



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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1.4 Overview of the State

This year's FY 2001 Maternal and Child Health (MCH) Title V block grant application incorporates the work of the past two years related to the development and implementation of Georgia's maternal and child health (MCH) systems pyramid to plan for the forthcoming five-year project period. Understanding the evolution and dynamics of the MCH system in Georgia requires a broad understanding of how the framework within which the system operates. Further, an overview of Georgia provides the backdrop for our state's comprehensive MCH needs assessment, priority setting, identification of state designated performance and outcome measures, as well as annual plan. (See Appendix A, Georgia State Map of 19 Public Health Districts).

State Profile:

Georgia, the largest state east of the Mississippi River, is the country's ninth most populous state. It is the fastest growing state east of the Rocky Mountains. The number of new Georgians since 1990 ranks the state fourth nationally in terms of size of population growth and sixth in terms of percent change. From 1998 to 1999, only three states -- Nevada, Arizona and Colorado, all with smaller populations than Georgia -- grew at a faster rate. Overall, Georgia has added more than 1.3 million people in the last nine years (20.2% increase from 6,478,149 in 1990 to 7,788,240 in 1999). Georgia's growth results from a combination of natural increase (i.e., births versus deaths), domestic migration and international migration; the state ranks 11th nationally in natural increase, 4th in domestic migration and 21st in international migration. In fact, metro Atlanta ranked first in the U.S. in domestic migration between 1990 and 1998 with 440,668 people moving to the area.

Four of Georgia's counties appear on the U.S. Census' list of the top ten fastest growing areas in the country. The growth in Georgia's fastest growing county, Forsyth, part of the Atlanta Metropolitan Statistical Area (MSA), has resulted from residential expansion. Similar growth accounted for the population increases in two of the three other Georgia counties on this list, Henry and Paulding counties in the Atlanta MSA, while Echols, a very rural county, 9th on the list, is experiencing spill-over growth from Valdosta. This growth, which began about 1960, represents a significant departure from the trend over the prior century when Georgia's population growth was consistently lower than the country's as a whole. During this earlier period, almost all of the increase was due to child-bearing and longer life-spans resulting from medical discoveries and better sanitary conditions; however, the recent growth is due to influx of populations from other parts of the United States, and even more recently, from other parts of the world (60% of the overall growth).

Once a rural, largely agrarian state, Georgia's increasingly diverse economy has a strong service component and is dominated by metropolitan Atlanta, which covers much of the northwestern area of the state. Almost half, 46%, of the State's population resides in the 20-county Atlanta MSA. Yet, 55 of Georgia's 159 counties have fewer than 10,000 residents and 124 counties are

classified as rural. More than one-third (37%) of the population lives in rural areas as compared to one-fourth nationally. In 43 Georgia counties, all rural, there are fewer residents today than in 1930; seven of these counties have seen population decreases of over 50% in the past 70 years. This contrast represents more than a difference in population numbers; it reflects the emergence of the two new Georgias – one a booming, high tech and service economy characterized by youth, multi-cultural diversity, and quick adaptation to social change and cultural fads; the other, by an aging population comprised of native born Blacks and Whites with strong roots in the community and traditional values.

Georgia's population growth has been uneven, concentrated in certain areas of the state. Besides Atlanta, this growth is focused in certain other metropolitan areas -- Macon, Savannah, Augusta, Columbus, and Athens, although none of these areas have experienced the level of growth of Atlanta. The northwest Georgia counties in the Chattanooga, Tennessee MSA and the state's seven coastal counties are also experiencing a boom in population growth. With the results of the 2000 census, the designation of one or two additional MSAs is expected – Dalton, a carpet manufacturing center in the northern Appalachian area and/or Valdosta, a diverse area with a strong military, academic and agricultural infrastructure, in south Georgia, along the Florida border. Rome and Cartersville will probably become part of either the Chattanooga or Atlanta metro areas, and eventually Brunswick will form part of a coastal MSA. The population growth in these areas is due to a combination of the development of second-home/retirement communities in the northwest mountains and along the coast from Charleston, South Carolina through Savannah, Georgia to Jacksonville, Florida, and the attraction of industry and a supporting service economy along interstate highways, major freight train corridors and ports with container ship facilities.

The influx of non-native U.S. born individuals in Georgia has been a new phenomenon. Until the last decade, almost all of the non-native born population was either migrant agricultural workers or a small nucleus of southeast Asians and Mexicans in the core DeKalb/Fulton Atlanta area. A strong Georgia economy and job market, moderate living expenses, sprawling development, and community support resources have made the state attractive to immigrants and refugees from around the world. Georgia is second only to Nevada in the percent increase in Asians and ranks fourth, behind Arkansas, Nevada, and North Carolina in its Hispanic growth rate. Moreover, Georgia's native born Black population has expanded to include Blacks moving from Caribbean nations and Africa. This diversity is evidenced by the origins of immigrants coming to metro Atlanta. Estimated numbers of Atlanta immigrants in 1997 were 100,000 from Mexico; 20,000 from Jamaica; 13,000 each from India and South Korea; and 10,500 from China.

More than 41,000 refugees have moved into the state since 1981 from countries such as Vietnam, Cambodia, Somalia, Sudan, Kenya, Iraq, Iran, Soviet Union, and Cuba. Georgia currently receives the seventh highest number of refugees in the United States. Fulton and DeKalb counties, in the Atlanta MSA, have been designated as two of the country's 50 high impact refugee areas, ranking 16th and 17th respectively. These refugees often bring them with special

health and psychosocial problems stemming from their experience. The national and ethnic composition of these refugees is constantly shifting, reflecting the ethnic and racial conflicts within their own countries. For example, this year a substantial number of Bantus from Somalia are expected. As the Somalian economy worsens, some Somalians are turning against those they consider to be the lowest element within their society, the Bantus, with violence and repression. When groups such as the Bantus immigrate, they have not only special health, psychosocial, and language problems typical of other immigrant groups, but also particular issues related to their minimal educational levels and lack of suitable skills. (The emergence of non-native English speaking populations in Georgia is further discussed under population characteristics.)

Poverty in Georgia has been intransigent despite the state's positive economic picture with job growth the second highest in the country next to Nevada. The unemployment rate is at its low (3.2%) for the past 30 years, yet the number of Georgians living in poverty, one in seven (1,000,000 people), has not changed. Moreover, Georgia continues to rank in the bottom ten states, nationally, in terms of children in poverty. Approximately one-quarter of Georgia's preschoolers and one-fifth of older children up to age 17 live below the federal poverty level (\$17,050 for a family of four). In 60 mostly rural counties, over 30% of children live in poverty. Georgia's FFY 2000 estimated per capita income for a four-person family is \$51,649 versus \$53,350 nationally. Georgia has one of the largest gaps between middle and upper income families in the country (annual average income of \$123,837 for the top one-fifth of Georgia families versus \$40,248 for an average family). While ranking 24th in terms of state median income, Georgia ranks 42nd worst in terms of income disparity among its residents. The wealthiest area in the state, metro Atlanta, has a median income of \$45,193 as compared to the state median income of \$33,623; 10 counties have median incomes of less than \$21,000. Two-thirds of the state's 122 rural counties have median incomes lower than that of Mississippi, the poorest state in the United States.

Georgia's seven major metropolitan areas have prospered in the 1990s. At the same time, nearly one-third of the state's 159 counties lagged behind in per capita income and remain economically underdeveloped; 46 counties, mostly stretching along a southwest corridor from Albany in the south to Augusta in the east, actually had higher unemployment rates in 1997 compared to 1990. These counties were marked by a loss of textile and agricultural jobs, and a loss of young people leaving the area for work and education.

Lurking beneath some of these seemingly positive indicators is a significantly different Georgia reflecting a polarization between those with the good life and those mired in the cycle of poverty and limited opportunity. A recent Brookings Institute Report highlights this stark contrast in the metro Atlanta region. According to the report, "Moving Beyond Sprawl," the poor tend to live in the southern parts of Atlanta and close-in southern suburbs, while the north side of the region has very low poverty rates and almost no areas of concentrated poverty. The poor are concentrated in high numbers in a few neighborhoods with Fulton and DeKalb counties having a disproportionate share of this poverty. All of the region's extremely poor neighborhoods are

found within the city of Atlanta itself. The poor are isolated from jobs by lack of public transportation which impedes their ability to travel to the northern areas of the region that are experiencing labor shortages. Moreover, the poor often lack the skills needed by high tech companies. Atlanta's current relentless suburban growth is actually a continuation of a pattern which began after World War II, facilitated by its transportation infrastructure, pro-growth politics and governing structure. This hypergrowth is changing the landscape of once rural counties like Forsyth, Cherokee, and Spalding, with new suburbanites seeking the good life moving into new areas without the social and physical infrastructure to support their arrival. Hidden here, too are pockets of poverty whose residents have health and social needs that are often left off of public agendas filled with zoning, school, and road construction issues.

As we examine maternal and child health needs, our analysis needs to move beyond the traditional view of black and White, and urban versus rural to a more richly textured assessment. This assessment will consider distinctions in geography but look beyond to find the hidden picture of poor Georgia where needs of residents must increasingly be addressed by the MCH system.

Population Characteristics: Georgia ranks as one of the states with the youngest population, with the 7th lowest median age (34.0 years of age compared to 35.5 in the U.S.). Two contributing factors in Georgia's ranking are its large number of minorities, who often have large families and at a young age; as well as the stream of young professionals of childbearing age moving into the state.

In 1999, Georgia's estimated child population under the age of 18 was nearly 2 million. Fifty-eight percent were White, 36% were Black Non-Hispanic, 3% were Hispanic, and two percent were Asian. Georgia has no tribal lands and a very small Native American population, significantly less than 1%. Fifty-one percent of children live in the 15 largest counties, while the remainder are spread throughout the other 144 counties. By 2005, the state's child population under the age of 18 is projected to be 2,154,700 (1,255,600 White; 779,600 Black Non-Hispanic; 70,900 Hispanic; 45,400 Asian and Pacific Islander; and 3,200 Native American), with 1.6 million being of school age between ages 5 and 17.

Almost one out of every three Georgians is Black, the fifth largest Black population of any state, about two-and-a-half times greater than the rest of the United States. Behind Florida, Georgia had the second biggest increase in Black population between 1990 and 1998, adding nearly 420,000 people. Atlanta MSA experienced a 27.9% increase in its Black population. The core metro Atlanta area is home to 37% of the state's total Black population. Fulton County, which includes most of the city of Atlanta, ranks nationally in the number of Blacks (403,000; 54.7% of the total county population). DeKalb County, which includes the remainder of the city of Atlanta, ranks 20th with a Black population of 272,000 (46% of the total county population).

Less than 3% of Georgians are foreign-born, compared to more than 5% of all persons in the South and almost 8% of all Americans. The Hispanic, Asian and "other" populations of Georgia,

now about 2%, more than doubled between 1980 and 1990 and is projected to triple over the next 25 years. Census Bureau estimates indicate Hispanics and Asians are the fastest growing populations in Georgia. South Georgia has large numbers of Hispanic migrant farm workers, while North Georgia has a less transient, quickly growing Hispanic community, engaged in the poultry industry around Gainesville (Hall County) and the carpet industry in Dalton (Whitfield County). In metro Atlanta, the Hispanic population increased 112% from 1990 to 1998, growing from 62,400 to 132,500; the Asian population expanded by 95%, from 53,600 to 104,700.

Over a five- year period, from 1992 to 1997, the number of Georgia students who needed English as a Second Language (ESL) classes increased 131%. Statewide, approximately 21,000 students now take these classes. The majority speak Spanish (13,650) or Vietnamese (1,923) at home. The remainder speak a number of other languages including Korean, Chinese, Laotian, Russian, and Arabic. Also, refugee and Hispanic populations are relying on the state's public health system for health care. For example, over 90% of the Hall County Health Department's obstetrical patients are Hispanic. (See Appendix B, Examples of the Department of Human Resources Program Materials in Other Languages).

James Johnston of the University of North Carolina, an expert in Hispanic immigration studies, has described Georgia as "one of the 'new Hispanic magnet states' that are picking up Latino immigration not only from Latin America but from 'port of entry' states, such as Texas and California." (*Atlanta Journal and Constitution*). Cobb County in metro Atlanta is now outpacing Gwinnett and DeKalb Counties, in metro Atlanta, and Hall County, just beyond the MSA as a destination for Hispanic workers. The number of Hispanics in Georgia is thought to be significantly undercounted, a problem exacerbated by large numbers of undocumented persons. Depending on estimates, the percentage of Hispanics in the four counties where their numbers are highest range from 3.8% to 12.2% in Cobb, 4.6% to 9.2% in DeKalb, 4.4% to 11.7% in Gwinnett, and 8.1% to perhaps as much as 42.8% in Hall County.

The state's total Asian population has reached 149,500. In descending order, the largest Asian populations reside in DeKalb, Gwinnett, Cobb, Fulton, and Clayton Counties, comprising the core five-county Atlanta metro area. The large influx from the Indian subcontinent, South Korea and China are attracted to Atlanta's strong economy.

Health Economics: As seen in the rest of the country, Georgia's strong economy has not impacted the level of health coverage. About 1.3 million Georgians lack health insurance coverage, ranking Georgia in the bottom ten states nationally. The percentage of the state's population without insurance has remained stable at approximately 17.5%, according to 1998 Census Bureau statistics. Among Blacks, the rate of those uninsured is almost 50% greater than among Whites. Among Hispanics, over one-third lack insurance. An estimated 370,000 of the state's uninsured are children (15.4% of all children), ranking Georgia 39th among all states. Approximately 695,000 children are Medicaid-enrolled; over 100,000 are Medicaid eligible but not enrolled; and about 150,000 are uninsured, living in families above Medicaid eligibility but

below 235% of federal poverty level, the July 2000 eligibility level for PeachCare for Kids. (See Appendix C, *Understanding Medicaid, A Handbook About Medicaid Services in Georgia*).

The number of children covered by Medicaid has dropped by almost 65,000, consistent with the national trend showing a fall-off in Medicaid enrollment as families leave the TANF rolls. The percent change in Georgia (50%) was the highest in the U.S. A recent HHS study indicates that Georgia is one of only six states that has not spent any set-aside funds to ensure that children and their parents would not lose Medicaid coverage when they lost cash assistance. At the same time, PeachCare for Kids has enrolled 75,640 kids (61% of eligible children) as of April 2000. PeachCare reached its two-year goal of 60,000 enrollees in just 12 months, by the end of 1999. Georgia was fourth in the number of new Child Health Insurance (Title XXI) enrollees, behind three other states, all of which have near or over 1 million eligibles. These figures do not include applicants referred to Medicaid from PeachCare for Kids. Those enrolled in PeachCare may include children who formerly received Medicaid under TANF, however, as the shift occurred, their mothers may have totally lost health care coverage.

The HMO penetration rate in Georgia (29.3%) lags behind the rest of the country where penetration has reached 38.8%; 1.45 million Georgians are members of HMOs. The largest plan is HMO Georgia (Blue Cross/Blue Shield) covering over 500,000 persons, with Kaiser Permanente providing care to 258,000 more individuals. In 1999, HMOs showed an improved profit picture resulting from premium increases and pull-backs in the Medicaid and Medicare markets. At this time, with the Grady Hospital System HMO ceasing operations in December 1999 after losing over \$6 million dollars since its inception, no Medicaid HMO is available in Georgia. All Medicaid services are provided through a gatekeeper system, Georgia Better Health Care, that has 4,200 physicians contracted with the Department of Community Health to serve as primary care case managers. These physicians receive a \$3.00 per member monthly case management fee; services provided are reimbursed at regular Medicaid fee-for-service rates.

The difficulties confronted by the health insurance industry are demonstrated in the troubles experienced by the Georgia Department of Community Health (DCH), which covers over 560,000 people through the State Health Benefits Plan. Just over one-quarter of state employees belong to a HMO while the remainder have selected a point-of-service (POS) plan. This past year, the projected deficit in the State Health Benefits Plan exceeded \$200 million dollars. Consequently, over 40% of the state's \$600 million surplus had to be appropriated to rescue this plan. Similar to other health plans, benefits had risen only 3% over the past two years, while medical costs climbed 12.5% and 14% respectively in the same two years. Drug costs increased 20%. As a result, significant rate increases, as well as disincentives to utilize the POS plan, are being put into effect. Moreover, a discounted rate structure, more in line with the amount paid by private insurers rather than the former full retail price charged the state, was agreed to by all the acute hospitals in the state at the risk of losing their affiliation with the State Health Benefits Plan. In a further step to reduce costs, a pharmacy benefit management contract is being negotiated with Express Scripts to cover Georgia's 1.2 million Medicaid recipients, 560,000 members of the

State Health Benefits Plan, and 90,000 enrollees in the University Systems' Board of Regents Plan. This marks the first time since the creation of DCH in 1999, that the combined clout of this membership base is being used to control costs across the plans.

The private health insurance industry also has been beset by changes. Notably, the State Insurance Commissioner has begun to enforce consumer-oriented legislation passed over the last two years and has levied substantial fines against various insurance companies. The institution of these fines has sent a clear signal to the industry that Georgia is no longer a "business-at-will" state. The consolidation among companies continues. Aetna and PruCare completed their merger. A proposed buy-out of the WellPoint/Blue Cross Plan by Aetna fell apart under pressure related to dominance of the market share. However, the WellPoint/Blue Cross merger still has not been formalized and remains in the courts with outstanding issues related to share distribution. This delay has stalled the creation of an \$80 million conversion trust foundation that will make health-related grants in Georgia.

The five-year impact of reduced Medicare payments to Georgia hospitals, resulting from the Balanced Budget Act of 1997, is estimated to be \$1.9 billion from 1998 to 2002. These cuts have occurred at the same time that the state reduced Medicaid payments to hospitals by more than \$100 million in state fiscal years 1997 to 1999. Additionally, the hospitals are bearing \$800 million a year in costs to treat uninsured patients on top of a \$77 million reduction in reimbursement through the Indigent Care Trust Fund. This year's amendments to the Balanced Budget Act, related to teaching hospitals, will help the state's five academic medical centers. Under the new arrangement, for instance, the three Emory hospitals (University, Crawford Long and Grady), who were slated to lose \$144 million over the five-year period, will assume this cut at a much slower rate. The partial restoration of disproportionate share payments will also benefit eligible Georgia hospitals.

The state's largest public hospital, Grady Memorial in Atlanta, continues to be plagued by economic shortfalls. This year, Grady received a federally funded bail-out of nearly \$53 million, and the state released a total of \$100 million owed to the hospital for Medicaid treatments, previously provided where billing had been delayed. As part of the arrangement, still another program management review has been instituted. However, based on prior experience, a long-term resolution for Grady cannot be expected.

Changes, such as those experienced by Grady, have had a strong impact on even long prosperous hospitals with strong patient bases. For example, the eight hospitals in metro Atlanta's Promina Health System saw a net income of \$11.1 million for the quarter ending September 1999 compared to the same period in 1997, when net income was \$20.3 million. In 1998, 62 of the state's 159 acute care hospitals lost money, an increase of 11 hospitals from the previous year; 48 of these money-losing hospitals are in rural areas. In some cases, investment income is all that is keeping hospitals in the black, and this slim "profit margin" is vulnerable to swings in the financial markets.

The cost of caring for indigent patients is one factor in the financial difficulties faced by Grady and other Georgia hospitals, that can no longer rely on Medicaid and Medicare payments to bolster their fiscal bottom line. Uncompensated care at WellStar Cobb Hospital increased from \$4 million to \$6 million, at DeKalb Medical Center from \$9.8 million to \$10.4 million, and Gwinnett Medical Center from \$2.7 million to \$5.1 million over a one-year period. (At Gwinnett Medical, just one case involving an undocumented person in a car wreck resulted in cost of care of over \$1 million; the patient died.)

Health Delivery System Environment: Reductions in payments from government programs and private insurers magnify other changes within Georgia's health care delivery system. This delivery system is faced with aging facilities, new technology needs, increases in marketplace competition and shifts from inpatient to outpatient care. For four Georgia hospitals, these factors resulted in their demise, this past year. The Bowden Area Hospital (41 beds) in rural west Georgia suffered major losses related to Medicare cuts and inability to match the services provided at the larger Tanner Medical Center in nearby Carrollton. Ridgecrest Hospital (49 beds) in Rabun County closed in August 1999, and Tattnell Memorial Hospital (40 beds) in Reidsville shut its doors in April 2000. These closings were not restricted to rural areas. West Paces Ferry Medical Center (294 beds) in Atlanta closed in December 1999 after seeing its bed occupancy drop to under 20%.

Private psychiatric hospitals also have closed after being confronted by managed care cost cutting that has changed the behavioral health care world with shorter stays and more outpatient treatment. This is placing more pressure on the public mental health system. Charter Behavioral System, faced with Chapter 11 bankruptcy, closed facilities in Athens, Macon and Augusta in February 2000, leaving six company hospitals operating in metro Atlanta, the company's biggest market where Charter has approximately 40% of the market share. The 24 bed psychiatric unit at WellStar Kennestone Hospital in Marietta has closed, cutting the available psychiatric beds in this system in half. The reduction in bed space has resulted in occasional overflow and turnaway of patients, with indigent patients being sent to Georgia Regional Hospital in Decatur, 25 miles away.

The Critical Care Access Program began the process of designation of rural hospitals this past year; as many as 45 of Georgia's 86 rural hospitals are eligible for designation and to date 13 have moved forward. 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. In the summer of 1999, Southwest Georgia Regional Medical Center became the first hospital in the state to gain this designation. As a result, Southwest Georgia Regional will receive an additional \$180,000 to \$200,000 a year in Medicare reimbursement. Five additional facilities have now received this designation: Southwest Georgia Regional in Cuthbert; Taylor/Telfair Regional in McRae; Bleckley Memorial in Cochran; Jasper Memorial in Monticello;

Morgan Memorial in Ocnoee; and Miller County in Colquitt. Two hospitals have been surveyed and are pending designation by the Health Care Financing Administration (HCFA): Effingham Hospital in Springfield and Dooley Medical Center in Vienna. Clinic Memorial in Homerville has an application in the review process and four additional hospitals are working on their applications.

In 1998, still more hospitals participated in networks and bought physician practices. Approximately 55% of Georgia acute care hospitals participated in a network in 1998 compared to 39% in 1996. Hospitals owning or operating a primary care practice increased from 31% in 1996 to 40% in 1998. The proportion of hospitals belonging to an alliance has remained relatively stable at 42% in 1998.

Infrastructure improvements and technology investments, once seen as perfunctory, are now necessary for survival of Georgia hospitals. Tobacco Settlement funds have been appropriated to support Senate Bill 195, passed in 1999, which permits grants to be given to rural hospitals lagging behind in modernizing their facilities and obtaining new equipment. Emory University's Crawford Long Hospital received Department of Community Health approval in November 1999 for a \$270 million redevelopment plan to revive its 90 year old structure and consolidate its services. St. Joseph's Hospital in suburban Atlanta is planning a \$32 million expansion and has filed an application in December 1999 for a \$30 million, 20 bed women's health center.

Excess bed capacity may result in still another wave of consolidation and closure or could result in some facilities trying to improve their services by better integrating patient care across all treatment settings. Hospital occupancy rates have declined statewide to below 50%, falling from 55.1% in 1995 to 44.1% in 1998. The average stay in a general hospital in Georgia has fallen by one day since 1990 to 4.8 days in 1998. Occupancy rates have been impacted by the demand of managed care for shorter stays, advances in surgery, shifting care from inpatient to outpatient settings, and pharmaceutical breakthroughs eliminating some hospital stays. In 1990, ambulatory care accounted for 52.6% of all surgery in Georgia hospitals; by 1997, this figure had risen to 65.8%. Outpatient visits to hospitals almost doubled since 1990, increasing to 7.7 million visits in 1998. Outpatient revenue as a percent of gross patient revenue increased from 22.3% to 35.3% in this same time period. This shift, which had benefitted the financial condition of hospitals, is expected to have negative consequences with amendments to the Balanced Budget Act related to outpatient services. Typically, at least 20% of a hospital's revenues come from outpatient services and 30-40% of this revenue is derived from Medicare. Georgia hospitals are expected to fare worse over all than the nation as a whole with Medicare payments for outpatient services dropping about 18%. Potentially, hospitals could be paid less than 70% of their costs according to the Georgia Hospital Association. St. Joseph's Hospital is projected to receive \$12.7 million less in outpatient Medicare reimbursements over a five year period, nearly 30% of the \$44 million expected in Medicare cuts. Grady Hospital losses are estimated to be about \$2.4 million a year; Grady's outpatient services make up nearly 40% of its total patient revenue, 16% of which is reimbursed by Medicare.

All of these factors have consequences for the public health system. While increased demands are placed on public health as a safety net provider for the uninsured and underinsured, traditional revenue streams from third party reimbursement and state grant-in-aid support are diminishing. For example, in Cobb County, 66% of all primary care visits were made by patients with no health insurance, and in Douglas County this figure was 80.4%. For the second consecutive year, in fiscal year 2000, county health departments absorbed a reduction in grant-in-aid funds which support essential public health functions. In fiscal year 1999, 61 counties shared a \$5 million reduction and in fiscal year 2000, 60 health departments assumed further cuts of \$3.6 million. An example of the impact of this cut is DeKalb County which took a \$400,000 decrease in fiscal year 2000 on top of a \$611,000 cut the previous year. This will force cuts in positions such as nurses and caseworkers in DeKalb's five primary care clinics that form a safety net for the area's Hispanic immigrants and refugee populations. Fulton County reduced HIV programs and immunizations to address its fiscal year 1999 \$848,000 cut.

Medicaid revenues earned from services to maternal and child populations provide substantial income for the 159 county health departments. Medicaid supported programs that provide these earnings include Family Planning, EPSDT Health Check, Perinatal Case Management (PCM), Pregnancy Related Services (PRS), and Diagnostic Screening and Preventive Services; Health Check and PCM are the largest generators of revenue, accounting for almost 70% of total earnings. Overall, health district Medicaid earnings have decreased by \$2.8 million, from \$16.5 million in fiscal year 1998 to \$13.6 in fiscal year 1999, a 17.3% decrease. Much of this decrease resulted from reductions in EPSDT Health Check earnings. These earnings decreased from \$17.1 million in fiscal year 1998 to \$5.3 million in fiscal year 1999, a 25.6% decrease in the one year period and a 62% decrease since fiscal year 1995. Private providers now account for 79% of Health Check earnings.

Georgia's problem with maldistribution of providers continues to impact access to care, particularly for uninsured and underinsured persons and residents of rural areas, especially those requiring specialty care. There are too many providers in urban areas and not enough in rural parts of the state. Moreover, the availability of providers to serve these populations is becoming even scarcer which has led to the designation of an increasingly large number of population groups for Health Professional Shortage Area (HPSA) status. Speciality care is more limited, generally located in areas with academic medical centers (i.e., Atlanta, Augusta, Macon and Savannah), leaving large portions of the state without access to this care. Fifty-three entire Georgia counties and seven partial counties are currently designated by the federal government as primary care HPSAs as are 78 population groups. These population groups include those below 200% of the federal poverty level, Medicaid eligible individuals, and migrant farm workers within specific geographic areas. Approval of a number of dental HPSAs is pending; this has been part of a specific initiative this year to respond to identified needs related to oral health services. In addition, 116 whole counties and 28 partial counties are designated as medically underserved areas. Three populations, Hispanics in Hall and Gwinnett counties and a low-income population in Franklin County, are designated as medically underserved.

Access to dental services continues to be a serious problem for Georgia children; 30% of tooth decay among poor children in Georgia remains untreated. In a statewide survey of school children, Black children had twice the number of untreated decayed teeth as White children. In a survey which followed a modest 1999 increase in Medicaid dental reimbursement rates, 496 out of 3,900 dentists indicated they would accept new Medicaid patients. This actually is an improvement over 1997 when only 259 dentists said they would accept these patients.

Oral health resources in the public sector are also limited. Only five community health centers have dental facilities while out of 159 health departments, 43 have treatment facilities and 64 offer preventive services. In an effort to encourage dentists to practice in underserved areas, in FY'00, a major thrust occurred to designate dental health manpower shortage areas with over 30 such areas receiving designation, quadrupling the total number. Currently, 51% of calls to PowerLine, Georgia's MCH toll-free hotline, were related to dental health, primarily access issues. Strong advocacy efforts by the Georgia Oral Health Coalition resulted in a FY'01 state appropriation of \$1 million for expanding the Oral Health Prevention Program statewide, a significant increase in Medicaid dental reimbursement rates, and a simplification in Medicaid dental reimbursement procedures.

Community level planning is beginning to effect changes in the health care delivery system. A notable effort was initiated this year in the Macon area, in central Georgia, to work through a broad-based community coalition to establish health care for all residents in a seven-county area utilizing a Phase I planning grant from the Robert Wood Johnson Foundation. The Foundation's Community in Charge initiative is providing the coalition with financial support and technical assistance to refine a comprehensive plan to provide care to all uninsured persons. In Miller County, a rural county in the southwest corner of the state, which has struggled to maintain the presence of a hospital and a physician, negotiations are underway with the Department of Community Health to eliminate duplicate services between the local public health department and the hospital.

National/State Initiatives Impacting Georgia's MCH System: Unlike past years when major federal legislative initiatives emerged, no new initiatives emerged during FY'00; however, two prior initiatives, Child Health Insurance Program (CHIP) and Temporary Assistance for Needy Families (TANF), continue to impact Georgia's maternal and child health population. The most significant opportunity for system improvement and service expansion arose from the Tobacco Master Settlement Agreement (MSA) from which Georgia will receive \$4.8 billion over the next 25 years. Georgia expects to receive the first installment of \$386 million this fiscal year. MSA funds will enable the state to establish new MCH services filling gaps and address previously identified needs. The status of CHIP PeachCare for Kids has been discussed above in the Health Economics Section. The impacts of the other two initiatives, TANF and the MSA, are discussed below.

TANF, having successfully reduced its rolls by 53.8% (62,000 families) from January 1997 through February 2000, is soon to be confronted with the four-year cash assistance eligibility deadline on December 31, 2000. An estimated 11,000 Georgia families are seen as hardcore cases, “unskilled, uneducated, unmotivated, and in some cases, unreachable.” Some of these families suffer from drug and alcohol addiction or chronic mental health problems. Others are stranded in rural and urban communities without nearby jobs or public transportation to get to available work, as well as lacking educational opportunities and/or child care resources. The fastest declining rolls have been in north Georgia where Whitfield County has led the way with a decrease of 80%. The slowest declines have occurred in south and middle Georgia where Cook, Dooley and Washington counties have experienced drops of less than one-third. Despite experiencing a 58.5% drop in cases since 1997, metro Atlanta’s core, Fulton County, still has roughly 20% of the state’s long-term welfare recipients cases. A post-eligibility strategy is beginning with a case-by-case assessment of long-term recipients, however, an overall plan has yet to be detailed for these cases as well as others who may re-enter the system and then exhaust their eligibility.

The MSA has yielded funds to support a wide spectrum of program initiatives and service expansions. Overall, health and social services fared better in Georgia’s allocation of MSA funds than was true in most other states. Although only about 10% of funds went directly to tobacco prevention efforts, upwards of one-half of all funds were directed towards health and social service delivery. The specific initiatives and expansions funded by the MSA are discussed in the state initiative section below.

State/DHR MCH-Related Initiatives: The recent State Legislative session which ended in April 2000 focused on two major issues impacting children, education reform and child welfare. Education reform legislation was the culmination of the work of the Education Reform Study Commission, appointed by Governor Barnes in 1999. However, the major restructuring of the child welfare system was precipitated by investigative reporting by the Atlanta Journal-Constitution, the state’s major newspaper. This series, appearing just before the legislative opening, revealed major flaws in the current child welfare system resulting in highly publicized child abuse deaths; 844 children who died of various causes in a five-year period were known to the state’s child welfare system. With this publicity, advocates were able to garner the support needed for changes that had been long sought.

