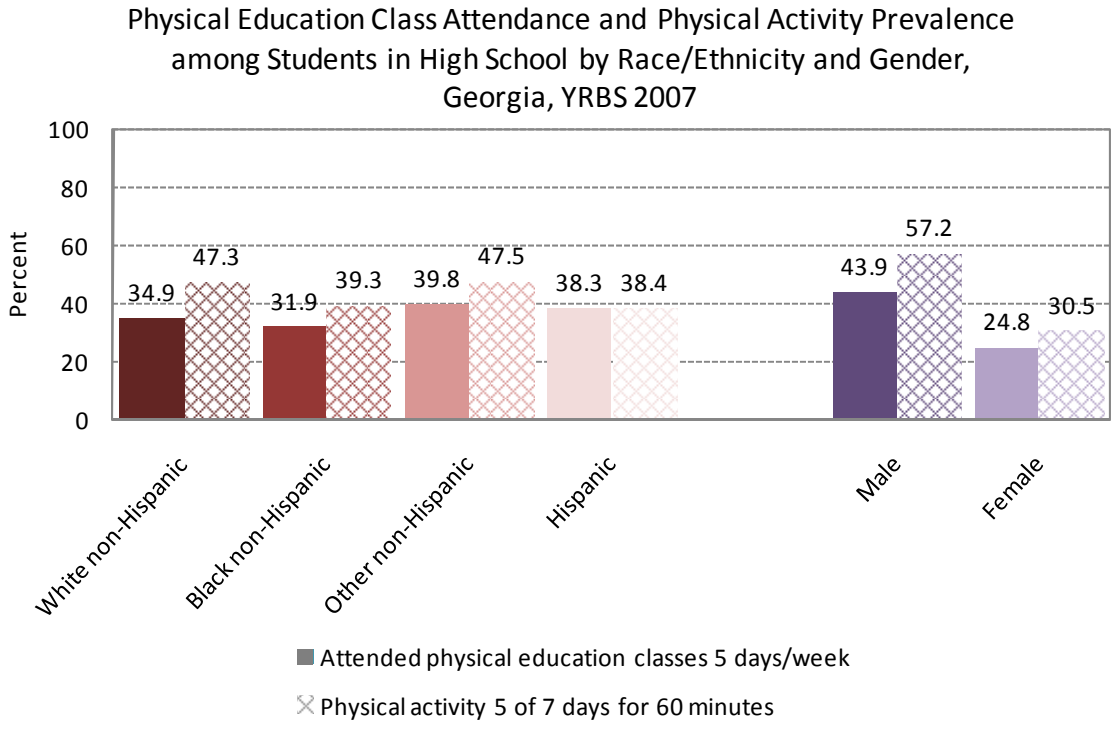


TELEVISION AND COMPUTER SCREEN TIME FOR THREE HOURS OR MORE PER DAY AMONG HIGH SCHOOL STUDENTS

More than 40 percent of high school students watch three or more hours of television per day. In 2007, the rate in Georgia was 72.4 percent higher than the *Healthy People 2010* objective. In 2007, the first year computer screen time was assessed on Georgia's YRBS, nearly a quarter of High school students reported spending three or more hours of computer screen time per day.

The percent of Black high school students who reported viewing three or more hours of television daily exceeded 60 percent. Fewer than 30 percent of White High school students reported viewing three or more hours of television daily. While the variation in television viewing by gender was limited, a greater percent of male high school students reported three or more hours of computer screen time daily.

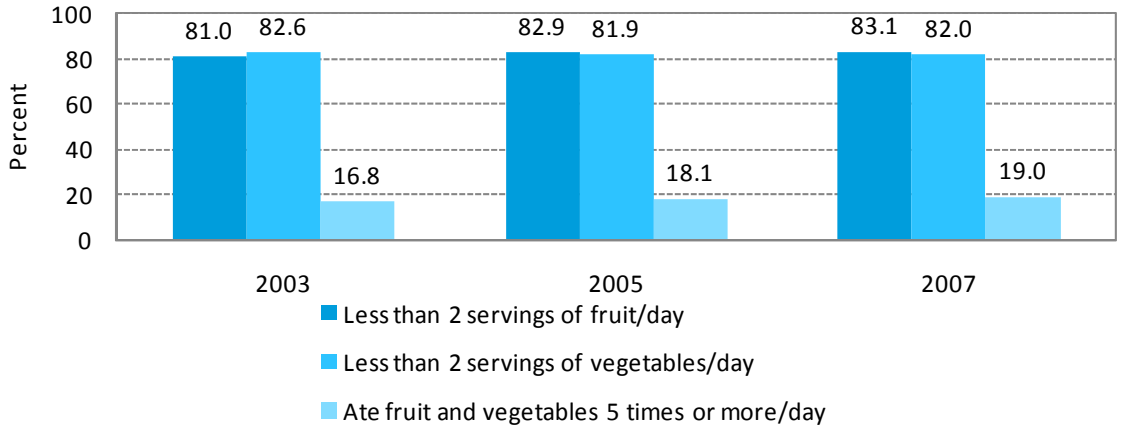




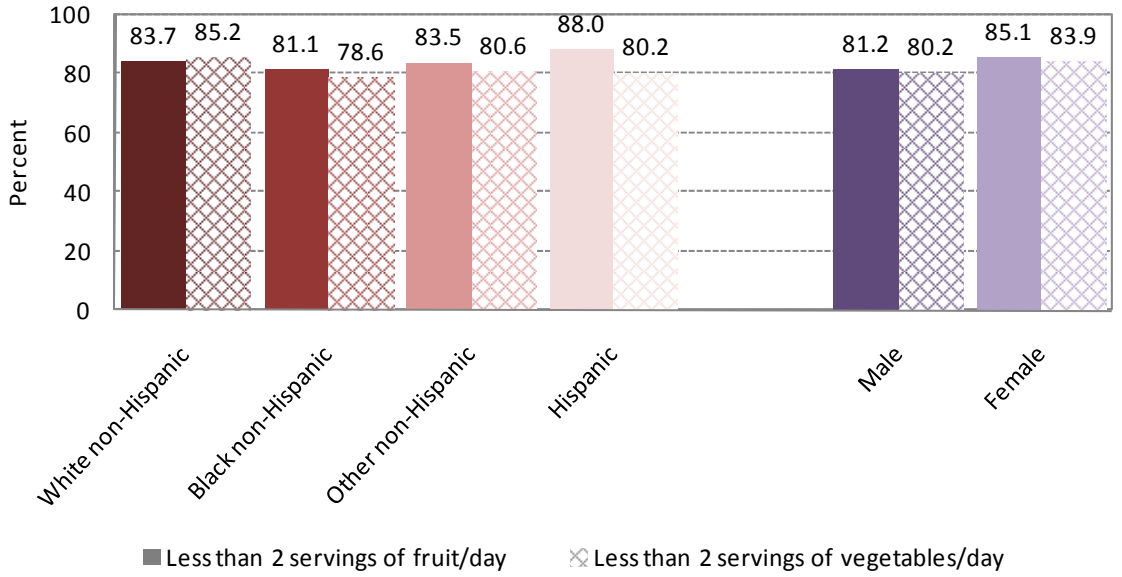
NUTRITION BEHAVIORS AMONG HIGH SCHOOL STUDENTS

Less than 20 percent of high school students report consuming two or more servings of fruits or vegetables daily. Two related *Healthy People 2010* objectives for nutrition are for 75 percent of people 2 years of age and older to consume at least two servings of fruits and vegetable daily and to increase the percent of children 2 years of age and older who consume at least three servings of vegetables daily to 50 percent. The low fruit and vegetable consumption reported in the high school population did not contribute to achieving these objectives. Analysis by race/ethnicity revealed that nearly twice the percent of Hispanic high school students consumed five or more servings of fruits and vegetables per day compared to White high school students.

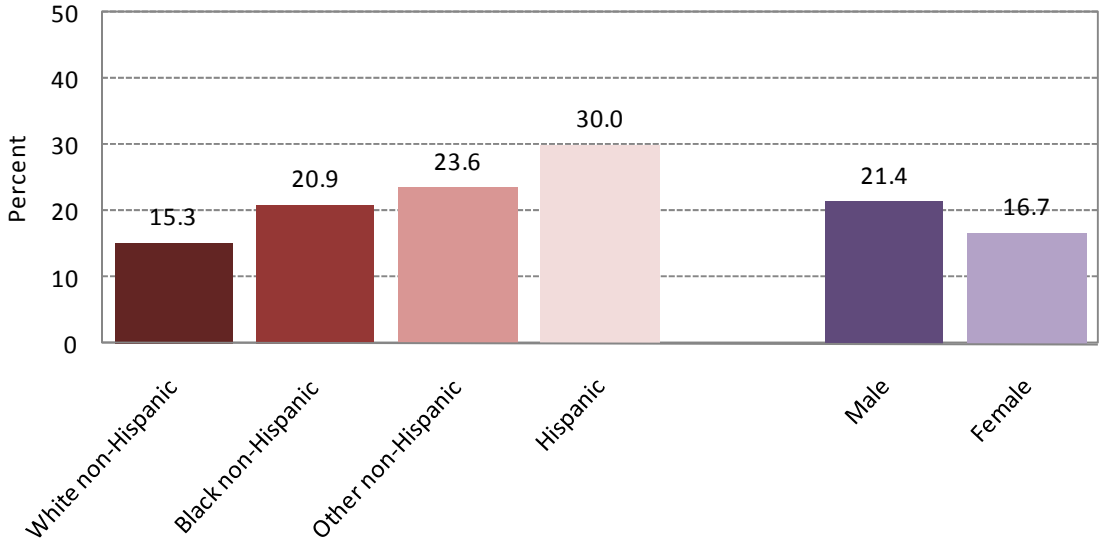
Nutrition Behavior among Students in High School, Georgia, YRBS 2003, 2005, and 2007



Consumption of Two or More Servings of Fruits and Two or More Servings of Vegetables by Race/Ethnicity and Gender, Georgia, YRBS 2007



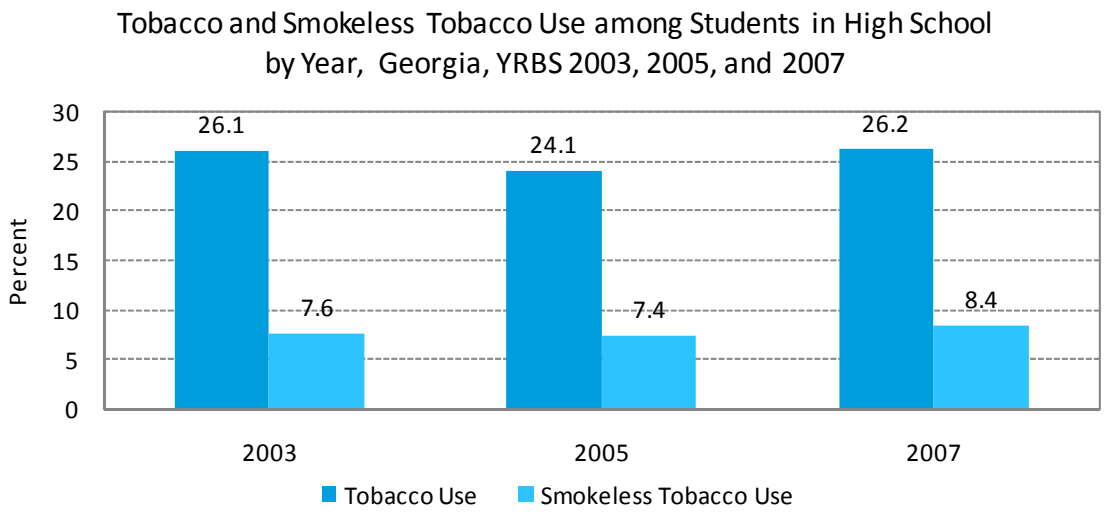
Consumption of Fruits and Vegetables Five Times or More per Day among Students in High School by Race/Ethnicity and Gender, Georgia, YRBS 2007

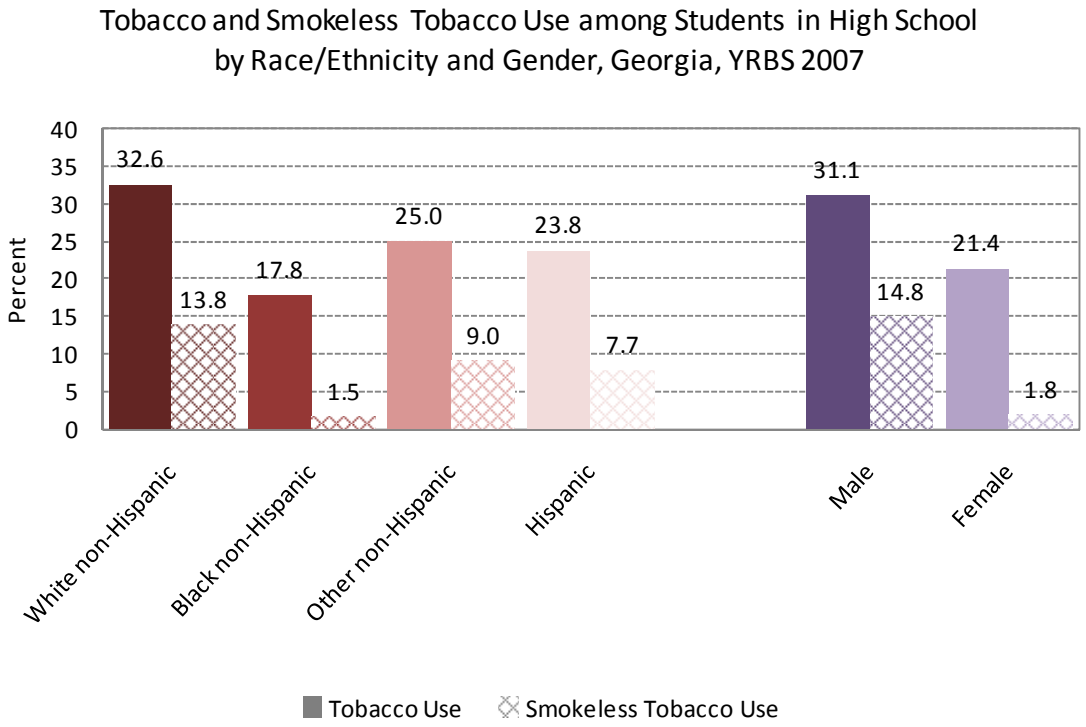


TOBACCO USE AMONG HIGH SCHOOL STUDENTS

The *Healthy People 2010* objective for adolescent tobacco use is 21 percent and 1 percent for adolescent smokeless tobacco use. In Georgia, among high school students, the tobacco use prevalence rate was approximately 26 percent annually. The average smokeless tobacco rate in 2003, 2005, and 2007 exceeded the *Healthy People 2010* objective by 680 percent.

Tobacco use was greater among White high school students compared to other racial/ethnic groups and greater among male high school students compared to female high school students. Smokeless tobacco use was lower among Black high school students and female high school students.



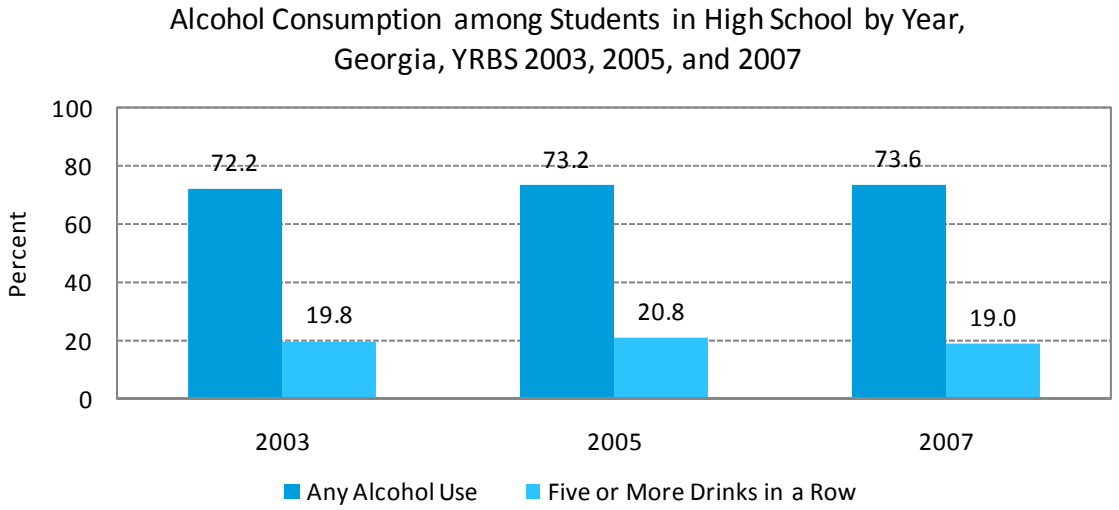


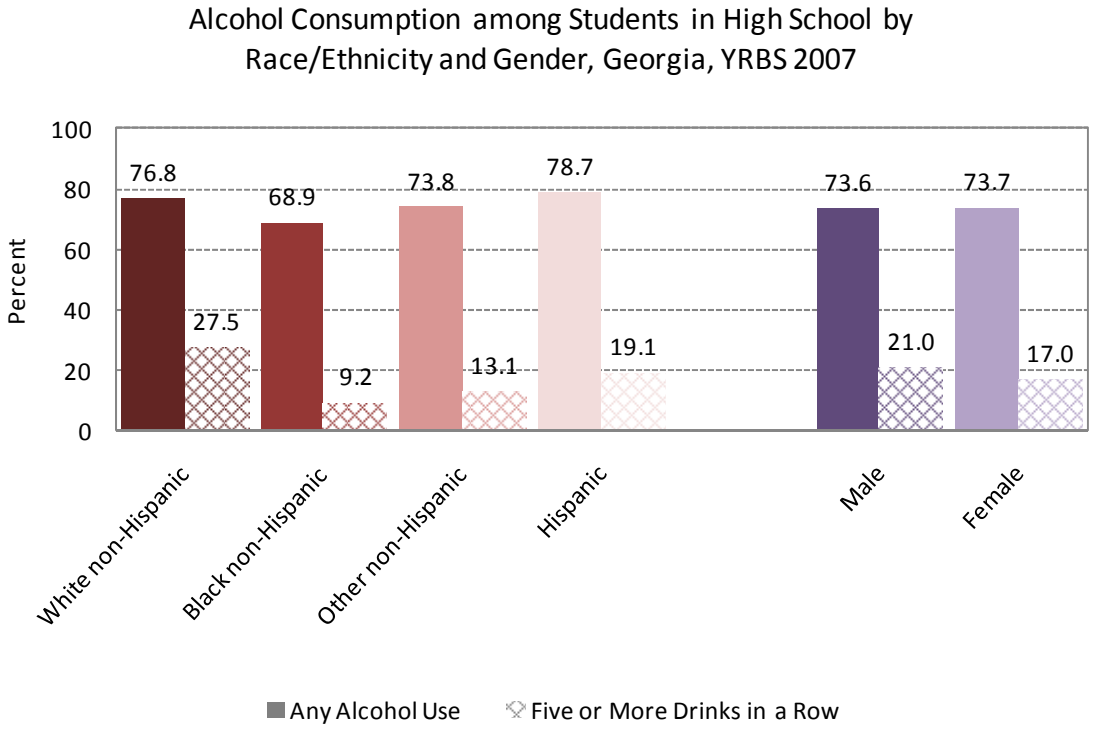
ALCOHOL USE AND BINGE DRINKING AMONG HIGH SCHOOL STUDENTS

Healthy People 2010 set a target of 29 percent of high schools seniors having never used alcohol. In Georgia, across all high school students, approximately 17 percent have never used alcohol. Lifetime alcohol use prevalence exceeded 70 percent among both male and female high school students and high school students of all racial/ethnic groups except Black high school students.

Approximately one-fifth of Georgia's high school students reported binge drinking (having five or more drinks in a row). The average binge drinking prevalence in 2003, 2005, and 2007 was 19.7 percent. The

average binge drinking prevalence was 885 percent greater than the *Healthy People 2010* objective for binge drinking of two percent. More than one-quarter of White high school students in Georgia reported binge drinking. This compared to less than 10 percent among Black high school students and less than 20 percent among Hispanic high school students. The prevalence of binge drinking was four percentage points greater among male high school students compared to female high school students.

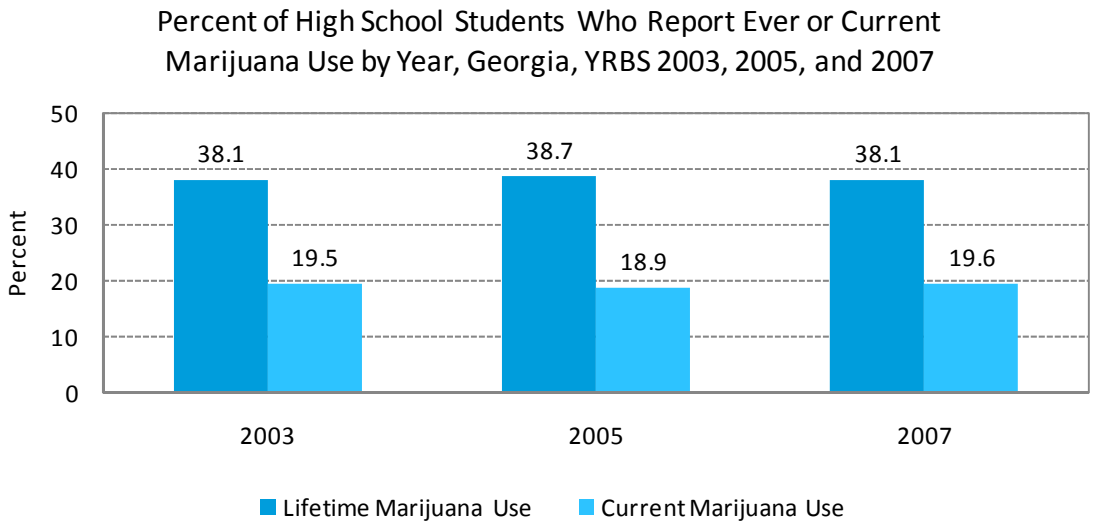


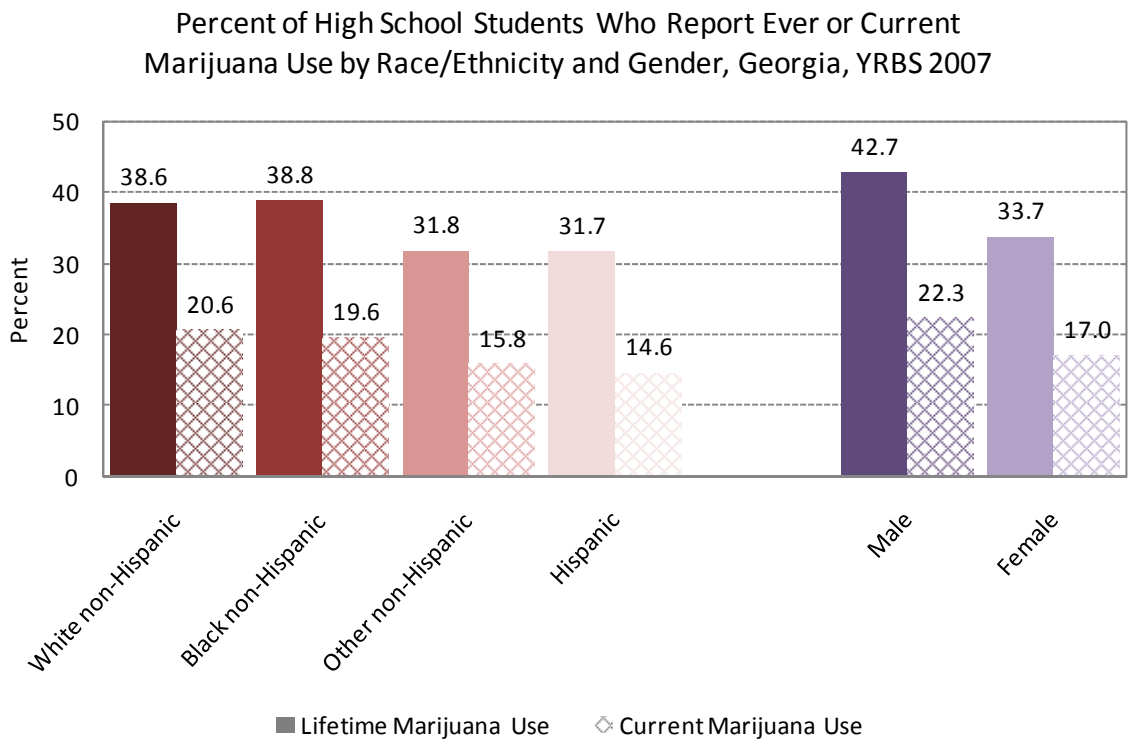


LIFETIME AND CURRENT MARIJUANA USE AMONG HIGH SCHOOL STUDENTS

Healthy People 2010 set a target of 56 percent of high schools seniors having never used illicit substances. Adolescents in Georgia fail to meet this objective when considering marijuana use alone. Nearly 40 percent of Georgia high school students reported lifetime marijuana use. The prevalence of lifetime marijuana use was greater for White and Black high school students than Hispanic high school students or students of other race/ethnicity. The prevalence of lifetime marijuana use was approximately ten percentage points greater among male high school students than female high school students.

Nearly one-fifth of all Georgia high school students reported current marijuana use (use in the past 30 days). The average rate of current marijuana use for 2003, 2005, and 2007 was 38.1 percent. This average rate was more than 5,000 percent greater than the *Healthy People 2010* objective for current marijuana use of 0.7 percent. Among White high school students, 20.6 percent reported current marijuana use as did 19.6 percent of Black high school students. Current marijuana use was greater among male high school students than female high school students.

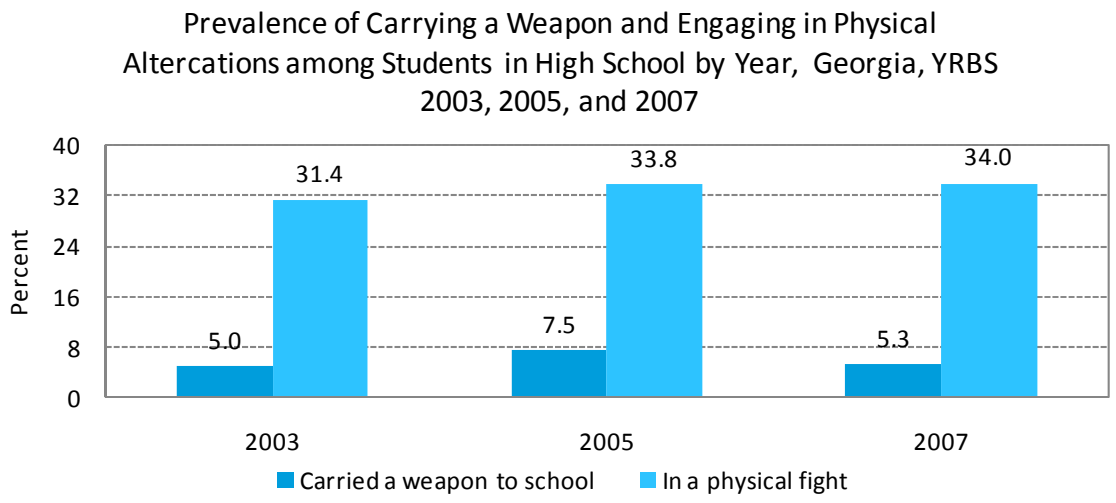


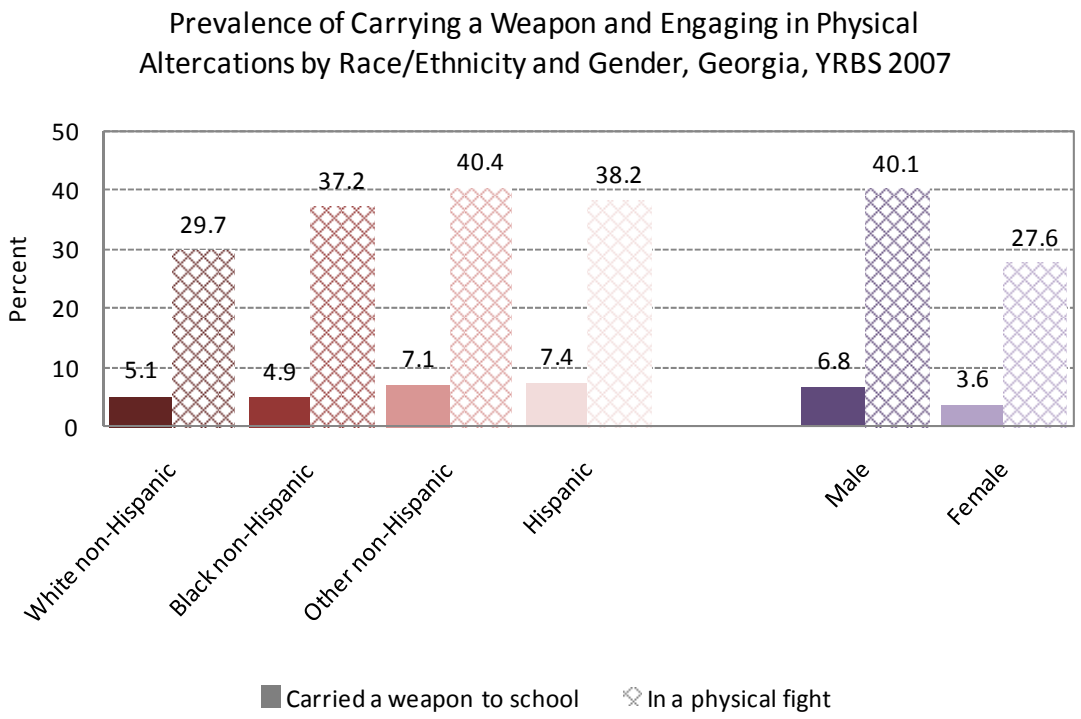


VIOLENCE AMONG HIGH SCHOOL STUDENTS

On average, 5.9 percent of high school students reported carrying a weapon to school. Black high school students met the *Healthy People 2010* objective for this measure in 2007 and White high school students were within five percent. The *Healthy People 2010* objective was also met among female high school students.

In 2005 and 2007, more than a third of the High school students in Georgia reported ever being in a physical fight. The percent for 2007, the greatest of the three data points presented, was within 6.3 percent of the *Healthy People 2010* objective for this measure. White high school students and female high school students surpassed the *Healthy People 2010* objective for this measure.





QUALITATIVE THEMES FOR ADOLESCENTS FROM STATEWIDE FOCUS GROUPS

The qualitative data section is organized by theme. These themes were identified through analysis of the data collected through the focus groups. There is standard information provided for each theme that includes sections on *Quantification*, *Description of the Health Concern*, and *Ideas about What is Needed to Improve* the identified need.

The *Quantification* section provides information about the frequency with which the theme was identified.

After reviewing the notes collected during the focus groups, themes were identified by analysts based on the information recorded as part of the focus groups. The *Description of the Health Concern* section provides quotes and ideas communicated by focus group participants that were used in defining the theme. As frequently as possible, direct quotes from focus group participants are used.

The *Ideas about What is Needed to Improve* the identified need section captures focus group participant ideas about possible strategies and solutions to improve that theme.

In limited instances, along with the identified themes, a section has been included labeled *Other Health Concerns*. This section includes a list of health care concerns among a specific population that were not mentioned with adequate frequency to be considered a theme, but were important to document.

ADOLESCENT PREGNANCY

QUANTIFICATION

Teen pregnancy is identified as a major health concern for adolescents by five of nine statewide stakeholder/consumer focus groups and two of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Focus group attendees energetically provided a variety of perspectives on how they view teen pregnancy and the health concern it poses to teens in their communities.

A stakeholder's observation is that "adolescents get into drug and alcohol experimentation, and premature sexual activity, leading to pregnancy and other diseases."

A major health concern of focus group attendees in several Georgia communities is the "rise in teen pregnancy and the increase in number of young girls having babies."

"Teen pregnancy is rampant" and similar views were heard in over half the community focus groups.

Several MCH stakeholder groups identified "teen pregnancy and sexual health" as a health concern that should be one of Georgia's top priorities.

Health Care providers shared a variety of concerns related to teen pregnancy.

- "There are different attitudes - we don't know if we are going to support them or throw them in the trash;"
- "We see repeat pregnancies due to the inability to pay for birth control or lack of education on spacing pregnancies;" and
- "Adolescent obesity impacts our ability to provide effective birth control because of health issues. This leads to pregnancy which leads to high risk pregnancy. There is a very complicated domino effect."

Teen parents who contributed to the focus groups were few but generally vocal. In one group, the teen mom shared a perspective that health care providers in the room did not agree with. "I was put in night school because I was pregnant with a special needs baby, even though my grades stayed in A's."

Another comment which yielded debate is that "teenagers are being required to return to school too soon – some say two to six weeks after delivering a baby." The focus group discussion did not resolve the debate about what was going on in the community around teen pregnancy.

IDEAS ABOUT SOLUTIONS

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of adolescents. Suggestions around teen pregnancy follow.

- Universal education is needed for pregnancy prevention among the teen population. Education should be targeted for teens, men and the community. This was noted by nearly 100 percent of stakeholder focus groups;
- We need "stronger programs" to address teen pregnancy;
- "In our community we need an improved and increased preventive services and teen services… We need more flexibility in use of funding";
- "Teen clinics and someone to speak to teens" are needed";
- "We need teens to have a sense of personal responsibility;"
- "We need abstinence and age-appropriate sex education;"
- We need "stronger community-based programs to address teen pregnancy, including outreach to boys; we need program development to involve the school board and the community, including faith community'"
- "We need to educate at an early age. To wait until sixteen is five years too late. Need to be more aggressive and graphic with education;"
- In another group a teenage girl suggests, "a class with nasty pictures would be effective." And another, "put information on billboards to draw attention;"
- What is needed is a "change of attitude toward teenagers" and "a change in attitude in the community about pregnancy prevention;"
- "We need to include STD education in teenage pregnancy prevention strategies;" and
- We need services "which will assist with keeping students who become pregnant in school."

ADDITIONAL QUOTES

"Now we see teens being treated for four STD's at a time."

ACCESS TO HEALTH CARE

QUANTIFICATION

Access to health care is identified as a major health concern for adolescents by five of nine statewide stakeholder/consumer focus groups and three of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

"Lack of adequate health care for adolescents" is a problem. "Adolescents aging out of Medicaid at age 18" leaves them without health care insurance. Many adolescents do not have insurance and "that number is growing." Others cite funding shortages, "CMS has limited funding and support services for adolescents."

Other aspects of the concern highlighted by stakeholders include the following.

- "There is a lack of specialty providers for adolescents;"
- "We see a lack of completion of heath checks in teen population. Chronic disease is not mentioned because they won't come in for appointments;" and
- Age-appropriate health care throughout the spectrum – age-appropriate supervision, development of age-appropriate life skills – ages 1 to 21 years is a health need as stated by roundtable group at the focus group for non-governmental and advocacy MCH organizations. \

IDEAS ABOUT SOLUTIONS

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of adolescents. Suggestions around adolescent access to care follow.

- Teen clinics where someone is available to speak with teens about pregnancy are needed;" and
- "It is hard to draw kids in to hear what you have to say without incentives. You need to be able to adapt funding and services to what works best in the community in which you live."

OBESITY

QUANTIFICATION

Obesity is identified as a major health concern for adolescents by four of nine statewide stakeholder/consumer focus groups and five of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

"Increased teen obesity rates" are an observation heard during focus group discussions about obesity among adolescents.

There are additional concerns associated with obesity among adolescents. Heard frequently is the concern about the "impact of obesity on the early onset of chronic health conditions."

Another concern associated with obesity is its impact on birth control effectiveness.

"Adolescent obesity impacts our ability to provide effective birth control because of health issues. This leads to pregnancy, which leads to high risk pregnancy. It is a very complicated domino effect."

Preadolescent and adolescent lifestyle issues (unhealthy eating, lack of physical exercise, smoking, drinking, etc.) were noted of concern in many stakeholder groups and are seen as contributing to the problem.

IDEAS ABOUT SOLUTIONS

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of adolescents. Suggestions around adolescent obesity follow.

- Family obesity counseling
- "Any approaches for adolescents need to involve parents"

MENTAL HEALTH

QUANTIFICATION

Mental health is identified as a major health concern for adolescents by four of nine statewide stakeholder / consumer focus groups and four of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Mental health is identified as a major health concern for adolescents. "Teenagers go through a lot – they need all the guidance they can get."

Of special concern is the mental health of young girls. "There's peer pressure among pre-teens around alcohol use, sexual activity, bullying, violence."

Several community focus group participants noted that "we see an increase in girls fighting in school. The real world they see on TV is not the real world. "

Teen suicide is an associated concern.

IDEAS ABOUT SOLUTIONS

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of adolescents. Suggestions around adolescent mental health follow.

- Counseling services for adolescents will "improve their self esteem and relations within the family;" and
- Provide mental health services. "We can [prevent tragedies].

UNHEALTHY BEHAVIORS/LIFESTYLES

QUANTIFICATION

Unhealthy behavior/lifestyle is identified as a major health concern for adolescents by five of nine statewide stakeholder/consumer focus groups and two of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Pre-adolescent and adolescent lifestyle issues (unhealthy eating, lack of physical exercise, smoking, drinking) were noted.

Major health concerns noted by focus groups also include:

- Teen driving
- Dropping out of high school
- "Higher rate of STD's in teens"
- "Teen smoking – cigarettes and everything"
- "Alcohol, drug experimenting and premature sexual activities leading to pregnancy and other diseases"
- "Peer pressure among pre-teens around alcohol use, sexual activity, bullying, violence"
- Not buckling up and putting infants in car seats
- Cell phone / texting

IDEAS ABOUT SOLUTIONS

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of adolescents. Suggestions around unhealthy behaviors/lifestyle follow.

- Teens need to "get a sense of personal responsibility;"
- Adequate sex education and appropriate services from pre-school though high school are needed;
- "Innovative health education approaches for early childhood through adolescence are needed - including health, behavioral health, lifestyle education and continuous support for child and for family unit;" and
- "Classes for adolescents to show them the reality of their actions" are needed.

VIOLENCE

QUANTIFICATION

Violence is identified as a major health concern for adolescents by five of nine statewide stakeholder/consumer focus groups and two of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Stakeholders noted a variety of violent situations in which some teens find themselves.

Gang violence is a major health concern noted during a number of focus groups. One community health care provider observed "gang violence – there's been a big change in the past five years. The gangs are drug based."

Another type of violence noted in a several groups is "domestic violence among teens." As one stakeholder observed, "some teens have grown up with domestic violence – they are the second generation."

And yet another kind of violence noted during the needs assessment focus group sessions is "an increase in girls fighting in school. The real world they are seeing on TV is not the real world."

IDEAS ABOUT SOLUTIONS

MCH stakeholders forwarded various ideas on what is needed to improve the physical and mental health of adolescents. No specific suggestions around violence emerged, however these suggestions were made in general discussion.

- Change of attitude toward teenagers
- Support services for teens
- Classes for adolescents that show them the reality of their action

OTHER HEALTH CONCERNS

The following is a list of health care concerns among adolescents that were not mentioned with adequate frequency to be considered a theme, but are important to document.

- Lack of support services for teens
- Need for a change of attitude towards teens
- Increase in adolescent hypertension and diabetes
- Health concerns that cannot be addressed in health clinic
- Lack of developmental opportunities for teens and youth
- Increased rate of STDs among teens

CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

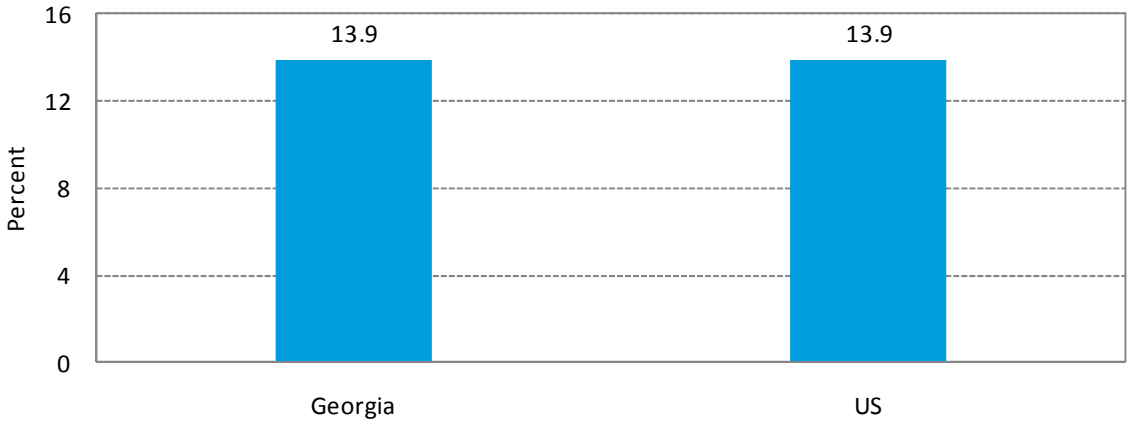
QUANTITATIVE ANALYSES

DESCRIBING THE CSHCN POPULATION IN GEORGIA

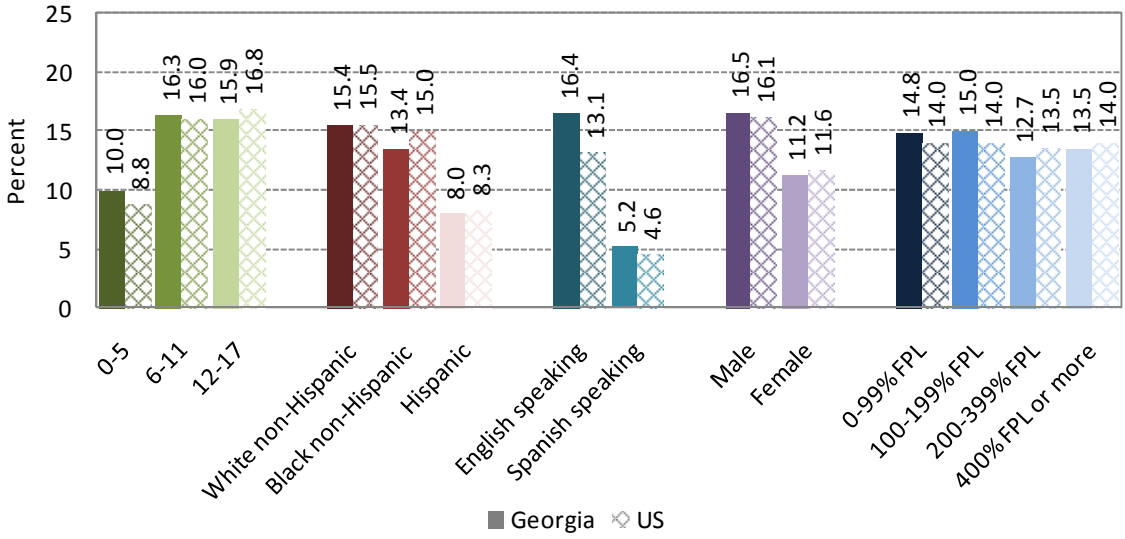
According to the 2005/2006 National Survey of Children with Special Health Care Needs, there were approximately 334,420 children in Georgia with special health care needs for a prevalence of 13.9

percent, which was identical to the nationwide prevalence. When stratifying by sociodemographic characteristics, the prevalence of children with special health care needs was similar between Georgia and the US. The prevalence of children with special health care needs was greater for male children than female children and greater for English speaking Hispanic children than Spanish speaking Hispanic children. The prevalence among English-speaking Hispanic children was approximately three times the prevalence among Spanish-speaking Hispanic children.

Prevalence of Children with Special Health Care Needs, Georgia and the United States, National Survey of Children's Health 2007



Prevalence of Children with Special Health Care Needs, Georgia and the United States by Age, Race/Ethnicity, Language, Sex, and Poverty, National Survey of Children's Health 2007



SOCIAL SECURITY INCOME RECIPIENTS UNDER 18 YEARS OF AGE

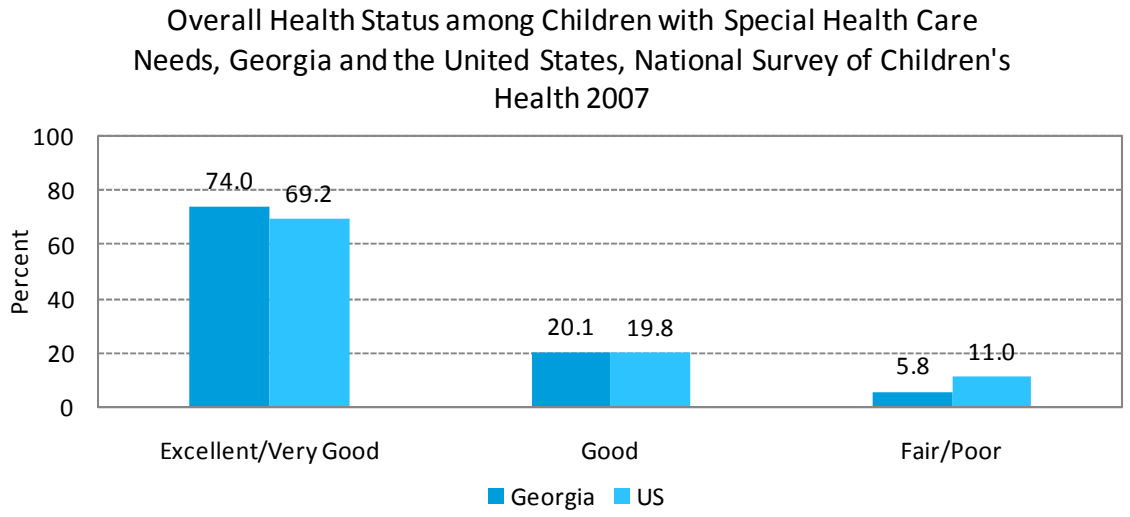
There are no estimates of the number or prevalence of children with special health care needs at the sub-state level. However, understanding patterns in the concentrations in children with special health care needs is essential to appropriate planning and resource allocation. Supplemental Security Income (SSI) program is a cash assistance program that provides monthly benefits to low-income aged, blind, or disabled persons in the 50 states. *SSI Recipients by State and County, 2009* is an annual report published annually by the Social Security Administration and provides information on SSI recipients less than 18 years of age by county. While the count of SSI recipients underestimates the number of children with special health care needs, it provides an estimate of the relative distribution of children with special health care needs within Georgia's 159 counties.

Fulton, DeKalb, Gwinnett, Clayton, Cobb, Richmond, Muscogee, Bibb, and Chatham counties accounted for 43.1 percent of all children less than 18 years of age who received SSI. Adding Dougherty, Henry, Houston, Lowndes, Newton, Douglas, and Clarke counties accounted for an 11.5 percent, nearly 55.0 percent of all children on SSI in Georgia.

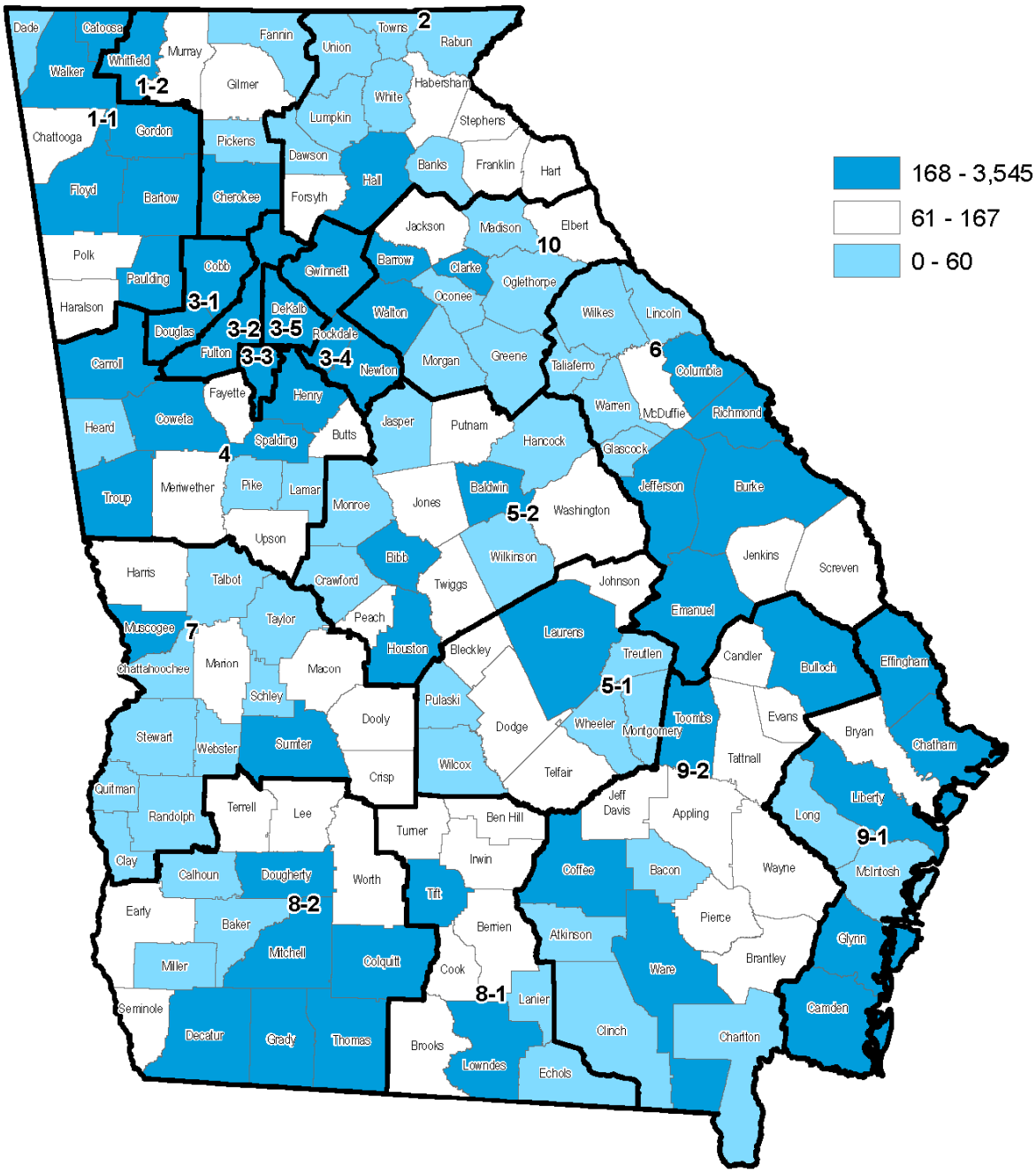
Twenty-four counties had a rate equal to or greater than 30 children receiving SSI per 1,000 children less than 18 years of age. Of these 24 counties, two had rates equal to or greater than 40 children receiving SSI per 1,000 children less than 18 years of age. Counties with greater rates had lesser populations and number of children receiving SSI. Of these 24 counties, six were among the top 100 counties with the greatest population with Dougherty County (24th largest county population) being the largest.

HEALTH STATUS AMONG CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The distribution of children with special health care needs with excellent/very good health status, good health status, or fair/poor health status was similar between Georgia and the US. In Georgia, nearly three-quarters of children with special health care needs reported excellent/very good health status. This compared to 86.2 percent in the non-CSHCN population in Georgia. The gap in the percent of children in excellent/very good health status between the CSHCN and non-CSHCN population was larger in the US (18.0 percent) than in Georgia (14.2 percent).



Count of SSI Recipients Less than 18 Years of Age, Georgia, SSI Recipients by State and County, 2009



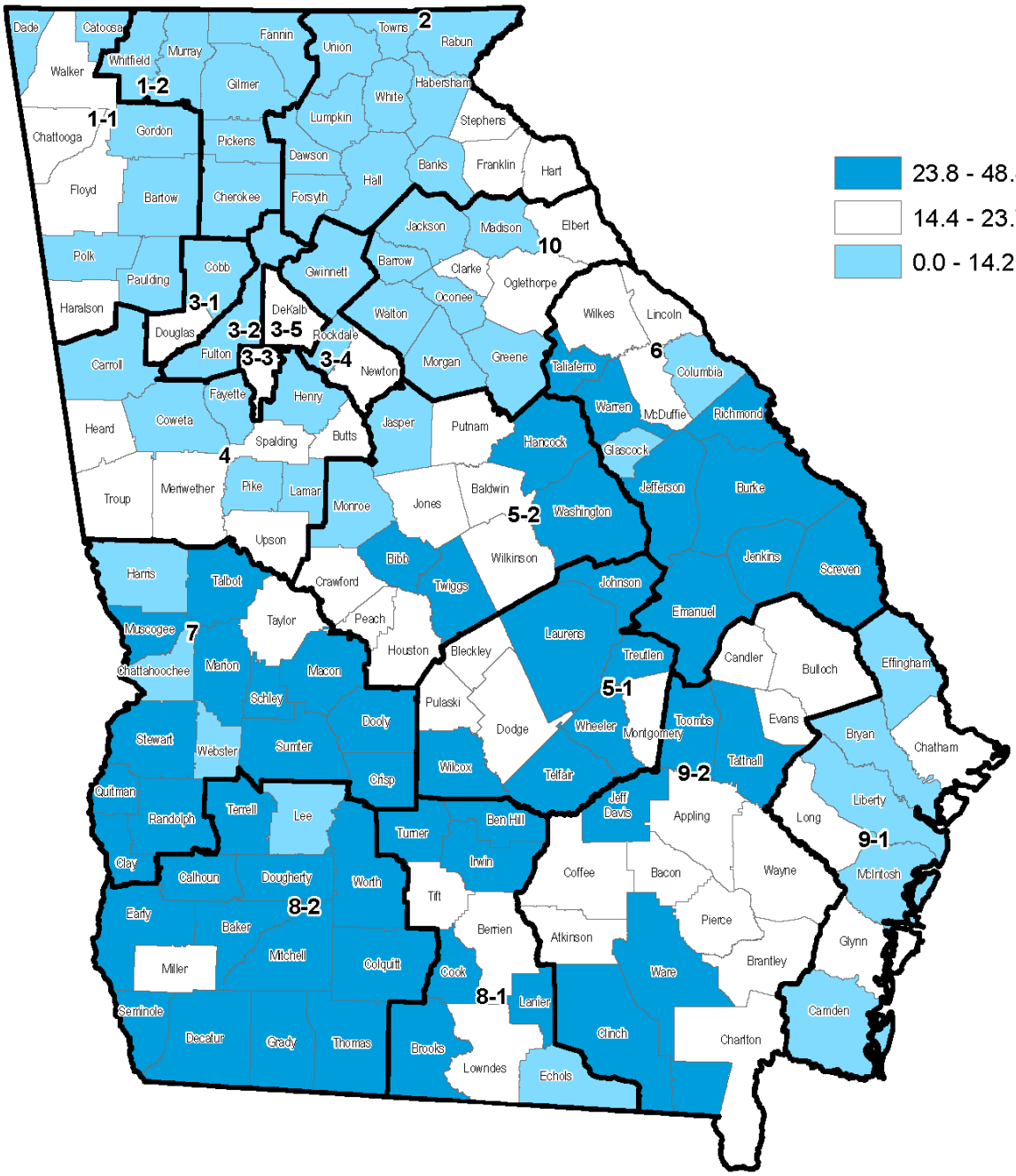
1-1 Northwest Health District (Rome)
1-2 North Georgia Health District (Dalton)
2 North Health District (Gainesville)
3-1 Cobb/Douglas Health District
3-2 Fulton Health District
3-3 Clayton County Health District (Jonesboro)
3-4 East Metro Health District (Lawrenceville)
3-5 DeKalb Health District
4 LaGrange Health District
5-1 South Central Health District (Dublin)
5-2 North Central Health District (Macon)
6 East Central Health District (Augusta)
7 West Central Health District (Columbus)
8-1 South Health District (Valdosta)
8-2 Southwest Health District (Albany)
9-1 Coastal Health District (Savannah)
9-2 Southeast Health District (Waycross)
10 Northeast Health District (Athens)

Office of Health Indicators for Planning (OHIP)
Epidemiology Branch
Division of Public Health
Georgia Department of Community Health

40 0 40 Miles

Created: July 2010
Source: Division of Public Health
Projection: Georgia Statewide Lambert Conformal Conic

Rate of SSI Recipients Less Than 18 Years of Age per 1,000 Children Less than 18 Years of Age, Georgia, SSI Recipients by State and County, 2009



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Office of Health Indicators for Planning (OHIP)
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40 0 40 Miles

Created: July 2010
Source: Division of Public Health
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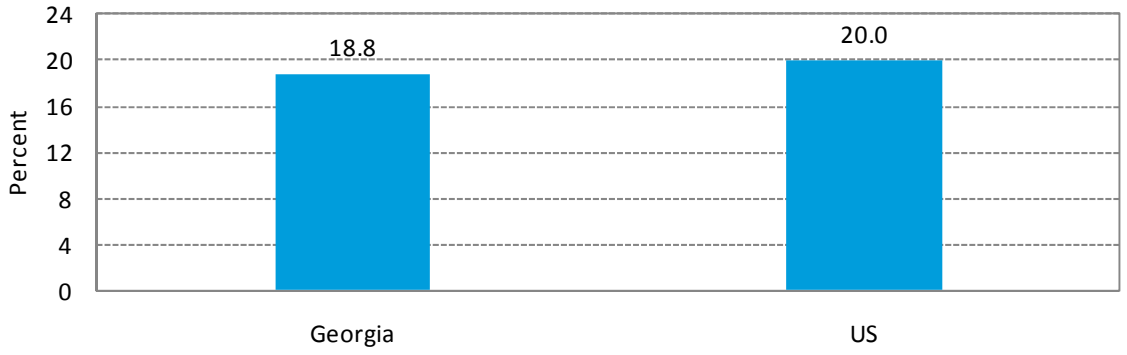
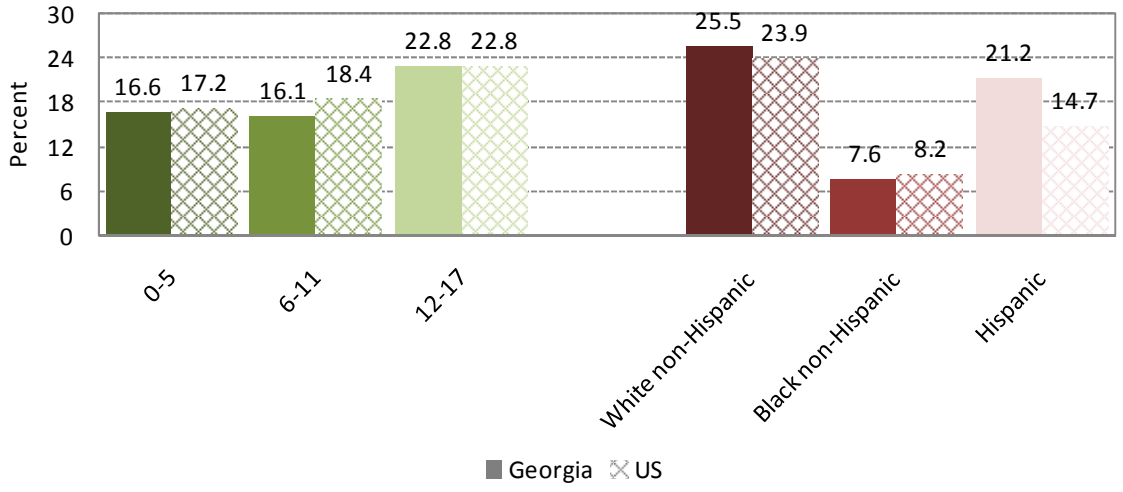
OUT-OF-POCKET COSTS FOR MEDICAL EXPENSES

Annually, approximately one-fifth of all families of children with special health care needs paid $1,000 or more in out-of-pocket medical expenses. The percent of families of children with special health care needs paid $1,000 or more in out-of-pocket medical expenses was greater among older children. A lesser percentage of Black children with special health care needs paid $1,000 or more in out-of-pocket medical expenses. This difference may indicate less intense medical issues among this group, fewer recognized medical issues among this group, or this difference may indicate an absence of access to care. Additional research is needed to understand this significant gap between racial/ethnic groups. When comparing Georgia to the US, there was minimal variation by age or race/ethnicity.



