

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

AN OVERVIEW OF HEALTH RANKINGS FOR GEORGIA

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

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

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

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

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

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

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

PREGNANT WOMEN, MOTHERS, AND WOMEN OF CHILD BEARING AGE

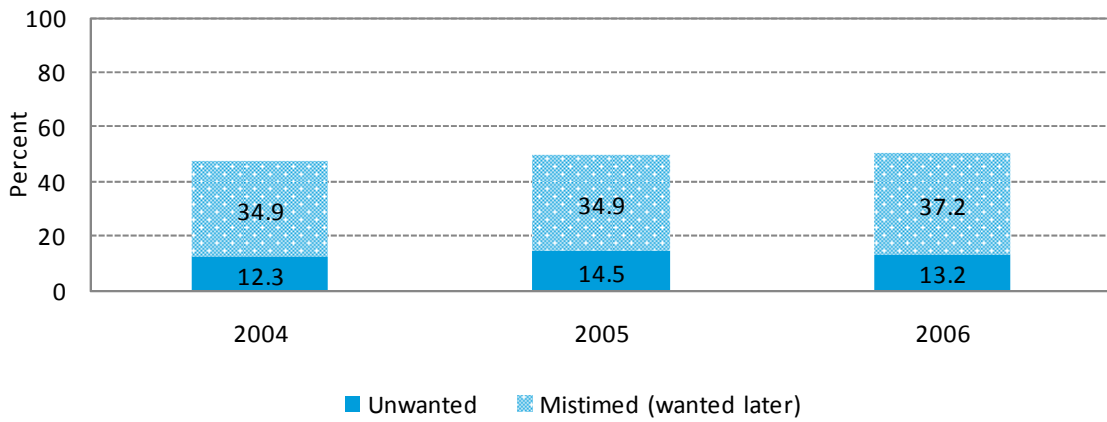
ANALYSIS OF QUANTITATIVE DATA

PREGNANT WOMEN

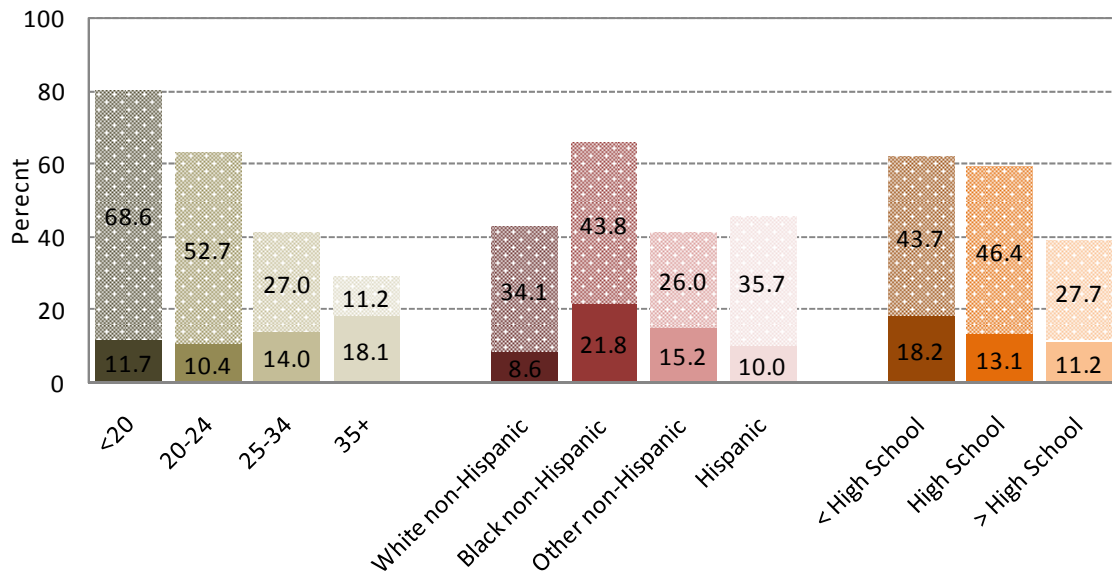
UNINTENDED PREGNANCY

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

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



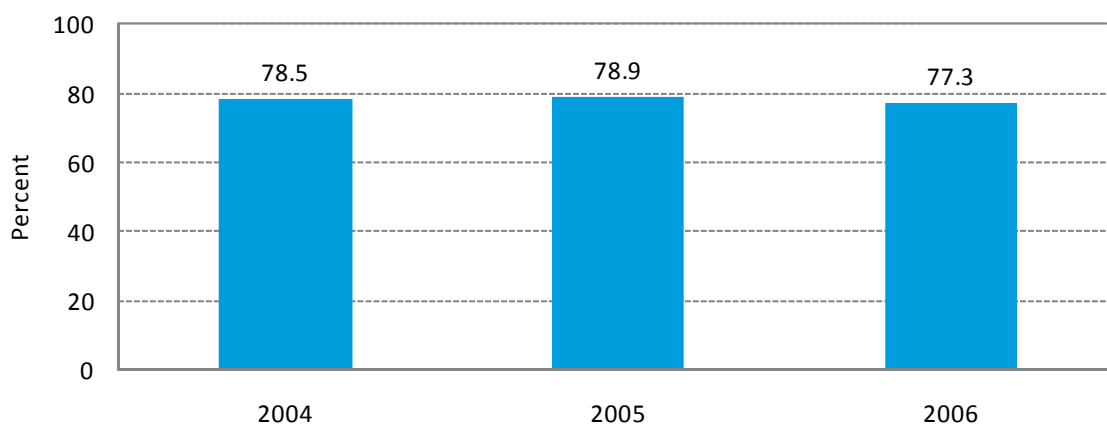
Percent of Births Reported to be Unintended by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