Responding to the Atlanta Journal-Constitution articles, the Department of Human Resources (DHR) Commissioner, Audrey W. Horne, appointed a 15-member panel to recommend DHR Division of Family and Children Services (DFACS) policy, staffing, and child protective services accountability changes. (See Appendix D, Child Protective Services Task Force Report - Executive Summary). Preliminary reports from this commission as well as member-initiated legislative bills passed during the 2000 session. Among the bills passed were the creation of an Office of Child Advocate in the Office of the Governor to oversee DFACS, authority for

physicians to assume temporary custody of children they believe are in imminent danger from abuse and neglect, broadened powers for the DHR commissioner and DFACS director, and structural changes in the juvenile court system to move the function from the county to the state level. These bills go into effect July 1, 2000. The Terrell Peterson Act, named in memory of one of the most horrific abuse cases, gives power to physicians to remove children. DHR and DFACS will now have power to fire local county DFACS directors and reject nominees for this position where previously only the Governor and county boards had this authority. The law also requires county DFACS boards to nominate appointees from a list of qualified candidates provided by the DHR commissioner and requires the head of county DFACS to make detailed annual reports of all children served, including disposition of cases. Healthy Families Georgia, a home visiting program for high risk families with newborns, received a boost of almost \$11 million to expand its intensive outreach services. The budget of Georgia Network of Child Advocacy Centers, 24 existing centers with expertise to assess children who have been sexually abused, was increased by about 50%.

The issues addressed in the education reform package included shifts in classroom control to increased local decision-making within a state mandated framework that addressed issues such as reduced class size and teacher accountability, funding to equalize expenditures among the over 180 school districts, and increased focus on academics. These reforms were sought to improve Georgia's historical low ranking status related to education performance, e.g., high school graduation, Georgia's MCH state-negotiated outcome measure. In addition, \$30 million from the MSA was allocated in an effort to fulfill the Governor's pledge of "a nurse in every school." With increased mainstreaming of children with special needs, the lack of trained health personnel to administer medications and provide care has become a larger concern. The Family Health Branch developed an approach to comprehensive school health which local school districts, working in conjunction with county health departments, may be able to adopt in the employment of school nurses. (See Appendix E, Family Health Branch Comprehensive School Health Plan). This expansion of school nurses represents a significant start towards the estimated \$75-90 million that may be needed for full implementation. Other funding increases were provided to expand the Alternative Education Program for youth experiencing difficulty in regular schools and for the improvement of the ratio of students to school social workers and psychologists. Additionally, support was given to establish a statewide school violence program located in the Georgia Emergency Management Agency (GEMA). The Family Health Branch plans to meet shortly with GEMA staff to explore collaborative activities.

Other significant state initiatives external to DHR include:

- ***Juvenile Justice (Department of Juvenile Justice)*** - The Juvenile Justice court system is being reorganized, moving from county courts where rotating justices lacked expertise and skills to a dedicated state level court system. At the same time, increased emphasis on community-based sentencing along with support services is occurring with expanded funding and the closing of residential detention centers, e.g., Lorenzo Benz which served metro

Atlanta youth. At the same time, the health needs of adjudicated youth are being addressed. A new collaboration with the DPH HIV Incarceration Initiative has started with expanded STD screening and prevention services. A risk factor study will better characterize these youth and improve service delivery.

- ***Medicaid Expansion (Department of Community Health)*** - As described above, Medicaid eligibility limits have been raised to 235% of federal poverty level for the Right From The Start Medicaid population and for Title XXI PeachCare. Eligibility has been extended for an additional year for transitional Medicaid eligibility for TANF recipients. Access to Medicaid and PeachCare reimbursed dental services have been furthered through an increase in reimbursement rates and a simplification in claims procedures to raise the number of dentists participating. The eligibility period for family planning services post-partum was expanded from the current 60 days to two years.

- ***Office of Women's Health (Department of Community Health)*** - The Office of Women's Health was established following the passage of legislation in 1999. DeFloris Baldwin, a nurse who directed graduate programs at Georgia State University, serves as executive director.
- ***Community Collaboration (Family Connection)*** - The Department of Education and the Department of Human Resources' DPH and DFACS community-based planning and service delivery collaboration is expanding from its current 148 counties to all 159 Georgia counties. Family Connection has provided a structure for community planning and joint initiatives.
- ***Cancer Research/Treatment/Prevention Consortium*** - Using MSA funds, Governor Barnes has proposed a collaborative effort to bring together cancer research, treatment, and prevention activities linking Georgia's four schools of medicine to other institutions. This center, for which funding will be sought in the FY'02 state budget, will include a community outreach program to educate Georgians on prevention and treatment.
- ***Commission on Men's Health*** - The 2000 Legislature established a commission to examine men's health issues which are perceived as overshadowed by and inextricably related to health concerns of women and children. The commission will produce a series of recommendations to be considered in the next legislative session; DPH will have input into these recommendations and is currently preparing a report on men's health. (See Appendix F, Draft Report on the Status of Men's Health, 2000).
- ***Joint Study Committee on Prevention and Emergency Care of Injuries in Georgia*** - The 2000 Georgia General Assembly passed a resolution creating this joint study committee to review concerns related to injury prevention and emergency care. DPH will provide information for their consideration.

Within DHR, in addition to the responses to national initiatives, several departmental initiatives are also underway:

- ***Ombudsmen for Mental Health/Mental Retardation/Substance Abuse Services*** - Passage of legislation in the 2000 session created state and community ombudsmen. The state ombudsmen will be under the direction of the Consumer's Insurance Advocate in the Governor's Office. Contracts will be entered into for a network of community ombudsmen who, following investigations, provide responses, recommendations and actions.
- ***Substance Abuse Service Expansion*** - The 2000 Georgia Legislature allocated \$5,000,000 for substance abuse prevention and avoidance that deals specifically with children, teens, and pregnant women, emphasizing long term care.

- ***Interpreter Services*** - DHR is currently developing a plan to meet the burgeoning need for interpreter services in its many programs. Funding for bilingual services has also been increased. Outside of DHR, the Georgia Mutual Assistance Association Consortium, which provides services to refugees under a contract with DHR, received a federal grant to train interpreters and start a language bank of people trained in medical and legal interpretation.
- ***Fatherhood Initiative*** - Increased funding has been provided to the Fatherhood Initiative which aims to engage male parents in assuming responsibilities in the lives of their children.
- ***Early Learning/Child Care*** - Over \$30 million in designated TANF funds were appropriated by the 2000 Georgia Legislature for a range of child care activities including worker training, Head Start improvement, increased slots, and higher reimbursement rates. The public-private Georgia Early Learning Initiative (GELI) received increased funding to develop its recommendations for improved early learning and child care services.
- ***Child Abuse, Domestic Violence, and Sexual Assault*** - Expanded funding occurred in all of these areas. Four new domestic violence shelters will be established along with expansion of domestic violence intervention programs. Additional funding was provided for the Georgia Network on Child Advocacy Center.
- ***Autism*** - Funding was provided specifically for enabling services to assist 600 families coping with children with autism.

Several important initiatives have been launched with DPH; the Family Health Branch has either primary responsibility or is assuming a major collaborative role in these efforts.

- ***Universal Newborn Hearing Screening*** - Following the creation of a Governor's Committee on Newborn Hearing Screening during the 1999 legislative session, program plans to implement screening have been generated. (See Appendix G, Universal Newborn Hearing Screening Flow Chart). These plans focus on screening protocols, provider education, community awareness, and data management and evaluation. The implementation of these plans will be supported through funding from several sources: \$2 million from the MSA to purchase screening equipment and reimburse providers for screening, diagnostic, and intervention services; a \$150,000 per year grant from HRSA MCHB to support core staff and systems development; and an ongoing state appropriation of \$140,000 for activities related to the committee and statewide provider training. With these funds, expansion of screening from the current 30% of all newborns to at least 90% is anticipated within the next three years. Appalachian Regional Commission funding has been received to provide dual hearing screening equipment in hospitals in the state's Appalachian Region.
- ***Oral Health*** - The Georgia Dental Public Health Plan received \$1 million to focus on providing dental prevention to low income, high risk children in school-based programs in

rural areas. The initiative will be launched with a state summit, for which HRSA support is pending that will bring together stakeholders to address communication, coordination and collaboration in order to establish a cohesive system to deliver services. Among the services to be offered are school-based fluoride mouthrinse programs, dental sealants, dental health education, school-based screening, and dental referrals. (See Appendix H, Oral Health Plan). These activities will be implemented statewide with teams comprised of a public health dentist and hygienist who will use portable dental equipment to provide these services. In addition, emergency dental services will be provided in local health departments and community health centers, for which HRSA funds have been requested to expand the number of community health centers providing dental services from five to nine.

- ***Asthma*** - The Family Health Branch developed a collaboration with the American Lung Association (ALA) - Georgia Chapter. Through a contract with ALA, a household, random digit-dial prevalence survey will determine asthma rates among children and characterize the population with asthma. A structured interview study will be conducted to examine reasons for high emergency room usage for asthma treatment. Results from these two studies, along with other asthma morbidity and mortality data analysis, will be analyzed with the results published in a report as well as serving as a foundation for the development of strategic directions. (See Appendix I, Asthma Contract, Survey, Study, and Report).
- ***Tobacco Prevention*** - MSA funds will support a major expansion of current tobacco prevention initiatives, which are primarily youth focused. The five goals of this initiative are deglamorization of tobacco use through media initiatives, elimination of environmental tobacco smoke, prevention of initiation of tobacco use, promotion of quitting, and elimination of disparities among populations. The strategies, at a state and local level, are community-based initiatives, effective use of media, policy changes related to access and environmental tobacco smoke, and surveillance and evaluation. Each of the 19 health districts will be funded to implement a core set of activities and additional funds will be awarded to voluntary health organizations for state-level initiatives.
- ***Perinatal HIV Transmission*** - DPH has received a CDC HIV Perinatal Transmission Prevention grant to assure that HIV positive, pregnant women are identified prior to delivery and are linked to appropriate OB and HIV care including therapies to reduce the risk of HIV transmission to the infant. The initiative is a collaboration between the HIV/STD Section in the Prevention Branch and the Women's Health Section in the Family Health Branch. The three initiative components are outreach to and enhanced case management of pregnant women who are HIV positive or at very high risk of infection during and following their pregnancies in five metro Atlanta counties, professional education of physicians who provide OB/GYN services regarding the importance of offering HIV testing to all pregnant women as well as increasing HIV therapeutic interventions at delivery hospitals, and social marketing directed to women of reproductive encouraging them to know their HIV status and providing a positive message about available therapies and prevention of perinatal HIV transmission.

- ***Suicide Prevention*** - A breakthrough in dealing with youth suicide occurred in the appropriation of funds to examine this issue and develop initial intervention directions. This support was garnered through extraordinary efforts of one family impacted by the death of their daughter who used their energies to create the Suicide Prevention Advocacy Network (SPAN). DPH will be working closely with this advocacy group as it moves forward to develop epidemiologic and programmatic activities.
- ***Adolescent Asset Building*** - Working with several other stakeholder state agencies and private organizations, the FHB has taken leadership in developing a competency-based training model for staff who work with adolescents to build their assets. Through a contract with DPH, the University of Georgia has structured a six module curriculum that includes the status of Georgia's youth, pre-adolescent and adolescent development, the asset approach to youth development/ programmatic responses to developmental needs, the program development process, family involvement and resiliency, and community involvement. Included within the curriculum are assessment instruments, exemplary program models, youth development publications, and selected youth development website addresses. The competencies include caring and commitment to youth, knowledge of adolescent development, specific skills, and critical thinking. Included in knowledge of adolescent development are cultural, gender, and faith factors as well as the impact of disability and chronic illness. Skills include leadership, communication, facilitation, conflict resolution, collaboration, program development, family and parent involvement, and community involvement. (See Appendix J, Assets Curriculum). Training will commence later this year and includes staff from not only DPH but all stakeholder agencies and organizations.
- ***Faith-based Public Health Initiative*** - DPH launched a major effort to engage the faith community as a partner in public health prevention. At the core of this initiative is the issue of teen pregnancy. A major conference which included leaders of all faiths was held at the Carter Center in May 2000 with Rosalyn Carter taking an active role. The keynote speaker, Sarah Brown, Director of the National Campaign to Prevent Pregnancy, focused on the paradigm shift from the medical model to the faith-based or spiritual model of teen pregnancy, health-speak versus God-speak. The role outlined for the faith leaders is putting values into healthy lifestyle/risk behavior decision-making. (See Appendix K, Keynote Presentation by Ms. Sarah Brown, Director of the National Campaign to Prevent Teenage Pregnancy).
- ***Men's Health Initiative*** - The overall goal/objective of the Men's Health Initiative is to address men's health and the impact of men on women's health. This will be achieved by the following three distinct areas:

- 1) The formation of a professional and culturally diverse study group, that will be provided quantitative and qualitative data, which will enable them to develop a vision and offer recommendations;
- 2) Development of a clinical model for men's health to be adopted by the Division of Public Health; and
- 3) Development and presentation of a two-day workshop targeted to providers of Title X and other health care provider that have potential impact on men's health. (See Appendix L, Men's Health Initiative Work Plan).

D. Description of Process Used by the Family Health Branch Administrator to Determine the Importance, Magnitude, Value and Priority of Competing Factors Upon the Environment of Health Care Delivery in Georgia

During the current year, FFY'00, the Family Health Branch has continued to build its infrastructure, expand stakeholder relationships, and engage local public health agencies and providers in carrying activities at all levels of the pyramid. A particular focus was putting in place stronger management structure and building the infrastructure capacity for programmatic activities. These directions were based on initial exploratory needs assessment conducted in FFY'99 and the further refinement which occurred the following fiscal year. The FFY'99 Block Grant Application outlined a recast maternal child health system along with a new role for the Family Health Branch. The comprehensive needs assessment conducted this year in preparation for our FFY'01 application has further directed Branch activities. Details regarding these efforts are described in the annual plan section of this grant application (Section IV).

The Family Health Branch's mission and goal statement provides the values framework that guides its operations.

Family Health Branch Vision/Mission Statement

We believe that healthy, well-educated children and families are the keys to optimal individual growth and development essential to maintaining safe and economically sound communities.

We believe in...

- * ethical decisions and actions
- * prevention
- * community ownership
- * commitment to a scientific process

Therefore, we are committed to promoting the physical, mental, spiritual, and social well being of children and families through partnerships with communities. These beliefs will be reflected in all policies, procedures, program development and funding mechanisms (decisions) that are part of any business done by, with or on behalf of the Family Health Branch.

1.5 The State Title V Agency.

1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

Overview of Georgia's Title V Organization: The Family Health Branch (FHB), part of the Division of Public Health (DPH), Department of Human Resources (DHR), is Georgia's Title V Agency. The charge of the Branch is promoting the health of the state's mothers and infants, women of childbearing age, children, adolescents and children with special health care needs. The Branch works toward: 1) early and comprehensive health services to women of childbearing age and their infants in an environment that fosters personal dignity; 2) timely and comprehensive health services to children which promote the optimal attainment of their individual abilities; and 3) comprehensive health services to adolescents in an environment that fosters personal responsibility, encourages independence, and promotes positive health behavior. To carry out these responsibilities, the Branch is involved in policy and planning activities, oversees the operations of various MCH programs in local health departments and other organizations, and provides technical assistance and training.

Under the leadership of Family Health Branch Director, Rosalyn K. Bacon, M.P.H., an assessment process was initiated at the Branch level in 1998 to strengthen and reshape Public Health's MCH programs throughout the State. The principal goals that evolved from the assessment process were to: (1) build "system capacity;" (2) improve the delivery of services; and (3) positively impact the health status of infants, children, children with special health care needs, adolescents, women and men. To address these goals, a comprehensive reorganization plan was

devised for the FHB in 1999 to shift the Branch “psychology and philosophy” from program based services to population-based services. At every level of the FHB, a number of structural and functional changes were made. Beginning in FY 2000, the reorganization plan was fully implemented to bring about significant improvements in the levels of communication, collaboration, coordination and community focus among programs within the Branch. As this reorganization plan moves forward, its impact will begin to permeate into the broader statewide MCH system.

This paradigm shift has been critical in order for the Branch to be more competitive, innovative and representative of the needs of Georgia’s families. The FHB adopted the “**Seven C’s**” to guide its shift to population-based services. **Competence** and **commitment** comprise the foundation; the remaining guiding principles, **communication, cooperation, coordination, collaboration, and community-focus**, serve to unite staff in the Branch to realize its reorganization goals.

The nature and scope of the current FHB organization is described below:

- **The Office of the Director of the Family Health Branch:** The FHB Director, Rosalyn K. Bacon, provides leadership and vision for the Branch. She directs and oversees the overall Branch administration, serves as the lead staff person for “family health” policy development for the Division, and is responsible for developing and implementing a marketing and public relations plan that incorporates both internal and external marketing and public relations strategies. In addition, she has the chief responsibility for advocacy of the Branch and its programs and services throughout the MCH system.

The Acting Operations Director, Beverly James, is responsible for: (1) oversight of the daily operations and administration of the Branch; (2) oversight of the administration of the Branch budget and contracts; (3) management of human resources/ personnel and employee relations; and (4) the development of a comprehensive annual work plan for the Branch. The Directors of the Offices of Administrative Support, Beverly James, and Contract Management and Compliance, John Neal, report to the Operations Director.

The Director of the Programs and Services Section, Eve Bogan, is responsible for the day-to-day operations of the FHB programs and services and the direct supervision of four Population Team Leaders (Women’s Health, Infants and Children’s Health, Adolescent Health and Youth Development, and Children with Special Needs Population Teams). She is responsible for providing technical assistance and support to Population Team Leaders and population-based work teams (e.g., assistance with the development of population-based work plans and the development and design of new and revised programs and services.)

The Director of the Policy, Planning and Evaluation Section (PPE), Gala Hambrick, works closely with the Director of Programs and Services to provide leadership to the Branch’s Population Teams for priority-setting, planning, and policy development. In this role, PPE coordinated the FY’01 MCH needs assessment which provided the basis for this application. The PPE Director works closely with the Division’s Maternal and Child Health Epidemiology Unit to assess and monitor the health status of Georgia’s children and families and the Health Assessment Section on data related policy and operational issues.

The Data Team Leader, Elana Morris, has responsibility for branch-level data concerns. She provides leadership and guidance to each of the Branch Managers and the Data Analyst in each of the four population teams. Her work includes development and implementation of information systems improvements for the Branch.

- **The Programs and Services Section:** The Program and Services Section was created to: (1) assure quality; (2) assure collaboration and integration of programs and services within the Branch; and (3) improve the quality of technical assistance that is provided to local health departments and communities.

With regard to Continuous Quality Improvement (CQI), the FHB has developed a “Framework for Continuous Quality Improvement Implementation Plan.” (See Appendix M for Plan). The purpose of the plan is to outline the scope and nature of a CQI framework as an organizational strategy for the ongoing development of a more competitive, innovative and responsive family health system in Georgia. The framework is designed to move the entire organization toward cooperating to achieve a transition of the FHB from an “administrate” to a “facilitate and support” role in service delivery.

Population Team Leaders, who function as program managers, report to the Director of Program and Services. This change has improved supervision and leadership to program management staff as well as improved the availability and distribution of technical assistance and support to the Branch’s programs and services. Medical Consultants are contracted to provide medical oversight and consultation to the Director and the four Population Teams.

Under the old FHB structure, Branch units included the Nutrition Program, Women’s Health Program, the Child and Adolescent Health Unit, the Immunization Program, Office of Adolescent Health and Youth Development, and the Center for Resources Planning and Development (Children 1st). In addition, within the Child and Adolescent Health Unit, there were a number of programs and services which crossed over several MCH population groups. These programs and services included: Health Check (EPSDT), Babies Can’t Wait (BCW) Program, Children’s Medical Services Program, Hearing and Vision Screening Program, Genetics Program, SIDS/Other Infant Death (OID) Program, School Health Program, and Newborn Metabolic and Sickle Cell Screening. (See Appendix N, Family Health Branch Program Fact Sheets).

With the reorganization, the Programs and Services Section redistributed and restructured the organization of these programs and services using a “population group” model. The programs in the former Child Health and Adolescent Unit separated into: (1) Infant and Child Health, and (2) Children with Special Needs. Programs and services within each of the four “population groups” are now assigned as follows: ***The Office of Infant and Child Health Services*** incorporates: 1) Comprehensive Child Health Services (Screening Services) - Health Check, Metabolic and Sickle Cell Screening, Hearing and Vision Screening, and Scoliosis Screening; 2) School Health; and 3) Child Development and Safety - Child Development, Child Fatality, and Sudden Infant Death Syndrome (SIDS)/Other Infant Death (OID). A significant change in the philosophy and operations related to Children 1st occurred this year. Rather than Children 1st, the identification, tracking, and linkage system for at risk children, existing as a stand alone program, it has been recast as the underlying process used by all infant and toddler and children with special needs programs to coordinate case finding and management. As such, Children 1st is now integrated into all of the work of population teams.

As of July 1, 1999, another significant change was effected with the transfer of the ***Office of Immunization*** from the FHB to the Prevention Branch. Despite a change in reporting, the close working relationship between Immunization and the FHB remains unchanged.

Immunization is a critical service provided infants and children as part of their overall well child care.

The Office of Adolescent Health and Youth Development includes: 1) Comprehensive Adolescent Health Services, and 2) Youth Development (an outgrowth of the former Teen Plus Program) - Abstinence Education, Adolescent Male Involvement, Youth Involvement, and Community Involvement.

The Office of Children with Special Needs includes: 1) Babies Can't Wait (BCW), 2) Children's Medical Services (CMS), 3) Genetic Services, and 4) High Risk Follow-up.

The Office of Women's Health includes: 1) Maternal High Risk Services - Perinatal and Prenatal Care and Resource Mothers; 2) Reproductive Health Services - Family Planning and Preconceptional Health, and 3) Preventive Women's Health Services - Chronic Disease Collaboration, Sexual Assault Prevention and Education, and Intimate Partner Violence Activities.

In our current Branch structure, nutrition and physical activity and oral health now cut across the four population groups. The Offices of Nutrition and Physical Activity and Oral Health continue to report directly to the FHB Director, with their roles expanded to include increased programmatic and evaluation support for services across the population groups.

The team leader for each of the four population groups has similar responsibilities. They include:

- 1) accountability;
- 2) establishing viable, functional community partnerships and linkages, both within and outside the Branch;
- 3) providing technical assistance and support to providers (e.g., physicians, health departments, health districts, hospitals, and community based organizations);
- 4) developing and/or revising programs and services using relevant research which is derived from community and population based needs assessments and demographic and qualitative data studies;
- 5) being conversant with existing local, state and federal policies and their impact on programs and services of the FHB;
- 6) advocating and supporting the development and implementation of programs and services which are in line with the cultural competencies and expectations of the Branch;
- 7) developing and implementing effective health promotion and outreach activities;

- 8) participating in quality assurance and continuous quality improvement activities of the Branch;
- 9) implementing proactive marketing plans for their respective programs and services;
- 10) participating in the implementation of the Branch's public relations plan;
- 11) monitoring the effectiveness of programs and services;
- 12) reporting and publishing results of interventions and outcome data from the respective programs and services they manage; and
- 13) assuring programs and services are based on appropriate medical care standards.

- **Operations Section:** Financial and personnel functions are centralized in the FHB Operations Section, which provides oversight of daily operations and administration, contracts, management of human resources/personnel and employee relations. This Section is comprised of two offices, the Office of Administrative Support (OAS) and the Office of Contract Management and Compliance (CMC).

The OAS is staffed by a Director, Program Assistant, Administrative Operations Coordinator and four Senior Operations Analysts. Each Operations Analyst and the Administrative Coordinator is assigned to several programs within the Programs and Services Section and performs a range of financial management procedures for their respective programmatic areas. The Office is responsible for:

- 1) reviewing and revising all aspects of the existing financial reporting system;
- 2) refining and overseeing the processing and payment of all major expenses and accounts payable within the FHB;
- 3) monitoring requests for and payment of field purchase orders for all programs within the Branch;
- 4) working collaboratively with the Office of Contract Management and Compliance to ensure that all contracts comply with state and federal regulatory requirements and internal quality control and compliance measures;
- 5) working closely with Branch Program staff to develop budgets for grant applications, monitor grant spending and ensure appropriate compliance with funding guidelines;
- 6) organizing and formalizing budgeting procedures in all Branch programs;
- 7) developing and implementing a "user friendly" budget information database which has accurate, up-to-the-minute "on-line" access features for all programs and is conversant with the other software within the Division and Department;
- 8) developing, implementing and maintaining an effective inventory system for all major purchases within the Branch; and
- 9) serving as the liaison between the FHB, Division, and the Office of Planning and Budget Services in the Department of Human Resources.

OAS is also responsible for FHB human resources management and assists FHB Managers in the development of new positions and modification of existing positions. OAS screens and

organizes the interview process for all Branch applicants and develops and implements a centralized orientation process for all new hires.

The Office of Contract Management and Compliance includes a Director, Contract Administrator, Senior Operations Analyst, and a Program Analyst. It is responsible for:

- 1) developing contractual relationships (e.g., contract terms and deliverables);
- 2) formally documenting the proposed relationships into well written, executed contracts;
- 3) developing and implementing a contract compliance program which encompasses both internal and external compliance activities;
- 4) developing and implementing a contract reporting mechanism to advise Branch Program Managers on a quarterly basis of the status of each open contract;
- 5) serving as the liaison between the FHB, the Division and DHR's Office of Contract Management and Office of Audits;
- 6) working closely with the OAS within the FHB to develop quality control standards;
- 7) reviewing, on an annual basis, the Independent Audit Reports of applicable FHB contractors; and
- 8) performing programmatic audits of both Branch (internal) and contractual (external) programs and services.

- **The Policy, Planning and Evaluation Section (PPE):** The development of policy and programs, based on needs assessment, incorporate external environmental changes, internal needs, along with existing capacity assessment to provide the foundation for FHB directions. The PPE Section is responsible for these activities as well as program evaluation. This Section's positions include a Director, Administrative Assistant, two Research and Policy Consultants, a Statistical Analyst, and Family and Community Involvement Consultant. It also engages external planning and evaluation consultants as needed. PPE designed and conducted the Branch's FY 2001 MCH needs assessment process.

Principal PPE duties and responsibilities include:

- 1) formulating strategies and guidance to address policy challenges;
- 2) coordinating annual and five-year needs assessments and using the results of these assessments to guide program development and set priorities;
- 3) developing program evaluation strategies;
- 4) monitoring Healthy People 2000 and 2010 objectives;
- 5) analyzing relevant health care legislation and its impact on Branch programs;
- 6) researching best practice models;
- 7) working closely with the Director of Programs and Services Section to develop Branch programs and set Population Team priorities;
- 8) identifying baseline data and performance measures for Branch services;
- 9) identifying outcome measures for MCH populations served by the Branch; and

- 10) collaborating with the Maternal and Child Health Epidemiology Unit and the Health Assessment Section to assess and monitor health status of MCH populations served by the Branch.

The FHB evaluation framework serves as a guide for programs. Included in this framework are evaluation philosophy and expectation, level of evaluation, the relationship between evaluation and continuous quality improvement (CQI), evaluation roles and responsibilities, population team evaluation implementation approaches, and a timeframe for evaluation reporting. At the core of the framework is the belief that decisions should be data driven and evaluation needs to permeate all levels of the MCH system and FHB.

Building the MCH System:

The FHB restructuring has been built on a reorganization plan that was formalized in July 1999. The goal is to develop the FHB organizational capacity and leadership that realizes the vision and mission of the Branch. This plan uses the seven C's - competence, commitment, communication, cooperation, coordination, collaboration, and community focus - to achieve desired outcomes. The five desired outcomes are 1) increased coordination and integration of MCH services; 2) greater accountability for services provided by the FHB; 3) greater emphasis on prevention-oriented population based-activities; 4) continuous program development with decisions that are fact-based, future-oriented, operationally attainable, and measurable; and 5) improved effectiveness and efficiency of administrative operations.

Three objectives have been established to reach the goal. *Objective 1* is to improve the effectiveness of the programs and services administered by the FHB. Strategies to achieve this objective include providing leadership for priority setting, planning and policy development that support community efforts to assure the health of MCH populations; improve the capacity of the Branch to assess and monitor MCH status to identify and address problems/issues; and evaluate the effectiveness, accessibility and quality of direct and population-based MCH services.

Objective 2 is to improve coordination and cooperation among programs administered by the FHB to facilitate service integration. Strategies related to reaching this objective are streamlining and consolidating, where appropriate, like programs and services to reduce duplicative activities and maximize resources in order to improve efficiency and effectiveness; identifying key functional and operational areas in which coordination is needed to improve the work of FHB; and developing an annual FHB work plan that identifies intra- and inter- linkages between each population team and the Branch director's office as well as linkages among the teams themselves.

Objective 3 is to increase accountability for programs and services administered by the FHB. Strategies directed at attainment of this objective are developing the organizational structure and substructures to facilitate the role and responsibility of the Branch within the larger MCH system; linking the needs of populations and identified priorities established through the needs assessment

and priority setting process to specific program activities delineated in the annual MCH and Branch work plans as well as to individual employee performance measurement forms (PMF); and emphasizing and operationalizing key DHR-wide PMF responsibilities related to organizational commitment, customer service, and teamwork. The reorganization plan includes action steps, responsible units, target dates, and needed resources.

Building the MCH System - Family Health Branch Programs and Activities:

As the FHB reorganization plan is implemented, several shifts are occurring which reflect moving from framing to detailing the plan. Over the past two years, efforts have been concentrated on the state FHB infrastructure as ultimately reflected in the reorganization plan and concomitant activities. With progress underway, the focus can begin moving towards actual MCH systems redesign and building. In undertaking this redesign and building, the efforts must move beyond the public health agency structure to incorporate other state agencies, service providers, and advocacy groups as critical components with specific roles and responsibilities. Leadership needs to become a shared responsibility among all partners based on a common vision. Moreover, the state has been at the center of attention for efforts focused within the FHB. As systems development proceeds, efforts need to be refocused at the district and county level with strong linkages built between the state and local level. These efforts and the linkages which ensue must include public health agencies as well as other local agencies, service providers, and community leaders and move beyond the health delivery system to others who also have a prevention focus. Initially, broad areas were focused upon as macro-level issues needed to be addressed, e.g., service integration, data, basic skills and competencies around the seven C's, etc. As this has occurred, specific programmatic areas and issues have been identified which need concentrated attention.

Highlights of the past year and next steps to bring about the new directions discussed above follow for each of the population teams.

Infant and Child Health - As systems building has moved forward, specific efforts were directed in five areas:

- Metabolic/Hemoglobinopathy Newborn Screening - Screening of newborns for the sickle cell trait began July 1, 1999. In conjunction with the expansion of screening, extensive changes were instituted related to the tracking and follow-up system. The system has been totally computerized and with the availability of data, quality assurance is now being done at the hospital level. This will enable targeted training and technical assistance in the future.

Universal screening for sickle cell diseases began October 1, 1998, and is done on the same filter paper specimen used to the seven metabolic tests. A Voice Response System (VRS) was installed in the State Laboratory in October 1998. The VRS allows providers to obtain a paper's newborn screening test results by obtaining a PIN number that allows access to the VRS.

- Universal Newborn Hearing Screening - The passage of HB 717, in 1999, has provided the foundation for the development of universal newborn hearing screening in Georgia. A State Advisory Committee on Newborn Hearing Screening was formed in the fall of 1999 to guide this effort. Subsequently, funding was obtained from MCHB for state systems development and the Appalachian Regional Commission to purchase screening in birthing hospitals in 19 North Georgia counties. Moreover, the 2000 session of the Georgia General Assembly approved the Governor's request for \$2 million in Tobacco Master Settlement funds to institute local level screening, referral, diagnostic evaluation, intervention, and treatment. Children 1st is expected to play an integral role in service coordination. With this combined funding, expanded screening should be implemented by no later than January 2001. In future years, identification of children with hearing impairments will be extended to those with acquired or progressive hearing loss. (See Appendix G, Universal Newborn Hearing Screening Flow Chart).
- Child Health Integration/Children 1st: Children 1st has been reconceptualized as the point of entry and referral system for Georgia's infants and children. In addition, the ages of the children included in the system has been expanded by one year through age five, with an anticipation of extending the age range further. These changes relate to the development of a child health integration model in which stand alone services are brought together through development of an entry portal and use of a common linkage and referral system. (See Appendix O, Child Development Process Model). Over time, this is expected to lead to a better allocation of staff and financial resources, less dependent on association with a given program or service.
- Health Check EPSDT - Heretofore, Health Check in FHB focused almost primarily on quality assurance. Over the past year, discussions have occurred with Medicaid, who funds this activity and Health Check is being reshaped and broadened beyond health to include child well-being and development as essential elements in overall screening. Among the areas which will be included are child safety, parenting and typical child development. An action plan is now being written to reflect this reconceptualization.
- Building Community Partnerships - To facilitate community knowledge of FHB programs and how the continuum of Branch services impacts the health of Georgia's children, the FHB hosted a meeting on December 15, 1999 for 35 health care and advocacy organizations, including the Georgia Chapter of the American Academy of Pediatrics, Spina Bifida, and March of Dimes. In addition to program presentations, opportunities for collaboration were discussed.