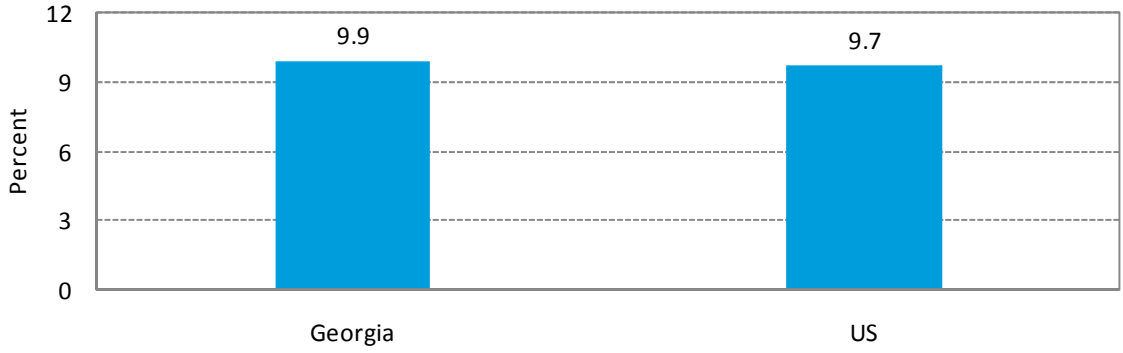
Prevalence of Children with Special Health Care Needs Whose Families Pay $1,000 or More Out-of-Pocket in Medical Expenses for Child, Past 12 months by Age and Race/Ethnicity, Georgia and the United States, National Survey of Children's Health 2007

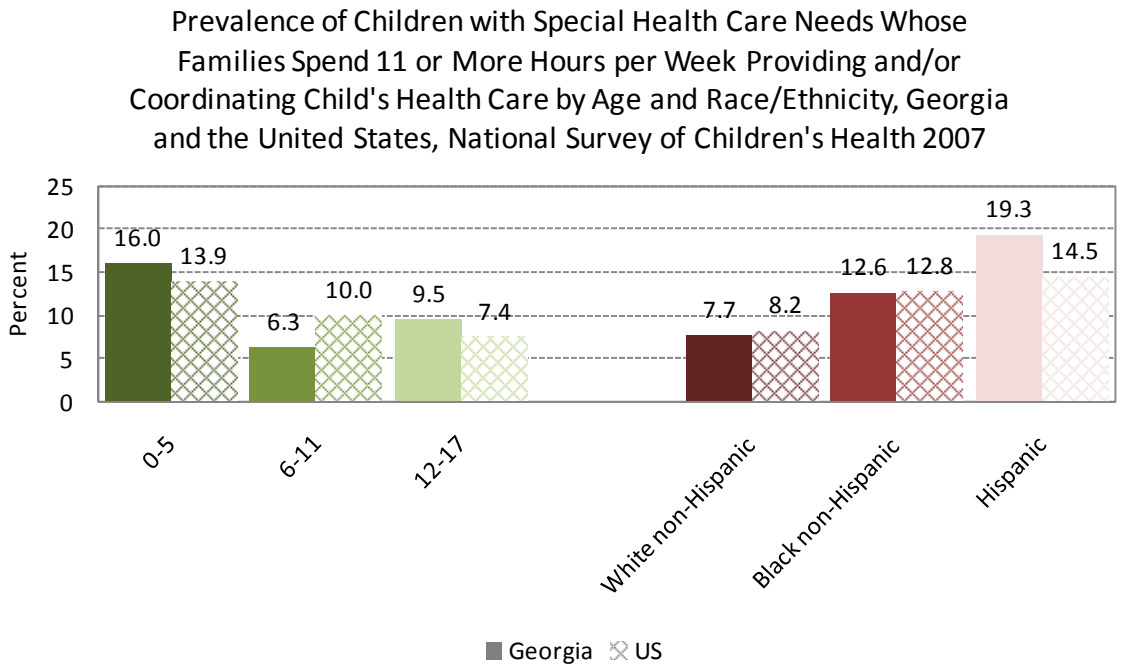


TIME PROVIDING AND/OR COORDINATING CHILD'S HEALTH CARE

In Georgia and the US, approximately ten percent of families of children with special health care needs spent eleven hours or more per week providing or coordinating their child's health care. This percent was greater among younger children and Black and Hispanic children. Differences within race/ethnicity may be indicative of an absence of resources or a greater need for parent support. When comparing Georgia to the US, there was minimal variation by age or race/ethnicity.

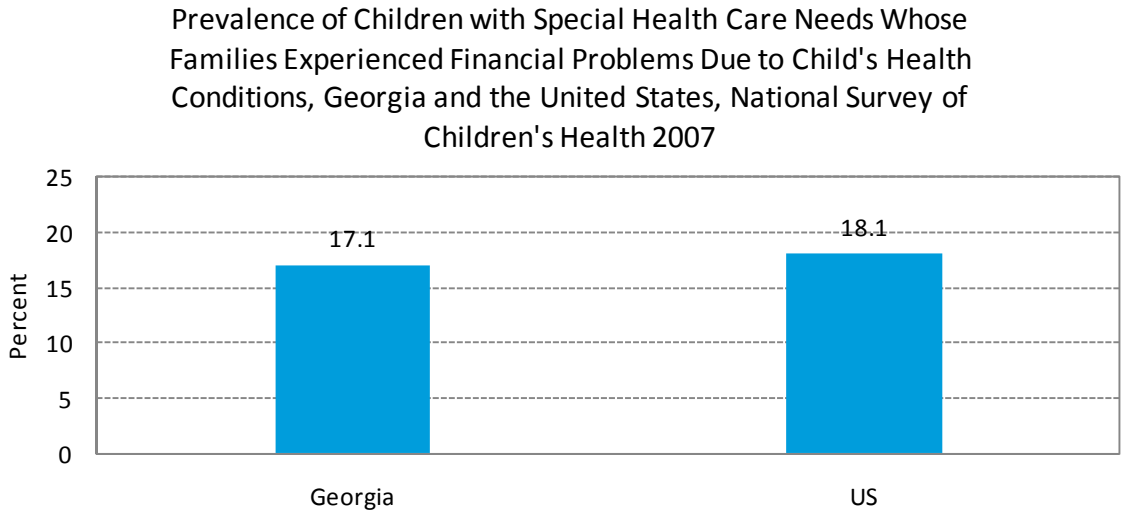
Prevalence of Children with Special Health Care Needs Whose Families Spend 11 or More Hours per Week Providing and/or Coordinating Child's Health Care, Georgia and the United States, National Survey of Children's Health 2007

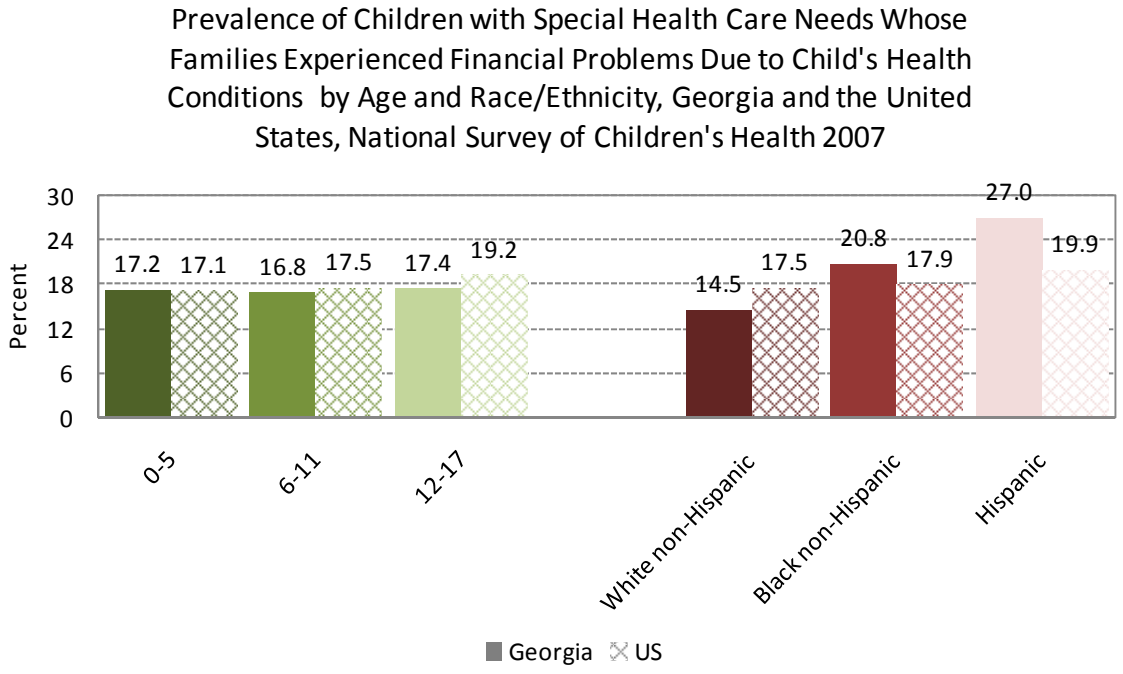




FINANCIAL PROBLEMS DUE TO CHILD'S HEALTH CONDITIONS

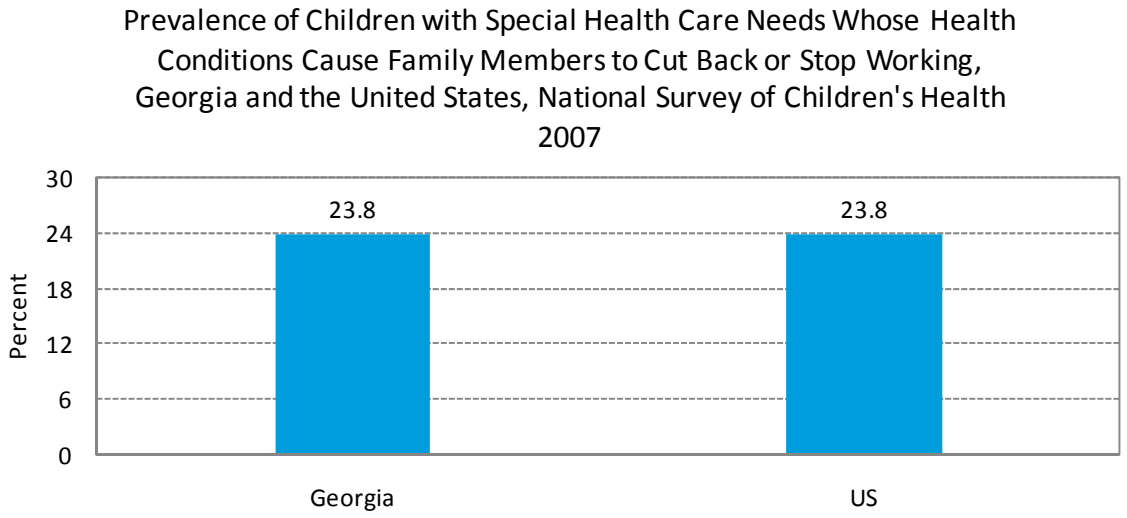
Nearly 20 percent of families with a special health care needs child in Georgia and the US reported experiencing financial problems due to their child's health conditions. A greater percent of Black and Hispanic families of children with special health care needs reported financial problems due to their child's health conditions than did White families.

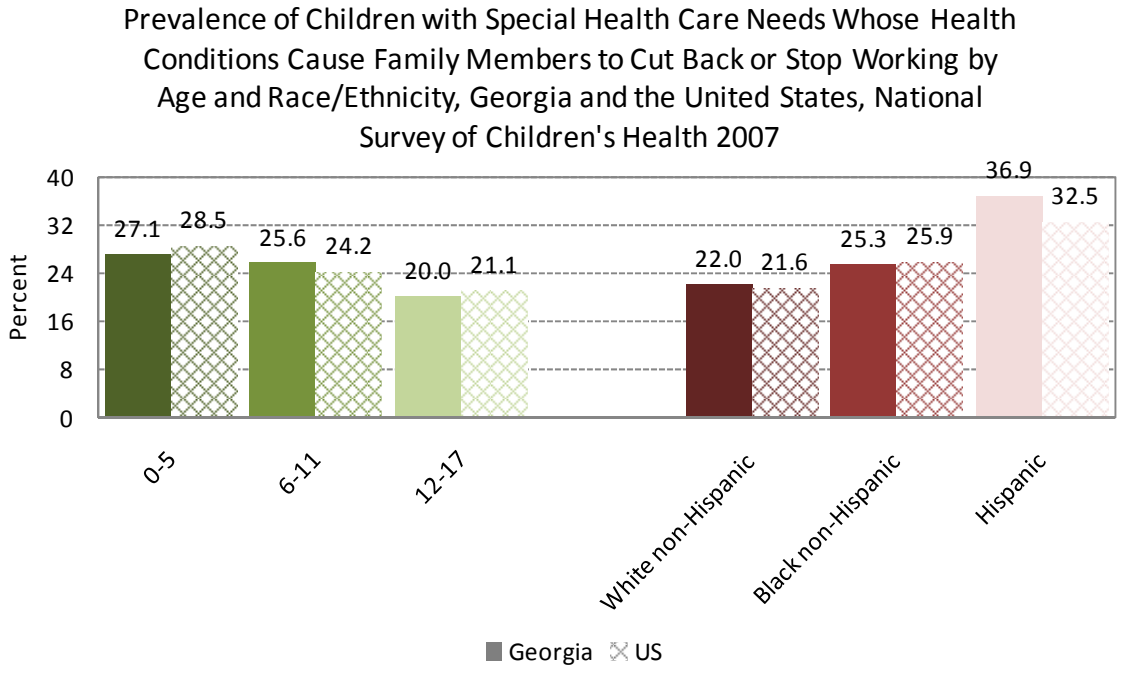




WORK LIMITATIONS DUE TO CHILD'S HEALTH CONDITIONS

In Georgia and the US, 23.8 percent of children with special health care needs had health conditions that required family members to cut back or stop working. The percent of children with special health care needs had health conditions that required family members to cut back or stop working was lower among older children, but higher among children of Hispanic ethnicity.





NATIONAL OUTCOME MEASURES

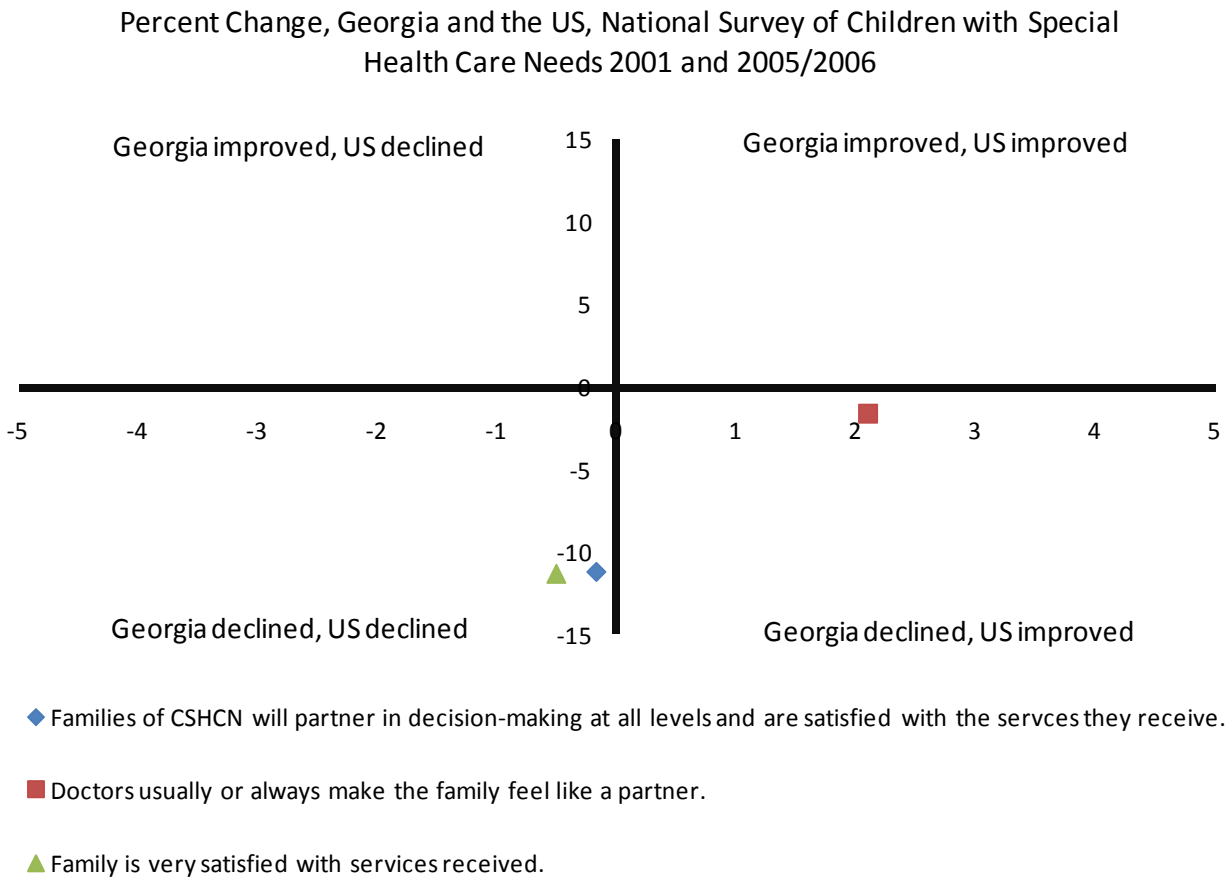
OUTCOME 1: PARTNERING IN DECISION MAKING AND SATISFACTION WITH SERVICES

For all indicators, Georgia had better rates than the US in 2001. However, in the 2005/2006 survey, the US had better rates than did the US. Between 2001 and 2005/2006, the percent of parents of children with special health care needs who reported being very satisfied with the care they received decreased 11.3 percent. The percent of parents of children with special health care needs who reported that doctors usually or always make the family feel like a partner increased in the US between 2001 and 2005/2006, but decreased in Georgia.

Partnering in Decision Making and Satisfaction with Care, Georgia and the US, National Survey of Children with Special Health Care Needs 2001 and 2005/2006						
	2001 CSHCN Survey			2005/2006 CSHCN Survey		
	Valid #	% Success	US/GA Gap	Valid #	% Success	US/GA Gap
Outcome 1. Families of CSHCN will partner in decision-making at all levels and are satisfied with the services they receive.						
Georgia	346	60.8	3.3	770	54.0	(3.4)
US	15,254	57.5		39,664	57.4	
Doctors usually or always make the family feel like a partner.						
Georgia	717	87.4	1.5	756	86.0	(1.7)
US	36,837	85.9		38,825	87.7	

Partnering in Decision Making and Satisfaction with Care, Georgia and the US, National Survey of Children with Special Health Care Needs 2001 and 2005/2006						
	2001 CSHCN Survey			2005/2006 CSHCN Survey		
	Valid #	% Success	US/GA Gap	Valid #	% Success	US/GA Gap
Family is very satisfied with services received.						
Georgia	350	64.7	4.6	771	57.4	(2.4)
US	15,490	60.1		39,734	59.8	

For the questions included in this table, there were no changes to the question between 2001 and 2005/2006.



OUTCOME 2: COORDINATED AND COMPREHENSIVE CARE IN A MEDICAL HOME

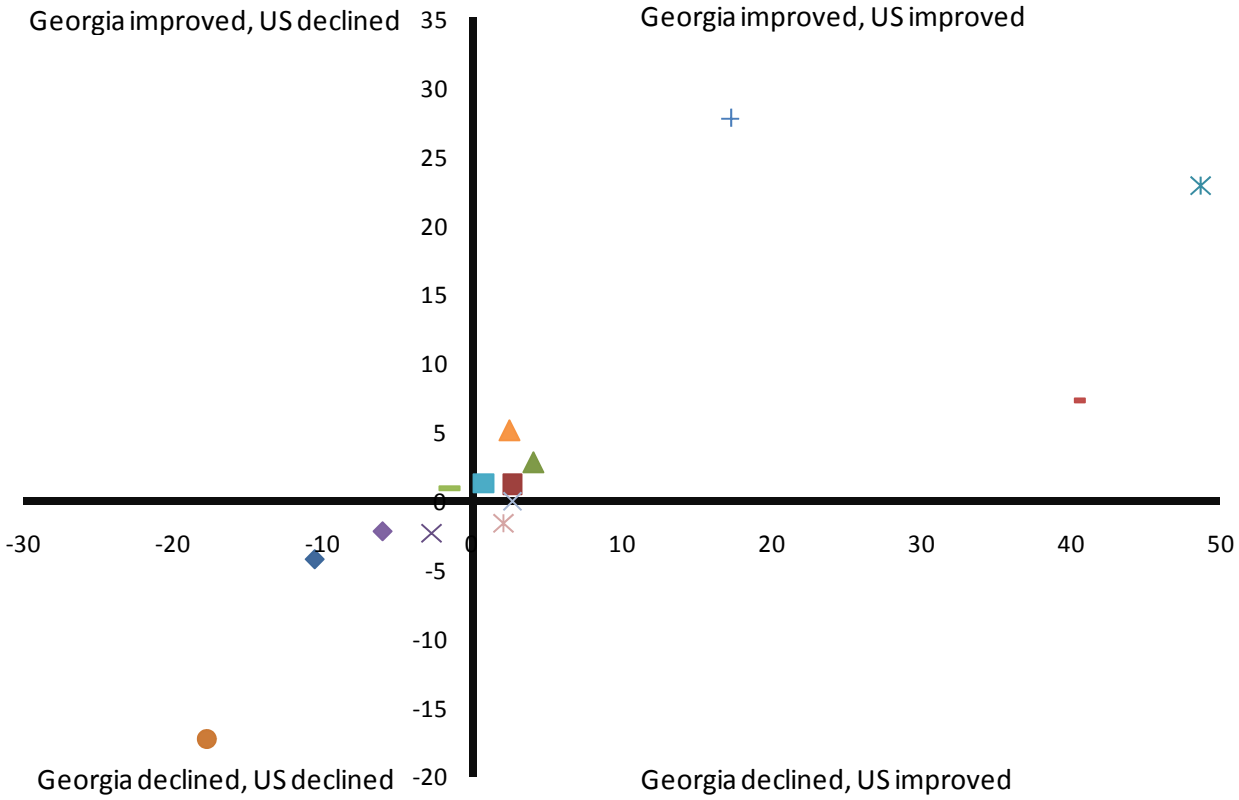
The percent of families of children with special health care needs that received coordinated ongoing comprehensive care within a medical home declined in the US and Georgia between 2001 and 2005/2006. Among all measures, the gap between the percent in the US and Georgia was minimal. There was little variation in the percent changes for each measure when comparing percent changes in the US and Georgia between 2001 and 2005/2006.

Coordinated and Comprehensive Care in a Medical Home, Georgia and the US, National Survey of Children with Special Health Care Needs 2001 and 2005/2006						
	2001 CSHCN Survey			2005/2006 CSHCN Survey		
	Valid #	% Success	US/GA Gap	Valid #	% Success	US/GA Gap
Outcome 2. CSHCN will receive coordinated ongoing comprehensive care within a medical home.*						
Georgia	704	49.4	(3.2)	759	47.3	0.2
US	36,710	52.6		38,886	47.1	
The child has a usual source of care.						
Georgia	742	91.1	0.9	792	92.2	(0.7)
US	38,628	90.5		40,551	92.9	
The child has a usual source for sick care.						
Georgia	745	91.5	0.9	793	94.1	(0.2)
US	38,744	90.6		40,614	94.3	
The child has a usual source for preventive care.*						
Georgia	744	98.9	0.1	792	96.5	(0.6)
US	38,737	98.8		40,626	97.1	
The child has a personal doctor or nurse.*						
Georgia	745	86.7	(2.3)	790	91.1	(2.4)
US	38,711	89.0		40,658	93.5	
The child has no problems obtaining referrals when needed.						
Georgia	389	77.0	(1.1)	266	82.6	3.7
US	20,042	78.1		13,358	78.9	
The child receives effective care coordination.*						
Georgia	65	48.4	8.6	585	59.5	0.3
US	4,356	39.8		30,971	59.2	
Family usually or always gets sufficient help coordinating care, if needed.*						
Georgia	65	81.3	(0.6)	335	67.2	(0.2)
US	4,527	81.9		17,803	67.4	
Family is very satisfied with doctors' communication with each other.*						
Georgia	51	48.6	(5.8)	501	62.1	(1.7)
US	3,710	54.4		26,706	63.8	
Family is very satisfied with doctors' communication with other programs.*						
Georgia	45	46.8	9.7	171	50.2	(1.9)
US	3,196	37.1		11,077	52.1	

Coordinated and Comprehensive Care in a Medical Home, Georgia and the US, National Survey of Children with Special Health Care Needs 2001 and 2005/2006						
	2001 CSHCN Survey			2005/2006 CSHCN Survey		
	Valid #	% Success	US/GA Gap	Valid #	% Success	US/GA Gap
The child receives family-centered care.						
Georgia	695	64.4	(2.4)	757	65.0	(0.8)
US	36,018	66.8		38,242	65.8	
Doctors usually or always spend enough time.						
Georgia	717	79.0	(4.7)	754	77.3	(1.5)
US	36,799	83.7		38,765	78.7	
Doctors usually or always listen carefully.						
Georgia	716	86.5	(1.6)	756	87.6	(1.2)
US	36,872	88.1		38,809	88.8	
Doctors are usually or always sensitive to values and customs.						
Georgia	704	83.0	(3.9)	750	87.2	(1.8)
US	36,425	86.9		38,555	89.0	
Doctors usually or always provide needed information.						
Georgia	712	81.9	1.0	755	81.9	(1.2)
US	36,734	80.9		38,773	83.1	
Doctors usually or always make the family feel like a partner.						
Georgia	717	87.4	1.5	756	86.0	(1.7)
US	36,837	85.9		38,825	87.7	

* Indicates that the question has been revised between 2001 and 2005/2006. This makes individual comparison between years difficult. However, changes in the question should not influence the comparison of absolute changes between the US and Georgia as the question change would have had equal impact on each population.

Percent Change, Georgia and the US, National Survey of Children with Special Health Care Needs 2001 and 2005/2006

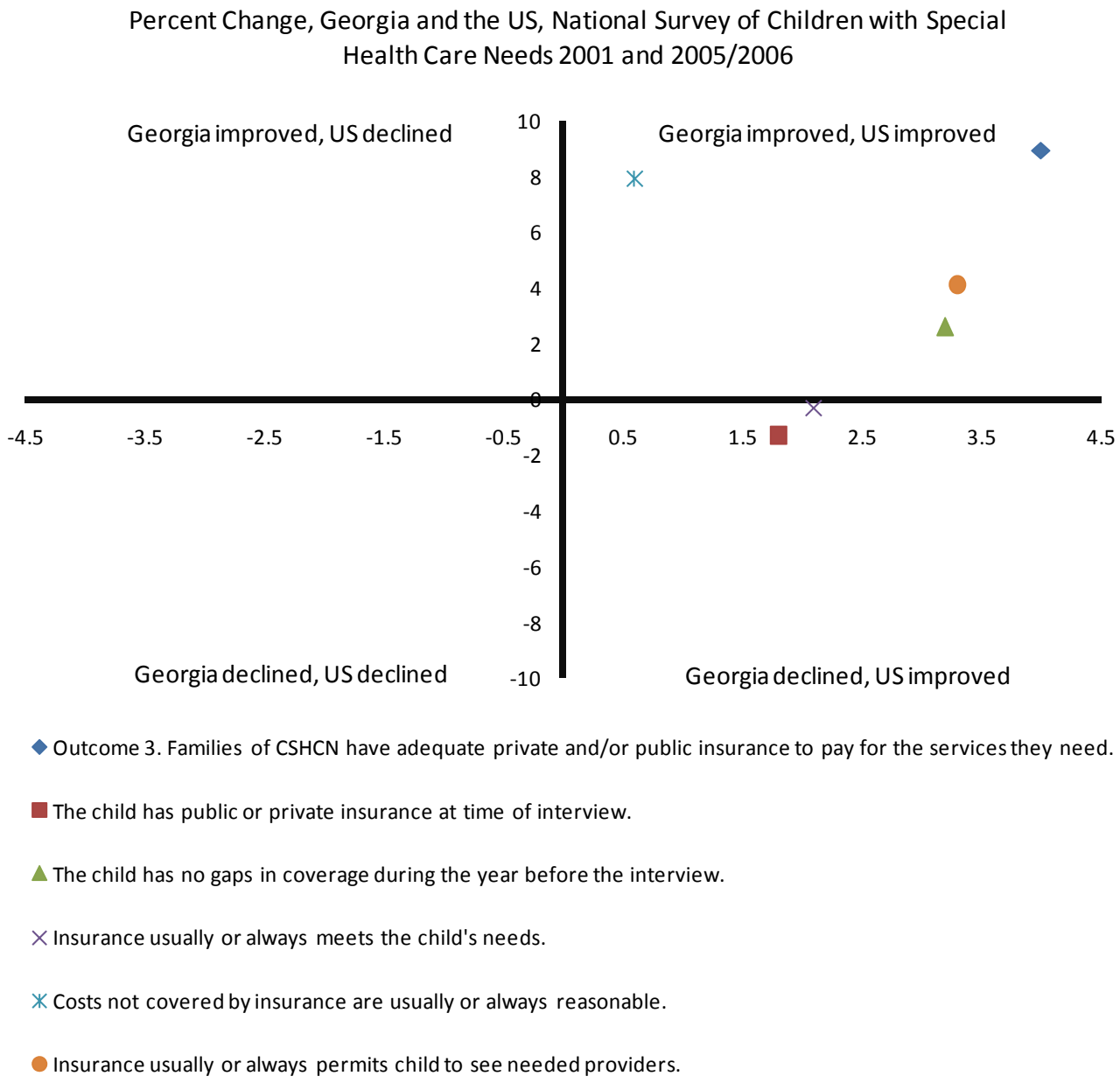


- Outcome 2. CSHCN will receive coordinated ongoing comprehensive care within a medical home.*
- The child has a usual source of care.
- The child has a usual source for sick care.
- The child has a usual source for preventive care.*
- The child has a personal doctor or nurse.*
- The child has no problems obtaining referrals when needed.
- The child receives effective care coordination.*
- Family usually or always gets sufficient help coordinating care, if needed.*
- Family is very satisfied with doctors' communication with each other.*
- Family is very satisfied with doctors' communication with other programs.*
- The child receives family-centered care.
- Doctors are usually or always sensitive to values and customs.
- Doctors usually or always provide needed information.
- Doctors usually or always make the family feel like a partner.

OUTCOME 3: ADEQUACY OF INSURANCE

The gap in the percent of families of children with special health care needs with adequate public or private insurance decreased between Georgia and the US in 2005/2006 compared to 2001. A greater percent of respondents nationwide than in Georgia indicated that costs not covered by insurance were usually or always reasonable. However, in the 2005/2006 survey, the percent in Georgia exceeded that of the US. The percent change chart indicates that among most measures there was improvement among children with special health care needs in Georgia and the US. For measures that declined in Georgia while increasing in the US, there was a less than 1.5 percentage point difference between 2001 and 2005/2006 in Georgia.

Adequacy of Insurance, Georgia and the US, National Survey of Children with Special Health Care Needs 2001 and 2005/2006						
	2001 CSHCN Survey			2005/2006 CSHCN Survey		
	Valid #	% Success	US/GA Gap	Valid #	% Success	US/GA Gap
Outcome 3. Families of CSHCN have adequate private and/or public insurance to pay for the services they need.						
Georgia	716	56.4	(3.2)	780	61.2	(0.8)
US	37,388	59.6		40,038	62.0	
The child has public or private insurance at time of interview.						
Georgia	748	96.7	1.9	791	95.4	(1.1)
US	38,866	94.8		40,723	96.5	
The child has no gaps in coverage during the year before the interview.						
Georgia	746	87.3	(1.1)	790	89.6	(1.6)
US	38,781	88.4		40,563	91.2	
Insurance usually or always meets the child's needs.						
Georgia	706	86.2	(0.7)	758	85.9	(2.6)
US	36,618	85.5		39,007	87.3	
Costs not covered by insurance are usually or always reasonable.						
Georgia	692	68.7	(2.9)	761	74.1	2.1
US	35,794	71.6		38,839	72.0	
Insurance usually or always permits child to see needed providers.						
Georgia	711	86.1	(1.7)	762	89.6	(1.1)
US	36,706	87.8		39,032	90.7	



OUTCOME 4: SCREENING AND PREVENTIVE CARE

The three measures in the following table were not previously collected in the 2001 National Survey of Children with Special Health Care Needs. Among children with special health care needs in Georgia, 65.3 percent reported being screened early and continuously for special health care needs. This was 1.5 percentage points greater than the percent in the US. While the percent of children with special health care needs who received routine preventive medical care was similar in the US and Georgia, the percent of children with special health care needs who received routine preventive dental care was 2.3 percentage points greater in Georgia than the US.

Screening and Preventive Care, Georgia and the US, National Survey of Children with Special Health Care Needs 2005/2006			
	2005/2006 CSHCN Survey		
	Valid #	% Success	US/GA Gap
Outcome 4. Children with special health care needs are screened early and continuously for special health care needs.			
Georgia	788	65.3	1.5
US	40,491	63.8	
Child has received routine preventive medical care in past year.			
Georgia	790	76.7	(0.4)
US	40,583	77.1	
Child has received routine preventive dental care in past year.			
Georgia	782	80.8	2.3
US	40,144	78.5	

OUTCOME 5: ORGANIZATION OF COMMUNITY-BASED SYSTEMS

More than 90 percent of children with special health care needs in Georgia reported the availability of community-based service systems organized so that families can use them easily. The percent in Georgia was 1.9 percentage points greater than in the US. While there were significant changes to the question between 2001 and 2005/2006, the percent change between the two surveys was similar between Georgia (21.5 percent) and the US (19.9 percent).

Organization of Community-Based Systems, Georgia and the US, National Survey of Children with Special Health Care Needs 2001 and 2005/2006						
	2001 CSHCN Survey			2005/2006 CSHCN Survey		
	Valid #	% Success	US/GA Gap	Valid #	% Success	US/GA Gap
Outcome 5. Community-based service systems are organized so families can use them easily.*						
Georgia	346	74.9	0.6	789	91.0	1.9
US	15,310	74.3		40,344	89.1	

* Indicates that the question has been revised between 2001 and 2005/2006. This makes individual comparison between years difficult. However, changes in the question should not influence the comparison of absolute changes between the US and Georgia as the question change would have had equal impact on each population.

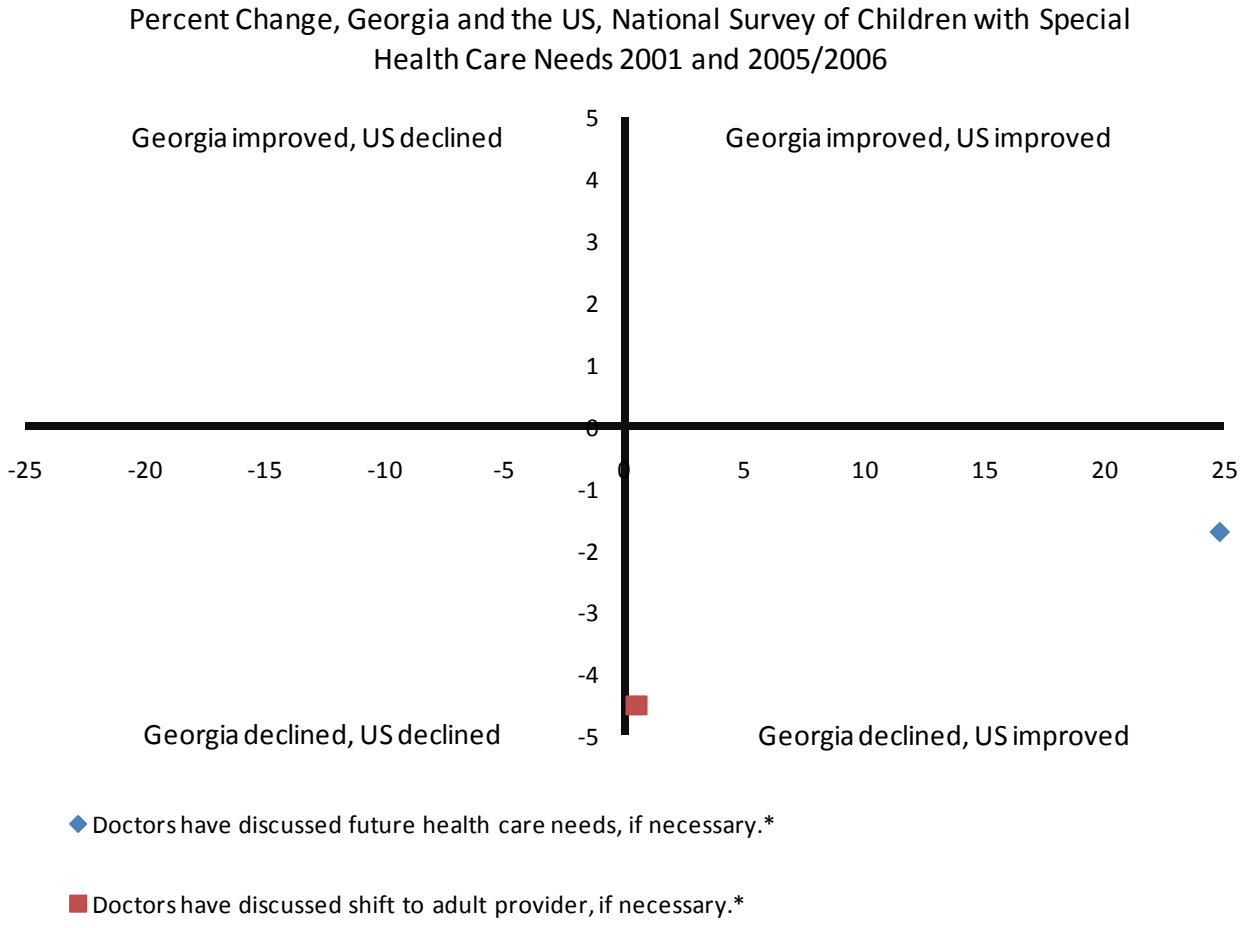
OUTCOME 6: TRANSITION TO ADULTHOOD

Throughout the comparisons made between Georgia and the US, the largest gaps existed in the area of transition. For each of the measures, with the exception of the percent of children with special health care needs who had usually or always been encouraged to take responsibility for his/her health care

needs, the gap between the US and Georgia ranged from 4.4 percentage points to 7.9 percentage points. With all questions rewritten between 2001 and 2005/2006, the percent change chart revealed little information. Only two measures were included in the chart as the increase in the other measures exceeded 300 percent. Of the two measures included, the percent of children with special health care needs who reported that doctors have discussed future health care needs increased in the US but declined in Georgia. While this question changed, the relative impact of the change should be experienced equally in the US and Georgia. The percent of children with special health care needs whose doctors discussed the shift to an adult provider followed a similar pattern of a US increase and Georgia decline. However, these changes were less than two percentage points.

Transition to Adulthood, Georgia and the US, National Survey of Children with Special Health Care Needs 2001 and 2005/2006						
	2001 CSHCN Survey			2005/2006 CSHCN Survey		
	Valid #	% Success	US/GA Gap	Valid #	% Success	US/GA Gap
Outcome 6. Youth with special health care needs receive the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*						
Georgia	97	8.9	3.1	314	37.0	(4.2)
US	5,351	5.8		16,889	41.2	
The child receives anticipatory guidance in transition to adulthood.*						
Georgia	97	15.7	0.4	259	31.9	(6.3)
US	5,414	15.3		14,414	38.2	
Doctors have discussed future health care needs, if necessary.*						
Georgia	99	59.0	9.0	242	58.0	(4.4)
US	5,533	50.0		13,171	62.4	
Doctors have discussed shift to adult provider, if necessary.*						
Georgia	55	35.7	(6.1)	82	34.1	(7.9)
US	2,871	41.8		4,585	42.0	
The child has usually or always been encouraged to take responsibility for his or her health care needs.						
Georgia				345	77.9	(0.1)
US				18,062	78.0	

* Indicates that the question has been revised between 2001 and 2005/2006. This makes individual comparison between years difficult. However, changes in the question should not influence the comparison of absolute changes between the US and Georgia as the question change would have had equal impact on each population.



QUALITATIVE DATA ANALYSES

The qualitative data section is organized by theme. These themes were identified through analysis of the data collected through the focus groups. There is standard information provided for each theme that includes sections on *Quantification*, *Description of the Health Concern*, and *Ideas about What is Needed to Improve* the identified need.

The *Quantification* section provides information about the frequency with which the theme was identified.

After reviewing the notes collected during the focus groups, themes were identified by analysts based on the information recorded as part of the focus groups. The *Description of the Health Concern* section provides quotes and ideas communicated by focus group participants that were used in defining the theme. As frequently as possible, direct quotes from focus group participants are used.

The *Ideas about What is Needed to Improve* the identified need section captures focus group participant ideas about possible strategies and solutions to improve that theme.

In limited instances, along with the identified themes, a section has been included labeled *Other Health Concerns*. This section includes a list of health care concerns among a specific population that were not mentioned with adequate frequency to be considered a theme, but were important to document.

TRANSITION TO ADULTHOOD

QUANTIFICATION

The transition to adulthood is identified as a major health concern for children with special health care needs (CSHCN) by all seven CSHCN needs assessment community focus groups, and selected as one of Georgia's top five health issues by five of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

The focus group information suggests there is widespread concern about the "successful transition to adulthood" and "to adult care" of children with special health care needs. This concern about the "transition from pediatrician to adult systems of care" is communicated by consumers/parents as well as health care providers; they emphasize various aspects of the challenge it poses to the health of a child with special health care needs.

One major concern is that medical and other services are not available for children (18 to 21 years) aging out of Medicaid. If needed services are available, they are "very limited."

Health Care providers point out that there are "no resources for special needs clients after they reach age 21 other than through mental health/mental retardation centers."

There are concerns that "safety risks exist" due to the lack of, or limited access to, special needs medical team services. "Medical team services (if they were available in the surrounding area) are not available to the individual after age 21."

Some stakeholders are alarmed about the absence of special needs medical team services in their communities; and if they are available in the community, they are in short supply or at a great distance from the child and family needing services.

Another concern about the period of transition to adulthood is that "there is a lack of activities after graduation." The social isolation that began early in life is continued and amplified. One parent of a child with special health care needs asks, "After they are no longer in school, what do we do with them? There is nothing available."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN WITH SPECIAL HEALTH CARE NEEDS' HEALTH

Stakeholders of CSHCN services forward various ideas about what could improve the physical and mental health of children with special health care needs. Suggestions around improving the child's transition to adulthood follow.

- "A formalized transition program is needed that can help parents and children understand and navigate as they move into a new system of care;"
- "We need post-secondary youth transition assistance that includes non-traditional placements;" and
- We need "transition mentors that can assist parents and youth with their applications, residential or day care, and to help with enrollment in adult programs and services."

LACK OF INCLUSION OPPORTUNITIES

QUANTIFICATION

The lack of inclusion opportunities is identified as a major health concern for children with special health care needs by six of seven CSHCN needs assessment community focus groups and is stated as one of Georgia's top five health issues by one of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

There are concerns about "social isolation" and "bullying." Community focus group participants consistently pointed out that there are "limited social outlets, vocational services, services for after-school-age youth." In addition, there is the "lack of opportunity for physical activity at home or at school" and "after-school activities and volunteer activities."

Stakeholders/parents in the community focus groups also expressed a great degree of concern about the situation in their communities as follow.

- "Playgrounds are not accessible to my child unless we go to hospital therapy; but of course, there are no other children to play with, and it is not helping with development;"
- "Where I live playgrounds are not designed for wheelchairs. And there aren't a lot of sidewalks. Wheelchairs and special strollers have to go into the street;"
- "I have a 14-year-old and a 13-year-old. The 13-year-old is the one with special needs. My 13-year-old is never able to go to the dances. They need to dances to go to and feel like normal children;"
- "We need more social activities for children with special needs. My daughter just sits at home with nothing to do;" and
- "There are not enough services for deaf children in my community."

Child care for pre-school-age children is also highlighted in every community focus group as a necessary but missing service. Without childcare, the young child with special health care needs "is not getting the opportunities for social development." A group of health care providers forwarded their concern that "access to daycare programs is important because it is the opportunity to teach healthy lifestyles at an early age."

The "lack of inclusion opportunities in schools" and "lack of opportunity to interact with typical children" are also concerns. See *Educational Services and Opportunity in Schools* section of this report.

Stakeholders/parents expressed concern and sometimes frustration and anger about what they see as the "variation in what is available according to where you live."

Perceptions of inequities in distribution of resources were heard in south metro Atlanta and south Georgia community focus groups. "The north part of Atlanta has more programs for children, like baseball. There are fewer activities on the south side. We have to go so far for programs. On the south side there are no programs for our children."

One stakeholder/parent concluded, "We have poor resources."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE THE HEALTH OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

CSHCN stakeholders forwarded various ideas on what is needed to improve the physical and mental health of children with special health care needs. Suggestions around necessary services and the lack of inclusion opportunities follow.

- "More recreational activities and supports that integrate the children with special health care needs and their families into the community are needed. Accessible playgrounds, special needs recreational teams, special needs camps, Special Olympics, and community education that helps mainstream children with special health care needs and their families into community activities" are all needed;
- "Recreation is needed. Children with special needs need adapted recreation facilities and services;"
- "Access to activities is needed – playgrounds or recreational parks are not designed to accommodate special needs children;"
- "Park recreation services with trained person in the recreational areas for emergencies" are needed;
- "Community education that helps mainstream children with special health care needs and their families into community activities" is needed; and
- "Kids in the state need more activities or organizations for deaf children."

Stakeholders also communicated observations of positive changes in opportunities for inclusion.

- "There is one community in our district that has a special needs basketball league. There are families moving into the community so their child can participate in the league;" and
- Another parent noted change in accessibility and shares advice with other parents, "Take kids where they can interact. The aquarium didn't have anything for special needs children, but now they have ramps."

PARENT/CARETAKER KNOWLEDGE AND FAMILY SUPPORT

QUANTIFICATION

Parent/caretaker knowledge and family support is identified as a major health concern for children with special health care needs by all seven CSHCN needs assessment community focus groups, and - forwarded as one of Georgia's top five health issues by six of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Parent/caretaker knowledge

Parent/caretaker knowledge is viewed as "key to creating a chance for the well being of a child with special needs." More than half of the child health providers and advocacy group members providing perspective on Georgia's critical needs say that parent/caretaker education should be a priority for Georgia. Knowledge of resources is essential for any parent/caretaker of a child with special health care needs. Some are concerned that there is "misunderstanding or lack of knowledge about available services."

Parents/caretakers also appear to view their knowledge as key, and expressed their needs for information from health care providers.

- "I ran against not knowing where to go. We need to know the avenues to pursue;"
- "Parents shouldn't have to dig for information;"
- "The only way you know something is through word of mouth;" and
- "There are a lot of parents that don't know about IEP/504 plans. When conditions are not so apparent, providers are not as eager to move on it."

Some specific knowledge needs noted by stakeholders follow.

- Parenting skills
- Training to handle children with hearing impairment problems
- Nutritional education
- Health and wellness lifestyles
- Asthma triggers, symptoms, and needed medications

Family support

One health care provider expressed the notion that was heard in most community focus groups, "To maximize the potential of children with special needs, you need to take care of the parents as well."

Caregiver supportive services are highlighted as necessary and missing for families and caregivers of children with special health care needs. "Family support and education (respite care, flexible employment) are needed."

Caregivers today are unique and varied. "There are families with increased need for support, including families in poverty, grandparents raising grandchildren, children and families involved with DFCS and the foster care system, and undocumented families."

Respite care is a specific and critical need cited in every CSHCN consumer/stakeholder group contributing to the needs assessment.

- "There is no respite care. My friend can get no one to help her. She can't get help anywhere. He's so big now he's beating her and she can't get help;" and
- "There is such parental overload and stress due to juggling work, school, home, child care and out-of-town medical visits."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN WITH SPECIAL HEALTH CARE NEEDS' HEALTH

CSHCN stakeholders forwarded various ideas on what is needed to improve the physical and mental health of children with special health care needs. Suggestions around addressing parent/caretaker knowledge and family support follow.

- "Parent education on the child's diagnosis" is needed;
- "Parent education regarding health/wellness lifestyle" is needed. Provide "education on dangers of second-hand smoke, drugs and alcohol;"
- "We need a resource center;"
- Conferences for parents and siblings of children with special needs are needed;
- Interactive Web site could help parents and providers share information. "Somebody can post something to let people know what they found out;"
- "Educate the community on services CMS provides;"
- Pre-pregnancy education for CSHCN is needed;
- "Educational opportunities including free English classes for families with limited English proficiency" are needed;
- "Knowledge of resources" is essential. Suggestions for approaching educating communities, families, providers include: "Make a booklet of resources created by parents. The booklet should be made available to every parent." "Every state office should be providing pamphlets and flyers with known resources." "Use technology;"
- "Support groups for all ages" are also essential and much needed, as noted by consumers/stakeholders in every community focus group. "I still go back to the support group. It gives the parent an opportunity to talk with other parents and gives kids the opportunity to interact. We need to have a regular time." "If small groups could get together it would be better;"
- Respite care is essential and is lacking, as noted by consumers/stakeholders in every community focus group. "Many parents of children with special health care needs are worn out and need respite care;"
- "Support services, including respite, home modifications (ramps, widened bathroom doors, roll-in showers, etc.)" are needed; and
- "We need more resources and literature. Right now there are not any conferences on disabilities….Some time ago I went to a conference in Atlanta and they had a session for siblings, which was great for my daughter. It helped her deal with her sister better."

THIRD PARTY COVERAGE ISSUES

QUANTIFICATION

Third party coverage issues are identified as a major health concern for children with special health care needs by all seven CSHCN needs assessment community focus groups, the steering committee of the Early Childhood Comprehensive System (ECCS), and six of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Child health provider and advocacy group representatives cite their concern about system-level realities, and several groups forward their interest in macro-level issues: "Insurance reform (Medicaid, SCHIP, private)," "health care financing," "health concerns created by the changes in Medicaid/CMO," and **"I**ack of adequate private health insurance coverage."

Three major themes that emerged from focus groups are concerns around coverage gaps, reimbursement and definition of medical necessity.

"Gaps in insurance and coverage of services" are a major health concern expressed in all of the consumer and stakeholder groups contributing to the needs assessment. The steering committee of ECCS forwards their concerns about the "limited or lack of Medicaid coverage for Title V programs and services, and lack of continuous coverage under Medicaid." Additionally, there is great concern about the "lack of adequate private health insurance coverage."

The result, as heard repeatedly in community focus groups, is "certain medical services are not covered by Medicaid or third party." Consumers and other stakeholders noted the following.

- "Insurance and Medicaid do not cover all of the developmental and medical services, therapies and supplies for children with certain conditions such as hearing loss, PKU and autism;"
- "Medicaid is unavailable for acute transportation. You have to make your reservation at least three days in advance;"
- There are "difficulties in getting durable medical equipment covered under Medicaid after client has been approved for waiver;"
- "Medicaid denials of head CT scans for patients with VP shunts" are a problem; and
- "The hearing equipment (FM system and hearing aid) is not covered by either Medicaid or CMS."

Parents/stakeholders share some of their personal stories about how they have worked, sometimes successfully, to get their child's health needs met.

- "Babies Can't Wait came to my rescue. We didn't know for the first two years what was wrong with my child. He had severe hearing disabilities. CMS is my lifesaver; they were there to cover what insurance would not. We had to go three to six months with no insurance so they would pick him up and cover him;"
- "You have to give up one service to get another service. To get respite care at home we had to give up CMS to get Source;"

- "I needed a new hearing aid and Medicaid did not help. I called other people, and they said they could not help. I called CMS and they helped, they helped with my son's walker and hearing aid;" and
- "My insurance was exhausted and thankfully CMS was there to help."

Tiredness is also evident in some of the parent/caretaker comments heard in the focus group.

- "You fill out a lot of papers just to be turned down. In other states, you get more therapy and nursing hours. Here your child has to be at the last breath before you get nursing care;"
- "It's a lot of fighting to get therapy services;" and
- "You have to fight for everything you get. I'm tired of fighting."

Another aspect of the issues with third party coverage is captured in the suggested priorities forwarded by child health provider and advocacy group representatives to "provide adequate reimbursement for services."

- "Cost of providing services has increased while reimbursement rates have been stagnant or have decreased;"
- "Medicaid is not paying enough for deaf services. CMS helps a lot;"
- "Medicaid did not pay for the medicine the doctor prescribed; they gave me the generic drug;"
- "Adequate Medicaid reimbursement for G-tubes, pledgets. saline tubes, and MIC-KEY tubes?" is needed; and
- "Reimbursement of positioning chairs" is a problem.

Differences defining medical necessity are noted as an associated problem.

- "Families are frustrated because insurance companies and CMO's are not telling them that their child does not qualify for therapy services or no longer qualifies. They are frustrated and don't know what to do;" and
- "[Physicians] need more flexibility in determining what is medically necessary."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN WITH SPECIAL HEALTH CARE NEEDS' HEALTH

CSHCN stakeholders forwarded various ideas on what is needed to improve the physical and mental health of children with special health care needs. Suggestions around third party coverage issues follow.

- Address problem with "limited funding to provide CMS care for uninsured and/or undocumented children;"
- "The wish list would be to fill the gaps in insurance coverage. Funding for rehabilitative services;"
- "Funding assistance with purchase of needed equipment" is needed;
- "Health insurance coverage for all children" is needed;
- Provide "access to medical coverage for children and young adults not eligible for Medicaid and Peach Care due to citizenship and/or age;"
- We need "continuity of Medicaid services;"
- We need "easy access to waiver funds for respite and durable medical equipment;"

- "Improve access to funding sources;"
- "Affordable health insurance for children with special needs over the age of 18 who are low income and not eligible for SSI or Medicaid (i.e., diabetic students)" is needed;
- "For the self employed or self insured, [we need] access to medication at a decent cost. We pay $300/month just for maintenance medication;" and
- Health Care providers say that they "need more flexibility in determining what is medically necessary."

TRANSPORTATION

QUANTIFICATION

Transportation is identified as a major health concern for children with special health care needs by all seven CSHCN needs assessment community focus groups and specifically identified as one of the top five concerns by two of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Transportation for children with severe physical handicaps is a major concern.

"Distance of travel to access services" is a reality for many parents/caregivers, making transportation challenges a serious problem. "Outside of the school setting, there is no place where children can go to get therapy without having to drive long distances. "

A reality for families of children with special health care needs, highlighted as a concern for health providers in communities, is "lack of transportation for out-of-town medical care."
There is acknowledgment of the serious transportation issues for regions of the state without public transportation.

"Transportation is very hard for families – there's no public transportation. It's difficult if you have to go to Augusta and pay parking and other costs. May need to find a way to get to an appointment. It's difficult."

Some stakeholders spoke of the availability of a Medicaid van and problems associated with its use. "Medicaid transportation issues" were expressed in four different community focus groups.

- "Medicaid transportation provides late arrivals to medical appointments, causing parents to miss appointments;"
- "Transportation is a problem for us. I hear it's unreliable (the Medicaid van), and with that being the only transportation it's a problem;"
- "I had a parent tell me you have to wait until everyone is finished before you can leave, and that sometimes they are not showing up;"
- "Medicaid is unavailable for acute transportation. You have to make your reservation at least three days in advance, no matter who begs;" and
- "Consistent transportation assistance is a necessary service, and it is just not available."

Given the transportation difficulties experienced, one parent stated her conclusion, "I prefer other alternatives, like driving without a license, or if I can, paying a lot of money for private taxi service to avoid missing a medical appointment that took three to six months waiting to get after the Medicaid transportation caused cancellation of late appointment arrivals."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN WITH SPECIAL HEALTH CARE NEEDS' HEALTH

CSHCN stakeholders forwarded various ideas on what is needed to improve the physical and mental health of children with special health care needs. Suggestions around addressing transportation issues follow:

- "What is needed? A transportation system;"
- "Transportation resources, especially in rural areas" are needed;
- Availability of "transportation that can accommodate wheelchairs" is needed; and
- Transportation assistance for parents/caretakers of CSHCN is needed.