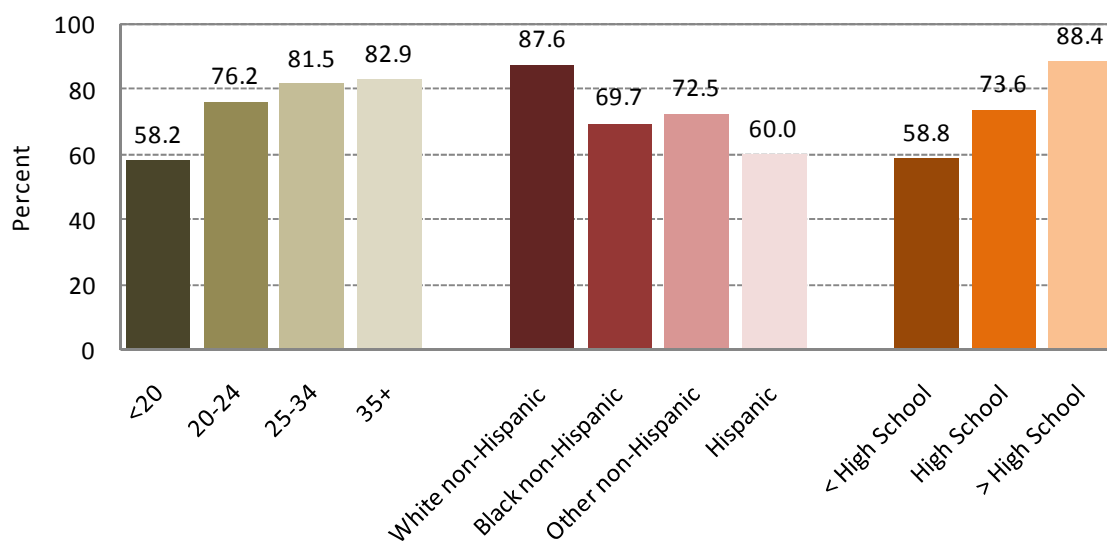
RECEIVING PRENATAL CARE IN THE FIRST TRIMESTER

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

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



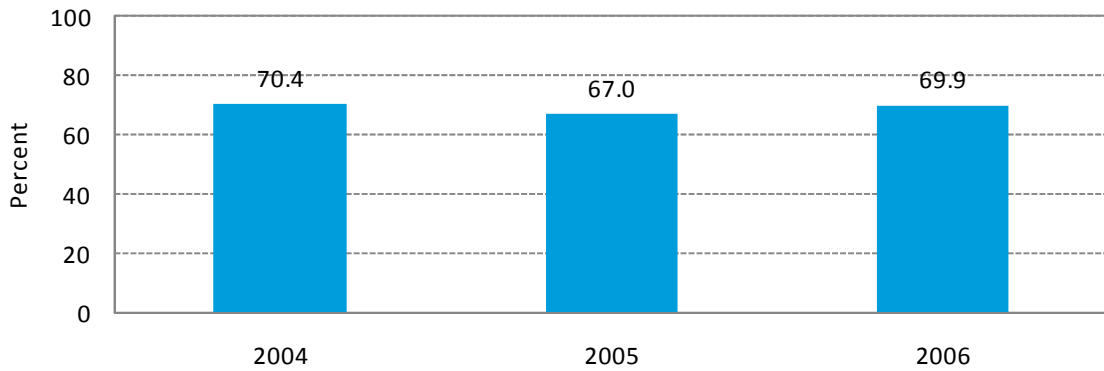
Percent of Mothers Who Received First Trimester Prenatal Care by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



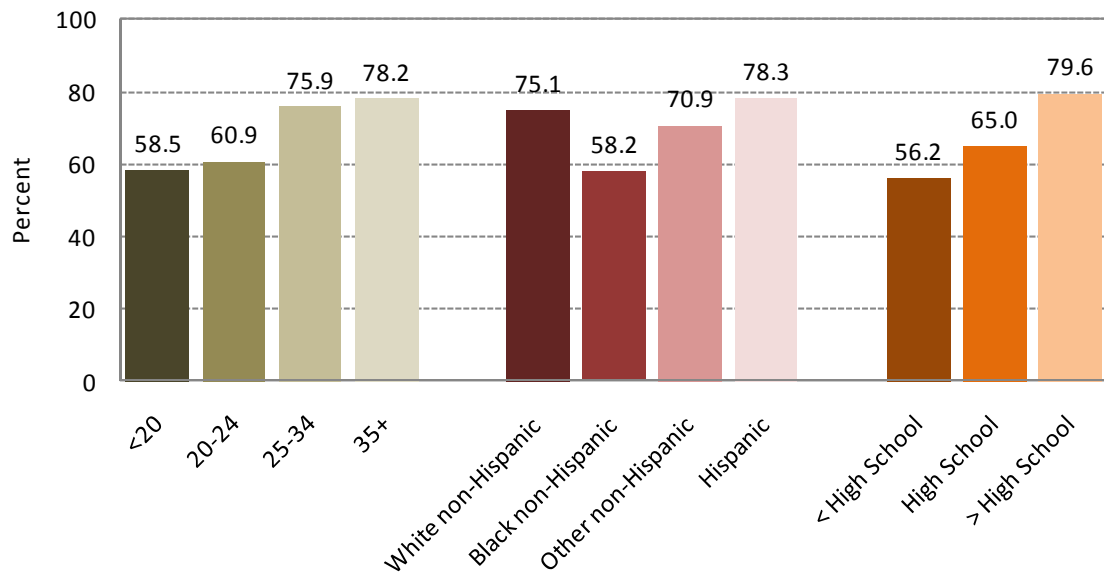
Ever Breastfed

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

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



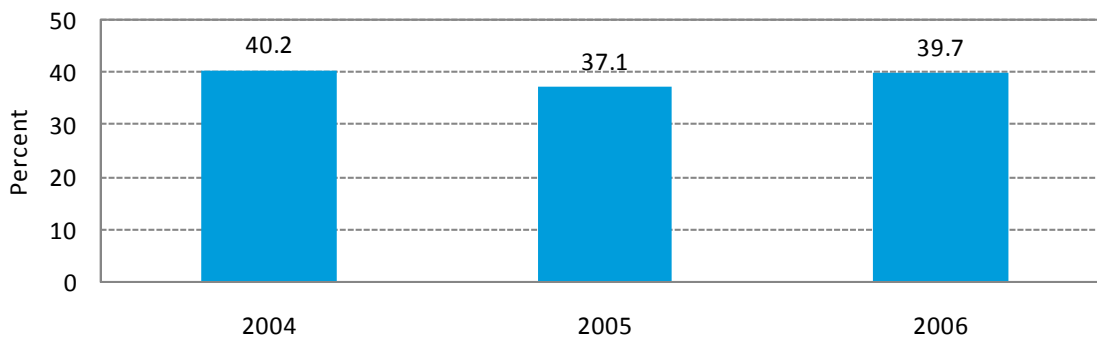
Percent of Mothers Who Reported Ever Breastfeeding Their Infant by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



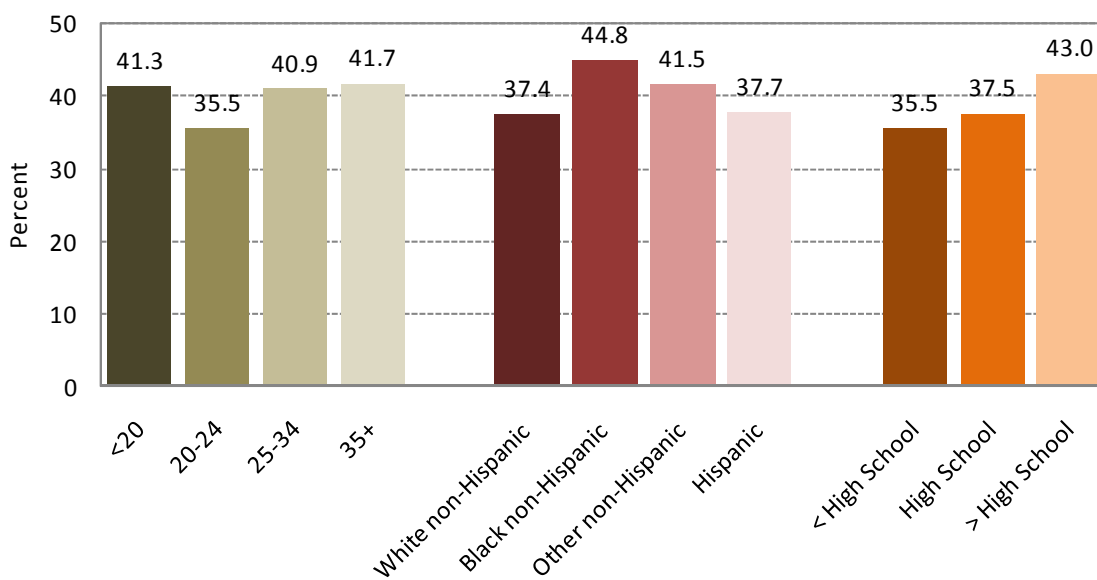
Exclusive Breastfeeding through Two Months of Age