Adolescent Health and Youth Development - Starting with a special initiative specifically addressing teen pregnancy four years ago, adolescent health and youth development has increased its scope and now encompasses the full range of health and development issues. In doing so,

FHB's Adolescent Health and Youth Development (AHYD) has adopted a system approach based on defined strategies premised upon a positive assets model. During this past year, accomplishments in this regard include:

- Building State and Local Infrastructure - Beginning July 1, 1999, positions approved by the legislature were formally established. These positions include a core state staff and coordinators in each of the 19 health districts. The work of the staff will utilize outcomes and processes for stakeholder engagement that have been developed this year. Moving toward the model to the front line, the University of Georgia assets curriculum (discussed elsewhere in this document) will be used to give youth workers competencies and skills required to effectuate the assets model. At this time, key state organizations are being engaged and the curriculum is being piloted, with an expected roll-out in early 2001.
- Movement From Health Risk to Value/Behavior Orientation - The overall directions of FHB AHYD reflect a major shift from a health risk model focused on sexual activity to a value/behavior model which emphasizes decision-making by youth based on their belief system emerging from an positive perception of self. Several avenues are being pursued to bring about this change. Key new players are being brought into the dialogue, including the faith community, the Department of Education, and Department of Labor. In addition, FHB publications are incorporating this new view. For example, the recently published report on "*Georgia Teenage Births and Pregnancies: Statistics, Responses, and Consequences*" includes a discussion on value/behavior strategies that impact teen sexual activity (See Appendix P for Report).
- Adolescent Health Manual - As a companion to the assets model curriculum, Georgia State University School of Nursing has worked with Dr. Alan Gottlieb, FHB's pediatric consultant, to develop a manual on comprehensive adolescent health and well-being for youth workers. Work is underway to integrate this manual into the youth assets model.
- "You Are Worth The Wait" - A statewide abstinence education campaign, "You Are Worth The Wait," has been launched. This campaign is based on input from teenagers and messages that they have indicated will make a difference in thinking and behavior.

Children with Special Needs - With a total staff turnover in children with special needs leadership positions, much history and specific content has been lost; however, at the same time, an opportunity was created to restructure the system for services to this population. Two major thrusts have been initiated in carrying out this restructuring; continuation of the shift of services in the metro Atlanta from public health to private providers and integration of Babies Can't Wait (Part C of IDEA) and Children's Medical Services (Title V). BCW has benefitted from a more defined approach and set of services throughout the state. Over the next year, concentrated efforts will continue to bring this structure to CMS while at the same time integrating the two

programs. (See Appendix Q, Children with Special Needs Newsletter). Among the efforts underway are:

- Infrastructure - Consistency among the services in the 19 health districts is being sought through the promulgation of standards along with the development of a policy and procedures manual. Along with this, data collection is being standardized following newly established DPH data policy guidelines.
- Engagement of Private Providers - In order to accomplish the shift of direct services away from public health, the network and involvement of private providers needs to be strengthened. As a first step, the Georgia Chapter of the American Academy of Pediatrics and Public Health will be conducting a joint meeting in the fall.

Women's Health - Systems development addressing Women's Health has lagged somewhat behind the other three population areas due to critical staff vacancies. However, the framework for a vigorous effort has been constructed and activities building on this framework will be underway before the end of the year. Strides to undertake this effort will depend on the hiring of a population team leader to replace Dianne Norris who left on retirement disability. The core for system development exists in the range of Women's Health programs and services, however, priorities among them have not been established nor have linkages been created. Over the next several months, the in-depth assessment process will continue and culminate with targeted approaches aimed creation of a seamless system. The first steps in this effort are:

- Regional Perinatal Planners - The state's perinatal health program has been arranged and organized around community-based regions that relate to six perinatal centers throughout the state. Data from other states that have regionalized perinatal systems show improved outcomes from high-risk deliveries in terms of decreased perinatal morbidity and mortality. In addition, by decentralizing perinatal planning activities, regions and communities can be assured that activities, regions and communities can be assured that activities will be tailored to their specific needs and concerns. Regionalization enables the development of comprehensive, cooperative networks of public and private health care providers as well as community and intersectoral (social service, business community, etc.) stakeholders.

Perinatal Planners have been hired for each of the six areas. Biographical sketches can be found in Section 1.5.1.3 (Other Capacity). The FHB is working with the Planners and other stakeholders to establish a regional perinatal planning process to assure a health care system of risk appropriate care for the total cohort of reproductive-aged women, pregnant women, males fathering their infants, and infants. Each health district, in conjunction with its designated perinatal center, will determine its own method for establishing the regional perinatal planning process. The Regional Perinatal Planning Council (RPPC) will initiate the process. The purpose of the RPPC is to establish, coordinate, and monitor a community-based reproductive health planning process at the district and regional level. Efforts are

taken to ensure the inclusion of a significant number of consumers and persons within the community in the planning process.

Ultimately, the process will:

- build on existing accomplishments, while continually assessing opportunities for improvement in the health of women, infants, and children;
 - measure indicators of quality, availability, access, coordination, appropriateness, and delivery of services to women of reproductive age and their children;
 - apply the principles of total cohort accountability to assess outcome and direct continuous quality improvement (CQI);
 - commit to broad stakeholder involvement in decision-making; and
 - use direct/region/state specific data and benchmarks to measure indicators.
- Restructuring of Babies Born Healthy - In reviewing the Babies Born Healthy program, which provides prenatal care for women without third-party coverage, two concerns were uncovered: lack of consistency among the health districts and the formula for resource allocation. Work was done over the past year to revise the formula, using current data and weighting to reflect priorities. Each district received a given amount to assure infrastructure with the remainder set aside for direct services. Over the next several months, the assessment underway should lead to a more consistent set of services among the districts. (See Appendix R, Babies Born Healthy Summary).
 - Perinatal HIV Transmission Prevention - DPH was awarded a CDC HIV Perinatal Transmission Prevention supplement to assure that HIV positive, pregnant women are identified prior to delivery and linked to appropriate obstetrical and HIV care, including therapies to reduce the risk of HIV transmission to the infant. The initiative is a collaboration between two DPH units - the HIV/STD Section in the Prevention Branch and the Women's Health Section in the FHB. There are three major components: 1) outreach to and enhanced case management of pregnant women who are HIV positive or at very high risk of infection during and following their pregnancies in five metro Atlanta counties; 2) education and training of physicians who provide ob/gyn services regarding the importance of offering HIV testing to all pregnant women so they can know their HIV status and: 3) social marketing directed to women of reproductive age, particularly focused at those at greatest risk of HIV infection, encouraging them to know their HIV status and providing a positive message about available therapies and prevention of perinatal HIV transmission.

Building the MCH System - Family Health Branch Capacity and Competencies:

An increasing emphasis continues to be placed on carefully planned, coordinated staff training and development activities to enable Branch staff to improve their level of knowledge and job performance. Major training highlights since the submission of the last MCH plan include:

- Consultants' Retreat (8/24/99) - key FHB staff and consultants participated and shared information about consultant responsibilities.
- FHB Coordinators' In-service Training (10/13 and 10/14/99) - brought together state and local MCH coordinators to weave a state and district partnership through a unified vision for healthy children and families. Specifically, the training acquainted district coordinators with the reorganized FHB network and the future vision for the state's MCH delivery system; presented information on major MCH issues; and provided specific skills sessions to build the capacity of the district coordinators to carry out their roles and responsibilities within the new framework.
- Adolescent Health and Youth Development/University of Georgia Institute of Human Development and Disability Stakeholder Meeting (10/7/99) - FHB and AHYD staff shared their vision and philosophy of adolescent health and youth development and set forth objectives for future work. The Institute outlined upcoming project activities to strengthen adolescent prevention activities, facilitate cooperation, and enhance the exchange of information among stakeholders.
- Workshop on A Holistic Approach to Adolescent Health and Youth Development (11/17/99) - nationally recognized speakers shared the successes and challenges of their work with adolescents, reported on programs they have observed or evaluated around the U.S., and described the framework upon which these programs were built. Information was also presented on how to engage private partnerships.
- Conference on Low Birth Weight in Minority and High Risk Women (12/99) - approximately 75 statewide perinatal stakeholders (primarily state staff, advocates, district health officers, and district women's health staff) attended the conference to discuss the relationship and status of the multiple factors (i.e., Medicaid, sexually transmitted disease data, health status of the mother before pregnancy) that might affect infant mortality, as well as the need to collect data and examine possible correlations. Following a presentation on Georgia-specific data related to infant mortality and a discussion of district and state data needs and concerns, Robert Goldenberg, M.D., the Principal Investigator for a research project on low birthweight in minority and high risk women, presented this findings. His research demonstrated that very few interventions show evidence of effectiveness in reducing low birthweight, but emphasized regionalized care as a critical strategy in reducing morbidity and mortality. To maximize effectiveness, he urged meeting participants to focus interventions around what we *do* know, such as the link between bacterial vaginosis and low birthweight, and the increased likelihood of subsequent premature births. Some participant recommendations included the development of a statewide "cookbook protocol" for interconceptional care of pregnant women, identifying and pursuing research-related issues, and identifying pregnant women at highest risk, to improve their health status and pregnancy

outcomes. Recommendations from this meeting will play a critical role in the state's regional perinatal planning process.

- Mega Meeting (4/00) - the Office of Adolescent Health and Youth Development met with the Youth Development Coordinators (YDCs) to update them and provide a forum for all to share accomplishments, challenges, and concerns. Major items discussed included the roles and relationships of YDCs in the Office of Adolescent Health and Youth Development and in their districts, completion of Georgia State University's CAPS (Comprehensive Adolescent Preventive Services) training and the impending piloting of the University of Georgia's Youth Development Curriculum. Presentations also provided information on programmatic areas such as contract requirements, budget and funding issues, reporting requirements, and Grant-in-Aid. The Adolescent Health and Youth Development Team Leader moderated a panel discussion. Panelists included Dr. Barbara Sugland, Senior Managing Partner of CARTA, Inc., who addressed issues surrounding youth development trends and data, and Dr. Joyce Walker, Director of the Center for 4-H Youth Development, who shared information relative to current and best practices for the application of youth development-focused curriculums.

Building Family Health Branch Evaluation Capacity: FHB recognizes the need for measurement of outcomes is critical to the determination of program effectiveness. An internal steering committee has been formed to develop the framework to ensure the establishment, design, implementation and maintenance of self-evaluation practices in the FHB. The four major focus areas are: 1) outcome setting and stakeholder involvement for each population served by FHB; 2) logic model training for all staff; 3) population-based evaluation planning; and 4) the development of a FHB evaluation framework. (See Appendix S, Draft Family Health Branch Evaluation Framework).

FHB's Departmental, Division and Branch Framework:

The framework in which the Branch functions is provided in the tables of organization at the end of this section (1.5.1.1). With almost 5,000 state and local employees, the Division of Public Health (DPH) is part of the *Georgia Department of Human Resources (DHR)* superagency which brings together family protective services, income maintenance, child care, mental health/mental retardation/substance abuse services, regulatory oversight services, and rehabilitation under a single umbrella. The department's five divisions are Aging Services, Public Health (DPH), Mental Health/Mental Retardation/Substance Abuse (MHMRSA), Rehabilitation Services, and Family and Children Services (DFACS). DHR also includes the Office of Regulatory Services and the Office of Adoptions. Administrative and support functions, including human resources, information technology and budget and financial services, are consolidated at the departmental level.

The DHR Commissioner, Audrey Horne, is appointed by and accountable to the State Board of Human Resources. This board is appointed by the Governor to provide general oversight of the

agency's activities by establishing policy, approving goals and objectives and other appropriate activities.

Included in the Commissioner's office are the Assistant Commissioner for Special Projects; the Office of the Assistant Commissioner for Policy and Government Services, which includes fraud and abuse, communications, legal services and constituent services; and the offices of Planning and Budget Services, Financial Services, Technology and Support, Human Resource Management, Audits, Human Resource and Organizational Development, and Adoptions.

The Division of Public Health is the designated state health agency as well as the state agency for children with special health care needs. DPH is headed by Kathleen E. Toomey, M.D., M.P.H., who is on the Department Management Team, which is increasingly emphasizing inter-divisional activity. At the Division level, branches include Family Health, Epidemiology, Prevention, Environmental Health, Chronic Disease Prevention and Health Promotion, the State Public Health Laboratory, and the Women, Infants and Children Program (WIC). Each of these branches has responsibilities which inter-relate with Family Health Branch activities, requiring strong working relationships. For example, the Environmental Health Branch oversees Lead Poisoning Prevention, Injury Prevention, and Emergency Medical Services for Children.

State Statutes Relevant to Title V Program Authority: The mission of Public Health in Georgia is to promote and protect the health of Georgians. The Official Code of Georgia (31-2-1 and 31-3-5) supports this mission by empowering the Department of Human Resources and the local county Boards of Health to employ all legal means to promote the health of the people. County Boards of Health develop and establish community-based systems for preventive and primary care services for pregnant women, mothers and infants, children and adolescents through local planning, direct provision of services and collaboration.

Two governing bodies, the Board of Human Resources and the county boards of health, have key oversight and regulatory responsibilities. The State Board of Human Resources has 15 members, but not more than two, from each congressional district in the state. The members are appointed by the Governor and confirmed by the Senate for staggered five year terms. Seven members of the board must be professionally engaged in rendering health services, and at least five of those seven must be licensed to practice medicine in Georgia. The Board establishes the general policy to be followed by the Department, makes budget recommendations, and appoints the commissioner. At the county level, boards of health, each with seven members, are required by state statute. These boards oversee the activities and budgets of the local public health departments and have regulatory and enforcement powers.

Georgia law permits the establishment of administrative multi-county districts with the consent of county governments and boards of healths in the counties involved. Nineteen such districts currently exist in Georgia, ranging in size from 1 to 16 counties. Each district has a health director, appointed by the DHR Commissioner and approved by the boards of health of the

concerned counties. The District Health Officer, a physician, serves all of the counties in common and has all of the powers and duties as the director of a single county board of health. Typically, each district health office is staffed by a district health director, administrator, program manager, community epidemiology, chief of nursing, environmentalist, and program and support staff. District offices are located in the “lead” county of the district, usually the largest county in population. Local level responsibilities are set forth in county grant-in-aid contracts which describe programmatic activities and provide financial support to carry them out.

Direct services are provided by the county health department. County health departments are Medicaid providers of Health Check, Family Planning, Perinatal Case Management, Pregnancy Related Services, and Diagnostic Screening Services and Prevention Services (DSPPS) Option. Funds to support county health departments come from fees, state grant-in-aid, county tax levies, and external grants. The number of employees in a local health department ranges from 2 to 698 persons. One-fifth of Georgia’s population, approximately 1.2 million people, receive health services within the local public health system.

1.5.1.2 Program Capacity

The Family Health Branch's capacity to provide: 1) preventive and primary care services for pregnant women, mothers, and infants; 2) preventive and primary care services for children; and 3) services for children with special health care needs; 4) rehabilitation services for blind and disabled children under the age of 16 receiving benefits under Title XVI; and 5) family-centered, community-based, coordinated care including care coordination services for children with special health care needs and facilitate development of community-based systems of services for such children and their families is described in Appendix T, Title V Program Capacity Description. This chart displays each of the state programs that are part of the MCH system and indicates number of state, local, and community staff; whether the program is statewide or specific only to certain counties; and provides the number of persons served in the past year.

1.5.1.3 Other Capacity

A summary of the number and location of central and outstationed staff providing administration, planning, evaluation, and data analysis capabilities as well as direct services is provided below. A description of Family Health Branch staff qualifications follows:

Number and Location of Central and Outstationed Staff

Location	Admin.	Planning	Program Support Consultation	Eval.	Data Analysis	Direct Service
Central	17	5	30	3	12	0
Outstationed	95	103	0	9	12	610

Family Health Branch staff qualifications and capabilities:

Malissa Abdulla, M.S.W. is the *Director/Team Leader* for the Office of Infant and Child Health Services. Ms. Abdulla, a licensed clinical social worker, earned a Masters degree from the University of Tennessee. She is board certified and holds ACSW and Diplomate credentials. Ms. Abdulla started the social work department at Emory University Hospital, served as Director of Social Work at the Medical College of Georgia, and worked as a corporate director in a home care management services company.

Joseph Alderman, D.D.S., is the Director of Oral Health. D. Alderman has extensive experience in dentistry and oral health practice. He earned his Doctorate dental degree from Creighton University in Omaha, Nebraska. Dr. Alderman has served as Director of the state program since 1981.

Rosalyn K. Bacon, M.P.H. was appointed *Director of the Family Health Branch* in November, 1998. Ms. Bacon has experience in all facets of MCH activities. Her ten year career began with administrative responsibilities which progressed to assuming the position of deputy branch director under Virginia Floyd, M.D. Ms. Bacon has extensive experience in fiscal management and other operational areas.

Paul Blake, M.D., M.P.H. is *Chief of the Epidemiology Section* in the Division of Public Health's Epidemiology and Health Information Branch (EPIB). He is also Acting Program Manager in the Maternal and Child Health Epidemiology Unit, Epidemiology Section, EPIB, DPH and Acting State Epidemiologist. He received his B.A. from Boston University College of Liberal Arts, his medical degree from the Boston University School of Medicine, and his M.P.H. from Harvard School of Public Health. His prior positions include Assistant Director for Medical Science, Division of Bacterial and Mycotic Diseases (DPMD), National Center for Infectious Diseases (NCID), Centers for Disease Control and Prevention (CDC); Chief, Foodborne and Diarrheal Diseases Branch, DBMD; Chief, Enteric Diseases Branch (EDB), DBMD; Medical Epidemiologist, Division of Bacterial Diseases; and Assistant Chief and Epidemic Intelligence Service Officer; Field Services Branch, Epidemiology Program, CDC. His public health activities in 16 countries have included investigations, prospective studies, consultations, evaluations of programs, and training.

Eve Bogan, M.A. is the *Director of the FHB's Office of Programs and Services and Acting Director of the Women's Health Section*. From 1992 to 1999, she was Director of Georgia's Early Intervention Program for Infants and Toddlers established under the Individuals with Disabilities Education Act. She is a graduate of Sarah Lawrence College (BA) in liberal arts and Hebrew University (MA) in sociology/anthropology. She counseled adolescent substance abusers, did policy research and taught prior to joining the South Carolina Governor's Office in the Health Policy Research Unit. She subsequently became the first director of South Carolina's Maternal, Infant and Child Health Council. Subsequently, she assumed the position of director of the South Carolina Mental Health Association and then became South Carolina's first coordinator of the BabyNet Early Intervention Program. After moving to Louisiana, she worked first at the Louisiana State University (LSU) Medical Center as a policy consultant for the Louisiana Early Intervention Program, and then as director of the LSU Agent Orange Family Systems Project. In 1992, Ms. Bogan relocated to Georgia where she served as consultant to and then Director of Georgia's Babies Can't Wait (Early Intervention) Program.

Frances Cook, R.D. serves as the *Director of Nutrition and Physical Activity*. Her responsibilities involve working with state, district, and community partners to integrate nutrition services in all health systems. Program initiatives include planning and evaluation, training and consultation. Ms. Cook received a Master's Degree in Foods and Nutrition from New York University and the designation of a Certified Public Manager from the University of Georgia.

Zoe Fludd, M.S.W., the *Family and Community Involvement Specialist*, is a graduate of New York University. She holds a master's degree in Clinical Social Work. Ms. Fludd has had extensive experience working in a variety of settings including work as a clinical therapist, substance abuse counselor, and an HIV/AIDS medical social worker. She also has first hand experience in the provision of Family Preservation Services, including in-home crisis counseling and parent training facilitation.

Gala Hambrick, M.P.A. is the *Director of the Policy, Planning, and Evaluation Section*. Prior to joining the Family Health Branch, Ms. Hambrick was a consultant who specialized in program planning, community relations and government relations for private and government organizations. She is a graduate of Georgia State University (BS) in health administration/health planning and Central Michigan University (MPA) in health administration. She has developed numerous women's health programs and infant health initiatives that are modeled in many areas of the State. Ms. Hambrick has also served as local planner for Fulton County, has conducted research for the National Association of Counties, and served as Administrative Director prior to leading the Board of Fulton County Commission Special Projects office.

Beverly Y. James, the *Acting Operations Director*, has over 16 years of administrative experience acquired working in the governmental and private sectors. For the past year, she has worked in Family Health Branch as the Branch Administrator. For two years prior to that, she worked for DHR in the Office of Planning and Budget Services with the Mental Health/Mental Retardation/Substance Abuse Team. She also worked part-time for DeKalb Technical College in its Adult Education System as an instructor of computer software. She also worked previously in the DPH Office of Nutrition as the Fiscal Agent. Ms. James earned her B.A. in Human Resource Management at the University of South Carolina.

Elana Morris, M.P.H., the *Branch Data Team Leader*, received her Masters of Public Health in 1996 from the Emory University School of Public Health. She began working full-time in public health in 1997 as a Health Information Analyst for the Health Assessment Section of the Division of Public Health. Since 1999, she has been working for the Division's Family Health Branch. She oversees a team of data managers and statistical analysts to support the FBH population teams in building data capacity and analyzing data for program development and evaluation.

John Neal, M.P.A. is *Director of the Contracts Management and Compliance Unit* in the FHB. He earned his bachelor and master degrees from the Georgia State University School of Accounting. Mr. Neal worked in the private sector before joining the Georgia Department of Medical Assistance as Deputy Director for the Division of Program Management. He then transferred to the Division of Public Health, Department of Human Resources.

Mohamed Qayad, M.P.H. serves as *Project Manager and MCH Epidemiologist* in the Division of Public Health's MCH Epidemiology Unit. He received his medical degree in 1981 from Somali National University, Mogadishu, Somalia, a mastership in community medicine from the

University of Khartoum, Khartoum in 1986, and a MPH in epidemiology from Tulane University in 1990. He is responsible for analyzing Georgia's births, deaths, fetal deaths, and induced abortion data as well as estimating infant mortality and teen age pregnancy rates for the state and its 159 counties and 19 health districts. He distributes Georgia Vital Statistics data to the health district epidemiologists and planners and provides technical support in SPSS and SAS programming to the health districts and Health Assessment and MCH Epidemiology Unit.

Julia Samuelson, M.P.H. received her B.S.N. at Arizona State University in 1982 and her MPH at Johns Hopkins University in 1987. She worked for six years in Vietnam and Ethiopia on a variety of maternal and child health activities. She has served as an EIS Officer at the Centers for Disease Control and Prevention from 1998-2000, based in the Georgia MCH Epidemiology Unit.

Wendy S. Sanders, M.Ed. is the *Director of the Babies Can't Wait (BCW) Early Intervention Program and Acting Population Team Leader for the Office of Children with Special Needs Services* in the Family Health Branch. She has worked with special needs populations in a variety of capacities both in the public health and education arenas since 1978. She has experience in policy and program implementation for CSHCN at the local, regional, state, and national level.

Alma Turner became the *Team Leader of the Office of Adolescent Health and Youth Development* effective September 1, 1999. She has over 20 years experience working with youth. Prior to joining FHB, she was the Executive Director of the Chatham-Savannah Youth Services Corps

Regional Perinatal Planners:

Melody Brown, R.N., B.S.N. graduated from Georgia College of Nursing in 1991. She began her career as a nurse working with families in perinatal health care. She has worked in the areas of neonatal intensive care, pediatrics, newborn nursery and labor and delivery, in urban and rural community hospital settings. She has served as a full-time Nursing Faculty and Advisor with an Associate Degree R.N. Program, teaching in the specialties of pediatrics and maternal/child nursing. During this time, she began graduate studies in Families. She also worked in a hospital setting as Patient/Staff Educator and has functioned in several other administrative nursing roles within the hospital setting. She currently works as a regional perinatal planner.

Rhonda Burton, B.A., M.S has ten years of public health experience, beginning as an environmentalist. She has eight years of experience in STD/HIV disease programs, where she served as the DeKalb County Board of Health as a front-line supervisor. She also worked at the state lab as a Senior Laboratory Scientist in the Georgia Newborn Metabolic Screening Program. Prior to becoming a regional perinatal planner, she was employed as a Clinical Research Association, monitoring clinical drug trials.

Janice Daniels, R.N., B.S.N., M.N. attended undergraduate school at the University of Washington in Seattle, where she received her Bachelor of Science in nursing. In 1993, she returned to school at Emory University to pursue her Masters Degree in nursing and a minor in teaching. After receiving her Masters, she worked as faculty/staff at Emory University and was co-coordinator of an adolescent health station and clinical instructor for undergraduate and graduate students. She worked in labor and delivery for a year prior to becoming a regional perinatal planner.

Suzanne Hardison, R.N. began her nursing career as a registered nurse in 1971 in Florida. Her past years of nursing practice have centered around maternal and infant nursing in such clinical areas as labor and delivery, postpartum, intensive care nursery, and mother baby center. She also has worked in an OB/GYN infertility office and a home visiting program designed to assess and teach early discharged mothers. Her previous position, prior to becoming a regional perinatal planner, was as the Nurse Manager of the Mother/Baby Center in a Regional Perinatal Center.

Dale Loyd, R.N., B.S.N. worked at Grady Memorial Hospital in the Neonatal Intensive Care Unit moving to South Georgia to work with a private pediatric practice for a number of years. For approximately 15 years, she served as Director of Children's Health Services for the Southeast Health District in Waycross, Georgia. She currently works as a regional perinatal planner.

C. Morfaw, R.N. initially trained in business and economics and spent approximately six years planning, implementing and evaluating rural development projects. During this time, she also conducted research on rural economic issues, especially as they impact the survival and viability of limited resource farmers. In 1995, she began nursing school. On graduation, she became the Ryan White Title III Project Manager in Health District 8-1 in Valdosta, Georgia. In this capacity, she was responsible for developing community-based plans and securing funds to help improve the health and well-being of families and individuals infected and affected by HIV/AIDS. She currently serves as a regional perinatal planner.

Ellen Usman, R.N., M.S.N. has a dual master in nursing degree in Community and Teaching Nursing. She has had experience as an educator, manager, program planner, researcher, and bedside nurse. She has worked across population life spans in obstetrics, labor and delivery, newborn and neonatal intensive care nursery, pediatrics and adult health. She currently works as a regional perinatal planner.

Family Health Branch Consultants:

Carlyle Bruce, Ph.D. has over 10 years of experience in consulting with and evaluating local, state, and federally funded programs and agencies. He is President and Co-Founder of Wellsys Corporation, an Atlanta-based consulting firm. He has extensive experience in grant writing,

program development, program evaluation, and service delivery. Dr. Bruce received his doctorate in clinical child and family psychology from Georgia State University. His sub-specialty concentration was community-organizational psychology.

Dale Ferguson, B.A. has over 25 years of experience in corporate and consulting environments. She is president of InnerWorks Group, a leadership consulting firm. Prior to this, she was Senior Vice-President and Managing Director with Drake Beam Morin, Inc., a leading career and change management consulting firm. She also spent 11 years with AT&T and Bell Systems where her career spanned management positions in marketing, sales and human resources.

Monica Herk, Ph.D. has provided evaluation and public policy consulting to a wide range of government and non-profit agencies including the FHB; the Healthy Mothers, Healthy Babies Coalition of Georgia; the Georgia Academy; the Georgia Office of School Readiness; the DHR Office of Regulatory Services; the State Data Research Center at Georgia Tech; and the Georgia School Age Care Association. She has consulted regarding prenatal incentive programs, child indicators, evaluation planning, content for social policy websites, adolescent health and youth development, child care licensing standards, alternative schools, database design, and school age child care. Before beginning her own consulting practice in 1997, Dr. Herk worked as a Senior Policy Analyst on education issues for the Georgia Governor's Office of Planning and Budget. Prior to that position, Dr. Herk was Policy and Research Associate for the Georgia School Age Care Association. She earned her doctorate and a masters in Public Affairs from the Woodrow Wilson School of Public Affairs at Princeton University.

Rebekah Hudgins is an anthropologist/epidemiologist currently working as an independent consultant. She has worked with the DPH and CDC in active surveillance; conducted ethnographic research including extensive home visits in Jamaica; conducted drug studies both in Jamaica and the United States; and currently works with the FHB as an evaluation consultant. She also serves as a member of the State Evaluation Team for the Georgia Policy Council/Family Connection. Throughout these endeavors, she has focused on the intergenerational and environmental aspects of women's and children's health and the importance of the family and community context.

Carol Massey, M.B.A. has over 20 years experience as a manager, ten years of which have been spent working with nonprofits. She directs the Nonprofit Board Builders Program at the Non-Profit Resource Center. Ms. Massey also has worked as executive director of an educational finance authority and of a community health center; deputy director of a child advocacy organization; and as a compliance auditor for federally-funded nonprofit health organizations. She specializes as a consultant in leadership development and management. She has been certified as a Trustee Educator with the Trustee Leadership Development, a project of the Lilly Endowment, Indianapolis, Indiana. She is also a certified facilitator of Frontline Leadership, Zenger-Miller, Inc.

Deborah Nicholson has over 15 years experience in developing organizational readiness. As a consultant and trainer, her services focus on increasing the individual and team effectiveness of staff by assisting the leadership in aligning mission requirements with human needs. Ms. Nicholson is certified through the Department of Defense as a human relations/equal opportunity advisor and trainer. She has served in various leadership positions in military, public and private organizations and has experience in strategic planning and change management at the policy, administrative and implementation level. Clients include state and local governments, school systems and for-profit and non-profit health, education and human service organizations.

Rod Taylor, M.P.A. has worked extensively in the health sector. His employment experiences include: teaching hospitals, a federally funded HMO, private-not-for-profit community health centers (330), an Independent Practitioner's Association, a professional medical membership organization (AAP), and state and city public health departments. In Chicago, Mr. Taylor was the Director of the Families with a Future Initiative for the city's Department of Health, a community-based initiative to reduce infant mortality. He also served as a policy advisor to the Commissioner and Mayor regarding community relations and community development. In Boston he served as Assistant Deputy Commissioner and Director of the Division of Family Health Services at the Boston Department of Health and Hospitals and as Executive Director of Mattapan Community Health Center. In 1995, he moved to Georgia and became Assistant Director for the Family Health Branch. He is currently working as a strategic management and organizational development consultant.

Denise Townsend has over 20 years of experience in organizational development, information design and development, and telecommunications. She is President and Co-Founder of Wellsys Corporation, an Atlanta-based consulting firm. Prior to forming Wellsys Corporation, Ms. Townsend provided organizational consulting through her own firm. For nearly two decades, she held management positions with a Fortune 500 telecommunications firm in areas of strategic planning, policy and issues assessment, marketing research and analysis, and new product development.

Medical Oversight:

To assure that FHB programs and services reflect sound clinical practice and medical research, the FHB has contracted with medical consultants to work with each of the four population teams in the Branch. The consultants and a summary of their activities is provided below.

Women's Health

- Bruce Work, M.D., Perinatologist
Medical College of Georgia (MCG)
MCG Rank: Professor, Obstetrics and Gynecology
Certification: Diplomate, The American Board of Obstetrics and Gynecology, Inc.
Diplomate, Division of Maternal-Fetal Medicine, The American Board of Obstetrics and Gynecology, Inc.