AVAILABILITY OF SPECIALITY CARE AND SERVICES

QUANTIFICATION

The availability of specialty care and services is identified as a major health concern for children with special health care needs by all seven CSHCN needs assessment community focus group and the nine roundtable at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

"Early and periodic screening" and the "timely provision of health services by appropriate providers" appears to be the predominant view of what is lacking and much needed to adequately address the well being and health needs of children with special health care needs. In addition, "there is a lack of primary care providers who will accept severely affected clients due to complexity of case management."

Physicians in the focus group highlighted some of their concerns around specialty services.

- There are "gaping holes in specialty areas – pediatric subspecialties. No pediatric orthopedic, no pediatric neurologist. We don't have full time specialists, especially social workers. We are missing people in every specialty area especially for children with special health care needs;"
- "We need more pediatric specialists. Parents have to take their children to a specialist out of town which means they must take time off from work and children must miss school;" and
- "When there are only 10 pediatric orthopedists in the entire state of Georgia, it makes it almost impossible to get a timely appointment. Families can wait four to six months for an appointment."

There is great concern about "access to medical home specialists" and the "lack of specialty care and services" faced by parents/caretakers of children with special health care needs throughout the state,

and especially noted as problematic for rural Georgia. There are "children without a primary care provider who can help coordinate care and ensure the child receives well care, such as immunizations."

Access to care and specialty services are also particularly pronounced for families of children with special health care needs who are underinsured, uninsured or undocumented.

The availability of quality interpreters is an additional barrier for some consumers/parents, and impacts the provision of care. "Interpretation is not accurate most of the time, and as a non-bilingual parent, I am unable to express the corrections needed." It adds to the "challenges in navigating through the system."

Given the shortages of qualified health care providers and thus the (often distant) location of available services for families, there is the need to travel long distances or wait for many months for an appointment. This reality is highlighted as critical problems by parents/caretakers of children with special health care needs. Their comments illustrate the multi-faceted problem.

- "One family in our district has been on a waiting list a year to see a physician for their child who may have autism. The average mental health specialist wait time in the district is six months;"
- "Jacksonville and Savannah are the only ones that have a clinic for diabetes;"
- "Some services you have to go to Savannah for. Back pumps can't be done in Statesboro;"
- Consumers/parents appear upset about what they see as "disparities of services which vary county to county;"
- "I had to wait three months to see a nutritionist;"
- "When I go to the pediatrician's office they see my child after a long time waiting at their reception area. We are rushed through the treatment, and we may have to go to the emergency room because there are no specialized medical personnel in Clayton County limits;"
- Long waiting times for appointments with specialists are typical;
- "Physicians or specialists and other services are all up north or downtown. The hours are from 8:00 – 5:00 and you have to take the whole day off work to drive all the way there;" and
- "My son is nine years old. The first seven years I went to Scottish Rite. I spent a lot of money on tolls and parking."

Some health providers view the problem as due, in part, to "lack of providers who will accept Medicaid." Others explained that "distance is a problem for providers; they won't come out, they say it is too far."

Concerns about what is occurring around physicians' making referrals to specialists are also evident in these stakeholder comments.

- "Pediatricians are not identifying children with minor feeding disorders;"
- "The small town pediatrician just does not know about the resources;"
- Mothers say they have difficulties trying to access specialty services through a referral from the primary care physician; and
- "It is a constant struggle" for parents who want to have a second opinion about their child's condition.

Health Care providers in community focus groups highlight how their challenges have changed over time.

- "Cost of providing services has increased while reimbursement rates have been stagnant or have increased;"
- "Access to therapists is becoming more and more difficult. In addition to reluctance to accept Medicaid reimbursement rates, providers have to deal with a large amount of paperwork and appeals if a request is denied by Medicaid. There is no incentive for them to work with the CMS population;" and
- "CMS clinics are overloaded."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN WITH SPECIAL HEALTH CARE NEEDS' HEALTH

A priority forwarded by most of the roundtables of health providers and advocacy groups providing input to the needs assessment is to address Georgia's "shortage of specialty services, both health and education" and the subsequent problem of access to qualified specialists.

CSHCN stakeholders forwarded various ideas on what is needed to improve the physical and mental health of children with special health care needs. Suggestions around what is needed to improve the availability of specialty care and services follow.

- "More qualified providers (developmental pediatricians to adult providers) who accept Medicaid are needed;"
- "Adequately fund CSHCN programs;"
- "Attract subspecialists to underserviced areas;"
- Address shortage of mental/behavioral health specialists;
- "Support services such as case management are needed to help with education and planning for the children to make sure they are aware of the resources that are available in the community;" and
- Provide special incentives to attract subspecialists. "There is a model for serving underserved areas."

INFRASTRUCTURE/SYSTEM ISSUES

QUANTIFICATION

Infrastructure/system issues are identified as a major health concern for children with special health care needs by all seven of the CSHCN needs assessment community focus groups and the nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

A health value cited as the desired priority for Georgia forwarded by several roundtable groups at the focus group of non-governmental maternal and child health provider and advocacy groups is that "all children with special health care needs receive appropriate coordinated ongoing comprehensive care. "

As noted by half of the focus group with advocates and providers, early screening and identification of children with special health care needs and provision of appropriate follow-up services is a major health need concern.

Service delivery concerns emerged in every focus group with CSHCN stakeholders. They cite a "lack of care coordination" and the need for case management.

- "I think there could be better coordination between services and programs (e.g., public health, school system mental health), especially when children are transitioning out of certain programs and get certain ages;"
- There is special concern for "children without a primary care provider who can help coordinate care and ensure the child receives well care, such as immunizations;"
- Children with major feeding disorders need a case manager; and
- "Lack of care coordination for children with tube feeding and other nutritional disorders transitioning from WIC to Medicaid is a problem."

The timeliness of screening and delivery of care is sometimes of utmost importance. The time it takes for approvals is another service delivery concern.

- We need "shorter approval process for vision drops to prevent blindness. There is a short window of opportunity, and delays can result in blindness;" and
- "Increase in Medicaid approval time for special formulas, medicines, and supplies that are life sustaining – up to three weeks for formulas and medicines; three to four weeks for DME has become a real problem."

Inadequate resources are a concern cited in every focus group of CSHCN stakeholders. Distribution of funding is a concern of parents/stakeholders in some areas, and they are unclear why that is so.

- "Funding just sent to the north counties;" and
- "There is an unequal distribution of funds."

Availability of quality interpreters is also a commonly cited problem. "Interpretation is not accurate most of the time, and as a non-bilingual parent, I am unable to express the corrections needed."

Some parents state they have experienced "poor customer service" and feel their views are not valued. Also heard in several community focus groups is that parents have experienced "discrimination among local agencies."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN WITH SPECIAL HEALTH CARE NEEDS' HEALTH

CSHCN stakeholders forwarded various ideas on what is needed to improve the infrastructure/system issues for children with special health care needs. Suggestions around addressing the infrastructure/system issues follow.

- Provide access and availability to early identification and intervention/appropriate follow-up;
- Parity of mental and physical disabilities is needed;

- Address the need for each child to have a medical home which will provide annual visits, a care plan, continuity of care;
- Document the receipt and quality of services;
- Do something to decrease the challenges in navigating through the system;
- Maximize the availability of assistive technology;
- Use technology and telemedicine to address specialty needs;
- "Measure health outcomes, quality of life and educational academic achievement;"
- "Policy and practice changes that support all children regardless of special needs including early childhood mental health" are needed;
- Address the linkages needed to provide for "transitions between programs and care coordination;"
- "The health care system has changed over the last few years. Public health needs to look at where its niche is in the system. In determining the niche, we need to look at how well Medicaid and the private sector are doing in providing care for infants, children, adolescents and children with special needs and what the gaps are. We just have impressions of what is happening and need data from our sister agency Medicaid to see what percent of children are getting routine well baby examinations; "
- Improve access to funding sources;
- "All medical specialists should share information about treatments with other professionals and parents;"
- Case management is needed; and
- "Better communication between Medicaid care coordinator and physicians." is needed.

LIMITED EDUCATIONAL SERVICES IN SCHOOLS

QUANTIFICATION

Educational services and opportunities in schools are identified as a major health concern for children with special health care needs by four of seven CSHCN needs assessment community focus groups and two of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

A concern of consumers and stakeholders heard in various community groups is the notion that Georgia's "education system is not adequate for special needs children."

Views of that concern can be heard in stakeholder input collected in the community focus groups.

- There is a "lack of educational services for children with special health care needs, including no specialized services, inadequately trained staff, and no accountability for school staff as far as what happens with children;"
- "Poor quality education services" is an issue;
- "In my community the education is horrible for special education. The children do not get the same education as regular kids, and they are not seen as individuals;"

- "When my child started regular class, the teacher had no training with special education…Teachers and schools are not equipped for children with special needs to interact with regular kids;"
- "My problem with the school system is trying to get the services that will help my child. The problems are with the teachers and getting someone within the school system that will help get the kids' needs met." There are "no trained personnel in the schools that will help the kids with special needs;" and
- "No Child Left Behind does not work. Teachers are just pushing the kids through rather than working with the kids to help them at their level. It needs to be amended for special needs children."

Parents of special needs children expressed discouragement about what was not available to their child. One parent's view follows.

- "Most people think old people and special needs kids are being cared for, but that is not true. There needs to be a better system in the school, because the community acts like children with special needs do not exist."

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN WITH SPECIAL HEALTH CARE NEEDS' HEALTH

CSHCN stakeholders and consumers forwarded various ideas on what is needed to improve the physical and mental health of children with special health care needs. Suggestions around educational services and opportunity in schools follow.

- "Education services are needed;"
- "Improve educational opportunities – reinstate school nurses; provide better training for faculty/staff on working with children with disabilities;"
- "More training for teachers and principals with special needs in the school system. We feel no one cares;"
- "Regular education teachers need more training on how to deal with children with special needs;"
- "Adequate technology in schools" would help;
- After-school programs for children and adolescents, "programs the kids can participate in," are needed;
- "Measurement of health outcomes, quality of life and educational academic achievement" of CSHCN is needed; and
- Address the "shortage of specialty services, both health and education."

MENTAL HEALTH

QUANTIFICATION

Mental health is identified as a major health concern for children with special health care needs by four of seven CSHCN needs assessment community focus groups and two of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Inadequate access to mental health services is a concern to parents/stakeholders and health care providers. Several stakeholders suggest a high priority for Georgia should be "appropriate mental health screening and services for children with disabilities and their families" and "adequate amount of mental health resources." Health Care provider group highlighted these concerns because "mental health issues evolve as the special needs child progresses."

Consumers and stakeholders in community focus groups also emphasized the gaps in mental health services in their communities. Behavioral health providers are viewed as providing necessary services, but are not available in some areas of the state.

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN WITH SPECIAL HEALTH CARE NEEDS' HEALTH

CSHCN stakeholders and consumers forwarded various ideas on what is needed to improve the physical and mental health of children with special health care needs. Suggestions around addressing the concern about the availability of mental health services to children with special health care needs follow.

- Provide "inpatient and outpatient mental health, where you actually get therapy for the child. That would be new around here;"
- "We need more mental health services for children, adolescents, adults;"
- "Improve mental health and psychological services;"
- Provide "more inpatient psychiatric services;" and
- "Make available mental health services/counseling in the schools."

OTHER HEALTH CONCERNS

The following is a list of health care concerns among children with special health care needs that were not mentioned with adequate frequency to be considered a theme, but are important to document.

- Functional homelessness among families of children with special needs; and
- Health care provider education to foster a caring attitude towards special needs children and families, and to equip them to provide care for special needs children, make referrals.

SECTION 4: MCH PROGRAM CAPACITY BY PYRAMID LEVEL

DIRECT AND ENABLING HEALTH CARE SERVICES

GEORGIA'S DIRECT HEALTH CARE SYSTEM

Georgia's health system consists of five interconnected components – private providers, hospitals, community health clinics, regional behavioral health and developmental disabilities services, and the state's public health system which has two separate elements, the Medicaid/PeachCare payment system and county public health services.

PROVIDERS

The most recent (2004) Health Resources and Services Administration (HRSA) report, "State Health Workforce Profiles," showed Georgia's health workforce status across a large range of professions.

Georgia Health Professional Summary, 2000		
Profession	Number Employed	State Rank (of 50)
Physicians	13,700	39
Psychiatrists	749	25
Physician Assistants	1,232	24
Registered Nurses	68,000	42
Nurse Practitioners	2,260	33
Certified Nurse Midwives	389	9
Licensed Practical Nurses	20,000	10
School Nurses	1,143	Not available
Dentists*	5,018	23
Dental Hygienists	4,760	23
Pharmacists	6,020	29
Psychologists	1,110	48
Social Workers	7,360	47
Physical Therapists	2,660	43
Occupational Therapists	1,790	35
Speech-Language Pathologists and Audiologists	2,020	42
Respiratory Therapists	2,520	20
Dieticians and Nutritionists	940	47

*Reported number of dentists varies based on reporting source.

The Georgia Department of Labor (DOL) employment projections to 2012 indicate that health care and social assistance employment is expected to grow the fastest of all industry sectors in the state, with an annual rate of 3.2 percent and the addition of more than 125,000 new jobs. Eight of the twenty fastest growing occupations are in the health services industry. DOL projects a growth rate of 5.4 percent for medical assistants, 5.1 percent for dental hygienists, 4.9 percent in dental assistants, 4.8 percent in physician assistants and in medical records and health information technicians, 4.3 percent in home health aides, 4.1 percent respiratory therapists, and 3.6 percent in surgical technologists. Registered nurses (RN), the largest of all health care occupations is the occupation with the second most expected job growth, with a projection of 19,880 newly created RN positions.(1)

Georgia faces challenges in meeting the demand for health care occupations. The Georgia Board for Physician Workforce, the state agency responsible for advising the Governor and General Assembly on physician workforce and medical policy and issues concluded in 2006 that growth in medical specialties was minimal or negative; there were substantial problems in geographic distribution of primary care physicians, pediatricians, and obstetricians/gynecologists; and the state will require new physicians just to maintain current capacity.(2)

A 2007 state senate study committee report on the shortage of doctors and nurses in Georgia also concluded that the state is facing a severe shortage of physicians and nurses. Data gathered by the American Medical Association (AMA) supports this conclusion. The AMA found that Georgia ranked 40th in the nation in per capita number of practicing physicians and 42nd in its per capita supply of registered nurses.(3) Georgia ranks 34th in the number of medical students per capita and 37th in medical residents per 100,000 population.(4)

The Senate Committee also recommended that medical school enrollment in Georgia be increased. A 2008 medical education study on behalf of the University System of Georgia of the Georgia Board of Regents is serving as a road map for statewide expansion of Georgia's public medical education system. A partnership is being developed between the Medical College of Georgia (MCG), the state's only public university devoted exclusively to health sciences, and the University of Georgia (UGA), the leading public research university.(5) With full implementation of the plan, through its partnership with UGA, MCG School of Medicine could expand from its current level of 745 students to 1,200 by 2020, an increase of approximately 60 percent in medical students.(5)

As of July 2009, there were 101,762 registered nurses (RNs) licensed in Georgia; however, not all of these RNs were practicing full-time. Some were retired, but maintained their licensure; others were working only part-time as a nurse or were employed in a nearby state.(6) Several federal labor sources suggest that only approximately 65,000 of the nurses licensed in Georgia in 2009 were working full-time.(6) Georgia consistently ranks in the bottom ten states in terms of the number of RNs per population (670/100,000 in 2008).(6)

Despite the recession, nursing employment rates have remained relatively steady in Georgia and the US as a whole, and there are still more jobs than there are nurses. A shortfall of an estimated 16,400 registered nurses in Georgia in 2010 is expected to grow to 37,700 by 2020.(7) One impact in Georgia's economic downturn has been an increase in the number of former part-time nurses who are returning to the workforce as full-time workers, as well older nurses who are delaying plans to retire. This has expanded the pool of experienced nurses in the workforce.(8)

In response to the Senate Committee recommendation to increase nursing school enrollment, the state University System, Technical College System, and private institutions have been working to address the state's shortage of RNs. In 2008, the University System and Technical College System graduated 2,231 new pre-licensure nurses, approximately 1,000 more graduates than in 2002. This gain reflects an increase in the number of nursing programs operated by the Technical College System. In addition, approximately 300 RNs graduated from private nursing institutions as part of the 2007-2009 academic year.(8)

HEALTH PROFESSIONAL SHORTAGE AREAS (HPSA) AND MEDICALLY UNDERSERVED AREAS (MUA)

Health Professional Shortage Areas (HPSAs) are designated by the federal Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population. Georgia has 125 Mental Health Professional Shortage Areas (MPHSAs), 136 Primary Health Professional Shortage Areas (HPSAs), and 94 Dental Health Professional Shortage Areas. Most counties in Georgia include an MUA.

GEORGIA STATEWIDE AREA HEALTH EDUCATION CENTER (AHEC) NETWORK

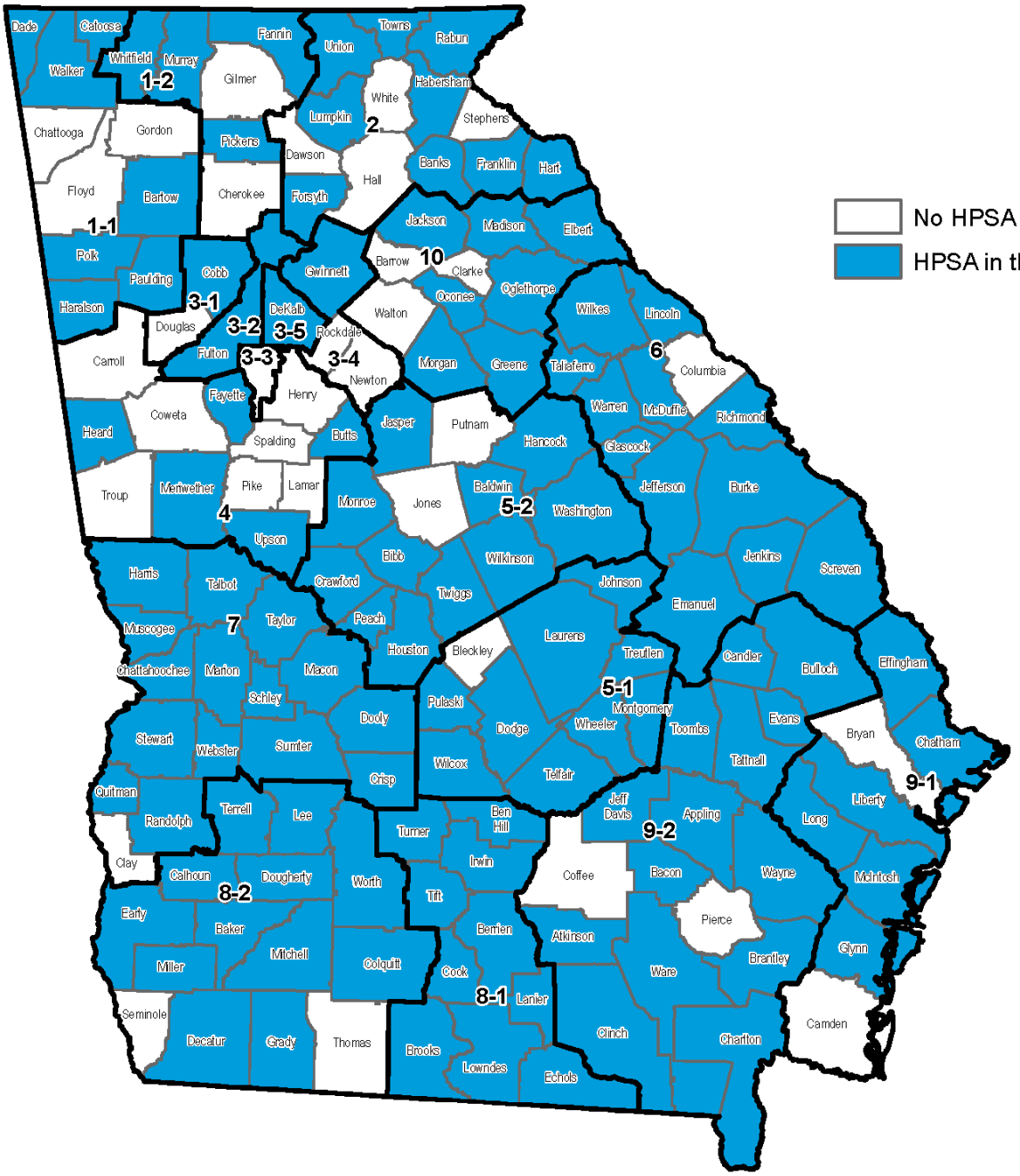
AHEC Network is a partnership between the Medical College of Georgia and Mercer University School of Medicine. The Statewide AHEC Network has represented a growing partnership of health providers, health professionals, educators, state agencies, and communities joined together to respond to the problems of health professional supply and distribution in rural and underserved areas of the state.

The state's six AHECs work with secondary youth, college and technical college students, displaced workers, older adults, and second career seekers. Programs include general health careers recruitment presentations, health career fairs, and a wide range of video, manual and classroom resources. In addition, intensive programs include health career camps and clubs, as well as academies designed for middle and high school math and science teachers. In 2009, the AHEC network served 48,562 health careers participants and over 150,662 participated between 2007 and 2009. Only 11 of the state's 159 counties did not have an AHEC sponsored health careers recruitment or education program.

The AHEC Network also provides assistance and support for health professions students completing community-based clinical training, including identification and credentialing of training sites, faculty development of community-based preceptors, student orientation to the community, student travel, and/or housing support during rotations, and site visits. Over 11,160 health professions completed community-based clinical rotations supported by one of the six regional AHEC centers between 2007 and 2009, including 3,893 in 2009. The 11,160 health professionals included 3,035 physicians, 1,601 physician assistants, 656 nurse practitioners, 1,706 nurses, and 4,169 "other."

The statewide AHEC Network also works to retain health care providers in the workforce. Professional isolation in rural areas of the state is addressed by connecting community-based providers to academic institutions as well as providing relevant and accessible continuing education opportunities for all levels of providers. Between 2007 and 2009, 32,882 AHEC participants completed AHEC-sponsored continuing education courses. Participants came from all 159 Georgia counties with 9,071 completing continuing education courses in 2009.(9)

Primary Care Health Professional Shortage Areas



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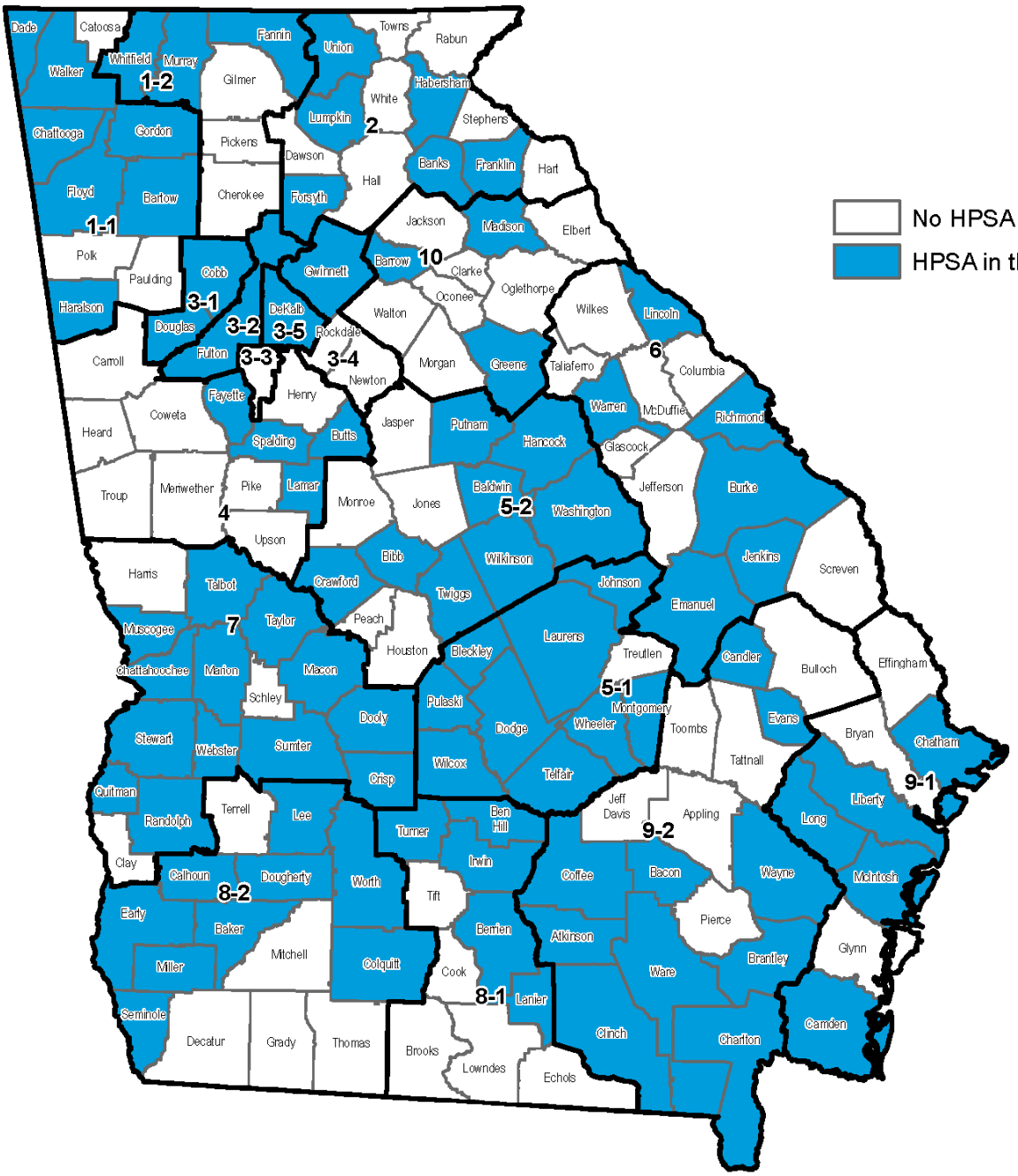
Dental Health Professional Shortage Areas



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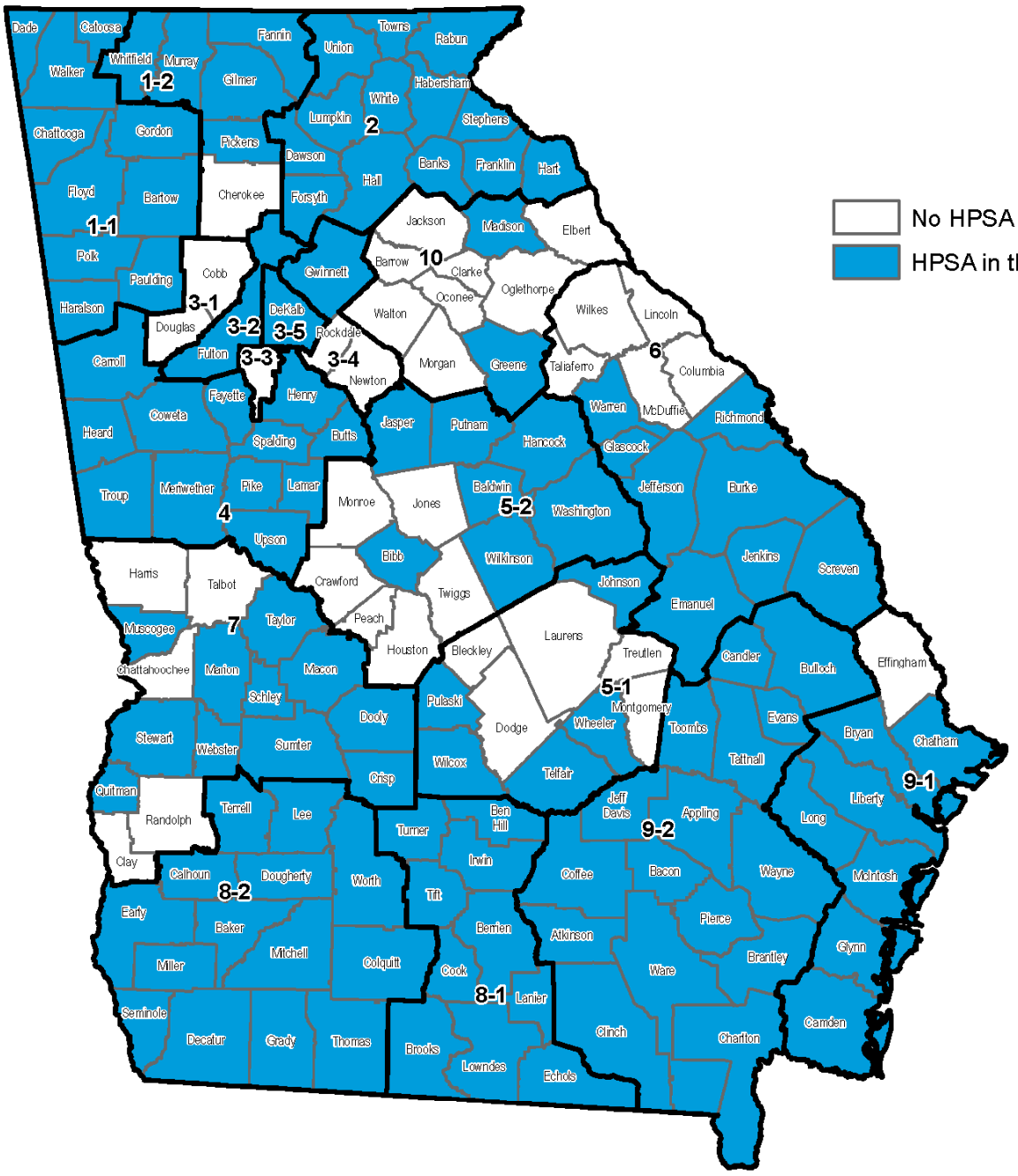
Mental Health Health Professional Shortage Areas



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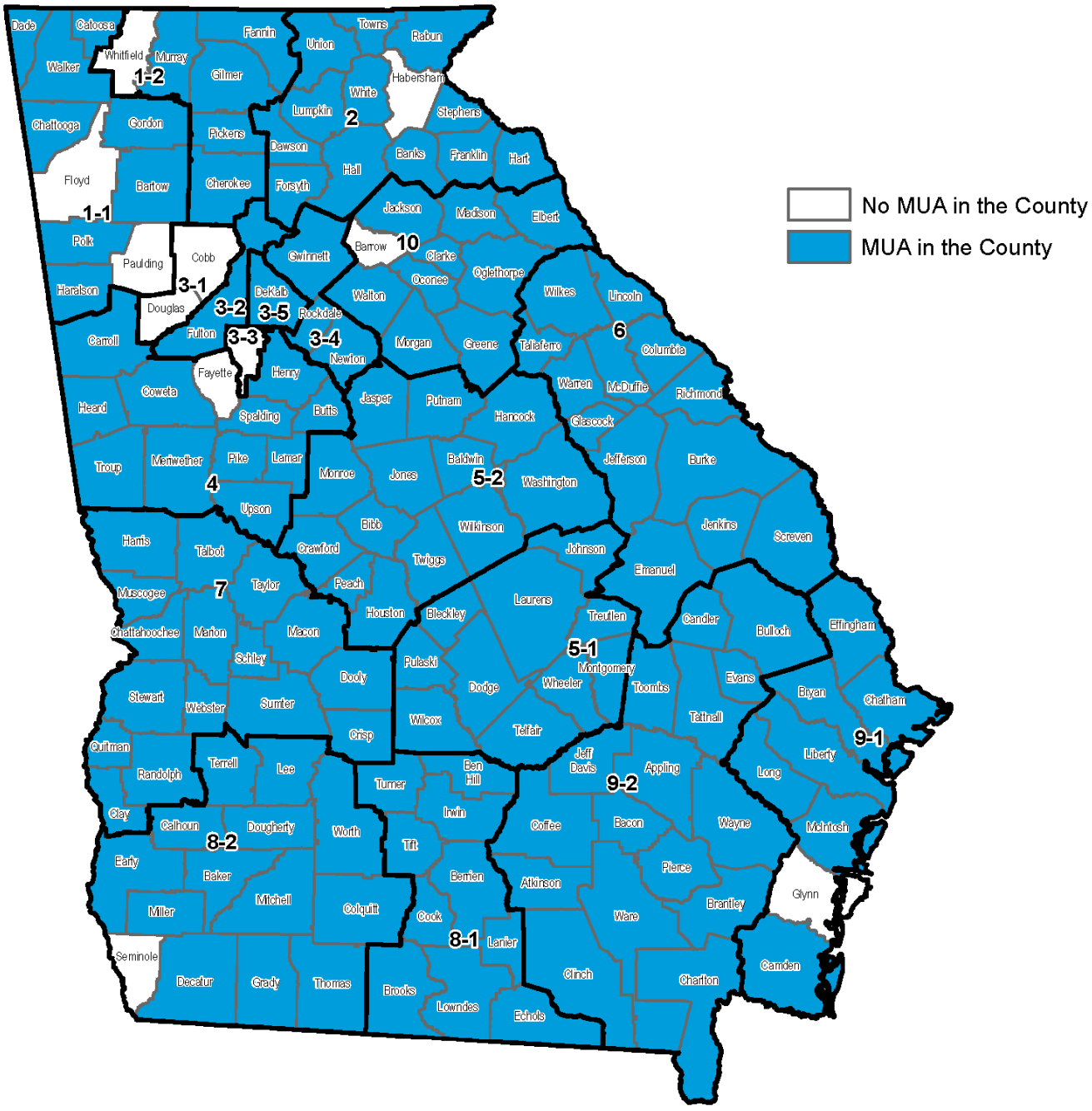
Medically Underserved Areas



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HOSPITALS

There are approximately 200 hospitals in Georgia, including 149 acute care facilities. There is at least one hospital located in 111 of the state's 159 counties.(10) According to a 2008 American Hospital Association survey, the state's hospitals employed more than 138,000 persons; delivered 142,000 babies yearly; provided 959,000 inpatient admissions, 3.8 million emergency room visits, and 10.3 million other outpatient visits; and had an average daily census totaling almost 17,000.(11)

TRAUMA CENTERS

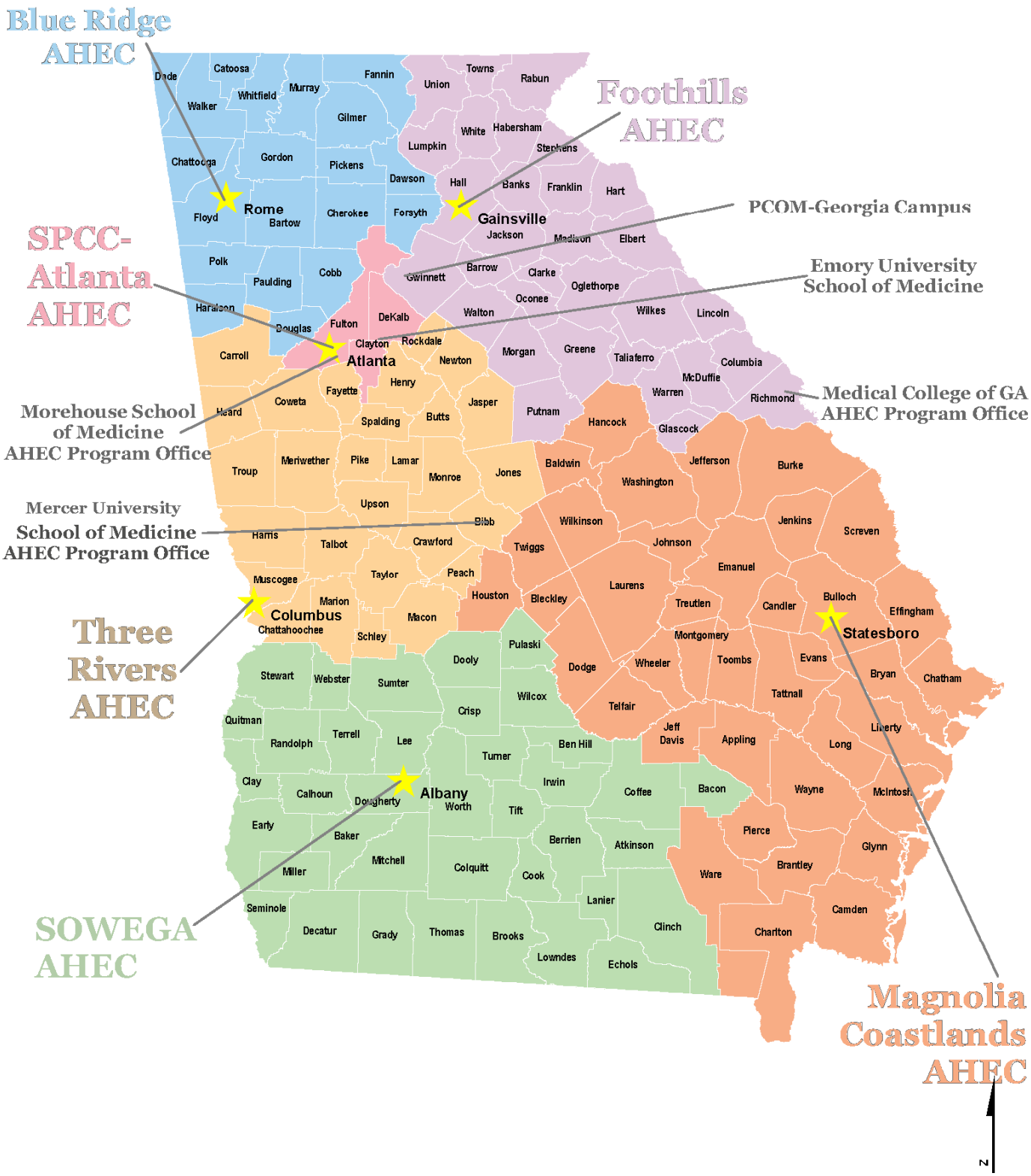
One critical aspect of the hospital-based delivery system is the availability of trauma and emergency care. Georgia, which does not have a statewide trauma system, has 15 trauma centers. The state's Trauma Centers are ranked as levels 1, 2, 3, or 4. A level 1 trauma center is the most comprehensive and has a full spectrum of capacity with surgical subspecialties and a clinical research programs. Most of Georgia's level 1 trauma centers are academic facilities. Like a level 1, a level 2 trauma center has a full spectrum of capacity with surgical subspecialties, but is not required to have a clinical research program. A level 3 trauma center is a community hospital with general surgical, orthopedic, and anesthetic capacity, but without a full spectrum of surgical subspecialty capacity. A level 4 trauma center is generally a small facility which has the capacity to evaluate, stabilize, and transfer major trauma patients to other facilities for more definite care. All of the state's trauma centers function within a complex system that includes pre-hospital care and transport, definitive surgical or critical care, rehabilitation, and injury prevention. In addition, all levels of trauma centers participate in the state's trauma data registry.(12)

The trauma facilities are primarily clustered around metro Atlanta, Augusta, Columbus, Macon, and Savannah, leaving huge gaps in the state for persons requiring timely, quality trauma care. Another issue affecting trauma care is the lack of direct dial 911 in 21 counties in south and middle Georgia, areas traversed by I-75, I-20, I-16, and I-95. The lack of facilities and the ability to rapidly get trauma patients to quality definitive care during the initial "golden hour" negatively impacts patient survival and outcomes.

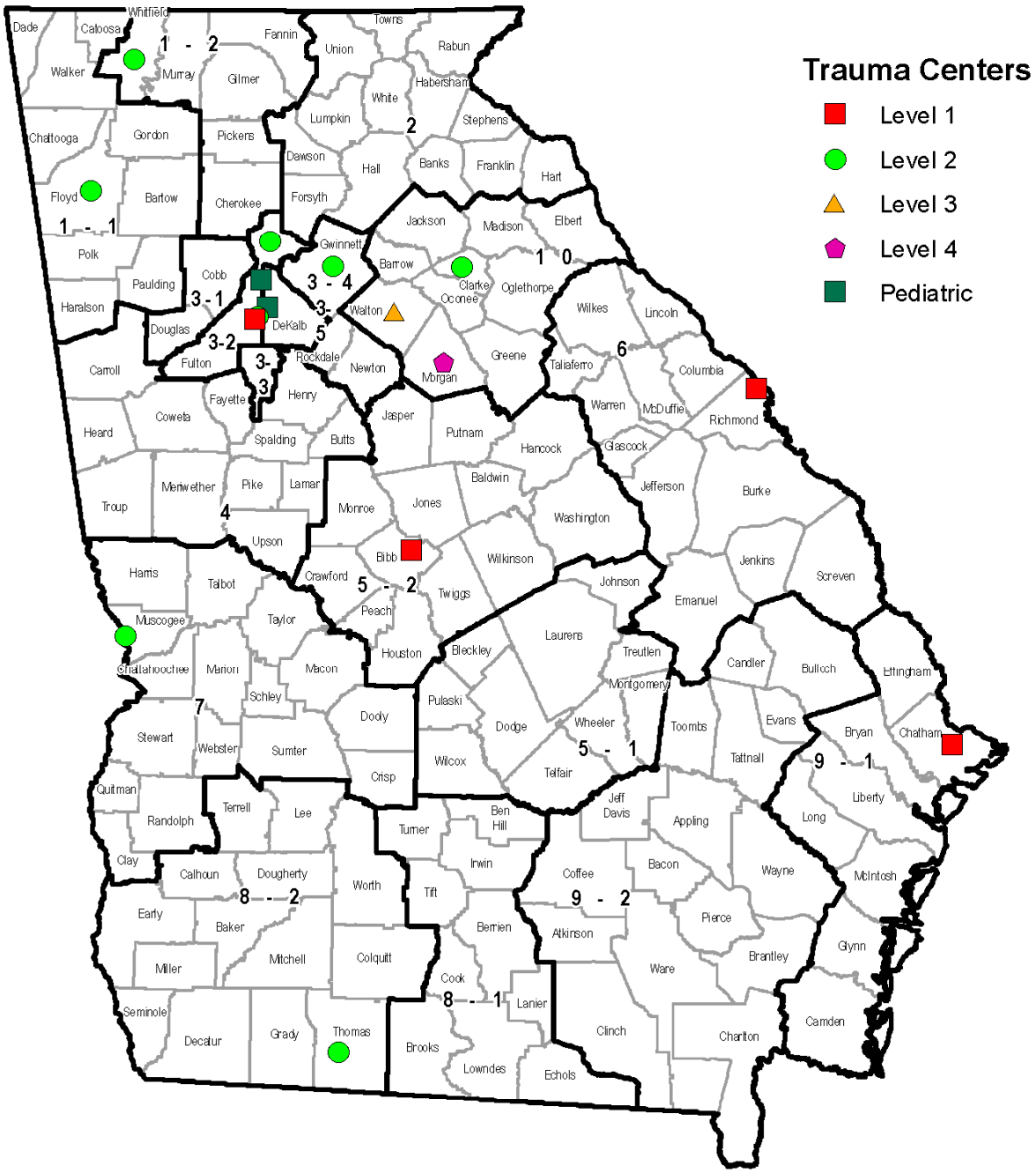
CRITICAL CARE ACCESS HOSPITALS

Sixty-seven rural hospitals are eligible for Critical Care Access designation; 34 hospitals are currently designated. This federal program raises Medicare reimbursement rates for eligible facilities and provides cost-based reimbursement from Medicaid and the Georgia State Health Benefit Plan for outpatient services in return for agreeing not to 1) operate any more than 25 beds, 2) team with a larger facility to deliver inpatient care, and 3) limit inpatient care provided to an average of no more than 96 hours.

Georgia Statewide AHEC Network



Trauma Hospitals in Georgia



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GEORGIA REGIONAL PERINATAL CARE NETWORK

The Georgia Regional Perinatal Care Network (GRPCN) is a formalized system that was established in 1970 under Legislative Authority Title XIX and Title V of the Social Security Act. The goals were to assure the availability of and access to comprehensive prenatal care and specialized obstetric and newborn care. Georgia was divided into six perinatal regions: Atlanta, Macon, Columbus, Savannah, Albany and Augusta. A state designated regional perinatal center (RPC), is located in each region and provides comprehensive care to eligible mothers and infants under guidelines set forth by Georgia Department of Community Health, Maternal and Child Health Program. Services include prenatal care, delivery, postpartum care, transportation, and developmental follow-up. Additionally, the RPCs provide outreach and education to area providers to ensure a seamless community-based system.

The high-risk Maternal and Neonatal Program is jointly funded by the State and Medicaid. In 1991,the RPCs contracted with the National Perinatal Information Center/Quality Analytic Services (NPIC/OAS) to assist in the development of a funds distribution and reporting system that would be viewed as fair, consistent, and sensitive to the differences in patient populations across the six centers. Fulton-DeKalb Hospital Authority Perinatal Center encompasses three hospitals. NPIC/QAS has been involved with the distribution of these high risk perinatal funds since 1991.

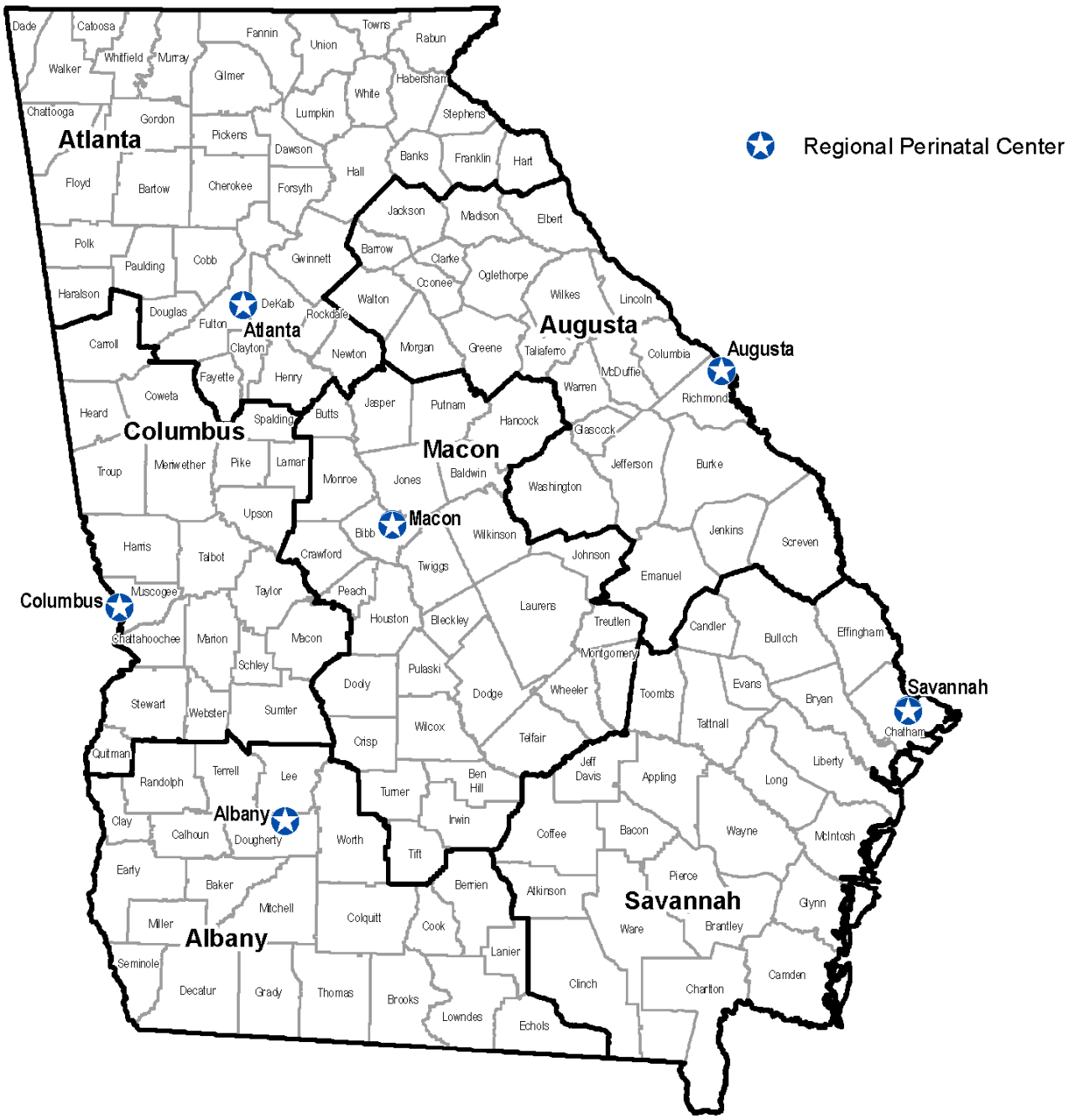
The funds distributed are earmarked for the payment of direct costs associated with the care of high risk mothers and infants at the regional centers as well as administrative costs associated with outreach, education and transport services provided to hospitals within each center's region. The payments for direct costs of care are designed to fill the gap between the traditional insurance, under-insured, private pay reimbursements and the cost of high risk services as well as support the care of uninsured or insured patients with incomes less than or equal to 250% of the federal poverty level.

IMPACT OF THE ECONOMIC DOWNTURN ON GEORGIA'S HOSPITALS

In 2009 the Georgia Hospital Association surveyed its membership to help determine the impact of the state's economic downturn on hospitals throughout the state. Sixty-three (63) hospitals and health systems responded to the survey. The data showed that like other Georgia businesses, the state's hospitals have had to make difficult operating decisions while still trying to meet the health care needs of the individuals they serve. Survey respondents indicated that:

- More than six of 10 Georgia hospitals had to, or were considering, reducing staffing;
- One of three had to, or were considering, reducing services;
- Nearly three out of four hospitals had experienced increases in bad debt and charity care since October 2008;
- Six of 10 hospitals reported that the recession had affected their ability to meet day-to-day operating expenses;
- Nearly three of four hospitals were postponing or reconsidering capital expenditures;
- Over half had experienced declines in elective procedures (often the most profitable procedures for hospitals);
- More than half had seen a decline in charitable conditions/philanthropy; and
- More than eight of 10 hospitals reported an increase in physicians who were seeking support from the hospital (i.e., hospital employment, increased payment for services).(13)

Georgia Regional Perinatal Care Network



With the continued economic downturn and the increasing number of individuals who have lost their jobs and health insurance, hospital emergency rooms, which by law must seen all patients regardless of ability to pay, provide a safety net for the state's uninsured and underinsured. As a result, Georgia hospitals are experiencing even greater financial pressure.

The state's Medicaid shortfall has added to the financial pressures Georgia hospitals are facing. To fund Medicaid in FY 2011, the 2010 Georgia General Assembly passed a 1.45 percent bed tax on hospital beds. The full impact of this tax on Georgia's public and private hospitals has not been determined. Major changes are also anticipated with implementation of federal health care reform signed into law in March 2010. The increase in insured individuals as a result of the legislation could help hospitals, particularly safety net hospitals that currently serve many uninsured patients. It could also mean an increase in the number of Medicaid patients that a hospital serves. Hospitals may lose money if their Medicaid patient population increases significantly because Medicaid does not reimburse hospitals the full cost of a Medicaid patient's care.(13)

COMMUNITY HEALTH CENTERS (CHC)

Georgia's CHCs offer a comprehensive range of primary health care and other services including around-the-clock care, acute illness treatment, prenatal care, well-child care, physicals, preventive services, health education, nutritional counseling, laboratory, x-ray, and pharmacy services. The state's network of 28 community health centers serves over 238,000 Georgians each year in over 70 of the state's 159 counties.(14)

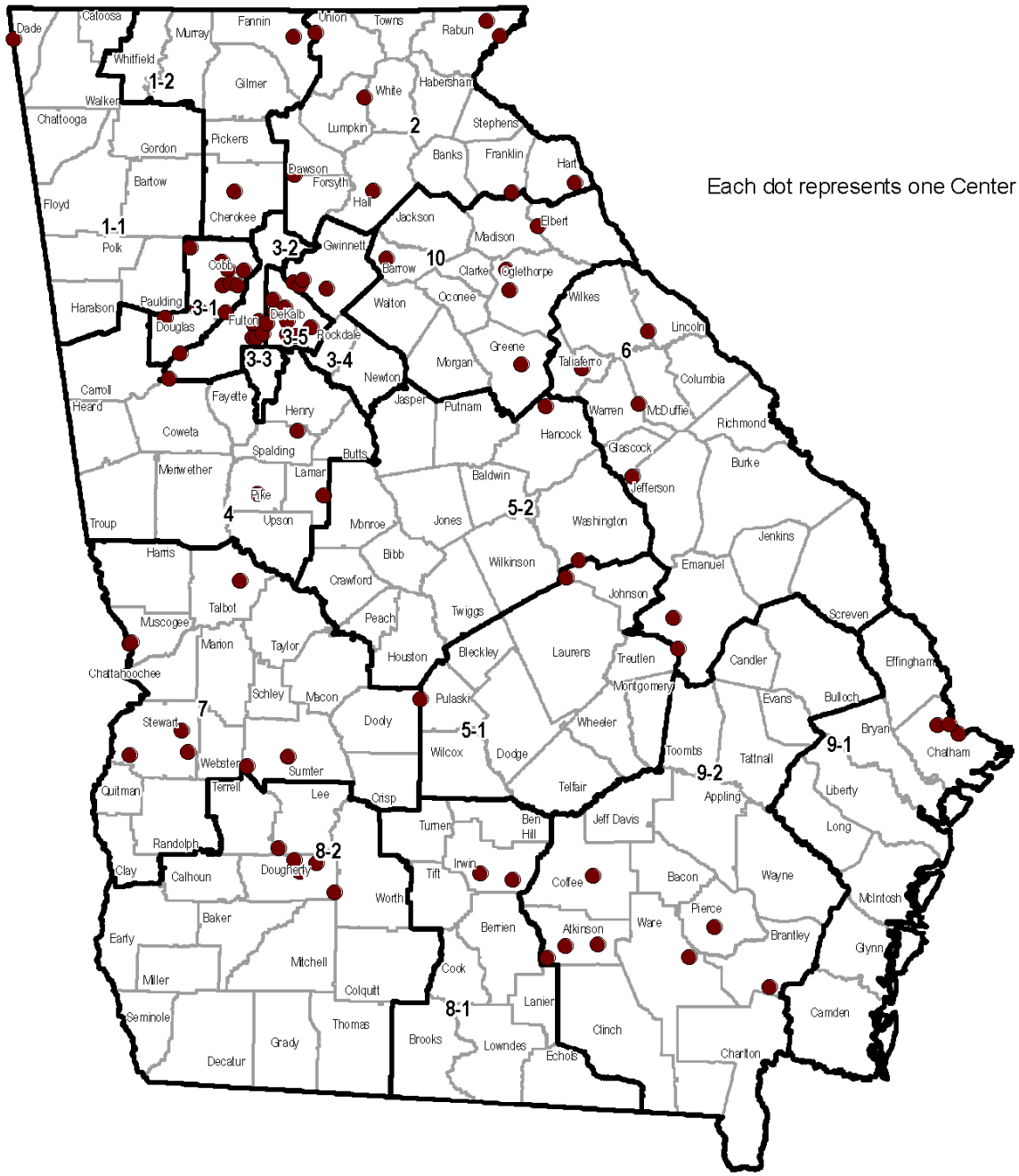
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) provides treatment and support services to Georgia citizens with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD has nearly 9,000 employees whose work is structured in three divisions by disability area: Mental Health, Addictive Diseases, and Developmental Disabilities.

DBHDD operates seven regional state hospitals and provides and oversees community-based services across the state. Five regional DBHDD offices negotiate contracts, manage resources assigned to the regions for community-based and state hospital services, and ensure service access, protection of client rights, and prevention of client neglect and abuse. Each region is required to have an array of mental health and substance abuse services available through a variety of contracted providers. Determination of service needed is based on individual assessment.(15)

In July 2006, the State of Georgia implemented the Georgia Crisis & Access Line (GCAL), a single toll-free telephone number (1-800-715-4225) that individuals can call 24-hours/seven days a week to be connected to local services for mental health, developmental disabilities, and addictive diseases. Previously, each region of the state had a different access number. Managed by Behavioral Health Link (BHL), GCAL was one of sixteen finalists for the 2009 Innovations in American Government Awards from the Harvard Kennedy School's ASH Institute for Democratic Governance and Innovations Award. BHL Call Center clinicians provide brief clinical screening, triage, and service linkage for 25,000 incoming calls per month. Last year, BHJL answered over 300,000 incoming calls.