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

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



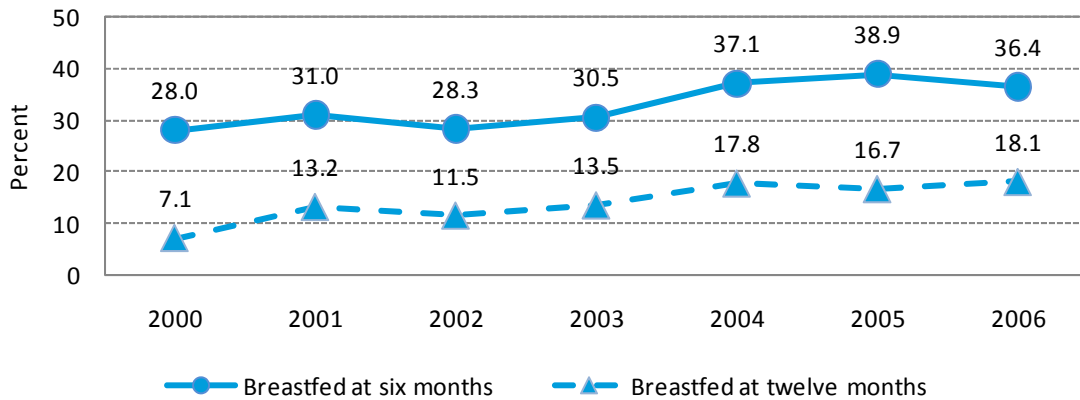
Percent of Mothers Who Reported Exclusively Breastfeeding Their Infants for at least Two Months by Maternal Age, Race/Ethnicity, and Education, Georgia, PRAMS 2006



Any Breastfeeding through Six and Twelve Months of Age

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

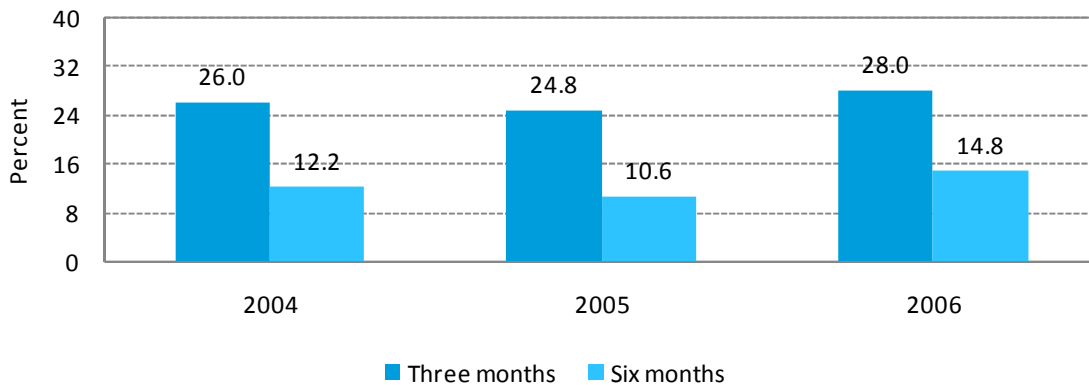
Percent of Women Who Reported Any Breastfeeding at Ages Six and Twelve Months by Year, Georgia, National Immunization Survey 2000 through 2006



Exclusive Breastfeeding through Three and Six Months of Age

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

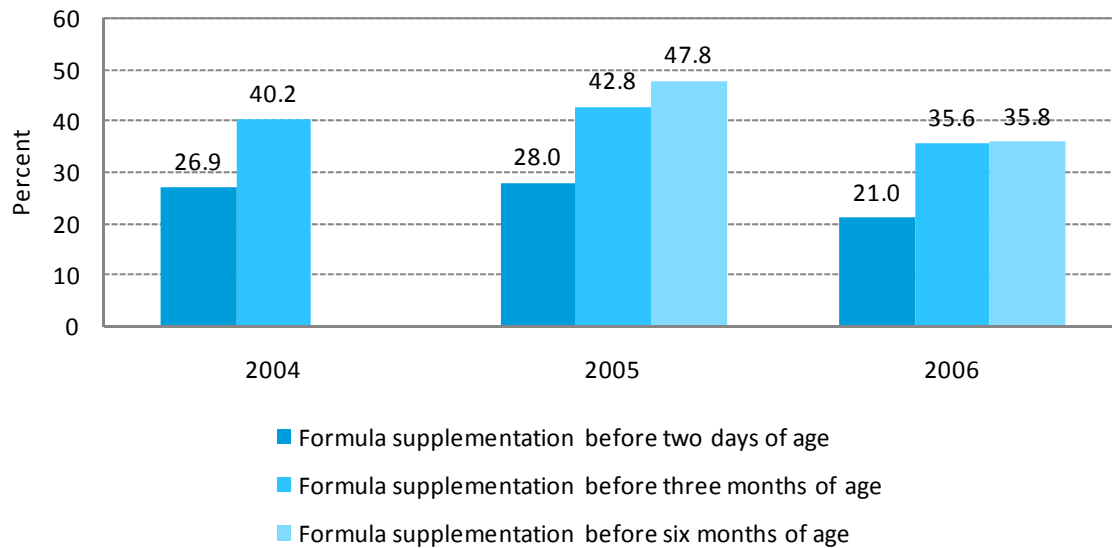
Percent of Women Who Reported Exclusive Breastfeeding at Ages Three and Six Months by Year, Georgia, National Immunization Survey 2004 through 2006



Formula Supplementation

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

Percent of Women Who Reported Formula Supplementation Before Ages Two Days, Three Months, and Six Months by Year, Georgia, National Immunization Survey 2004 through 2006



Barriers to Initiation and Reasons for Breastfeeding Cessation

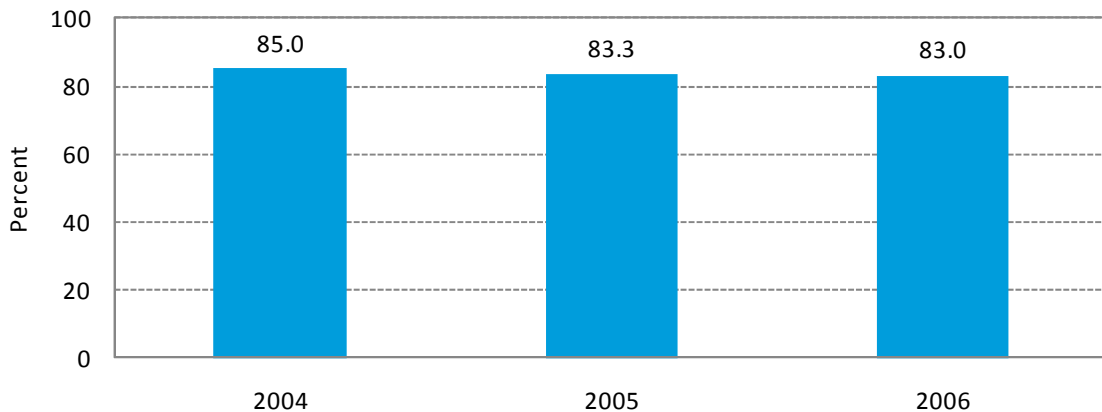
Not liking breastfeeding was the most commonly cited reason for not initiating breastfeeding. The percent of mothers citing this reason was more than double the next two most prevalent reasons cited. Limited milk supply and the belief that breastmilk was not satisfying their infant were the top two most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