Infant and Child Health

- Madeline Murad, M.D., Private Practice Pediatrician
Atlanta, Georgia
Certification: Board Certified in Pediatrics by the American Academy of Pediatrics

Adolescent Health and Youth Development

- Bethann Jenks, M.D., Private Practice Pediatrician
Atlanta, Georgia
Certification: Board Certified in Pediatrics by the American Academy of Pediatrics

Children with Special Needs

- Department of Pediatrics
Medical College of Georgia

The Children with Special Needs contract with the Medical College of Georgia enables access to a broad range of pediatric specialists and allied health personnel to address the presenting needs of children. The consultants represent a broad range of experience, national and international, as well as a link to the Academy of Pediatrics.

The Director of the Office of Maternal and Child Health Epidemiology position is currently vacant. Efforts are underway to recruit a medical epidemiologist to fill this position, formerly held by James W. Buehler, M.D.

Description of number and role of family members on Family Health Branch staff:

The Family Health Branch has created the Family Partnerships Initiative to enhance family participation in all aspects of planning, development, implementation and evaluation of maternal and child health services in Georgia. The Family and Community Involvement Consultant, Zoe Fludd, heads up the initiative. She was hired to assure and enhance consumer input and family involvement in all areas of health planning. (See biographical sketch above) Her responsibilities include:

- serving as a liaison and advocate for families, especially those receiving maternal and child health services;
- developing and coordinating a process for obtaining input from large numbers of families statewide for planning and evaluation services;
- using input from families and other team members to develop strategies for reaching underserved populations of children and families;
- securing participation of families in the development of services, educational materials, training programs, community-based partnerships and special projects, as appropriate;
- facilitating development and providing leadership for the Family Advisory Committee which includes state and local representation from programs which provide maternal and child health services;

- convening the Family Advisory Committee, disseminating information and resources to families prior to the meeting, and developing and preparing materials for families;
- planning and providing training for staff and families on the principles of family involvement and support;
- developing and maintaining links with other agencies, parent organizations and support groups, and other providers; and
- developing strategies for providing opportunities for family representatives in advocacy and leadership roles.

The previous Family Involvement Consultant, Patty Atkins, participated in the development of this block grant application.

Nine family representatives assist the Babies Can't Wait Program with policy, federal grant review, training for family members and providers, and encouragement of local and state parent involvement. A SIDS/Bereavement Specialist position is funded through the National SIDS Alliance to provide family-focused input to the FHB in program planning and policy formation for all SIDS issues, with an emphasis on bereavement support, professional training, and risk reduction measures. The SIDS/Bereavement Specialist also acts as a liaison between parents/parent groups and program staff to facilitate the expression of parent ideas, interests and/or issues, and concerns, and develops methods to assess parent satisfaction with statewide bereavement support and SIDS risk reduction services. In addition, several of the local level FHB programs have integrated family involvement into their activities, i.e., Title X (Family Planning) District Patient Advisory Councils, Office of Nutrition peer counselors for breastfeeding, local Interagency Coordinating Councils in all 19 Health Districts as part of the Babies Can't Wait Program, and CMS family advisory boards.

1.5.2 State Agency Coordination

The Family Health Branch works with a broad array of organizations in the public and private sectors. Input from these external sources related to overlapping MCH concerns and larger changes occurring that affect the MCH system is key in assisting the FHB Director and the Policy, Planning and Evaluation Section in policy and planning efforts (See Appendix U, Family Health Branch Relationships Inventories).

A description of relevant organization relationships among state and local agencies and other relevant organizations follows.

- **Division of Public Health** - as described above, the Department of Human Resources' Division of Public Health (DPH) is responsible for preventing and controlling disease and injury and promoting healthy lifestyles. Over 5,000 state and county employees in the Public Health state office, 19 health districts and 159 county health departments administer services that promote the health and well-being of the whole community. County health departments

also offer direct care to low-income individuals and people from underserved populations, or work with private medical providers to assure that those groups receive the care they need.

DPH regularly collects, analyzes and shares information about health conditions, risks and resources in communities so that public health officials can make good public health policies with appropriate priorities and goals.

The Epidemiology and Health Information Branch in the state office collects information about mortality and morbidity patterns and health-related experiences and behavior. In 1998, the Vital Records Office registered approximately 330,000 births, deaths, abortions, marriages and divorces. The *Health Assessment Section* uses these records to produce vital statistics that can show the most common causes of death, as well as information about issues such as fertility and teen pregnancy. This information, together with hospital discharge data and other information, helps local health district staff design plans to improve the health of communities.

The Epidemiology Section oversees special surveys that are used by public and private groups to encourage behavior change and guide health policy. The Behavior Risk Surveillance System surveys Georgians yearly to determine the need for education about issues such as tobacco and alcohol use, seatbelt use, and exercise. The Pregnancy Risk Assessment Monitoring System collects information from women about prenatal care and their health-related behavior before and during pregnancy and after delivery. The State of the Heart Report and the Georgia Stroke Report, produced jointly with the American Heart Association, reports on trends in cardiovascular disease. The Cancer Registry collects information on new cases of cancer. A wide range of case data and prevention information is available to medical professionals and researchers as well as the public through the internet.

Physicians, hospitals, laboratories, health departments and other health providers routinely report cases of notifiable diseases to PH and the Epidemiology Section analyzes these data to identify risks to public health. The *Public Health Laboratory* plays a major role in detecting and controlling infectious diseases and environmental health threats. The laboratory system also identifies metabolic diseases and blood disorders in newborns.

The *Tuberculosis Control Program* works with local health agencies and with private providers to oversee active cases and increase directly observed therapy. The *Sexually Transmitted Disease Program* offers testing, counseling, education, treatment and partner notification. A wide variety of PH activities help to prevent the spread of HIV/AIDS, including counseling and testing, voluntary partner notification, and case management.

The Georgia Family Planning Health Program (GFPHP), located in the Women's Health Section of the Division's Family Health Branch, offers health education, health care and family planning to help women and men stay healthy and have healthy babies. GFPHP

includes nonprofit agencies and public health departments in every Georgia county who work together to make affordable family planning services available to all Georgians. The program's direct family planning services are supported by Title X federal and state funds.

The Division funds 19 rape crisis centers throughout the State that provide services to victims of sexual abuse including a 24-hour crisis line, crisis counseling, assistance to victims undergoing a forensic medical exam, assistance for victims and their families throughout criminal proceedings, long-term counseling and support groups. The centers also provide prevention education to parents, civic organizations, and middle school, high school and college students to reduce the incidence of sexual assault and intimate partner violence. A manual, *Georgia Protocol for Responding to Victims of Sexual Assault*, has been developed and training provided to 450 law enforcement, medical, district attorney, and victim services personnel.

The Women, Infants and Children (WIC) nutrition program provides special supplemental foods, nutritional counseling and breastfeeding support and education to low income women and their children up to age five. Georgia's WIC program is the eighth largest in the nation and second largest in the southeast. It reaches over three quarters of those women and children estimated to be eligible in Georgia. In addition to giving pregnant women, new mothers, and children vouchers for basic foods and for those who do not breastfeed, infant formula, WIC staff encourage women to breastfeed and counsel them concerning nutrition. WIC staff also identify affordable prenatal care and encourage eligible participants to apply for Medicaid, food stamps, TANF, immunization and other services. To qualify for WIC benefits, a woman must have a total family income of no more than 185 percent of the federal poverty level. She must be either pregnant or breastfeeding, or have given birth within the past two months. Children are eligible up to their fifth birthday.

The Immunization Program offers guidance and technical assistance on immunization issues to county health departments and private providers; provides access to vaccines to county health departments, community health centers, homeless programs, and private providers and through Vaccines for Children program; and assures immunization coverage including vaccine preventable communicable disease outbreaks. Georgia law requires all children entering school or daycare to show proof of immunization. The state recommends that by the age of two, children should have received four doses of vaccine for diphtheria, tetanus and pertussis (DTP/DTaP), one for measles, mumps and rubella (MMR), four for haemophilus influenza B (HIB), three for polio (IPV or OPV), three for hepatitis B (HBV), and one dose of varicella for chickenpox. All children entering school or day care must have completed the 3-shot hepatitis B series. A new recommendation urges parents to bring their 11 or 12 year old children to a doctor or clinic for hepatitis B vaccinations if they are not already vaccinated; for a tetanus and diphtheria vaccination if their last shot for these diseases was five or more years ago; and for varicella if they have not had the vaccine or chickenpox.

The Health Promotion Section administers programs that prevent chronic disease, including promotion of tobacco use prevention, physical activity and good nutrition. “Take Charge of Your Health,” a campaign begun by the Office of Nutrition and Physical Activity in 1998, encourages Georgians to adopt healthy eating habits that reduce the risk of chronic disease. The office also coordinates a statewide system to provide nutrition and breastfeeding education to participants in the Women, Infants and Children program.

The Georgia Childhood Lead Poisoning Prevention Program distributes information throughout the state to inform the general public about lead poisoning, collects data to define the nature and extent of the state’s problem, and collaborates with other agencies to solve Georgia’s lead poisoning problem. All 19 public health districts test children for lead poisoning. Environmental health specialists investigate for lead hazards when a child’s blood is found to have a high level of lead, and help property owners develop a plan for eliminating the problem.

The Division’s *Cancer Control Program* funds health departments to screen 10,000 low income women for breast cancer and 125,000 low income women for cervical cancer. It also funds cancer centers to provide treatment for 500 low income cancer patients with highly curable disease.

The Office of Pharmacy provides pharmaceuticals to health department clinics and vaccines to Vaccine for Children providers. The Office of Pharmacy also offers public health staff and the citizens of Georgia information on drugs and diseases, medico-legal issues, drug cost analysis, drug cost-effectiveness, drug purchasing and inventory management, disease management, and health promotion activities.

The Division’s regulatory functions include licensing and monitoring 250 ambulance services, medical first responders and neonatal transport services. Last year, DPH certified approximately 840 emergency medical technicians, and 22 trauma centers at hospitals.

Injury prevention programs work with Safe Kids of Georgia, Inc. and other community coalitions to promote the correct use of car safety seats and bicycle helmets. Over 5,000 child safety seats and training on their use are provided each year to low income families. The program works with fire departments to install smoke detectors in high-risk homes, homes with small children, and homes of older Georgians.

- **Division of Mental Health/Mental Retardation/Substance Abuse (MHMRSA)** - is also part of the DHR. The state is divided into 13 service delivery regions, each served by a board composed of local representatives. Each regional board is responsible for determining local needs and contracting with appropriate organizations to deliver services. The regional boards contract with seven state hospitals, one mental retardation institution, 28 community

service boards, county boards of health and other providers. Special units in four state hospitals in Atlanta, Milledgeville, Savannah, and Thamesville serve children and adolescents who require short-term inpatient care. Two hospitals, in Columbus and Rome, offer long-term treatment for severely emotionally disturbed teenagers through the state Multi-Agency Team for Children (MATCH) program. Among the community-based services offered under contract with 13 Regional Boards are: 1) inpatient and outpatient treatment, support services and residential treatment; 2) emergency services and respite care; 3) day care programs to teach work and daily living skills; 4) group homes, supervised apartments and other living arrangements; 5) community case management services; and 6) prevention and education programs. Most Georgia communities have prevention activities, such as preschool programs, parenting programs, teen centers, and mentoring or tutorial programs to help young people avoid alcohol and other drug use. The Division sponsors the annual Georgia Red Ribbon drug-free living campaign and a toll-free Helpline to provide prevention information. Over the last two years, MHMRSA has expanded alcohol and drug treatment services for addicted women who are pregnant or who have small children, and for women on welfare when addiction is a barrier to employment (Ready for Work Program).

Public Health works with MHMRSA around a number of state and local level concerns which relate to the MCH population. The two Divisions have begun to work more closely together in two areas during the past two years, youth risk prevention and tobacco use prevention. With leadership from the FHB Director and Chief of the Substance Abuse Prevention Unit, state agencies involved in addressing youth risk behaviors have come together to begin discussing potential common planning, training and coordination issues. As part of this effort, FHB staff are working closely with the Substance Abuse Prevention Unit on the implementation of a prevention needs assessment, the development of a Center for Substance Abuse Prevention and Treatment-funded statewide substance abuse treatment needs assessment, and a substance abuse and violence prevention collaborative pilot. Additionally, the DPH Tobacco Use Prevention Program is coordinating its efforts with those of MHMRSA which focuses primarily on Synar Amendment enforcement and Regional Board prevention services.

An ongoing dialogue, along with an array of activities, also exists around mental retardation and mental health concerns. A Mental Health representative serves on the Babies Can't Wait (BCW) inter-agency coordinating council. Several local BCW programs engage mental health providers to offer needed services to children. BCW also represents Public Health on the Governor's Council on Developmental Disabilities which advocates for the needs of this population. State Children's Medical Services staff is on the MATCH Committee which finds services and makes placements for children with severe mental illness.

- **Division of Family and Children Services (DFACS)** - is responsible for: 1) protective services for children and adults, 3) Medicaid eligibility determinations, 3) subsidized child

care, 4) troubled children placement, 5) Temporary Assistance for Needy Families (TANF) and food stamp, 6) job training and job search assistance for welfare applicants and recipients, and 7) child support enforcement and collection, and social services. In a structure that parallels local public health agencies, 159 county DFACS offices administer these services. Direct linkages and work groups are maintained between DPH and DFACS to assure Medicaid eligibility, streamlining and removal of access barriers. Extensive referral linkages exist between Public Health and DFACS at the county level, particularly in the *Children 1st* program.

The Family Violence Program, located in the Division, approves and administers funds to Georgia's family violence programs. Staff also provide technical assistance and training, information to family violence staff and boards, and certification for shelters based on standards set by DHR's Advisory committee on Domestic Violence. Georgia has 41 certified family violence programs, operated by private, nonprofit organizations. They provide 24 hour crisis lines, legal and service advocacy, children's programs, parenting support and education, emotional support, and community education. Thirty-eight of these programs also offer emergency safe shelters. A statewide toll-free crisis line (1-800-33-HAVEN) automatically connects callers to the nearest family violence agency.

The Fatherhood Program, created by the Division's Child Support Enforcement (CSE) office, helps parents who are unable to pay their child support. The program offers job placement, vocational training, counseling and a chance to earn a GED and the opportunity to play a supportive role in the lives of their children. The Fatherhood Program is available to any non-custodial parent paying child support through CASE who is unemployed or employed but earns less than \$20,000 per year; has children receiving TANF; and/or who lacks a high school diploma or GED. CSE has contracted with the Georgia Department of Technical and Adult Education to provide training (including parenting skills and child development instruction) and services at each of Georgia's 33 technical institutions and at three colleges with technical divisions. There are currently about 1,400 participants in the program.

- **Office of Regulatory Services (ORS)** - inspects, monitors, licenses, registers and certifies a variety of health and child care facilities including hospitals, laboratories, home health agencies, long term care facilities, day care centers, group day care homes, residential care facilities, and private adoption agencies. It also administers programs that receive and investigate complaints about such facilities. The Office works to ensure that facilities and programs operate at acceptable levels, as mandated by state statutes and by rules and regulations adopted by the Board of Human Resources. ORS also certifies various health care facilities to receive Medicaid and Medicare funds through contracts and agreements with the Georgia Department of Community Health and the Health Care Financing Administration and Food and Drug Administration of the U.S. Department of Health and Human Services.

- **The Social Security Administration, Rehabilitation and Disability Prevention Unit** - contracts with the DHR Office of Rehabilitation Services (ORS) for state disability adjudication services. This unit determines the eligibility of children birth to age 21 for SSI and hears appeals.
- **Office of Adoptions** - was created in January 1997 to streamline the state's adoption programs and increase the rate of adoptions for children with special needs who are in the permanent legal custody of DHR. County DFACS departments make home studies, document cases, approve adoptive homes, prepare children and parents for adoptions, and place children in adoptive homes.
- **Department of Community Health** - the 1999 Georgia General Assembly passed legislation (SB 241) that consolidated the Department of Medical Assistance (Medicaid), State Health Planning Agency, and State Employees Health Benefit Plan under one new agency, the Department of Community Health (DCH). The State Health Planning Agency conducts overall state health planning and makes certificate of need determinations. Medicaid maintains a renewable, annual contract for administrative and support services with the Department of Human Resources (DHR). Under this agreement, DHR agrees to provide support services and Medicaid agrees to pay the appropriate Federal share of the administrative cost of these services, on a quarterly basis. The following services are provided by Public Health under this contract: eligibility determination, training, family planning, Health Check outreach, Health Check screening and follow-up, Refugee Resettlement program, perinatal case management, Right from the Start Medicaid, regional infant intensive care program, local health planning, MCH epidemiology, and WIC referrals. Public Health and Medicaid work together around a number of specific initiatives arising from these contracted activities. DPH and the FHB also work with DCH's Office of Women's Health which serves as a clearinghouse of information on non-reproductive health issues as well as a link to other groups and institutions in the state involved with women's well being. Georgia is one of eight states to establish a women's health office. First Lady Marie Barnes serves as Honorary Chairperson of the Office of Women's Health Advisory Council which was established in August 1999. Former First Lady Rosalind Carter is an honorary Council member.
- **The Department of Corrections and Department of Juvenile Justice** - interact with Public Health around communicable disease issues, particularly STD, AIDS, nutrition education and tuberculosis. The Family Health Branch has developed Male Involvement programs for youth detained in juvenile detention facilities. The Division is beginning to work with adjudicated teens around risk behaviors.
- **The Department of Education** - has a memorandum of agreement with the commissioners of Community Health and Human Resources 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 Public Health and the schools. The Department is responsible for the Youth Risk Behavior Survey and the CDC Youth Tobacco Survey. Data from these surveys are important to FHB planning and health outcome efforts.

- **Children’s Trust Fund** - disperses funds for grants to public and private child abuse and neglect prevention programs and funds services connected with child abuse and neglect prevention. The agency is part of the State Agency Prevention Work Group.
- **Relevant Councils** - *The Council on Maternal and Infant Health* is legislatively mandated to “serve in an advisory capacity to the DHR and any other state agencies in all matters relating to maternal and infant health.” The Council, composed of obstetricians, pediatricians, family physicians, consumers, and other providers, monitors pertinent legislation affecting women and infants, and publishes information related to maternal and infant health. *The Governor’s Council on Developmental Disabilities* serves as an advisory body and provides broad policy advice and consultation to the FHB. *The Interagency Coordinating Council (ICC) for Early Intervention*, mandated under Part C of IDEA, is appointed by the Governor to advise and assist DHR in planning, coordinating and implementing a statewide system of early intervention services for children with or at risk for developmental delays. *The Governor’s Children and Youth Coordinating Council* was created to provide effective coordination and communication between providers of services for adolescents and children. The Branch’s Office of Adolescent Health and Youth Development works closely with the Council to implement Georgia’s abstinence education program.
- **Federally qualified health centers** - 17 community health centers (CHC) and corporate headquarters with 70 access sites provide comprehensive preventive and primary health. About 175,000 Georgians, the majority of whom are children and women ages 19-40, receive services each year. *The Georgia Association for Primary Health Care* works with the Branch to distribute family planning supplies and vaccines. The GAPHC outreach coordinator facilitates linkages between public health and the various CHCs. A number of CHCs provide perinatal case management services and newborn follow-up. There is an specific effort underway to co-locate and complement public health and community health center services, ultimately resulting in a more seamless system of care.
- **Tertiary care facilities** - the Branch has established relationships throughout the state with tertiary care facilities and technical resources that have enhanced the Branch’s capacity to offer services to women of childbearing age, infants, children and adolescents. The state has six NICUs, four Level I pediatric trauma centers, four children’s hospitals, and two burn units.

- **Technical resources** - the Branch works with a number of public health and health professional educational programs and universities, including SITE, GSAMS, Telemedicine, and EDUSIT. CMS is collaborating with the state's Distance Learning and Telemedicine Program (GSAMS) network of 59 health care and correctional sites and three tertiary hub sites (Medical College of Georgia, Emory University School of Medicine and Eisenhower Medical Center). Georgia's Telemedicine program has been recognized as a national leader in this field, bringing specialty health care to areas with limited access. For example, the Ware County DPH CMS Program uses Telemedicine to consult with specialists at the Medical College of Georgia in Augusta. BCW also utilizes telehealth technology across many districts. Telehealth is a simple technology that consists of linking two parties by use of VIA TA (a simple camera that connects to a television monitor) and regular telephone lines. This technology allows service coordinators and providers to provide consultation or supervision of therapies/activities directly in the home with families from a different location.

All four of the State's medical schools have faculty that participate in the CMS program. The children's hospitals (Egleston Hospital/Scottish Rite Hospital and Hughes Spalding in Atlanta and Medical College of Georgia in Augusta) make their educational programs available at reduced fees for CMS and other public health staff. As a result of its proximity, the Centers for Disease Control and Prevention (CDC) is a valuable resource in providing technical assistance and resources to the Branch. The Rollins School of Public Health at Emory University continues to work with the Branch in many areas: internships for students; program evaluation and outcome evaluation; and technical assistance and consultation. The Morehouse School of Medicine works closely with the Branch on issues impacting women. Several other universities (Georgia State, University of Georgia, and Clayton State) also work with the Branch.

- **Professional organizations** - The DPH and Branch work on an ongoing basis with the Medical Association of Georgia, Georgia State Medical Association, Georgia American Academy of Pediatrics and other professional groups to promote increased private sector involvement in serving women and children in need.
- **Advocacy organizations** - The Branch, along with DPH, works collaboratively with major maternal and child health advocacy organizations, such the March of Dimes, Health Mothers/Healthy Children, Georgians for Children (Kids Count), Save the Children, and Safe Kids of Georgia.

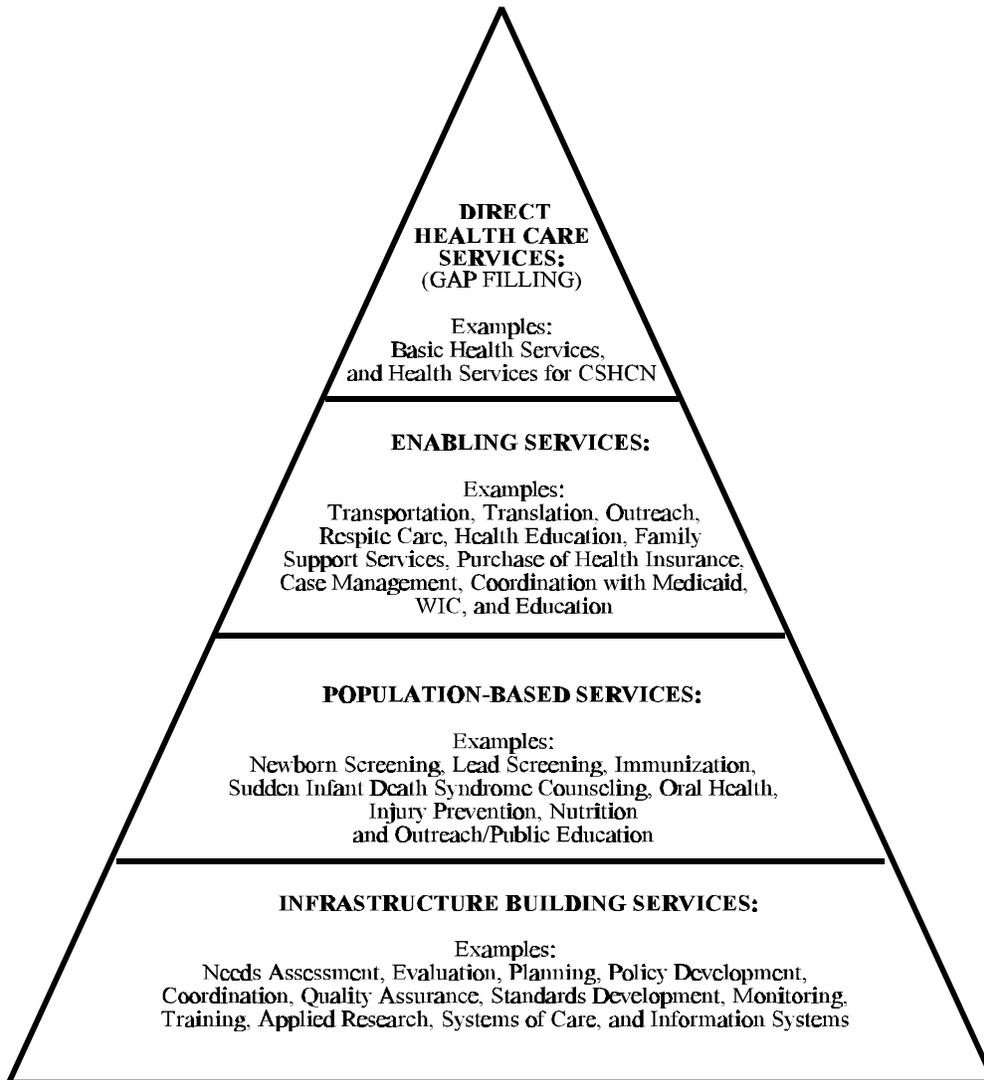
II. REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

See Forms 3-5

Figure 2

**CORE PUBLIC HEALTH SERVICES
DELIVERED BY MCH AGENCIES**



MCHB/DSCH 10/20/97

2.2 Annual Number of Individuals Served

See Form 6, Form 7, Form 8 and Form 9

2.3 State Summary Profile

See Form 10.

2.4 Progress on Annual Performance Measures

The accomplishments of the Title V program, by each level of the pyramid, are discussed below. Depending on the nature of the activity which has taken place, the activity is indicated at the level of the pyramid relevant to the activity itself, and not according to ascribed level of the performance measure. Within each level, activities are ordered by national and then state performance measure.

FY'00 ACTIVITIES BY PYRAMID LEVEL

Infrastructure:

NPM 1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State CSHCN Program.

- Worked on tracking component to identify SSI beneficiaries. (*Target population: CSHCN*)
- Identified elements for inclusion in CMS quarterly report to identify SSI beneficiaries. Development ongoing. (*Target population: CSHCN*)

NPM 2: The degree to which the State CSHCN Program provides or pays for specialty care and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

- Completed decentralization of largest CMS clinic in the state with the development of community-based services in 20 sites around the state. (*Target population: CSHCN*)

NPM 3: The percent of CSHCN in the State who have a “medical/health home”.

- Developed strategies for improved tracking of “medical/health home” for inclusion in CMS and BCW databases and have begun identifying strategies with AAP for improved collaboration. (*Target population: CSHCN*)

NPM 4: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies combined.

- Established genetics newborn screening advisory committee. Work group meets monthly to address recommendations. (*Target populations: infants, CSHCN*)

- Developing hospital/provider evaluation reports. *(Target populations: infants, CSHCN)*
- Correcting database problems. *(Target populations: infants, CSHCN)*

NPM 5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B.

- Served on committee responsible for reviewing and revising Georgia's rules and regulations for immunization and developed combined forms for schools and day care. *(Target populations: infants, children, CSHCN)*

NPM 6: The birth rate (per 1,000) for teenagers 15 through 17 years.

- Established 14 program core goals and objectives through collaborative efforts with national, state, and local stakeholders. *(Target population: children and adolescents)*
- Developed protocol for the planning and implementation of district youth development work plans. Trainings have been provided by certified HR 457 Abstinence trainers in 11 counties. *(Target population: adolescents)*
- Conducted four Regional Round Tables dialogues between AHYD and stakeholders to initiate regional networking, help identifying training priorities and needs of programs. *(Target population: adolescents)*
- Established Youth and Adult Advisory Groups in all funded Comprehensive Adolescent Health and Youth Development Centers. Groups submitted semi-annual reports. Community and district activities have been implemented throughout 19 districts as result of advisory groups. *(Target population: women, adolescents)*

NPM 7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

- Convened health districts to discuss group expectations around Georgia Oral health Prevention Plan (GOHPP). *(Target population: children and adolescents)*
- Distribute funding based on 12 dental health regions. All state funding will be used to purchase portable equipment to support personnel. *(Target population: children and adolescents)*

- Developed a new database in Microsoft Access for the Oral Health Program, which will provide a greater capability to monitor the number of third grade children who received protective sealants on at least one permanent molar. *(Target population: children)*

NPM 8: The rate of deaths to children ages 1-14 caused by motor vehicle crashes per 100,000 children.

- Prepared public health nurses to offer age-appropriate anticipatory guidance to families during child screens. Health Check assessment forms include car seat safety as one of educational topics for age appropriate anticipatory guidance. *(Target population: infants and children)*

NPM 9: Percentage of mothers who breast fed their infants at hospital discharge.

- Included breastfeeding in strategic plans for all 19 health districts. *(Target population: women, infants)*
- Included breastfeeding education and requirements in Competency Based Skills I workshops. *(Target population: women, infants)*
- Expanded mailing list to inform local coalitions about Georgia Breastfeeding Task Force activities. *(Target population: women, infants)*
- Formed two new breastfeeding coalitions in Dalton and Savannah health districts. *(Target population: women, infants)*
- Held Breastfeeding Advisory Committee meetings in January 2000 to discuss statewide activities. *(Target population: women, infants)*
- Worked with medical consultant to disseminate information on contraindications to breastfeeding, as well as signs of a well-fed breastfed infant, through the Georgia AAP Breastfeeding Committee. *(Target population: women, infants)*
- Continued Office of Nutrition participation in the biannual DHR SID/OID workgroup meetings. *(Target population: women, infants)*
- Coordinated discussion meetings throughout fiscal year 2000 with staff from the Office of Nutrition, the State WIC Program, the Center for Disease Control and Prevention (CDC), and Viking Computing (a contractor with the Georgia WIC Program) to identify current issues and concerns with the pediatric and pregnancy surveillance systems and to determine possible options for improving data collection and data accuracy. *(Target population: women, infants, and children).*

NPM 10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.

- Established Newborn Hearing Screening Advisory Committee (i.e., representation from Council on Maternal and Infant Health, State Interagency Coordination Council for Early Intervention, General Assembly appointees). First meeting held September 7, 1999 in conjunction with Georgia Public Health Association Convention in Savannah. Subsequent meetings held quarterly in Macon. *(Target population: infants)*
- Received funding to purchase equipment for birthing hospitals. *(Target population: infants)*
- Received HRSA funding to develop infrastructure. *(Target population: infants)*
- Developed plans to include assure appropriate genetic testing and counseling included in protocols and guidelines being developed by the Newborn Hearing Screening Advisory Committee. *(Target population: infants)*

NPM 11: Percent of CSHCN in the State CSHCN Program with a source of insurance for primary and specialty care.

- Increased PeachCare for Kids eligibility to 235% of federal poverty level. *(Target population, infants, children and adolescents, CSHCN)*

NPM 12: Percent of children without health insurance.

- Continued implementation of Georgia's CHIP, PeachCare for Kids statewide. The program, administered by DMA, provides a comprehensive package of health services for children in families whose income is below 237% of the federal poverty level and who are ineligible for Medicaid or without other health coverage. *(Target population: infants, children and adolescents, CSHCN)*
- Received funds from HRSA for Healthy Childcare Georgia 2000 Quality Initiative that focuses on childcare setting as avenue of health insurance. *(Target population: infants, children and adolescents)* (See Appendix V, Questionnaires -- Healthy & Safe Child Care: Viewpoint of Directors and Viewpoint of Home Providers).

NPM 14: The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.

- Required each health district to have at least one local ICC. ICC membership must be at least 20% parents, including minority parents, parents of children with disabilities aged 12 or younger. *(Target population: CSHCN)*
- Utilized BCW parents, along with community providers, to monitor health district activities. *(Target population: CSHCN)*
- Utilized BCW's 12 parent educators to work statewide, engaging parents in districts, providing support for families. In addition, some districts have hired family members at the local level. *(Target population: CSHCN)*
- Managed two Parent to Parent contracts, one of which included the BCW Central Directory of Early Intervention Services which links parents to other parents of children with similar disabilities. *(Target population: CSHCN)*
- Worked collaboratively with Georgia Affiliate of SIDS Alliance to spread word regarding risk for SIDS as well as developing strategies for supporting bereaved families in Georgia. *(Target population: women)*

NPM 15: Percent of very low birth weight live births.