Federally Qualified Health Centers



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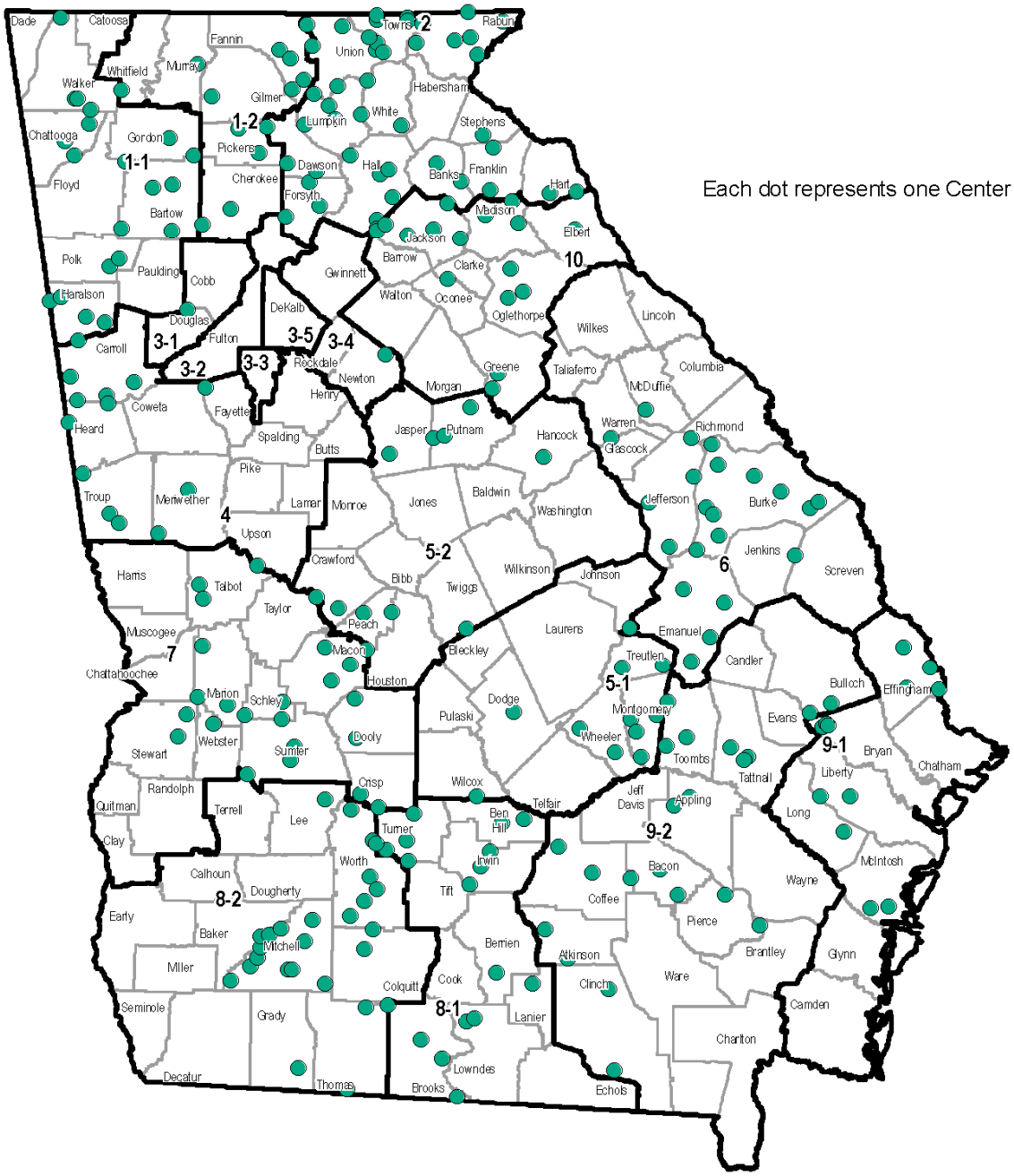
Rural Health Centers



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Projection: Georgia Statewide Lambert Conformal Conic

Target populations include adults with chronic mental illness, adults with severe addiction problems, parents or caregivers of children or adolescents with severe emotional disturbances, and adults and adolescents struggling with suicidal thoughts or a psychiatric crisis. Telephone interpreting services are provided to callers with limited English proficiency. The level of service needed is determined and callers are offered a choice of providers. GCAL is staffed with professional social workers and counselors to assist those with urgent and emergency needs. Those callers who need more routine services are directly connected with the agency of their choice and given a scheduled appointment.

In addition, a website, www.mygcal.com, offers users a list of DBHDD providers and services by county as well as contact information for the regional office that services the user's community.(16) Many individuals approach the state DBHDD service delivery system looking for various types of help. (Not everyone who seeks assistance is in need of mental health or addictive disease services.) In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment is carried out by GCAL clinicians using DBHDD Core Customer child and adolescent and adult eligibility criteria. If the individual does not have sufficient indications of a mental illness and/or substance related disorder, then an appropriate referral to other services or agencies is provided. If the child, adolescent, or adult does appear to have a mental illness and/or substance related disorder, s/he is referred to the designated agency or agencies within their service area for a comprehensive evaluation, treatment and support services as appropriate. Consumers are able to specify the distance they are willing to travel and the call center identifies service providers within that proximity to the individual's zip code location. Consumers can also choose to contact local providers directly for services.

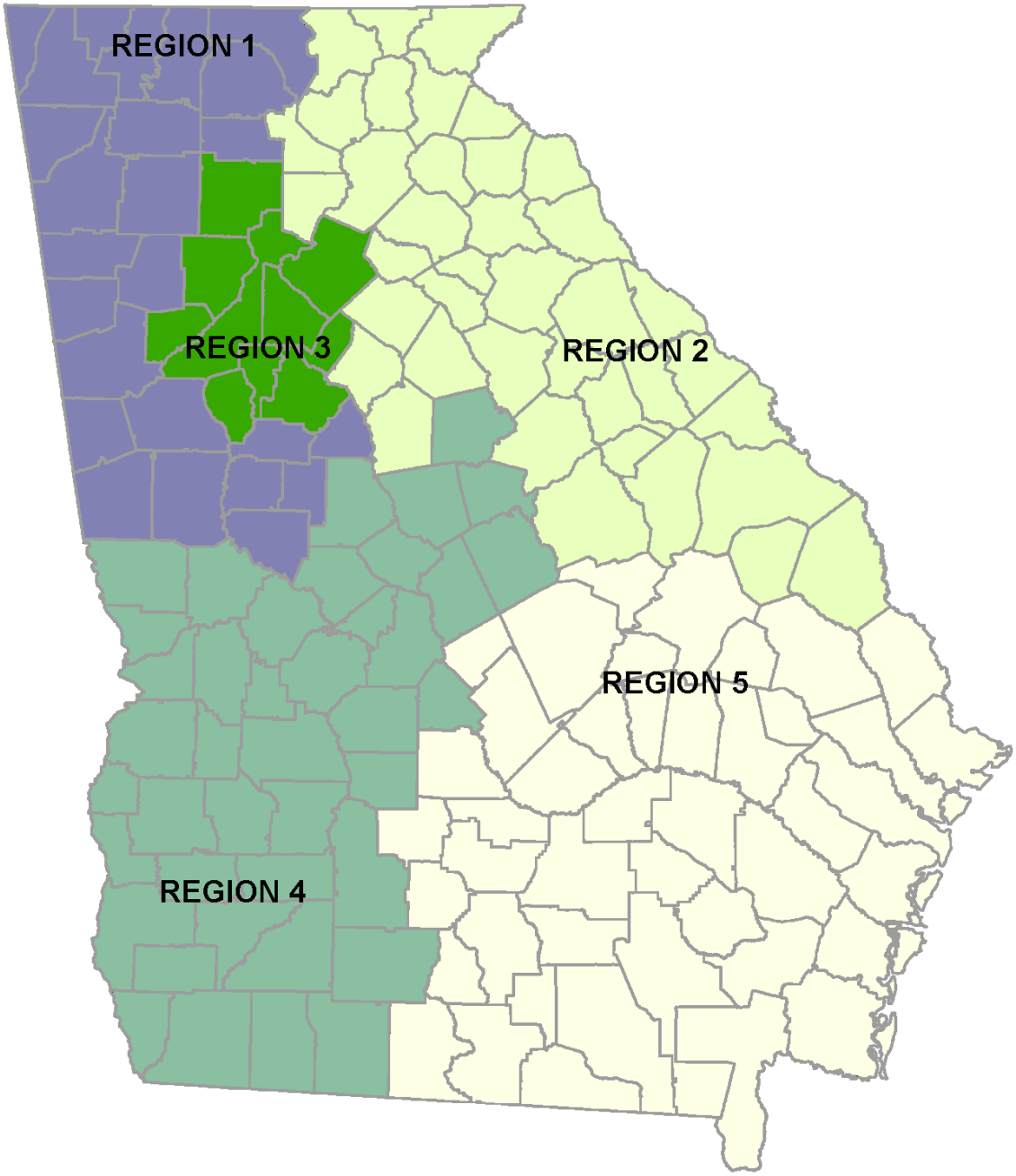
DBHDD's Developmental Disabilities services are focused on people with developmental disabilities with chronic conditions that were developed before age 22 and that limit their ability to function mentally and/or physically. State-supported services are aimed at helping the family continue to care for a relative when possible, serving people who do not live with their families in a home setting, and promoting independence and self-determination. The services a person receives depend on a professional determination of level of need and the services and other community resources available. Services may include family support, supported employment, respite services, inpatient services in one of seven state-operated hospitals that serve people with severe and profound mental retardations (individuals may be admitted only under special circumstances for temporary and immediate care during a crisis), community residential alternative or community living support, and community access services that help meet an individual's needs and preferences for active community participation.(17)

MEDICAID/PEACHCARE FOR KIDS

The Department of Community Health (DCH) administers the state's Medicaid and PeachCare for Kids State Child Health Insurance (CHIP) programs. Of DCH's $12.3 billion FY 2010 budget, Aged, Blind and Disabled Medicaid accounts for 42.9 percent of the DCH budget, Low-Income Medicaid 38.9 percent), and PeachCare for Kids 4.2 percent.(18) Medicaid's FY 2010 state appropriation of $1,390,745,935 reflected a cut of $664,946,931 from the FY 2009 base. Further budgets cuts were required in the FY 2011 state appropriation as a result of the state's revenue shortfall.(18)

Georgia's Medicaid program provides health care for 1.4 million children, pregnant women, and people who are aging, blind and disabled. The average monthly Medicaid enrollment in FY 2008 was 1,253,453.(19) The average annual payment per Medicaid recipient was $5,005.(20)

Georgia Mental Health Regions



Office of Health Indicators for Planning (OHIP)
Epidemiology Branch
Division of Public Health
Georgia Department of Community Health

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Created: July 2010
Source: Division of Public Health
Projection: Georgia Statewide Lambert Conformal Conic

To be eligible for Low-Income Medicaid, adults and children must meet the standards of the former Aid to Families with Dependent Children (AFDC) program (family of four income limit of $6,000 per year). Pregnant women and their infants with family income at or below 200 percent of the FPL are eligible for Right from the Start Medicaid for Pregnant Women and Their Infants (RSM Adults and Newborns). Children under the age of one whose family income is at or below 185 percent of the FPL, children ages one to five whose family income is at or below 133 percent of FPL, and children ages six to nineteen whose family income is at or below 100 percent of the FPL are eligible for Right from the Start Medicaid Children (RSM Children).

Pregnant women, children, aged, blind, and disabled individuals whose family income exceeds the established income limit may be eligible under the Medically Needy program. This program allows a person to use incurred/unpaid medical bills to "spend down" the difference between their income and the income limit to become eligible.(21)

For the Katie Beckett program, which covers children up to age 18, income is ignored. Eligibility is based on medical need of institutional care. For individuals who do not meet legal immigration criteria, Georgia's Medicaid program provides coverage for emergency medical services as long as the individual meets all other Medicaid eligibility requirements.

The Children's Intervention Service (CIS) program offers coverage for restorative and rehabilitative services in non-institutional settings (i.e., home, therapist's office, child care, or community setting) for Medicaid-eligible members from birth up to age 21 with physical disabilities or with a developmental delay. CIS services must be determined to be medically necessary and be recommended and documented as appropriate intervention by a physician. Beginning September 1, 2006, a prior authorization was required for units over eight per member per month for therapy in the same specialty. These units include the evaluation visit. A prior authorization is based on medical necessity and can be approved for up to six months.(22)

In June 2009, 997,488 adults and children were enrolled in Low-Income Medicaid. DCH has projected an increase of 7.7 percent in enrollment between June 2009 and June 2010 (1,074,482 enrollment) and a 2 percent increase from June 2010 to June 2011 (1,096,502 enrollment).(23)

In Georgia, the State Children's Health Insurance Program (SCHIP) is called PeachCare for Kids. It provides health care for children through the age of 18 years whose families make too much money to qualify for Medicaid and who cannot buy their own health insurance. The children must live in a home where the income is at or below 235 percent of the FPL. Health benefits include primary, preventive, specialist, dental care and vision care. PeachCare for Kids also covers hospitalization, emergency room services, prescription medications and mental health care. Each child in the program has a Georgia Healthy Families Care Management Organization (CMO) that is responsible for coordinating the child's care.(24)

PeachCare for Kids exceeded its two year enrollment goal in its first year of operations. Georgia ranks fourth nationally in numbers of enrolled children. Only California, New York, Florida, and Texas have enrolled more children. In June 2009, 205,370 children received services funded by PeachCare for Kids, down from the 250,000 children enrolled in 2008. Enrollment was projected to increase by 8 percent by June 10 (221,972 enrollment) and 8 percent between June 2010 and June 2011 (239,917 enrollment).(25) The average annual payment per child was $1,399.(26)

In Federal Fiscal Year (FFY) 2010, the state's enhanced SCHIP Federal Medicaid Assistance Percentage (FMAP) is 75.57 percent, with Georgia eligible to receive $3 in federal funding for every $1 of state funding.(27) The FY 2010 state appropriation was $87,937,542, a cut of $10,735,387 from the FY 2009 base.(28)

Effective June 1, 2006, Georgia implemented Georgia Families, a managed care program through which health care services are delivered to members of the state's Medicaid and PeachCare for Kids programs. Georgia Families is a partnership between DCH and private Care Management Organizations (CMOs) to ensure accessible and quality health care services for Medicaid and PeachCare for Kids managed care members. DCH contracts with three CMOS: AMERIGROUP Community Care, Peach State Health Plan, and WellCare of Georgia, Inc.

By providing a choice of health plans, Georgia Families intends to enable members to select a health care plan that fits their needs. DCH's Medicaid Division monitors the CMOs to ensure compliance with contractual requirement standards for contract management, member services, provider services, and quality services.(28)

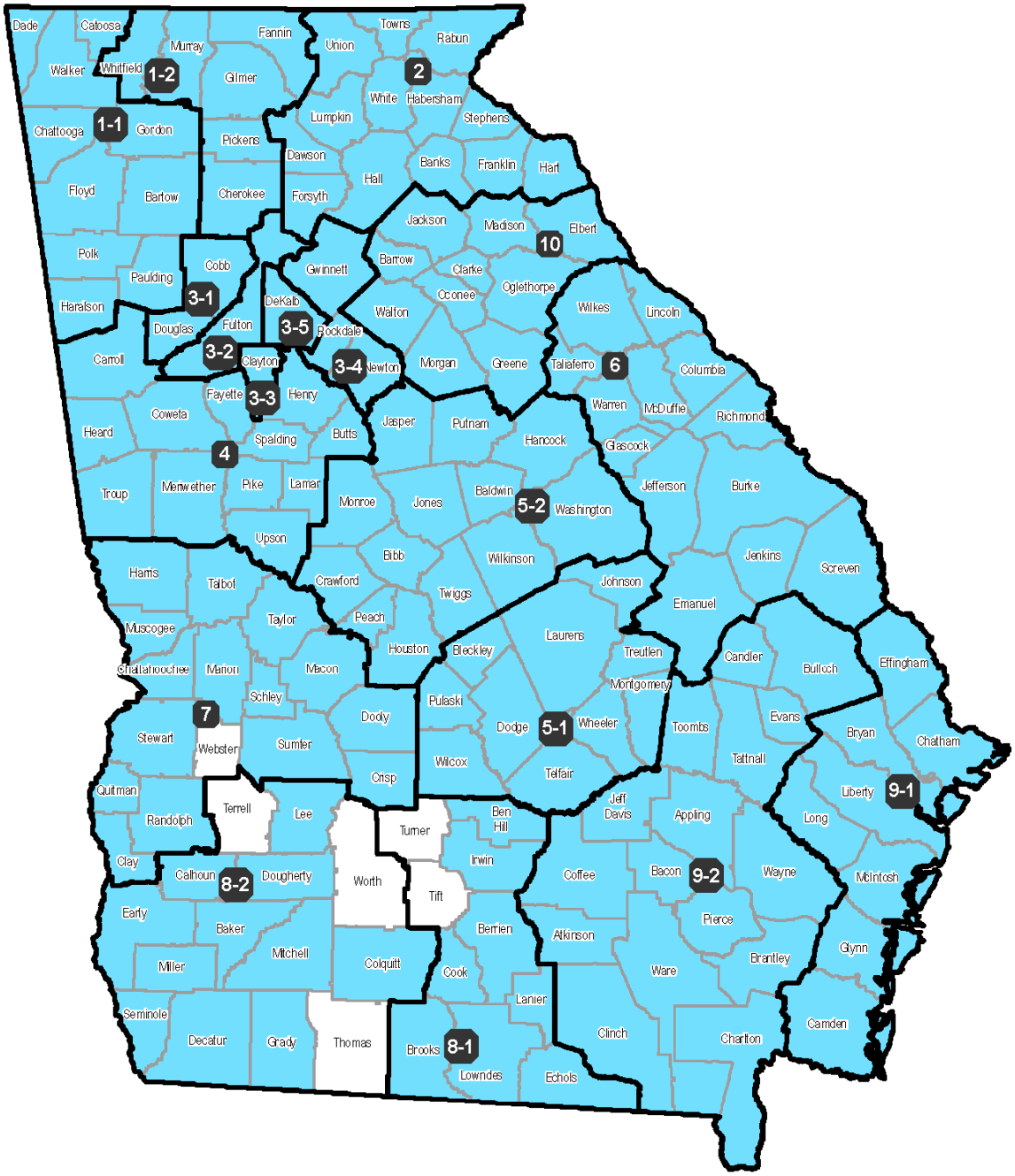
Georgia Families provides health care services to children enrolled in PeachCare for Kids and certain men, women, children, pregnant women, and women with breast or cervical cancer covered by Medicaid. Excluded populations include children in foster care and the remainder of Georgia's Medicaid population, including aged, blind, and disabled citizens.

Children with disabilities who have not been determined eligible for Supplemental Security Income (and do not therefore receive the previously mentioned Children's Intervention Services under Medicaid Aged, Blind and Disabled program), receive services from the CMOs through the Low Income Medicaid program.

PUBLIC HEALTH

Service delivery in the state's public health system is carried out by 159 county boards of health. These boards of health are combined into 18 district units, ranging from one to sixteen counties in size, and they are overseen administratively by a district office that provides management services and programmatic support. Each district is led by a physician district health officer who reports to the state office of the DCH Division of Public Health. The county boards of health provide direct health care services, environmental health activities, and work with community partners in their county around issues of common concern. Approximately 97 percent of the county health departments' funding comes from the state in the form of general Grants-in-Aid (GIA). The FY 2010 general GIA state appropriation was $68,154,008 a decrease of $3,703,320 from the FY 2009 base. (29)

WellCare Care Management Organization Service Area



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Office of Health Indicators for Planning (OHIP)
Epidemiology Branch
Division of Public Health
Georgia Department of Community Health

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Created: June 2010
Source: Division of Public Health
Projection: Georgia Statewide Lambert Conformal Conic

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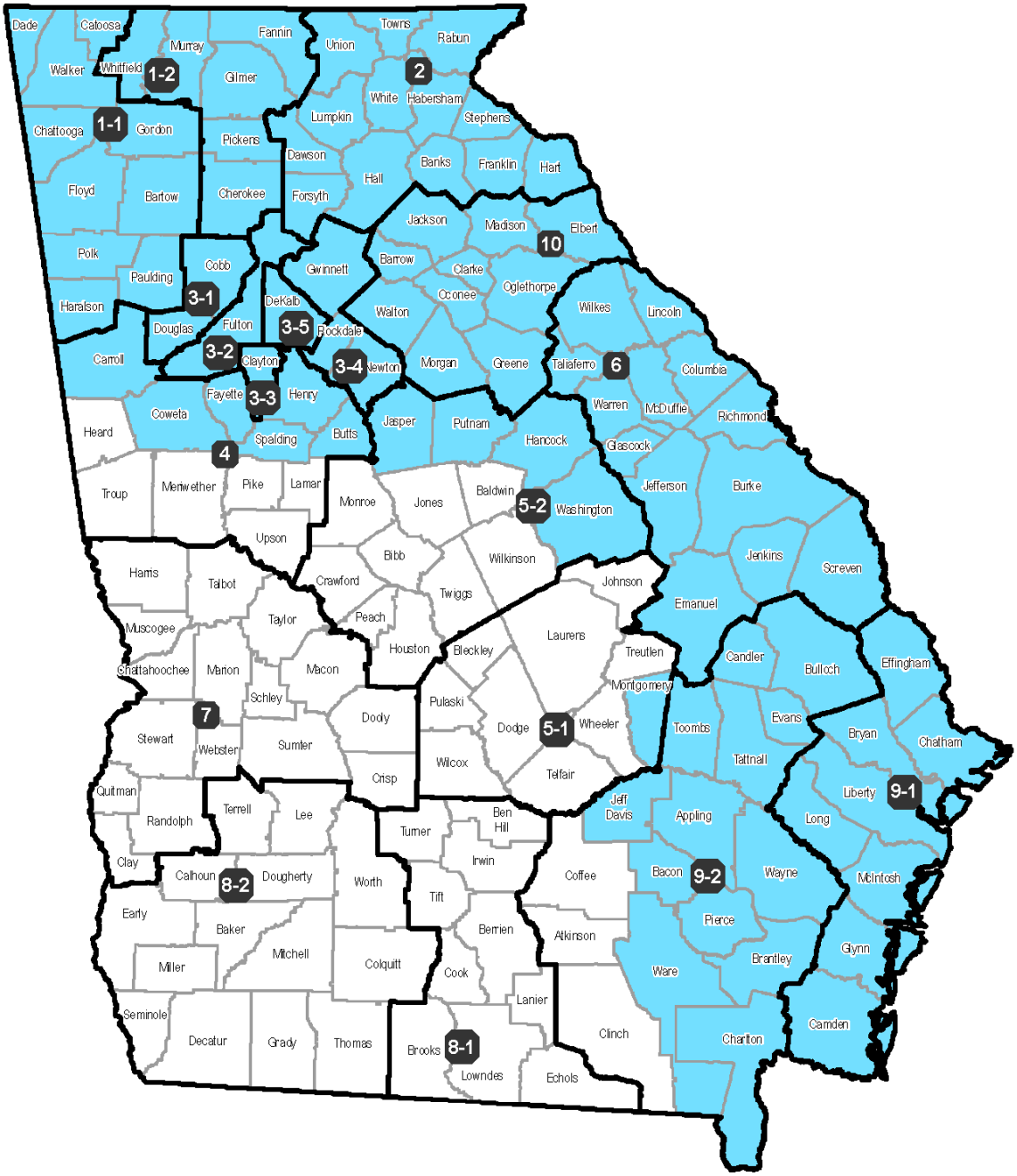

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Georgia Department of Community Health

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Created: June 2010
Source: Division of Public Health
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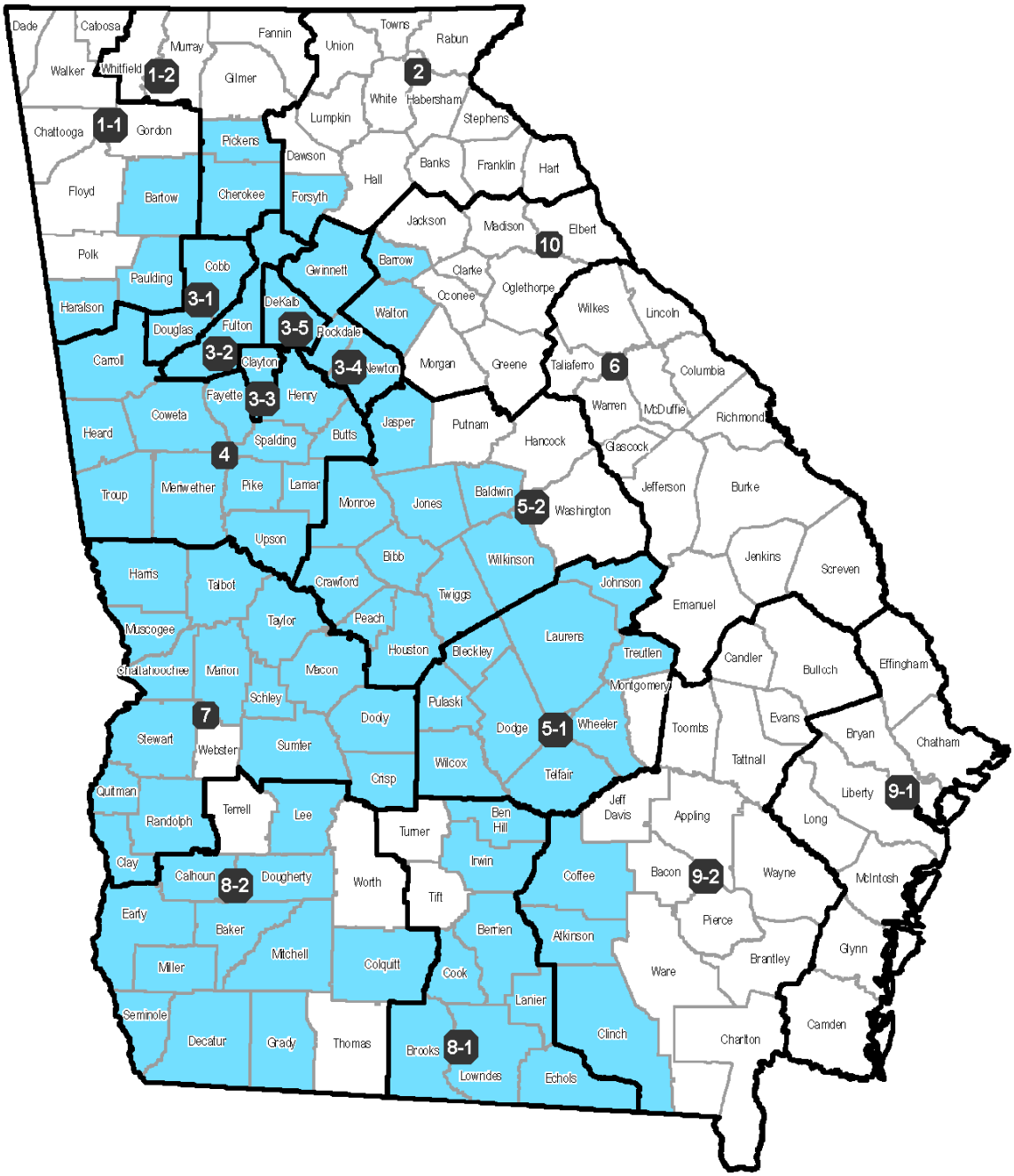
Peach State Care Management Organization Service Area



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Epidemiology Branch
Division of Public Health
Georgia Department of Community Health

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Created: June 2010
Source: Division of Public Health
Projection: Georgia Statewide Lambert Conformal Conic

At the state level, there are six Division of Public Health programs.

- Health Promotion and Disease Prevention
- Epidemiology and State Labs
- Immunization and Infectious Disease
- Maternal and Child Health and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Environmental Health
- Vital Records

These programs are described in detail in *Section 2: Partnership and Collaboration Building Efforts* beginning on page 41 of this document.

In addition, the state office oversee**s** general and programmatic grants-in-aid (GIA) to the 159 county health departments. Twenty-six percent of the State Office of Public Health's funding comes from the state. The FY 2010 state appropriation of $158,616,578 included a cut of $25,702,432 from the previous year's base.(29) The continuing economic downturn in 2010 resulted in an additional reductions in the FY 2011 budget passed on April 29, 2010. This cut continues a trend from the last several years in which public health GIA to county health departments have been reduced.

In addition to budget cuts, like much of the rest of the nation, Georgia's Public Health services have been impacted by a public health nursing shortage. Contributing factors include budget constraints, non-competitive salaries, extended job vacancies, ineffective recruitment and retention, staffing reductions, job furloughs, and bureaucratic hiring practices. Georgia's overall registered nurse shortage, aging population of nurses, and inadequate number of baccalaureate nursing graduates are also factors.(30)

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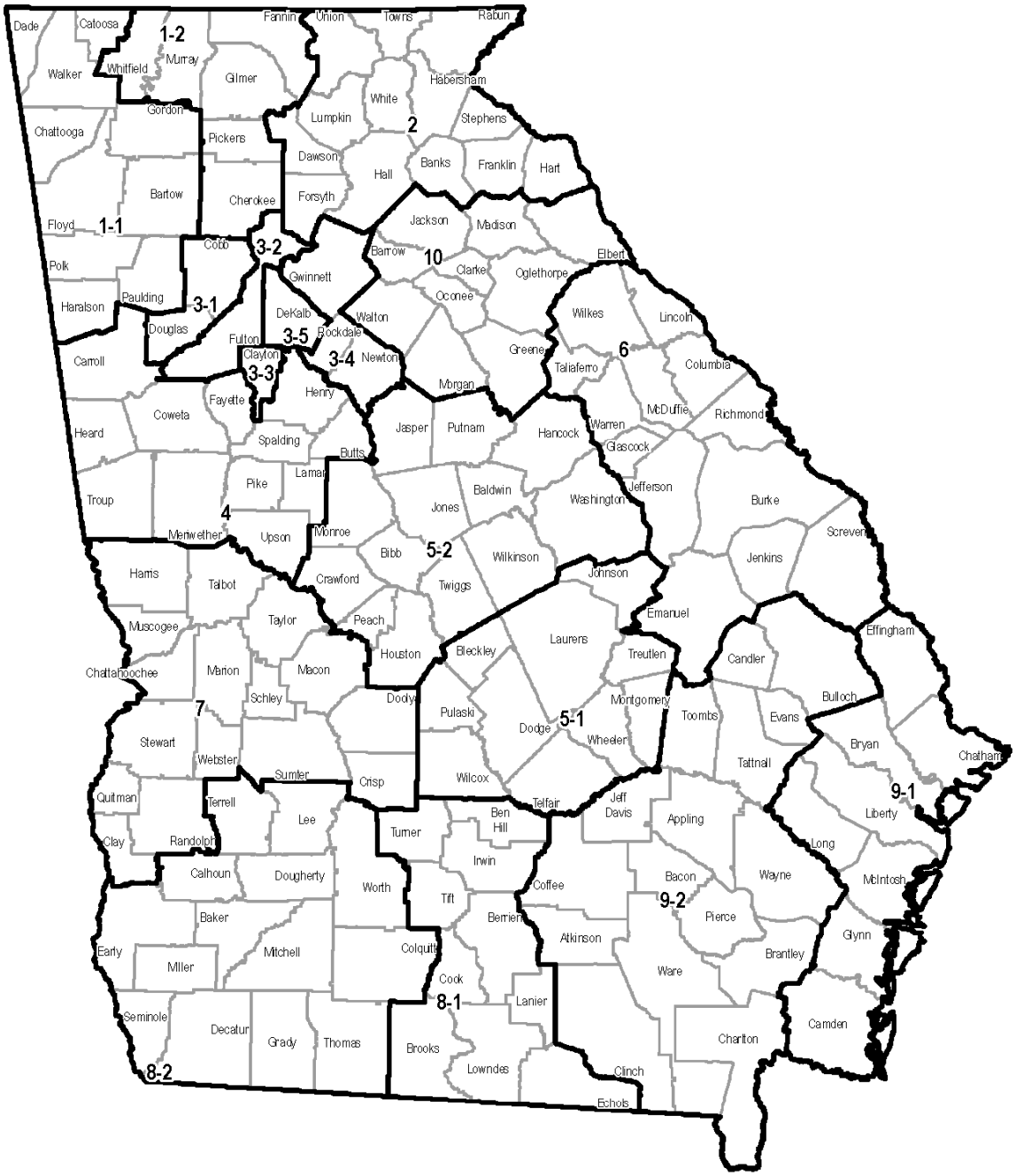
Georgia Public Health Districts



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FAMILY PLANNING SERVICES

The mission of the Georgia Family Planning Program is that all women and men in Georgia will have knowledge of and access to opportunities for optimal health care for themselves and their families, therefore, enabling families to plan and space their children to improve the health of women and children.

Family planning is essential to the well-being of women, men, adolescents, and the community at large. It offers individuals opportunities to plan and space their pregnancies in order to achieve personal goals and self-sufficiency.

In keeping with its mission, the Georgia Family Planning Program has developed strategies and implemented services directed toward the reduction of unintended pregnancies and improvement of birth outcomes.

The goals of the Family Planning Program are:

- To reduce unintended pregnancies in order to avoid the poor outcomes (health, social, and economic) related to unintended pregnancies
- To improve birth outcomes through preconception health promotion
- To promote the health of mothers by providing basic reproductive health care to women in need

Family Planning services are provided directly by county health departments and contracted agencies using various combinations of federal, state, and locally supported staff. Services are provided in a private, customer-friendly atmosphere. Confidentiality of clients is respected and protected. Medical services covered under the Family Planning Program include the following.

- Comprehensive assessment, including history and examination, for males and females
- Provision of FDA-approved contraception, including voluntary sterilization
- Evaluation and management of contraceptive-related problems
- Collection of specimens for specific laboratory tests, such as Pap smears, urinalysis, hemoglobin, gonorrhea, etc.
- Infertility assessment
- Postpartum evaluation
- Genetic assessment, counseling, and referral
- Evaluation and management of sexually transmitted diseases and common gynecological problems
- Pregnancy testing and counseling

In addition to medical services, the Family Planning Program provides the following educational and/or counseling services.

- Abstinence and pregnancy postponement counseling
- Reproductive and preventive health education
- Adoption awareness
- Self breast/testicular examination
- Counseling on risk factors associated with sexually transmitted diseases and HIV
- Substance abuse counseling
- Tobacco cessation counseling
- Violence and sexual abuse counseling and referral
- Counseling on risks and benefits of contraceptive methods
- Problem-specific counseling and referral

The following data from FY09 help to quantify the impact of the Georgia Family Planning Program.

- 143,809 unduplicated clients, including 139,472 females and 4,337 males, received services
- 48,186 unduplicated users obtained a pap smear
- 65,682 unduplicated users received a breast examination
- 57,689 unduplicated users were tested for Chlamydia inflection
- 63,426 unduplicated users were tested for Gonorrhea infection
- 15,881 unduplicated users were tested for Syphilis infection
- 18,569 unduplicated users were tested for HIV
- 76,493 unduplicated users received preconception counseling
- 16,032 unduplicated users received abstinence skills training
- 247 clients received sterilizations

HOME VISITING PROGRAMS

The Georgia Birth to Five Coalition is a statewide advocacy coalition composed of organizations and individuals. Its mission is to promote the healthy development, education and care of all Georgia's children to ensure that they are prepared for an engaged, educated and productive childhood and adulthood by advancing an integrated and comprehensive set of policies and investments.

The Coalition's work is organized through workgroups. A Home Visiting Work Group of providers and advocates has been convened to share best practices, engage in advocacy, and promote home visiting as an important component of Georgia's early childhood system.

The Georgia Home Visiting Work Group has worked to identify home visitation programs throughout Georgia. While the list that has been compiled does not include all of the publicly funded home visiting programs administered by Georgia agencies such as Public Health or those implemented through Title I schools, this is the most comprehensive listing of home visitation programs currently available in Georgia and the Work Group continues to update the list. It is also important to note that the number of programs fluctuates over time. The information included in this section and subsequent map represent information received as of June 15, 2010.

EARLY HEAD START

Early Head Start (EHS) is a federally funded child development program for low-income families with infants and toddlers and pregnant women. Its mission is to promote healthy prenatal outcomes for pregnant women, to enhance the development of young children, and to promote healthy family functioning. Child development services that programs must provide directly or through referral include: early education services in a range of developmentally appropriate settings; home-visits, especially for families with newborns; parent education and parent-child activities; comprehensive health and mental health services, and high quality child care services, provided directly or in collaboration with community child care providers.

In Georgia, there are 30 Head Start grantees. Of these grantees, l9 have only Head Start Programs, two grantees only provide Early Head Start, and 11 have both Head Start and Early Head Start (Georgia Head Start Association Needs Assessment, December 2009). An additional seven Early Head Start programs were funded since January 2010 with an estimated 1,500 families served.

HEALTHY FAMILIES GEORGIA

Healthy Families America (HFA) is a national initiative of Prevent Child Abuse America. HFA is a voluntary home visiting program designed to help parents of newborns get their children off to a healthy start. The initiative promotes positive parenting and child health and development, thereby preventing child abuse, neglect and other poor childhood outcomes. Healthy Families America initiates services prenatally or at birth and uses a standardized assessment tool to identify families who are most in need of services. Services are offered to families for up to five years.

In Georgia, there are 9 sites serving 12 counties and 1,123 families, as of April 2010.

NURTURING PARENT PROGRAM

The Nurturing Georgia's Families Project (NGF) works to prevent child abuse, neglect, and substance abuse via in-home visitation and group-based programming. The Project includes three strategies for prevention: community-based workshops, training, and program delivery.

In Georgia, there are 13 Nurturing Parenting Programs, as of October 2009.

PARENTS AS TEACHERS

Parents as Teachers (PAT) is an international early childhood parent education and family support program. PAT serves families throughout pregnancy until the child enters kindergarten. Goals are: increase parent knowledge of early childhood development and improve parenting practices; provide early detection of developmental delays and health issues; prevent child abuse and neglect; and increase children's school readiness and school success. The model includes four components: personal or home visits using the Born to Learn curriculum; family group meetings; periodic developmental, health, vision and hearing screenings; and connections to community services.

In Georgia, there are 46 programs serving 44 counties and 1,712 families, as of April 2010.

PROJECT HEALTHY GRANDPARENTS

Project Healthy Grandparents is a community service research project of the College of Health and Human Sciences at Georgia State University. The mission is to improve the quality of life for families in which grandparents are raising grandchildren in parent-absent homes. The program provides social work and health services, support groups, legal assistance referrals, and improved access to community resources.

In Georgia, there is one program serving two counties and 45 families, as of April 2010.

HEALTHY START

Healthy Start is a program of the US Department of Health and Human Services, Maternal & Child Health Bureau. It was initiated in l991 as a broad effort to address racial and ethnic disparities in maternal and infant health outcomes, with a target population to include women and infants through two years postpartum. The three core program goals for Healthy Start are to reduce racial and ethnic disparities in

access to and utilization of health services, improve the local health care system, and increase consumer/community voice and participation in health care decisions. The five service components include: outreach, case management, health education, perinatal depression screening, and interconception care.

In Georgia, there are five federally-funded Healthy Start programs.

SAFECARE

SafeCare is a parent-training curriculum for parents who are at-risk or have been reported for maltreatment. Through SafeCare, trained professionals work with at-risk families in their home environments to improve parents' skills in three domains: home safety, health, and parent-child interactions. SafeCare is generally provided in weekly home visits lasting from 1 to 2 hours. The SafeCare program typically lasts 18-20 weeks for each family. The training for SafeCare is provided by the National SafeCare Training and Research Center, Georgia State University.

In Georgia, 22 provider agencies serving DFCS-referred families have been trained in SafeCare, as of June 2010.

GEORGIA CAMPAIGN FOR ADOLESCENT PREGNANCY PREVENTION, COMMUNITY-BASED DOULA PROGRAM

The Georgia Campaign for Adolescent Pregnancy Prevention (GCAPP) Community-Based Doula program, a national model, provides first time pregnant teens ages 10 – 19 with a trained birth assistant to provide social and emotional support during pregnancy, labor, and post delivery. The Doula program seeks to prevent incidences of complications during pregnancy and increase bonding between mother and child.

In Georgia, there is one program serving two counties and 100 families, as of June 2010.

HEALTH CHECK

Health Check is Georgia's well child or preventive health care program for Medicaid-eligible children birth to 21 years of age and PeachCare for Kids-eligible children birth to 19 years of age. It is the Early and Periodic Screening, (EPS) component of the EPSDT program for the State of Georgia. The Diagnostic and Treatment (DT) service components are provided by either the Health Check screening provider, if qualified to perform those services, or upon referral to an appropriate service provider of the member's choice.

Health Check screenings provide children and adolescents access to comprehensive medical care to support early detection and treatment of health conditions and aid in prevention.

Health Check screenings are provided according to a schedule based on recommendations of the American Academy of Pediatrics and include the following.

- Comprehensive health and developmental history
- Comprehensive physical exam

- Vision and hearing screening
- Appropriate immunizations
- Health education/Anticipatory guidance
- Laboratory tests
- Dental referrals

POWERLINE

The PowerLine is Georgia's only bilingual toll-free telephone hot line that continues to connect low income families to the appropriate channels they need to receive health care in their communities. Through the Powerline, consumers can obtain referrals from Georgia's most extensive database of public health providers and facilities. Included in this database are physicians and clinics accepting Medicaid, reduced fees, low cost fees and also houses a number of FREE clinics and providers. The Powerline also tracks data that policymakers have relied on for years as important decisions are being made and considered. Through the PowerLine, positive change in the maternal child health arena has been documented, legislated, and achieved. Powerline is also being used as an effective evaluation tool for public health media campaigns implemented throughout Georgia.

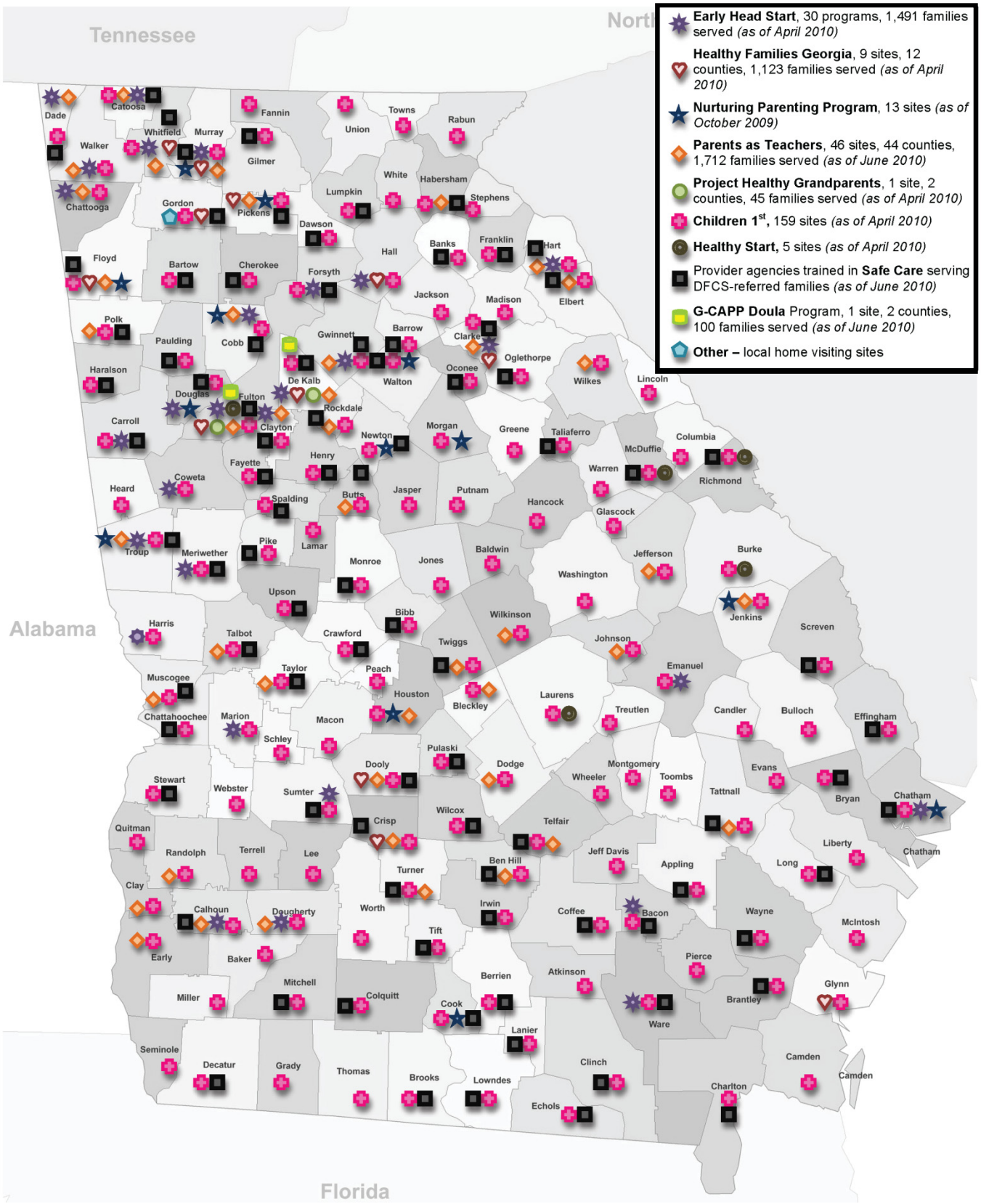
Georgians can contact Powerline at from 8:00 am to 7:00 pm daily to gain access to services that include the following.

- Physicians
- Dentists
- Prenatal services
- Answers to breastfeeding questions
- WIC Customer Service
- HIV testing sites
- Dental, vision and hearing screenings
- Public health clinics and referrals
- Links to Georgia Healthy Families and the Medicaid Care Management Organizations

PERINATAL HEPATITIS B PREVENTION PROGRAM

In 1991, the CDC funded the Perinatal Hepatitis B Prevention Program (PHBPP) for all states. The mission of the program is to ensure all infants born to hepatitis B positive women are given the opportunity to live free from hepatitis B disease. This program is a case management program that tracks the hepatitis B positive mother and her infant as well as her household contacts. The Advisory Committee on Immunization Practices (ACIP) and American Academy of Pediatrics (AAP) recommends infants of hepatitis B infected mothers receive both the hepatitis B immune globulin (HBIG) and the hepatitis B vaccine (HepB) within 12 hours of birth. The case management process continues until the infant receives the 3 dose series of hepatitis B vaccine and the post vaccination serology (PVT). CDC estimates that between 514 and 782 annual births to hepatitis B infected woman are delivered in Georgia. For infants born in 2008, the PHBPP identified and case managed 427 pregnant hepatitis B positive women. Previously, positive lab reports entered into the State Electronic Notifiable Disease Surveillance System (SENDSS) were the only method the program used for identifying hepatitis B

Map of Home Visiting Programs in Georgia 2010



positive pregnant women. Now several methods are being used to identify additional hepatitis B positive pregnant women. Two fields in the birth certificate indicate that the mother may be hepatitis B positive. Mother's hepatitis B status and the whether or not the infant was administered HBIG both assist the program in identifying cases. The program then traces the information back to the mother's hospital medical record to discover her hepatitis B status. Other ways to find pregnant hepatitis B positive women is through the Refugee Health Program. Upon entrance to this country, refugee women are tested for both pregnancy and hepatitis B status. Lastly, the Georgia Registry of Immunization Transactions and Services (GRITS) is queried to identify infants that received HBIG. Both HepB and HBIG are entered into the vital records system and downloaded into GRITS, ongoing monitoring of these fields is completed quarterly by the program. These methods of identification are still new to the program, but will potentially increase the caseload by over a hundred new cases a year.

In June of 2009, six months after the field of hepatitis B immune globulin (HBIG) began downloading into GRITS, errors were noticed. Infants who did not receive HBIG were shown in GRITS as receiving the HBIG. The program traced this back to hospital birth clerk data entry errors in the birthing hospital. The program received many calls from physician offices regarding the improper entry. As a collaborative effort, PHBPP and Vital Records composed a memo that was sent to all birthing hospitals. Ongoing monitoring of the hospital HBIG data is completed by PHBPP to ensure HBIG errors do not occur again.

Hepatitis B surface antigen (HBsAg) is a standard prenatal test recommended by ACOG, CDC, and AAP. Laboratory companies, hospitals, or other provider offices report most positive hepatitis B laboratory reports to SENDSS. The program investigates all laboratory reports of women between the ages of 10-50 to obtain their pregnancy status. The program has trained two public health students to assist in the investigation. This has led to earlier identification of pregnant women.

After the women are found to be pregnant, the program enters the women into the state database. The program prints the case and sends it to the local public health districts for follow-up. The program has one district case manager for each of the 18 health districts. District case completion compliance was minimal in past years. With the creation of e-mailed case logs, the districts and state are able to reconcile the case information. The case log contains all cases in the respective district and shows where they are in their follow-up. This also decreases the number of faxes and mailings. In addition, knowledge among the case managers has increased due to training provided by the state for low-compliance districts. Lastly, updated protocol was written and published in the Immunization Manual for district case managers.

Provider education has also increased with creation of a poster. The poster titled "For Care of Infants Born to Hepatitis B Positive Women" gives the pediatric and hospital providers a protocol that is used to prevent this disease. This poster references the AAP 2009 Red Book and contains lab interpretation for the post vaccination serology. Many of the district case managers use the poster as an education tool for the pediatric providers.

For state FY 2010, the Georgia Immunization Program's Grant-In-Aid selected deliverables that include the PHBPP. These deliverables allowed case managers to account for the cases they were following as well as identify case contacts. For SFY 2011, deliverables for PHBPP are more demanding, by requiring numbers of cases that have completed their HepB series or PVT. Also in 2011, deliverables require follow up with household and sexual contacts of the hepatitis B infected mother. To assist with the testing and vaccination of these contacts, American Recovery and Reinvestment Act (ARRA) funds provided HepB at no cost to all public health districts.

All of these improvements in the program have assisted with improved case completion. For case managed births born in 2007, (reported to CDC in March of 2009) districts completed 45 percent all required follow-up. For case managed births in 2008 (reported to CDC in March of 2010), case managers increased the number to 67 percent. That is over a 20% increase in case management completion in one year.

The PHBPP is collaborating with SENDSS staff to create an internet-based case management system. This extensive system will include electronic laboratory reporting (ELR) of hepatitis B reports and will extract data from Vital Records birth certificates and GRITS. Also included will be form letters for case managers to use for all providers, hospitals, and infected mothers. ELR and these records are received and matched with VR birth data. Work on designing and linking case management is ongoing. The Immunization Program also hired one FTE programmer to assist with this process.

The program is also working to create an educational website for obstetrical providers, pediatric providers, hospitals, infected mothers and public health staff. Currently, public health students are working to help select, edit and create materials for the website.

Another portion of the program is to increase awareness in the hospitals of hepatitis B prevention. PHBPP teamed with the Women's Health Unit in the MCH Program which has contracts with eight birthing hospitals/regional perinatal centers (RPC). The group expanded to include a Perinatal Infectious Disease Team. The surveys and chart abstraction tools included information for perinatal Hepatitis B, HIV, syphilis and pertussis. Also included in the survey was information pertaining to reporting of infectious diseases and immunizations. The need for state standards to be implemented regarding perinatal infection policy was evident from our hospital surveys. Led by the PHBPP Coordinator, a perinatal infectious disease work group is working to establish standards that will be included in the perinatal guidelines used by the RPCs.

Plans to increase OB/GYN awareness of perinatal hepatitis B prevention will begin the collaboration with the OB/GYN society. A contract has been drafted to include OB/GYN society members to receive blast faxes, educational articles and trainings in reference to PHBPP. A protocol poster for OB/GYNs, nurse midwives and labor and delivery staff is drafted and waiting on graphic design improvements and subsequent approval from the department.

Because hepatitis B affects the Asian community at higher rates than other communities, PHBPP has collaborated with the local Center for Pan Asian Community Services (Doraville, GA) to educate staff/volunteers on perinatal hepatitis B prevention. The information taught is to be translated into many Asian languages. Collaborations in drafting material in several languages are ongoing.

Children's Health Care of Atlanta (CHOA), PHBPP, and AAP have written a proposal to increase the HepB birth dose rate and perinatal hepatitis B prevention statewide. In this three-year plan, four specific aims will be included in this project. The first aim relates to investigating the current state of perinatal hepatitis B prevention in Georgia. Simultaneously, the second aim involves the development and testing of an effective parent education program that may be packaged for statewide dissemination. The third aim involves integrating results from the first two aims. The results will be used to synthesize a statewide strategic plan with recommendation to aid the birthing centers. The final aim involves mobilizing birthing centers to adopt the strategic plan and implement the parent education curriculum.

Collaborations with other programs both internal and external have proven to be beneficial to the program. Continued work with these entities will only strengthen the existing program.

BABIES CAN'T WAIT

Babies Can't Wait (BCW) is Georgia's statewide interagency service delivery system for infants and toddlers with developmental delays or disabilities and their families. BCW is established by Part C of the Individuals with Disabilities Education Act (IDEA) which guarantees all eligible children, regardless of their disability, access to services that will enhance their development. Additional information about IDEA and national efforts supporting the implementation of the early childhood provisions of the law is available through the National Early Childhood Technical Assistance Center.

The Babies Can't Wait Program in Georgia is administered by the Georgia Department of Community Health, Division of Public Health and is located in the MCH Program. As the lead agency, the Division of Public Health ensures that:

- services are provided in accordance with federal guidelines;
- families have access to the services which are needed to enhance their child's development; and
- training is available to ensure that professionals who work with children and families have up-to-date information.

Babies Can't Wait is administered through the 18 public health district offices throughout the state. Through the 18 offices, children and families in every county in Georgia can access early intervention services.

CHILDREN'S MEDICAL SERVICES

CMS is the state and federally funded Title V Children with Special Health Care Needs Program. Eligibility for the program includes medical and financial requirements. The financial requirements are updated yearly. Families with incomes greater than 150% of the Federal Poverty Level (FPL) through 236% of the FPL will be required to participate in the cost of the care of their child. Children who are Medicaid or PeachCare enrolled, who receive SSI, and who are in foster care are financially eligible for CMS services.

CMS offers care coordination by nursing and professional staff for every child. Medical and surgical treatment services may be available through private providers. These services may include hospitalization, physician service, surgical service, durable medical equipment, medicines, and supplies for the medical eligible condition(s).

In CMS, children from birth to age 21 with eligible chronic medical conditions receive comprehensive, coordinated specialty care. The medical eligibility includes, but is not limited to, the following conditions.

- Asthma, cystic fibrosis, and other lung disorders
- Some hearing disorders
- Neurological and neurosurgery disorders including seizures, benign tumors, hydrocephalus, and others

- Orthopedic and/or neuromuscular disorders including cerebral palsy, spina bifida, scoliosis, clubfeet, congenital or traumatic amputations of limbs, and others
- Visual disorders including cataracts, glaucoma, strabismus, and others
- Diabetes and other endocrine and genetic disorders
- Craniofacial anomalies (including cleft lip/palate)
- Congenital cardiac conditions

BREAST AND CERVICAL CANCER SCREENING PROGRAM

Deaths from breast and cervical cancers could be avoided if cancer screening rates increased among women at risk. Deaths from these diseases occur disproportionately among women who are uninsured or underinsured. Mammography and Pap tests are underused by women who have no source or no regular source of health care, women without health insurance, and women who immigrated to the United States within the past 10 years.

This program provides access to timely breast and cervical cancer screening and diagnostic services for low-income, uninsured, and underserved women who are between the ages of 40 through 64 years for breast cancer and 21 through 64 for cervical cancer. Priority is given to women who were never or rarely screened and women aged 50-64 whose income does not exceed 200 percent of the federal poverty level.

Services provided by the program include the following.

- Clinical breast examinations
- Pelvic examinations
- Pap tests
- Referrals for mammograms (if 40 or over)
- Diagnostic evaluation if results are abnormal
- Referrals to treatment through the Women's Health Medicaid Program

BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT

In 2000, Congress passed the Breast and Cervical Cancer Prevention and Treatment Act, which gives states the option to offer women in the National Breast and Cervical Cancer Early Detection Program access to treatment through Medicaid. To date, all 50 states and the District of Columbia have approved this Medicaid option. In 2001, with passage of the Native American Breast and Cervical Cancer Treatment Technical Amendment Act, Congress explained that this option also applies to American Indians/Alaska Natives who are eligible for health services provided by the Indian Health Service or by a tribal organization.

The Georgia Department of Community Health provides treatment for breast and cervical cancer and cervical pre-cancer to eligible women. WHMP was established in July of 2001 by the National Breast and Cervical Cancer Prevention and Treatment Act of 2000 with matching funds appropriated through the Georgia Cancer Coalition. The WHMP is administered by the Department of Community Health.

Services provided by the program include:

- Breast and cervical cancer and cervical pre-cancer treatment
- Full coverage Medicaid that includes the full range of services not only cancer treatment
- Services continue until all cancer treatment has been provided

In order to participate in the program, participants must meet the following criteria:

- Must be financially eligible for the Georgia Breast and Cervical Cancer Program
- Must be diagnosed with breast or cervical cancer or cervical pre-cancer (CIN II or III)
- Must be under 65 years of age
- Must have no health insurance coverage and not eligible for Medicare or Medicaid
- Must be a Georgia resident who is a US citizen or qualified alien

To access services, any uninsured, low-income (not greater than 200% of the federal poverty level) woman who has been diagnosed with breast or cervical cancer should go to the county health department in her county of residence.

CHILDREN 1ST

Children 1st is the "Single Point of Entry" to a statewide collaborative system of public health and other prevention based programs and services. This system helps parents provide their young children with a healthy start in life. It allows at-risk children to be identified early and gives them a chance to grow up healthy and ready for school. Participation is voluntary and there are no financial requirements for enrollment into the program.

The four primary goals of Children 1st are:

- To promote early identification of all children with conditions (medical or socio-environmental) that place them at risk for poor health and/or developmental outcomes;
- To serve as a single point of entry to connect with other public health programs and community services;
- To assist families in recognizing and addressing needs that affect their capacity to provide healthy, safe and nurturing environments for their children; and
- To generate data necessary for planning, policy development and service delivery at the state and community level, and improve the health and developmental outcomes of Georgia's children.

Children 1st has five key functions:

- The identification of infants at-risk for developmental delay using an algorithm applied to all births in Georgia;
- The screening of all births and children up to age five;
- The assessment of children and families at risk;
- The referral/linkage of children and families with risk conditions to appropriate services; and
- The monitoring of individual children from birth to age five with risk conditions.

In FY09, 61,361 newborns/children identified as at risk for needing medical and/or developmental services, 13,324 assessments were completed on at-risk children; 6,897 assessments were conducted in the home, 13,141 children were linked to a primary health care provider (private and public), and 35,003 children were monitored for health and developmental status (duplicated count). Additionally, Children 1st linked approximately 12,000 children to Medicaid who otherwise may not have been enrolled.

PRENATAL CARE THROUGH BABIES BORN HEALTHY

The Babies Born Healthy (BBH) Program helps low-income, uninsured and underinsured pregnant women access comprehensive, quality, prenatal services as early as possible in their pregnancy. Services are provided through partnerships with local providers, such as physicians, nurses, nurse midwives, nurse practitioners, nutritionists, social workers, and health educators.

Babies Born Healthy funds are used for prenatal care and some other limited services. Program providers provide comprehensive perinatal services and link clients to appropriate programs that ensure healthy outcomes for women and their babies. These services include, but are not limited to, WIC, Children 1st, Babies Can't Wait and Family Planning.

In SFY 2009, the Babies Born Healthy provided access to 3,235 pregnant women for prenatal care services. In SFY 2010, the funding available for Babies Born Healthy was approximately $3 million of state funds. Due to budget cuts and the need to prioritize services, this budget was reduced to $750,000 in FY 2011 and new client enrollment was suspended.