Barriers to Initiation of Breastfeeding and Reasons for Breastfeeding Cessation, Georgia, PRAMS 2006				
Rank	Barriers to Initiation	Prevalence (%)	Reasons	Prevalence (%)
1	Did not like breastfeeding	51.7	Limited milk supply	39.8
2	Other barriers	20.9	Milk did not satisfy infant	37.9
3	Return to work or school	19.4	Difficulty nursing	25.5
4	Other children	17.3	Return to work or school	23.2
5	Mother too sick or on medication	11.9	Sore nipples	20.0
			Other reasons	

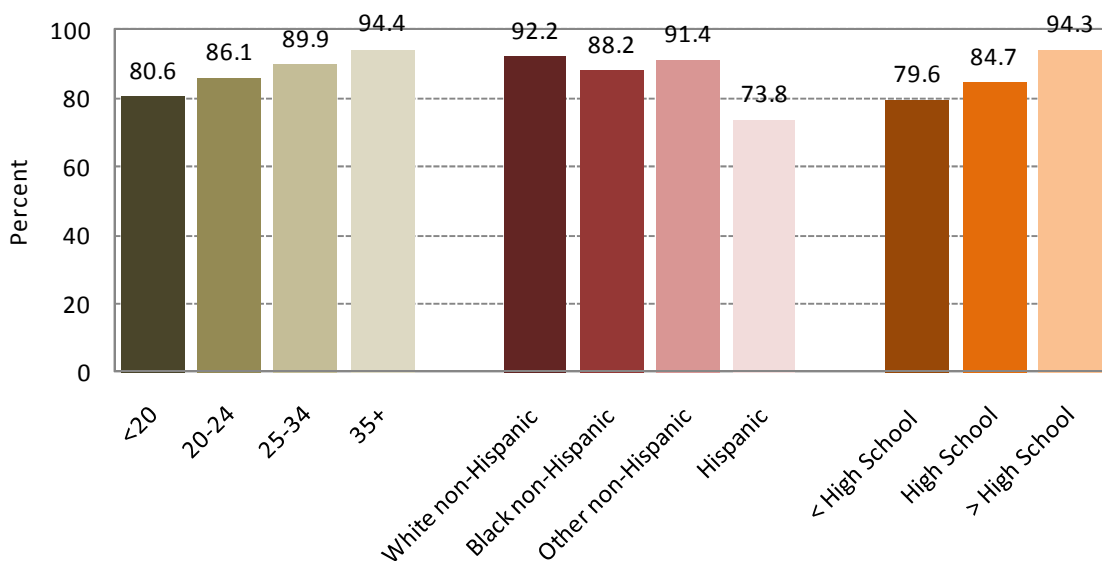
POSTPARTUM BIRTH CONTROL USE

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

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



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



WOMEN OF CHILDBEARING AGE

LEADING CAUSES OF MORTALITY AMONG WOMEN AGES 18 TO 44

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

Top 10 Causes of Mortality among Women Ages 18 to 44 Years, Georgia, Hospital Discharge Data 2007			
Ages 18 to 19 Year			
Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	28	1,554.0
2	Assault (Homicide)	6	333.0
3	Accidental Poisoning and Exposure to Noxious Substances	4	222.0
4	Septicemia	3	166.5
5	Leukemia	2	111.0
6	Intentional Self-Harm (Suicide)	2	111.0
7	Sickle Cell Trait and Disease	1	55.5
8	Meningococcal Infection	1	55.5
9	Pneumonia	1	55.5
10	Other Heart Disease	1	55.5
Ages 20 to 24 Years			
Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	65	3,607.5
2	Assault (Homicide)	15	832.5
3	Accidental Poisoning and Exposure to Noxious Substances	12	666.0
4	Intentional Self-Harm (Suicide)	12	666.0
5	Other Heart Disease	10	555.0
6	Septicemia	6	333.0
7	Human Immunodeficiency Virus (HIV) Disease	5	277.5
8	Pneumonia	4	222.0
9	Diseases of the Musculoskeletal System and Connective Tissue	4	222.0
10	Pregnancy, Childbirth and the Puerperium	3	166.5

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

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

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

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

ANALYSIS OF QUANTITATIVE DATA

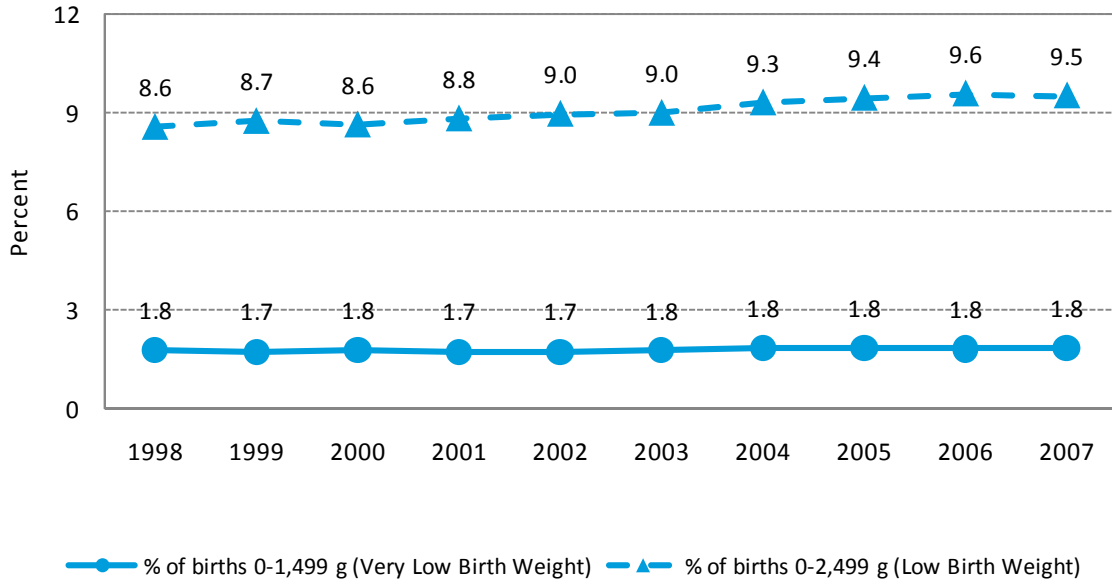
LOW BIRTH WEIGHT (LESS THAN 2,500 GRAMS) AND VERY LOW BIRTHWEIGHT (LESS THAN 1,500 GRAMS)

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

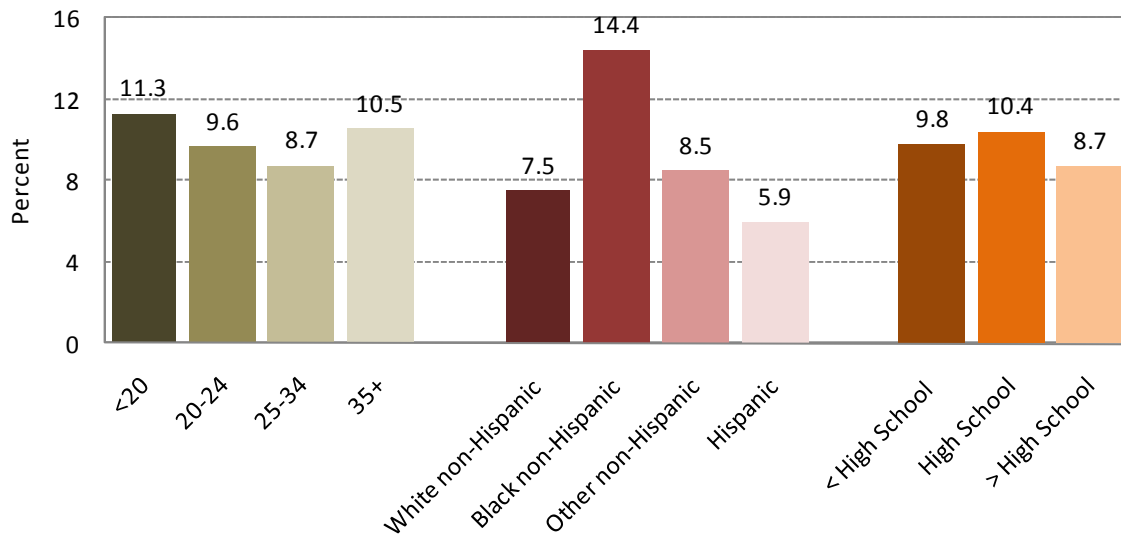
When stratifying by maternal age, race/ethnicity, and maternal education, low birth weight and very low birth weight had similar patterns. For both indicators, there was a U-shaped curve for maternal age. Women who had more than a high school education had a lower rate for each indicator than women with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