- Updated Preconceptual Health Manual and Life Planner brochure. *(Target population: women, infants)*
- Updated districts on low birthweight levels in CDC nutrition surveillance systems at Nutrition Services Director meeting in May 2000. *(Target population: women, infants)*
- Conducted staff training on WIC risk criteria, nutrition assessment and hematological testing at Competency Based Skills Level I training in February 2000. *(Target population: women, infants)*
- Identified high risk behaviors among pregnant and parenting adolescents. *(Target population: women, infants, adolescents)*
- Worked with planners in six perinatal regions to structure regional reproductive health plan that will utilize perinatal indicators as part of outcome process. *(Target population: women, infants)*
- Worked with DMA to unbundle OB care and delivery to facilitate delivery at risk appropriate facilities. Discussed with perinatal center leadership. *(Target population: women, infants)*

- Worked with DMA and Regulatory Services (ORS) to link payment to levels of neonatal hospital certification. ORS is in the process of rewriting their rules and regulations to include certification of neonatal hospital process. DMA is currently reviewing the proposal. *(Target population: women, infants)*
- Continued development of six region perinatal planning system which includes the health district(s) and regional tertiary center related to that district(s). Hired regional perinatal coordinators. *(Target population: women, infants)*
- Developed action plan outlining implementation of recommendations on reducing the Black/White infant mortality gap. *(Target population: women, infants)*

NPM 16: The rate (per 100,000) of suicide deaths among youths 15-19.

- Included suicide prevention as an outcome indicator for services provided by local districts' AHYD programs. *(Target population: adolescents)*

NPM 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. (See also NPM 15)

- Worked with perinatal planners to set up monitoring system to enable regions to monitor high risk deliveries. *(Target population: women and infants)*

NPM 18: Percent of infants born to pregnant women receiving prenatal care in the first trimester. (See NPM 15.)

- Worked with case management providers on effective outreach strategies. *(Target population: women and infants)*

SPM 1: Determination of attainment of critical milestones in implementation and utilization of Georgia Perinatal Guidelines. (See also NPM 15)

- Sent updated perinatal guidelines to hospitals, public health coordinators, and private physicians. Published on Public Health web site. *(Target population: women, infants)*

SPM 2: Presence of key components that comprise a comprehensive approach to address maternal substance abuse.

- Appointed to Division of MHMRSA advisory committee to provide oversight to Center for Substance Abuse Treatment funded statewide treatment needs assessment. Had discussions with MHMRSA. *(Target population: women)*

SPM 3: Evaluation of the state capacity to prevent use of tobacco, alcohol and other substances by children and adolescents.

- Continued to strengthen relationships between FHB, DPH's Tobacco Use Prevention Program and the Division of MHMRSA. *(Target population: adolescents)*
- Included representation from tobacco prevention program on school health technical assistance/training committee. *(Target population: adolescents)*
- Appointed to Division of MHMRSA advisory committee to provide oversight to Center for Substance Abuse Treatment funded statewide treatment needs assessment. *(Target population: adolescents)*
- Expanded tobacco prevention program implemented at Gordon County Middle Schools to include additional schools. *(Target population: adolescents)*

SPM 4: Degree to which MCH planning processes exhibit essential characteristics of community involvement, needs identification, strategy development and implementation plans.

- Continued implementation of a two-year grant from the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services to support development and use of indicators of children's health and well-being in state and local policy work. *(Target population: infants and children, adolescents, CSHCN)*
- Completed newborn hearing screening hospital survey. *(Target population: infants, CSHCN)*
- Developing plan to provide newborn hearing screening equipment "technology" *(Target population: infants)*
- Continued building the Georgia Coalition for Nutrition Education, coordinated by the Office of Nutrition through a grant from USDA. The Coalition has worked to promote better health behaviors statewide. Local communities have plan special projects to increase awareness of the *Take Charge* messages. *(Target population: all)* (See Appendix W, *Take Charge* Campaign Materials).
- Continued to educate the public about importance of folic acid in preventing neural tube birth defects. The Georgia Folic Acid Task Force has worked to involve more community partners in their grassroots cooperative efforts to disseminate information through a Spring folic acid awareness campaign. The Task Force, which includes FHB representation, has assessed community needs and solicited community partnerships to assist in further assessments, planning and implementation of strategies. *(Target population: women)*

- Provided on-site technical assistance and consultation to health districts on implementation of nutrition education plans. *(Target population: all)*
- Conducted three community-based nutrition assessment and planning training workshops in Spring 2000 utilizing the Moving to the Future model. *(Target population: all)*
- Participated with Coastal Child Cohort Surveillance Group and the Southeast Perinatal Regional Planning Council regarding nutrition data links to WIC database. *(Target population: all)*
- Collaborated with Office of Nutrition and AAP to address obesity in childhood and adolescents. *(Target population: children and adolescents)*

SPM 5: Degree to which risk positive children, birth to age 4, are referred to appropriate public health programs, linked with a primary health care provider, and referred for community services.

- Formed work group to develop model for assuring developmental follow up across all Family Health Branch programs. Work group completed Child Health Process Model to ensure children get into family health programs through central portal of entry. Includes developmental follow-up. *(Target population: CSHCN)*
- Continued to strengthen partnership with the Georgia Chapter of the AAP by maintaining a contract liaison position to further the work of all child health program efforts, improve service coordination for children birth to 21 years of age, with special emphasis on improving AAP member support of Children 1st. *(Target population: children, CSHCN)*

SPM 6: Percent of eligible child deaths statewide reviewed by county level child fatality review subcommittees.

- Provided Child Fatality Review Updates at SIDS/OID Work Group meetings. Director of the Office of Child Fatality Review participates in the Work Group. *(Target population: infants, children and adolescents)*
- Continued to encourage each county fatality review committee to designate a prevention advocate. The role of the advocate is to serve as a liaison with community groups, focus team members on identification of strategies for prevention of child death in the community, assist with location of resources for prevention and intervention efforts, and advocate for implementation of identified prevention and intervention efforts. *(Target population: infants, children and adolescents, CSHCN)*
- Established contractual agreement with Hughes Spalding Children's Hospital to identify abused children and provide them with appropriate resources. *(Target population: infants, children and adolescents)*

SPM 8: Percent of children enrolled in the CSHCN Program receiving case management services.

- Provided children enrolled in BCW with CMS services. *(Target population: CSHCN)*
- Provided children enrolled in BCW with comprehensive service coordination as defined in IDEA, Part C. *(Target population: CSHCN)*
- Began process of further defining levels and intensity of case management services for all children enrolled in CMS. *(Target population: CSHCN)*

SPM 9: Percent of counties engaged in “Safe Kids” injury prevention coalitions.

- Worked with SAFE Kids coalitions throughout the State. 47 coalitions are located in all major urban areas except Albany. *(Target population: children)*
- Trained two child care health consultants who are developing a statewide system of child care health and safety consultants. Developing curriculum to offer training to public health personnel statewide. Plan to pilot program in North and Southeast Georgia. *(Target population: infants and children)*
- Included representative of SAFE Kids Georgia on Healthy Child Care Georgia Advisory Committee. *(Target population: children)*

SPM 10: Rate of asthma related to hospitalizations 0 to age 21.

- Implemented contractual agreement with Hughes Spalding Children’s Hospital to educate patients with asthma and their parents to understand more about the disease and its management. *(Target populations: children and adolescents)*
- Continued work of division level asthma working group to identify major issues and develop strategic directions for further asthma prevention and control related activities. Task Force includes FHB, Epidemiology, and Chronic Disease Units. *(Target population: children, adolescents)*
- Gathered preliminary information regarding the impact of asthma on children in Georgia. Reviewed DMA claims database study and learned about ZAP asthma project. *(Target population: children, adolescents)*
- Met with Georgia Chapter of American Lung Association to explore potential asthma related activities. *(Target population: children, adolescents)*

Population-Based:

NPM 4: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies combined.

- Continued newborn screening. (*Target populations: infants, CSHCN*)

NPM 6: The birth rate (per 1,000) for teenagers 15 through 17 years.

- Referred all teen mothers, at birth of child, to Children 1st. Staff worked with teens to help them remain in school. Responsible sexual behavior, family planning and delayed subsequent pregnancy discussed during voluntary family assessment. Also worked, whenever possible, with father in teen birth. (*Target population: adolescents*)

NPM 7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

- Supported fluoridation of water systems to increase number of people served by community water systems with fluoride in the optimal range (0.7 ppm - 1.2 ppm FL). (*Target population: infants and children*)

NPM 8: The rate of deaths to children ages 1-14 caused by motor vehicle crashes per 100,000 children.

- Included car seat safety as one of the Child Health Assessment form's educational topics for age appropriate anticipatory guidance. (*Target population: infants and children*)

NPM 10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.

- Expanded universal hearing screening from 10 hospitals to 30. Fifteen hospitals are conducting hearing screenings using either Otoacoustic Emission (OAE) or Automated Auditory Brain Stem Screening (AABR) on infants having "risk factors." (*Target population: infants, CSHCN*)

SPM 9: Percent of counties engaged in "Safe Kids" injury prevention coalitions.

- Adopted injury prevention as an area of focus by all FBH population teams. (*Target population: all*)

Enabling:

NPM 1: Percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State CSHCN Program.

- Continued to receive referrals of SSI eligible children and refer them to the local community for eligibility determination for CMS and other public health programs at the local level. (*Target population: CSHCN*)
- Began identification of strategies for improving ongoing tracking abilities of this population. (*Target population: CSHCN*)

NPM 2: The degree to which the State CSHCN Program provides or pays for specialty care and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

- Provided care coordination (service coordination) for BCW children and assisted in accessing and/or paying for certain specialty services for BCW and CMS populations. *(Target population: CSHCN)*

NPM 3: The percent of CSHCN in the State who have a “medical/health home”

- Developed strategies at the local program level for continuous and ongoing monitoring of medical/health home for children enrolled in BCW and CMS. *(Target population: CSHCN)*

NPM 4: Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies combined.

- Held four workshops, in conjunction with the Newborn Screening Laboratory, on collection of filter paper specimens. *(Target populations: infants, CSHCN)*
- Provided genetics information, through SIDS and Genetics collaborative activities, to SIDS parents seeking answers. *(Target populations: infants, CSHCN)*
- Continued collaboration with Emory University Division of Medical Genetics to assure coordination of nutrition services to metabolic patients. *(Target populations: infants, CSHCN)*

NPM 5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B.

- Developed listing of resources from the Immunization Program (NIP) at the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics to summarize evidence, which does not indicate a casual relationship between SIDS and vaccines. *(Target population: infants, CSHCN)*
- Placed resource list on Public Health SIDS resource web page (<http://health.state.ga.us/programs/sids/related.shtml>) *(Target population: infants, CSHCN)*

NPM 6: The birth rate (per 1,000) for teenagers 15 through 17 years.

- Collaborated with Boys/Girls Clubs, YWCAs and YMCAs in outreach activities, particularly around male involvement. *(Target population: children and adolescents)*
- Provided four statewide HR 457 Abstinence trainings, two new staff orientation conferences, two bidders’ conferences, and other technical assistance requests. *(Target population: adolescents)*

- Held statewide Youth Development Conference (11/99) that included numerous key stakeholders and Youth Development experts. Several workgroups were conducted and a state committee has been established to determine cross training methods. Two statewide Youth Development modules have been developed by the University of Georgia and Georgia State University. Trainings began in January 2000. (*Target population: adolescents*)
- Working with public health nutritionists on preventing early childhood caries. (*Target population: children*)
- Contracted with Morehouse College and implemented Parent Network. Trainings took place in Floyd, Fulton, Hancock, and Houston counties. Updated program plans to include enhancing and expanding services to two additional areas. (*Target population: adolescents*)
- Provided dental sealant awareness/education in Macon via web page. (*Target population: children and adolescents*)

NPM 8: The rate of deaths to children ages 1-14 caused by motor vehicle crashes per 100,000 children.

- Included family safety in Children 1st family assessment. Families without car seats for children in the home linked with community car seat resources. (*Target population: infants and children*)
- Developed specialized car seat resources for families with CSHCN. (*Target population: infants and children*)
- Provided car seat information to women bringing their newborn infants to clinic for WIC Program certification. (*Target population: infants and children*)
- Developed instructions to prepare public health nurses to offer age appropriate anticipatory guidance to families during well child screens. (*Target population: infants and children*)
- Expanded car seat safety training to one per month. (*Target population: infants and children*)
- Participated in Governor's Life Savers 2000 conference. (*Target population: infants and children*)

- Included proper use of car seats and seat belts in all Health and Safety Workshops for day care providers. *(Target population: infants and children)*
- Provided anticipatory guidance to parents and adolescents regarding motor vehicle safety. *(Target populations: women, adolescents)*
- Identified new AHYD strategies to enhance prevention strategies for adolescent driving procedures. *(Target population: adolescents)*
- Submitted 222 Children 1st referrals to Injury Prevent/Safety agencies. Partnership with Children 1st resulted in child seat safety distribution in 31 counties. All programs have been evaluated. Bike helmet programs in five counties. *(Target population: infants, children and adolescents)*

NPM 9: Percentage of mothers who breast fed their infants at hospital discharge.

- Collaborated with Georgia Chapter of the AAP Breastfeeding Committee to develop plans to provide more consistent and in depth training to medical residents and to provide updated information to physicians around the State. *(Target population: women, infants)*
- Continued Children 1st support for breastfeeding. Family assessment includes questions about breastfeeding, and support is offered to new mothers who are breastfeeding. *(Target population: women, infants)*
- Initiated Loving Support campaign statewide in June 1999, providing educational materials and posters. *(Target population: women, infants)*
- Ran radio ads and exhibited posters on the Georgia News Network and Georgia Association of Broadcasters from July 1999 - June 2000. *(Target population: women, infants)*
- Initiated billboards statewide promoting the Loving Support campaign, displaying WIC Hotline telephone number. *(Target population: women, infants)*

NPM 10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.

- Utilized failed screening test in the hospital as a trigger for Children 1st to contact the family. Pass or failure is recorded on Children 1st screen and referral form completed by delivery hospital or by provider for older child. *(Target population: infants and children, CSHCN)*

- Conducted briefing on HB 717 (Establishment of Newborn Hearing Screening Committee) for DPH director. *(Target population: infants and children)*

NPM 11: Percent of CSHCN in the State CSHCN Program with a source of insurance for primary and speciality care. (See also NPM 12.)

- Linked Children 1st families lacking a source of insurance for primary and specialty care with Medicaid, PeachCare for Kids, etc. *(Target population: CSHCN)*
- Provided eligible CSHCN families with information on PeachCare for Kids, i.e., sent letters explaining program, included applications with letters, etc. *(Target population: CSHCN)*

NPM 12: Percent of children without health insurance.

- Enrolled 75,640 children (61% of eligible children) in PeachCare for Kids as of April 2000. *(Target population: infants and children, adolescents, CSHCN)*
- Served on Healthy Mothers, Healthy Babies advisory group which provides information to the public regarding access to health care statewide. *(Target population: infants and children)*
- Audited PeachCare records and encourage applications for PeachCare by families seen in public health departments in non-Medicaid program. *(Target population: infants and children)*
- Utilized other available health care resources, such as the Georgia Partnership for Caring, to access health care for children and women lacking insurance. *(Target population: all)*
- Linked Children 1st families lacking a source of insurance for primary and specialty care with Medicaid, PeachCare for Kids, etc. *(Target population: children and adolescents)*
- Facilitated ways in which public health supports outreach efforts for PeachCare, i.e., sent letters and applications to families, helped families fill out applications and/or deal with application problems. *(Target populations: infants, children and adolescents)*
- Distributed PeachCare applications to parents at annual Kids Care Fair, held at 20 sites in Metro Atlanta. *(Target populations: infants, children and adolescents, CSHCN)*

NPM 13: Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.

- Assisted CMS families in assuring access to services through Medicaid. (*Target population: CSHCN*)
- Assisted nearly 100% of BCW children who are Medicaid eligible in receiving Medicaid services. (*Target populations: CSHCN*)
- Worked with DMA and Healthy Mother, Healthy Babies to identify number of dentists providing care for children enrolled in Medicaid, PeachCare for Kids as well as number of underserved or unserved children. (*Target population: children, CSHCN*)
- Provided services and improved access to dental school-based services. (*Target population: children and adolescents*)
- Distributed portable dental equipment to 12 dental health districts that enables provision of services as well as prevention at community activities (e.g., health fairs) (*Target population: children and adolescents*)
- Implemented Newborn Linkage Program to enable pregnant Medicaid recipients to choose a Medicaid primary care provider (PCP) or Grady managed care organization (Fulton and DeKalb Counties) provider before or shortly after birth of child; offer education on how Medicaid's Georgia Better Health Care (GBHC) primary care case management program works; schedule initial two week appointment for infant with newly selected provider; facilitate entry of the child into GBHC with a PCP of mother's choice or refer mother to the Grady MCO; and encourage mother to complete child's Health Check visits at regular intervals. (*Target populations: infants and children, CSHCN*)

NPM 14: The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.

- Included family participation in state and local Children1st activities. Have a steering committee of family representatives to help with MCH issues. Encourage districts to include families in policy and planning activities. (*Target population: CSHCN, children*)
- Included parent members on BCW's state Interagency Coordinating Council (ICC). All ICC meetings include opportunity for public comment. Family members serve on ICC committees. (*Target population: CSHCN*)
- Provided technical assistance and support to local Interagency Coordinating Council and BCW staff, through the Statewide Public Awareness Committee. Interacted with other local and state councils in planning for appropriate services for young children in Georgia. (*Target population: CSHCN*)

- Provided ICC funds to pay eligible parents' travel to conferences and other events. Reimbursed families for travel and child care expenses for ICC and some BCW meetings. *(Target population: CSHCN)*
- Invited family members to all BCW trainings. *(Target population: CSHCN)*
- Maintained family involvement funding into health district CMS allocation formula to enhance family participation at the local level (e.g., travel reimbursement, reimbursement for participation in advisory board activities.) *(Target population: CSHCN)*
- Involved parents and parent educators in the development of BCW guidance and implementation materials on provision of services in natural environments. *(Target population: CSHCN)*
- Continued project to obtain computer equipment donations in order to allow families to access SIDS e-mail discussion groups and other bereavement resources on the Web. *(Target population: infants and children)*

NPM 15: Percent of very low birth weight live births.

- Supported use of interconceptional model to help Children 1st mothers who have had a low birthweight baby prevent having another LBW baby. *(Target population: women, infants)*
- Promoted early entry into WIC Program to receive supplemental nutrition through WIC vouchers and nutrition counseling by nutritionists in health clinics. *(Target population: women and infants)*
- Promoted "Take Charge of Your Health" nutritional messages with low income women in WIC and Food Stamp Programs to reduce the incidence of high risk pregnancies through better nutrition. *(Target population: women and infants)*
- Required local WIC program staff to provide high risk nutrition follow up to caregivers of low birthweight infants. Follow up includes making appropriate referrals, networking with CMS and BCW, based on participant needs. *(Target population: women and infants)*

NPM 16: Rate (per 100,000) of suicide deaths among youths 15-19.

- Included discussion of suicide on the developmental tool used for adolescents ages 10-21 years. *(Target population: children and adolescents)*
- Included appropriate lifestyle education geared towards ages 10-21 at health screening visits. *(Target population: children and adolescents)*

- Promoted adult supervised activities and mentoring and peer leadership services. AHYD centers, abstinence education providers, and Comprehensive Adolescent Health Centers made mentoring, peer leadership and parent trainings available. *(Target population: adolescents)*

NPM 18: Percent of infants born to pregnant women receiving prenatal care in the first trimester. (See also NPM 15.)

- Encouraged women seen in Family Planning clinics to seek prenatal care as early as possible after know they are pregnant. *(Target population: women and infants)*

SPM 1: Determination of attainment of critical milestones in implementation and utilization of Georgia Perinatal Guidelines. (See NPM 15)

- Disseminated guidelines. *(Target population: women and infants)*

SPM 2: Presence of key components that comprise a comprehensive approach to address maternal substance abuse.

- Included substance use/abuse in client assessments conducted by family planning providers who have received additional training in substance abuse counseling. *(Target population: women)*
- Held meetings with MHMRSA staff. *(Target population: women)*
- Implemented preconceptional training package for public health districts that includes tobacco, alcohol and other drugs. *(Target population: women)*
- Assessed substance use within the family, including the mother, during voluntary Children 1st family assessments. Provided health education and/or linkages where appropriate. *(Target population: women)*
- Worked with rape crisis centers to implement sexual assault prevention program for schools, based on state legislation. Training school personnel and public safety officials, other members of the community on sexual assault. *(Target population: women)*
- Facilitated access to appropriate services if a BCW or CMS family identified substance abuse as an issue. *(Target population: women)*
- Continued to educate professionals and general public, especially pregnant women and families of newborns, about reducing risk of SIDS through prenatal smoking cessation and

smoke-free environment, early prenatal care, breast feeding, use of firm bedding materials and supine sleep position for infant. *(Target population: women)*

SPM 3: Evaluation of the state capacity to prevent use of tobacco, alcohol and other substances by children and adolescents.

- Addressed high risk behaviors, including alcohol and other drug use, with sexually active teens served by Family Planning Program. Provided education about barriers to prevent unwanted pregnancies. *(Target population: adolescents)*
- Provided educational materials on tobacco use prevention to all middle schools in Gordon County. *(Target population: adolescents)*
- Incorporated tobacco use on the developmental questionnaire, used for ages 6 to 21 years, during Health Check screens. *(Target population: adolescents)*
- Implemented Georgia Spit Tobacco Education Program as part of CHARGE held statewide. Provided training on spit tobacco prevention to health professionals and school personnel. *(Target population: adolescents)*

SPM 5: Degree to which risk positive children, birth to age 4, are referred to appropriate public health programs, linked with a primary health care provider, and referred for community services.

- Linked Children 1st families receiving voluntary family assessment to primary health care providers and referrals to appropriate public health programs and community services. Collected district data on number and type of Children 1st referrals. *(Target population: infants and children, CSHCN)*
- Identified risk positive children during Health Check assessments and referred them to appropriate care. *(Target population: infants and children, CSHCN)*
- Identified 21,410 total births; 5,864 screened risk positive. Linked 2,274 to private providers and 625 to public health. Made 3,100 referrals to the community services; 1,535 to public health. *(Target population: infants and children, CSHCN)*
- Provided Denver II training to Public Health staff and other private providers, as requested. *(Target population: infants and children, CSHCN)*
- Collaborated with the AAP medical home coordinator to conduct site reviews and offer training to private providers as needed. *(Target population: children, CSHCN)*

- Collaborated with DMA and AAP to develop Health Check training program statewide. *(Target population: infants and children)*

SPM 6: Percent of eligible child deaths statewide reviewed by county level child fatality review subcommittees.

- Participated in five Child Fatality Review trainings statewide. *(Target populations: infants and children, adolescents)*
- Shared Georgia curriculum for first responders with EMS for children; self-study module being developed. *(Target populations: infants and children, adolescents)*
- Trained three regional perinatal nurses and Crawford Long nurses as trainers in grief processes. *(Target populations: infants and children, adolescents)*
- Distributed Georgia Back to Sleep: A Newsletter of the SIDS/OID Work Group, and HeartLine, the newsletter of the SIDS Alliance of Georgia, twice a year to the chairs of the county child fatality review subcommittees. *(Target population: infants, children and adolescents)*

SPM 7: Degree to which information on and support for effective parenting methods for children birth to age 21 is available throughout the MCH system.

- Included parenting issues in Resource Mothers Program curriculum and biannual training provided by Georgia Cooperative Extension Agency. *(Target population: all)*
- Incorporated provision of health and parenting education into Children 1st assessment. Referrals to community parenting resources are made, if needed. Linkages made to public health (7,732 referrals), social service and community-based services (11,569); genetics (142); lead (67) ; high risk infant follow-up (3,422): Children’s Medical Services (2,495); Family Planning (1,649); Food/Nutrition (1,373); Adult Education (Literacy, GED) (1,696); Medicaid (784); Housing/Shelter (694); Clothing (513); Legal Services (407); and Employment Counseling/Training (448). Referrals also made to: BCW (1,606), Parenting Classes/Programs (1,148), Primary Care Providers (8,003), Child Care (352 - general day care - typical and CSHCN, after school programs, respite care); Transportation; English as second language; Family support (Healthy Families, HIPPY); Injury Prevention and Child Safety; Substance Abuse; Neighborhood and Recreational Opportunities; Mental Health; Head Start; Children’s Health Insurance Program/PeachCare for Kids; and Family Violence. *(Target population: all)*
- Provided parenting assistance, as part of federally mandated service entitled “Family Training,” as it relates to child’s disability. BCW interventions focus on guiding/teaching parents how to effectively participate and intervene with child to enhance child’s growth and development. *(Target population: CSHCN)*

- Presented Better Brains for Babies curriculum to 212 trainers, representing 74 counties. 119 trainers reported during active trainings. *(Target population: infants)* (See Appendix X, Better Brains for Babies Materials).
- Worked with Foster Care to assure sleep safety education is included in training of foster parents. *(Target population: infants)*
- Provided workshops for BCW families that included a variety of parenting component; addressing needs of siblings; needs and participation of fathers; and dealing appropriately with stress when parenting child with special needs. *(Target population: all)*
- Presented early brain development workshops (Better Brains for Babies) at Southwest Georgia Dietetic Association, Competency Based Skills Level II, and GSAMS training for nutrition assistants. *(Target population: all)*
- Promoted messages about good parenting skills in Take Charge of Your Health train-the-trainer sessions. *(Target population: all)*
- Provided funding to each district for parenting videos and pamphlets. *(Target population: all)*

SPM 8: Percent of children enrolled in the CSHCN Program receiving case management services.

- Continued utilization of Children 1st as the point of entry/intake in many health districts across the State for children birth to four who are identified with socioeconomic, medical, and/or biological conditions that put them at risk for poor developmental or health outcomes. Appropriate referrals were made and linkages were monitored up to the child's fourth birthday. *(Target population: infants and children, CSHCN)*
- Provided case management (service coordination) services to 100% of children enrolled in BCW, and increased number of children in CMS receiving comprehensive case management. *(Target population: infants and children)*

SPM 9: Percent of counties engaged in "Safe Kids" injury prevention coalitions.

- Submitted 222 Children 1st referrals to Injury Prevention/Safety agencies in SFY 2000 to date. Partnership with Children 1st resulted in car safety seat distribution in 31 counties. All programs were evaluated. *(Target population: infants and children)*

- Increased bike helmet usage among at risk children in five communities. (*Target population: infants and children*)
- Identified families, through Children 1st voluntary family assessment, who are in need of a smoke detector. Linked families with their local fire department for installation. Agencies involved in either the home assessment, purchase of detectors, or installation included Ninth District Opportunities, Office of Injury Prevention and Safety, Children 1st, local fire departments, and Community Action Agencies. (*Target population: infants and children*)
- Distributed child safety seats, educational materials and incentives at roadchecks conducted through the Child Passenger Injury Prevention Project. (*Target population: infants and children*)
- Presented health and safety workshops, including slum corner prevention and emergency care, in Columbia, Macon, and Augusta to family day care providers and resource and referral staff. (*Target populations: infants and children, adolescents*)
- Worked with Safe Kids programs to get information out on back sleep positioning. Reducing SIDS is a national Safe Kids goal. (*Target population: mothers, infants*)

Direct Medical Care:

NPM 1: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State CSHCN Program.

- Provided habilitation services, coordinated by BCW for 100% of babies in Babies Can't Wait (BCW). (Small number of these children are also in CMS.) (*Target population: CSHCN*)

NPM 2: The degree to which the State CSHCN Program provides or pays for specialty care and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

- Provided CMS at the community level in 20 sites around the state. (*Target population: CSHCN*)
- Provided or paid for specialty care and subspecialty services for CSHCN enrolled in the CMS Program. (*Target population: CSHCN*)
- Provided High Risk Infant Program specialty and subspecialty care to CSHCN. (*Target population: CSHCN*)

- Provided additional specialized formulas, as needed, for infants and children who qualify for WIC and CMS and/or BCW. (*Target population: CSHCN*)
- Held pediatric neurology clinic (once or twice a month) in Dalton CMS with a contracted pediatric neurologist services to children with neurological involvement. (*Target population: CSHCN*)
- Implemented clinic in the Dalton CMS, staffed by a neonatologist, to assess undiagnosed patients, patients with genetic disorders, and new referrals. (Clinic began July, 1999.) Neonatologist also sees premature infants for BCW. (*Target population: CSHCN*)

NPM 5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B.

- Included immunization assessment in voluntary Children 1st home assessment. If children's status not up to date, encourage parents to get them immunized. (*Target population: infants and children*)
- Worked with Georgia WIC Program to improve immunization coverage among WIC participants. Local WIC staff assess immunization status of all infants and children participating in the Program. When immunizations are given at health department, immunization appointments and WIC appointments are scheduled concurrently whenever possible. When provided by a private provider, staff is asked to request that immunization record be brought to next WIC appointment. (*Target population: infants and children*)

NPM 6: The birth rate (per 1,000) for teenagers 15 through 17 years.

- Provided intensive case management at the local level to young women in Family Planning Program who have become sexually active to clarify issues the client might have, ensure that they have access to family planning methods and are continuing to use the method have chosen. (*Target population: adolescents*)
- Funded and collaborated in implementation of Grady Hospital Family Planning Program's "Preventing Second Pregnancies" Project and "Postponing Sexual Involvement" program. (*Target population: adolescents*)
- Referred teen mothers, at birth of child, to Children 1st. Attempted to keep mother in school, family planning discussed as well as delay of subsequent pregnancies. (*Target population: adolescents*)

NPM 7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

- Continued contractual agreement with children and youth program in Augusta that served children in the dental program. (*Target population: children and adolescents*)
- Completed implementation of Seal Georgia projects in all 12 dental health regions. 453 eligible children seen and 13653 sealants placed. (*Target population: children and adolescents*)
- Allocated funding in Grant-In-Aid to obtain portal dental equipment. (*Target population: children and adolescents*)

NPM 9: Percentage of mothers who breast fed their infants at hospital discharge.

- Offered women seen in family planning clinics methods of contraception that would be compatible with breastfeeding. Clients encouraged to continue breastfeeding as long as feasible. (*Target population: women, infants*)

NPM 10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.

- Identified children, through Children 1^s, up to age 4 for serious problems/abnormalities. (*Target population: infants and children, CSHCN*)
- Screened infants for newborn hearing through Electronic Birth Certificate or manual process. Positive screens referred to primary provider and/or the following: HRIFU, BCW/EL, CMS. (*Target population: infants*)

NPM 15: Percent of very low birth weight live births.

- Emphasized preconceptional health and planned pregnancies in family planning services. Staff encourage use of folic acid and provide folic acid tablets free of charge to women. (*Target population: women, infants*)
- Addressed high risk behaviors with family planning clients that may increase risk of low birth weight births. Counseled, diagnosed and treated STD to prevent LBW babies. (*Target population: women, infants*)
- Provided specialized formula, through WIC, to low birthweight infants when formula prescribed by a physician. (*Target population: women and infants*)

NPM 16: The rate (per 100,000) of suicide deaths among youths 15-19.

- Adopted suicide prevention as a goal in adolescent health and youth development programs. *(Target population: adolescents)*

NPM 18: Percent of infants born to pregnant women receiving prenatal care in the first trimester. (See NPM 15.)

- Continue to address through case management outreach. *(Target population: women and infants)*

SPM 1: Determination of attainment of critical milestones in implementation and utilization of Georgia Perinatal Guidelines. (See NPM 15.)

SPM 2: Presence of key components that comprise a comprehensive approach to address maternal substance abuse.

- Funded 22 programs to provide prevention services and services for victims of sexual assault. Funded four districts to develop plans to address sexual assault. All 25 Rape Crisis centers are participating in planning process, including four districts funded to develop plans around sexual assault. Staff have been trained on needs assessment and on evaluation. *(Target population: women)*

SPM 3: Evaluation of state capacity to prevent use of tobacco, alcohol and other substances by children and adolescents.

- Provided education and counseling activities regarding tobacco, alcohol and other drug use in 30 AHYD sites across State. *(Target population: adolescents)*

SPM 10: Rate of asthma related hospitalizations 0 to age 21.

- Implemented chronic lung program in southwestern part of the state (Albany). Program is partnering with Medical College of Georgia to provide Telemedicine support to decrease the amount of family and provider travel time required. *(Target population: CSHCN)*

2.5 Progress on Outcome Measures

See Form 12.