POPULATION-BASED SERVICES

NEWBORN SCREENING

UNIVERSAL NEWBORN HEARING SCREENING AND INTERVENTION

The most crucial period for language development is the first year of life. Without newborn screening, hearing loss is typically not identified until two years of age. Universal screening for all newborns prior to discharge from the hospital or birthing center is essential for the earliest possible identification of hearing loss and, consequently, for language, communication, and educational potential to be maximized. Approximately 400 to 500 newborns a year are expected to be identified with sensorineural hearing loss and linked to intervention, including amplification.

As a result of new legislation passed in 1999 (O.C.G.A. 31-1-3.2), the Georgia Department of Community Health, Division of Public Health developed and implemented a statewide Universal Newborn Hearing Screening and Intervention (UNHSI) initiative. The Universal Newborn Hearing Screening and Intervention (UNHSI) Program maintains and supports a comprehensive, coordinated, statewide screening and referral system. UNHSI includes screening for hearing loss in the birthing hospital; referral of those who don't pass to diagnostic audiological evaluation, and linkage to appropriate intervention for those babies diagnosed with hearing loss. Technical assistance and training about implementing UNHSI is provided to hospitals, primary care physicians, audiologists, early interventionists, and public health staff. The program is monitored for continuous quality improvement.

The Division of Public Health developed recommended guidelines for UNHSI. Hospitals are encouraged to work with their District Public Health Director and other community partners, such as pediatricians, pediatric audiologists, and otolaryngologists, to develop the infrastructure for a comprehensive UNHSI system. This system included the following components: universal newborn hearing screening, follow-up screening for babies who do not pass the in-hospital screen, diagnosis of hearing loss, and linkage to intervention. During SFY 2000, less than 50 percent of newborns were screened for hearing loss. During FY 2007, 99 percent of newborns were screened for hearing loss – over 140,000 babies. Data from SFY 2009 indicated over 98 percent of Georgia's newborns had received a hearing screening prior to hospital discharge.

All Georgia birthing hospitals are required to report the numbers of newborns screened, the number who passed the screening, and the number of those screened who did not pass, on a quarterly basis. In addition, hospitals are required to report to Public Health, through the Children 1st Coordinator in each health district, any newborn who does not pass the hearing screening, to assure that babies are linked to the follow-up services they need. The state office for UNHSI continues to collect and compile screening data from all Georgia birthing hospitals each quarter.

State law (O.C.G.A. 31-1-3.2) provides that "every licensed or certified hospital and physician shall educate the parents of newborn infants born in such hospitals of the importance of screening the hearing of newborn infants and follow-up care." To assist in this effort, DPH developed and approved two Georgia-specific educational brochures for parents of newborns, *Have You Heard?* and *Georgia's Newborn Screening Tests*. These materials are available in English, Spanish, Korean, and Vietnamese. Additionally, Georgia's Resource Guide for Families of Children with Hearing Loss is available to help families with their questions and concerns about their child's hearing loss and assist them in finding local resources for services. The resource guide is available in English and Spanish.

METABOLIC AND HEMOGLOBINOPATHY SCREENING

The Georgia Newborn Screening Program (NBS) is now over three decades old. Georgia law (OCGA 31-12-6 & 31-12-7) and Rules and Regulations (Chapter 290-5-24) requires that every live born infant have an adequate blood test to screen for 28 disorders. These disorders include: Phenylketonuria, Congenital Hypothyroidism, Maple Syrup Urine Disease, Galactosemia, Tyrosinemia, Homocystinuria, Congenital Adrenal Hyperplasia, Biotinidase Deficiency, Medium-Chain Acyl-CoA Dehydrogenase Deficiency, Sickle Cell Disorders (SS, SC, S-beta thalassemia), Isovaleric acidemia, Glutaric acidemia type I, 3-OH 3-CH3 glutaric aciduria (HMG), Multiple carboxylase deficiency, Methylmalonic acidemia, (Cobalamin A and Cobalamin B deficiency) 3-Methylcrotonyl-CoA carboxylase deficiency (3MCC), Propionic acidemia, Beta-ketothiolase deficiency, Very long-chain acyl-CoA dehydrogenase deficiency (VLCAD), Long-chain L-3-OH acyl CoA dehydrogenase deficiency (LCHAD), Trifunctional protein deficiency, Carnitine uptake defect, Citrullinemia, Argininosuccinic acidemia, and Cystic Fibrosis.

The NBS Program is a six part preventive health care system designed to identify and provide early treatment for the 28 selected inherited disorders that otherwise would cause significant morbidity or death. The components are as follows.

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

The goals of the Georgia Newborn Screening System are to ensure the following:

- Every newborn in Georgia has a specimen collected for newborn screening
- All infants whose test results are outside the normal limits for a newborn screening disorder receive prompt and appropriate follow-up testing
- All newborns diagnosed with a metabolic, endocrine, or hemoglobin disease are entered into and maintained on appropriate medical therapy

The Newborn Screening Unit within the Maternal and Child Health Program has primary responsibility for education, follow-up, medical diagnosis, and management. Screening is the primary responsibility of the Georgia Public Health Laboratory (GPHL). Evaluation of the NBS Program is a shared responsibility between the NBS Unit and GPHL.

FOLLOW-UP

The primary function of the follow-up component is to locate infants with positive screening results and to facilitate the entry of these infants into the diagnostic and management components of the NBS system in a timely fashion. Abnormal results for cystic fibrosis, metabolic and endocrine disorders are reported by the Georgia Public Health Laboratory to the newborn screening follow-up program at Emory University Division of Medical Genetics. Emory follow-up staff are responsible for reporting abnormal results to the appropriate health care provider, aiding in the location of the newborn with an abnormal screen, and making recommendations for follow-up testing. Additionally, follow-up staff coordinate confirmatory testing and ensure that all diagnosed newborns are referred to the appropriate specialist for treatment and long-term management. Medical geneticists and the Metabolic Nutrition Program are responsible for providing medical and nutritional treatment and management for the metabolic patients. Emory Genetics Laboratory is also available to provide genetic laboratory testing and clinical genetic services. In 2009, 136 newborns were diagnosed with one of the 25 metabolic disorders.

The follow-up of abnormal results that suggest actual hemoglobin disease are divided between the Division of Pediatric Hematology/Oncology at the Medical College of Georgia in Augusta, and the Georgia Comprehensive Sickle Cell Center at Grady Heath System in Atlanta. Grady and MCG follow-up staff are responsible for reporting abnormal results to the appropriate health care provider, aiding in the location of the newborn with an abnormal screen, and coordinating confirmatory testing. Additionally, they ensure that all diagnosed newborns are referred to the appropriate specialist for treatment and long-term management. The Pediatric Sickle Cell Clinic and the Adult Sickle Cell Clinic at the Medical College of Georgia, as well as its outreach clinics, provide comprehensive care for pediatric and adult patients. The Georgia Comprehensive Sickle Cell Center at Grady Health System is the world's first 24-

hour adult comprehensive primary care clinic for patients with sickle cell syndromes. In 2009, 164 newborns were diagnosed with sickle cell disease.

The Titus H.J. Huisman Hemoglobinpathy Laboratory at the Medical College of Georgia serves as Georgia's preferred reference lab for sickle cell disease, thalassemia and other hemoglobin disorders. Prior to 2008, the documentation of follow-up activities by the MCG and Grady follow-up coordinators was recorded on paper and in simple Excel spreadsheets. The lack of a centralized data system contributed to difficulties reporting accurate follow-up data and monitoring and evaluating follow-up performance. In 2008, a web-based follow-up and tracking module was implemented for sickle cell follow-up. The module includes a worksheet for the follow-up coordinators to record key data elements and notes; monitoring reports to track the number and status of referrals received; and a specimen tracker to document specimens received and results reported by the MCG Hemoglobin Lab. The module facilitates accurate data reporting and the monthly review of cases by the Hemoglobin Workgroup to ensure that abnormal cases receive timely confirmation testing and treatment. In 2008, 153 newborns were identified with sickle cell disease; 164 were identified in 2009.

All disorders on the Georgia newborn screening panel are reportable under State Law, Official Code of Georgia Annotated (O.C.G.A. 31-12-2), which mandate the reporting of notifiable diseases and Chapters 290-5-3.02 and 290-5-24 of the Rules of Department of Community Health, which regulate the reporting of notifiable diseases and metabolic disorders. Cases of birth defects are reportable to the Division of Public Health through the Georgia Birth Defects Reporting and Information System (GBDRIS) within seven days of the confirmatory diagnosis. In addition, a child identified with a disorder on the Georgia newborn screening panel requires a referral to Children 1st.

EDUCATION/EVALUATION:

The Newborn Screening Unit employs a nurse consultant to coordinate NBS education activities for parents and providers, as well as provides training and technical assistance to providers regarding acceptable standards for newborn screening collection. Ongoing activities include providing newborn screening brochures for hospital, health care providers, district and local health departments and other stakeholders; conducting training workshops and classes to birthing facilities and health care providers regarding proper specimen collection, updating the Newborn Screening Website, conducting telephone consultations, and promoting the goals of the program through professional organization conferences, newsletters, and other communication methods.

Most recently, a teleconference was organized for eight facilities including five Perinatal Regional Centers, two birthing hospitals, and Georgia Public Health Laboratory on new standards for blood collection and screening for preterm, low birth weight and sick babies.

The Newborn Screening Program generates hospital reports to monitor specimen collection and transport performance of birthing facilities. The program tracks unsatisfactory specimen categories and rates, missing data, transit days to reach GPHL, and specimens collected outside of the acceptable timeframe. In July 2009, the practice of sending hardcopies of these reports to facilities on a quarterly basis was discontinued. Instead, these reports were built into SendSS Newborn Genetics module for easier access to receive and review their screening reports. All 94 birthing facilities were registered for access to the system, and then trained on the procedure for accessing these reports. Each month which facilities have or have not reviewed their report in SendSS is monitored. Staff also identify and contact the facilities with the greatest unsatisfactory specimen rate to discuss causes and identify methods for

improvement. If necessary, a face to face meeting is scheduled with hospital administration staff to discuss a quality improvement plan for NBS collection. The state's overall unsatisfactory rate for May 2010 was 1.42 percent, compared to 11.24 percent in September 2007, 2.36 percent in September 2008, and 3.09 percent in September 2009.

LEAD SCREENING

The mission of the Georgia Childhood Lead Poisoning Prevention Program (GCLPPP) is to eliminate childhood lead poisoning in Georgia. The goals of the program are as follow.

- Update and implement the statewide lead poisoning screening plan
- Improve and redefine statewide lead poisoning surveillance system that incorporates electronic reporting of all blood lead levels and ensures the timely dissemination of information
- Establish policies and procedures that ensure the appropriate screening and follow-up of children at risk for lead poisoning
- Create health education, communication, and technical assistance programs for the general public, professionals, and staff that highlight the importance of lead poisoning prevention
- Develop multi-faceted and culturally appropriate primary prevention activities
- Evaluate the program completely in terms of process and impact

Screening for lead poisoning helps identify children who need interventions to reduce their blood lead levels. Many children who may have been exposed to lead or who are at risk for lead poisoning are not screened. This makes their chances of being harmed by lead greater. Parents and providers should know when a child should be tested for lead poisoning. All children enrolled in Medicaid and PeachCare for Kids should be tested for lead poisoning.

In addition to screening, children with elevated blood lead levels may receive a home visit and lead abatement services.

ADOLESCENT HEALTH AND YOUTH DEVELOPMENT

The Adolescent Health and Youth Development (AHYD) Unit is located in the Division of Public Health, Health Promotions and Disease Prevention Program. The AHYD Unit was established as a result of the teenage pregnancy prevention initiative funded by the Georgia General Assembly beginning in FY 1998. The aim of the teenage pregnancy prevention initiative is to prevent welfare dependency and improve economic opportunity and responsible parenting. Funding for the program is administered through a contract between Georgia Departments of Community Health (DCH) and the Division of Family and Children Services (DFCS). Funds are provided to support the planning, development, implementation and evaluation of successful programs that address the broad range of social and economic factors that affect teen behavior, including substance abuse, violence, tobacco use, obesity, and teen sexual activity before marriage.

AHYD funds health education and promotion programs in communities throughout Georgia including 30 Teen Center Programs in 28 counties and a District Youth Development Coordinator (YDC) in all 18 public health districts in Georgia. Funded AHYD program strategies and activities include programs for youth such as abstinence education, drug and alcohol prevention education, adolescent reproductive health services; parent educational seminars; and training programs designed to increase community

awareness about teen pregnancy. District and county health departments actively partner with other local youth organizations/providers to co-sponsor events and to assure that youth have access to needed services and opportunities within their communities (e.g., legal services, tutoring and academic support, entrepreneurship, mental health counseling, youth development, physical activity, socialization, mentoring, and related services).

AHYD-funded programs and services build on the strengths or assets of individual youth, their families, and individual communities; promote optimism about the futures of the youth it serves; and provide youth with important skills so that they can resist peer pressure and make healthy choices. The goal of Georgia's Adolescent Health Unit is to help adolescents grow up healthy, educated, connected to their families and communities, and employable.

IMMUNIZATION PROGRAM

Through collaboration with public and private providers, advocacy groups, and other stakeholders, the mission of the Immunization Program is to work to increase immunization rates for all Georgians and decrease the incidence of vaccine-preventable diseases.

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

PROGRAM MANAGEMENT

The work of the Immunization Program is carried out through the efforts of trained State staff and through partnership and collaboration with medical organizations, other state agencies, and community coalitions. Vaccine financing is accomplished through the use of state and federal funds to provide vaccine for uninsured and under-insured children in Georgia and for certain adult populations.

VACCINE MANAGEMENT

The Immunization Program oversees the acquisition, distribution, and management of vaccines through the Vaccines for Children (VFC) Program, as well as vaccine acquired through state and other federal funding.

PROVIDER QUALITY ASSURANCE

The Immunization Program has developed ongoing programs to inform and educate providers and to promote immunizing all age groups at every appropriate opportunity. These efforts are accomplished through the use of State staff and through collaboration with professional organizations to provide education to and assessment of individual medical practices. Other education programs include the provision of resource materials both directly to providers and through exhibits at professional conferences; the availability of a daily oncall line; and the addition of immunization messages to appropriate community and coalition newsletters.

SERVICE DELIVERY

The Immunization Program continues an ongoing effort to make sure that immunization services are available to all Georgia citizens. They do this by providing vaccine through the Vaccines for Children (VFC) Program; encouraging public health districts to provide off-hours clinics; offering educational materials and services for culturally diverse populations; and encouraging providers to develop reminder and recall systems.

CONSUMER INFORMATION

The Immunization Program supports and uses activities that will enhance the public's awareness of the importance of immunizations for all age groups. Among other things, consumer education is accomplished through the distribution of pamphlets and flyers to providers for their clients and also directly to the public through health fairs; the availability of an oncall line that consumers can call directly to get information; and the use of radio ads and public service announcements on current immunization issues.

SURVEILLANCE

The Immunization Program works closely with other programs in the Division of Public Health to coordinate, monitor, and report the incidence and follow-up of vaccine-preventable diseases in Georgia.

POPULATION ASSESSMENT

Since the year 2000, the Immunization Program collaborates annually with the Epidemiology Branch of the Division of Public Health to conduct a population-based survey of two-year-old children living in Georgia. Other assessment activities include school and child care facility immunization inventories, and the use of data from the Behavioral Risk Factor Surveillance System (BRFSS) to enhance program planning, especially in the areas of influenza and pneumococcal immunization services to adults 65 years of age and older.

GEORGIA REGISTRY OF IMMUNIZATION TRANSACTIONS AND SERVICES

The Georgia Registry of Immunization Transactions and Services is designed to collect and maintain accurate, complete and current vaccination records to promote effective and cost-efficient disease prevention and control. The Georgia Immunization Registry Law, passed in 1996 and expanded by House Bill 1526, requires reporting by " any person who administers a vaccine or vaccines licensed for use by the United States Food and Drug Administration to a person." Several options will be available for submitting immunization records to the Registry. Georgia's immunization providers will also have quick and easy access to immunization records on individual children and be able to generate a variety of reports on their immunization status.

The goals of the Georgia Immunization Registry are as follows.

- Assure that all persons in Georgia receive appropriate, timely immunizations to lead healthy, disease-free lives
    - Assist providers and public health officials in reminding individuals when they or their children need or are past due for vaccination(s)
    - Assist public health officials in assessing and improving community immunization status
- Assure access to up-to-date immunization records of Georgians
    - Assist providers in evaluating the immunization status of their patients
    - Avoid duplicate immunizations
- Meet the needs of Georgia's Immunization Registry mandate
- Provide a registry that is cost-effective, user friendly, and efficient

GEORGIA'S NUTRITION AND PHYSICAL ACTIVITY INITIATIVE

Funded by the Centers for Disease Control and Prevention, Georgia's Nutrition and Physical Activity Initiative (the initiative) is a joint effort between the Division of Public Health and its partners to prevent obesity and other chronic diseases through healthy eating and physical activity initiatives across the life span. The initiative efforts focuses on promoting and increasing breastfeeding, increasing healthy eating, increasing physical activity, and reduced television/screen time in various settings by promoting education and building skills, and implementing policy and environmental changes.

DEMONSTRATION PROJECTS

The Georgia Nutrition and Physical Activity Initiative launched community demonstration projects in seven local communities. The demonstration project enabled local communities to develop community action plans addressing physical inactivity and poor nutrition by addressing policy, systems, and/or environmental changes. The communities developed strategies to leverage resources and coordinated efforts with multiple partners to address at least two of the following target areas: increasing physical activity; increasing the consumption of fruits and vegetables; decreasing the consumption of sugar sweetened beverages; increasing breastfeeding initiation, duration, and exclusivity; reducing the consumption of high energy dense foods; or decreasing television viewing. The communities began implementation of the community action plans in July 2009.

OPERATION FRONTLINE GEORGIA

The Georgia Nutrition and Physical Activity Initiative spearheaded the launch and establishment of Operation Frontline in Georgia (OFL-GA). In February 2009, in partnership with the Georgia Coalition for Physical Activity and Nutrition (GPAN), Operation Frontline commenced in Georgia. Operation Frontline provides families with hands-on training, teaching preparation of healthy, tasty meals on a limited budget. Operation Frontline had 100 graduates in the first three months of programming. OFL-GA has started to measure short-term and intermediate progress. The program graduates have provided self-reported nutrition behaviors at three and six months post-intervention. The indicators showed an increase in fruit and vegetable consumption, and reduced consumption of calorie dense foods.

BREASTFEEDING

The first of its kind in the country, the Georgia EPIC (Educating Physicians in their Communities) Breastfeeding Program was begun in 2007 and continues to provide free peer to peer breastfeeding education for physicians, their office personnel and medical residents. The program is administered via a contract with the Georgia Chapter of the American Academy of Pediatrics. It targets pediatricians, obstetricians and family practice physicians in counties with the lowest breastfeeding rates but is offered statewide. This year it is expanding from one basic curriculum to three.

Other statewide activities include partnering with the Georgia Breastfeeding Coalition and encouraging workplace support for breastfeeding women using "The Business Case for Breastfeeding" tool kit. Breastfeeding specialists contact businesses and help them create lactation programs for their employees. Approximately twelve businesses with established, successful lactation programs have been awarded hospital grade breast pumps for their lactation rooms.

WIC BREASTFEEDING PEER COUNSELOR PROGRAM

Since 2005, The Loving Support through Peer Counseling Program has been a core WIC service. Peer counselors provide specific breastfeeding support and educational services in Georgia WIC to supplement existing WIC breastfeeding education and support. Currently, there are thirteen Districts with an active Peer Counselor Program.

Active WIC Peer Counseling Programs		
District		Number of Peer Counselors
1-1*	Northwest Health District (Rome)	11
2*	North Health District (Gainesville)	8
3-1	Cobb/Douglas Health District	10
3-3*	Clayton Health District	4
3-4	East Metro Health District (Lawrenceville)	8
3-5	DeKalb Health District	9
4*	LaGrange Health District	14
5-1	South Central Health District (Dublin)	4
6	East Central Health District (Augusta)	7
7*	West Central Health District (Columbus)	4
9-1	Coastal Health District (Savannah)	4
9-2*	Southeast Health District (Waycross)	5
10	Northeast Health District (Athens)	5
Total		93

*New Peer Counselor Programs added January, 2010

Through continued expansion, all health districts and the two WIC contract sites will have peer counselors by 2012.

Planned Expansion of the WIC Peer Counselor Program		
	District	Comments
	Southside Medical	Received funding 6/10
	Grady WIC	Received funding 7/10
8-1	Valdosta	Will start FFY 2011
1-1	Rome	FFY 2012
3-2	Fulton	FFY 2012
5-2	Macon	FFY 2012
8-2	Albany	FFY 2012

Food and Nutrition Services (FNS), United States Department of Agriculture (USDA) along with Georgia WIC have a strong belief in the value of Peer Counselors which resulted in the added funding and expansion. Federal Fiscal Year (FFY) 2010, Georgia WIC received a two year grant in the amount of $2,327,469 from FNS/USDA and Georgia WIC will add approximately $1,000,000 in additional funding by the end of FFY 2011. Six new programs received funding for new Peer Counselor programs. Due to contract negotiations, Southside Medical and Grady WIC received funding in June/July, 2010 and are recruiting for Peer Counselors. The goal of Georgia WIC is to have Peer Counselor programs in all Districts by the end of FFY 2012. Beginning FFY 2011, District 8-1 (Valdosta) will receive funding.

POPULATION-BASED HEALTH PROMOTION AND DISEASE PREVENTION PROGRAMS

The Health Promotion Disease Prevention (HPDP) Program, Division of Public Health administers several population-based programs addressing major causes of poor health. While these programs do not have a specific focus on women, infants, children, and families, through the use of Title V Block Grant funds and through opportunities for increased collaboration, the HPDP Program can increase the focus on MCH populations. A description of these programs follows.

ASTHMA CONTROL PROGRAM

The Georgia Asthma Control Program (GACP) is part of a national initiative launched by the Centers for Disease Control and Prevention, National Center for Environmental Health to reduce the burden of asthma and improve the health and quality of life for all persons affected by asthma through effective control of the disease.

The objectives of the Asthma Control Program are as follows.

- Maintain a comprehensive surveillance system in Georgia by using data to track patterns and trends related to prevalence, burden and risks
- Implement science-based best practices to achieve positive health impacts
- Increase awareness and knowledge of the public and community regarding asthma-related issues
- Identify training needs and opportunities to improve knowledge, skills, attitudes, and practice regarding asthma

- Increase knowledge and improve the ability of patients and families to self-manage their asthma.
- Increase awareness and management techniques among disparate populations.
- Promote the highest standards available for the care, management and treatment of asthma.

Georgia Asthma Control Plan (GACP) developed a partnership with the Georgia Association of School Nurses (GASN). Through this partnership, the GASN will lead efforts towards the adoption and implementation of the CDC's Asthma Friendly Schools Initiative throughout Georgia school systems. The core components of the program include: establishing management and support systems for asthma friendly schools; providing appropriate school health and mental health services for students with asthma; providing asthma education and awareness programs for students and school staff; providing a safe and healthy school environment to reduce asthma triggers; providing safe, enjoyable physical education and activity opportunities for students with asthma; and coordinating school, family and community efforts to better manage asthma symptoms and reduce asthma-related school absences. The goal of this initiative is to reduce asthma related hospitalizations, emergency department visits and days missed from school.

DIABETES PREVENTION AND CONTROL PROGRAM

The Georgia Diabetes Prevention and Control Program (DPCP) was established to address the problem of diabetes in Georgia. Funded by the Center for Disease Control and Prevention, the DPCP works with a myriad of partners to develop and implement evidence-based strategies to reduce the burden of diabetes and health-related complications resulting from uncontrolled diabetes.

The objectives of the Diabetes Prevention and Control Program are as follows.

- Conduct surveillance to define the burden of diabetes and related risk factors
- Provide communication to increase awareness about diabetes
- Build community capacity to improve access to resources and services for people with diabetes (including self-management resources)
- Improve quality of care in health care delivery systems
- Reduce diabetes-related disparities in communities most affected by diabetes
- Increase knowledge and awareness of diabetes risk factors prevention, including A1c screening, hypertension management, and cholesterol control
- Establish/modify health care systems to reduce cost, increase access to care, and improve the quality of care for Georgians with diabetes

The Georgia Diabetes Prevention and Control Program was recognized by the Centers for Disease Control and Prevention, Division of Diabetes Translation for achieving the Healthy People 2010 target for Hemoglobin A1c screening. This recognition symbolizes the Georgia DPCP's commitment to improving the well-being of those affected by diabetes.

LIVE HEALTHY GEORGIA

To help the people of Georgia live healthier lives and to reduce the burden of chronic disease and other illnesses, Governor Sonny Perdue and the Georgia Department of Community Health (DCH), Division of Public Health launched the Live Healthy Georgia campaign. The campaign encourages Georgians of all

ages to make better health a priority by following the guidelines of the Live Healthy Georgia campaign: *Be Active, Eat Healthy, Be Smoke Free, Get Checked and Be Positive*. The Live Healthy Georgia campaign provides a consistent brand and infrastructure that can be leveraged by all Division of Public Health programs to develop and launch media messages.

RAPE PREVENTION AND EDUCATION PROGRAM

The Georgia Rape Prevention and Education (RPE) Program is part of a national effort launched by the Centers for Disease Control and Prevention in response to the Violence Against Women Act of 1994. The program provides funding to states to support the planning, development, implementation and evaluation of rape prevention and education programs.

Currently, rape and sexual violence prevention activities are underway in nine public health districts, covering 38 counties. Local grantees work in collaboration with rape crisis centers, state sexual assault coalitions, non-profit agencies and other community partners to implement the following: educational seminars; training programs for professionals; operation of hotlines; training programs for students and college campus personnel designed to reduce the incidence of sexual assault; and awareness activities that address drug facilitated sexual assault.

The Rape Prevention and Education program activities are guided by six prevention principles:

- Prevent first-time perpetration and victimization;
- Reduce modifiable risk factors while enhancing protective factors associated with sexual violence perpetration and victimization;
- Use the best available evidence when planning, implementing, and evaluating prevention programs;
- Incorporate behavior and social change theories into prevention programs;
- Use population-based surveillance to inform program decisions and monitor trends; and
- Evaluate prevention efforts and use the results to improve future program plans.

TOBACCO USE PREVENTION PROGRAM

Funded by the Centers for Disease Control and Prevention, the Georgia Tobacco Use Prevention Use Program works to reduce disease, disability, and death related to tobacco use by addressing four goal areas:

- Preventing the initiation of tobacco use among young people;
- Promoting quitting among young people and adults;
- Eliminating nonsmokers' exposure to environmental tobacco smoke (ETS); and
- Identifying and eliminating the disparities related to tobacco use and its effects among different population groups.

Fifty of the 181 public school systems in Georgia have adopted a 100 percent Tobacco Free School Policy, protecting approximately 850,000 youth from the dangers of secondhand smoke. The Tobacco Free Schools Project was initiated to reduce teen tobacco use and eliminate exposure to secondhand smoke (a Class A carcinogen). Implementation of the Tobacco Free Schools Policy prohibits the use of tobacco products on school property and includes buildings, grounds, and vehicles used to transport

students. The policy also applies to all off-campus sponsored events. Adoption of the policy protects students, staff, and visitors from the harmful effects of secondhand smoke 24 hours a day, 7 days per week.

In May 2008, Georgia launched a Nicotine Replacement Pilot in five districts with high tobacco prevalence. As a result of this pilot, enrollments for Quit Line services increased by 600 percent. The results from the pilot validate the need for enhanced support for tobacco cessation. Funding recommendations from the Centers for Disease Control and Prevention support the need for an increased investment in cessation support, such as nicotine replacement therapy.

ORAL HEALTH PROGRAM

The mission of the Oral Health Unit is to prevent oral disease among Georgia's children through education, prevention and early treatment. The Oral Health Unit plays a vital role in improving the quality of life and eliminating health disparities for all of Georgia's children. Oral Health Unit programs focus on preventing, controlling and reducing oral diseases and conditions as well as promoting healthy behaviors. Dental Public Health staff coordinates local, state, and federal resources to address the burden of oral disease and promote cooperative working relationships among state agencies and community organizations to promote oral health as part of a child's total well-being.

SERVICES PROVIDED

In FY 2009, a total of 219,492 children received dental prevention, education, and treatment services provided by Georgia's Dental Public Health Programs.

PREVENTION

Oral diseases are a major health concern affecting almost every person in Georgia. Dental caries and periodontal diseases have an enormous economic and social impact and can result in serious systemic problems, pain, and suffering. Most oral diseases are preventable, and the Oral Health Unit promotes and implements preventive measures for all of Georgia's citizens.

Dental Sealants

A plastic coating is placed on the chewing surfaces of permanent molar teeth to seal out food and bacteria that cause tooth decay. In FY 2009, dental public health personnel placed 17,721 sealants on the permanent molars of Georgia children.

DENTAL HEALTH EDUCATION

Public Health dental hygienists teach school children the importance of proper brushing, flossing, and good nutrition for good dental health. More than 50,000 school children were reached in FY 2009.

SCREENING AND REFERRAL

Dental Screenings

Dental examinations of the mouth are performed to see if there are any dental or oral problems. The most common dental problems that children have are dental decay, gum disease, and malocclusion. Most of these problems are preventable. Early diagnosis and prompt treatment can eliminate pain, infection, and progressive oral diseases. Public health dentists and hygienists include screenings as part of school-based prevention programs. These programs are offered at elementary schools where more than 50 percent of children qualify for the Free-and-Reduced Lunch Program.

Dental Referrals

If a child is found to have oral health problems, a referral note is sent to the parent/guardian regarding the child's condition and detailing available resources. More than 50,361 school children were screened and referred for treatment in FY 2009 through public health dental programs. The report *Oral Health of Georgia's Children: Results from the 2005 Georgia Third Grade Oral Health Survey* provides the results of a statewide screening assessment (http://health.state.ga.us/pdfs/familyhealth/oral/2005 GeorgiaThirdGradeSurveyApril2006.pdf) documents results of a statewide screening assessment.

TREATMENT

More than 171,740 dental treatments were provided for 28,278 children in FY 2009. The first priority for treatment is given to children who need emergency dental services because of pain or infection, and who are eligible for the Free and Reduced Meal Program (185 percent Federal Poverty Level). Basic dental treatment services include the following.

- Exams
- Cleanings
- Dental sealants
- Silver (amalgam) and tooth colored (composite) fillings
- Stainless steel crowns
- Minor nerve treatments
- Extractions

Clinic locations and hours depend on local and state resources available. Information about specific dental services, hours, and location of services can be obtained by calling the local health department or health district dental contact. Payment for dental treatment services is based on a sliding fee scale based upon ability to pay. Many health departments have a minimal administrative fee. Public health dental services are provided to children and pregnant women who are enrolled in Medicaid and PeachCare programs, as well as to low-income patients on a sliding-fee scale (based on the patient's ability to pay).

COMMUNITY WATER FLOURIDATION

Georgia is geographically the largest state east of the Mississippi River covering 58,000 square miles. It has 159 counties and over 340 public community water systems that provide fluoridation to about 8.9 million Georgia citizens. Water fluoridation has been proven to reduce dental decay for both children and adults, but maintaining water fluoridated at the optimal level with so many community systems can present a challenge.

For the most effective results in Georgia, the optimal concentration of fluoride in the finished water should be maintained at 0.85 parts per million (ppm). (0.85 of 1 part fluoride to one million parts of water) with a lower limit of 0.7 ppm. and an upper limit of 1.0 ppm. It is only through constantly maintaining the recommended average (0.85 ppm.) can the citizens expect maximum reduction in tooth decay. Studies have shown proportionately reduced benefits when the fluoride concentration falls below this recommended concentration. Monitoring fluoridation in a large state with over 300 water plants fluoridating is a large task. Healthy People 2020 includes the objective to increase the proportion of people served by community water fluoridation. To maintain the success of water fluoridation in Georgia the funding to support CWF program is necessary. Grant funding has supported the success of CWF in Georgia.

The goal of the Georgia Oral Health Unit (OHU) of the Maternal and Child Health (MCH) Section is to maintain the proportion of Georgians served by optimally fluoridated water systems at 96 percent or better. Approximately 349 rural and urban communities in Georgia are healthier by having had the burden of dental disease reduced along with systemic diseases, such as cardiovascular problems and diabetes, associated with poor oral health. Community water fluoridation helps Georgia to reduce the proportion of children with dental decay (OH HP2010 21-1), as well as reduce dental decay among older Georgians with exposed root surfaces associated with aging. Thus, fluoridation also aids in increasing the proportion of adults who have never lost a tooth due to decay or periodontal disease (HP2010 21-3), and decreasing the number of Georgians who have lost all of their natural teeth (HP2010 21-4).

Grant funding allows the Division of Public Health to contract with the Georgia Rural Water Association to train water plant operators in fluoridation procedures and public health benefits, provide technical assistance, and inspect water plant operations to ensure they meet CDC standards. They also collaborate with the Georgia Public Health Laboratory to monitor fluoride levels and ensure that fluoridation information is recorded in CDC's Water Fluoridation Reporting System (WFRS).

Successes of the CWF in Georgia include the following.

- In 2008, CDC awarded 159 water systems in Georgia their "Water Fluoridation Quality Award" for reporting 12 continuous months of optimal fluoride levels in WFRS;
- In 2008, CDC also produced a national fluoridation report that showed an increase of 3 percent of Georgia's population receiving the benefits of water fluoridation over the 2000 report;
- Georgia exceeds the HP2010 goal by over 20 percent, and now ranks sixth in the US in fluoridation with 95.8 percent of the population served by public community water systems receiving optimally fluoridated water; and

- A CDC-University of Georgia study showed that water fluoridation saves about $19 per person per year in dental care costs. The increase of 3 percent in population receiving water fluoridation amounts to about 271,600 more people and a savings of $5.16 Million per year in dental expenses for Georgia.

Georgia Rural Water Association along with the OHU staff, the State Lab and water plant operators provide high quality services to Georgia's communities with a balance of responsibilities with GRWA managing the following.

- Reporting monthly results of water evaluations to GA DCH, OHU, the Georgia EPD Drinking Water Section, and the Public Health Lab;
- Monitoring through site visits to 334 water fluoridation water systems will include: type of water system (ground or surface), type of chemicals added to the water including type of fluoride used, sodium fluoride levels; sodium fluorosilicate or fluorosilicate acid;
- Examining daily logs on fluoride levels at the time the sample was taken, where the water samples were taken to ensure accurate testing;
- Checking and documenting the condition of the fluoride equipment used to inject the fluoride into the water supply;
- Ensuring safe storage of the bags or drums of extra fluoride;
- Ensuring all chemicals meet NSF specifications and are American Water Works Association (AWWA) approved and safe for drinking water;
- Certifying that all fluoridated systems are maintained and operate in compliance with all state laws, rules, and regulations as set by the Board of DNR and the CDC but not limited to such laws, rules, and regulations;
- Providing immediate on-site assistance to any public water system in the State of Georgia following receipt of any monitoring results which indicate that the fluoride level exceeds the primary maximum contaminate level. Direct the public water system to take appropriate corrective action and send another sample to the public health laboratory for testing;
- Maintaining an updating fluoride overfeed manual and ensure all plant operators understand all procedures;
- Ensuring all plants are participating fully in CDC's Water Fluoridation Reporting System (WFRS) providing, at a minimum, monthly updates of changes in the fluoridation status of water systems and for those systems that adjust the fluoride content of the water – monthly average of daily testing for each system and compliance with state testing requirements;
- Offering accurate safe operator training for handling the fluoride products; and
- As per CDC, "Fluoride remains a safe compound when maintained at the optimal level in water supplied to the distribution system; however, an operator might be exposed to excessive levels if proper procedures are not followed or if equipment malfunctions. Thus, the use of personal protective equipment (PPE) is required when fluoride compounds are handled or when maintenance on fluoridation equipment is performed. The employer should develop a written program regarding the use of PPE. The water supply industry has a high incidence of unintentional injuries compared with other industries in the United States; therefore, safety procedures should be followed."

All plants must have full knowledge of fluoridation systems, types of community fluoridation, equipment used and ventilations systems for types of fluoridation. The number of well-trained technicians at

GRWA must be adequate to ensure optimum levels of fluoride according to the Department and CDC guidance.

The GRWA has the established network of water engineers and certified fluoridation staff regionally positioned to monitor, train and respond to CWF plant requests and emergency needs. The cost to the state to duplicate these services would far exceed the present costs from the PHHS grant support of the GRWA contract. Loss of the grant funding would result in either obtaining other grant support or state funds at a time when resources are limited. Without state or grant matching funding acquiring the human resource talent with the knowledge, skills, and abilities to duplicate the services would be difficult and costly with the state possibly realizing a lost leading position in CWF success. Research supports the claim, without CWF the caries rate increases, this leads to increased pain and suffering and increased costs.

INJURY PREVENTION

The Injury Prevention Program is housed within the Georgia Department of Community Health/Division of Emergency Preparedness and Response, along with the EMS and Trauma programs. The main functions of the Injury Program include:

- The provision of technical assistance in program evaluation and coalition building to local community groups;
- The provision of injury data to community groups and the public at large;
- The distribution of safety equipment such as child safety seats, bike helmets, smoke detectors and the dissemination of knowledge on proper use of safety equipment, and
- The provision of general support to local coalition in helping promote safe and injury-free life styles and behaviors.

These injury prevention activities are primarily grant-driven with the Centers for Disease Control and Prevention (CDC), the state's Governor's Office of Highway Safety (GOHS), and the National Highway Traffic Safety Administration being the major funders. In FY 2011, the Title V MCH Block Grant joined these other major funders as a primary source of support.

CHILD OCCUPANT SAFETY INTERVENTIONS AND EDUCATION

There are many risks of premature death in Georgia; none is greater than our roadways. Motor vehicle injuries are a leading cause of death in Georgia. In 2006, 54 children age 0-14 died and over 11,000 were injured in motor vehicle crashes in Georgia. Thirty-three percent of fatal child occupants were not buckled up. Hospitalization charges for the same period for children age 0-14 in Georgia due to motor vehicle traffic injuries were over $14.9 million.

The Child Occupant Safety Program strives to ensure that Georgia's children are safe while riding in motor vehicles. Income eligible families in over 125 Georgia counties receive child safety seats and education in their use through a Mini-Grant Program. The Safe School Buses Program addresses challenging issues including transportation of pre-school age children and children with special health care needs. The “Keeping Kids Safe” Hospital Training Program promotes discharge of newborns in appropriate child restraints.

The program focuses on the prevention of injury through child safety seat education and the hands-on training of parents and caregivers. By using collaborative relationships with community stakeholders, the program seeks to promote sustainability. Special attention has been dedicated to ensuring the availability and to support appropriate training to install car seats for children with special health care needs.

Teddy Bear Stickers (TBS) are placed on all child safety seats distributed through the statewide Mini-Grant Program that provides child safety seats and education in their proper use to low income families in Georgia. Through the TBS Program, Georgia's Injury Prevention Program is notified when a seat with the Teddy Bear Sticker is involved in a crash, and the family can receive a replacement child safety seat.

RESIDENTIAL FIRE PREVENTION PROGRAM

The Residential Fire Prevention Program reduces fire related injuries and deaths by working with fire departments to install smoke alarms in high-risk housing. The Program collaborates with fire departments throughout Georgia to identify high-risk areas within their jurisdictions. They then canvas those areas and install smoke alarms and provide fire safety education. The Program requires a major investment for the fire department as each home visit takes around twenty minutes and requires two firefighters to educate, complete forms, and install alarms. The Program is currently being conducted in more than 25 areas of the state. Sites are chosen from applications by fire departments and are based on the availability of funds. Over 116 lives were potentially saved by smoke alarms installed by the program in the past three years of funding. This number is more than most other states carrying out the program. During this period, the program visited more than 6,110 homes. The Program is funded by a grant from the Centers for Disease Control and Prevention to the Georgia Division of Public Health. Resources are also provided by Georgia Title V, MCH Program of the Georgia Division of Public Health and by the Georgia Firefighters Burn Foundation. The program is conducted in cooperation with the Georgia Office of the Fire Marshal.

INFRASTRUCTURE-BUILDING

Infrastructure building will expand in Georgia during the next five year cycle. The Georgia MCH Program has made a significant commitment to improving infrastructure building throughout the maternal and child health community in Georgia, which is consistent with the priority need to *Improve the maternal and child health surveillance and evaluation infrastructure.* Therefore, this subsection is a review of current infrastructure building activities and a discussion of what activities, projects, and plans are in development for implementation in subsequent years.

DATA COLLECTION, RESEARCH, AND SURVEILLANCE

MCH EPIDEMIOLOGY SECTION

Based on the findings presented in *Maternal and Child Health Epidemiology in State health Agencies: Guidelines for Enhanced Functioning* (http://www.uic.edu/sph/dataskills/publications/UIC_MCH_Epidemiology_Guidelines_06-17-08.pdf), the responsibility for MCH epidemiology was moved from the Epidemiology Program to the MCH Program in March 2010. A new MCH Epidemiology Section was created in the MCH Program. With this shift, using funds from across all programs within the MCH

Program, several new epidemiologist positions were created in the MCH Epidemiology Section. This includes a position for an MCH Section Director, who will function as the State MCH Epidemiologist, and report directly to the MCH Program Director.

The planned surveillance, research, monitoring, and evaluation activities indicated here and in the Title V MCH Services Block Grant FY 2011 application will be the responsibility of the MCH Epidemiology Section. Selecting high quality staff and leadership for the MCH Epidemiology Section is vital to the future success of the MCH Program and the MCH Program's ability to meet its mission and vision.

OFFICE OF HEALTH INDICATORS FOR PLANNING

The Office of Health Indicators for Planning leads the health assessment component of the Georgia Division of Public Health. The major purpose of OHIP is to provide valid and reliable evidence about the health status of the population of Georgia. The evidence of health status and other health related phenomena provided by OHIP is used to direct the Division's policies and actions. OHIP defines policies and methods for creating analytical health information, and will maintain a single, standard information repository to support health assessment models and decisions, interventions and policies made by the Division. OHIP's internal operations include:

- Information quality;
- Health statistics;
- Epidemiological modeling and information mining;
- Geographic Information Systems and spatial analysis;
- Intelligent information systems that include evidence-based business rules and forecasting health events; and
- Web based distribution of health statistics and forecasting models.

OHIP functions include the following.

- Assure valid and reliable health information
- Stewardship of divisional information requirements, standards, and policies
- Determine relevant, valid and reliable population health indicators
- Distribute relevant health assessment information products which will be used to direct Division policy
- Create and maintain a single standard repository of divisional information

ONLINE ANALYTICAL STATISTICAL INFORMATION SYSTEM (OASIS)

OASIS is a suite of interactive tools used to access the Georgia Department of Community Health, Division of Public Health's standardized health data repository. OASIS and the Repository are designed, built, and maintained by OHIP. The mapping tool included in OASIS was designed by OHIP and developed and maintained by the University of Georgia's Carl Vinson Institute of Government, ITOS Division.

The standardized health data repository used by OASIS is currently populated with Vital Statistics (births, deaths, infant deaths, fetal deaths, induced terminations), Georgia Comprehensive Cancer Registry, Hospital Discharge, Emergency Room Visit, Arboviral Surveillance, Risk Behavior Surveys (Youth Risk

Behavior Survey (YRBS), and Behavioral Risk Factor Surveillance Survey (BRFSS)), STD, and population data. Expansion to include other datasets/data sources is planned. Indicators for each dataset are selectable by a variety of population, disease, and survey characteristics. Where applicable, data may be queried by age groups, race, ethnicity, sex (person), census tract, county, health district, legislative district, state (place), and year (time).

OASIS plays an integral role in program planning, which includes determining target population areas, formulating financial plans, monitoring program effectiveness, program evaluation and reporting program outcomes. OASIS' cutting-edge data querying tools can be used to:

- Develop profiles and report cards for counties or districts,
- Assess community health needs, prioritize health problems, and evaluate programs,
- Assemble data for grant writing, health analysis, special projects or state legislative reporting,
- Examine data by census tract to identify high risk populations, and allocate resources, or
- Identify areas that contribute a disproportionate share of a health issue,
- Target problem areas to analyze specific health problems and outcomes,
- Create a basis for health communications or health advocacy,
- Apply GIS to analyze varied environmental risks focused on disease process, economic status and other environmental variables that influence health outcomes, and
- Map several geographic areas to compare varied health outcomes.

GEORGIA CRASH OUTCOME DATA EVALUATION SYSTEM

The Crash Outcome Data Evaluation System (CODES) is a program facilitated by the National Highway Traffic Safety Administration as a component of its State Data Program. CODES uniquely uses probabilistic methodology to link crash records to injury outcome records collected at the scene and en route by emergency medical services, by hospital personnel after arrival at the emergency department or admission as an inpatient and/or, at the time of death, on the death certificate.

CODES is designed to foster and cultivate crash-outcome data linkage for highway safety applications at the state level, supporting State Highway Safety Offices, State Public Health and Injury Prevention Departments, State Emergency Medical Services Agencies, State transportation departments, and other such agencies; and to facilitate participation in NHTSA coordinated multistate studies using linked data at the Federal level.

To support CODES program objectives, NHTSA sponsors cooperative agreements that provide software access, technical assistance, and program assistance to CODES state programs to link information about State-reported crashes and their consequences, and to analyze and disseminate the information. Analyses of linked data help inform state traffic safety professionals and coalitions to determine and implement data-driven traffic safety priorities CODES evolved from a need to quantify and report on the benefits of safety equipment and legislation in terms of mortality, morbidity, injury severity, and health care costs, and has built proactive partnerships between the traffic safety and public health agencies, which own the state data, and NHTSA, which provides access to the software and training resources that make the linkage feasible. NHTSA maintains a CODES facilitating infrastructure to provide technical support and assistance to sites while also encouraging each site to build state-level collaborations and perform relevant analyses within their states.

While data from CODES is not presented in this needs assessment, through increased awareness of these data, it is expected that information from CODES will be included in Needs Assessment Updates in upcoming annual applications for the Title V MCH Services Block Grant.

GEORGIA COMPREHENSIVE CANCER REGISTRY

The Georgia Comprehensive Cancer Registry (GCCR) is a statewide population-based cancer registry collecting all cancer cases diagnosed among Georgia residents since January 1, 1995. This information furthers our understanding of cancer and is used to develop strategies and policies for prevention, control, and treatment. The availability of this data at the state level allows health researchers to analyze geographic, racial, and other differences that provide clues that point to risk factors. This data also helps in determining where early detection, educational, or other programs should be directed.

The Georgia Department of Community Health, Division of Public Health has designated the Georgia Center for Cancer Statistics (GCCS) at the Rollins School of Public Health at Emory University as its agent for the purpose of collecting and editing cancer data.

GCCR is a participant in the National Program for Cancer Registries (NPCR) that was established by the Centers for Disease Control and Prevention (CDC) in 1992 through the Federal Cancer Registry Amendment Act (Public Law 102-515). NPCR provides funding and guidance for the development of cancer registries throughout the United States. GCCR is also a member of the North American Association of Central Cancer Registries (NAACCR), which is a professional society that was established in 1987. NAACCR provides ongoing development of cancer registries and the establishment of registry standards.

GEORGIA VIOLENT DEATH REPORTING SYSTEM

Since 2002, the Centers for Disease Control and Prevention (CDC) has funded select states to collect information on violent deaths as part of the National Violent Death Reporting System (NVDRS). Violent deaths include homicides, suicides, accidental deaths from firearms, deaths related to terrorism, deaths from legal intervention, and those of undetermined intent. Georgia's system, named the Georgia Violent Death Reporting System (GVDRS), has been funded since 2003.

GVDRS is part of the national system, NVDRS, that was built upon an earlier pilot system, the National Violent Injury Statistics System (NVISS). Emory University participated in NVISS and collected data on violent deaths in Fulton and DeKalb counties.

The following data sources are included in the state violent death reporting system.

- Death certificates
- Medical examiner and/or coroner records
- Police records (Supplemental Homicide Reports at a minimum)
- Crime laboratory records

While data from GVDRS is not presented in this needs assessment, through increased awareness of these data, it is expected that information from GVDRS will be included in Needs Assessment Updates in upcoming annual applications for the Title V MCH Services Block Grant.

EXPANDING EXISTING SURVEILLANCE EFFORT – BRFSS, YRBS, AND PRAMS

Georgia has the standard data collection instruments found in many states. These include BRFSS, YRBS, and PRAMS. Each of these surveillance systems has been described in the *Section 1. Process for Conducting the Needs Assessment* in the *Data Sources* subsection beginning on page 32 of this document. While each of these data systems provides reliable estimates at the state level, using MCH funds, significant expansion is planned for each.

For BRFSS, YRBS, and PRAMS, expansion plans include providing reliable estimates at the sub-state level. Georgia's 18 public health districts would benefit from having data at a sub-state level to compare health status within the state and to improve targeting of interventions. While funds may not allow each surveillance system to provide sub-state population estimates with each administration, a regular schedule for this special sampling can be developed and implemented.

Working collaboratively with the Epidemiology Program, the MCH Program will seek to add questions to the Georgia BRFSS. These state-added questions will address topics that include, but are not limited to, breastfeeding, family planning, and long-acting reversible contraception. The information collected from these state-added questions will be used to inform program development and implementation and may be used to inform policy decisions.

A significant limitation of the Georgia YRBS is the absence of adolescent sexuality questions. Staff throughout the Division of Public Health will continue to work with the Georgia Department of Education and local school districts throughout Georgia to encourage the inclusion of these questions on future administrations of the YRBS questionnaire.

NEW RESEARCH AND SURVEILLANCE

With the selection of *Improve the maternal and child health surveillance and evaluation infrastructure* as a priority need, the focus on creating new sources of data to inform policy and program development will increase. Through relationships with academic partners and through internal resources, the MCH Program plans to identify data gaps and suggest possible solutions. These solutions may include the following.

- Data linkages
- Enhanced data collection and analysis

DATA LINKAGES

A possible source of enhanced research is improved data linkages between programs to leverage the existing, available administrative data and identify possible opportunities for data-driven collaboration. Two planned projects focusing on linking data include investigating the association between prenatal and birth indicators and subsequent involvement in child protective services and investigating the association between foster care involvement and adolescent pregnancy. Findings from each of these studies have the potential to have immediate translation to and impact on public health practice. State System Development Initiative funds will be used to fund the necessary expertise to design and implement these projects.

ENHANCED DATA COLLECTION AND ANALYSIS

The MCH Program through the MCH Epidemiology Section plans to enhance data collection throughout all programs. Two planned activities are the implementation of a Georgia WIC Infant Feeding Practices Survey and Georgia Infant Health and Safety Study.

Georgia WIC and the MCH Epidemiology Section will develop a self-administered survey for WIC participants to measure breastfeeding practices and behaviors; attitudes, knowledge, and beliefs; experiences relating to hospital practice, public breastfeeding, and workplace breastfeeding. The data will be collected and analyzed at the state level and district level, which will provide state and local breastfeeding staff and advocates information on which to develop strategies to improve breastfeeding rates in Georgia WIC. This surveillance activity will complement breastfeeding data collected through the National Immunization Survey, BRFSS, and PRAMS. These data will contribute to the development of activities associated with Title V MCH Services Block Grant National Performance Measure 11.

To support the priority need *Decrease infant mortality and injury*, the MCH Program with an academic partner will develop and implement the Georgia Infant Health and Safety Study. This survey will investigate the prevalence of such behaviors as sleep position, bed sharing, breastfeeding practices, and other practices associated with infant morbidity and mortality. This survey will complement data through PRAMS.

In addition to these specific, planned activities, the MCH Program plans to devote funds to support innovative primary and secondary data analyses. The MCH Program plans to develop a small grants program that will fund the analyses of existing data sets within the Division of Public Health. Recipients of these funds would be required to work collaboratively with staff in the MCH Epidemiology Section. The amount available for any one award would likely not exceed $5,000. A larger grants program is planned to fund original research projects with greater scope. These research projects must directly rate to a national or state performance measure or priority need and must generate data that could be used for secondary data analysis by others. This larger grants program will be developed to be similar to the MCH Research Program in HRSA's MCH Bureau. These external research projects will be complemented by internal research projects led by staff in the MCH Epidemiology Section. Planned research within the MCH Epidemiology Section includes an investigation of the impact of racism on birth outcomes to be conducted in WIC and the difference in birth outcomes at the hospital-level based on a self-designation to determine capacity compared to the objective application of a standardized criteria.

ENHANCED EVALUATION AND MONITORING

In the MCH Program, there will be an increased focus on evaluation and monitoring to ensure optimal impact of funds and efficient program operation. All existing projects will be reviewed to determine if current monitoring strategies are satisfactory. An implementation plan for programs in need of additional monitoring will be developed. In addition to program monitoring, all programs will be reviewed to determine possible evaluation points. Evaluation plans will be developed and implemented. New projects will only be approved for implementation if a detailed evaluation plan is included with the request.

To improve programs and service delivery, all programs within the MCH Program will be encouraged to conduct routine consumer satisfaction surveys and focus groups. The consumer surveys conducted through the 2010 Needs Assessment may serve as an example of how public comment and input can contribute to an application. At the time of submission of the 2010 Needs Assessment, the Georgia WIC Program was currently collecting public comment. The WIC process was strengthened by strong collaboration with the MCH Epidemiology Section. It is expected that several other programs will follow the example set by Georgia Title V and WIC.

STATE ELECTRONIC NOTIFIABLE DISEASE SURVEILLANCE SYSTEM

Several MCH programs utilize the State Electronic Notifiable Disease Surveillance System (SENDSS) for data collection statewide. SENDSS is a state-developed, state-support data collection system. The security of all data entered into SENDSS will be supported by Secure Socket Layer (SSL) 128-bit encryption using VeriSign certification. Public health officers, state officials, and other designated individuals will be provided access to a password-protected set of dynamic web pages and web-based tools. Currently, the primary user of SENDSS is the Newborn Screening Unit, but expansion to other programs is planned.

COORDINATION WITH OTHER GROUPS AND ORGANIZATIONS

Coordination with other groups and organizations is detailed in *Section 2. Partnership Building and Collaboration Efforts* beginning on page 41 of this document.

INTEGRATED EFFORTS FOR PROGRAM PLANNING AND IMPLEMENTATION

There are several administrative structures within the Division of Public Health and the MCH Program to promote integration of program planning and implementation. In the Division of Public Health, all program directors report to a single deputy director. The deputy director has weekly individual meetings with each program director allowing her to help identify opportunities for integration between programs. There is also a weekly meeting between all programs that allows opportunities for presentations and sharing of current projects.

Georgia Title V is located within the MCH Program along with the Georgia WIC Program, Georgia Title X Family Planning Program, the Newborn Screening Unit, Babies Can't Wait Program, Children's Medical Services Program, Children 1st, Perinatal Hepatitis B Prevention Program, Oral Health Unit, and the MCH Epidemiology Section. All of these programs reports to a single program director. Through regular leadership meetings and strategic planning sessions, this organizational structure facilitates program integration. The Georgia WIC Program is a cornerstone for collaboration within the MCH Program. By integrating services within WIC to provide additional services to the WIC client population and referrals to other services, the MCH Program can ensure that the more than 300,000 WIC clients maximize their available benefits and services. Collaborations between Georgia WIC and the Babies Can't Wait Program seeks to incorporate developmental specialists in WIC clinics to facilitate referrals to Babies Can't Wait services. This collaboration also facilitates child/parent find services that are necessary for follow-up services provided through the Newborn Screening Unit and Perinatal Hepatitis B Prevention Program. The MCH Epidemiology Section collaborates with all other programs to ensure appropriate monitoring and evaluation of all programs.

The focus on program integration extends beyond those programs organizationally located in the MCH Program and Division of Public Health. With other programs in the Division of Public Health, a selected list of collaborations follows.

- Collaboration between the WIC Program and Immunization Program will seek to improve immunization rates among WIC participants
- Collaboration between the Injury Prevention Program and CYCHSN Unit will seek to ensure proper training and availability of car safety seats for children and youth with special health care needs
- Collaborations between Georgia Title V, the Georgia WIC Program, the Georgia Title X Family Planning Program, and Health Promotion and Disease Prevention Program will enhance effort around adolescent health and pregnancy prevention, preconception health promotion, tobacco use, and obesity prevention

Regular quarterly meetings organized to monitor progress on the FY 2011 Title V MCH Services Block Grant activity plan will create an opportunity to nurture and ensure collaborations within the MCH Program and between Division of Public Health programs that serve women, infants, children, and families.

Increased integration with Medicaid is a goal of the MCH Program. There are several programs in the MCH Program funded by Medicaid (Health Check, Regional Perinatal Centers) or that bill Medicaid (Children's Medical Services, Babies Can't Wait, Children 1st). Children enrolled in Medicaid also have adjunctive eligibility in WIC. Strategies are needed to ensure that children enrolled in Medicaid are enrolled and participate in WIC.

The MCH Program is also seeking improved integration with other programs in different state agencies that serve children and families. This includes the Department of Education, Department of Family and Children Services, and the Department of Education. Opportunities for integration with these state agencies are described in *Section 2. Partnership Building and Collaboration Efforts* beginning on page 41 of this document.

WORKFORCE DEVEOPMENT

Workforce development is an area of increasing focus for the MCH Program, Division of Public Health, and Department of Community Health. While the Department of Community Health has often been a site for student internships and practicum opportunities, more formal processes are being developed to improve the match between student and opportunity. Despite funding restrictions, the MCH Program, using available federal funds, has successfully allowed staff to travel to conferences and workshops throughout the US. This includes attendance at annual AMCHP meeting, MCH Epidemiology Conference, and upcoming MCH Partnership Meeting. In FY 2011, the MCH Program is planning to host a statewide conference. This conference will include professional development opportunities for attendees.

For FY 2011, workforce development has been elevated to a goal for DCH's strategic plan. DCH recognizes the importance of ensuring the availability of adequate, knowledgeable human resources to accomplish its mission. Because employers compete from the same labor pool, workforce planning is critical for attracting and retaining the talent needed to achieve the organizational mission.

CSHCN CONSTRUCTS OF SERVICE

STATE PROGRAM COLLABORATION WITH OTHER STATE AGENCIES AND PRIVATE ORGANIZATIONS

The following organizations work collaboratively with the MCH Program staff to broaden and enhance service delivery, health care access, and support services throughout Georgia for children with special health care needs.