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

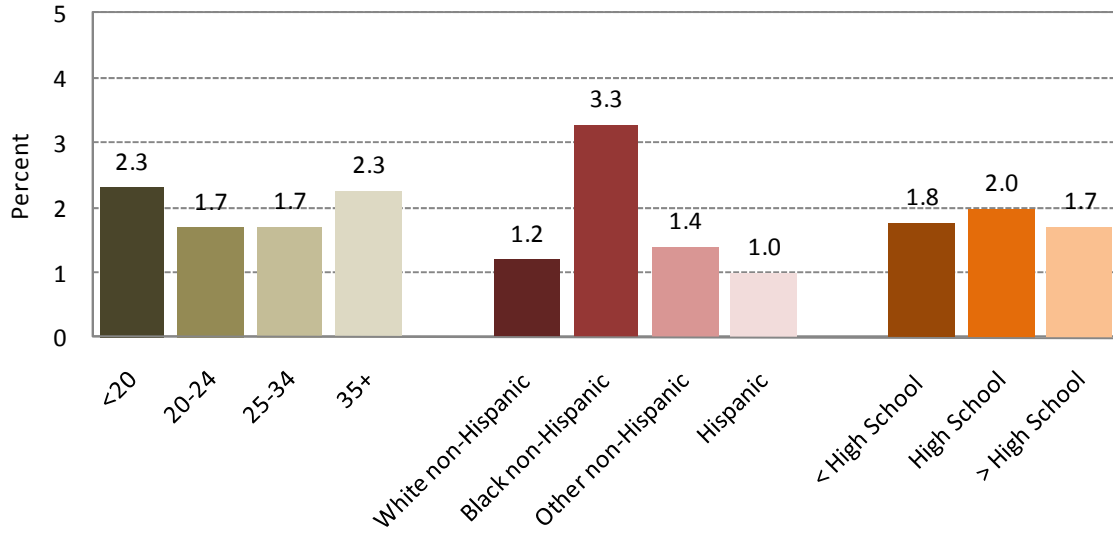
Percent of Deliveries with an Infant Weight of Less than 2,500 grams (Low Birth Weight) and Less than 1,500 grams (Very Low Birth Weight) by Year, Georgia, State Vital Records 1998 through 2007



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



Percent of Deliveries with an Infant Weight of Less than 1,500 grams
 (Very Low Birth Weight) by Maternal Age, Race/Ethnicity, and
 Education, Georgia, State Vital Records 2007



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

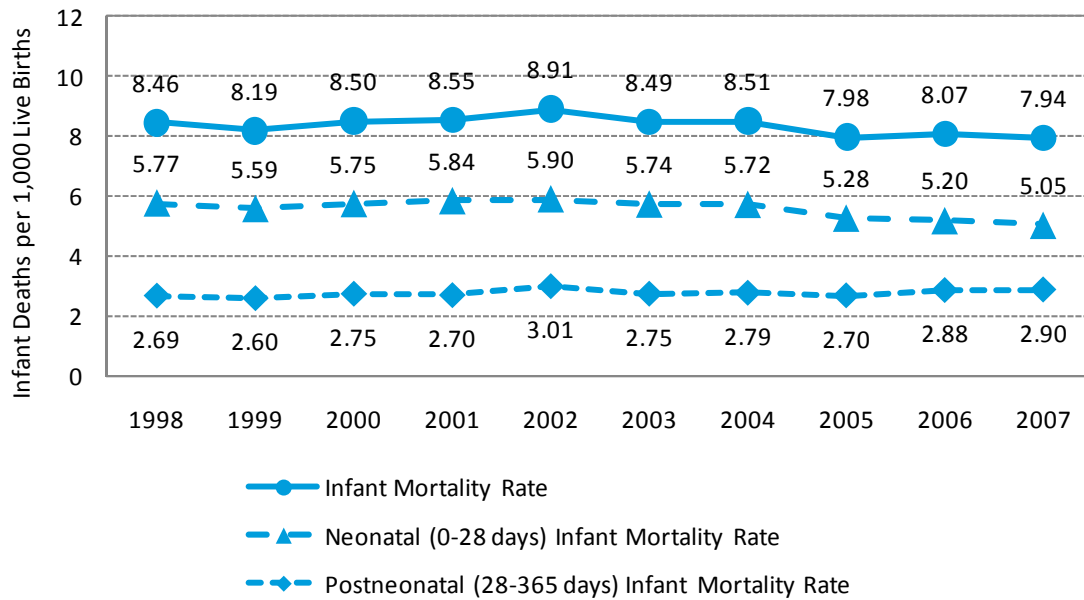
Beginning with 2003, there has been a decline in the neonatal infant mortality rate. In 2002, the neonatal mortality rate was 5.90 infant deaths in the first 28 days of life per 1,000 live births, but this rate declined to 5.05 infant deaths in the first 28 days of life per 1,000 live births by 2007.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

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

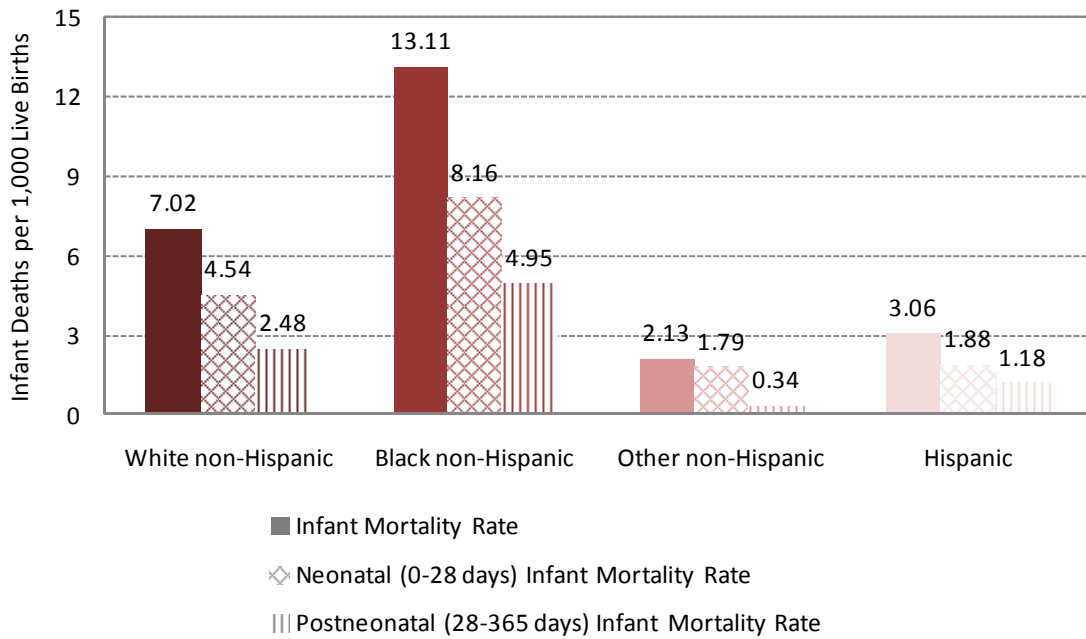
The linked birth-death record allowed for examination of the association between maternal educational attainment and maternal age and infant mortality. Younger maternal age and maternal educational attainment of a high school degree or less were both associated with greater infant mortality rates.