III. REQUIREMENTS FOR THE APPLICATION [Section 505]

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

The current FY'01 needs assessment builds on the assessment process which was first established in the development of Georgia's FY'99 MCH Block Grant application. Emerging from the base needs assessment was the recommendation to develop FHB infrastructure to carry out planning, policy development and analysis, and evaluation activities. In 1999, the Office of Policy, Planning and Evaluation (PPE) was created to implement these functions. In this role, PPE was responsible for conducting the state's FY'01 MCH needs assessment, and the development of work plans for FHB units, reflecting the identified needs, priorities, and performance indicators.

The process used for the FY'01 needs assessment is a refinement of the approach used during the last two years. The components of the assessment consisted of five phases: 1) planning and design; 2) data gathering and assessment; 3) analysis/synthesis; and 4) recommendations and priority-setting; and 5) branch work plan development. In Phase 1, a search was conducted to collect existing background materials and already completed MCH related needs assessments, a multi-faceted external environmental scan was carried out, and focus groups and key informant interviews took place. The planning phase specified objectives; constructed a plan overview; determined seven focus areas around which the needs assessment was conducted; identified broad themes for each module; developed detailed questions related to these themes; defined the data synthesis and analysis plan; identified data sources; selected data collection strategies established a timeline; prioritized data collection activities; designed the required instruments; and determined key resources, roles, and responsibilities. (See Appendix Y, FY '01 Needs Assessment Process and Results).

Using the design framework, assessment and data collection commenced. Over 30 face-to-face and telephone key informant interviews occurred. The interviews were conducted with persons from various public agencies, academic institutions, service providers, and advocacy groups as well as staff in other DPH units whose work impacts FHB. Areas covered in these interviews included key issues affecting maternal, child and adolescent health; state and national trends; changes affecting the target population, strengths and weaknesses of current policies and programs; and future directions. These interviews were conducted by PPE staff and consultants. In addition to the key informant interviews, surveys were conducted with children with special health care needs providers, specifically Children's Medical Services and Babies Can't Wait coordinators. Focus groups with current and/or potential FHB consumers extended the range of data utilized in the needs assessment to incorporate family and community viewpoints. These six focus groups were held in different areas of the state with participants randomly selected by telephone from a list of residents of the communities in which the focus groups were held. In addition to those randomly selected, parents of children with special needs were included in three

of the focus groups. The focus groups elicited views on the most important health needs of Georgians, personal knowledge and experience with MCH services and programs, insights regarding health insurance and accessibility of health services, and perceptions about the role of the state in setting health care policy. To complete the picture of Georgia, the last element in the assessment and data collection phase, was collection of demographic data including population characteristics and morbidity and mortality information.

Based on the data gathered, analysis and synthesis involving relevant staff from FHB units was initiated in Phase 3. The first step of this process was compilation of data which was followed by review and analysis conducted by the planners in each of the population teams guided by PPE staff. Compilation was comprised of review of key informant responses, aggregation of survey results, transcription of focus group sessions, and identification of common themes from each group. Summary documents specific to each component were then prepared for assessment by and input from the population team planners. The planners identified common themes and prepared reports relevant to their focus area related to implications and future directions.

Using these reports, the process proceeded to the development of recommendations and priority setting. Meetings were held to present the report finding to both internal and external stakeholders. The stakeholders identified cross-cutting themes and priority issues and their impact on FHB. These issues were then examined against the existing FHB priorities to determine whether the priorities needed to be modified to reflect assessment conclusions. Following these stakeholder meetings, the internal workgroup was reconvened to finalize FY'01 FHB priorities and state negotiated performance measures as well as to develop a plan to address recommendations.

3.1.2 Needs Assessment Content

The needs assessment is organized around seven focus areas which move from macro level perspective of demographics, social issues, economy, and research and biotechnology to a more immediate level of social policy and legislative issues and infrastructure to the most internal concerns related to DPH and FHB organizational issues. Findings and recommendations related to each of these areas are highlighted below. (See Appendix Z, Environmental Scan Reports and Summaries).

Certain key health and welfare indicators give a sense of direction in Georgia related to the MCH target population. Recent Kids Count rankings indicate that “on average a higher rate of Georgia children were poorer, lacked health insurance, and were at risk for pregnancy or death.” From the 1999 to the 2000 Kids Count report, other findings indicate that Georgia’s ranking increased from 44th to 46th nationally for teenage birth rate; 40th to 41st for percent of low birthweight babies; and from 30th to 37th for percent of children in poverty. The percent of children in poverty is 23% compared to 21% nationally; percent of low income children without health insurance 26% compared with 25% nationally; and rate of teenage deaths by accident, homicide and suicide 65/100,000 compared to 58/100,000 nationally. The rate of teenage deaths, however, showed

improvement from the 1999 report while the percent of children in poverty and of low income children without health insurance worsened. On a positive front, a significant improvement was shown in percent of teenagers who are high school dropouts, where the ranking improved from 45th to 40th.

Demographics: Demographic findings are incorporated into the Georgia overview, Section 1.4. More detailed data, along with tables and charts, are provided in the Appendices. From the MCH perspective, the most significant issue is the rapidity of change in the population, both in terms of the rate of growth and a shift in internal demographics, i.e., emergence of a suburban Georgia, the in-migration from other areas of the country, and the increasing diversity in terms of racial and ethnic groups. These issues, at a policy level, have implications related to quality of life and the ability of the infrastructure and public service delivery systems to meet needs. On a broader level, concern needs to be given to resource allocation issues so that service availability reflects the shifting demographic pattern. Specifically, the FHB needs to develop and support enhanced surveillance capacity to monitor trends and patterns of disease as well as sentinel events. An example related to a specific health condition is asthma; as air pollution has become a growing problem, a surveillance system for tracking asthma should be developed.

The increasing ethnic diversity of Georgia's population provides an opportunity to explore the ramifications of this shift. Over half of the state's 19 health districts have experienced an increase in the number of Hispanic speaking residents. The transient nature of Hispanic migrant workers in the textile, agricultural and poultry regions of the State impede access to care. Complicated by language barriers and cultural beliefs, women of migrant families often do not openly seek health services and often, district staff may not be aware that they are moving or residing in their service area. In areas, such as Hall County in Northwest Georgia, many Hispanics are no longer considered to be migrant workers, but rather full-time residents who have come to work and raise their families. Hispanics in the Hall community are becoming business owners with numerous restaurants and Hispanic grocery stores specializing in foods native to their culture opening up in Hall County and surrounding areas. In Gainesville, Georgia, 11 of 14 taxicab companies in operation are owned by Hispanics. As the Hispanic community grows, the public health district has begun addressing their specific health concerns. Health care was identified in a recent community study as the second most significant issue faced by the Hispanic community in Hall County (Public Health District 2), with communication listed as their chief concern.

In their efforts to deliver services to the Hispanic population, health departments in District 2 and other public health districts in the State with increasing numbers of Hispanics have encountered several problems. The largest majority of Latinos living in Northeast Georgia are from Mexico, followed by significant numbers coming from Colombia, El Salvador, Nicaragua, and Honduras. In Habersham County in Public Health District 2 (Gainesville), many of the Hispanic resident are from Guatemala. The various dialects create a language problem for the area health departments, which already suffer from a shortage of trained bilingual staff. Illiteracy within the Hispanic population in the region also poses a concern for staff because many Hispanic patients have

reading level of 5th grade or below in their native language. As a result, it is not sufficient for the district to have its forms and consents printed in Spanish; but bilingual staff also are vital. Staff, however, must not only have the capability of speaking the language, but also the ability to relate to clients on a cultural level.

In regions of the state with Hispanic undocumented and migrant workers populations, individuals seeking care at a health department may use multiple identifications. One client may have five charts, each bearing a different name and date of birth. Without proper identification, combined with the language barrier, it becomes very difficult for the nurse to provide continuity of care.

As noted above, language and cultural competency can be a significant problem in delivering health services for Hispanic populations. Approximately 91 percent of Hall County Health Department's obstetrical (OB) patients are Hispanic. Patients often do not enter prenatal care until the second or third trimester. A high incidence of domestic violence has also been observed in the Hall County Health Department's Hispanic OB population, resulting in the need for counseling in their native population and mostly importantly, an explanation of their legal rights, since most fear deportation if they report the abuse. In addition, many of the OB clients do not seem to understand appointments and may also have no transportation, which results in their seeking care at non scheduled times when a translator may not be available. These barriers, coupled with a need for translators, can lead to severe clinic flow problems.

Other major issues facing Hispanic populations also have an impact on health care delivery. A November 21, 1999 article entitled "Hispanics face health care crisis," which appeared in *The Times* (the largest daily newspaper in District 2), identified the following issues:

- *A breakup of the traditional Hispanic family structure* - due in part to the need for both parents to work, often at multiple jobs, in order meet the needs of their family in their new adopted country. This in turn leads to decreased supervision for the children of these immigrants, making them more vulnerable to temptations like sex and drug use.
- *Religious beliefs and cultural background of Hispanics can result in silence about sensitive topics like sex* - Hispanic leaders report there is little discussion of sexual issues in Hispanic homes and any that does occur is usually very "macho" or male-oriented, impacting acceptance of family planning and other health care services. This leads to the need to raise awareness in the Hispanic community regarding teen pregnancy, sexually transmitted diseases, HIV/AIDS, sexual assault, and domestic violence.
- *Hispanics have higher rates for certain chronic illnesses and diseases when compared to Whites or Blacks* - The National Cancer Institute reports Hispanic women have twice as much cervical cancer as White women do. Other federal statistics show Hispanic women, compared with Whites, have higher maternal mortality rates and are only one-third as likely to get prenatal care. Research also shows that Hispanics have higher rates of diabetes than

other groups in the country. And while Hispanics have lower diagnostic rates of breast and colon cancer, they are more likely to die from the diseases, according to the National Cancer Institute.

- *Hispanics are less likely to have doctors* - Hispanic-American leaders report many Hispanic people believe that an illness is the will of God; therefore, medical help is not sought. Lack of transportation, long working hours, language barriers, little understanding of the importance of preventive medicine and poor health insurance coverage also contribute to the problem of inadequate health care access.

Public health districts and communities throughout Georgia with growing numbers of Hispanics are becoming increasingly attuned to the needs of their Hispanic populations. To improve the delivery of culturally appropriate services and overcome language barriers, some health departments have hired bilingual staff. In others, interpreters are available on an as needed basis. As the State's Hispanic population continues to grow, more of Georgia's county health departments will need to develop and implement strategies to overcome language barriers as well as to provide culturally appropriate services.

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

The data below highlights relevant aspects of Georgia's MCH population, describing morbidity, mortality, risks, gaps and disparities. Following these highlights are needs of each population group related to levels of the MCH pyramid. Detailed data are found in the needs assessment reports include in the Appendices.

Women's Highlights

Birth Rates: Access to preconceptional counseling, early pregnancy diagnosis, and early prenatal care help reduce maternal and infant morbidity and mortality. As seen in the tables below, an increase in Georgia births has occurred in the White and other populations. The number of Black births has remained stable over the four-year period. Final 1998 data is not yet available.

Live Births 1994-1998

Year	Total	White	Black	Other
1994	110,984	69,548	39,993	1,443
1995	112,246	71,189	38,141	2,916
1996	113,986	72,727	38,276	2,983
1997	118,169	75,538	39,724	2,907
1998	122,366	78,167	41,274	2,925

Crude Birth Rate, 1994-1998*

Year	Total	White	Black	Other
1994	15.9	14.2	19.0	19.4
1995	15.8	14.3	18.2	21.5
1996	15.8	14.3	17.9	20.5
1997	15.8	14.5	18.7	18.8
1998	16.0	14.8	18.9	17.5

*Crude birth rate is the total number of live births per 1,000 total population.

Georgia's total crude birth rate has remained stable. There has been a slight increase in the White crude birth rate while the Black crude rate has remained stable during this five year period. While little change is seen in the overall birth rate, the picture related to teens reflects a desired decrease in teen births, particularly among the youngest White and among all Black adolescents. The section below provides more details regarding the teen birth rate for both Blacks and Whites.

Teen Pregnancy: Teen pregnancy is highly correlated with poverty, weak basic academic skills, risk taking behaviors and substance abuse. Current data on teen behavior is not due to a lack of adequate sample in the YRBS conducted for the past several years.

**Teen Births - White, Black and Total
1994-1998**

Teen Births* White	Age at outcome	1994	1995	1996	1997	1998
	15-17	2,995	3,326	3,262	3,145	3,128
	18-19	5,289	5,377	5,609	5,746	6,113
	15-19	8,302	8,703	8,871	8,891	9,241
Rate of Live Birth per 1,000	15-17	32.5	35.0	33.4	31.3	30.7
	18-19	88.0	88.3	89.0	89.2	90.9
	15-19	54.5	55.8	55.2	53.9	54.6

Teen Births* Black	Age at outcome	1994	1995	1996	1997	1998
	15-17	4,049	3,956	3,793	3,869	3,392
	18-19	4,823	4,864	4,809	4,937	5,100
	15-19	8,872	8,820	8,602	8,806	8,492
Rate of Live Birth per 1,000	15-17	79.4	73.8	68.2	67.8	59.4
	18-19	144.2	141.0	132.2	129.9	126.2
	15-19	105.0	100.1	93.6	92.7	87.0

Teen Births* Total**	Age at outcome	1994	1995	1996	1997	1998
	15-17	7,094	7,336	7,108	7,071	6,576
	18-19	10,214	10,366	10,518	10,761	11,291
	15-19	17,308	17,702	17,626	17,832	17,867
Rate of Live Birth per 1,000	15-17	48.6	48.3	45.4	43.9	40.3
	18-19	106.8	106.5	103.7	102.9	102.6
	15-19	71.6	71.1	68.3	67.1	65.4

* Number of teen mothers, e.g., teen who delivered twins counted once

** Total = total includes Black, White, and other races. Therefore, Black and White do not add up to total.

As indicated in the tables above, the total live birth rate for all teens, 15-19, has dropped 8.7 percent from 71.6 per 1,000 to 65.4 per 1,000. The substantial decrease in births for 15-17 year olds contributed significantly to this drop; a decrease of 17.1 percent. Among white teens, 15-17 year olds experienced a decrease in the rate of live births while the rate among 18-19 years old increased slightly, possibly reflecting a decision for later motherhood. Among Black teens, however, the decrease in live births was significant and seen in all age groups. The overall

decrease among Black teens was 17.1 percent. Among the youngest Black teens, age 15-17, the decrease over these five years was 25.2 percent. Among older Black teens, age 18-19, the birth rate decrease was 12.5 percent. The overall number of births to Black teens ages 15 to 19 dropped by almost 400 births.

Low birthweight: According to Carolyn Hogue, an Emory University School of Public Health maternal epidemiologist, low birthweight is the single most important predictor of infant mortality and morbidity. Risk factors for low birthweight are race, smoking, age (young or over 35 years), lack of education, lack of a support system, short interpregnancy interval, and maternal health status. The percent of low birthweight infants in Georgia has remained static, decreasing only 0.2% over the 1990-1998 period, from 8.7% to 8.5%. Low birthweight statistics in Georgia show a significant racial disparity. During this time period, the percent of Black low birthweight infants decreased from 13.1% to 12.7%. The percent of White low birthweight infants increased from 6.2% to 6.4%. This disparity has a disproportionate effect on our overall low birthweight since over one-third (33.6%) of all Georgia births are to Black women.

**Low Birthweight White, Black and Total
Georgia 1990-1998**

LBW, White	1990	1991	1992	1993	1994	1995	1996	1997	1998
LBW #	4,359	4,186	4,104	4,310	4,406	4,631	4,658	4,968	5,015
LBW %	6.2%	6.1%	6.0%	6.3%	6.4%	6.5%	6.4%	6.6%	6.4%
LWB, Black	1990	1991	1992	1993	1994	1995	1996	1997	1998
LBW #	5,294	5,171	5,268	5,207	5,014	5,001	4,880	5,164	5,249
LBW %	13.1%	12.9%	13.1%	13.0%	12.9%	13.2%	12.8%	13.0%	12.7%
LBW total	1990	1991	1992	1993	1994	1995	1996	1997	1998
LBW #	9,775	9,481	9,502	9,669	9,576	9,835	9,736	10,393	10,462
LBW %	8.7%	8.6%	8.6%	8.7%	8.6%	8.7%	8.6%	8.8%	8.5%

LBW = birth weight less than 2500 grams

Total = total includes Black, White and other races. Therefore, Black and White do not add up to total.

Infant mortality: Georgia's infant mortality rate decreased from 12.3 in 1990 to 8.5 in 1998; a decrease of 30.9 percent. During this time period, the rate for White infants decreased from 9.0 to 6.0; the rate for Black infants decreased from 18.4 to 13.5. Much of the reduction was in the rate of neonatal death (infants less than 28 days old) reflecting improvements in perinatal services such as utilization of obstetric technologies and treatments used in newborn intensive care nurseries (Women's Health Data Book). Reductions in infant mortality also may reflect decreases in SIDS due to the Back to Sleep initiative.

**Infant Mortality, White, Black and Total
Georgia 1990-1998**

IM, White	1990	1991	1992	1993	1994	1995	1996	1997	1998
IM #	632	508	490	495	487	467	452	467	473
IM rate	9.0	7.4	7.1	7.2	7.0	6.6	6.2	6.2	6.0
IM, Black	1990	1991	1992	1993	1994	1995	1996	1997	1998
IM #	743	737	637	649	626	580	569	546	557
IM rate	18.4	18.3	15.8	16.3	16.1	15.2	14.9	13.7	13.5
IM, total	1990	1991	1992	1993	1994	1995	1996	1997	1998
IM #	1389	1254	1139	1150	1126	1058	1047	1021	1035
IM rate	12.3	11.4	10.3	10.4	10.1	9.4	9.2	8.6	8.5

IM = infant mortality

Rate per 1,000 births

Total = total includes Black, White and other races. Therefore, Black and White do not add up to total.

Sexually Transmitted Diseases: STD, beyond being a problem in themselves, are indicative of unsafe sexual practices which result in unplanned pregnancies. High sexually transmitted disease and HIV rates, especially in minority females, threaten fertility, pregnancy outcomes and general quality of life in a number of Georgia counties. Chlamydia is the most common reportable STD in Georgia. As many as 80% of women have no signs or symptoms and underdiagnosis is a major problem. Through efforts to universally screen women for chlamydia in public health settings and improvements in reporting of notifiable diseases, the number of cases reported has increased significantly, however, this probably represents an increase in reporting status rather than an actual trend related to the infection. Gonorrhea is the second most prevalent STD with 18,541 total reported cases in 1997, ranking Georgia 4th in the U.S.

In Fulton County, for example, the county’s seroprevalence rates for HIV have been the highest in the State for 1997 and 1998. There is a high incidence of HIV/AIDS infection among Fulton County females of childbearing age due to heterosexual transmission from HIV infected partners. This poses a threat to the female as well as her infant if she becomes pregnant. The Fulton County Department of Health provides confidential STD education, screening treatment or treatment referral at all health center, mobile and community based sites that serve adolescents and women. In FY 99, 5,833 unduplicated clients received routine education and screening for an STD or vaginal infection.

Women’s Health Concerns: Advances in public health have played a major role in increasing the life expectancy of women by nearly two-fold over the past century. The fact that women are living longer has created new public health challenges to improve the quality of women’s lives as they age. The “1999 Report on the Status of Women’s Health in Georgia” was compiled by the Georgia Department of Human Resources’ Division of Public Health to provide a picture of the health and well-being of women in the State. (See Appendix AA for this Report). The table below highlights a number of key health issues identified in this report.

Issue	Highlights	Data
Unplanned pregnancies	Unplanned pregnancy continues to be a problem for women in Georgia. In the past five years, women reported that nearly one of every two births occurred as a result of an unplanned pregnancy.	Sixty-two percent of women whose births were covered by Medicaid and 28 percent of women whose births were covered by private insurance, reported that their pregnancy was unplanned.
Lack of health insurance coverage	Compared to the United States, Georgia women are more likely to be without any health insurance. In 1997, 18 percent of United States women aged 18 to 64 had no insurance, compared to 20 percent of Georgia women.	One-fifth of Georgia women aged 18 to 64 are without health insurance coverage. Younger women are more likely to be without health insurance than older women. In 1998, 30 percent of women aged 18 to 24 were without health insurance compared to 19 percent for women aged 25 to 44 and 17 percent of women aged 45 to 64.

Issue	Highlights	Data
<p>Health behaviors</p>	<p>Health behaviors such as smoking, conditions related to eating habits such as obesity, and physical inactivity are on the rise, increasing the risk among women of developing many chronic health conditions. On the positive side, there has been an increase in the percentage of Georgia women screened for breast and cervical cancer, which reduces the risk of cancer death through early detection.</p>	<p>In 1996, 11 percent of all female deaths in Georgia were attributable to cigarette smoking.</p> <p>According to the Behavioral Risk Factor Surveillance System (BRFSS), there has been a steady increase in the percentage of Georgia women who are overweight, from 17 percent in 1984 to 33 percent in 1998.</p> <p>The percentage of Georgia women aged 50 or older who have had a mammogram in the past two years from 61 percent in 1995 to 63 percent in 1997 according to the BRFSS. In 1998, 85 percent of Georgia women had a Pap smear in the last year. (BRFSS)</p>
<p>Infectious diseases</p>	<p>Infectious diseases such as chlamydia and HIV are concerns for Georgia women. Chlamydia is the most common reportable sexually transmitted disease in Georgia. HIV infection has become a heterosexual epidemic in Georgia, with women accounting for increasingly larger proportion of cases.</p> <p>Nearly half of the women with AIDS in Georgia live in a rural area.</p>	<p>The number of reported chlamydia cases in Georgia rose from 11,757 in 1996 to 21,169 in 1998, reflecting increased screening effort by the Division of Public Health's collaboration with public and private providers to increase chlamydia screening.</p> <p>Between 1992 and 1996, HIV was the leading cause of death among Black women aged 15 to 44 in Georgia.</p> <p>From 1993 to 1997, the percentage of total reported AIDS cases among Black women increased from 13% to 20% while the percentage for White women remained stable at 2%.</p>

Issue	Highlights	Data
<p>Chronic health conditions</p>	<p>Chronic health conditions such as cardiovascular disease, cancer, arthritis and osteoporosis are affecting more Georgia women, particularly as the life span of women increases. In 1910, only three percent of Georgia females were over 64 years of age compared to 12 percent in 1998.</p> <p>About 68% of all deaths in Georgia are due to the four most common diseases: cardiovascular disease, all cancers, chronic obstructive pulmonary disease, and diabetes.</p>	<p>Cardiovascular disease (CVD), which includes heart disease and stroke, is the leading cause of death of women in Georgia. In 1997, 12,591 women in Georgia died of CVD compared to 10,868 men. In that same year, ten percent of White females and 24 percent of Black females who died of CVD, died before the age of 65.</p> <p>Cancer is the 2nd leading cause of death among Georgia women. From 1981 to 1996, the female age-adjusted cancer death rate increased eight percent, from 122/100,000 to 132/100,000.</p> <p>In 1996, an estimated 13 percent of the Georgia population had low bone mass or osteoporosis; women accounted for 80 percent of those cases.</p>
<p>Unintentional and intentional injuries</p>	<p>Motor vehicle crashes are the leading cause of death among Georgia women aged 15 to 44.</p> <p>Women are more likely than men to be murdered by an intimate partner.</p> <p>Suicide affects far more White women than Black women in Georgia.</p>	<p>From 1989 to 1998, motor vehicle crashes caused more than 2,000 deaths for women aged 20 to 44.</p> <p>From 1989 to 1998, homicide was the 2nd leading cause of death among Black women aged 20 to 44 compared to 5th leading cause among White women 20 to 44.</p> <p>From 1989 to 1998, suicide was the 3rd leading cause of death among White Georgia women aged 20 to 44 during this time period and not among the top 10 leading causes for Black women.</p>

Issue	Highlights	Data
<p>Violence against women</p>	<p>It is not clear whether or not women are at a greater risk of intimate partner violence (IPV) during pregnancy, but studies indicate that 7 to 20 percent of women in the US experience IPV during pregnancy. IPV during pregnancy has been linked to LBW, increased risk of miscarriage, and maternal post partum depression. It can also be an indicator of future family violence involving children.</p> <p>The GWHS found that women were most likely to be raped by someone they knew such as a husband, boyfriend, date or relative. Most sexual assault happens to women below the age of 20.</p> <p>Georgia has 41 certified family abuse shelters; this number ranks the state among the lowest in the U.S.</p>	<p>Results from the 1995 Georgia Women’s Health Survey (GWHS) indicated that 30 percent of women aged 15 to 44 experience IPV during their lifetimes and about 6 percent experience it in a given year. The study also found that women with low income were more likely to have experienced IPV.</p> <p>Nearly 20 percent of women aged 15 to 44 reported they had been sexually assaulted by a man according to the 1995 GWHS. Only 13 percent reported being raped by a stranger. According to the GWHS, 2/3 of women who reported experiencing sexual abuse, experienced it for first time before age 20.</p> <p>Approximately 50,000 calls were received by the Georgia domestic violence crisis hotline in 1998. Family violence programs served about 18,000 adults and 10,000 children and provided shelter for 3,257 women and 3,693 children. Sixty-four percent of victims surveyed were married to the men who abused them. Half sought medical treatment for their injuries and 16% required hospitalization.</p>
<p>Mental illness</p>	<p>Certain mental illnesses, such as depression, some anxiety disorders and eating disorders, affect more women than men. Depression affects about twice as many women as men in the US. At least 90 percent of all cases of eating disorders in the US occur in women.</p>	<p>According to the 1997 Behavioral Risk Factor Surveillance System, 30 percent of Georgia women reported their mental health as “not good” on one or more days of the previous month.</p>

Issue	Highlights	Data
Substance abuse	Recent studies of substance abuse treatment needs have shown that a higher percentage of Whites than Blacks report having a substance abuse problem. The studies also indicate that the problem is greatest among youths aged 18 to 24.	Prevalence estimates of substance abuse treatment needs among Georgia women indicates highest treatment need (9.5% versus 4.6% Black women) among White women ages 18-24. 7.1% of White women and 3.4% of Black women ages 25-34 are in need. 5.4% of White women ages 35-44 and 2.5% of Black women are in need.

“1999 Report on the Status of Women’s Health in Georgia - A Picture of Women’s Health and Well-Being,” Georgia Department of Human Resources Division of Public Health.

Disparities among Georgia’s Black and White women: Black women, ages 20-44, are more than twice as likely to die than White women in this same age group. The mortality among Black women is 184/100,000 compared to 86/100,000 for White women. With the exception of motor vehicle crashes and suicide, Black women die at a higher rate than White women for all the leading causes of death among women. For White women in this age group, motor vehicle crashes comprise 18% of all deaths (15/100,000) and were responsible for almost 2,000 deaths between 1989 and 1998. The next two leading causes of death combined, breast cancer and suicide, account for 15% of all deaths among White women. For Black women, HIV and homicide are the two leading causes of death. Twelve percent of all deaths to Black women were due to HIV with almost 1,000 women dying from 1989-1998, a rate of 22/100,000. In the same time period, homicide killed just over 800 women, a rate of 18/100,000. Young Black women are also more likely to die of chronic diseases, such as other forms of heart disease, breast cancer, stroke, and heart attack, than are White women in the same age group.

Health Risk Behaviors: The health risk behaviors suggest areas where public health interventions can significantly impact health status. Key risk behaviors are summarized below.

Safety Belt Use: Seat belt use is critical in the reduction of the severity of injuries and the prevention of injuries and/or death, possible outcomes of motor vehicle crashes. Between 1984 and 1997, a steady decline has occurred in the percentage of Georgians age 18 and over who do not always wear a seat belt. Women were consistently more likely than men to use seat belts. Despite the progress, seat belt usage in 1998 among Georgia adults was 75%, below the year 2000 goal of 85%.

Tobacco Use: Tobacco use is the leading cause of preventable death; in 1996, 11% of all female deaths in Georgia were attributed to cigarette smoking. Although the onset of cardiovascular disease, cancer, and other chronic diseases associated with smoking typically occurs among older women, the smoking behavior usually begins in adolescence or young adulthood. Currently, men

are still more likely to smoke cigarettes than women, but in Georgia the gap between male and female smokers has been narrowing since 1984. Also, among teens, almost no gap exists between male and female smokers.

Physical Activity and Weight: Physical inactivity and being overweight are also factors that can increase a person's risk for cardiovascular disease, diabetes, arthritis, and other chronic health conditions. According to the Behavioral Risk Factor Surveillance System (BRFSS), a steady but significant increase in the percentage of women who are overweight is observed, from 17% in 1984 to 32% in 1997. Between 1984 and 1998, only about one in three women (37%) was involved in regular physical activity. However, the trends in physical activity have fluctuated during this period. Georgia ranks as the state with the highest percentage of obese adults.

Cancer Screening: Positive trends have occurred among Georgia women in the area of cancer screening. Georgia has reached or exceeded nearly all national Healthy People Year 2000 objectives for cancer screening. Sixty three percent of women aged 50 and older had a clinical breast exam and mammogram in the past two years, meeting the Healthy People 2000 goal of 60%. The goal was also reached for Black women. NCI and the American Cancer Society recommend that women begin having annual Pap smears, a screening test for cervical cancer, by the age of 18 or once they become sexually active. According to BRFSS, in 1998, 85% of women over age 18 had a Pap smear in the last three years meeting the Healthy People 2000 goal of 85%. Low income women also surpassed the 80% goal. In fact, the percentage of low income women that had a Pap smear in the last three years was 86%, slightly above the percentage for all women.

Reproductive Health: Issues related to reproductive health have a dual impact both on the mother and the infant.

Smoking and Pregnancy: Consistently, PRAMS data indicates that new mothers report a decrease in smoking from before pregnancy to during pregnancy and then an increase again after delivery. In 1997, 22% reported smoking in the three months prior to pregnancy, 11% during the last trimester of pregnancy, and 18% in the two to six months after delivery. In 1997, 11% of women reported smoking during pregnancy, a 42% decrease from 16% in 1993. Of the women who continued smoking cigarettes during the last trimester of pregnancy, 65% reduced the number of cigarettes smoked and 32% smoked the same or more as compared to pre-pregnancy levels.

Drinking and Pregnancy: In the three months before pregnancy, the percentage of mothers who reported drinking (one or more alcoholic drinks per week) remained relatively unchanged, ranging from 39% to 46%. Between 1993 to 1997, drinking during the last three months of pregnancy declined steadily from 13% in 1994 to 5% in 1997. Of the women who drank during pregnancy, 1993 to 1997, 36% reduced the amount of drinking and 55% drank the same amount or more as compared to pre-pregnancy levels. Eighty-two percent of women who drank before pregnancy quit drinking during their pregnancy.

Unplanned/Unintended Pregnancy: An unplanned or unintended pregnancy, a pregnancy that happens to a woman who feels the pregnancy should not have occurred at all or should have occurred at a different time, continues to be a problem for women in Georgia. Nearly half (47%), of Georgia women reported that their pregnancy was unintended, 34% wanted to be pregnant later and 13% did not want to be pregnant at all. About 62% of women whose births were covered by Medicaid and 28% of women whose births were covered by private insurance reported that their pregnancy was unplanned. The percentage of unintended pregnancies declined by 13% from 52% in 1993 to 45% in 1997.

Infants, Children and Adolescents Highlights

Infants

Causes of Infant Mortality: The infant mortality rate has been declining consistently since 1980 for all Georgians, both Blacks and Whites. The disparity between the Black and White infant mortality rates has remained steady; Black babies are about twice as likely as Whites to die. From 1990 to 1997, the infant mortality decreased 30% from 12.3/1,000 births to 8.6/1,000. The decrease in infant mortality was more significant among Whites than Blacks. Among Whites, the infant mortality decreased 31% from 9.0 per 1,000 births to 6.2/1,000 births. Among Blacks it decreased 26% from 18.4/1,000 births to 13.7/1,000 births. The leading cause of infant mortality is congenital anomalies, contributing to 1,682 deaths from 1990 to 1997. The next leading category of death in this time period include “other perinatal conditions” (1,369 deaths), prematurity/low birth weight (1,344 deaths), SIDS (1,143 deaths) and respiratory distress syndrome (961 deaths). Looking at infant mortality trends, a decrease in deaths due to SIDS, respiratory distress syndrome (RDS) and “other perinatal conditions” has been evidenced. The most significant decrease in a single cause of infant death was RDS, a 52% decrease, from 1.71/1,000 births in 1990 to 0.82 in 1997. The decrease in SIDS was 33% from 1.44/1,000 births in 1990 to 0.97 in 1997. The decrease for “other perinatal conditions” was 30%, from 1.85/1,000 births in 1990 to 1.29 in 1997. No trend has emerged related to prematurity/low birthweight (LBW) or congenital anomalies.