GEORGIA BRAIN AND SPINAL INJURY TRUST FUND COMMISSION

The Georgia Brain and Spinal Injury Trust Fund Commission has provided over $8 million to more than 2,000 Georgians with traumatic brain and/or spinal cord injuries since 2003. As the state's Lead Agency on Traumatic Injuries, the commission administers the central registry to identify those who are injured, distributes resources through the Trust Fund and advocates for improvement in statewide services. One of the MCH staff with expertise in CSHCN participates on the Commission's Advisory Committee.

GOVERNOR'S COUNCIL ON DEVELOPMENTAL DISABILITIES

The Governor's Council on Developmental Disabilities (DD Council) serves as an advisory body on disability issues for children and adults with developmental disabilities and provides broad policy advice and consultation to state agencies. A representative from the DD Council participates on BCW Interagency Coordinating Council.

BABIES CAN'T WAIT INTERAGENCY COORDINATING COUNCIL

The Babies Can't Wait Interagency Coordinating Council (ICC) for Early Intervention, mandated under Part C of IDEA, is appointed by the Governor to advise and assist DPH in planning, coordinating and implementing a statewide system of early intervention services for children with or at risk for developmental delays. The Council includes several required state agency partners and parents of children with disabilities.

GEORGIA COMMISSION ON HEARING IMPAIRED AND DEAF PERSONS

The Georgia Commission on Hearing Impaired and Deaf Persons consists of seven members. At least two of the members must be hearing impaired persons, and the remaining five members of the commission are selected from among parents of children who are hearing impaired persons, persons who are involved with hearing impaired persons or programs, and representatives of private providers of services to hearing impaired persons. Each commission member serves for a three-year term. The commission serves as the principal agency of the state to advocate on behalf of hearing impaired persons by working to ensure those persons have equal access to the services, programs, and opportunities available to others. It assists hearing impaired persons and parents of hearing impaired persons who are students in advocating for equal access to services, programs, and opportunities; advises the governor, General Assembly, and commissioner of community health on the development of policies, programs, and services affecting hearing impaired persons and on the use of appropriate

federal and state moneys for such purposes; and creates a public awareness of the special needs and potential of hearing impaired persons.

GEORGIA DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) provides treatment and support services to people with mental illness and addictive diseases, and support to people with mental retardation and related development disabilities. DBHDD has five regions. Each region has a regional office, which is an extension of the DBHDD state office to the local area. The regional office oversees the network of state-supported DBHDD community and hospital services in the region.

Services provided by DBHDD for children and youth who are seriously emotionally disturbed (SED) focus on family support and intervention and preventing crises whenever possible. When crises do occur, public mental health services aim to serve the child in the home or close to home if possible, and to avoid hospitalization, which can be traumatic for young children. The services a child and family receives depends on a professional determination of level of need and the services and other community resources available. Services vary by region and may include: crisis services, outpatient services, community support services, intensive family intervention, and outdoor therapeutic programs. Current child and adolescent mental health initiatives include Community Based Alternatives for Youth (CBAY) and KidsNet Georgia. The CBAY 1915(c) Waiver Home and Community-Based Services demonstration program uses a systems approach that targets youth served by multiple agencies, striving to coordinate, blend, and braid programs and funding to create a comprehensive behavioral system that ensures youth are placed in and remain in intensive residential treatment only when necessary and that a coordinated system of services at the community level is available.

GEORGIA DEPARTMENT OF EDUCATION

Georgia Department of Education (DOE) oversees public education throughout the state, ensuring that that laws and regulations pertaining to education are followed and that state and federal money appropriated for education is properly allocated to the Georgia's 180 local school systems. DOE is comprised of five offices under the State Superintendent of Schools: the Office of Policy and External Affairs; Office of Standards, Instruction, and Assessment; Office of Education Support and Improvement; Office of Finance and Business Operations; and Office of Technology services. The Divisions for Special Education Services and Supports, located in Standards, Instructions, and Assessment, include programs and services that support local school districts in their efforts to provide special education and related services to students with disabilities. Targeted areas for services and supports include accessible instructional materials, assistive technology, curriculum access and alignment, dropout prevention, family engagement, least restrictive environment, positive behavior supports, and transition. Additional services include ensuring compliance with federal and state regulations for special education, collecting and analyzing data on education services and outcomes, providing guidance and oversight for federal and state special education funds, and coordinating resolution requirements as required by state and federal requirements. DOE has a memorandum of agreement with the DCH as required for the two lead agencies under the Individuals with Disabilities Education Act (IDEA) Part B special education and Part C early intervention for child find and transition at age three requirements. A representative from DOE participates on the BCW Interagency Coordinating Council, interagency agreement on child find, data sharing and transition at age three years.

GEORGIA PARENT INFANT NETWORK FOR EDUCATIONAL SERVICES

The Georgia Parent Infant Network for Educational Services (PINES) is a statewide intervention program for families of children birth to five years of age with a diagnosed hearing impairment and/or a visual impairment. Families receive information and training to assist their children to develop to their potential across all areas of development. All services, which are free, are provided in the home or other appropriate natural environment. Babies Can't Wait provides funding through IDEA to GA PINES for additional services to infants and toddlers with hearing loss.

EASTER SEALS

Easter Seals provides services to children and adults with disabilities and special needs to maximize their potential, through their four chapters: Easter Seals North, South, East and West Georgia. Services may include, but is not limited to: medical rehabilitation services, respite care/family support program, comprehensive day program for adults and a home for medically fragile children. Easter Seals of North Georgia is the contracted provider for the Babies Can't Wait program for the Gwinnett, Rockdale and Newton county district.

HANDS AND VOICES – GEORGIA CHAPTER

Hands and Voices – Georgia Chapter is a parent-driven, non-profit organization, providing families with children who are Deaf or Hard of Hearing with the resources, networks, and information they need to improve communication access and educational outcomes for their children. Its outreach activities, parent/professional collaboration, and advocacy efforts are focused on enabling Deaf and Hard-of-Hearing children to reach their highest potential.

GEORGIA CENTER FOR LEADERSHIP IN DISABILITY

Georgia Center for Leadership in Disability (CLD) provides interdisciplinary education, community services, research and dissemination of finding, with the goal of improving the lives of people with developmental disabilities of all ages and their families. As a University Center for Excellence in Developmental Disabilities (UCEDD), the CLD is part of a national network of federally funded UCEDDs and a member of a major advocacy and policy organization, the Association of University Centers on Disability. The UCEDD in Research and Service, Institute on Human Development and Disability, housed at the University of Georgia in Athens, supports training and technical assistance and holds the lending library for CSHCN.

BOARD OF REGENTS, UNIVERSITY SYSTEM OF GEORGIA, UNIVERSITY OF GEORGIA, VALDOSTA STATE UNIVERSITY, AND GEORGIA STATE UNIVERSITY

Board of Regents, University System of Georgia, University of Georgia, Valdosta State University and Georgia State University are currently contracted through the Babies Can't Wait Program to support the Comprehensive System of Personnel Development (CSPD) under Part C of Individuals with Disabilities Education Act (IDEA) to provide technical assistance and training in a variety of methods to health districts, service providers, and families related to the effective and appropriate provision of early intervention services.

GEORGIA HEAD START ASSOCIATION, HEAD START, AND EARLY HEAD START

Georgia Head Start Association, Head Start and Early Head Start programs provide comprehensive early childhood and family development services to children from birth to five-years-old, pregnant women and families. Head Start and Early Head Start programs deliver comprehensive services designed to foster healthy development in low-income children and their families. Head Start agencies provide individualized services in the areas of education and early childhood development; medical, dental, and mental health; nutrition; parent involvement and family support. Head Start emphasizes responsive and appropriate services for each child's and family's developmental, ethnic, cultural, and linguistic heritage and experience. All programs must adhere to federal Program Performance Standards. The standards define the services that programs are to provide to the children and families they serve. The standards include a requirement for a disabilities service plan, when appropriate focused on providing strategies for meeting the special needs of children with disabilities and their parents. A representative from Head Start is a required member of the BCW ICC.

GEORGIA DEPARTMENT OF HUMAN SERVICES

Georgia Department of Human Services (DHS), Department of Children and Family Services (DFCS) is responsible for investigating child abuse; finding foster homes for abused and neglected children; helping low income, out-of-work parents get back on their feet; assisting with child care costs for low income parents who are working or in job training; and providing support services and programs to help troubled families. DFCS and DPH are working to identify and explore opportunities to better serve the children and families of Georgia. DFCHS and DPH recently signed an interagency agreement related to implementation of the referral requirements under the Child Abuse Prevention and Treatment Act (CAPTA) and under IDEA for children age birth to three involved in substantiated cases of child abuse or neglect.

BRIGHT FROM THE START: THE DEPARTMENT OF EARLY CARE AND LEARNING

Bright from the Start: the Department of Early Care and Learning (DECAL) is responsible for meeting the child care and early education needs of Georgia's children and their families. DECAL oversees a wide range of programs focused on children ages birth to school age and their families. These programs include administering Georgia's Pre-K Program; licensing and monitoring the state's center-based and home-based child care facilities (approximately 10,000); overseeing the federal Child and Adult Care Food Program and the Summer Food Service Program; maintaining the Standards of Care Program and Family Homes of Quality to help child care providers enhance their program quality; housing the Head Start State Collaboration Office; administering the federal Even Start dollars to promote family literacy; and providing technical assistance, training, and support to families and child care providers who care for children with special needs. DECAL collaborates with Head Start, Family Connection Partnership, the Department of Human Services Family and Children Services, DPH, and Smart Start Georgia to blend federal, state, and private dollars to enhance early care and education. DECAL and DPH have a memorandum of agreement for enhanced services to support early childhood health and development for children and youth. BCW and DECAL work together to enhance services for preschool children with special needs and their families.

PARENT TO PARENT OF GEORGIA

Parent to Parent of Georgia is a statewide agency that serves children and youth with disabilities and their families. Parent to Parent offers an on-line data base of various resources such as child care, respite care or support groups that are available in local areas, provides parent-to-parent matching service, training sessions for parents on a wide variety of topics, and assists local areas in organizing parent support groups. Parent to Parent of Georgia is a free service and is funded in part by the Georgia Department of Community Health, Division of Public Health. Parent to Parent houses the MCHB federally funded Family to Family (F2F) health information center for families of children with special health care needs. The F2F is associated with the Family Opportunity Act of 2005. F2Fs provide health information, training and support to families of children and youth with special health care needs, and the professionals that serve them. F2Fs help families develop the skills necessary to cooperatively and effectively participate in planning and decision making in health-related issues. Parent to Parent holds the contract for central directory for BCW.

STATE SUPPORT FOR COMMUNITIES

CSHCN direct services programs include the Individuals with Disabilities Education Act funded early intervention program, Babies Can't Wait, and the Title V funded CSHCN program Children's Medical Services (CMS). Both programs are administered through the 18 public health district offices throughout the state, with the exception of one district where the BCW program is administered through a contract with Easter Seals of North Georgia.

BABIES CAN'T WAIT

Babies Can't Wait (BCW) is Georgia's statewide interagency service delivery system for infants and toddlers with developmental delays or disabilities and their families. The Division of Public Health is the lead agency responsible for administering the BCW program. Through the MCH Program, DPH ensures that services are provided in accordance with federal guidelines; that families have access to the services which are needed to enhance their child's development; and training is available to ensure that professionals who work with children and families have up-to-date information. Core services provided at no cost to families include developmental evaluation/assessment, individualized family service plans (IFSP), procedural safeguards (parent's rights), service coordination, and transition planning. Services subject to a system of payment (i.e., private insurance, Medicaid, family cost participation) include assistive technology, health services, nutrition services, physical therapy, special instruction, audiology, medical diagnostic services, psychology services, speech/language therapy, family training and counseling, nursing services, physical therapy, occupational therapy, social work, and vision services.

CHILDREN'S MEDICAL SERVICES

Children's Medical Services (CMS) is the Title V CSHCN program that serves children and youth with disabilities age birth to 21 that have a medical diagnosis on the approved CMS list and meet financial eligibility criteria. CMS provides care coordination, specialty medical evaluations and treatment for eligible children and youth who have complex medical conditions. Core CMS services include care coordination with a comprehensive plan of care, assurance that a child has a medical home with a primary care provider, and transition planning for youth ages 16 to 21 years of age. Services for eligible

conditions include comprehensive medical evaluations, specialty medical/surgical care, diagnostic tests, durable medical equipment, inpatient/outpatient hospitalization, and medications.

COORDINATION OF HEALTH COMPONENTS OF COMMUNITY-BASED SYSTEMS

The CMS staff in the 18 health districts assist families of CSHCN in identifying and accessing insurance resources. Educational sessions have been provided to Health District Coordinators on Medicaid (i.e., Right from the Start Medicaid, Emergency Medicaid, Deeming Waiver and Medically Needy Spend Down). Regular updates are provided on any changes in the Medicaid programs.

CMS coordinators and BCW service coordinators assess upon admission and annually, whether or not a child has a medical home. Children and families referred to CMS and BCW are connected with a primary care provider (PCP), if not already connected. Coordinators regularly review medical home information and include medical home information as part of the plan of care or individual family service plan.

COORDINATION OF HEALTH SERVICES WITH OTHER SERVICES AT THE COMMUNITY LEVEL

Several district CMS programs contract with specialty physicians to staff clinics to provide medical services to the children with special health care needs in underserved areas of Georgia. CMS uses these opportunities to assist in the provision of care coordination and medical management services to the children and families who would otherwise have to travel long distances to see a physician. The specialty clinics are named after the conditions they serve including: orthopedic, plastic surgery, genetic, scoliosis, seizure, sickle cell, chronic lung, cardiac, cleft lip and palate, developmental, pulmonology, asthma, neurosurgery, urology, hearing, and neurology.

In District 8-1 (Valdosta), the first pediatric urology telemedicine clinic started in June 2009 through collaboration with Georgia Partnership for Telehealth. The CMS Coordinator is actively recruiting for pediatric specialists in pulmonology and endocrinology to expand clinic opportunities.

Throughout the state, CMS staff coordinated with various programs through various outreach efforts, in order to reach additional children. Outreach efforts included: administering H1N1 vaccine in the schools, providing H1N1 information and educational material at clinics, providing H1N1 PowerPoint presentations for educators and daycare agencies, and patient/home visits; providing diabetic education, funding diabetic camps for children, providing budgeting fact sheets, emergency preparedness guideline information, cavity prevention and 'baby bottle teeth' information sheets, seizure triggers education, and First Aid training.

All of the 18 health district CMS Coordinators provide asthma education to children with asthma and their families regarding the following: recognizing and avoidance of triggers in the home and in their environment; recognition of signs of distress and plan of action; identifying signs of distress and alerting an adult when away from home; the importance of having an asthma action plan; and, the relationship between obesity and asthma. The coordinators provide asthma education to school nurses with emphasis on avoidance of triggers and asthma management with the use of the child's asthma action plan. Some districts provide funding for the tuition for asthma camps such as Camp Breathe Easy or they sponsor the camp in their district. The Georgia Asthma Control Program (GACP) has provided funding to support asthma education efforts in seven health districts and their communities: 3-1 Cobb/Douglass, 3-3 Clayton, 5-2 North Central (Macon), 8-1 South (Valdosta), 9-2 Southeast (Waycross),

and 9-1 Coastal (Savannah). These districts received funds up to $15,000 to assist them in their individual work plans to improve asthma outcomes via education.

GACP partners with local health districts to promote the adoption of "Asthma Friendly School" policies. Through the partnerships with the health districts, GACP targets school age children, and the birth-to-age-four populations. GACP has partnered with the Georgia Association of School Nurses (GASN) to provided asthma education and awareness to students, staff and parents. The GASN was funded through the health districts to purchase nebulizers, pulse oximeters, spacers, and peak flow meters to better serve the children that they encounter. As a result of the above mentioned partnership the GASN has formed an Asthma Taskforce. The goal is to assist in making all Georgia Schools asthma friendly. The National Association of School Nurses (NASN) is also a partner that provides training on asthma awareness including environmental triggers. GACP has partnered with Children's Health Care of Atlanta (CHOA) to work with families, schools, and health providers to assure children with asthma achieve their health and learning potential. GACP also partners with the Environmental Protection Agency (EPA) and the American Lung Association (ALA) to provide asthma training to various county and local entities. With funding from the Center for Disease Control (CDC), the GACP collects asthma surveillance data and publishes a comprehensive report on the burden of asthma in Georgia. GACP has an active statewide coalition that is chaired by one of the directors of the Area Health Education Center (AHEC).

In addition, the district CMS Coordinators partner with district Health Promotion programs in providing information and support to children with asthma and their families. The Southeast Health District (Waycross) provides on-site clinical services and telemedicine services to patients with asthma. Through a cooperative agreement with Satilla Regional Medical Center, a pediatric respiratory therapist comes to the clinic to perform Pulmonary Function Tests on children prior to being seen by the physician, which saves families travel to different locations for testing and care. The Respiratory therapist and CMS nurse also provide asthma education for patients and families during their visits. This district covers 16 counties in southeast rural Georgia and partners with several communities and schools to provide asthma education activities and events. Camp Iwannabreathe serves children and families in Charlton County. It is a two-day camp that started in 2005 for Charlton County students grades kindergarten through eighth held at a local elementary school. Kids participate in educational sessions and fun activities on the first day and are treated to a field trip on the second day. Parents are invited to an education and information session on the first day.

Camp Huff and Puff targets children ages 5 through 12 years with asthma, their siblings, and their caregivers from Pierce and Ware Counties. The camp began in 2006 and is hosted and sponsored by the Division of Public Health and community partners. The 8-1 South Health District (Valdosta), obtained a grant from Health Care Georgia Foundation to provide asthma education in April 2009. The district CMS nurse, through this grant provides asthma education and training, and, assures that each child has an asthma action plan that is signed by the primary care provider and is given to the parent and the school nurse. If the child qualifies for CMS, s/he is enrolled so that financial assistance may be provided if needed for medicines, equipment or office visits. The district CMS nurse partners with the American Lung Association, Tift Regional Hospital, South Georgia Medical Center, Valdosta and Tift Technical schools and Valdosta State University Nursing School to assist with two asthma day camps. Parents with children that have asthma are on the planning committee to assist in education classes, registration and other activities.

The 5-2 North Central Health District (Macon) CMS Program provides asthma education to school nurses in 5 county schools systems. Educational plans used are "A is for Asthma", "Asthma 101" and "Open

Airways" which are endorsed by American Lung Association. The district CMS coordinator serves on an asthma coalition/advisory council which develops and coordinates these activities as well as offers asthma education to daycare providers. The coalition also provides learning experiences for local Girl Scout troops to earn asthma education patches. The district CMS coordinator also collaborated with the district health educator in Houston County in the development of outreach activities for World Asthma Day.

PROCESS FOR ASSESSING CHARACTERISTICS DOCUMENTING FAMILY PARTICIPATION IN CSHCN PROGRAMS (FORM 13)

Families of children with special health care needs, Parent to Parent of Georgia, and the Georgia AMCHP Family Representative all contributed to the assessment of family participation in CSHCN programs (Form 13). Information used to complete this form included the following.

- A self-assessment completed by each public health district. Self-assessments in three of the 18 public health districts (1-1, 3-1, and 5-1) were greater than those in the other 15 public health districts;
- Data were gathered from a meeting with family members of children with special health care needs;
- A standard tool was distributed to family leaders in the Children Medical Services programs in each public health district by leadership in Georgia Parent to Parent; and
- Georgia Parent to Parent conducted key informant interviews with selected Children's Medical Services District Program Coordinators to determine how families were involved in their programs and the degree of support families received.

In previous submissions of the Title V MCH Services Block Grant application, families were not involved in the preparation of Form 13. This has been noted in past federal reviews as an area for improvement. With expanded family involvement in the completion of Form 13, Georgia's score has declined between the FY 0210 and FY 2011 applications from eighteen to seven, respectively. This decline reflects the change in the process of completing Form 13 rather than an actual decline in family involvement.

SECTION 5: SELECTION OF STATE PRIORITY NEEDS

METHODOLOGIES FOR RANKING/SELECTING PRIORITIES

IDENTIFY NEEDS

Quantitative data analyses and qualitative data collected through statewide focus groups were reviewed by the NAW. Using these data, the NAW identified 55 needs among women and infants, children, and children with special health care needs. This list of needs included all identified themes from the qualitative data, most of which were also supported by quantitative data analyses. When a need that was not identified as a theme in the qualitative data was considered by the NAW to be either a serious threat to maternal and child health in Georgia, this need was also included.

CONDUCT SURVEYS

Two surveys were conducted to determine if greater consensus could be reached on which of the 54 identified needs were most likely to be among the top priority needs in Georgia. After both surveys were completed, only needs that were selected among the top fifteen needs by at least 20 percent of all respondents received consideration at the Title V Priority Needs Selection meeting. Needs that did not meet this requirement are identified in the preceding table.

MEDICAL SOCIETY AND DISTRICT HEALTH DIRECTOR SURVEY

On April 14, 2010, the Georgia district health directors; representatives from the Georgia Chapter of the American Academy of Pediatrics, Georgia Academy of Family Physicians, and Georgia Obstetric and Gynecological Society; and Division of Public Health staff working with MCH-related programs were convened for a meeting. The purpose of this meeting was for participants to learn about the mission and activities of the participating organizations and to discuss commonalities that could be leveraged for improved collaboration. This meeting presented an opportunity for feedback on which of the 54 needs may be most important. At the conclusion of the meeting, a survey listing all 54 needs was distributed to each participant. The instructions were to select the 15 needs the respondent thought to be most important for Georgia. This survey was completed by 45 respondents.

ALL EMPLOYEE SURVEY

An online survey was created and distributed to all Division of Public Health staff working in Atlanta and throughout Georgia to ensure all staff had an opportunity to participate in the 2010 Needs Assessment. The survey was created and administered using Survey Monkey®. The survey consisted of a listing all 55 needs with the instruction to select the 15 needs the respondent thought to be most important for Georgia. The order of the needs was randomized for each respondent to reduce any potential instrumentation bias.

To notify staff to the availability of the survey, a link to the survey was sent via e-mail on May 14, 2010, by the Director of the Division of Public Health. The e-mail was distributed by Director of the Division of

Public Health to increase the likelihood that staff would read the e-mail and participate in the survey. A reminder was sent to all staff on May 24, 2010. The survey closed on May 28, 2010.

This survey was completed by 311 respondents. While the 311 respondents constitute a convenience sample, there was near equal participation between Atlanta-based staff and staff located throughout Georgia. Most respondents (62.7 percent) indicated that they had "some" or "much" expertise in maternal and child health. Information about the respondents is included in the table below.

Characteristics of Respondents to the Division of Public Health All Staff Survey	
Characteristic	Percent of Respondents
Years of Employment with the Division of Public Health	
0 to 3 years	30.2
4 to 7 years	19.6
8 to 11 years	14.5
More than 11 years	35.7
Supervisory Role	
Manager	44.7
Non-Manager	55.3
Expertise in Maternal and Child Health	
None	7.4
Little	18.6
Some	37.0
Much	25.7
Very Much	11.3
Workplace	
Central Office	53.9
Public Health District	46.1

HOST TITLE V PRIORITY NEEDS SELECTION MEETING

The Title V Priority Needs Selection Meeting was planned for June 3 and 4, 2010. Invitations were distributed to representatives from non-profit organizations, providers, parents of children with special health care needs, academic institutions, and public health district staff. A list of all participating organizations is included in Appendix E. One week prior to the Title V Priority Needs Selection Meeting, confirmed attendees received a list of the 44 needs that were to be considered and the quantitative and qualitative data included in *Section 3. Strengths and Needs of the Maternal and Child Health Population Groups* of this document beginning on page 64.

During the first day of the meeting, participants were asked to assess the 44 maternal and child health needs identified through the data analysis process on five criteria using a scale ranging in value from one (lowest value) to five (greatest value). The criteria, rationale, and a description of the scoring used are included in the table below.

Assessment of Maternal and Child Health Needs Used at Title V Priority Needs Selection Meeting		
Criterion	Rationale	Values
Seriousness of Issue	Consider the potential for this issue to result in severe disability and death in the state.	1 = Problem is not life threatening or disabling to individuals or the community. 2 = Problem is not life threatening but is sometimes disabling. 3 = Problem can be moderately life threatening or disabling. 4 = Problem can be moderately life threatening, but there is strong likelihood of disability. 5 = Problem has high likelihood of death and disability.
Economic and Social Impact	Consider the increased monetary costs, such as health care, social services, employers, productivity, society, associated with issue in the state.	1 = Economic / societal cost is minimal. 2 = There is some potential increased costs. 3 = There is likely to be moderate increased costs. 4 = There is likely to be substantial increased costs. 5 = There are great economic and societal costs.
Political Will to Address Issue	Consider the degree to which local and state political will supports action necessary to impact issue.	1 = Political will is absent at the community or state level. 2 = Political will is present at a low level in the community. 3 = Political will is present at a moderate level in the community. 4 = Political will is present at a high level in the community, and a low or moderate level at the state level. 5 = Political will is present at a high level in both the community and at the state level.
State's Ability to Impact, Prevent or Improve It	Consider the degree to which an issue can be impacted, prevented or improved through a state effort.	1 = The issue can't be prevented, improved, impacted. 2 = The issue can be impacted, prevented, or improved in a low to moderate way but requires resources beyond those that are already present in the state. 3 = The issue can be impacted, prevented, or improved in a significant way but requires resources beyond those that are already present in the state. 4 = The issue can be impacted, prevented, or improved in a low to moderate way with existing resources. 5 = The issue can be impacted, prevented, or improved in a significant way with existing resources.
If you could address only one need, how important is this one?	Consider this need in light of the other needs.	1 = Not important 2 = Somewhat important 3 = Moderately important 4 = Highly important 5 = Essential to address

Meeting participants were assigned to specific tables. Prior to assigning scores, table discussion occurred to allow the sharing of expertise, ideas, opinions, and points of view. However, each person

individually scored each of the 44 needs. To help make this task more manageable, the 44 needs were assessed in four sessions with eleven needs assessed per session. The number of assessments received varied by group as attendance changed throughout the day (Session 1: 50 completed surveys, Session 2: 51 completed surveys, Session 3: 48 completed surveys, Session 4: 54 completed surveys). An attendee was required to participate in the group discussion for his/her assessment to be accepted and included in the overall total score. Following data entry, an average for each need by criterion was determined. Once the average by criterion was determined, weights were applied and a sum calculated. Prior to the meeting, the NAW assigned weights to criterion to allow those criteria that were determined to be more important to have greater influence than the other criterion. Weights ranged from one to three. Economic and social impact received a weight of one; seriousness of the issue and importance of this need were assigned a weight of two; and political will and the ability to impact, prevent, or improve the need were assigned a weight of three. All needs considered by attendees were ranked in descending order by total weighted score.

During the second day, the results of the scoring exercise were shared and discussed. In the same table groups as on the first day, there was peer-to-peer conversation about the results followed by a conversation with the Title V MCH and CSHCN directors for Georgia. Also shared with the meeting participants were the ten selected priority needs. The selected needs strongly mirrored the results of the work from the previous day. The meeting participants and Title V MCH and CSHCN directors discussed each need to ensure clarity, appropriate wording, and consensus.

LIST OF POTENTIAL PRIORITIES

The following table lists all items considered for inclusion as state priority needs. Items are sorted by their weighted score as assigned by the attendees at the Title V Priority Needs Selection Meeting. For each item, brief comments are provided as to the reason for not selecting the need. The selection of Georgia's ten priority needs follows the scoring from the Title V Priority Needs Selection Meeting with some exceptions that are explained in the table.

Georgia's Top Priority Needs and Other Needs Considered for Inclusion								
		Stakeholder Scores from Title V Priority Needs Selection Meeting						
		How serious is the issue	Economic and social impact	Political will	Ability to impact, prevent, or improve	How important is this one need?	Total	
		Weights						
Rank	Need	2	1	3	3	2		Reason for Not Selecting as a Priority Need
1	Decrease the rate of deliveries resulting in infants weighing less than 2,500 grams.	4.5	4.5	3.3	3.3	4.1	41.4	Combined with need #2 into one priority need.
2	Decrease the infant mortality rate.	4.7	4.0	3.1	3.4	4.0	41.1	Selected as a top priority need.
3	Increase the percent of pregnant women who receive adequate prenatal care.	3.9	3.8	3.6	3.4	3.9	40.4	Addressed in National Performance Measure #18.
4	Reduce motor vehicle crash mortality among adolescents 15 to 17 years of age including increase seat belt use.	4.5	3.3	3.6	3.6	3.3	40.4	Selected as a top priority need.
5	Decrease rates of obesity among children and adolescents.	3.6	3.9	3.5	3.2	3.8	38.8	Selected as a top priority need.
6	Increase the availability of family planning services.	2.9	3.9	3.2	3.8	4.1	38.8	This need was not selected as a priority need due to the changing circumstances for family planning in Georgia. In January 2011, Georgia Medicaid will implement a women's health waiver. This waiver will have a significant and as yet undefined impact in Georgia. Title X is administered in Georgia by the MCH Program. While not a priority need, Title V will work with Title X and Medicaid to ensure that all opportunities created by the implementation of the waiver are seized.
7	Reduce repeat adolescent pregnancy.	3.3	4.0	2.9	3.7	4.0	38.4	Selected as a top priority need.
8	Ensure that infants are raised in a safe environment that reduces injury.	3.7	3.3	3.2	3.5	3.5	38.0	Combined with need #2 into one priority need.
9	Increase developmental screening for children in need.	3.2	3.5	3.1	3.6	3.6	37.2	Selected as a top priority need.
10	Reduce the rate of unintended pregnancy among all women under 25 years of age.	3.2	3.7	2.9	3.4	4.0	37.2	Assessed political will to address the need averaged less than a score of three. This need can be addressed through National Performance Measure #8. For women 18 to 24 years of age, this need is associated with need #6, which was selected as a top priority need.
11	Improve the maternal and child health surveillance and evaluation infrastructure.	2.6	3.3	3.0	3.9	3.6	36.4	Selected as a top priority need.
12	Increase the percent of children, including children with special health care needs, who have a medical home.	3.4	3.3	3.1	3.4	3.4	36.4	Selected as a top priority need.
13	Improve childhood nutrition.	3.1	3.4	3.2	3.4	3.4	36.2	Selected as a top priority need.

Georgia's Top Priority Needs and Other Needs Considered for Inclusion								
		Stakeholder Scores from Title V Priority Needs Selection Meeting						
		How serious is the issue	Economic and social impact	Political will	Ability to impact, prevent, or improve	How important is this one need?	Total	
		Weights						
Rank	Need	2	1	3	3	2		Reason for Not Selecting as a Priority Need
14	Increase awareness of the need for preconception health care among women of childbearing age.	3.2	3.3	3.1	3.6	3.2	36.2	Selected as a top priority need.
15	Reduce risk-taking behaviors among adolescents through education and injury prevention messages.	3.7	3.1	3.1	3.3	3.2	36.1	The issue is too broadly focused. Total score ranked outside of the top ten.
16	Reduce the rate of maternal mortality.	4.1	3.2	2.9	3.0	3.4	36.0	Prevalence/impact in Georgia is limited. Total score ranked outside of the top ten.
17	Improve the health care system through improved coordination of services.	2.9	3.2	3.0	3.4	3.9	35.8	The issue is too broadly focused. Assessed seriousness of need averaged less than a score of three. Total score ranked outside of the top ten.
18	Increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs.	3.4	3.5	3.0	3.2	3.5	35.7	Selected as top priority need to ensure that the needs of CSHCN were represented among top priority needs.
19	Reduce the adolescent pregnancy rate, especially among Hispanic adolescents.	3.2	3.6	2.7	3.3	3.7	35.4	Assessed political will to address the need averaged less than a score of three. Total score ranked outside of the top ten. This need can be addressed through National Performance Measure #8. This need is associated with need #6, which was selected as a top priority need.
20	Promote coordination of medical coverage to identify and address coverage gaps, reimbursement issues, and variable definitions of medical reimbursement.	3.1	3.4	3.1	3.0	3.5	35.1	The issue is too broadly focused. Total score ranked outside of the top ten.
21	Decrease the percent of children and adolescents exposed to violence including homicide among Black and Hispanic male youth.	4.0	3.5	2.9	2.7	3.3	34.9	One of five needs with an average assessed seriousness of the need of four or greater. However, assessed political will to address the need and ability to impact, prevent, or improve need averaged less than three. Total score ranked outside of the top ten.
22	Increase the number of deliveries with appropriate birth spacing.	3.1	3.4	2.8	3.3	3.3	34.8	Assessed political will to address the need averaged less than a score of three. Total score ranked outside of the top ten. This need is associated with need #6, which was selected as a top priority need.
23	Increase the percent of women who choose a birth control method following pregnancy.	2.7	3.3	2.8	3.6	3.5	34.8	Assessed political will to address the need averaged less than a score of three. Total score ranked outside of the top ten. This need is associated with need #6, which was selected as a top priority need.

Georgia's Top Priority Needs and Other Needs Considered for Inclusion								
		Stakeholder Scores from Title V Priority Needs Selection Meeting						
		How serious is the issue	Economic and social impact	Political will	Ability to impact, prevent, or improve	How important is this one need?	Total	
		Weights						
Rank	Need	2	1	3	3	2		Reason for Not Selecting as a Priority Need
24	Increase the percent of children under the age of five who receive a preventive dental examination.	2.9	3.2	2.8	3.4	3.4	34.2	Assessed seriousness of this need and political will to address the need averaged less than a score of three. Total score ranked outside of the top ten. This need can be addressed through National Performance Measure #9.
25	Improve awareness of publicly-funded health care and enabling service options (WIC, PeachCare, Medicaid, Early Head Start, Babies Can't Wait).	2.3	2.8	3.1	3.8	3.0	34.1	Assessed seriousness of this need and economic and social impact of the need averaged less than a score of three. Total score ranked outside of the top ten.
26	Educate parents about the impact of unhealthy lifestyles on child health and development.	3.1	3.2	2.7	3.2	3.3	33.9	The issue is too broadly focused. Assessed political will to address the need averaged less than a score of three. Total score ranked outside of the top ten. Parents may be engaged through activity plans for several national performance measures.
27	Reduce the rate of obesity among women of childbearing age.	3.4	3.3	2.8	3.0	3.2	33.7	Assessed political will to address the need averaged less than a score of three. Total score ranked outside of the top ten.
28	Reduce the rate of emergency room visits resulting from infant falls.	3.4	2.9	2.7	3.2	3.0	33.5	Assessed economic and social impact of the need and the political will to address the need averaged less than a score of three. Total score ranked outside of the top ten. This need is associated with need #2, which was selected as a top priority need.
29	Ensure the availability of mental health screening and treatment, when necessary, among children and adolescents.	3.1	3.5	2.5	3.0	3.5	33.3	Assessed political will to address the need averaged less than a score of three. Total score ranked outside of the top ten.
30	Improve nutrition among women of childbearing age.	2.9	2.9	2.7	3.2	3.3	32.8	Three criteria upon which the need was assessed averaged less than a score of three. Total score ranked outside of the top ten.
31	Reduce rates of Chlamydia among women 18 to 21 years of age.	3.0	3.0	2.4	3.4	3.1	32.8	Assessed political will to address the need averaged less than a score of 2.5. Total score ranked outside of the top ten.

Georgia's Top Priority Needs and Other Needs Considered for Inclusion								
		Stakeholder Scores from Title V Priority Needs Selection Meeting						
		How serious is the issue	Economic and social impact	Political will	Ability to impact, prevent, or improve	How important is this one need?	Total	
		Weights						
Rank	Need	2	1	3	3	2		Reason for Not Selecting as a Priority Need
32	Increases services and health education for foster parents and children known to child protective services.	3.0	2.9	2.5	3.3	3.0	32.4	Assessed economic and social impact of the need and the political will to address the need averaged less than a score of three. Total score ranked outside of the top ten. Parents may be engaged through activity plans for several national performance measures.
33	Increase the availability of breastfeeding support and education.	2.1	2.6	2.7	3.7	2.8	32.0	Three criteria upon which the need was assessed averaged less than a score of three. Assessed seriousness of this need averaged less than a score of 2.5. Total score ranked outside of the top ten. This need can be addressed through National Performance Measure #11.
34	Increase the ability of schools and the educational system to support the needs of children with special health care needs to maximize potential educational achievement and participation with other children in a regular school environment.	2.5	3.1	2.9	3.2	2.7	31.7	Three criteria upon which the need was assessed averaged less than a score of three. Total score ranked outside of the top ten.
35	Increase the supply of specialty providers including physicians, audiologists, and physical and occupational therapists.	3.0	3.4	2.6	2.6	3.1	31.3	The issue is too broadly focused and Title V has limited influence over provider supply. Assessed political will and ability to impact, prevent, or improve the need averaged less than a score of three. Total score ranked outside of the top ten.
36	Increase parenting skills.	2.8	3.1	2.4	3.1	3.0	31.0	Assessed seriousness and political will to address the need averaged less than a score of three. Political will to address the need averaged less than a score of 2.5. Total score ranked outside of the top ten. Parents may be engaged through activity plans for several national performance measures.
37	Increase community acceptance of breastfeeding.	2.0	2.6	2.8	3.5	2.7	30.9	Four criteria upon which the need was assessed averaged less than a score of three. Assessed seriousness of this need averaged a score of two. Total score ranked outside of the top ten. This need can be addressed through National Performance Measure #11.
38	Increase available and appropriate transportation to facilitate children with special health care needs access to services.	2.8	2.7	2.7	2.9	2.9	30.7	All criteria upon which the need was assessed averaged a score less than three. Total score ranked outside of the top ten.

Georgia's Top Priority Needs and Other Needs Considered for Inclusion								
		Stakeholder Scores from Title V Priority Needs Selection Meeting						
		How serious is the issue	Economic and social impact	Political will	Ability to impact, prevent, or improve	How important is this one need?	Total	
		Weights						
Rank	Need	2	1	3	3	2		Reason for Not Selecting as a Priority Need
39	Increase family support for parents.	2.5	3.0	2.5	3.0	2.8	30.2	Three criteria upon which the need was assessed averaged less than a score of three. Total score ranked outside of the top ten. Parents may be engaged through activity plans for several national performance measures.
40	Improve physical activity among women of childbearing age.	2.7	2.7	2.3	3.1	2.9	30.1	Four criteria upon which the need was assessed averaged less than a score of three with the average score for political will less than 2.5. Total score ranked outside of the top ten.
41	Improve support for transportation to medical appointments.	2.7	3.2	2.4	2.7	2.8	29.5	Four criteria upon which the need was assessed averaged less than a score of three with the average score for political will less than 2.5. Total score ranked outside of the top ten.
42	Increase the proportion of parents who believe they are a partner in the care of their children with special health care needs.	2.0	2.0	2.1	3.3	2.5	27.6	Three criteria upon which the need was assessed averaged less than a score of 2.5. Assessed seriousness of this need averaged a score of two. Total score ranked outside of the top ten.
43	Increase opportunities for children with special health care needs to participate in routine activities with other children of the same age/developmental stage.	1.9	2.3	2.4	3.0	2.5	27.1	Four criteria upon which the need was assessed averaged less than a score of three with the average score for seriousness less than two. Total score ranked outside of the top ten.
44	Reduce lifetime and current marijuana use.	2.2	2.2	2.3	2.8	2.1	26.4	Four criteria upon which the need was assessed averaged less than a score of 2.5. Total score ranked outside of the top ten.
Not Ranked	Increase the percent of parents who report reading to young children.							These needs did not accrue at least 20 percent of all votes in two surveys to assess potential priority needs. Given the limited support for these needs through survey responses, they were not assessed at the Title V Priority Needs Selection Meeting.
Not Ranked	Decrease appointment wait times to see health care providers.							
Not Ranked	Decrease the rate of late preterm (34 to 36 weeks gestational age) deliveries.							
Not Ranked	Improve transition to adult care providers from pediatric providers.							

Georgia's Top Priority Needs and Other Needs Considered for Inclusion								
		Stakeholder Scores from Title V Priority Needs Selection Meeting						
		How serious is the issue	Economic and social impact	Political will	Ability to impact, prevent, or improve	How important is this one need?	Total	
		Weights						
Rank	Needs	2	1	3	3	2		Reason for Not Selecting as a Priority Need
Not Ranked	Increase awareness of and screening for post partum depression.							These needs did not accrue at least 20 percent of all votes in two surveys to assess potential priority needs. Given the limited support for these needs through survey responses, they were not assessed at the Title V Priority Needs Selection Meeting.
Not Ranked	Increase parent satisfaction with the services they receive for their children with special health care needs.							
Not Ranked	Increase the percent of women who gave birth who consumed an appropriate amount of folic acid prior to conception.							
Not Ranked	Increase the proportion of infants placed on their backs to sleep especially among African American women.							
Not Ranked	Reduce smokeless tobacco use.							
Not Ranked	Reduce the rate of deliveries via Cesarean section.							

PRIORITIES COMPARED WITH PRIOR NEEDS ASSESSMENT

The primary difference between the priority needs selected during the 2005 Needs Assessment and the 2010 Needs Assessment is the specificity of the priority needs. In the 2005 Needs Assessment, the priority needs selected were more broad addressing broad topic areas rather than specific needs within the broad topics areas.

Georgia's Top Priority Needs, 2005 and 2010	
Current Georgia Top Priority Needs (2010)	Past Georgia Top Priority Needs (2005)
1. Decrease infant mortality and injury	1. Assure early access to prenatal and postpartum care for pregnant women
2. Reduce motor vehicle crash mortality among children ages 15 to 17 years	2. Promote healthy nutritional behaviors and physical activity among the MCH population
3. Decrease obesity among children and adolescents	3. Reduce unintentional and intentional injury
4. Reduce repeat adolescent pregnancy	4. Improve oral health
5. Increase developmental screening for children in need	5. Promote preconception health
6. Improve the maternal and child health surveillance and evaluation infrastructure	6. Promote healthy behaviors and reduce risk-taking behaviors among adolescents
7. Improve childhood nutrition	7. Reduce health disparities among the MCH populations
8. Increase awareness of the need for preconception health care among women of childbearing age	8. Assure a comprehensive system of age appropriate screening, referral, and follow-up for children from birth through age 21
9. Increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs	9. Assure an adequate MCH workforce
	10. Develop partnerships to support the overall health and well-being of the MCH population

In the 2010 Needs Assessment, many of the priority needs selected are within the broad topic areas identified in the 2005 Needs Assessment but are more specific. When comparing the priority needs from 2005 to the priority needs from 2010, with the exception of one priority need, all priority needs in 2010 are related to priority needs selected in 2005. While not explicitly stated in the priority needs for 2010, all priority needs in 2010 are expected to reduce health disparities among MCH populations and utilize partnerships to improve outcomes; two needs explicitly identified in 2005.

The table below identifies the overlap between the priority needs selected in 2005 and 2010, priority needs that were not included in 2005, and priority needs that were included in 2005 that were not included in 2010.

Comparing Georgia's Top Ten Priority Needs from 2005 and 2010	
Current Georgia Top Priority Needs (2010)	Past Georgia Top Priority Needs (2005)
Decrease infant mortality and injury	Reduce unintentional and intentional injury
Reduce motor vehicle crash mortality among children ages 15 to 17 years	Reduce unintentional and intentional injury
Decrease obesity among children and adolescents	Promote healthy nutritional behaviors and physical activity among the MCH population
Reduce repeat adolescent pregnancy	Promote healthy behaviors and reduce risk-taking behaviors among adolescents
Increase developmental screening for children in need	Assure a comprehensive system of age appropriate screening, referral, and follow-up for children from birth through age 21 years
Improve the maternal and child health surveillance and evaluation infrastructure	Assure an adequate MCH workforce
Improve childhood nutrition	Promote healthy nutritional behaviors and physical activity among the MCH population
Increase awareness of the need for preconception health care among women of childbearing age	Promote preconception health
Increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs	No similar priority need in 2005
No similar priority need in 2010	Assure early access to prenatal and postpartum care for pregnant women Improve oral health

Two priority needs identified in 2005 are not addressed in the priority need identified in 2010. These are:

- assure early access to prenatal and postpartum care for pregnant women
- improve oral health

While two priority needs from 2005 are not included in the 2010 priority needs, each of these needs is addressed, at least partially, through national performance measures. National Performance Measure 18 addresses early entry into prenatal care. National Performance Measure 9 addresses oral health by measuring the percent of children in third grade who have dental sealants on at least one molar.

PRIORITY NEEDS AND CAPACITY

Georgia's priority needs can be linked to the four services levels of the Title V Pyramid: Infrastructure Building, Population-Based Services, Enabling Services, and Direct Health Care. Several of the priority needs address more than one pyramid level. There is also adequate available capacity to impact each of the priority needs. The following table lists each priority need, the pyramid level addressed, and a brief summary of available capacity.

Priority Needs by Pyramid Level and Existing MCH Program Capacity					
Priority Need	IB*	PBS*	ES*	DHC*	Existing Capacity to Address Need and Possible Activities
Decrease infant mortality and injury	X	X	X	X	There is significant capacity to address infant mortality and injury. To build infrastructure and understanding of infant mortality, capacity exists to perform detailed analyses of infant mortality at the county level including perinatal periods of risk analyses. Strategic coordination with WIC will allow the communication of messages to a high risk population. Through the Children 1st Program, very low birth weight infants receive home visiting follow-up care. By applying an algorithm to the electronic birth file, all infants born in Georgia are screened for socio-economic risk factors that may contribute to developmental delay or infant mortality. Through partnerships with the Georgia Chapter of the American Academy of Pediatrics, the Georgia Obstetrical and Gynecological Society, and Georgia Association of Family Physicians, strategies can be developed with the provider community that may include tailored messaging to clients. Through WIC and Title V, strong support for breastfeeding promotion also contributes to reducing infant mortality and injury. Developing partnerships with the Georgia Injury Prevention Program, Georgia Safe Infant Sleep Committee, and Georgia Child Death Review will strengthen and guide activity development to address this need.
Reduce motor vehicle crash mortality among children ages 15 to 17 years	X	X			Capacity to address this need reside in the Division of Emergency Preparedness, Injury Prevention Program. The Injury Prevention Program can identify training and population-based messages to reduce the motor vehicle crash mortality through a variety of interventions.

Priority Needs by Pyramid Level and Existing MCH Program Capacity					
Priority Need	IB*	PBS*	ES*	DHC*	Existing Capacity to Address Need and Possible Activities
Decrease obesity among children and adolescents	X	X	X		Decreasing obesity among children and adolescents will require significant collaboration. The MCH Program has several opportunities to impact the obesity rate in early childhood through WIC. New legislation requiring all students to receive a fitness assessment has created an opportunity for collaboration between the Division of Public Health, Department of Education, and the Georgia Children's Health Alliance. These partners are working together to ensure that the information collected through the assessment can be used to strengthen existing surveillance and to target and evaluate health promotion interventions.
Reduce repeat adolescent pregnancy	X		X		Capacity exists within the MCH Program to analyze and produce annual reports on the prevalence of repeat adolescent pregnancies. Increased collaboration with delivery hospitals and medical providers could lead to increased referrals for adolescent mothers to family planning services provided through the public health districts or Title X. Protocols can be developed between the WIC and the Family Planning Program to increase referrals and to ensure completion of referrals.
Increase developmental screening for children in need		X	X	X	Through several MCH programs and improved collaboration, there is significant capacity available to address this need. The Part C Early Intervention Program (Babies Can't Wait), Children 1st, and Children's Medical Services all encounter children ages birth to five years of age. Additionally, discussions have occurred to develop plans to include developmental assessments throughout Georgia WIC clinics. Through existing partnerships with medical providers, the MCH Program can work to promote the need for every child in need to have appropriate developmental screening.

Priority Needs by Pyramid Level and Existing MCH Program Capacity					
Priority Need	IB*	PBS*	ES*	DHC*	Existing Capacity to Address Need and Possible Activities
Improve the maternal and child health surveillance and evaluation infrastructure	X				The MCH epidemiology capacity in the MCH Program is increasing. As recommended in *Maternal and Child Health Epidemiology in State Health Agencies: Guidelines for Enhanced Functioning,* MCH Epidemiology was moved to be administratively located within the MCH Program in April 2010. The administrative change ensures seamless interaction between epidemiology and program staff. The newly created MCH Epidemiology Section includes a section director and nine FTEs. With increased staffing, the MCH Epidemiology Section Director will work with stakeholders to understand their data needs and the existing data gaps.
Improve childhood nutrition		X	X		Capacity exists to improve childhood nutrition through the Nutrition Unit in the Nutrition and WIC Section. While the Nutrition Unit has focused on the WIC population, this focus can be expanded to provide increased population-based messaging. MCH Program staff have contributed to discussion pertaining to farm-to-school initiatives and initial plans have been made to develop a request for proposals to fund increased nutrition education in schools that also develop school-based gardens. To ensure inclusion for children with special health care needs, Nutrition Unit staff have provided training and nutritionists have been hired to support Georgia's Part C Early Intervention Program – Babies Can't Wait.
Increase awareness of the need for preconception health care among women of childbearing age		X	X	X	There are several opportunities for the dissemination of preconception health messaging through MCH programs. The Family Planning Program in the Women's Health Unit has opportunities to develop standard messages that can be delivered through client contacts. Through improved collaboration with Medicaid and the implementation of Georgia's Women's Health Waiver, there will be opportunities to increase population-based media messages pertaining to family planning and preconception health. Through coordination with WIC, women who have given birth can receive interconception health messages to increase the likelihood of healthy future pregnancies. The MCH Program will need to work with the Health Promotion and Disease Prevention Program and internal experts in communications to develop strategies to ensure broad dissemination of preconception health messages.

Priority Needs by Pyramid Level and Existing MCH Program Capacity					
Priority Need	IB*	PBS*	ES*	DHC*	Existing Capacity to Address Need and Possible Activities
Increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs	X				Current contracts with the Georgia Chapter of the American Academy of Pediatrics and the Georgia Association of Family Physicians provide access to practicing providers. With the assistance of these partners, surveys will be implemented to determine the current attitudes of practicing providers to treating children with special health care needs. MCH Program staff will work to develop recognition programs for providers who have positive attitudes toward treating CSHCN and who ensure family involvement in decision making.

* IB – Infrastructure Building, *PBS – Population Based Services, *ES – Enabling Services, *DHC – Direct Health Care

PRIORITIES BY MCH POPULATION GROUPS

Each of the three primary population groups served by the Title V MCH Services Block Grant is represented in Georgia's top ten priority needs. The table that follows identifies the population group(s) addressed by each priority need. Four of the priority needs address multiple population groups.

Georgia's Top Ten Priority Needs by Population Group, 2010			
	Women and Infants	Children and Adolescents	Children with Special Health Care Needs
Decrease infant mortality and injury	X		
Reduce motor vehicle crash mortality among children ages 15 to 17 years		X	
Decrease obesity among children and adolescents		X	X
Reduce repeat adolescent pregnancy		X	
Increase developmental screening for children in need			X
Improve the maternal and child health surveillance and evaluation infrastructure	X	X	X
Improve childhood nutrition		X	
Increase awareness of the need for preconception health care among women of childbearing age	X	X	
Increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs			X

PRIORITY NEEDS AND STATE PERFORMANCE MEASURES

DISCUSSION OF STATE PERFORMANCE MEASURES

A brief discussion of the relationship between each state performance measure and the selected priority needs follows. Detail sheets for each state performance measure are included in the FY11 Application, Form 16. Included with the discussions are the planned activities for each state performance measure to be undertaken in FY11.

STATE PERFORMANCE MEASURE 1. PERCENT OF HIGH SCHOOL STUDENTS WHO ARE OBESE (BMI ≥ 95TH PERCENTILE)

This state performance measure was included in response to the priority need *Decrease obesity among children and adolescents*. While the measure focuses on high school, behaviors that contribute to obesity are developed at much earlier ages. Therefore, activities for this measure may focus in younger age groups. This measure also allows for activities that address precursors to obesity such as poor nutrition and limited physical activity.

ACTIVITIES

Activity 1. Fund elementary schools to implement school-based gardens and enhanced nutrition education.

Activity 2. Initiate discussions with the Health Promotion Disease Prevention Unit to identify opportunities for collaboration around obesity prevention.

Activity 3. Conduct an environmental scan to identify possible environmental correlates of increased rates of obesity.

Activity 4. Participate in a public/private partnership with the Department of Education to implement statewide fitness assessments.

STATE PERFORMANCE MEASURE 2. INFANT MORTALITY RATE AMONG INFANTS BORN WEIGHING MORE THAN 1,500 GRAMS AND WHO SURVIVE PAST THE FIRST 27 DAYS OF LIFE

This state performance measure was included in response to priority need *Decrease infant mortality and injury*. This state performance measure targets infant mortality rates in a specific sub-group. This sub-group was chosen because it is this subgroup that is most susceptible to public health interventions. Activities for this state performance measure will include, but are not limited to, safe sleep practices, infant injury prevention, and SIDS prevention. Infant death among this specific sub-group are less likely due to congenital defect, low birth weight or extreme prematurity, or other condition not compatible with life.

ACTIVITIES

Activity 1. Prepare a surveillance report that describes and analyzes trends in infant mortality between 1998 and 2008.

Activity 2. Establish a statewide task force to make recommendations in infant mortality prevention.

Activity 3. Develop and implement a statewide infant health and safety survey.

STATE PERFORMANCE MEASURE 3. NUMBER OF ABSTRACTS SUBMITTED, REPORTS PREPARED, PRESENTATIONS MADE, AND PUBLICATIONS SUBMITTED FOR PEER REVIEW WHERE MCH PROGRAM STAFF ARE AUTHORS OR CO-AUTHORS

This state performance measure was included in response to priority need *Improve the maternal and child health surveillance and evaluation infrastructure*. The Georgia MCH Program has made a significant commitment to improving the MCH surveillance and data infrastructure in Georgia. The selection of this priority need demonstrates the demand for data among Georgia's MCH stakeholder community. This state performance measure was included to measure the planned investment in epidemiology staff, development of new surveillance systems, and improvement in existing surveillance system. This state performance measure was included to ensure that data and information is disseminated to contribute knowledge to the MCH field and to MCH stakeholders throughout Georgia. Success in reaching this state performance measure will also impact responses to Health System Capacity Indicator 09A and 09B.

ACTIVITIES

Activity 1. Outline a research agenda for the MCH Program.

Activity 2. Identify data and knowledge gaps and strategies to address these gaps.

STATE PERFORMANCE MEASURE 4. DEATHS TO CHILDREN AGES 15 TO 17 YEARS CAUSED BY MOTOR VEHICLE CRASHES PER 100,000 CHILDREN

This state performance measure was included in response to priority need *Reduce motor vehicle crash mortality among children ages 15 to 17 years*. While Health Status Indicator 03C addresses the death rate per 100,000 for unintentional injuries for youth aged 15 through 24 years old due to motor vehicle crashes, adolescents between 15 and 17 years of age are unique in that they are new to driving, are still residing with their parents, and are in high school. This group requires tailored interventions that are unique from interventions that may be effective among older adolescents (18 through 24 years of age).

ACTIVITIES

Activity 1. Establish or maintain rural Community Mobilization Groups.

Activity 2. Host at least ten traffic safety events or projects carried out within the Southeast Rural Road Initiative region during the program year

Activity 3. Provide survey and crash data charts and maps from at least six counties detailing at least four risk factors to Regional Traffic Enforcement Networks and the North East Georgia Rural Roads Initiative groups for use in planning.

STATE PERFORMANCE MEASURE 5. AMONG CHILDREN FIVE YEARS OF AGE AND YOUNGER WHO RECEIVED SERVICES THROUGH THE MCH PROGRAM, THE PERCENT WHO RECEIVED A DEVELOPMENTAL SCREEN

This state performance measure was included in response to the priority need *Increase developmental screening for children in need*. The US Department of Health and Human Services recommends developmental screening for all infants and young children as part of routine medical care. Programs within MCH, specifically Children's Medical Services, Babies Can't Wait, Children 1st, and WIC, will encounter more than 300,000 unique children five years of age and under. This presents an opportunity to confirm that these children had a developmental screen or to administer a screen, when necessary. This state performance measure introduces accountability that can encourage systems changes to improve the availability of early identification, diagnosis, and treatment of developmental delays.

ACTIVITIES

Activity 1. Identify a standard tool and protocol for developmental screening to be used in all MCH programs.

Activity 2. Develop a reporting and measurement strategy that can be applied throughout all MCH programs.

Activity 3. Develop a strategic plan and identify pilot sites to implement developmental screens for all WIC clients.

STATE PERFORMANCE MEASURE 6. PERCENT OF PEDIATRICIANS AND FAMILY PHYSICIANS WHO HAVE POSITIVE ATTITUDES TOWARD TREATING CHILDREN WITH SPECIAL HEALTH CARE NEEDS

This state performance measure was included in response to the priority need *Increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs*. This state performance measure will require increased collaboration with partners in the medical community to participate in an annual assessment and activities to increase positive attitudes among the provider community. In addition to the existing provider community, improved relationships with Georgia medical schools could yield opportunities to educate medical students about the needs among and treatment for children with special health care needs. It is hypothesized that improvements in this state performance measure may lead to an increase in the supply of providers, including those who accept Medicaid, and who are willing to provide optimal care for children with special health care needs.

ACTIVITIES

Activity 1. Design and implement a survey in partnership with the Georgia Chapter of the American Academy of Pediatrics and the Georgia Association of Family Physicians to measure physician attitudes to treating children with special health care needs.

Activity 2. Meet with leaders in Georgia medical schools to develop a strategy to expose medical students to treating children with special health care needs.

Activity 3. Develop an awards and recognition program for providers who excel at providing services for children with special health care needs.

STATE PERFORMANCE MEASURE 7. PERCENT OF VERY LOW BIRTH WEIGHT INFANTS (<1,500 GRAMS) ENROLLED IN FIRST CARE

This state performance measure was included in response to priority need *Decrease infant mortality and injury*. Infants born weighing less than 1,500 grams are the most vulnerable and at risk for infant death. This state performance measure was selected to clearly indicate the priority that Georgia places on ensuring that these infants have the greatest possible probability for success. Services provided through the First Care, which is funded through a combination of state and federal funds, include home visiting, follow-up, and referral services.

ACTIVITIES

Activity 1. Develop and implement a protocol and standardized operating procedures to provide home visits to infants delivered weighing less than 1,500 grams.