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

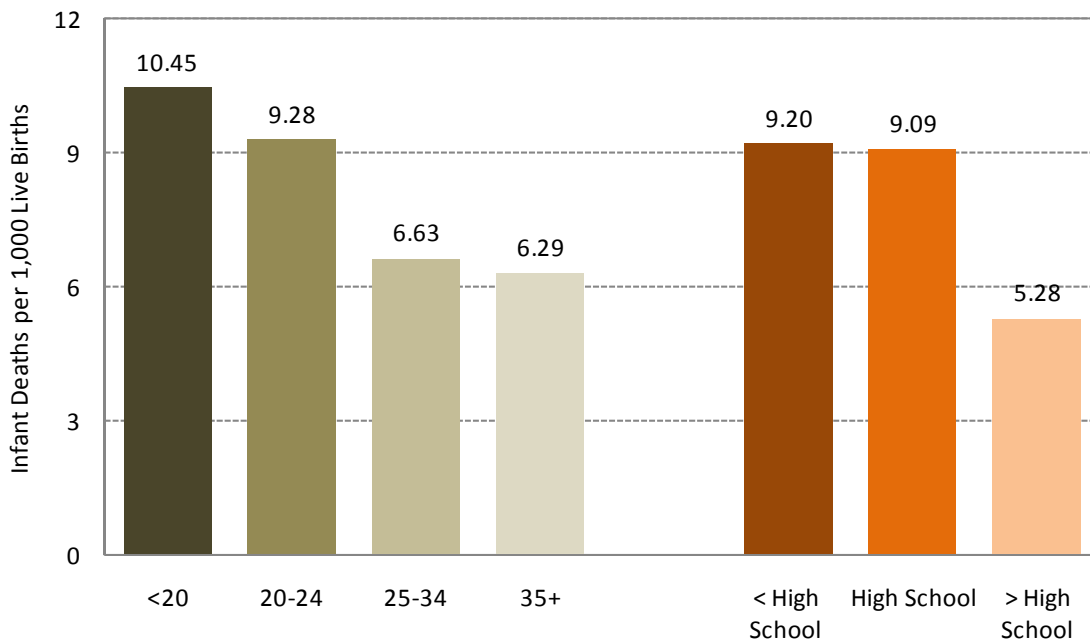
Infant Mortality, Neonatal Infant Mortality, and Postneonatal Infant Mortality by Year, Georgia, State Vital Records 1998 through 2007



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



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



EXCESSIVE INFANT DEATHS AND PERINATAL PERIODS OF RISK

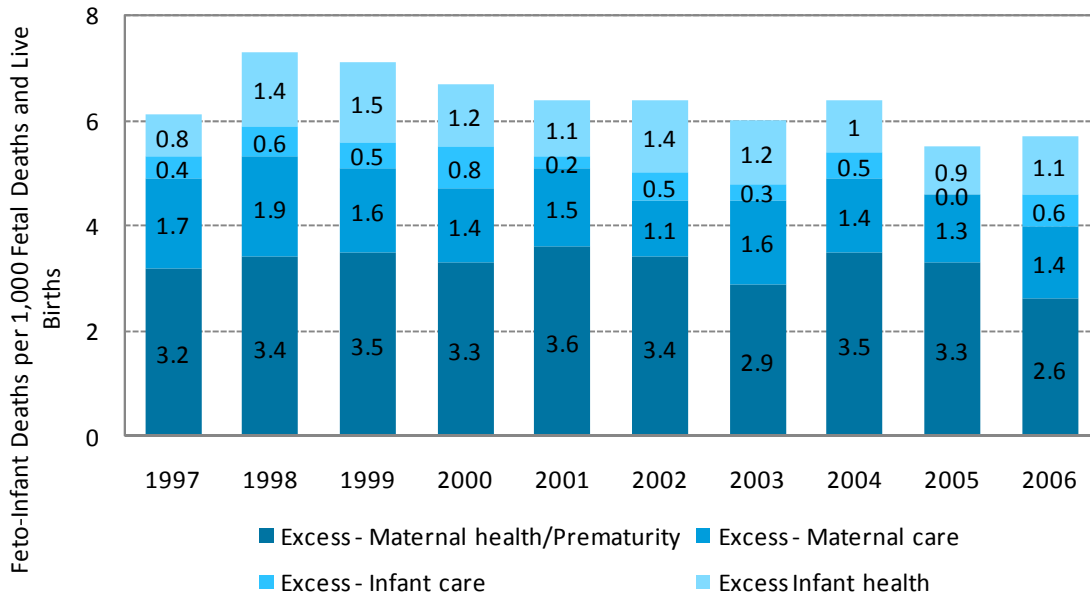
The Perinatal Periods of Risk (PPOR) framework allows for the calculation of excess death by subtracting the infant mortality of a selected subgroup from the fetoinfant mortality rate (fetal deaths of at least 20 weeks gestational age and all infant deaths) in the general population. The reference group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

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

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

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

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



INFANT BEDSHARING

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

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

Top 10 infant inpatient diagnoses (based on ICD codes) by Race, Georgia, Hospital Discharge Data 2007			
Rank	Diagnosis – All Infants	Diagnosis – White Infants	Diagnosis – Black Infants
1	Pneumonia	Pneumonia	Pneumonia
2	Disorders Per Short Gestation and LBW, not elsewhere classified	Disorders Per Short Gestation and LBW, not elsewhere classified	Disorders Per Short Gestation and LBW, not elsewhere classified
3	Respiratory Distress of Newborn	Respiratory Distress of Newborn	Respiratory Distress of Newborn
4	Asthma	Asthma	Asthma
5	Septicemia	Infections of Kidney	Septicemia
6	Unknown	Septicemia	Unknown
7	Infections of Kidney	Unknown	Sickle Cell Trait and Disease
8	Congenital Malformations of the Nervous System	Congenital Malformations of the Nervous System	Assault (Homicide)
9	Falls	Falls	Congenital Malformations of the Nervous System
10	Sickle Cell Trait and Disease	Other Heart Disease	Falls

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

INFANT EMERGENCY ROOM VISITS

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

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

WELL INFANT CARE THROUGH ONE WEEK FOLLOWING DISCHARGE

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

ANALYSIS OF QUANTITATIVE DATA

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

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

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

Top 10 Causes of Mortality among Children Ages 1 through 21 Years, Georgia, State Vital Records 2007

Ages 6 to 9 Years

Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	9	607.5
2	Assault (Homicide)	8	540.0
3	Leukemia	7	472.5
4	Other Heart Disease	6	405.0
5	In Situ and Benign Neoplasms	4	270.0
6	Septicemia	3	202.5
7	Accidental Discharge of Firearms	3	202.5
8	Accidental Exposure to Smoke, Fire and Flames	2	135.0
9	Accidental Drowning and Submersion	2	135.0
10	Malignant Neoplasms of Meninges, Brain, and other parts of CNS	2	135.0