Neonatal Mortality: About two-thirds of all Georgia infants deaths occurred in the neonatal period, from birth to 28 days of life. From 1990 to 1997, the most likely cause of neonatal death was “other perinatal conditions” leading to 1,325 deaths, followed by prematurity/LBW (1,324 deaths) and congenital anomalies (1,261 deaths). Congenital anomalies, “other perinatal conditions,” and prematurity/LBW, the top three causes of death among infants in their first year, in the majority cases occurred during the neonatal period. Deaths due to RDS: “other perinatal conditions” and “other perinatal respiratory conditions” declined between 1990 and 1997. However, no obvious or consistent trends could be observed with neonatal mortality due to congenital anomalies and prematurity/LBW.

Postneonatal Mortality: The postneonatal period refers to the period of infancy from greater than 28 days to one year of life. SIDS is the most significant cause of death among infants in the

postneonatal period, greater than 28 days to one year of life . Most SIDS deaths occur between the first and third month of life. There has been a 28% decrease in death rate in the postneonatal period from SIDS between 1990 and 1997, from 1.27/1,000 births in 1990 to 0.91/1,000 in 1997. In 1991, the American Association of Pediatricians (AAP) put into place recommendations to reduce SIDS deaths; a 13% decrease in the SIDS rate from SIDS between 1991 and 1992 is likely a result of these recommendations. The national “Back to Sleep” campaign initiated in 1994 may have impacted the 25% decline in SIDS rates from 1994 to 1995. PRAMS 1996-1997 data show Georgia had the greatest decrease in the prevalence of stomach positioning, a 26.8% decrease, and the most improvement in use of the back to sleep position, a 55.5% increase.

Children (1-9 years of age) Highlights

Leading Causes of Child Death: The number one cause of death among children is motor vehicle crashes (MVC) (22%) followed by “all other unintentional injuries” (22%), congenital anomalies (8%), homicides (5%), and other forms of heart disease (5%). Injuries, MVC, other unintentional injuries and homicide account for almost one half (49%) of all deaths among children. MVC and other unintentional injuries are the two leading causes of death for all four subgroups (White male, White female, Black male, and Black female). Overall, Black children both males and females had higher death rates, 53/100,000 population and 43/100,000 respectively, compared to White male and female children, 33/100,000 population and 25/100,000, respectively.

Death due to infectious disease ranks 4th and 5th among White male and White female children respectively. The rate of death was just as high for Black children; however, it was not high enough to be included on the top five causes of death for these children. In general, Blacks experienced higher death rates for each of the top five causes of death than their White counterparts. According to the breakdowns, between 1989 and 1998, homicide was more common among Black males than in any other group, causing 7% of all deaths, and among Black females, causing 6% of all deaths.

Child Abuse and Neglect Incidents: Confirmed reported incidents of abuse and neglect among children declined steadily between 1994 and 1997, by about 24%, from 15 incidents/1,000 population to 12 incidents/1,000 population in 1997, a 32% decrease among both Black and White children. Despite the decline in the rates of abuse and neglect among Black and White children, Black children consistently had more incidents of abuse and neglect than White children. By far, the largest proportion of confirmed incidents in 1997 were due to neglect whether physical or emotional. Physical abuse accounted for 15% of confirmed incidents, sexual abuse for 9%, and all other causes for another 10% of incidents.

Childhood lead poisoning: The most common cause of lead poisoning is exposure to deteriorating lead-based paints, lead contaminated dust or lead contaminated soil or dust in houses built before 1978. More than a million homes in Georgia were built before 1978 and may contain lead-based paint.

Adolescent (10-19 years of age) Highlights

Leading Causes of Death: Injuries are responsible for almost three-quarters (74%), of all deaths among adolescents in Georgia, mirroring national trends. Injuries are responsible for the four leading causes of death among adolescents: motor vehicle crashes (MVC) ranking number one, followed by homicide, all other unintentional injuries, and suicide. Adolescent behavioral factors associated with these injuries include: engaging in physical fights, carrying weapons, not using seatbelts, and drinking alcohol. Adolescent males, both Black and White, have a significantly higher mortality rate than adolescent females. The rate of death among Black males is the highest at 95/100,000 followed by White males at 74/100,000, White females at 38/100,000 and Black females at 36/100,000. In terms of actual numbers, White adolescent males account for the most deaths with about 2,500 deaths from 1989 to 1998 compared to 1,700 deaths among Black adolescent males, 1200 for White females, and 600 for Black females.

Suicide was more common in both White male and female adolescents compared to Black male and female adolescents, with White adolescent males at greatest risk. Although suicide ranked as the second cause of death among both White male and female adolescents, White adolescent males are at greater risk than females of dying as a result of suicide (11/100,000 compared to 3/100,000).

Homicide was more common among Black male and female adolescents compared to their White counterparts. Black adolescent males were at highest risk for homicide, accounting for over 35% of their deaths, a rate of 33/100,000 versus 23% of all Black adolescent female deaths, a rate of 7/100,000.

Risky Behaviors and Attitudes: The 1996-1997 high school dropout rate in Georgia remained fairly stable at about 8/100 students enrolled. Dropout rates were stable among both Black and White students, however, Black students (9.7/100 enrolled students) were more likely than White students (7.4/100 enrolled students) to drop out of high school.

Between 1990 and 1994, Georgia saw significant increases in the total numbers of arrests of juveniles, from 3.2 arrests/100 youths age 10 to 17 to 5.8/100. However, between 1994 and 1997, the total juvenile arrests has decreased slightly. Juvenile arrests increased for both Blacks and Whites between 1990 and 1994. Among Blacks, juvenile arrests almost doubled, from 5.9/100 in 1990 to 10.9/100 in 1994. Among Whites, the increase was even larger, from 1.4/100 to 3.9/100 in the respective time period. In terms of both rate and actual numbers, between 1989 and 1997, there were more juvenile arrests among Blacks than Whites. In 1997 alone, 49,124 juvenile arrests were made.

For the most part, tobacco use among Georgia youth appears to mirror national data and trends. Looking at use of any tobacco product among the middle school students surveyed by the 1999 YTS, 55% have used a tobacco product at some point, while 19% identify themselves as current users. When the question focuses on cigarette smoking, 49% report having "ever smoked" even

one or two puffs; 14% consider themselves current smokers; and 4% say they smoke frequently. Smokeless tobacco use, traditionally a particular problem in Southern states, was tried by 12% of all middle school youth and 4% indicate current use. Cigar smoking, seen by some as a fad, has use rates substantiated by surveyed Georgia youth at 30% lifetime and 8% current.

A closer examination of the data reveals lifetime use by male students at 59% and for female students at 50%, a relatively narrower gap than historical data would suggest. Cigarette use at any point by males was 51% and by females was 47%; current use was the same for both male and female middle schoolers, 14%; and frequent use was reported by 4% of the males and 3% of the females. Reports of ever trying smokeless tobacco were three times higher among male (18%) than female students (6%). The overall current use of smokeless tobacco was 7% among males and 2% among females. Cigar smoking was tried by 38% of the males and 21% of the females; and 11% of the males and 5% of the females say they still are smoking cigars.

While tobacco use among White (54%) and Black students (53%) is surprisingly similar, and in keeping with national trends, use among Hispanic middle school students (68%) is significantly higher. This pattern is consistent, regardless of the type of tobacco product - cigarette smoking among 49% of Whites, 46% of Blacks, and 63% of Hispanic students; smokeless tobacco use among 15% of Whites, 6% of Blacks, and 21% of Hispanic students; and finally, cigar smoking among 28% of the Whites, 30% of the Blacks, and 43% of the Hispanic students. With the rapidly growing number of Hispanics in Georgia's population, this data points to a population to target.

The statewide 1999 Drug-Free School survey allows us to look at tobacco use among youth who are somewhat younger (5th grade) and a bit older (10th grade) as well as 8th graders, who were included in the YTS. The data supports the observation that the transition from elementary school (5th grade) to middle school (6th grade) marks a period of elevated risk-taking behavior.

STDs, including HIV/AIDS, are a serious problem among Georgia adolescents. In 1998, more than 16,000 adolescents were diagnosed as having one of several STDs: 6,095 cases of Gonorrhea, 10,412 cases of Chlamydia, and 23 cases of Primary and Secondary Syphilis. Although the number of reported AIDS cases are very low among adolescents, young adults aged 20 to 29 years old ranked third in terms of the number of reported AIDS cases compared to the other age groups comprising about 17% of AIDS cases in the state. Since AIDS may not develop for another ten years after HIV infection, many of these young people may have been infected as teenagers.

The number of AIDS cases diagnosed annually in Georgia adolescents aged 13 to 19 is very small relative to those in the older age groups, making up about 0.5% of the total number reported cases between 1995 and 1999. However, AIDS cases dramatically increase among 20 to 29 year olds, indicating HIV was contracted in adolescence.

Children With Special Needs (0 to 21 years of age) Highlights

Birth Defects: The Metropolitan Atlanta Congenital Defects Program (MACDP) is Georgia's only birth defects surveillance system, covering a five county area. MACDP, operated by CDC, is the country's oldest registry and has been operational since 1968. Approximately 1,200 cases are captured by MACDP annually. About 3% of all children are born with a major birth defect and approximately 5% of these children will die from their defect in infancy. The trend in the rate of total birth defects in metro-Atlanta showed a rise in birth defects from 1969 through 1988, followed by a decline since that time. From 1969-1973 the rate was 24.53/1,000 live births compared to 42.00/1,000 from 1984-1988 and 32.42/1,000 for 1994-1998. The rate of spina bifida has steadily declined in metropolitan Atlanta from 1968 to 1998. In 1968, the rate was 1.44 per 1,000 live births compared to 0.45 per 1,000 live births in 1998. In an effort to improve the early identification capabilities, the Family Health Branch developed a neuro tracking system for highrisk pregnant women. (See Appendix BB, Neuro Tracking System Flow Chart).

Developmental Disabilities: A similar registry operated by CDC, the Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP), was established in 1991 for surveillance of developmental disabilities. The MADDSP, based on searching record systems such as schools, hospitals and state programs for persons who have developmental disabilities, determines the prevalence of the following developmental disabilities among 10-year-old children. The most recent data available from MADDSP is for 1991-1994. During that period, mental retardation was the most prevalent developmental disability among 10 year olds with 13.8/1,000 children aged 10. The rate of cerebral palsy was 2.7/1,000, 1.4/1,000 for hearing impairment, and 1.1/1,000 for vision impairment.

Babies Can't Wait, Georgia's Early Intervention program, serves children with a developmental delays ages 0-3. Approximately 7,000 Georgia children were served in the calendar year 1999. Because there is no statewide developmental disability surveillance system, there is no way to ascertain the total number of children eligible for the program.

Perinatal AIDS: From 1982 to 1999, a total of 184 cases of perinatal AIDS cases were reported. The number of cases increased steadily from one case in 1982 to 29 cases in 1994. Beginning in 1995, the number of cases began declining; in 1999, three cases were reported. Zidovudine (ZDV) use has been responsible for much of this reduction.. However, Georgia does not currently have a reportable HIV system.

Asthma: The rate of hospitalizations due to asthma is highest among the youngest children ages 0-4 and decreases with each five year age group through age 19. At age 0 to 4, the rate is 34.7/10,000 compared to 13.4/10,000 for children ages 5 to 9, 9.1 for children ages 10 to 14, and 5.2 for children ages 15 to 19. Changes in health insurance payment policies that are reflected in hospital discharge coding, which were instituted in 1998, are the likely reason for the number of hospitalized children from 1997 to 1998. From 1997 to 1998, the number of children

hospitalized for asthma captured in the discharge data decreased from 5,855 cases in 1997 to 3,524 in 1998.

Levels of the Pyramid

As part of the needs assessment process, each FHB population team examined the services that fell within its realm of responsibility according to the four levels of the pyramid. In this assessment, each team assessed existing resources, gaps and barriers, existing enabling services, gaps in enabling services, and the role that the FHB is currently playing as well as the role that the Branch should be played. A matrix, reflecting their findings, was developed for each population group, with a separate matrix for nutrition which cuts across all groups. (See Appendix Y, FY '01 Needs Assessment, for completed matrices.) These matrices provide a basis for looking at what ought to be as contrasted with the current status of MCH services in Georgia. The major conclusions related to this process, grouped by population, are below.

Women: Health related concerns include the impact of STDs, prevention of pre-term delivery, reproductive health services for disabled women, depression, obesity, and health disparities. Policy concerns focus on parental consent for teen services, compensation for volunteer resource mothers, and cultural competence of health care providers. The resource issues cited were adequate clinic staffing, wait times for clinic appointments, funding to expand the Resource Mothers Program, and the ability to deal with undocumented residents. The broader emerging issues on which the FHB will need to focus in the coming years include the increasing number of medically fragile infants, women ineligible for services due to time limits of welfare reform, RU-486, and lack of abortion providers.

Infants and Children: Several key issues were identified related to infants and children. A major concern is inadequate community-based services and/or providers, in some areas, to meet the needs of children identified through various screening programs. Also, meeting the needs of an increasingly multicultural population, both in terms of public awareness and outreach activities as well as direct clinical service delivery, was noted for increased attention. School health was cited as a specific program for which attention needs to be directed in order to capitalize on the funding made available this legislative session. Resulting from a shift from the public to the private sector, a restructured approach must be developed related to EPSDT Health Check screens in order to ensure follow up. Lastly, the need for improvement of data bases, both to fill gaps and reduce fragmentation of existing databases, has been identified.

Adolescents: The targeting of youth development programs and activities focused on sexually active and pregnant and parenting adolescents was seen as a major issue. (See Appendix P, *Georgia Teenage Births and Pregnancies: Statistics Consequences and Responses*). In addition, the need for more resources for preventive case management was noted. A concern was expressed about fire arm safety issues in this age group. Emerging issues include, once again, the need to address the needs of the state's increasingly diverse adolescent population and a better

meshing between the public and private health sectors, particularly focused on school health.

Children with Special Needs: A number of specific concerns were cited by the Children with Special Needs group. Family transportation to services, both local and longer distance for specialty care, are needed. Cutting across all population groups, issues related to serving an increasingly multicultural population were raised. A particular issue for families with children with special needs was difficulty related to family involvement and compliance with recommendations resulting from language barriers and cultural influences. Inadequate reimbursement rates for children with special needs providers is a barrier. These providers, who must have a more specialized knowledge base, spend more time evaluating and working with these children, who often have more needs and more complex needs, and require more services. The lack of emphasis and knowledge about prevention of secondary conditions associated with primary conditions of children with special needs and risk reductions behaviors to deal with adolescents with special needs is also a concern. Specific family needs raised are lack of child care, respite care, and care in the school system, as well as services that address the emotional and mental health needs of children with special needs and their families.

3.1.2.2 Direct Health Care Services - (See Appendix CC, Direct Services and Population-Based Services Matrices).

3.1.2.3 Enabling Services - (See Appendix CC, Direct Services and Population-Based Services Matrices).

3.1.2.4 Population-Based Services -(See Appendix CC, Direct Services and Population-Based Services Matrices).

3.1.2.5 Infrastructure Building Services -(See Appendix CC, Direct Services and Population-Based Services Matrices).

3.2 Health Status Indicators

See forms C1-C3 and D1-D2.

3.2.1 Priority Needs

During the past two years, the needs assessment process focused on the strengths, weaknesses, opportunities, and threats within the State's MCH system. These assessments emphasized infrastructure and capacity building as requisite for long term MCH systems development. The major directions to build this infrastructure were leadership and policy development, district level health planning, quality assurance, overcoming disparities in health and health access, a shift from direct clinical service to case management, and integration of categorical programs.

This year's need assessment generated core themes which cut across MCH populations and levels of the pyramid. These themes, around which our work for the next five years will be structured, are:

- ***Population and Social Dynamics*** - With the changing "face" of Georgia, both in terms of size and diversity, issues related to allocation of resources and provision of relevant

services must be confronted by policy-makers and service providers. Of particular note for Georgia is concern related to non-English speaking clients which necessitates changes in staffing skills, program content, and sometimes policies themselves.

- ***Prevention*** - Prevention is the mantra for public health and MCH . In all of its forms - primary, secondary and tertiary - policies and programs need to be measured against a prevention yardstick. Preventable morbidity and mortality interventions start with the promotion of healthy lifestyles and safe behaviors. Over time, performance of the FHB focused on such efforts will be reflected in improvement of Georgia's health status indicators.
- ***Injury Prevention*** - Injury prevention emerged as a key issue impacting all MCH population groups. Both in terms of morbidity and mortality, the toll of injury in the MCH population has been understressed and underfunded. Additionally, the DPH organizational structure to address injury in Georgia, with injury assigned to a different branch, has impeded coordinated and collaborative activity.
- ***Coordination and Collaboration*** - while the multiple partners and stakeholders in the MCH system are all working towards the same goal - healthy and self sufficient families - they tend to do so in a fragmented and isolated manner. Efforts to leverage resources, share data, and coalesce forces have not reached their potential. Opportunities exist in terms of program planning and implementation, personnel, research, data and advocacy.
- ***Quality and Appropriate Services*** - From planning to implementation through evaluation, the quality and appropriateness of services needs to be at the center of attention. At the planning stage, activities should be based on existing data, focused research and/or successfully evaluated models. Measures for quality assurance, benchmarking, and outcome and impact evaluation should be incorporated throughout. Training and technical assistance play key roles in assuring that services are of maximal benefit.
- ***Access and Utilization*** - Several barriers exist related to service access and utilization: lack of knowledge about their existence; information about specifics; transportation difficulties; lack of child care; perceptions regarding eligibility; and language. Enabling activities that facilitate consumer use of services are required if available are to reach target populations.
- ***Data Systems*** - A critical role exists for the FHB in ensuring the collection and dissemination of quality data. Moreover, the data must be transformed into information and knowledge for decision-makers and opinion-formers. This must occur not only at the state level but also at the local level where there is often a more direct relationship between the data and the consumer.

The needs assessment process and core themes validate and reaffirm the established Georgia MCH priority needs. (See Appendix Y, FY '01 Needs Assessment). These priorities, set forth below, continue to provide the framework guiding planning and policy development.

Improving Health Status

- Improve health status related to conditions with preventable morbidity and mortality (i.e., infant morbidity and mortality, decrease health disparities, HIV/STDs and maternal infections, and asthma).
- Promote healthy life styles to reduce maternal, infant and childhood morbidity (i.e., alcohol and drug use, unplanned pregnancy and high risk sexual behaviors, tobacco use, and poor nutrition).
- Promote safe behaviors to reduce injury and violence.
- Work in partnership with families to promote their ability to raise healthy children (i.e., preconceptional health, early brain development, SIDS, and parenting skills throughout childhood).

Improving Services

- Improve the integration and coordination of the MCH delivery system at the organizational and individual level.
- Develop effective partnerships with families, providers, community organizations, and businesses as well as other governmental agencies.
- Develop standards and measures of quality assurance for MCH services.

Building System Capacity

- Support health districts in developing plans focused on community assets and resources that address local MCH needs.
- Develop information systems to improve decision-making at state, district, and local levels.
- Assure the MCH workforce possesses the skills sets and competencies relevant to the evolving health environment.

3.3 Annual Budget and Budget Justification

The FY 2001 Budget for the Federal-State block grant partnership totals \$242,472,661. Of this amount, \$16,990,732 are Title V funds. The remaining amounts represent State Funds totaling \$140,644,766, \$75,217,825 in Other Funds, and \$9,619,338 in Program Income. Other Federal funds that support Maternal and Child Health (MCH) activities in Georgia are estimated at \$172,668,472. This represents a variety of Federal Programs including four (4) Healthy Start Projects; Abstinence Education; Emergency Medical Services for Children (EMSC); Women, Infants, and Children (WIC), an Evaluation Grant from ASPE for Child Indicators Development, and Comprehensive Child Care. This brings the grand total for the State MCH Budget to \$415,141,133 (see line 10 of Form 2).

As noted above, the total Federal-State Block Grant Partnership for Georgia for FY 2001 is \$242,472,661 (see line 7 of Form 2). The breakout is as follows:

A.	Pregnant Women	\$ 25,025,833
B.	Infants < 1 year old	\$ 43,357,515
C.	Children 1 to 22 years old	\$125,968,816
D.	CSHCN	\$ 32,751,564
E.	All others	\$ 12,960,094
F.	Administration	\$ 2,408,839

(See Form 4, Section I)

Types of Services by Levels of the Pyramid

For FFY 2001, \$ 117,290,106 is budgeted for **Direct Medical Care Services**. This includes prenatal care and delivery services for pregnant women not eligible for Medicaid, services for high risk pregnant women, neonatal intensive care services for infants, medical services for children with special needs, and clinical services provided through local county health departments.

Georgia has budgeted \$39,012,224 under **Enabling Services** for FFY 2001. Activities included under this level of the pyramid are case management services for pregnant women, outreach to pregnant women and children, nutrition education activities targeting low income families, coordination, translation and transportation activities provided through local health departments and/or community based organization and assessment; monitoring, and referral/linkage activities for children birth to age four.

For **Population Based Services**, the state has budgeted \$57,086,172. These activities include Immunization, Oral Health Prevention, Newborn Vision, Hearing and Metabolic Screening, SIDS prevention and Child Fatality reviews. Lead screening and injury prevention activities are also included in these funds.

Georgia has budgeted \$29,084,159 for **Infrastructure Building Services**. This includes funding for the Maternal and Child Health Epidemiology Unit, Health Assessment Unit, and the Policy, Planning, and Evaluation Section of the Family Health Branch. Funds have also been designated to support regional MCH planning activities as a collaboration between hospitals, local health departments, and community collaborative planning activities. Additionally, funds support state office operations including salaries, travel, and provision of technical assistance and training to families, providers, and key MCH partners.

The total Federal-State Block Grant Partnership for FFY 2001 includes approximately \$9,700,000 in Program Income (See Form 2, line 6). This income is derived from Medicaid earnings for services provided to pregnant and post partum women, preventive health care services to children, and reproductive health services to women.

3.3.1 Completion of Budget Forms

See Forms 2-5.

3.3.2 Other Requirements

Of the Title V requested allocation (\$16,990,732), \$8,239,467 or 48.49% is earmarked for preventive and primary care for children. Approximately 45%, or \$7,680,197, is earmarked for children with special health care needs, and 4.05% or \$687,813 is earmarked for Title V administrative costs. These percentages are in keeping with the 30/30 required by Title V. The remaining \$383,255 is used to support comprehensive health services for women.

The state required match on our FFY 1999 MCHBG Budget of \$16,803,713 is \$12,602,785. Using Georgia's Office of Financial Services MCH Block Grant Expenditure Report, the FFY 1999 state match is \$19,852,216 (as of 3/31/00). Georgia's maintenance of effort (MOE) level is \$36,079,622. Our current MOE level is \$36,870,393 for the FFY 1999 grant as of 3/31/00. We do not anticipate any budget issues relative to MCH Block Grant Match requirements for the FFY 2001 budget. (See Appendix DD, Maintenance of Effort).

State and federal funds are allocated based on priority needs identified through the MCHBG development process. This process includes reviewing health status and outcomes for women and children, projecting future needs and assessing current capacity/infrastructure. The Branch, in concert with the Division of Public Health, makes recommendations for funding levels for services to women and children. These funding requests are then processed through the Georgia General Assembly's Annual Appropriations Bill. The Department of Human Resources also develops a fact sheet on the MCHBG. This fact sheet includes Title V requirements, line item description of the Title V budget, and a brief description of each program/service that is funded with Title V funds. This fact sheet is then distributed statewide and is used for the public hearing process. Interested partners, stakeholders, families, and advocates are encouraged to provide testimony to the DHR Board on the appropriateness and use of Title V funds.

3.4 Performance Measures

3.4.1 National "Core" Five Year Performance Measures

Notes providing Georgia specific details related to the national "core" five year performance measures have been added as relevant on individual performance measures.

3.4.1.1 Five Year Performance Targets

See Form 11 for Georgia's performance objectives for the national performance measures.

3.4.2 State "Negotiated" Five Year Performance Measures

A state performance outcome measure detail sheet has been completed for each of Georgia's selected measures.

3.4.2.1 Development of State Performance Measures

The figure below provides Georgia’s negotiated performance measures along with identification of the pyramid level of service, type of service, and target population for both core and negotiated performance measures.

FIGURE 4
PERFORMANCE MEASURES SUMMARY SHEET

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DH C	E S	PB S	I B	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home.”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g., the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X

Core Performance Measures	Pyramid Level of Service				Type of Service		
	DH C	E S	PB S	I B	C	P	RF
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN Program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program.				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.				X		X	
15) Percent of very low birth weight live births.				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				X			X

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DH C	E S	PB S	I B	C	P	RF
1) Degree to which the Georgia Perinatal System has been enhanced to provide a continuum of coordinated services from preconceptional to interconceptional care. (Target population: women and infants) REVISED				X	X		
2) Presence of key components that comprise a comprehensive approach to address maternal substance abuse. (Target population: women and infants)				X	X		
3) Evaluation of state capacity to prevent use of tobacco, alcohol and other substances by children and adolescents. (Target population: children)				X	X		

Negotiated Performance Measures	Pyramid Level of Service				Type of Service		
	DH C	E S	PB S	I B	C	P	RF
4) Degree to which districts have established integrated MCH plans. (Target population: all) REVISED				X	X		
5) Degree to which risk positive children, birth to age 4, are referred to appropriate public health programs, linked with a primary health care provider and referred for community services. (Target population: infants and children)			X			X	
6) Degree to which state and local public health agencies are actively involved in the statewide child fatality review process. (Target population: infants and children) REVISED			X			X	
7) Degree to which age-appropriate parenting and/or child development information for grades K-5 is made available to families, care givers, schools, and providers through a statewide system of collaboration and linkages. (Target population: infants, children, adolescents, CSHCN) REVISED		X			X		
8) Percent of children enrolled in the CSHCN program receiving case management services. (Target population: infants and children)		X				X	
9) Percent of counties with an active “Safe Kids” type broad-based injury prevention coalition. (Target population: infants and children)		X			X		
10) Rate of asthma related hospitalizations 1 to age 19. (Target population: children and adolescents) REVISED	X						X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services
 IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

3.3.2.2 Discussion of State Performance Measures

The process that was used to engage all Family Health Branch program managers and planners in formulating the state performance measures was described in the needs assessment section of this block grant application. The relationship between the state's priority needs, national and state performance measures and outcomes measures is displayed in the table that follows. Branch activities over the past year have focused on Georgia's national and state performance measures.

Relationship of Priority Needs to Performance and Outcome Measures

Measures	National Performance Measures										State Measures										Outcome													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27							
Preventable morbidity/mortality	•	•	•	•	•	•	•		•	•	•	•	•		•		•	•	•	•	•		•	•			•	•	•	•	•	•	•	•
Healthy life styles						•		•	•						•	•		•	•	•	•		•		•	•			•	•	•	•	•	•
Safe behaviors								•								•					•	•	•		•				•	•			•	•
Family partnerships					•									•		•				•			•	•	•	•	•	•	•	•	•	•	•	•
Integration/coordination of MCH system	•	•	•	•	•					•			•	•			•	•	•		•	•	•		•	•	•	•	•	•	•	•	•	
Collaboration/partnerships	•	•			•		•	•	•		•	•	•		•	•		•	•	•	•	•	•	•	•	•	•		•	•	•	•	•	•
Quality assurance																•	•	•				•						•	•	•	•	•	•	•
District MCH health planning													•	•	•			•	•	•	•	•			•		•	•	•	•	•	•	•	•
Information systems					•													•		•	•	•			•			•	•	•	•	•	•	•
Workforce skills/competencies																		•			•			•	•									

3.4.2.3 Five Year Performance Targets

Georgia's state measures have been included on Form 11.

3.4.2.4 Review of State Performance Measures

Georgia's "negotiated" measures were reviewed during the face-to-face application review held with state and regional MCH staff in August 1998. Based on FY'01 MCH needs assessment findings and the core themes identified, several of Georgia's state negotiated performance measures have been revised as follows:

State Performance Measure #1 has been changed from "Determination of attainment of critical milestones in implementation and utilization of Georgia Perinatal Guidelines" to "**Degree to which the Georgia Perinatal System has been enhanced to provide a continuum of coordinated services from preconceptional to interconceptional care.**"

State Performance Measure #4 has been changed from "Degree to which MCH planning processes exhibit essential characteristics of community involvement, needs identification, strategy development and implementation plans" to "**Degree to which districts have established integrated MCH plans.**"

State Performance Measure #6 has been changed from "Percent of eligible child deaths statewide reviewed by county level child fatality review subcommittee" to "**Degree to which state and local public health agencies are actively involved in the statewide child fatality review process.**"

State Performance Measure #7 has been changed from "Degree to which information on and support for effective parenting methods for children birth to age 21 is available throughout the MCH system" to "**Degree to which age-appropriate parenting and/or child development information for grades K-5 is made available to families, care givers, schools, and providers through a statewide system of collaboration and linkages.**"

State Performance Measure #10 has been changed from "Rate of asthma related hospitalizations 0 to 21" to "**Rate of asthma related hospitalizations for children 1 to 19 years of age.**"

See Section 5.10 for revised detail sheets.

3.4.3 Outcome Measures

See Forms 12 and 13.

IV. REQUIREMENTS FOR THE ANNUAL PLAN [Section 505 (a) (2) (A)]

4.1 Program Activities Related to Performance Measures

The heart of the capacity building process over the past two years has been the reorganization of the FHB, the reallocation of MCH funds, and the recruitment of staff with the skills and expertise to support these new directions. These changes are beginning to be well established with the nucleus in place and over the next year substantial changes in the larger Georgia MCH system are anticipated. As leadership is embraced, requisite relationships cultivated, and operational approaches implemented, broad system changes will be effectuated. A critical next step is moving these strategies from the state down to the local level where frontline responsibility for community-based MCH activities resides. The FHB activities detailed below indicate movement in this direction.