Activity 2. Analyze the distribution of infants delivered weighing less than 1,500 grams and identify any correlates that distinguish these pregnancies/deliveries.

STATE PERFORMANCE MEASURE 8. PERCENT OF WOMEN OF REPRODUCTIVE AGE WHO CONSUME AN APPROPRIATE AMOUNT OF FOLIC ACID PRIOR TO PREGNANCY

This state performance measure was included in response to priority need *Increase awareness of the need for preconception health care among women of childbearing age*. While this priority need is broad, it was determined to first focus on improving folic acid use. This choice was supported by the impact of folic acid on birth defects and the current low rates of folic acid use reported by Georgia PRAMS. In both 2005 and 2006, the proportion of women who delivered an infant who reported consuming folic acid in the month prior to conception was approximately 25 percent. Before expanding to other preconception health messages, it is important to ensure that the rate of folic acid consumption, a cornerstone of preconception health messaging, increases to significantly greater levels.

ACTIVITIES

Activity 1. Develop standard messages regarding the importance of folic acid consumption for improved infant health.

Activity 2. Identify opportunities to distribute messages regarding the importance of folic acid consumption.

Activity 3. Explore the costs of a media campaign to promote folic acid consumption.

THE ASSOCIATION BETWEEN STATE AND NATIONAL PERFORMANCE MEASURES AND PRIORITY NEEDS

The tables that follows indicates the state and national performance measures that support each priority need with brief discussion of how these measures will allow Georgia to measure success in meeting its priority needs.

List of Georgia's Priority Needs and Associated State and National Performance Measures			
Priority Need	State Performance Measures	National Performance Measures	Measuring Success
Decrease infant mortality and injury	SPM 2 SPM 7	NPM 1 NPM 10 NPM 11 NPM15 NPM 17	Several state and national performance measures contribute either directly or indirectly to addressing this priority need. SPM 2 is worded in a way that directly addresses this priority need. In response to SPM 2, activities can address such threats to infant health and survival as infant safe sleep, infant falls, and exposure to second hand smoke. SPM 7 and the NPMs listed contribute indirectly to addressing this priority need. SPM 7 addresses the group at greatest risk for infant death by providing home visits to infants born weighing less than 1,500 grams. By identifying and providing follow-up for children who have failed a genetic screening, NPM 1 helps to ensure these children receive services necessary to prevent possible infant death. Through NPM 10, infant mortality resulting from motor vehicle crashes can be addressed through greater use of infant safety seats. Breastfeeding through the first six months of life and beyond (NPM 11) is associated with decreased morbidity and increased immunity. Activities focused on reducing cigarette smoking in the third trimester (NPM 15) and throughout the entire pregnancy will help to reduce poor birth outcomes that can contribute to infant death. NPM 17 helps to ensure that high risk deliveries occur in an environment that best supports infants who may have complicating conditions.
Reduce motor vehicle crash mortality among children ages 15 to 17 years	SPM 4		SPM 4 is worded to directly address this priority need.

List of Georgia's Priority Needs and Associated State and National Performance Measures			
Priority Need	State Performance Measures	National Performance Measures	Measuring Success
Decrease obesity among children and adolescents	SPM 1	NPM 14	SPM 1 is worded to directly address this priority need. The focus of the state performance measure is to reduce obesity among adolescents. However, interventions will need to be implemented prior to adolescence. The activity plan associated with SPM 1 will need to include activities in early and middle childhood and will need to address physical activity and nutrition. By contributing to reduced rates of obesity in early childhood, NPM 14 also contributes to success in meeting this priority need.
Reduce repeat adolescent pregnancy		NPM 8	This priority need will be addressed as an activity in NPM 8 activity plan.
Increase developmental screening for children in need	SPM 5		SPM 5 is worded to directly address this priority need. While the focus of the need is all children, SPM 5 limits the denominator to those children who are encountered through MCH programs.
Improve the MCH surveillance and evaluation infrastructure	SPM 3		SPM 3 is worded to directly address this priority need.
Improve childhood nutrition	SPM 1		While SPM 1 directly addresses obesity, improvements in childhood nutrition will contribute to reductions in obesity. This priority need will be addressed by ensuring that activities to improve childhood nutrition are included in the SPM 1 activity plan.
Increase awareness of the need for preconception health care among women of childbearing age	SPM 8	NPM 15 NPM 18	Several state and national performance measures can contribute to achieving success for this priority need. SPM 8 addresses folic acid consumption prior to conception. NPM 15 addresses cigarette smoking in the third trimester of pregnancy. By incorporating anti-smoking messages among child bearing age, NPM 15 can contribute to improvement in this priority need. NPM 18 addresses early entry into prenatal care. Early entry into prenatal care requires awareness and planning of pregnancy. Improved preconception messages to support NPM 18 will also positively impact this priority need.
Increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs	SPM 6		SPM 6 monitors the percent of pediatricians and family physicians with positive attitudes toward treating CSHCN. Provider willingness to care for CSHCN is central to ensuring adequate supply. Through activity plans associated with SPM 6, it is hypothesized that the percent of providers with positive attitudes can be increased, which may impact the supply of qualified providers serving CSHCN. Activities will equally focus on the existing provider community and students still matriculating in medical schools throughout Georgia.

SECTION 6: FEDERAL AND STATE OUTCOME MEASURES

NATIONAL OUTCOME MEASURES 1, 3, AND 4 – NEONATAL, POSTNEONATAL, AND INFANT MORTALITY RATES

National outcome measures 1, 3, and 4 address infant mortality, neonatal infant mortality, and postneonatal infant mortality rates. While there has been an overall decline between 1998 and 2007 in the infant mortality rate and neonatal mortality rate, postneonatal mortality rates have increased. Through the 2010 Needs Assessment, decreasing infant mortality and injury were added as a priority need. This led to the creation of State Performance Measures 2 and 7.

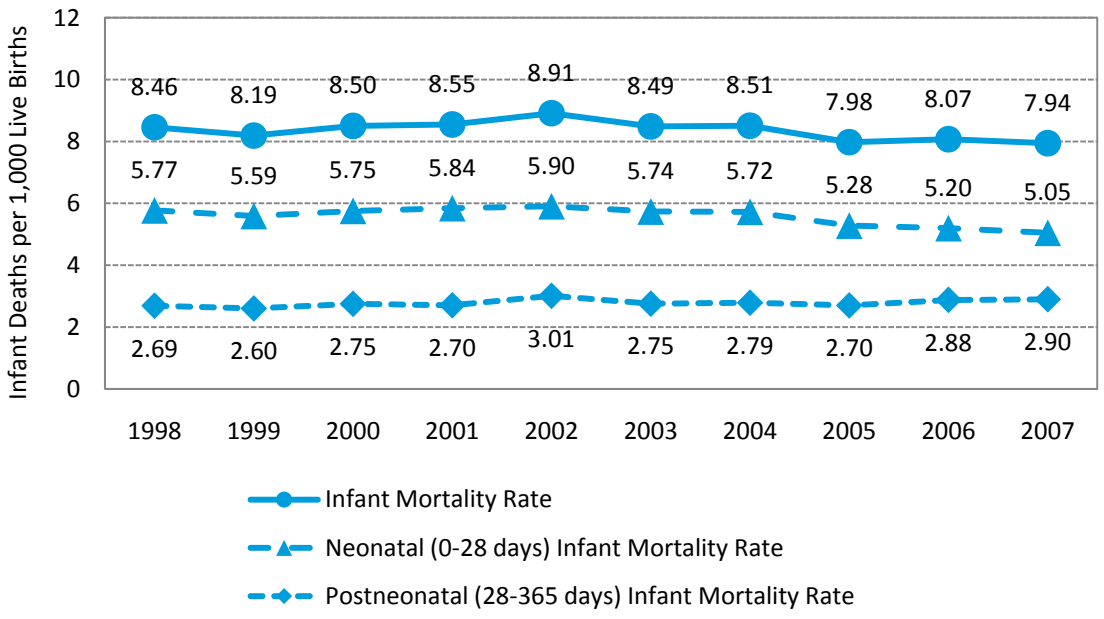
State Performance Measure 2 was limited to infant deaths occurring to infants born weighing at least 1,500 grams and surviving to the 27th day of life. This definition was created to correspond with the infant health cell of the perinatal periods of risk analysis. Between 1996 and 2007, 40 percent of all excess infant deaths were attributable to infant deaths meeting this definition. Activities associated with State Performance Measure 2 can address various threats to infant health and survival. These include infant safe sleep, exposure to second hand smoke, infant falls, and appropriate use of car seats.

State Performance Measure 7 seeks to support those infants delivered weighing less than 1,500 grams. These infants are at the greatest risk for infant mortality and, following discharge, these infants present unique care and developmental challenges. Home visitation can provide support to parents and increase the likelihood of infant survival.

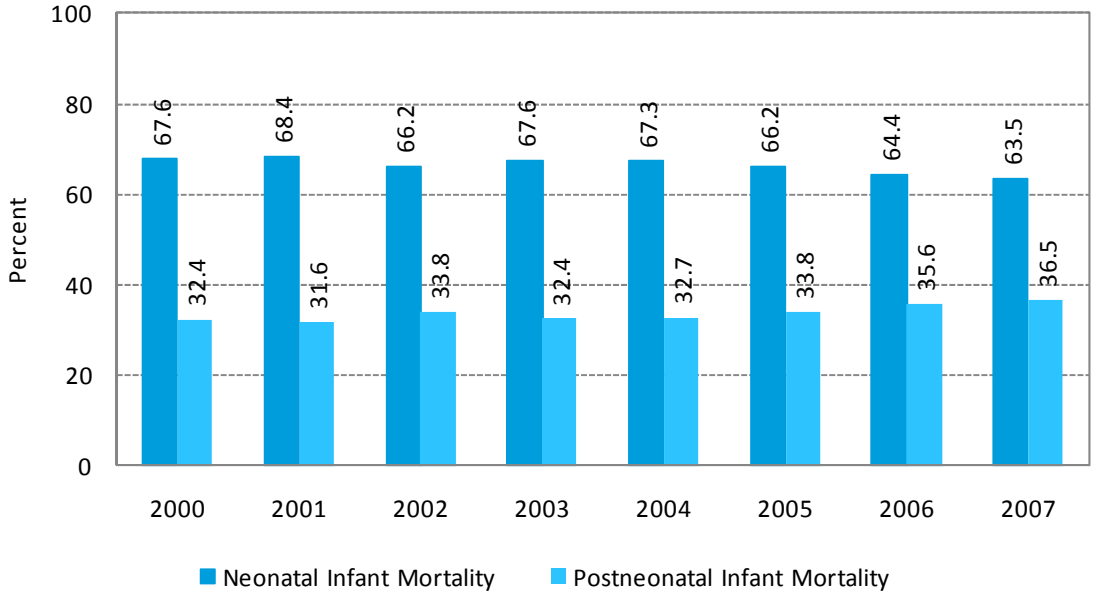
Several national performance measures can also contribute to reductions in this outcome measure that include National Performance Measures 1, 10, 11, 15, and 17. The activities associated with National Performance Measure 11 will help to reduce morbidity and mortality through improved breastfeeding initiation and duration. Through National Performance Measure 10, Title V distributes infant and child car seats. Through the Teddy Bear Sticker program, Georgia Title V can track those car seats involved in accidents and have a direct measure of lives saved. Activities associated with National Performance Measure 10 have potential to prevent neonatal and postneonatal deaths. Activities associated with National Performance Measure 15 can help reduce poor birth outcomes often associated with infant death. By ensuring that high risk infants are delivered at facilities that have the expertise to ensure optimal care is delivered, the associated activities can contribute to reductions in neonatal infant mortality rates.

The MCH Program has established partnerships with internal and external partners necessary to impact infant mortality rates in Georgia. Internally, this includes partnerships with the Georgia Family Planning Program, Georgia WIC, the Maternal and Child Health Epidemiology Section, the Children 1st program, and the 18 public health districts. Externally, this includes partnerships with the Georgia Chapter of the American Academy of Pediatrics, the Georgia Chapter of the March of Dimes, the Georgia Obstetrical and Gynecological Society, Georgia Academy of Family Physicians, the HRSA-funded Healthy Start sites throughout Georgia, and other advocacy and statewide service organizations throughout Georgia. Other state agencies that can contribute to reductions in infant mortality include the Division of Family and Children Services and the Governor's Office for Children and Families. By leveraging these existing partnerships, Georgia can develop and implement strategies and interventions that can impact these national outcome measures.

Infant Mortality, Neonatal Infant Mortality, and Postneonatal Infant Mortality by Year, Georgia, State Vital Records 1998 through 2007



Distribution of Infant Mortality by Neonatal and Postneonatal Mortality by Year, Georgia State Vital Records 2000 through 2007

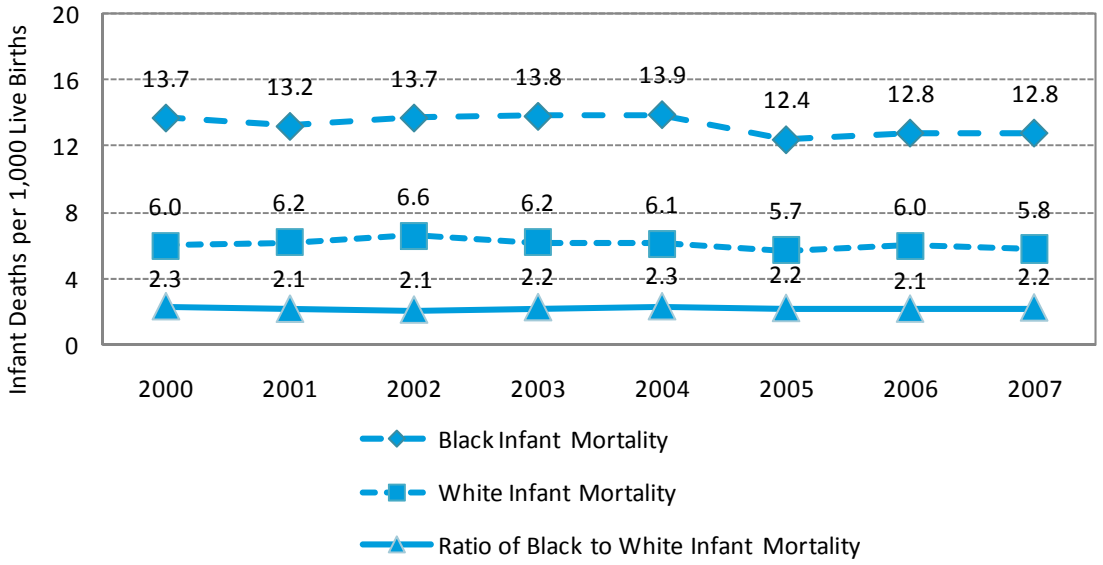


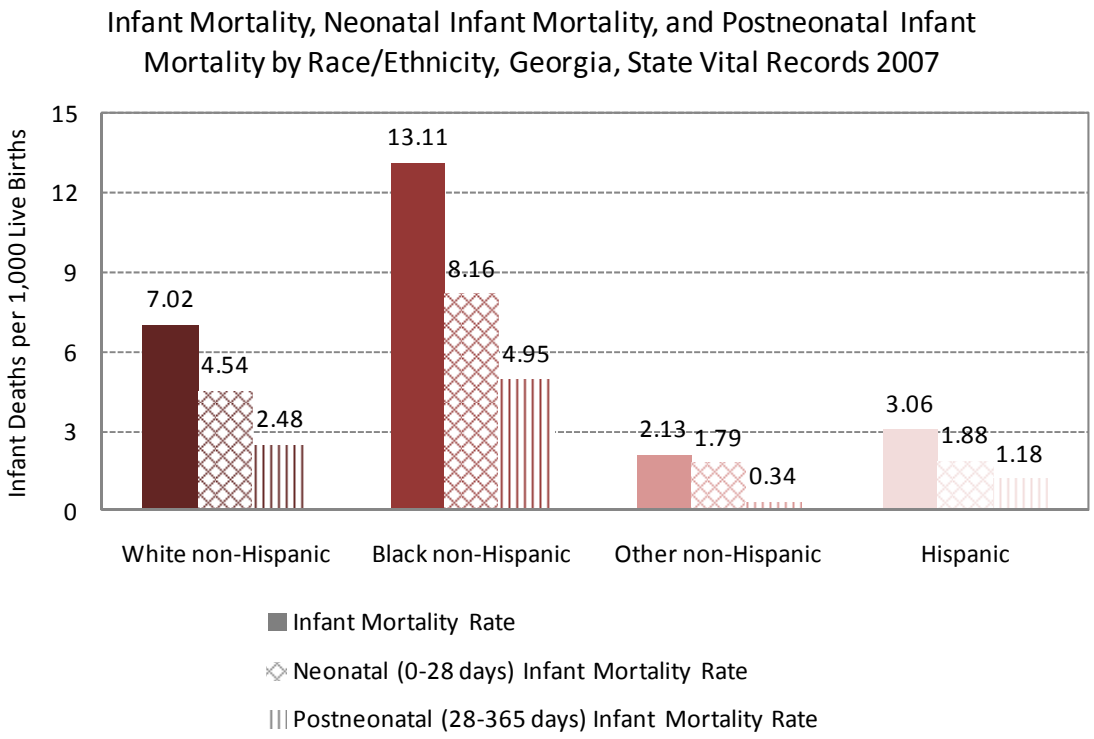
NATIONAL OUTCOME MEASURE 2 – RATIO OF THE MORTALITY RATE AMONG BLACK INFANTS TO THE MORTALITY RATE AMONG WHITE INFANTS

National Outcome Measure 2 addresses the ratio between infant mortality among Black infants compared to White infants. The ratio of the infant mortality rate among Black infants to the infant mortality rate among White infants has remained consistent from 2000 through 2007. The ratios for neonatal and postneonatal infant mortality are similar to ratio for overall infant mortality. The proportions of neonatal and postneonatal mortality rates within race are similar for White and Black infants.

Many of the activities and capacity discussed in the previous section (National Outcome Measures 1, 3, and 4) apply to National Outcome Measure 2. However, as Georgia moves forward to address infant mortality, increased emphasis will be dedicated to targeting and tailoring strategies specifically to reach Black mothers, families, and infants. To aid in this effort, an analysis will be conducted to determine differences in infant deaths between Black and White infants. This analysis will include the use of the perinatal periods of risk framework.

Infant Mortality among White Infants and Black Infants and the Ratio of Infant Mortality among Black Infants as Compared to White Infants by Year, Georgia, State Vital Records 2000 through 2007



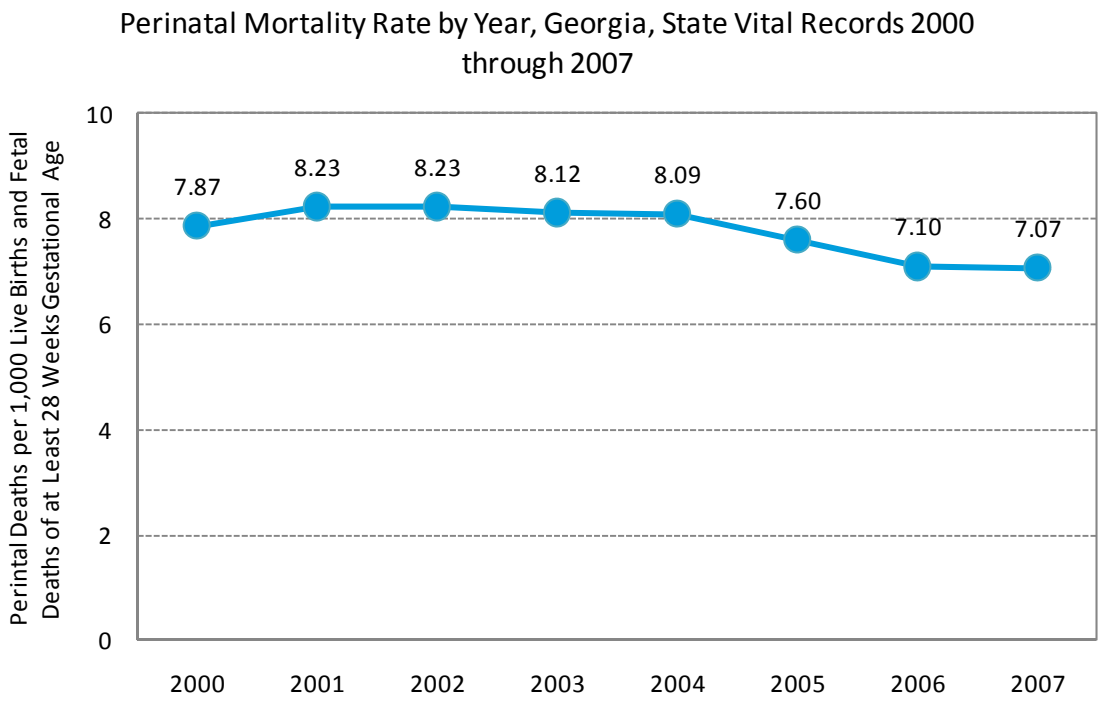


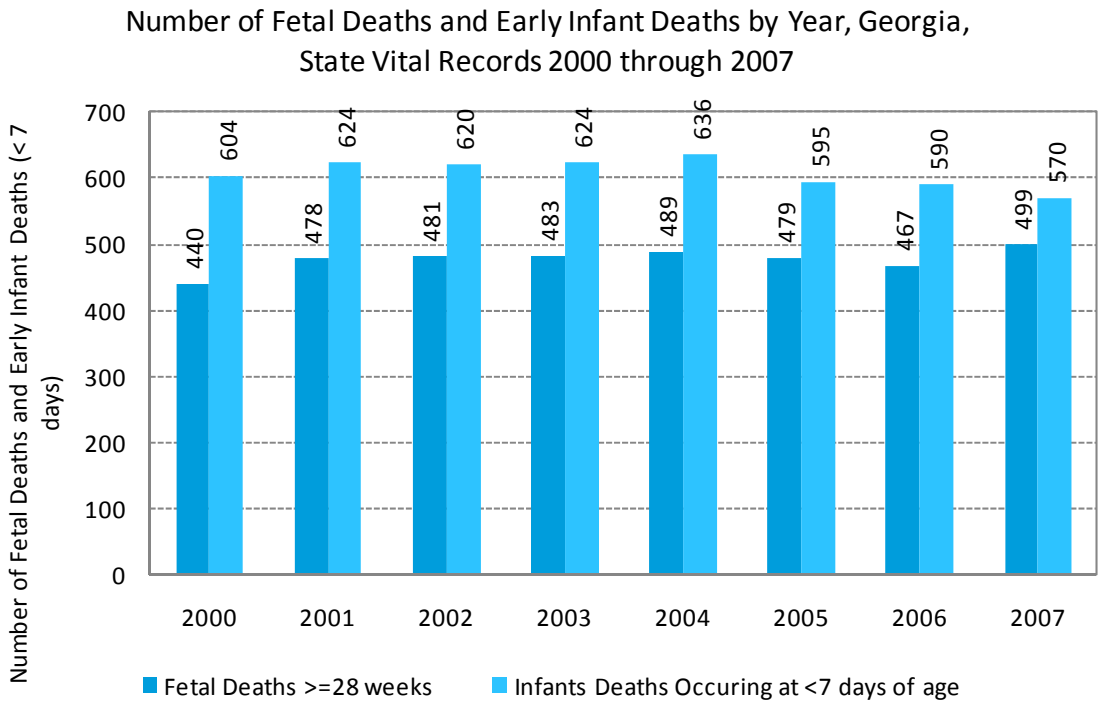
NATIONAL OUTCOME MEASURE 5 – THE PERINATAL MORTALITY RATE

National Outcome Measure 5 addresses the perinatal mortality rate. The three most recent years for which data are available are the lowest three perinatal mortality rates from 2000 through 2007. On average, annually, there are 477 fetal deaths of at least 28 weeks gestational age and 608 infant deaths within the first seven days of life.

Given the age at death, these are deaths that are best addressed through improved preconception health, improved high risk referral, and improved health behaviors. Improving messages pertaining to preconception health is a priority need for Georgia. State Performance Measure 8 seeks to increase folic acid consumption, which is a key component of preconception health. It is anticipated that increasing rates of folic acid consumption would serve as a marker for an overall increase in understanding and uptake of the broader preconception health message. To contribute to declines in the perintal mortality rate, the MCH Program can leverage client contacts in the Georgia WIC Program and the Family Planning Program to ensure broad distribution of standard preconception messages that include, but are not limited to, increased folic acid consumption.

National Performance Measures 17 and 18 address improved high risk referral and adequacy of prenatal care. Georgia plans significant work in the area of improved high risk referral to address the current practice of facilities self-designating their ability to care for high-risk deliveries. A project is underway to use objective standards to classify facilities, determine changes in facility perinatal care level based on the objective criteria compared with self-designation, and examine birth outcomes using the objective criteria compared to the subjective criteria.


Perinatal Mortality Rate by Year, Georgia, State Vital Records 2000 through 2007
Perintal Deaths per 1,000 Live Births and Fetal Deaths of at Least 28 Weeks Gestational Age
10
8
6
4
2
0
7.87
8.23
8.23
8.12
8.09
7.60
7.10
7.07
2000
2001
2002
2003
2004
2005
2006
2007


Number of Fetal Deaths and Early Infant Deaths by Year, Georgia, State Vital Records 2000 through 2007
Number of Fetal Deaths and Early Infant Deaths (< 7 days)
700
600
500
400
300
200
100
0
440
604
478
624
481
620
483
624
489
636
479
595
467
590
499
570
2000
2001
2002
2003
2004
2005
2006
2007
Fetal Deaths >=28 weeks
Infants Deaths Occuring at <7 days of age

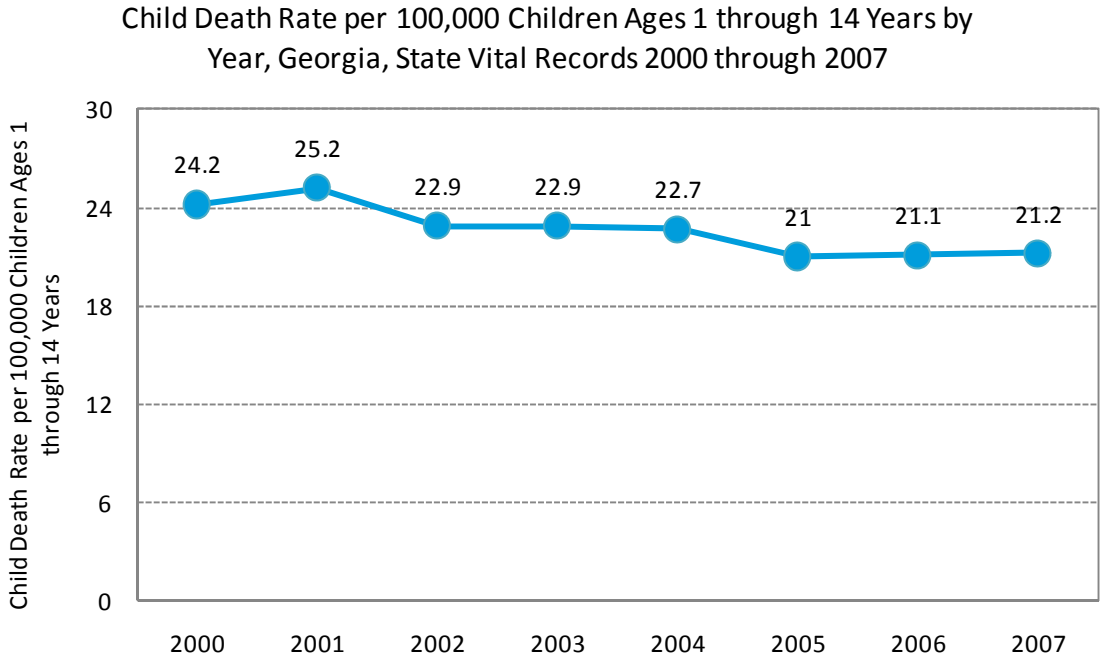
NATIONAL OUTCOME MEASURE 6 – CHILD DEATH RATE AMONG CHILDREN AGES 1 THROUGH 14 YEARS

From 2000 through 2007, there are approximately 400 deaths annually among children ages 1 through 14. For the most recent three years of data, the child death rate has been less than 21.5 deaths per 100,000 children 1 through 14 years of age. However, for the most recent two years of data, the rate increased.

NPM 10 addresses motor vehicle crash mortality, which is the leading cause of child death. Improved collaboration between the MCH Program, Injury Prevention Program, and Division of Family and Children Service can help to ensure that training in car seat installation is widely available to all providers who interact with young children and there are car seats available for distribution to families in need.

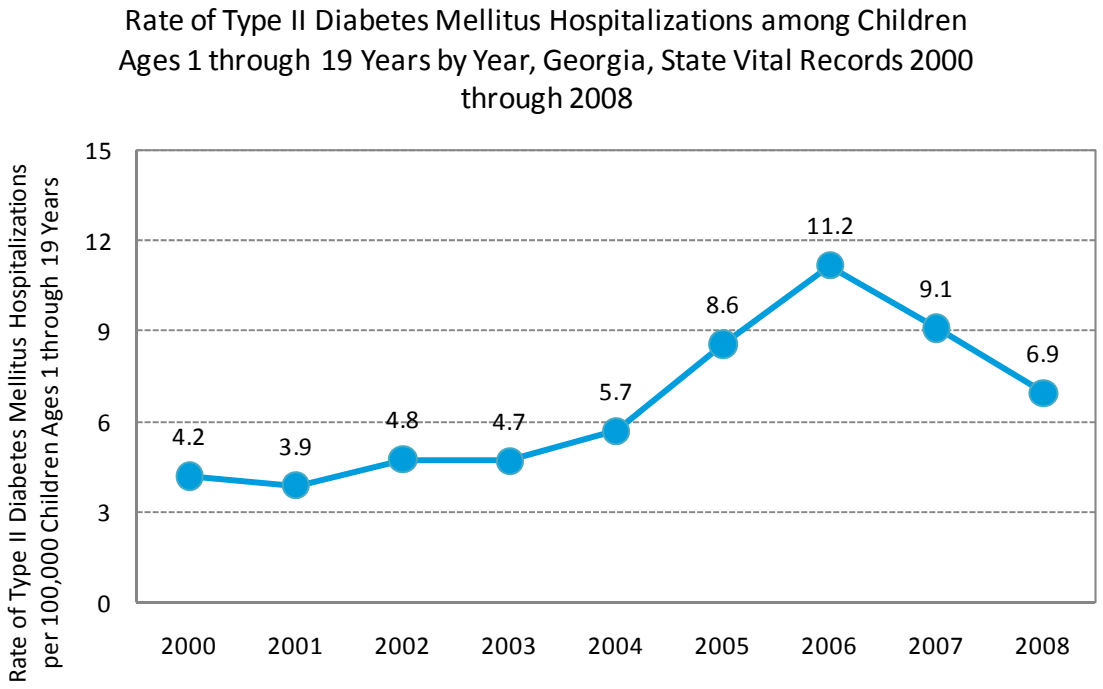
Other health promotion and disease prevention programs contribute to reduced child deaths that result from other causes. Programs that include, but are not limited to, nutrition, breastfeeding, newborn screening, poison control all contribute to reduced child death.

New partnerships will also contribute to reduced child death. Emerging partnerships with the emergency medical community will present opportunities to reduce child death from motor vehicle crashes and other causes. By improving the understanding of the circumstances of child death among MCH and Division of Public Health programs through enhanced communication and information sharing with the Georgia Child Fatality Review Program, new interventions and strategies can be implemented that can contribute to reductions in child death.



STATE OUTCOME MEASURE 1 – RATE OF TYPE II DIABETES HOSPITALIZATIONS AMONG CHILDREN AGES 1 THROUGH 19 YEARS

The intent of State Outcome Measure 1 was to measure a repercussion of the growing obesity epidemic among children in Georgia. While the overall rate has increased, which may be a result of increasing obesity, this measure has a limitation that makes interpretation difficult. The ICD-9 code for diabetes mellitus is 250 with fifth and sixth digit coding available to provide increased diagnostic specificity. To populate this measure, ICD-9 codes with the following fifth and sixth digits were excluded from the numerator: 01, 03, 11, 13, 21, 23, 31, 33, 41, 43, 51, 53, 61, 63, 71, 73, 81, 83, 91, and 93. Even with these exclusions, the ICD-9 250 codes remain a heterogeneous mix of diabetes types. Therefore, interpreting these data as pediatric type II diabetes mellitus may not be completely accurate; therefore, the hypothesis that increases in this measure relate to increased in pediatric obesity rates may be flawed. State Outcome Measure 1 will be retired in the FY11 Title V MCH Services Block Grant application. No new state outcome measures will be included for the upcoming five-year cycle to allow the MCH Program to focus on existing priorities and improvements.



APPENDIX A: FOCUS GROUP GUIDE

FOCUS GROUP PROTOCOL GUIDE

January - March 2010

Collecting Stakeholder and Consumer Input on Needs in the MCH and CSHCN Populations

Maternal and Child Health Program

Division of Public Health

Georgia Department of Community Health

BACKGROUND AND PROJECT GOALS

As part of the 2011 Title V Block Grant Application, the recipient of Title V funds in Georgia – the Maternal and Child Health Program in the Division of Public Health in the Department of Community Health – is required to complete a state wide needs assessment. This needs assessment occurs every five years and serves as a cornerstone for strategic planning and activity development to improve the health status of the maternal and child (MCH) population. Through the needs assessment process, the public health and health care needs of three distinct populations – (a) pregnant women, mothers, and infants (b) children and adolescents and (c) children with special health care needs (CSHCN) – will be identified. Through focus groups throughout Georgia, consumers, providers, advocates, stakeholders, and local public health officials will have an opportunity to offer their comments and opinions about the public health and health care needs of (a) pregnant women, mothers, and infants (b) children and adolescents and (c) CSHCN and help to define the scope of the perceived need throughout Georgia. This training guide explains the processes and protocols for conducting focus groups as part of the needs assessment process and helps to ensure consistency throughout the focus group process.

DEFINING A FOCUS GROUP

For the purposes of this needs assessment, a focus group will be understood to be a free-flowing interactive discussion facilitated in a comfortable, nonthreatening atmosphere. Through these focus groups, consumers, providers, advocates, stakeholders, and local public health officials can reveal their thoughts and opinions on a thematic area and discuss local issues, challenges, and needs centered on that specific thematic area. The size of any one focus group should not exceed 20 participants. The length of any one focus group should not exceed two hours in length.

FOCUS GROUP CONTENT

Focus groups will be held that specifically address the MCH population, and will focus on two specific populations – pregnant women, mothers, and infants and children and adolescents – and the CSHCN population. Sessions for the MCH population may include discussion of the CSHCN population as per definition since the MCH population is inclusive of CSHCN. Separate sessions specific to the CSHCN population will ensure that the needs and opinions of this group, which is relatively small in size in comparison to the MCH general population, are captured.

WHERE WILL SESSIONS BE CONDUCTED

Children with Special Health Care Needs

There will be seven community focus groups that will focus solely on the needs of children with special health care needs. Invitees to these groups will be primarily parents and families of children with special health care needs. Five of these focus groups will be conducted in English and two will be conducted in Spanish. These focus groups are scheduled to occur in Waycross, Clayton, Norcross, Macon, and Statesboro. There will also be two technology-enabled sessions, with utilization of a videoconference system, VICS and phone-in with written submissions. Participants in the technology-enabled sessions will include:

- Program Coordinators from the Babies Can't Wait and Children's Medical Services from DeKalb, East Metro, Dalton, Macon, Dublin, and Valdosta

Maternal and Child Health including Children with Special Health Care Needs

There will be nine community focus groups that will focus on the maternal and child health population including children with special health care needs. There will be six sessions to which families, advocates, and providers will be invited. These sessions will be held throughout Georgia in Augusta, Rome, Columbus, Clayton, and Waycross. A session in Clayton will be conducted in Spanish. There will also be several sessions conducted via the videoconference system, VICS. Participants in the VICS sessions will include:

- Health District Nursing Directors from Waycross, Valdosta, Columbus, LaGrange, Savannah, Clayton, and DeKalb
- Program Coordinators from WIC from DeKalb, East Metro, Dalton, Macon, Dublin, and Valdosta
- District Health Directors, MCH Program Managers or other interested staff invited from all Health Districts

In addition to the focus groups noted, there will be two special focus group sessions held to engage healthcare service, advocacy and governmental organizations. One special session for non-governmental advocacy and service organizations will be hosted and facilitated by Georgia's new MCH Director. This session will be held in Atlanta, Georgia where many statewide organizations are headquartered. There will also be one special session to engage the steering committee of Georgia's Early Childhood Comprehensive System (ECCS) in the Title V needs assessment. These sessions will be the only focus groups allowed to exceed twenty participants with modifications to the protocol as necessary to accommodate the venues and number of participants.

WHO WILL CONDUCT THE FOCUS GROUPS

Each focus group will be conducted by a two-person team that includes a facilitator and a recorder. The role of the facilitator will be to operate the focus group. The facilitator will make the initial introductions, initiate "small talk" at the beginning of each session, explain confidentiality of the session, and lead the discussion. The facilitator will be responsible for flip-charting during the course of the conversation as an aid to discussion and a record of key conversation points. Periodically, the facilitator should verbally summarize the flip-charting points for the participants to ensure that s/he is accurately capturing their comments.

The recorder will be responsible for greeting participants and distributing and collecting the participant information sheets. Once the focus group begins, the recorder will take necessary notes to capture the essence of the conversation.

For the recorder and facilitator, direct quotes will add significant depth to the qualitative data. The facilitator and recorder should be listening and capturing appropriate direct quotes.

CONDUCTING THE FOCUS GROUPS

This section describes in detail the various steps for setting up, conducting/facilitating and wrapping up the focus groups which are conducted in-person (i.e., not technology-enabled). Modifications for sessions conducted via videoconferencing are noted. Focus group handouts are available in English and Spanish, and will be used as appropriate to the audience.

During the Session

Arrival

1. Get in contact with the person in charge of providing your team the room/facilities for the session. Be sure to ask this person (if you have not already while setting up the session) about important details, such as the time that the facility closes, access to power, and bathroom locations. Arrive early for videoconference sessions, to allow time for connection checks with the VICS videoconference sites.
2. Set up the flip charts. Set up a place for the staff who will be taking notes throughout the session.
3. Rearrange the room (as necessary) to ensure that participants can see and hear the discussion and can comfortably participate.
4. Ensure that adequate numbers of the Title V Information Sheet, Participant Information Sheet, and Participant Contact Sheet are available. Sessions conducted via VICS videoconferencing require advance distribution of these participant materials.

Getting Ready

1. Greet participants politely and cheerfully, distribute (or, for sessions conducted via videoconference, confirm receipt of) the Title V information sheet, the participant information sheet, and the contact sheet. Encourage people to take refreshments (when available) and to be seated.
2. Organization of the seating arrangements (when seating is not optimally organized in a venue) and all set up needs to occur before the session begins while the participants are getting refreshments.
3. Collect all participant information sheets. Sessions conducted via VICS videoconferencing require follow-up collection of the sheets, consistent with advance directions provided to participants.
4. Accommodate all the late-comers in the session although you need to close the door of the facility once the session starts. The recorder should keep an eye on late arrivals and make sure that they receive and complete the participant information sheet and receive the Title V Information Sheet.

FACILITATING THE SESSION

Getting Started

Officially welcome all the participants and thank them for taking the time out of their busy schedule. Use the following introductory script for the participants:

> "Hello my name is _____ and I will be facilitating today's focus group. Working with me is _____ who will be serving as a note keeper. We are working with the Georgia Department of Community Health, Division of Public Health to help them identify what is needed to improve the

health of women, infants, children, including children with special health care needs, and families in Georgia.

We would like the discussion to be informal, so there's no need to wait for us to call on you to respond. In fact, we encourage you to respond directly to the comments other people make. If you don't understand a question, please let us know. We are here to ask questions, listen, and make sure everyone has a chance to share.

If we seem to be stuck on a topic, we may interrupt you and if you aren't saying much, we may call on you directly. If we do this, please don't feel bad about it; it's just our way of making sure we obtain everyone's perspective and opinion is included.

Your comments will be combined with the comments from other groups throughout the state to identify the public health and health care needs of women, infants, children, including children with special health care needs, and families in Georgia."

Ensuring Respect and Confidentiality

Prior to beginning the focus group, the facilitator should be sure to stress the following:

"It is very important that we are able to hear from everyone today and that everyone feels that their ideas and comments are respected by others. While we may not all agree, it is important that we have a respectful conversation. While disagreement is natural and can add to the depth of our conversation, it is important to remember not to criticize others for their beliefs. Please let's also agree to keep each other's identities, participation, and remarks private. Everything you tell us will be treated as confidential and quotes will not be attributed to any participants in the reports we will develop following these sessions. We hope you'll feel free to speak openly and honestly."

Distributing and Collecting the Participant Information Sheet

All participants must complete the Participant Information Sheet (page 9). The Participant Information Sheet should be distributed at the start of the session and collected as participants depart, unless it is a session conducted via VICS videoconferencing system. The recorder has the primary responsibility for collecting all Participant Information Sheets. Even if a participant chooses not to complete the form, it must be collected and a check placed in response to the first question to ensure an accurate participant count. Videoconference sessions require advance distribution of the sheet, and follow-up collection of the completed information.

Distributing and Collecting the Participant Contact Sheet

Public input is required as part of the Title V Block Grant application process. To help ensure that public comment is captured as part of our application process, the Participant Contact Sheet (page 10) has been included so that participants who may want to be part of the review activities can be included. Videoconference sessions require advance distribution of the sheet, and follow-up collection of the completed information.

When explaining and asking participants to complete the Participant Contact Sheet, please use the following script:

> "As part of the Title V Annual Block Grant Application, it is very important that we receive input from families and stakeholders like you. To help ensure that we receive input on our Title V Annual Block Grant Application, we would like to invite anyone who is interested to remain involved in the Title V Annual Block Grant application process by completing the Participant Contact Information Sheet so that we may contact you in the future to be part of the application review process. The review process will include public hearings and comment sessions and will be accessible by telephone and/or through the internet. We will not use the information that you provide for any other purpose that to include you in our application review process."

Distributing Title V Information Sheet

Distribute and review the Title V Information Sheet (page 11) with all participants prior to beginning the session.

Setting Ground Rules

Set the following ground rules for the session:

If MCH session,

> "We have roughly 60 minutes to listen to your thoughts about these two areas: the needs in your locality for women including mothers and pregnant women; needs in your locality for infants, children and adolescents 1-21 which may also include the needs of children with special health care needs. We want to be sure that each one of you has a chance to participate and we will spend about 30-35 minutes on each of these topics. We will try to capture your thoughts on the flipchart."

If CSHCN session,

> "We have roughly 60 minutes to listen to your thoughts about the needs in your locality for children with special health care needs. To help us start from the same place, I first want to review the definition of a child with a special health care need. As defined by the federal Maternal and Child Health Bureau, a child with a special health care need is defined as those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally. The special health care needs of children range in severity from issues such as asthma to profound physical and emotional limitations.

If VICS videoconference session,

> "We are pleased to have your participation in the focus group through VICS, our videoconference system. We will conduct this focus group following some special protocol to ensure everyone has opportunity to participate. We will specifically call upon each VICS site by name and invite people there to share their responses to each of the focus group questions. We will call upon each site

starting with the sites in North Georgia, and travelling south, concluding each round with the sites in South Georgia. After people at each site have had opportunity to respond to a question, and also hear the comments from all the other sites, we will "open the floor" for any additional comments. This will provide you an opportunity to respond to something someone else said, so please listen carefully, and jot down notes or thoughts as we hear from people at VICS sites throughout the state. If we become disconnected or you experience technological difficulties, please call us at this number _____. Are there any questions about the process before we begin?"

Beginning the Session

Session should proceed as follows:

1. Start the discussions following the major broad questions mentioned in the Focus Group Questions section below. Please note that there are really no strict set questions in the protocol that you need to rigidly follow because the focus groups are aimed at letting the respondents freely provide information in an unrestricted environment. Videoconference sessions require a slight modification to this approach, with the facilitator calling on each site by name to specifically invite responses from participants.
2. Your task as the facilitator is to make them feel comfortable so that they could speak freely and make sure that the discussion is taking place within the contours of the thematic areas. You need to make sure that all the participants get a fair share of their opportunity to talk during the time slot allotted for discussions and all the information they provide get appropriately captured in the flip charts or boards and summarized for everybody's benefit when needed.
3. While you facilitate the session, encourage all the participants to voice their thoughts and opinions, but try to keep a sense of control of the entire session and do not allow one or two people to dominate the session. This will be achieved by encouraging each member to voice one or two points, and then letting others talk. Remind them when needed that you will return to people for more feedback but you want all the participants to have an opportunity to talk.
4. Try to make a mental note on who said what and use that in your sum-ups so they feel welcomed and appreciate that you have been alert and receptive to their opinions. Do not cite anybody by their names.
5. While facilitating the discussions, please try to be very inclusive in your approach with the whole group of participants.

Wrapping Up the Session

1. Thank the participants and offer to answer any remaining questions.
2. Provide participants with the contact information for the Title V Director (Brian Castrucci, Title V Director and Director for the MCH Program, Telephone: 404-657-2851, Email: bccastrucci@dhr.state.ga.us) and let them know that they may contact the Title V Director with any questions about the focus groups or the Title V Block Grant.
3. Make sure that you have collected the Participant Information Sheet from all participants, or have communicated the collection procedure if it is a technology-enabled session.
4. Make sure that you have collected the Participant Contact Sheet from all interested participants, or have communicated the collection procedure if it is a technology-enabled session.
5. Facilitator collects flip chart.

6. If notes were taken on paper, recorder ensures that s/he has all notes. If notes were entered directly to a laptop, recorder ensures that two copies have been saved using two different file names.
7. Make sure that you follow the proper protocol for the rented facilities (cleaning up, locking up, informing authorities that you are done and thanking them, handling any necessary paperwork etc.) before leaving the venue.

FOCUS GROUP QUESTIONS

Key Questions

MCH Sessions, ask the following questions:

- In your communities, what do you think are the major health concerns for women including mothers and pregnant women?
- In your communities, what do you think is needed to improve the physical and mental health of women including mothers and pregnant women?
- In your communities, what do you think are the major health concerns for infants, young children, and adolescents including children with special health care needs?
- In your communities, what do you think is needed to improve the physical and mental health of infants, young children, and adolescents including children with special health care needs?

CSHCN Sessions, ask the following questions:

- In your communities, what do you think are the major health concerns for children with special health care needs?
- In your communities, what are the necessary services, including support services and clinical services, and providers that are not available for children with special health care needs? Are these services, including support services and clinical services, and providers available elsewhere in the state?
- In your communities, what do you think is needed to improve the physical and mental health of children with special health care needs?

Probing Questions

Please note that probing or prompting questions should be used to keep the discussion moving, promote full participation, stay within the time frames for each topic, and seek clarification on statements made by participants. When a problem or a need area is brought up by the participants, try to explore the problem deeper with questions like:

- "Why do you think this issue is a problem?"
- "What is the impact of this issue on people's health?"
- "Describe the nature of this problem/need?"
- "What are the various aspects of this problem?"
- "Are there other problems inherently related to this problem?"
- "What are some ways we could fix this issue?"

If the participants do not come up with enough issues related to a specific topic area and you have time in hand, you could ask,

- "Have any of the challenges you mentioned changed over time (or recently)?"
- "How?"

If only one issue (e.g., issue X) comes up in a session and you have listened enough on that issue, try to change the direction of the discussions to a possible new problem that the participants might bring up. Ask,

- "We have listened about issue X. Would you like to talk about other existing problems for these populations in your community? Let us hear about some other problems."

At the end of the discussions when you summarize the information from the flip charts for the participants, try to verify each need statement with the participants. For example, if shortage of medical providers in a community has been stated as an area of need for pregnant women, the need will be "to increase the number of medical providers for pregnant women." So, your question will be "Since you mention shortage of medical providers for pregnant women a problem in your community, there is obviously the need to increase the number of providers, right?" Note that the participants might come up with other related needs for a specific problem.

DEBRIEFING AND PREPARING THE DATA FOR SUBMISSION

Within 24 hours of completion of the focus group, the facilitator must:

1. Review the notes from the flip charts taken during the session.
2. Copy the information included on the flip charts into an electronic document using MSWord.
3. Complete the facilitator debriefing form (MCH – pages 12 – 13; CSHCN – page 18).

Within 24 hours of completion of the focus groups, the recorder must:

1. Review and edit notes collected during the session.
    a. If notes were recorded on laptop, review notes to add detail or clarity when necessary.
    b. If notes were taken on paper, notes are to be entered into MSWord. Detail and clarity can be added when necessary through this transcription process.
2. Complete the recorder debriefing form (MCH – pages 14 – 15; CSHCN – page 19).

Within 72 hours, the facilitator and recorder must:

1. Meet in-person or via telephone.
2. Review the debriefing forms prepared by each person.
3. Discuss any discrepancies in perceptions of the focus groups.
4. Complete the final debriefing form (MCH – pages 16 – 17; CSHCN – page 20) by combining all agreed upon elements from the facilitator debriefing form and the recorder debriefing form.

Facilitation teams conducting sessions in Spanish will follow the protocol for debriefing and preparing data as noted, with one additional requirement.

1. Translate the final debriefing form and notes into English.

2. Facilitation teams are allowed an additional 48 hours to complete this step.

SUBMITTING MATERIALS

Complete the Submission Checklist Form (page 21). Ensure all documents are included. Submit via US mail or other delivery service to:

Dr. Diane Schlachter
475 Nottingham Drive
Marietta, Georgia 30066

While the debriefing forms may be completed electronically, all materials listed on the Submission Checklist Form must be printed and submitted in one package. This will more easily allow for verification that all materials were submitted. Please be sure to send via a method that is traceable (e.g., FedEx, US Express Mail, etc.).

PARTICIPANT INFORMATION SHEET

____ **Please check here if you participated in today's session, but do not want to answer any of the questions below.**

Which of the following describes you? (Choose all that apply)

____ Parent of a child with special health care needs
____ Someone who received services from a public clinic or health department
____ An adolescent
____ A public health advocate
____ Women of child bearing age but not a parent
____ Parent of a child without special health care needs
____ A service provider (e.g., nurse, social worker, doctor, etc.)
____ Other. Please specify: _____

What is your gender? ____ Male ____ Female

What is your county of residence? _____

In your opinion, how do you think the health of the women and children of Georgia compare to other states?

____ Better in Georgia
____ About the same in Georgia as anywhere else
____ Worse in Georgia

Which of the following best describes you? (Please select only one answer)

____ White ____ Black or African American
____ Hispanic ____ Other: _____

What is your primary or main source of payment for your child's care?

____ Medicaid ____ Peach Care
____ Private Insurance ____ Tri Care
____ Uninsured ____ Other: _____

How would you describe your child's or children's special needs. Check all that apply.

____ I am not the parent of a child with special health care needs.
____ Child has functional limitations (difficulties walking, talking, eating, performing daily activities)
____ Child's condition is managed by prescriptive medicines only.
____ Child's condition requires more medical visits or special education or therapy than the typical child

PARTICIPANT CONTACT SHEET

As part of the Title V Block Grant application process, it is very important that public comment on the application is solicited and received. To help ensure that public comment is captured as part of our application process, we would like to be able to contact you to participate in future public hearings and comment sessions regarding the Title V Block Grant and associated activities. These public hearings and comment sessions will be accessible by telephone and/or through the internet. If you would like to participate in these upcoming sessions or learn more about the Title V Block Grant in the State of Georgia, please enter your information below.

Name _____

Address _____

City _____ Zip Code _____

Telephone Number _____

E-mail Address _____

_____ Please check here if you would like to participate in future meetings about the Title V Block Grant and/or the health status of the maternal and child health populations in Georgia.

Title V Block Grant Information Sheet

What is Title V?

When the Social Security Act was passed in 1935, the Federal Government, through Title V, pledged its support of State efforts to extend and improve health and welfare services for mothers and children. The goal of the Title V block grant is to:

> *Improve the health of all mothers and children consistent with the applicable health status goals and national health objectives established by the Secretary of the U.S. Department of Health and Human Services.*

The purpose of the Georgia Title V Program is to address the overall intent of the Block Grant to improve the health of all mothers, women of childbearing age, infants, children, adolescents and children with special health care needs (CSHCN). The state of Georgia has responsibility to provide and assure access to quality maternal and child health (MCH) services for mothers and children; provide and promote family-centered, community-based, coordinated systems of care for CSHCN and their families; and facilitate the development of community-based systems of care for the MCH and CSHCN populations.

What are the three populations served by the Title V Block Grant?

The three populations served by the Title V Block Grant include pregnant women, mothers, and infants; children and adolescents; and children with special health care needs.

What types of services or activities does Title V support?

Title V funds are used to design and implement a wide range of maternal and child health programs. Although specific initiatives may vary from year to year, examples of initiatives include increasing immunization rates, decreasing childhood injury, ensuring access to comprehensive perinatal care, and ensuring the availability of comprehensive care for children with special health care needs. Title V accomplishes it goals through collaboration with partners in state and local government and child advocacy organizations and with stakeholders and consumers.

What is the Title V Needs Assessment?

States that receive funding through the Title V Block Grant are required to complete a statewide needs assessment every five years. By reviewing information that is gathered from population surveys, services providers, partners, stakeholders, and families, the goal of the assessment is to prioritize the public health needs of the three populations served by the Title V Block Grant.

If you have additional questions about Title V in Georgia, please contact:

Brian C. Castrucci, MA
2 Peachtree Street, NW
Atlanta, GA 30303
Telephone: (404) 657-2851;
Email: bccastrucci@dhr.state.ga.us

FACILITATOR DEBRIEFING FORM – MCH SESSIONS

What were the primary themes for the question: *In your communities, what do you think are the major health concerns for women including mothers and pregnant women?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what do you think is needed to improve the physical and mental health of women including mothers and pregnant women?*

Provide any direct quotations from the focus groups that support these themes.

FACILITATOR DEBRIEFING FORM – MCH SESSIONS

What were the primary themes for the question: *In your communities, what do you think is needed to improve the physical and mental health of women including mothers and pregnant women?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what do you think are the major health concerns for infants, young children, and adolescents?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what do you think is needed to improve the physical and mental health of infants, young children, and adolescents?*

Provide any direct quotations from the focus groups that support these themes.

RECORDER DEBRIEFING FORM – MCH SESSIONS

What were the primary themes for the question: *In your communities, what do you think are the major health concerns for women including mothers and pregnant women?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what do you think is needed to improve the physical and mental health of women including mothers and pregnant women?*

Provide any direct quotations from the focus groups that support these themes.

RECORDER DEBRIEFING FORM – MCH SESSIONS

What were the primary themes for the question: *In your communities, what do you think is needed to improve the physical and mental health of women including mothers and pregnant women?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what do you think are the major health concerns for infants, young children, and adolescents?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what do you think is needed to improve the physical and mental health of infants, young children, and adolescents?*

Provide any direct quotations from the focus groups that support these themes.

FINAL DEBRIEFING FORM – MCH SESSIONS

What were the primary themes for the question: *In your communities, what do you think are the major health concerns for women including mothers and pregnant women?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what do you think is needed to improve the physical and mental health of women including mothers and pregnant women?*

Provide any direct quotations from the focus groups that support these themes.

FINAL DEBRIEFING FORM – MCH SESSIONS

What were the primary themes for the question: *In your communities, what do you think are the major health concerns for women including mothers and pregnant women?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what do you think is needed to improve the physical and mental health of women including mothers and pregnant women?*

Provide any direct quotations from the focus groups that support these themes.

FACILITATOR DEBRIEFING FORM – CSHCN SESSIONS

What were the primary themes for the question: *In your communities, what do you think are the major health concerns for children with special health care needs?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what are the necessary services, including support services and clinical services, and providers that are not available for children with special health care needs? Are these services, including support services and clinical services, and providers available elsewhere in the state?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what do you think is needed to improve the physical and mental health of children with special health care needs?*

Provide any direct quotations from the focus groups that support these themes.

RECORDER DEBRIEFING FORM – CSHCN SESSIONS

What were the primary themes for the question: *In your communities, what do you think are the major health concerns for children with special health care needs?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what are the necessary services, including support services and clinical services, and providers that are not available for children with special health care needs? Are these services, including support services and clinical services, and providers available elsewhere in the state?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what do you think is needed to improve the physical and mental health of children with special health care needs?*

Provide any direct quotations from the focus groups that support these themes.

FINAL DEBRIEFING FORM – CSHCN SESSIONS

What were the primary themes for the question: *In your communities, what do you think are the major health concerns for children with special health care needs?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what are the necessary services, including support services and clinical services, and providers that are not available for children with special health care needs? Are these services, including support services and clinical services, and providers available elsewhere in the state?*

Provide any direct quotations from the focus groups that support these themes.

What were the primary themes for the question: *In your communities, what do you think is needed to improve the physical and mental health of children with special health care needs?*

Provide any direct quotations from the focus groups that support these themes.