Ages 10 to 14 Years

Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	32	2,160.0
2	Assault (Homicide)	8	540.0
3	Cerebrovascular Disease	6	405.0
4	Other Heart Disease	5	337.5
5	Leukemia	5	337.5
6	Intentional Self-Harm (Suicide)	3	202.5
7	Human Immunodeficiency Virus (HIV) Disease	3	202.5
8	Accidental Exposure to Smoke, Fire and Flames	3	202.5
9	Accidental Drowning and Submersion	3	202.5
10	Aortic Aneurysm and Dissection	2	135.0

Ages 15 to 17 Years

Rank	Diagnosis	Count	Years of Potential Life Lost*
1	Motor Vehicle Accidents	85	4,717.5
2	Assault (Homicide)	35	1,942.5
3	Intentional Self-Harm (Suicide)	16	888.0
4	Accidental Poisoning and Exposure to Noxious Substances	10	555.0
5	Other Heart Disease	7	388.5
6	Leukemia	5	277.5
7	Accidental Drowning and Submersion	5	277.5
8	Other Forms of Chronic Ischemic Heart Disease	3	166.5
9	Pregnancy, Childbirth and the Puerperium	3	166.5
10	Septicemia	2	111.0

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

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

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

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

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

Top 10 Causes for Emergency Room Visits among Children Ages 1 through 21 Years, Georgia, Hospital Discharge Data 2007

Ages 6 to 9 Years

Rank	Diagnosis	Count
1	Falls	14,375
2	Asthma	6,362
3	Motor Vehicle Accidents	3,008
4	Diseases of the Musculoskeletal System and Connective Tissue	2,942
5	Unknown	1,990
6	Pneumonia	1,494
7	Bronchitis and Chronic Unspecified	994
8	Influenza	571
9	Assault (Homicide)	346
10	Sickle Cell Trait and Disease	253

Ages 10 to 14 Years

Rank	Diagnosis	Count
1	Falls	16,984
2	Diseases of the Musculoskeletal System and Connective Tissue	5,771
3	Motor Vehicle Accidents	5,244
4	Asthma	4,761
5	Unknown	2,599
6	Assault (Homicide)	1,697
7	Bronchitis and Chronic Unspecified	849
8	Pneumonia	728
9	Influenza	388
10	Intentional Self-Harm (Suicide)	304

Ages 15 to 17 Years

Rank	Diagnosis	Count
1	Motor Vehicle Accidents	7,398
2	Falls	7,106
3	Diseases of the Musculoskeletal System and Connective Tissue	5,456
4	Pregnancy, Childbirth, and the Puerperium	5,172
5	Assault (Homicide)	2,813
6	Asthma	2,129
7	Unknown	2,061
8	Intentional Self-Harm (Suicide)	738
9	Bronchitis and Chronic Unspecified	651
10	Infections of Kidney	492

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

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

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

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

Top 10 Causes for Inpatient Hospitalization among Children Ages 1 through 21 Years, Georgia, Hospital Discharge Data 2007

Ages 6 to 9 Years

Rank	Diagnosis	Count
1	Asthma	846
2	Pneumonia	450
3	Sickle Cell Trait and Disease	223
4	Unknown	205
5	Diabetes Mellitus	181
6	Diseases of the Musculoskeletal System and Connective Tissue	179
7	Motor Vehicle Accidents	162
8	Falls	126
9	Infections of Kidney	73
10	Nephritis, Nephrotic Syndrome and Nephrosis	65

Ages 10 to 14 Years

Rank	Diagnosis	Count
1	Asthma	481
2	Diseases of the Musculoskeletal System and Connective Tissue	422
3	Diabetes Mellitus	391
4	Pregnancy, Childbirth and the Puerperium	323
5	Sickle Cell Trait and Disease	306
6	Motor Vehicle Accidents	286
7	Unknown	251
8	Pneumonia	246
9	Falls	171
10	Infections of Kidney	74

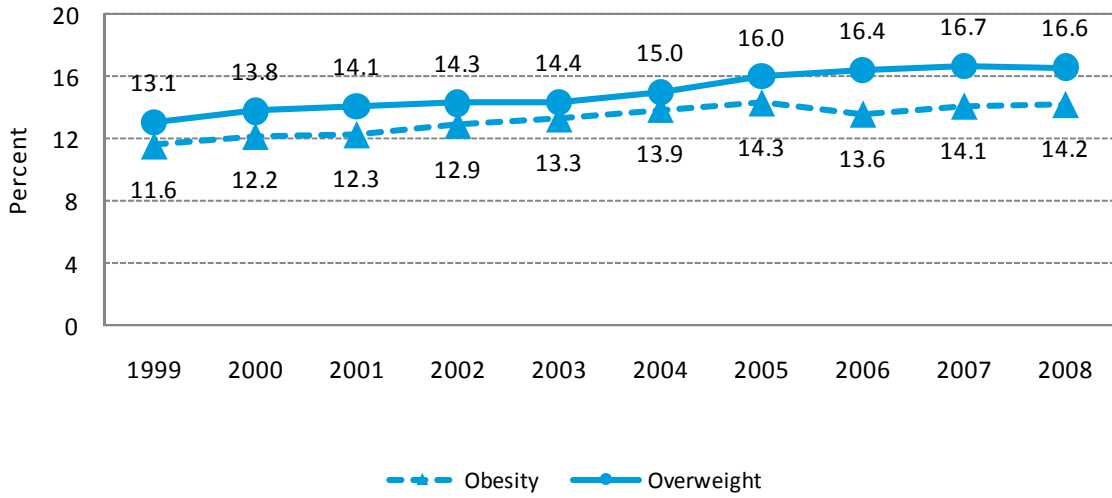
Ages 15 to 17 Years

Rank	Diagnosis	Count
1	Pregnancy, Childbirth and the Puerperium	6,283
2	Motor Vehicle Accidents	477
3	Diseases of the Musculoskeletal System and Connective Tissue	321
4	Sickle Cell Trait and Disease	315
5	Diabetes Mellitus	291
6	Unknown	245
7	Intentional Self-Harm (Suicide)	185
8	Pneumonia	160
9	Asthma	128
10	Falls	123

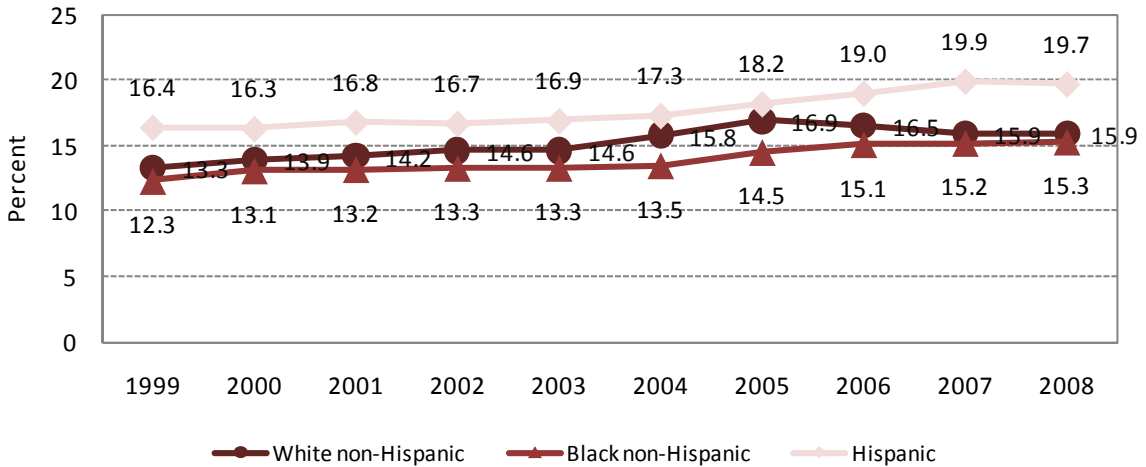
The percent of children 2 to 5 years of age enrolled in WIC who were overweight, which is defined among children as a BMI greater than the 85th percentile and less than the 95th percentile, increased 26.7 percent between 1998 and 2008. The increase in overweight was greatest among Black children 2 to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