FY'01 Annual Plan Program Activities

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<i>Infrastructure</i>	
<p>NPM 11 - Percent of CSHCN in the State CSHCN Program with a source of insurance for primary and specialty care. <i>(Target population: CSHCN)</i></p>	<p>See NPM 12 also</p> <ul style="list-style-type: none"> - Continue to work collaboratively across CSHCN programs and other population groups to refer and enroll children in Medicaid, PeachCare and SSI. - Assist Children 1st families in applying for Medicaid and/or PeachCare. - Partner with DMA to enroll eligible children in PeachCare and Medicaid. - Establish methodology for comprehensive data collection and analysis. - Establish task force to work on incorporating data into statewide data system.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>NPM 12: Percent of children without health insurance. <i>(Target population: infants, children, and CSHCN)</i></p>	<ul style="list-style-type: none"> - Participate with DMA and other collaborative partners to refer eligible children to PeachCare for Kids and Medicaid. - Incorporate latest information about PeachCare for Kids and Medicaid into training and outreach activities. - Continue to assist clients regarding the availability of and application process for PeachCare for Kids. - Continue representation by Child Health on advisory group for Healthy Mothers, Healthy Children, which provides information to the public regarding access to health care statewide. - Continue Children 1st membership on the Georgia Partnership for Caring Foundation, Inc./RWJ Covering Coalition and its Outreach and Strategy Committee. (Function is to identify and develop comprehensive, community specific outreach strategies for finding eligible families/kids.) - Offer technical assistance regarding PeachCare for Kids to public health districts at each Health Check site visit. - Monitor dental providers for Medicaid and Peach Care. <p>See also NPM 7.</p>
<p>NPM 13 - Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program. <i>(Target population: infants, children, and CSHCN)</i></p>	<ul style="list-style-type: none"> - Continue to collaboration between FHB population teams and with the DMA to enhance services to eligible clients. - Continue to work with DMA to improve outreach quality assurance in private sector through better data availability. - Develop approaches with DMA on how to provide Medicaid reimbursable services in a non-clinic environment in accordance with the new federal regulations requiring early intervention service prevention in a natural environment. - Address immunization rates in private sector through AAP collaboration and site audits. - Monitor dental services for Medicaid and PeachCare. - Standardize dental screening process by ordering and distributing guidelines to 19 health districts.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>NPM 14 - The degree to which the State assures family participation in program and policy activities in the State CSHCN Program. (<i>Target population: CSHCN</i>)</p>	<ul style="list-style-type: none"> - Survey selected Children with Special Needs families from different cultures and ethnicities as well as from varying economic and geographic areas to identify major issues and barriers. - Continue current family involvement activities across FHB programs. - Develop partnerships between CSN state/district/local staff and disease specific support organizations to recommend interventions for families. - Incorporate questions regarding issues, gaps, needs, solutions, etc. in future family survey conducted by CSN. Distribute surveys at conferences. - Identify and collaborate with key stakeholders to develop statewide resources to support parents of CSN (i.e., Speakers Bureau, workshops, lending library) - Assist local districts with family-focused training. - Continue to provide family training to address CSHCN issues. - Provide SIDS information and linkage to counseling/support to extended families, child care providers and co-workers as requested. - Train additional SIDS families throughout the State as peer contacts. - Seek additional computer equipment donations to link SIDS families to Internet resources.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>NPM 15 - Percent of very low birth weight live births. (<i>Target population: infants and CSHCN</i>)</p>	<ul style="list-style-type: none"> - Disseminate prenatal information to Adolescent Health Centers and District Youth Development Centers. - Continue collaboration within FHB population teams to ensure pregnant teens receive perinatal case management. - Continue collaboration within FHB population teams and with DHR's MCH Epi to identify adolescent pregnancy rates by county. - Participate with community planning groups to provide assistance with analyzing local data to target specific community issues to reduce disparities.- Develop process to determine impact of violence against pregnant and non-pregnant women and its impact on outcomes of pregnancy and health status of women. - Coordinate all outreach personnel across FHB population groups to identify and refer pregnant women in the 1st trimester to risk appropriate care. - Define cultural indicators for measures of preconceptional and interconceptional health. - Convene work group to develop plan to build a prevention support system for improving pregnancy outcomes and to support interconceptional interventions for reducing low birth rate babies. - Coordinate all outreach personnel across FHB population groups to identify and refer pregnant women in 1st trimester to risk appropriate care. - Identify educational opportunities across FHB population groups for specific risk behaviors. Identify gaps in educational opportunities. Through linkages with stakeholders determine most effective mechanism of providing educational opportunities. - Continue collaboration between the FHB's AHYD, Infant & Child Health, and Children with Special Needs to ensure that pregnant and parenting adolescents receiving AHYD services are aware of SIDS reduction precautions, benefits of breastfeeding, Babies Can't Wait Program, child development and positive parenting skills. - Continue to encourage use of folic acid. - Continue to address high risk behaviors with family planning clients.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>NPM 16 - The rate (per 100,000) of suicide deaths among youths 15-19. (<i>Target population: children</i>)</p>	<ul style="list-style-type: none"> - Through Adolescent Health and Youth Development (AHYD), provide psychosocial lifestyle education on topics such as self-esteem building, postponing sexual involvement, nutrition, abstinence, STD/HIV prevention awareness, etc. - Support development and implementation of AHYD's plan to prevent suicide and substance abuse. - Collaborate with DHR Office of Injury Prevention, Mental Health/Mental Retardation/ Substance Abuse and other state and local suicide prevention agencies to establish prevention awareness as a primary objective for AHYD programs and services. - Continue efforts in programs across State to provide a caring adult (mentor) for targeted youth. - Identify disassociative risk behaviors and signs and symptoms associated with adolescent depression.
<p>NPM 17 - Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates. (<i>Target population: women, infants, and CSHCN</i>)</p>	<p>See NPM 15.</p> <ul style="list-style-type: none"> - Continue development of surveillance and monitoring system.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>NPM 18 - Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester. <i>(Target population: women and infants)</i></p>	<p>See NPM 15.</p> <ul style="list-style-type: none"> - Continue collaboration between FHB Offices of Infant and Child Health, Women's Health and AHYD to promote the importance of prenatal care and positive parenting skills to pregnant and parenting adolescents. - Continue to encourage women seen in Family Planning clinics to seek early prenatal care. - Continue working with the Commissioner of the Department of Community Health to help ensure dental services as a necessary service for all pregnant women who are eligible for Medicaid. - Continue to provide updates on performance levels in CDC surveillance systems. - Provide funding to at least one half time dentist and one full time hygienist in each health district. - Provide prevention training to metro area dental hygienists.
<p>SPM 1 - Degree to which the Georgia Perinatal System has been enhanced to provide a continuum of coordinated services from conceptional to interconceptional care. <i>(Target population: women and infants)</i> REVISED</p>	<p>See NPM 15.</p> <ul style="list-style-type: none"> - Continue to coordinate utilization of Guidelines with Maternal and Infant Health Council.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>SPM 2 - Presence of key components that comprise a comprehensive approach to address maternal substance abuse. (<i>Target population: women and infants</i>)</p>	<ul style="list-style-type: none"> - Establish substance abuse prevention as a primary objective in AHYD Community and Male Involvement program services. - Collaborate among FHB Office of Women's Health, AHYD, DHR MCI Epi, Division of MHMRSA to develop data assessment collection to determine state and district baseline studies. Participate in Division of MHMRSA advisory group for Center for Substance Abuse Treatment funded statewide substance abuse treatment needs assessment. - Continue inclusion of substance use and abuse as part of Women's Health client assessment. - Identify educational opportunities across FHB population groups for specific risk behaviors. Convene work group to develop plan. Collect current status of health disparities by review of Women's Health District Plans and other relevant data. Develop training for outreach staff that address relevant risk behavior. - Coordinate all outreach personnel across FHB population groups to identify and refer pregnant women in 1st trimester to risk appropriate care. - Continue inclusion of substance use/abuse in Family Planning client assessments. - Continue to emphasize risks of maternal substance abuse in the Georgia Back to Sleep campaign to reduce the risk of SIDS. - Continue Women's Health staff participation (Ex-officio seat) on Commission on Family Violence. - Fund 22 programs to provide prevention services and services for victims of sexual assault. Implement sexual assault plans in 4 districts. Provide technical assistance to all 25 Rape Crisis Programs and support for plan implementation. - Conduct sexual assault prevention programs for schools, public service officials and communities at large. - Continue developing partnership with MHMRSA at state-level and determine best approach for community service board and district health collaboration.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>SPM 2 - Presence of key components that comprise a comprehensive approach to address maternal substance abuse. (<i>Target population: women and infants</i>) (CONTINUED)</p>	<ul style="list-style-type: none"> - Expand focus of program to address violence against women. - Ensure that violence against women and sexual assault prevention is incorporated in programs in all population teams.
<p>SPM 3 - Evaluation of state capacity to prevent use of tobacco, alcohol and other substances by children and adolescents. (<i>Target population: children</i>)</p>	<ul style="list-style-type: none"> - Address high risk behaviors, including tobacco, alcohol and other substances, in State's 39 Adolescent Health Centers and through the Family Planning Program. - Through use of "Georgia Talk," make information about tobacco use available to district child health coordinators and health educators. - Collaborate with the Division of Mental Health, Mental Retardation and Substance Abuse to address tobacco use by underage youth. - Incorporate current "best practice" recommendations regarding safe behaviors and healthy lifestyles into educational materials and awareness. - Continue to emphasize risks of maternal smoking and environment smoke in the Georgia Back to Sleep campaign to reduce the risk of SIDS. - Coordinate with national, state and local organizations to promote adolescent substance abuse prevention. - Monitor Georgia Spit Tobacco Education Program (GSTEP) for 4th and 5th grade students. - Participate in Division of MH/MR/SA advisory group to provide guidance oversight in the Division's Center for Substance Abuse Treatment funded Treatment Needs Assessment.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>SPM 4 - Degree to which districts have established integrated MCH plans. (<i>Target population: all</i>) REVISED</p>	<ul style="list-style-type: none"> - Collaborate with all FHB population groups and with community groups to determine ongoing services and implications for communities. - Collaborate with district staff to finalize Child Health Process Model. Develop work plan to promote use of model. - Assess role of School Health at the local level. - Participate in MCH/SLAITS survey, July 2000-June 2001. - Continue to involve community partners in their grassroots cooperative efforts to implement folic acid awareness. - Enhance AHYD Community Involvement and needs assessment services and promotional activities throughout the State's 19 health districts. - Implement annual District Community Involvement Action Plans. - Continue to offer training to the districts in promoting community involvement in the implementation of their nutrition education plans. - Continue to assist the Georgia Coalition for Nutrition Education in their nutrition education efforts, including planning and implementation of health promotion projects. - Continue to provide nutrition technical assistance, consultation and training to health districts. - Provide dental technical assistance and consultation to 19 districts. - Support DPH Health Assessment and local planning units in focus on MCH issues. - Utilize work groups, including district personnel, parents and disease specific organizations involved with Children with Special Needs (CSN) to refine and implement CSN work plan.
<p><i>Population-Based</i></p>	

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>NPM 4- Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemo-globinopathies combined. <i>Target population: infants and CSHCN)</i></p>	<ul style="list-style-type: none"> - Review hospital/submittor practice reports with submitters to provide specific feedback on newborn screening (NBS) practice. - Explore linking NBS database with birth records to monitor QA of NBS program. - Encourage hospitals to use NBS as a quality assurance measure. - Define long-term outcomes for children with diagnosed metabolic or sickle cell disorder. - Continue to provide information as available to SIDS parents who seek specifics about their infants' newborn screening results or other genetic questions.
<p>NPM 5 - Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus influenza and Hepatitis B. <i>Target population: infants and children)</i></p>	<ul style="list-style-type: none"> - Collaborate with the Office of Immunizations Clinic Assessment Software Application (CASA) in joint review of immunization status of children. - Assess immunization status on all children who receive service through health departments during review of child records. - Collaborate with the Immunization Program in assessing immunization rates of five year olds.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>NPM 6 - The birth rate (per 1,000) for teenagers aged 15 through 17 years. (<i>Target population: women and children</i>)</p>	<p>See NPM 15.</p> <ul style="list-style-type: none"> - Implement Abstinence Resolution HR 457 Programs and Youth Development activities throughout the 19 state districts. - Develop district-specific program action plans for adolescent pregnancy prevention and HR 457. - Continue to enhance core AHYD goals and objectives, training priorities and needs assessments with the assistance of District Youth Development Coordinators and stakeholders. - Conduct four weekly statewide promotions (Youth Development, Male Involvement, Community Involvement, and Abstinence Education) during month of May. - Develop district-specific AHYD program workplans in accordance with the University of Georgia (UGA) and Georgia State University (GSU) youth assets program modules. - Provide training and technical assistance to district Youth Development Centers and Community and Male Involvement program providers and implement UGA and GSU program modules. - Identify and distinguish pregnancy prevention and youth development programs and activities for cultural, age, and gender-specific adolescent populations. - Conduct a Male Involvement Pregnancy Prevention and Youth Development conference that includes workshops on program manuals, fatherhood, mentoring, positive communication, and violence prevention. - Cross train AHYD staff on the four core statewide programs: Comprehensive Adolescent Health Services, Community Involvement, Male Involvement and Abstinence Education/Promotion. - Collaborate with AHYD to incorporate educational messages into appropriate Infant and Child Health activities.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>NPM 7 - Percent of third grade children who have received protective sealants on at least one permanent molar tooth. <i>(Target population: children)</i></p>	<p>- Implement oral health programs in at least 49% of Georgia counties.</p> <p>-Implement elementary school-based Georgia Dental Program (approval of superintendents or principals in the elementary schools is necessary for projects. Provide at least 2 Dental Sealant projects in partnership with private dentists, private dental hygienists, schools of dentistry and local schools-Seal Georgia Project (focus grade 2-5). Provide dental sealants on permanent molars for eligible children who have no private dentists, lack access to dental services and have parent's consent in at least 1 school in each county in health districts with 5 or less counties, or at least 1 school in 50% of counties in health districts with 10 or more counties using portable dental equipment. Meet with district/local public health nutritionists to discuss early childhood caries (baby bottle teeth decay). Present Georgia Plaque Awareness Program to 1st and 3rd graders in at least 1 school in each county in health districts with 5 or less counties or at least 1 school in 50% of counties in health districts with 10 or more counties. Present Georgia Spit Tobacco Education Program to 4th or 5th grade students in at least 1 school in each county in health districts with 5 or less counties or at least 1 school in 50% of counties in health districts with 10 or more counties. Provide dental screenings and dental referrals in at least 1 school in each county in health districts with 5 or less counties or at least 1 school in 50% of counties in health districts with 10 or more counties. Provide diagnostic, preventive and basic dental treatment sessions in fixed dental public health facility for low income children, up to 285% of FLP, who have limited or no access and need emergency dental services.</p>

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>NPM 8 - The rate of deaths to children ages 1-14 caused by motor vehicle crashes per 100,000 children. (<i>Target population: children</i>)</p>	<ul style="list-style-type: none"> - Collaborate with all initiatives that promote and provide training on use of safety equipment (car seats). - Incorporate current “best practice” information regarding safety issues into educational materials. - Continue to collaborate with the DHR Injury Prevention to promote safety seat usage, helmet and knee pad use, and driving safety. - Continue to use Children Health Assessment forms during Health Check screens. Forms include car seat safety as one of educational topics for age appropriate anticipatory guidance. - Continue to collaborate with Safe Kids of Georgia in training efforts related to care seat usage. - Provide training and workshops to Family Day Care providers and public health employees regarding care seats and seat belt safety. - During Health Check screens, provide educational counseling to parents of infants and youth regarding motor vehicle safety. - Promote appropriate use of seat belts with Children 1st children and families. - Provide information to WIC recipients on consistent and correct use of care seats.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>NPM 9 - Percentage of mothers who breast-fed their infants at hospital discharge. (<i>Target population: women and infants</i>)</p>	<ul style="list-style-type: none"> - Continue to monitor WIC programs for compliance with regulations on promotion and support of breastfeeding: staff training, clinic environment, support services, and availability of a breastfeeding coordinator. - Work with local WIC programs to increase the number of community breastfeeding coalitions. Provide training and technical assistance. - Continue to work through the Georgia WIC Program Breastfeeding Advisory Committee, Georgia Task Force for Breastfeeding, Georgia Chapter of the AAP Breastfeeding Committee, and Southeastern Lactation Consultants Association (SELCA) to facilitate changes in health professional education, public perception and community support. - Continue to provide breastfeeding education to public health staff through Competency Based Nutrition and Lactation Management Skills training. - Disseminate information on contraindications to breastfeeding, as well as signs of a well-fed breastfed infant, through the Georgia AAP Breastfeeding Committee and health departments. - Conduct GSAMS training on breastfeeding for nutrition assistants. - Continue Office of Nutrition participation in the biannual DHR SIDS/OID work group meetings. - Continue promotion of breastfeeding in all SIDS risk reduction awareness activities. - Continue to offer contraceptives compatible with breastfeeding to women seen in Family Planning clinics. - Integrate breastfeeding into women's health programs. - Begin to collaborate with SELCA in the development of a resource/referral manual for statewide distribution. - Continue seeking to increase the number of pediatric and pregnancy surveillance records accepted by CDC for analyses, providing a better measure of health indicators for nutrition.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>NPM 10 - Percentage of newborns who have been screened for hearing impairment before hospital discharge. <i>Target population: infants and CSHCN)</i></p>	<ul style="list-style-type: none"> - Develop a state work plan through Newborn Hearing and Screening (NHS) Advisory Committee to promote universal newborn hearing screening and referral for diagnosis and care management and implement a statewide system. - Cooperate with appropriate key stakeholders to identify the coverage for diagnosis and treatment of hearing impaired children in concert with NHS Advisory Committee. - Continue to screen infants born in Georgia for Newborn Screening (pass or fail) and suspected hearing impairments. Of those who screen positive for hearing impairments, continue Children 1st referral of parents/care givers to a primary care provider and/or the following PH programs: High Risk Infant Follow Up, Children's Medical Services, Early Intervention/Babies Can't Wait Programs for further assessment, treatment and intervention. - Assure appropriate genetic testing and counseling. - Continue Children 1st screening of infants and children up to age 4 for Serious Problems or Abnormalities of Body Systems, which includes hearing impairments and suspected hearing impairments.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>SPM 5 - Degree to which risk positive children, birth to age 4, are referred to appropriate public health programs, linked with a primary health care provider, and referred for community services. (<i>Target population: CSHCN</i>)</p>	<ul style="list-style-type: none"> - Strengthen and improve process to identify, screen and refer children to appropriate services, using the Electronic Birth Certificate download and the manual-screening tool. - Disseminate best practice sleep safety and infant mortality risk reduction information through DHR SIDS & OID Work Group, newsletter, awareness activities, technical assistance and training. Children identified with medical or socio-environmental risk conditions will be referred to appropriate services and linked to a primary care provider to assure a medical home and comprehensive coordinated services. - Continue to identify and refer risk positive children for appropriate care during Health Check assessments. - Continue to provide Denver II training for PH staff and other private providers, as requested. - Continue to collaborate with AAP medical home coordinator to conduct site reviews and offer training to private providers as needed. - Continue to assess training needs of PH staff and offer Health Check training as needed.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>SPM 6 - Degree to which state and local public health agencies are actively involved in the statewide child fatality review process. (<i>Target population: infants and children</i>) REVISED</p>	<ul style="list-style-type: none"> - Co-facilitate collaborative process with the Office of Child Fatality Review to develop recommendations and develop implementation plan to promote public health's role in improving child fatality review. - Continue to provide PH focused input into development of training by the Office of Child Fatality Review for child fatality review committees. - Educate PH staff regarding prevention advocacy role and identify relevant staff to assume responsibility for targeted county public health departments. - Provide EMS personnel with training to increase knowledge of significant information related to death scene and to improve quality of data provided on the EMS trip report. - Target counties with EMS personnel that have dual roles as both EMS responders and coroners in order to improve the fatality review process. - Review timeliness of individual death certificate transmission from Vital Records to county coroners needs review. - Assure PH staff that encounter families that have experienced loss of child (EMS/ER staff, Children Ist, BCW, etc.) have skills to address grief processes and appropriately interact in the acute and long-term environments. - Support training for community members that addresses grief processes and appropriate interaction of coroners, law enforcement and other health/social services providers with families. - Work with Vital Records to provide on-going training provided death certificate reporters to improve the timeliness and accuracy of information provided on death certificates.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
SPM 6 (continued)	<ul style="list-style-type: none"> - Continue training county and district public health nurses, social workers, and/or other appropriate staff to provide initial grief support and referral to on-going support resources. - Inform child health advocates about child fatality review issues. - Convene intra-divisional, state-level child fatality review team consisting of Child Health, MCH Epidemiology, EMS-C, Injury, and Vital Records, at a minimum, to identify research and analytical concerns, review data, and develop prevention strategies. - Continue state office child fatality review participation in the biannual DHR SIDS/OID work group meetings.
<i>Enabling</i>	
NPM 3 - The percent of CSHCN in the State who have a "medical/health home." (<i>Target population: CSHCN</i>)	<ul style="list-style-type: none"> - Identify and collaborate with key stakeholders to promote the medical home concept through multiple methods. - Identify what data is currently available from various sources; identify gaps in data and establish methodology for comprehensive data collection and analysis. - Establish task force to work toward incorporating data into a statewide data system. - Document process developed to monitor a child's medical home status. - Continue collaboration with the Georgia Chapter of American Academy of Pediatrics (AAP) to increase knowledge of and support for Children 1st and CSHCN programs. - Continue to link children with medically necessary specialty services, coordinating with their medical home/primary care provider. - Continue to refine definition of CSHCN based upon data availability and planning to obtain necessary data.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>SPM 7 - Degree to which age-appropriate parenting and/or child development information for grades K-5 is made available to families, care givers, schools, and providers through a statewide system of collaboration and linkages.</p> <p><i>Target population: infants and children</i>) REVISED</p>	<ul style="list-style-type: none"> - Review and analyze existing parenting programs, activities and materials to develop a plan to increase awareness of parenting education opportunities. - Collaborate to implement and distribute child development and parenting materials, including a resource list for distribution to providers, families, district and local staff, including via web site. - Collaborate with other private and public agencies to present parenting workshops to potential parents, parents, and other care givers. - Coordinate activities around developmental follow-up, parenting and injury control issues. - Incorporate questions regarding issues, gaps, needs, and solutions in family surveys conducted by Children with Special Needs. - Continue to present early brain development workshops to diverse population groups statewide. - Continue to promote community and parental involvement through District Parent and Adult AHYD Advisory Boards. -- Collaborate with other private and public agencies to present parenting workshops to potential parents, parents, and other caregivers. - Work to include SIDS risk reduction education in parenting education for parents of newborns. - Continue “good role model” parenting emphasis in Office of Nutrition’s health promotions for the <i>Take Charge</i> messages. - Work with Public Health Nutritionists and parents/Head start, WIC clients about early childhood caries (baby bottle tooth decay). - Hold conference with Medicaid and others to discuss access to oral health services for Medicaid and PeachCare (as part of Georgia Oral Health Initiative)

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>SPM 8 - Percent of children enrolled in the CSHCN Program receiving case management services. <i>(Target population: CSHCN)</i></p>	<ul style="list-style-type: none"> - Continue Children 1st service as point of entry/intake in many districts across State for children birth to four who screen positive for specific socio-environmental, medical and biological conditions that could put them at risk for poor developmental or health outcomes. Appropriate families referred to appropriate social service, health care and community based services and/or linkage of child with a primary care provider. - Establish stakeholder work group to analyze status of children in the CSHCN program receiving case management services and make recommendations regarding case management services.
<p>SPM 9 - Percent of counties engaged in "SAFE Kids" injury prevention coalitions. <i>(Target population: infants and children)</i></p>	<ul style="list-style-type: none"> - Collaborate with all initiatives that promote and provide training on use of safety equipment. - Incorporate current best practice information regarding safety issues into educational materials. - Provide consultation on child health and safety issues. - Continue working to establish SAFE Kids coalitions. - Continue collaboration between FHB's Office of Infant and Child Health and AHYD and DHR Office of Injury Prevention to promote "Safe Kids" throughout the 19 districts. - Present injury prevention workshops, addressing poison prevention, water and sun safety, emergency planning, playground safety, and care seat safety, to family day care providers and other PH front line staff. - Continue to collaborate with SAFE Kids of Georgia in planning and presenting at annual workshop. - Require trained playground inspectors to inspect playgrounds for safety and make recommendations.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<i>Direct Medical Services</i>	
<p>NPM 1 - The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State CSHCN Program. (<i>Target population: CSHCN</i>)</p>	<ul style="list-style-type: none"> - Participate in MCH/SLAITS survey, July 2000-July 2001. - Develop work group of appropriate stakeholders to develop long range goals, objectives and recommendations for accessing data; implementing and monitoring progress.
<p>NPM 2 - The degree to which the State CSHCN Program provides or pays for specialty care and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients. (<i>Target population: CSHCN</i>)</p>	<ul style="list-style-type: none"> - Assess current status and data sources of Children with Special Needs provision of or payment for specialty care and subspecialty services. - Identify gaps and barriers. - Develop work group of appropriate stakeholders to develop long range goals, objectives and recommendations for implementing and monitoring progress. - Establish baseline. - Continue to distribute Georgia Back to Sleep: A Newsletter of the SIDS and Other Infant Death Work Group and HeartLine, the newsletter of the SIDS Alliance of Georgia twice a year to CMS and BCW programs. - In the event of the death of a child with special health care needs, provide bereavement information, materials, and/or training to professionals working with the family as appropriate. In addition, SIDS/OID coordinator and bereavement specialist will continue to assist in linking the family to grief support, if desired. - Continue to fund or arrange for funding of specialty services for children enrolled in CSHCN programs. - Facilitate referrals to PeachCare. - Continue to examine ways to better coordinate and integrate services across CSHCN programs and utilize resources from programs in other MCH population groups. - Continue to expand nutrition services so that licensed dietitians can provide nutrition counseling to children enrolled in BCW and CMS. - Provide annual training on nutrition assessment/ education for CSHCN.

Pyramid Level/Program Measures	FY'01 Annual Plan Program Activities
<p>SPM 10 - Rate of asthma related hospitalizations 1 to age 19. (<i>Target population: CSHCN</i>) REVISIED</p>	<ul style="list-style-type: none"> - Continue to build partnerships with managed care organizations and other providers to develop and promote standards of care in the management of asthma in children. - Promote research of environmental factors that exacerbate asthma in children; and support programs that provide case management of children with asthma. - Continue to provide community-based chronic lung services through Children's Medical Services. - Collaborate with Medicaid and other community-based asthma initiatives. - Collaborate with FHB population teams/sections and other agencies to develop an asthma strategy including surveillance, partnership development and interventions, based on the status of asthma in Georgia. - Continue collaboration between FHB's Offices of Infant and Child Health and Children with Special Needs and AHYD Comprehensive Adolescent Health Centers to promote asthma-related complications and awareness. - Explore collaborative opportunities with the Georgia Chapter of Pediatrics and with the Georgia Lung Association. - Target case management implementation to children with asthma. - Review appropriate literature and identify resources. - Coordinate with the Department of Education to assist in acceptance of prevention curriculum statewide. - Develop and implement coordinated activities between the Resource Mothers program in Women's Health and AHYD. - Develop training for outreach staff that address relevant risk behavior. - Develop coordinated educational materials and mechanism to engage parents.

4.2 Other Program Activities

Several toll-free hotlines offer access points in the entire MCH service system. Georgia's Title V toll-free hotline, *PowerLine*, is run by Healthy Mothers, Healthy Babies under a Family Health Branch contract. PowerLine assists women, pregnant women, parents, health care providers, social service agencies, community organizations, and any other individual or type of agency who is experiencing difficulties in obtaining information about health care and/or health care services. The PowerLine offers services in English and Spanish. Caseworkers are available Monday-Friday 8:30 AM through 5:00 PM.

Babies Can't Wait (Part C, IDEA) supports a separate toll-free number for families that provides a central directory of public and private early intervention services, research and demonstration projects, professional groups, parent support groups and advocate associations available in the state for children with or at risk for developmental delays. This central directory is operated by Parent-to-Parent of Georgia, a statewide parent-run organization. A unique feature of the hotline is that a parent of a child with a disability answers the phone. In addition to obtaining information about services, callers can be matched with supporting parents whose children have similar disabilities.

Outside of funded MCH activities, there are a number of other program activities which comprise the MCH system that significantly impact the Title V population. These programs include Health Check (EPSDT), Right from the Start Medicaid, WIC along with WIC nutrition services, Family Planning, and Immunization, as well as activities focused on CSHCN, such as the Governor's Council on Developmental Disabilities and Social Security determination. The relationship between the MCH program and these activities is described in Sections 1.5.1.1 (Organizational Structure) and 1.5.1.3 (Other Capacity) of this block grant application. The family leadership and support activities are also discussed in a subsection of 1.5.1.3, entitled description of number and role of family members on Family Health Branch staff.

4.3 Public Input [Section 505 (a)(5)(F)]

DHR and its FHB recognize the importance of public participation in the planning and implementation of maternal and child health services for the State's children and families. Public input is obtained in a variety of ways. DHR conducts annual public hearings throughout the State to provide opportunities for Georgians to speak and participate in the planning of Georgia's human services priorities. The DHR Board and Management Team traveled throughout the State in April, observing programs and listening to consumer concerns. This information gathering endeavor assisted the Board in setting priorities and direction for the next budget cycle. In addition, a public hearing under the purview of the Georgia Legislature's House and Senate Health and Human Services Budget Subcommittee was held in January 2000 for public comment on the MCH Block Grant and other federal block grant programs.

The FHB has been developing ongoing mechanisms for public input and involvement in all of its activities, both at the state and local level. In the past, a systematized approach to accomplish this

objective was lacking and public involvement was fragmented. Beginning with the Children's Initiative in the early 1990's, the critical nature of public involvement at all phases of program development, implementation, and evaluation was recognized. Consequently, FHB programs which have been launched since this time – BCW, Family Connection, Children 1st, and Adolescent Health and Youth Development – have incorporated public input and family participation from the early stages of their development. Last year, the FHB hired the Family Involvement Consultant to enhance family participation in all aspects of planning, development, implementation and evaluation of maternal and child health services in Georgia.

In preparing its MCH Block Grant application, the FHB requested public input on the ten MCH priorities that guide all Branch activities. (See Section 3.2.1 - Priority Needs) Over 150 statewide stakeholders, including key informants from the MCH needs assessment, district staff, providers, advocates, legislators, state staff, and others were targeted to provide feedback on how FHB priorities could be more relevant and appropriate to the emerging and evolving MCH environment in Georgia. Visitors to the FHB web site also were encouraged to provide input and additional guidance on FHB activities. Participants included:

External Organizations

Association of State and Territorial Health Officers (Darcy Steinberg)
Planned Parenthood of Georgia (Kay Scott, Carol Massey)
Georgians for Children (Gus Thomas)
Family Connection (Laurie Dopkins)
All Family Connection Regional Consultants and Coordinators
Head Start (Gwen Johnson, Robert Lawrence, Brenda Martin)
Healthy Mothers Healthy Babies (Sally Harrel)
CDC, Division of Adolescent and School Health (Dave Poehler)
CDC, Genetics (Carol Oakley)
Parent to Parent
Healthy Start (all sites)
Georgia Chapter of the American Academy of Pediatrics (Rick Ward)
Georgia Public Health Association
Georgia Perinatal Association
All other Family Health Branch service contractors
March of Dimes (Lorie Mayer)
Georgia Policy Center (Jennifer Edwards, James Ledbetter)
University of Georgia (Doug Bachtel)
Georgia State University (Donald Ratajczak)
Emory University School of Public Health (Arthur Kellerman, Kenneth Resnicow)
Georgia Perinatal Task Force (Al Brann)

Other State-Level Organizations

Division of Mental Health/Mental Retardation/Substance Abuse (Mary Hassel, Bruce Hoopes)

Department of Community Health, Division of Medical Assistance (Lisa Norris)
Department of Community Health, Office of Minority Health (Carol Snype Crawford)
Division of Family and Children Services (Ed Fuller)

Department of Education (Myra Tolbert)
Department of Juvenile Justice (Michele Staples-Horne)

With the Division of Public Health:
HIV/AIDS Prevention (John Beltrami)
MCH Epidemiology (Julia Samuelson, Hui Zhang)
All district health directors

4.4 Technical Assistance [Section 509 (a)(4)]

Over the coming year, the FHB will focus on systems building related to all levels of the pyramid. The Branch's three requested technical assistance areas, service integration for children with special needs focused on Babies Can't Wait and Children's Medical Services, case management across all FHB programs, and continuous quality improvement (CQI) reflect this direction. With regard to CQI, the FHB has developed a "Framework for Continuous Quality Improvement Implementation Plan." The purpose of the plan is to outline the scope and nature of a CQI framework as an organizational strategy for the ongoing development of a more competitive, innovative and responsive family health system in Georgia. The framework is designed to move the entire organization toward cooperating to achieve a transition of the FHB from an "administrative" to a "facilitate and support" role in service delivery. (See Appendix M, Framework for Continuous Quality Improvement Implementation Plan).

V. SUPPORTING DOCUMENTS

5.1 Glossary

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [*Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. (*Title V Sec. 501(b)(4)*)

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (*For budgetary purposes*) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic

illnesses and conditions and health-related education and behavioral problems. (*For planning and systems development*) - 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.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. State Program Collaboration with Other State Agencies and Private Organizations. States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.
2. State Support for Communities. State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.
3. Coordination of Health Components of Community-Based Systems. A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.
4. Coordination of Health Services with Other Services at the Community Level. A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death. Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health

problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals. Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshal Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds

collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the

Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.)

related to protecting components or potential components of the national wild and scenic rivers systems.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)

14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,

- (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
- (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
Office of Management and Acquisition
Department of Health and Human Services
Room 517-D
200 Independence Avenue, S.W.
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC

grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant

is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