SUBMISSION CHECK LIST

Date of Focus Group:

Location of Focus Group:

On which population did this session focus? MCH CSHCN

Facilitator Name:

Recorder Name:

Please confirm that the following materials were included by placing checking on each of the boxes below:

- Participant Information Sheets for all participants
- Participant Contact Sheets for all interested participants
- Electronic version of Flip Chart information
- Electronic version of Recorder notes
- Facilitator debriefing form
- Recorder debriefing form
- Final debriefing form

APPENDIX B: LISTING OF ALL PUBLIC COMMENTS RECEIVED THROUGH PUBLIC COMMENT WEBSITE

Public Comments on the
Title V Five-Year Needs Assessment and FY11 Activity Plan

The NA was thorough. Perhaps including too much data that does not translate into the plan. It is difficult to identify/sort out the priorities and the rationale why those were selected over others that may show worse outcomes. For example, among the most common causes of deaths, ER visits are Sickle Cell Disease and asthma. Under Performance Measure #2, page 2, activities are identified specifically for Diabetes. It is unclear why diabetes was selected when other health issues are more prevalent. Issues related to access to prenatal care and “mobile” clinics were identified repeatedly. However, no activities were proposed to address the issue. What are the top three priorities for infants/children/adolescents/children with special needs, women? Reduce falls? Reduce unintended pregnancies? Increase access to prenatal care? Again, the data presented was thorough. It is great that the state involved many stakeholders. The missing piece is the "prioritization" and relationship of the plan with the qualitative data. One can get lost with all the data. The role of public health districts and health departments in advancing the state agenda was not clear. Thank you for the opportunity.
The process of this task was handled in a professional and efficient manner. It was well organized and included many stakeholders from private and public agencies. Well done!
Increase opportunities to provide input.
The documents look pretty accurate. Good specifics about information derived from the focus groups. My only concern is that strategies suggested seemed to be from the professionals and not from the public. The same strategies, such as parent education, have been around forever without much success; probably because we are not asking consumers about what strategies will actually work.
I think Early and Preschool Head Start grantees and their policy councils, which include parents and community partners are stakeholder groups that would be good to include. The GA Head Start Collaboration office also is a source of information and has a needs assessment. Childhood obesity and nutrition are important priorities for Early and Preschool Head Start in GA as well as child safety. Early Head Start has recently expanded in GA and includes services to pregnant women. In addition Early and Preschool Head Start need at least 10% of the enrollment to be children with special needs as defined by an IFSP or IEP. E/PHS could be a stronger partner with MCHS. The GA Head Start Association holds two state conferences each year, one in Dalton and one in St Simons that attracts teachers, parents, family workers, administrators, community partners, etc. Since many of the MCHS activities involve children under age five, I think it is important to engage E/PHS as they see children and their parents every day.
I have reviewed all of the documents and was pleased with what I saw. I agree with the assessments and with the projected plan.
I am pleased to see Decrease Infant Mortality and Injury high on our list. I believe home visiting and parent education (as in Children 1st) to be the key to accomplishing this goal.
I agree with the top 10 priority needs for Georgia mothers and children.

I have been well informed during the phases of this assessment. I did participate in a focus group and felt that my ideas and concerns were heard by the group leaders. I feel that the grant developers reached out to many groups for input in selecting the top ten priority needs for Georgia. The process was comprehensive and inclusive and the result impressive. I can and will support the implementation of this plan and look forward to a more positive future for Georgia's women and children.
As a health care organization providing obstetrical care, we have seen a large number of women who do not obtain prenatal care in our area. The major reason is that none of our care providers accept Wellcare. When the new changes in Medicaid went into effect several years ago, none of our providers contracted with Wellcare. Unfortunately, women are automatically defaulted to Wellcare if they do not make the effort to choose once they are approved by Medicaid. People who make the assignments of the 3 plans within the state of Georgia need to be more aware of what programs are accepted in what areas so these women can get the correct coverage and get the prenatal care they need.
The Perinatal Health Partners/ Best Babies program in the Southeast Health District has been able to prove over the past 8 1/2 years improvement in infant birth weights and prematurity. It has a proven track record that the program works. Continue and expansion of the Perinatal Health Partners/Best Babies program statewide could help to bring Georgia's rankings into a more positive light. There needs to be more support statewide for public health programs and for the Babies Can't Wait and Children's Medical services programs.
Performance Measure 7: Monitors the 4:3:1:3:3 series. Curious why varicella was not included. Performance Measure 10: Activity 1 refers to safety seat distribution. The CDC Task Force on Community Prevention Services strongly recommends safety seat distribution with an educational component as an effective intervention strategy. Activity 1 makes no mention of an educational component for those receiving a safety seat.
1.)IDEAS ABOUT WHAT IS NEEDED TO IMPROVE WOMEN'S HEALTH - all categories: I see several comments under the various topic sections, for suggestions. Are any of these suggestions evidence based? Is it assumed that some of the interventions will follow the evidence based socio-ecologic model? 2.) RE: Draft Activity Plan: Is there a target date for Performance Measure 14? What evidence available supporting Activity 1 & 3 in terms of effectiveness? Will these activities be implemented across the state at the same time? If not, how will data for Performance measure be interpreted for effectiveness of these interventions? How will the survey for Activity 4 be used to meet the goal of Performance Measure 14?
I appreciate the very inclusive process used by MCH to help set priorities for Georgia. I also am struck by the number of important health concerns for which we have little political will to address. I feel the challenge to build more commitment among our elected officials.
I was fortunate enough to participate in the work shop to select the top ten priority needs for Georgia. I am truly impressed with the new direction at the state office and am looking forward to making significant changes in the health outcomes of Georgia's maternal and child health population. The collaborations and partnerships that have been made and/or strengthened will be beneficial to Georgia's families. So thank you Brian and the MCH staff.

I agree with the top priority of decreasing our infant mortality rates. I think we should utilize successful programs and replicate them state wide to assure adequate prenatal care and parenting skills for both the medically high risk pregnant woman and infants born into our state. We need to focus more on safety after the baby is born by providing educational opportunities within our communities for enhanced learning. Parents need to be given the skills they need to care for themselves during pregnancy and their babies after birth. Knowledge is power, we as public health need to provide them with the POWER to take better care of themselves by making healthier choices for them and their families.

Home visiting can be a very inexpensive and valuable empowerment tool for families. Providing individualized care in the home is important in the perinatal population. We need to enhance these services not cut them out.

Breastfeeding should be the norm in our country not an option. Data proves that breastfeeding is best for mom and baby. It is good for the community and health care cost as well. By encouraging moms to breastfeed we cut health care cost, we have healthier mothers and babies and decrease the potential for obesity later in life for the baby. We are PH we should promote prevention!

Substantiated cases of neglect/abuse need to be community wide concerns. Children who are the victims of such cases need to be removed from access of the perpetrators by being placed in a safe environment. All children deserve a safe place to grow and learn even if they live in the southeast part of our country. Our DFACS system does not work. We see children weekly who are still living in an unsafe environment. We need to intervene on these children's behalf. They do not have a voice. It is time for us to step up to the plate and go to bat for them.

Public health needs to get into the practice of advocating for their communities in all that we do. We need to make sure our communities know what services we offer and market our services. We have the ability to do lots of thing no one knows about. It's time to toot our own horn!

Thank you for compiling these very comprehensive documents to explain the state of maternal and child health in Georgia.

Motor vehicle accidents and falls are the leading causes of traumatic brain injury which places children at risk for death and sever disability. The Brain and Spinal Cord Injury Trust fund maintains a central registry that has been recording a stable around 24,000 emergency room visits for children under age 19 since 2004. Children under the age of 5 are the largest group in this reporting with annual reports of 9,000-10,000 emergency visits. Although there are efforts reported for motor vehicle prevention and safety for both mothers and children measure, there is nothing that addresses falls and inflicted injury as causes for children under age 5. Emergency room visit data can be an additional indicator of successful MVA and falls prevention efforts.

Further, the proposed performance measures (#10) and activities do not address the disabilities caused by brain injuries. Many families have to wait 90 days after a hospital admission to be seen by Babies Can't Wait. Children's Medical Services does not serve children with a diagnosis of traumatic brain injury. The disabilities caused by a brain injury are life long, with younger children most at risk for delayed effects of the injury that appear much later in life.

Performance measure #2: How do you plan to serve families who do not have computer access for the online modules?

Performance Measure 6: A definition of what constitutes a "transition plan" is needed. A comprehensive person centered plan developed with client identified stakeholders is preferred that addresses vocational, community connections, transportation and independence by facilitating self-determination. Oftentimes the transition plans in IEPs state, "the individual will identify their vocational interests" without identifying the circle of support for individuals with disabilities to be successful and independent in their communities.

In addition to developmental screening there should be screening for traumatic brain injury. As the draft report shows, falls, motor vehicle crashes and violence are three of the most common mechanisms of injury for children. Traumatic brain injury is the leading injury cited in this population (children).

Data should be captured by Children First and Children's Medical Services via expanded use of the appropriate ICD-9 codes on intake forms used by these agencies.

Children identified by ICD-9 codes 850-854 for concussion and head trauma, 995.55 Shaken Baby Syndrome, etc. should be listed on intake forms and used for electronic data collection (or incorporated into existing data systems used by GA MCHB agencies).

Children identified with traumatic brain injury should receive follow-up to see if they are making progress developmentally. TBI can manifest as deficits in cognitive, behavioral, mood, hearing, speech and vision that can have long-term, even life-long consequences. Proper identification and rehabilitation can improve health, education and quality of life outcomes for children and their families.

Early identification and rehabilitation will, in the long-term time horizon, save money for: the family, providers and governments. Healthy outcomes for Georgia will be achieved by implementing these simple steps.

The problem of childhood obesity is already substantial and is growing. There is a paucity of available services to assist in the treatment of those already obese. Additional services might become available if this were an adequately compensated service compensated under Medicaid including through the care-management organizations.

There is nothing in this document that speaks to individual responsibility. For example if we provide all the formula/food that a child can possibly consume then obesity will result no matter what else we do.

There was some very informative information. Alot of which I had no knowledge of. It appears that the strategies and approaches that you've come up with will eventually benefit all. There had to have been alot of effort in orchestrating these processes. Job well done. I will await the outcome.

I participated in the meetings held to select the 10 top priority needs for Georgia on June 3-4, 2010. I was impressed with the organization and method in which our groups worked to make these hard choices. It was two days of intense work lead by Brian Castrucci and I appreciate the leadership he has demonstrated pulling together the variety of interested parties to make the Title V FY11 Grant process meaningful and understandable.

Performance Measure 03: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

Activity 1. Educate state and district level staff, families, and medical and non-medical providers on the definition and components of a medical home.

What definition is DCH using for the patient centered medical home? Does it require NCQA certification? If so, only 1 practice in the state currently has this designation. If DCH is going to come up with its own definition of a medical home - you'll need buy-in from the primary care physician community - what does a medical home look like/need to be for DCH's purposes?

I participated in the Title V Needs Selection Meeting in June 2010. I was very impressed with the focus group information presented, the "real" grassroots process to identify the top ten priorities, and Brian Castrucci, Director of Maternal and Child Health. My organization operates Georgia's federally mandated call center, PowerLine, for Georgians to access health care. It is rewarding to KNOW that DCH is gearing up to truly serve women and children.

The process of development of the needs assessment has been dynamic and transparent. The activity plan for the National Performance Measures addresses targeted measures with measurable outcomes setting clear goals and objectives. Feedback and continued training will be important components of this plan.

I was so pleased to be invited to be a part of this process! The data provided was incredibly illuminated and instructive. I will use it in my own work, and do not remember ever getting something so helpful from the office of Maternal and Child Health, or any department in Georgia before.

The process of selecting priorities was very participatory. I enjoyed the dialogue and was impressed by the diversity of the group invited. The process was open and inclusive-- a breath of fresh air! While it was very hard to select the priorities and some of mine didn't make the list, I am confident that the process was a good one and can enthusiastically support Georgia's plan.

I have read the three documents and they seem to cover many aspects affecting maternal and child health. If the plans that are stated to help improve the noted problems can be accomplished, I feel we will have accomplished a major goal and offer better health outcomes to this population. This will be a major undertaking. A lot of "real" problems have been identified by those who have encountered the problems. I feel this was a very needed assessment and more accurate problems identified by going to the people and obtaining their side along with obtaining health care providers side of what is felt to be obstacles to better health outcomes.

On the priority needs document, page 14, increasing the availability of family planning services is identified as a need that serves woman and infants and children. Why is this not considered a service for children with special health care needs? It is my opinion that this population would benefit in many ways from family planning services.

I feel the needs assessment captures some of the general angst and frustration among families and public health providers who feel that the Medicaid CMO implementation has left children with special health care needs out in the cold by creating additional barriers to specialty care that were not there before. I'd like to see a third activity added to National Performance Measure 4 that would ensure policy efforts by Public Health at high levels within DCH to resolve longstanding Medicaid CMO barriers to services for BCW enrolled children with special health care needs i.e., network barriers for new or existing BCW providers, lengthy and inconsistent prior approval processes and denials of BCW services within the natural environment based on the availability of clinic-based therapy providers within a CMO defined geographic area. The output of this activity really needs to be a coordinated, collaborative state level agreement or MOU between Public Health and Medicaid policy makers that defines, clarifies and resolves all the payer of last resort issues between BCW and Medicaid CMOs.

I also applaud the recognition given to the need to improve the maternal and child health surveillance and evaluation infrastructure by its selection as one of the top ten MCH priorities We can really do a much better job of early identification, intervention, tracking, case management and follow-up across programs that serve women and children with special health care needs when we have a coordinated, integrated data system across all MCH and CSN programs at the local level.

Lagrange is noted for having an elevated number of the pregnant population smoking in the 3rd trimester of pregnancy. My opinion is that physicians and health care providers do not address this issue during early prenatal visits. It seems like society has somewhat accepted this as ok? Where are the TV ads and information showing what happens to a newborn in utero while the mother smokes. The hospital has tried to ban smoking, but it still goes on daily and is not properly addressed and counseled.

Lagrange is also mentioned for having an increased number of repeat births among adolescents ages 18-19 years old. 14% of our deliveries last year were from 18-19 year old population, but I am not sure what pregnancy it was? We could implement into our discharge planning more information about birth control and proper use of birth control along with the importance of letting a woman's body heal before she decides to get pregnant again. Giving patient's options of birth control and allowing them to choose what will best suit their life style. This type of teaching could be implemented into our discharge teaching classes.(classes could be arranged by age and gravida) Giving these teens a time to learn and talk away from family and visitors will help to promote learning and give them the opportunity to speak for themselves.

I think that with the health department no longer providing "Babies Born Healthy" this will have a negative impact on the prenatal care and the delivery of healthy babies.

Medicaid needs to take a more active approach in supporting breastfeeding mothers!!

Since car accidents are among the leading cause of deaths in women and children we NEED/ our community needs to offer Car Seat Safety classes and checks. I feel strongly that all babies and children be properly secured in motor vehicles. This is so simple, but most of the time overlooked. The staff upon discharge of newborns will report daily that car seats are not properly secured in the pt's cars.

Concerned that the Need to Increase Parenting Skills and Increase Family Support for Families ranked 36 and 39 respectively and would not be reflected as priority areas for the provision of Maternal and Child Health Services. Both areas are critical to improved health and developmental outcomes for children, particularly those 0-5 years of age. Recommend strongly that Community Health include specific strategies for partnering with the Division of Family and Children Services (DFCS)and other home and community based service systems to address these critical needs.

Partnering with DFCS to address teen pregnancy while children are in DFCS custody would help the outcome results as well as assist with a very unique population of teens. Partnering with DFCS Home Based Services Unit to distribute vital parenting information, including immunization and other health and safety information.

DPH and DFCS can look at a partnership in expanding home visiting funding through a partnership with WIC offices that can target 0-3 children with an evidence based model that increases a parent’s capacity to ensure well-being, safety, and healthy parent-child interactions.

In reviewing the survey results listing the highest priority needs, I am surprised to see that the issue of political will may impact program delivery. While political will is a reality, many of the offerings, benefits and services that can or may be provided through the government-supported network of health departments can serve as an important part of the social service safety net. Promoting healthy lifestyles is a community concern and the degree to which the programs are successfully administered on a voluntary basis are important to both the families and the other health and social service agencies working hand-in-hand within the safety net. I recommend the survey be distributed to a larger audience in future years to evaluate trends and be more inclusive of non-public health respondents. It appeared that half the respondents were from people who administer the programs. Where is the client and community feedback? I also suggest including more recent data. I have seen data as current as 2009 on child abuse and neglect from the DFCS agency for example. Thank you for the opportunity to respond.
The MCH Block grant draft was well put together. I learned alot and hope to see Georgia numbers improve.
I appreciated the opportunity to participate in the needs assessment and public forum process. The attitude of inviting related organizations in the needs assessment process is definitely a step in the right direction. I feel the data yielded a more comprehensive view of what is needed and opened the door to partnerships and the ability to visualize common ground. I feel this process will yield greater rewards during the implementation process.

Public Comments on the
Title V Five-Year Needs Assessment and FY11 Activity Plan
Specifically from Parents or Families of Children with Special Health Care Needs

1. Performance measure 11. More focus on all breastfeeding mothers, not just WIC. Maybe have certificates for hospitals that meet the Healthy people 2010 goals of breastfeeding initiation or the hospitals that improve their CDC''s mPINC scores.

2. Performance measure 17. Increase the availability of breast pumps to mothers that have a low birth weight baby. Offer assistance to a hospital that wants to start a milk bank.

As a health care provider and family member of a special needs child I believe, to better serve the public and promote the health of GA residents, it is imperative that funding be spent in areas that are geared toward those client's who are medically high risk. Programs such as Perinatal Health Partners and Best Babies Programs are targeting pregnant women who are medically high risk. They have proven to have positively effected the outcomes in the counties served, meaning fewer NICU admissions and maternal complications resulting in healthier moms and babies and health care dollars saved. High Risk Infant Follow Up service is also a valuable service to GA families who have had a baby admitted to the NICU by providing follow up home visits and case management ensuring these babies are receiving referrals to available resources after discharge from the hospital, assuring that our most vulnerable residents are not being lost in the system, which means delayed services and greater expense in the long term. Referrals to Babies Can't Wait, Children's First, local community agencies are detrimental for these children and families and greatly impact their health and well being not just as infants but through to adulthood.

It was very encouraging to take part in the Needs Assessment process for the Title V Block Grant this year. Given the short amount of time available, the process involved a wide variety of stakeholders. In addition, the selection process implemented during the Title V Priority Needs Selection Meeting provided a strategic method for selection resulting in (in my opinion) priority needs based on data, current political will in the state, and the ability to make an impact.

There really does need to be a better way to make young mothers aware of the importance of prenatal care. Create a program that gives free prenatal health care to mothers so at least the babies have a chance of survival. There should be a fine in place for girls(boys) under the age of 18 giving birth and for unwed girls(boys) having more than one child before age 25. There needs to be some sort of deferent because most young children think it is fun to be pregnant and have a child. The seriousness of the situation doesn't come into play. We really need to increase awareness or go back to the old fashioned line of thinking where the girl's are shamed and sent to a special home.

My daughter is profoundly deaf. When we got here, 7 yrs ago, to Clayton County, we didn’t find too much help at school was upset to. I am very disappointed with the way she was treated only because of her disability. I know your program is not about school complains but is good for you to know so you can help parent to learn how to speak for their children's rights. Now she is an adult, 19 yrs old but she succeeded with the foundation she build at her home school.

The Title V Application is well-written and extremely thorough. It is obvious that input was sought from consumers and providers alike. Families of children with special health care needs were invited to participate in the focus groups and stakeholders meetings to ensure they were not left out of the decision making process.

If Georgia is able to implement these strategies, our families should see positive improvements in maternal and child health.

Many of the campaigns used for the general population of children can also be used, or slightly modified to reach and support children with special health care needs. We must remember that children with special health care needs include those with chronic conditions such as asthma, diabetes, epilepsy, etc. And these children would definitely benefit from campaigns on teen pregnancy, safe driving, obesity, etc. Also, children with or at risk for developmental disabilities (BCW) function at a high enough level that general campaigns should be targeted to them as well.

I can hardly hide my enthusiasm about the future of Georgia's MCH Program.

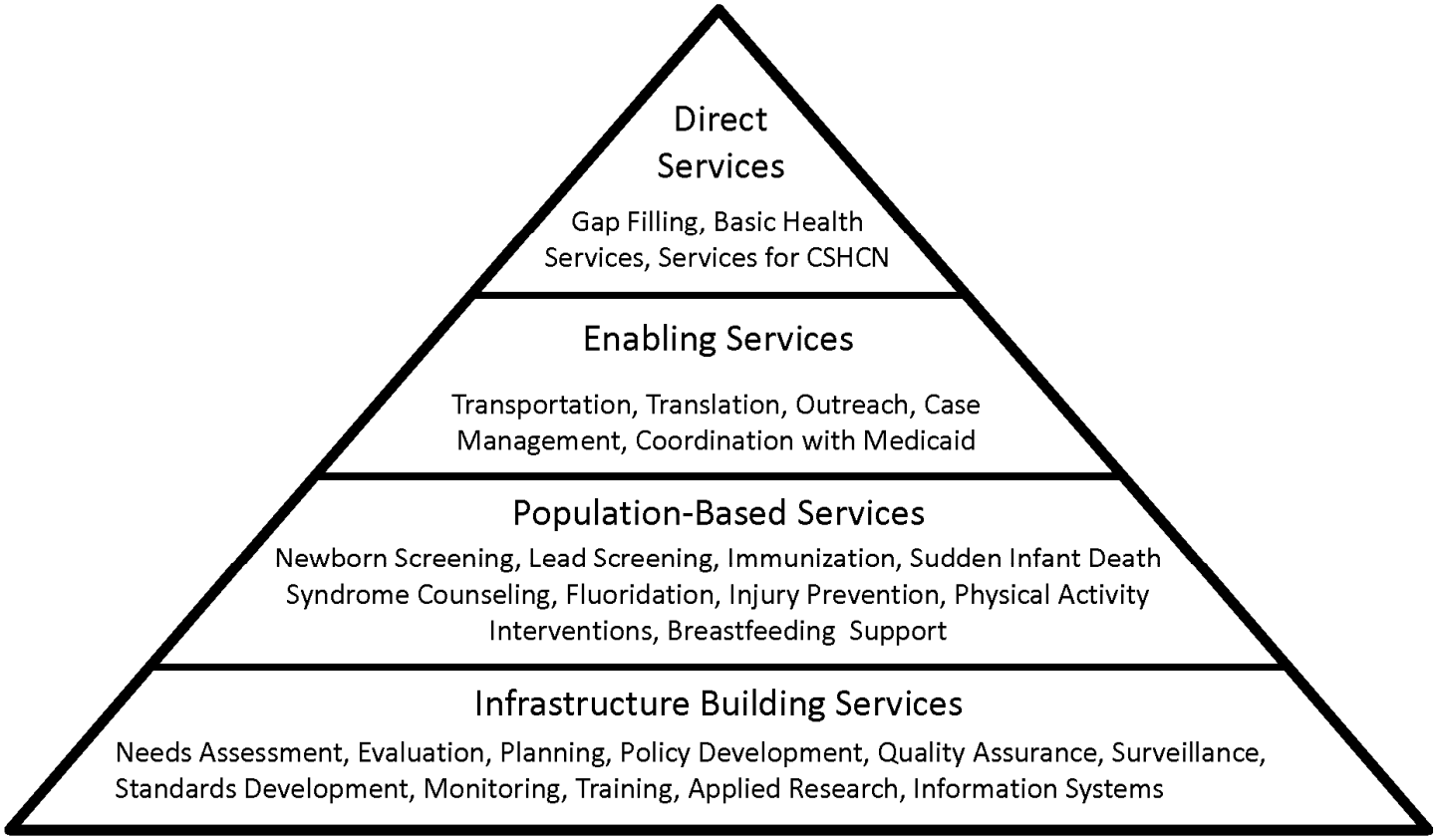
The scope and focus of each draft is on target for families in the State of Georgia. Success can come only if the performance measures are being followed through with support across the State of Georgia from providers and families receiving services. This can be achieved by starting with education on how, what, and where to get information and the source of quality care. The main key factor is educating professionals along with educating the families in taking steps in putting things in place.

I am a parent and a Director of an Organization that assist young teen mothers. These numbers are so important it gives our organization more insight on what type of situation we are dealing with and what should be the primary focus. I know the state is doing all they can to assist. However it takes organizations like ours to continue to help with this epidemic. Being a parent and also experiencing teen pregnancy as well gives me a deep respect and compassion for helping young mothers.

After reviewing the documents some performance measures were measures that could be classified as a group under infant mortality, but overall the measures identified were well thought out.

APPENDIX C: MCH PYRAMID OF HEALTH SERVICES

Maternal and Child Health Pyramid of Health Services



Source: Maternal and Child Health Bureau, Health Resources and Services Administration

APPENDIX D: PARTNERSHIPS

Georgia Maternal and Child Health Program Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
Annie E. Casey Foundation – Atlanta Civic Site	Steering committee member	Atlanta Civic Site participates on Early Childhood Comprehensive Systems (ECCS) Steering Committee.
Auditory Verbal Center, Inc.	Contractual, stakeholder committee member	Auditory Verbal Center, Inc. provides Auditory Verbal Therapy services for infants and children diagnosed with hearing loss and provides follow up diagnostic audiological testing for infants and children. Participates on UNHSI Stakeholders' Committee.
Black Child Development Institute – Atlanta Affiliate	Steering committee member	Black Child Development Institute – Atlanta Affiliate serves on ECCS Steering Committee.
Center for Black Women's Wellness, Inc. (CBWW)	HRSA funded Healthy Start site, Partner	A collaborative relationship exists between the Healthy Start projects throughout Georgia and Title V. The Healthy Start projects in Georgia have a unique community perspective offering strategic planning and information gathering for shared MCH goals in Georgia. Annually, the MCH Epidemiology team, in the MCH Program, provides data support to the Center for Black Women's Wellness, Inc.'s Federal Healthy Start Report.
Center for Child Well-Being (CCWB)	Steering committee member	CCWB participates in the MCH Program's ECCS Initiative Steering Committee.
Centers for Disease Control and Prevention (CDC)	Advisory committee and workgroup participant; UNHSI stakeholder meeting participate; partner and advisory – perinatal and maternal mortality	CDC staff participate in various NBS workgroups and NBS Advisory Committee. Also participate in the Universal Newborn Hearing Screening and Intervention (UNHSI) Stakeholder's meetings. MCHP NBS Unit staff attend CDC Newborn Screening meetings. CDC Subject Matter Experts (SMEs) from the Division of Reproductive Health participated in the Augusta Perinatal Symposium and provided input on the first draft of the Georgia Perinatal Capacity Survey. Through a state initiated Epi Aid, an EIS officer provided assistance with analyzing pregnancy associated deaths and maternal mortality. CDC SMEs from the Maternal Infant Health Branch have provided input on the development of a review process, and have membership on the Georgia Pregnancy Associated Mortality Review Planning Committee. The MCH Program is the Division of Public Health Sponsor on the Lupus Registry pilot conducted by the CDC National Center for Birth Defects and Developmental Disabilities (NCBDDD).

Georgia Maternal and Child Health Program Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
		NCBDDD and the Metro Atlanta Congenital Defects Program have participated in the MCH Program's Low Birth Weight Initiative (Plan for a Healthy Baby). CDC's Division of Adolescent and School Health compiled examples of how states have used Youth Risk Behavior Survey (YRBS) sexual behavior questions and responses. CDC also participates on the Georgia ECCS Steering Committee
Children's Health Care of Atlanta (Egleston, Scottish Rite, and Hughes Spalding campuses) (CHOA)	Non-contractual, advisory committee and workgroup participant	CHOA provides treatment and management for many of the state's newborns diagnosed with sickle cell disease or other significant hemoglobin. Participates in the NBS Advisory Committee and Hemoglobin Workgroup. Also serves as a partner in the CDC Registry and Surveillance for Hemoglobinopathies (RuSH) Project. Staff from their Cystic Fibrosis (CF) Center at the Scottish Rite and Egleston campuses also participate in the CF Workgroup and assist Emory Follow-up in the retrieval and diagnosis of infants with abnormal CF screening results.
DentaQuest	Advisory council	The Oral Health Unit serves on the Dentaquest Advisory Council, and is partnering with them to offer dental providers education on infant oral health and fluoride varnish use, as well as the public health benefits of community water fluoridation.
Department of Behavioral Health and Developmental Disabilities (DBHDD) KidsNet Georgia Project	Partner, advisory, steering committee member	The MCH Program is represented in the KidsNet Collaborative, the project's operational body which governs the project, and in several of KidsNet workgroups. MCH's ECCS Initiative has been integrated into the project as a subcommittee to help support efforts involving early childhood developmental screening and socio-emotional health. DBHDD staff, including the KidsNet Director, participate on the ECCS Steering Committee. DBHDD also is a member of the Georgia ECCS State Team. As a result of these collaborative activities, the KidsNet Part C Finance Committee has been moved to the ECCS Initiative as an ECCS Partnership Subcommittee work group. Adam Lesser with the Garrett Lee Smith Youth Suicide Prevention Project sits on the Injury Prevention Advisory Council. IPP and Epi staff are members of the Suicide Prevention Coalition of Georgia. DPH also works with DBHDD around a number of state and local level concerns that relate to the MCH population such as youth risk

Georgia Maternal and Child Health Program Partners and Stakeholders		
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		prevention and tobacco use prevention. A DBHDD Mental Health representative serves on the BCW Interagency Coordinating Council. DBHDD's Division of Addictive Diseases Office of Prevention Services provided Substance Abuse Mental Health Services Administrative block grant funding to help support the DPH's Healthy Families Georgia Mental Health Screening Project (HFG MHSP) which was implemented between October 1, 2008 and September 30, 2009.
Department of Community Health, Commission on Men's Health	Partner	The Commission on Men's Health helps increase participation of males in family planning clinic services.
Department of Community Health, Division of Emergency Preparedness and Response Division, Injury Prevention Program	Partner, advisory	Provide integrated injury prevention and safety messaging, evidenced based programming, policy analysis and support, evaluation and data collection across all MCH programs especially in areas of highest risk such as transportation for all children and safe sleep environments for infants.
Department of Community Health, Division of Medical Assistance	Partner and advisory – 1115 Waiver; partner and advisory – reducing low Birth Weight	The MCH Epidemiology team, in the MCH Program, provided data and analytic support for completion of an 1115 Waiver application. The MCH Epidemiology team also provided data, analytic support, and scientific input to the Reducing Low Birth Weight Workgroup; including systems modeling.
Department of Community Health, Division of Public Health, Health Promotion and Disease Prevention (HPDP)	Partner, steering committee member	HPDP's Asthma Control Program provides information regarding asthma best practices. CYSHCN staff member participated in the Georgia Asthma Advisory Council (composed of internal and external partners). HPDP participates on the ECCS Steering Committee. The Office of Nutrition and WIC collaborates with HPDP's Obesity Initiative, providing technical assistance in strategic planning for the implementation of programmatic components.
Department of Community Health, Division of Public Health, Epidemiology	Partner – Block Grant, partner – Region IV Network for data management and utilization	BRFSS, YRBS, Cancer Registry, and STD staff worked with MCH Program staff to provide information to support completion of the Title V Block Grant and Needs Assessment. BRFSS staff supported fulfilling the annual RNDMU request, which heavily utilizes BRFSS (preconception health) data.

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
Department of Community Health, Office of Minority Health	Partner	The Office of Minority Health identifies, assesses, and analyzes issues related to the health of the state's minority populations. It also monitors state programs, policies and procedures to assure they are inclusive and responsive to minority community health needs.
Department of Early Care and Learning (DECAL)	Partner, steering committee member	DECAL works with Babies Can't Wait (BCW) to enhance services for preschool children with special needs and their families. DECAL staff serve on MCH's ECCS Steering Committee. DECAL is implementing an "Agency Accepted Trainer" pilot program with other state agencies to provide for-credit-training for Georgia child care providers. The MCH Program has been identified as the first "Agency Accepted Trainer." MCH Ages and Stages training opportunities have been posted on the DECAL website and local training will be initiated by summer 2010.
Department of Education (DOE), including Division of Special Education	Interagency agreement, steering committee member	MCHP/CYSN program staff serve on DOE Transition to Adulthood Steering Committee. Staff work with vocational rehabilitation as well. DOE staff serve on BCW State Interagency Coordinating Council (ICC). Have interagency agreement for child find, data sharing and transition at age 3 services. DOE also participates as a member of the Early Childhood Comprehensive Systems (ECCS) Steering Committee. The Office of Nutrition and WIC collaborates with Georgia's School Nutrition Program in strategic planning as it relates to integrating nutrition education within their programmatic components. Additionally, the State Nutrition and WIC Director serves as a permanent member of the Farm-to-School initiative.
Department of Human Services (DHS), Division of Family and Children's Services (DFCS)	Partner, Memorandum of Agreement (MOA), mutual representation on advisory boards	DHS staff participate on the ECCS Steering Committee. MOA between DFCS and BCW assures that children less than 3 years of age who have a substantiated case of abuse or neglect or have a physical impairment or developmental delay are referred to BCW. BCW and DHS/DFCS work together to enhance services for children with special needs and their families. DPH staff sit on the DFCS Child Death and Serious Injury review team for the explicit purpose of developing policy and awareness of prevention strategies for children known to DFCS. The Office of Nutrition and WIC collaborates with the Georgia's Supplemental Nutrition Program

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
		(SNAP formerly Food Stamps) to ensure that its vendors are properly authorized and/or terminated within both Georgia's WIC and SNAP. Additionally, we are planning to work closer with networking with the newly USDA FNS funded SNAP Special Supplemental Commodity Program initiative.
Department of Juvenile Justice (DJJ)	Partner	DJJ, Corrections, Pardons and Parole, and MCH work collaboratively to strengthen relationships and create a continuum of care for youth leaving the state's youth detention centers to address their need for community-based health and mental health services.
Easter Seals	Partner	Easter Seals provides services and supports to families with special needs children and youth.
Emory University Division of Medical Genetics	Contractual	Emory University Division of Medical Genetics provides staff with expertise in metabolic conditions to locate infants with abnormal screens and bring to medical attention. Provides expert staff to perform diagnostic testing, treatment, and on-going management for metabolic disorders. Provides expertise in cystic fibrosis and endocrine disorders. Participates in various Newborn Screening (NBS) workgroups and the Newborn Screening Advisory Committee. The Office of Nutrition and WIC has a long-standing contractual relationship with Emory Medical Genetics in that they provide special metabolic foods/supplements to a segment of Georgia's WIC participants.

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
Emory University, School of Medicine and Rollins School of Public Health	Partner, advisor	MCH Epi partnered with a vaccine researcher, Saad Bin Omer, on analysis of PRAMS data, examining the association of seasonal influenza vaccination and birth outcomes (Preterm and Small for Gestational Age). Partnered with the MPH program for a student with perinatal nursing experience to develop a perinatal capacity survey as part of her master's thesis. The Department of Global Health Epidemiology provided review and input on the final draft of the survey. The Emory Center for Injury Control is a partner in convening researchers and practitioners to bridge the gap from research to application in addressing injury related issues.
Family Connection Partnership (FCP)	Steering committee member	FCP participates in MCH Program's ECCS Initiative Steering Committee. Also serves on the ECCS Planning Committee. FCP staff member serves as co-chair of ECCS Partnership Workgroup.
Fulton/DeKalb Hospital Authority/Grady Health System (GHS)	Contractual	GHS provides staff with expertise in sickle cell disease and other hemoglobin disorders to locate infants with abnormal screens and bring to medical attention. Participate in the Hemoglobin Workgroup and NBS Committee. Provides family planning services in a teen setting within Grady Hospital. Dr. Michael Lindsay services as co-chair for Georgia Pregnancy-Associated Mortality Review (PAMR).
Georgia Academy of Family Physicians (GAFP)	Contractual, advisory committee member	GAFP participates in NBS Advisory Committee meetings. Also serves on the ECCS Steering Committee. Promotes UNHSI/NBS to GAFP membership. Contract provides mechanism for promoting all MCHP programs to family physicians statewide. Provides feedback to DPH on strategies to improve the referral process and promote DPH programs to family physicians. Outreach efforts are conducted through office visits, statewide physician member meetings, trainings, and publications. GAFP is also partnering with the Oral Health Unit to provide physicians with information on oral health care during pregnancy, infant oral health care, and the application of fluoride varnish during well-child visits. Perinatal/Women's Health collaborated/ contracted with GAFP to produce and disseminate the Preconception Health Toolkit. GAFP distributed the toolkit to its membership and provides education on the importance of providing preconception health care. The Office of

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
		Nutrition and WIC has a long-standing contractual relationship with GAFP in providing technical assistance in networking with Georgia's Family Practitioners.
Georgia Association for Young Children (GAYC)	Steering committee member	GAYC participates on MCH's ECCS Steering Committee.
Georgia Association of School Nurses (GASN)	Partner	The Oral Health Unit has collaborated with GASN on updating the School Nurse Manual. Also provide local school district nurses with updates on oral health screening and treatment of emergency dental problems.
Georgia Babies Can't Wait Interagency Coordinating Council (BCW ICC)	Coordinating council	The BCW ICC includes several required agency partners and parents of children with disabilities.
Georgia Brain and Spinal Injury Trust Fund Commission (BSITFC)	Advisory committee	DCH has a gubernatorial appointee to the Commission. The BSITFC Executive Director, Craig Young sits on the IPP Advisory Council and the Georgia Falls Coalition. A MCHP/CYSHCN staff participate on Georgia Brain and Spinal Injury Trust Fund Advisory Committee. BSITFC staff member participates on MCH"s ECCS Steering Committee.
Georgia Breastfeeding Coalition	Coalition	The Georgia Breastfeeding Coalition promotes and supports breastfeeding throughout Georgia communities, health care facilities, worksites, schools and faith-based organizations through legislation, policy, social marketing, outreach and education. The Office of Nutrition works through the WIC Breastfeeding and State Breastfeeding Coordinators to ensure that consistent messages are disseminated through Georgia's Breastfeeding Coalition. Additionally, they are active members on the Coalition as they participate in strategic planning as it relates to advocating for environmental and policy changes related to breastfeeding.
Georgia Cancer Coalition	Partner	The Coalition helps increase awareness of cancer risk factors, including oral risk factors such as tobacco use and HPV.
Georgia Center for Leadership in Disability	Steering committee member	The Georgia Center for Leadership in Disability participates on MCH's ECCS Steering Committee.
Georgia Chapter – American Academy of Pediatrics (GA-AAP)	Contractual, advisory committee membership	MCH's partnership with GA-AAP provides a mechanism for promoting all MCH programs to pediatricians statewide. GA-AAP participates in NBS

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
		Advisory Committee meetings. Promotes UNHSI/NBS to GA-AAP membership. Dr. Wendell Todd serves as Georgia's Chapter Champion for the UNHSI Program. Dr. Robert Forbes serves as the Chair of the Oral Health Task Force and leader of the AAP Oral Health Initiative in Georgia. The GA-AAP has been a key partner in securing Medicaid reimbursement for fluoride varnish for both dental and medical providers, and in promoting infant oral health care. GA-APP provides the *Educating Physicians in Communities* (EPIC) program in collaboration with MCH state breastfeeding coordinator. EPIC educates physicians about public health programs inclusive of a comprehensive review of WIC services/benefits. The Office of Nutrition and WIC has a long-standing contractual relationship with GAFP in providing technical assistance in networking with Georgia's Pediatricians as well as disseminating EPIC information. GA-AAP staff member participates on MCH's ECCS Steering Committee.
Georgia Chapter of the American Lung Association (GA ALA)	Partner	GA ALA provides "Asthma 101" education to CYSHCN district care coordinators. Serves as a community partner for chronic lung conditions, including asthma.
Georgia Children's Health Alliance	Partner, advisor, steering committee member	The MCH Epidemiology team, in the MCH Program, provided scientific support in identifying relevant indicators and appropriate data sources for a child health report. The Georgia Children's Health Alliance participates on MCH's ECCS Steering Committee.
Georgia Coalition Against Domestic Violence (GCADV)	Advisory committee and work group participant	GCADV participated in Project Connect, a coordinated public health initiative to respond to domestic and sexual violence. GCADV has a received a grant from the Family Violence Prevention Fund to work with Georgia's Perinatal/Women's Health – Department of Public Health programs to provide opportunities to change systems in regard to response to victims. They have convened an Advisory Group for the project including MCH and IPP staff.

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
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Georgia Commission on Hearing Impaired and Deaf Persons	Advocate	The Georgia Commission on Hearing Impaired and Deaf Persons advocates for children with hearing loss.
Georgia Dental Association (GDA)	Advisory committee member	GDA has been a long-term advocate in the state legislature to maintain funding for the dental health program, increase access to dental care for low-income children and adults, and promote community water fluoridation. The GDA partners with DPH every year to host Give—Kids-A Smile (GKAS) events throughout the state of Georgia in February.
Georgia Dental Hygienists' Association (GDHA)	Non-contractual	The GDHA is partnering with the Oral Health Unit to promote increased dental sealant application and work with district dental programs in sponsoring-based dental sealant events.
Georgia Early Childhood Comprehensive Systems (ECCS) Steering Committee	HRSA grantee, steering committee	The primary purpose of Georgia's HRSA funded ECCS Initiative is to assist in efforts to build and implement a comprehensive statewide system of care that supports family and community approaches to promote positive early development and early school success. The ECCS Steering Committee provides input on Initiative activities. Steering Committee Developmental Screening and Partnership Workgroups help carry out activities to achieve Initiative goals.
Georgia Head Start Association (GHSA)	Advisory committee member; referral network	The UNHSI Coordinator participates on Head Start Health Advisory Committee and has formed a strong referral network for follow up testing on children who do not pass their initial screening upon registration with Head Start. GHSA participates as member of the ECCS Steering Committee. Provides community input. Contributing to the development and implementation of developmental screening. Participating in mapping of resources and identification of gaps and barriers. State Oral Health Office provides training sessions on oral health for Head Start center directors and staff. Oral Health collaborated with Head Start on 2006 Head Start Oral Health Survey. Next survey will be implemented 2011. The Office of Nutrition and WIC has worked with Head Start in marketing campaigns to ensure that our mutual clientele are serviced by each program.
Georgia Health Policy Center (GHPC) at	Partner, advisory	The MCH Epidemiology team, in the MCH Program, worked with GHPC to

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
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Georgia State University		develop a policy brief on influenza vaccination during pregnancy. GHPC worked on MCH Low Birth Weight Initiative, serving on the Systems modeling team.
Georgia Hospital Association (GHA)	Advisory committee member	GHA participates in Newborn Screening Advisory Committee meetings.
Georgia Obstetrics and Gynecology Society (GOGS)	Partner	The MCH Program has partnered with GOGS to develop a state pregnancy associated mortality review. GOGS has identified one-time start-up cost funding and obstetrical leadership, and the MCH Program has committed ongoing funding to ensure sustainability and provided epidemiological and program support. GOGS has facilitated and participated in the development of a MCH Program working group to improve understanding of birth data use and improve data quality at birth facilities. GOGS has provided subject matter expertise and review of the MCH Program efforts to measure perinatal capacity and appropriate perinatal care. GOGS partnered with the MCH Program to ensure information transferred to its membership was consistent with Public Health messages on H1N1 vaccination during pregnancy. GOGS provides Perinatal/Women's Health program updates to its members.
Georgia Office of the Child Advocate, Child Fatality Review Panel (CFR)	Partner, Mutual Advisory Committee representation	DPH is represented on CFR by legal proxy by Lisa Dawson, IPP Program Director. The Executive Director of the Office of the Child Advocate Melissa Carter is on the IPP Advisory Council. The two programs have shared several projects including convening the Safe Sleep Workgroup, updating Mandatory Reporter guides for PH professionals and developing the Child Injury Prevention Framework.
Georgia Parent Infant Network for Educational Services (PINES)	Stakeholder committee member, contractual	The UNHSI Program sponsors at least one Georgia PINES staff member to attend the National Early Hearing Detection and Intervention (EHDI) Conference. Staff participate in the UNHSI Stakeholder's Committee. Two new contracts are pending to provide Georgia PINES with financial support for Early Hearing Orientation Specialist visits and other activities to support families of infants and children birth to five identified with hearing loss.

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
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Georgia Parent Teacher Association (PTA)	Steering committee member	The Georgia PTA serves on the MCH Program's ECCS Initiative Steering Committee.
Georgia Public Health Association	Partners	DPH/MCH staff are members of the Georgia Public Health Association and participate in annual Association meetings.
Georgia Public Health Laboratory (GPHL)	Contractual	GPHL receives NBS bloodspot cards and conducts the screening tests. Reports the abnormal results to the follow-up contractors at Emory, Grady, and MCG. GPHL also provides split-sample testing for fluoride levels to assure the quality of fluoridation by community water systems through a contractual agreement with the Georgia Rural Water Association and the Oral Health Unit.
Georgia Rural Water Association (GRWA)	Contractual	GRWA provides technical assistance to water plant operators in the use and maintenance of fluoridation equipment, and in monitoring fluoride provision to assure optimal fluoridation levels in community water systems.
Georgia State University (GSU) Project Skilled Credentialed Early Interventionist	Contractual	GSU provides BCW with a Comprehensive System of Personnel Development (CSPD) for the Georgia Part C early intervention program.
Governor's Council on Developmental Disabilities (DD Council)	Coordinating Council member, steering committee member	The DD Council participates on the BCW State Interagency Coordinating Council (SICC) and the MCH ECCS Steering Committee
Governor's Office for Children and Families (GOCF)	Steering committee member	GOCF participates on ECCS Steering Committee.
Grady Comprehensive Sickle Cell Center	Contractual	This contract calls for the operation of a 24 hour a day acute care facility, outpatient clinical care, and early intervention care for patients with sickle cell anemia and other symptomatic patients, age 18 and older. Provides sickle cell expertise and participate in the NBS Advisory Committee and Hemoglobin Workgroup. Also serves as a partner in the CDC Registry and Surveillance for Hemoglobinopathies (RuSH) Project.

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
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Hands and Voices – Georgia Chapter	Stakeholder committee member, sponsorship	The UNHSI Program sponsors at least one Hands and Voices member to attend the National Early Hearing Detection and Intervention (EHDI) Conference. Staff participate in the UNHSI Stakeholder's Committee. The UNSHI Program sponsors speakers and other educational activities.
Healthy Mothers, Healthy Babies (HMHB)	Contractual	HMHB serves as the statewide director of services for low-income women and children and provides information to MCHP that informs planning. Operates the *POWERLINE*, a toll-free, bilingual helpline for medical and dental health care referrals funded by MCHP. Refers callers to appropriate WIC Clinics and records reports of complaints or fraud. Promotes UNHSI/NBS in prenatal classes and to PowerLine callers. HMHB staff collaborate with Perinatal/Women's Health staff on initiatives at the state office, including Preconception Health and Text4Baby. State staff attended annual HMHB national conference and provide a letter of support for grant submitted by HMHB.
Healthy Start	HRSA grantee, partner	There are four Healthy Start sites in Georgia: Atlanta Healthy Start, Augusta Partnership for Children, Enterprise Community Health Start, and Heart of Georgia Healthy Start. A collaborative relationship exists between the HRSA funded Healthy Start projects throughout Georgia and Title V. The Healthy Start projects in Georgia have a unique community perspective offering strategic planning and information gathering for shared MCH goals in Georgia. The Georgia Pregnancy Associated Mortality Review, in the MCH Program, has partnered with Enterprise Community Healthy Start to oversample women in the two counties served by this Healthy Start. This partnership will support evaluation of the Healthy Start Program as well as support the evaluation of PRAMS measures.
Hemophilia of Georgia (HOG)	Contractual	HOG provides case management services for adult and pediatric patients with hemophilia and other bleeding disorders. Also purchases clotting factor or insurance for treatment for individuals with hemophilia who are uninsured.
Hispanic Health Coalition of Georgia, Inc.	Partner	The Hispanic Health Coalition of Georgia, Inc. helps increase awareness of MCH issues and services in the Hispanic population.

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
Latin American Association	Partner	The Latin American Association helps increase awareness of MCH issues and services in the Hispanic population.
March of Dimes Georgia Chapter	Advisory committee participant	The March of Dimes Georgia Chapter participates in NSB Advisory Committee meetings. The Office of Nutrition and WIC has worked closely with the March of Dimes in ensuring that we collaborate on Folic Acid health promotion campaigns.
Marcus Autism Center	Partner	The Marcus Autism Center offers comprehensive diagnosis and therapy for children with autism and related disorders
Medical College of Georgia (MCG)	Contractual, partner and advisory - regional perinatal	MCG provides staff with expertise in sickle cell disease and other hemoglobin disorders to locate infants with abnormal screens and bring to medical attention. Provides expert staff to perform diagnostic testing, treatment, and on-going management for sickle cell disease and other hemoglobin disorders. Staffs the pediatric and adult outreach sickle cell clinics. Participates in the Hemoglobin Workgroup and the Newborn Screening Advisory Committee. Staff from the Cystic Fibrosis (CF) Center at MCG participate in the CF Workgroup and assist Emory Follow-up in the retrieval and diagnosis of infants with abnormal CF screening results (non-contractual). Their geneticist, Dr. Flannery performs the CMS Genetics clinic in Savannah (non-contractual). Also serves as a partner in the CDC Registry and Surveillance for Hemoglobinopathies (RuSH) Project. Perinatal Directors at MCG have provided subject matter expertise and review of the MCH Program efforts to measure perinatal capacity and appropriate perinatal care.

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
Medical College of Georgia School of Dentistry	Non-contractual	The MCG School of Dentistry partners with Oral Health Unit to provide community health externship sites for fourth year dental students in rural public health clinics throughout the state. The students help increase the capacity of the clinics to provide dental care, while receiving a valuable experience working in rural communities.
Metro Audiology Association	Committee member, provider feedback/input	The Metro Audiology Association provides input and feedback to the UNHSI to the program from area educational audiologists. Members participate in UNHSI committee meetings.
Morehouse School of Medicine (MSM)	Committee member	MSM partnered with the Oral Health Unit to advance the efforts of the Community Oral Health Research Workgroup to translate and disseminate research advances in oral health to the community level.
National Healthy Mothers, Healthy Babies (NHMHB)	Outreach partner	Georgia has partnered with NHMHB to promote its educational program Text4Baby. Text4Baby delivers timely health tips via text messages providing information and support to pregnant women and new mothers, especially among underserved populations.
Natus	Contractual	Contract is pending. Natus will provide hearing screening equipment, training, and technical expertise.
Newborn Genetics Screening Advisory Committee	Advisory committee	This group, which was initiated in February 2000, is comprised of representatives from various public and private organizations in the state who play some role within the system for screening, diagnosis, and intervention for metabolic and hemoglobin disorders. Involved organizations include the Georgia Chapter of the American Academy of Pediatrics, Georgia Chapter of the Academy of Family Physicians, Emory University Division of Medical Genetics, Medical College of Georgia, Grady Comprehensive Sickle Cell Center, Sickle Cell Foundation of Georgia, Inc., Georgia Hospital Association, Northside Hospital, and March of Dimes.

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
Northside Hospital	Advisory committee participant, partner and advisory - data quality, advisory – perinatal systems	Northside Hospital participates in NBS Advisory Committee meetings. Partnered with the MCH Program to develop a working group to improve understanding of birth data use and improve data quality at birth facilities. Provided subject expert review on the development of a perinatal capacity survey.
Parent to Parent of Georgia	Contractual, partner, steering committee member	Parent to Parent of Georgia holds the contract for the Part C statewide central directory. Houses the Family 2 Family Health Information Center, the Office of Special Education Programs (OSEP) sponsored Parent Training and Information Center (PTI), and Family Voices State Affiliate organization. Partnered in 2010 MCH needs assessment. Parent to Parent serves on the MCH's ECCS Steering Committee.
Pediatric ENT of Atlanta (PENTA)	Advisory committee member	PENTA, one of largest pediatric audiology groups in the Atlanta area, participates in the UNHSI Stakeholder's Committee.
Pediatrix	Contractual	Pediatrix is under contract with several hospitals in the state to perform hearing screenings and follow up testing on children who do not pass their initial screening upon registration with Head Start.
Prevent Child Abuse Georgia	Steering committee member	Prevent Child Abuse Georgia serves on MCH Program's ECCS Initiative Steering Committee.
Public Health Districts/County Health Departments	Partner, contractual, steering committee member	The MCH Program has partnered with the Augusta Health District for a series of Symposiums on Perinatal Care in their District and Perinatal Region. Some of Grant-in-Aid programs function out of health departments, providing programs for high risk mothers and infants. FOCUS-MOMS program provides case management, referral services, prenatal education to women, particularly women who have had a high risk delivery or low Birth Weight baby. District staff serve on MCH ECCS Steering Committee.
Quality Care for Children Child Care Resource and Referral Agency	Steering committee member	Quality Care serves on ECCS Steering Committee.
Refugee Family Services, Inc.	Steering committee member	Rural Family Services, Inc. serves on the MCH Program's ECCS Initiative Steering Committee.
Regional Perinatal Centers (RPCs)	Contractual	The MCH Program contracts with six designated perinatal centers

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
		throughout Georgia: Fulton-DeKalb Hospital Authority – subcontractors Emory Midtown, Children's Health Care of Atlanta at Egleston, MCG Health, Inc., The Medical Center, Inc., and Phoebe Putney Memorial Hospital. The RPCs provide high risk services to mothers and infants and their region. The RPCs also provide transportation for high risk neonates and education and leadership outreach within their regions.
Regional Training Center (RTC) for Family Planning – Title X-Region IV Cicatelli Associates	Federal partner	Through a federal contract (Department of Health and Human Services District IV), RTC provides training, technical assistance, and regional conferences for all DHHS Title X funded programs in Georgia. An educational needs assessment is performed each year with providers and learning objectives are identified. Each state in the region schedules eight specific training activities. Region-wide webinars that benefit all Title X providers are offered six times a year. During FY 2010, Georgia received technical assistance on how to make family planning clinics more efficient through patient flow analysis activities.
Sickle Cell Foundation of Georgia, Inc. (SCF)	Sub-contractual	Through a sub-contract with the Grady Comprehensive Sickle Cell Center, SCF provides counseling, education, and testing for families with sickle cell disease and sickle cell trait. Participates in the NBS Advisory Committee and Hemoglobinopathies (RuSH) Project.
Sheltering Arms – Early Education and Family Centers	Steering committee member	Sheltering Arms serves on MCH Program's ECCS Initiative Steering Committee.
State Community Water Fluoridation Advisory Council	Stakeholder committee member	The State Community Water Fluoridation Advisory Council meets quarterly to address emerging issues impacting the quality and extent of the state water fluoridation program.
Southeast AIDS Training and Education Center (SEATEC)	Contractual	SEATEC provides training and education HIV testing, use of the rapid testing process, perinatal HIV transmission, and treatment.
Southeast Newborn Screening and Genetics Collaborative (SERC)	Non-contractual	NBS Unit staff and epidemiology staff are beginning to participate in regional activities, including SERC's long-term follow up initiative.

Georgia Maternal and Child Health Program (MCHP) Partners and Stakeholders		
Organization	Nature of Partner/Stakeholder's Relationship (i.e., contractual, sub-contractual, advisory, partner, etc.) with MCHP	Relationship Description/Scope
State Interagency Coordinating Council (SICC)	Partners	The SICC includes several required agency partners and parents of children with disabilities. BCW State Program Coordinator provides an update at quarterly meetings.
Tender Care Clinic	Steering committee member	Tender Care participates on the MCH Program's ECCS Steering Committee.
United Way of Metropolitan Atlanta/SMART Start	Steering committee member, contractor	United Way of Metropolitan Atlanta/Smart Start serves on the MCH Program's ECCS Steering Committee and Planning Team.
University Center for Excellence in Developmental Disabilities Education, Research and Services (UCEDD), Institute on Human Development, and Disability, University of Georgia	Contractual	The University Center for Excellence in Developmental Disabilities supports training and technical assistance. Maintains video resource library for CYSN. Assists in maintaining BCW Access data base. Provides financial management support to state office and district level programs.
University of Georgia (UGA) Audiology Clinic	Stakeholder committee member, follow up testing and counseling	Audiology Clinic staff actively work with the UNHSI Program to perform follow up testing and counseling for infants and children. Staff participate in UNHSI Stakeholder's Committee meetings.
University of Georgia Cooperative Extension Service	Steering committee member	The UGA Cooperative Extension Service serves on the MCH Program's ECCS Steering Committee.
Universal Newborn Hearing Screening Intervention (UNHSI) Stakeholder's Committee	Stakeholder committee member	The Universal Newborn Hearing Screening and Intervention (UNHSI) Stakeholder's Group was initiated in April 2010. It is comprised of representatives from various public and private organizations in the state who play some role within the system for screening, diagnosis, and intervention for hearing loss. Involved organizations include Pediatric ENT of Atlanta (PENTA), Hands and Voices (Georgia Chapter), Auditory Verbal Center, Inc., Babies Can't Wait, Pediatrix, Georgia PINES, the Georgia Chapter of the American Academy of Pediatrics, and the Georgia Chapter of the Academy of Family Physicians.
Valdosta State University	Contractual	Valdosta State University supports training and technical assistance for BCW.

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Voices for Georgia's Children	Partner, advisory – 1115 Waiver, data provision, advocacy	Through advocacy, original research and analysis, Voices for Georgia's Children addresses three strategic priorities: 1) a long term policy agenda for children; 2) expanding and educating leadership for children; and 3) building public will to improve child well-being. Voices provides yearly information on key child health indicators, including oral health status. Once identified as the Division of Medical Assistance's partner on the 1115 waiver, the MCH Epidemiology team, in the MCH Program partnered with Voices for Georgia's Children to ensure accurate and reliable information related to the waiver was available. A Voices staff member serves on the MCH ECCS Steering Committee.

APPENDIX E: TITLE V PRIORITY NEEDS SELECTION MEETING ORGANIZATIONAL ATTENDEE LIST

Participant Organizations
Title V Priority Needs Selection Meeting
June 3 and June 4, 2010

A list of the organizations whose representatives participated in the Title V Priority Needs Selection Meeting is presented below. Multiple representatives attended for some of the organizations listed. In addition to the organizations listed, several family members with children with special health care needs also attended.

- American Academy of Pediatrics-Georgia Chapter
- Children's Health Care of Atlanta
- Emory University, Department of Human Genetics
- Georgia Academy of Family Physicians
- Georgia Council on Developmental Disabilities
- Public Health District Staff
    - Clayton County Health District (3-3)
    - Coastal Health District (9-1)
    - Cobb Douglass Health District (3-1)
    - East Metro District (3-4)
    - Fulton Health District (3-2)
    - North Georgia Health District (1-2)
    - Northeast Health District (10)
    - South Health District (8-1)
    - Southeast Health District (9-2)
- Division of Public Health, Department of Community Health
    - Environmental Health Program
    - Infectious Disease and Immunization Program
    - Maternal and Child Health Program
    - Maternal and Child Health Epidemiology Section
    - State Public Health Laboratory
- Georgia Family Connection Partnership
- Georgia Hospital Association
- Georgia Obstetrical and Gynecological Society
- Georgia State University, Georgia Health Policy Center
- Georgia's Children's Health Alliance
- Healthy Mothers, Healthy Babies Coalition of Georgia
- Heart of Georgia Healthy Start
- Medela Inc.
- Parent to Parent of Georgia
- SAFE Kids of Georgia
- Voices for Georgia's Children