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

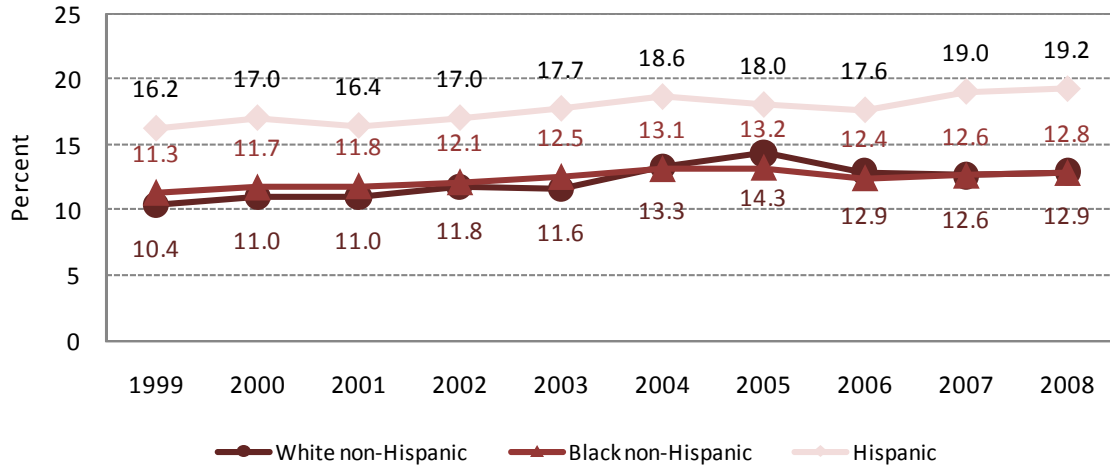
Prevalence of Overweight and Obesity among WIC Participants Ages Two to Five Years, Georgia, PedNSS 1999 through 2008



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



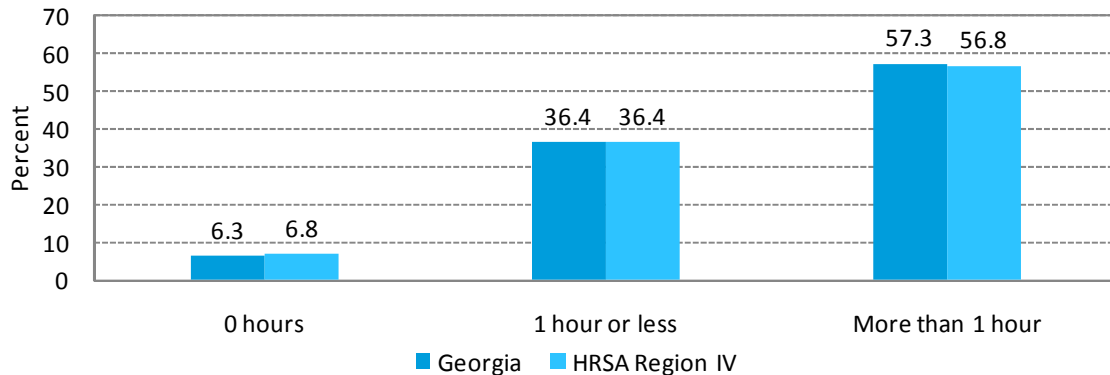
Prevalence of Overweight (85th to less than the 95th percentile) among WIC Participants Ages Two to Five Years by Race/Ethnicity, Georgia, PedNSS 1999 through 2008



SCREEN TIME AMONG CHILDREN AGES 1 TO 5 YEARS

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

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

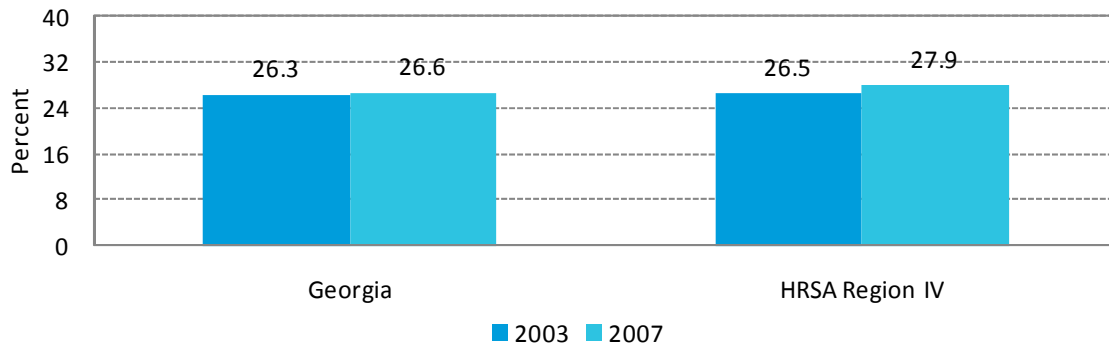


SOCIAL/EMOTIONAL DEVELOPMENT

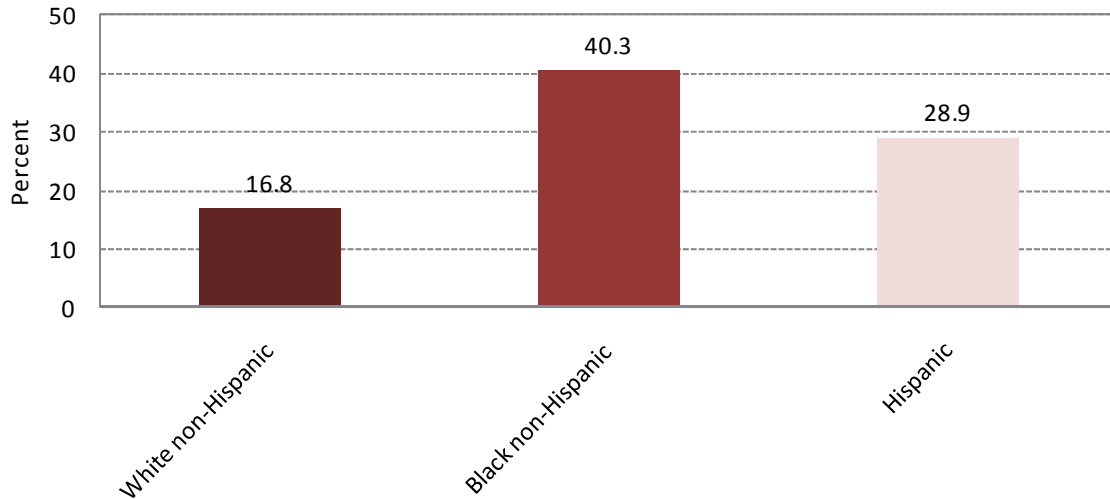
RISK OF DEVELOPMENTAL OR BEHAVIORAL PROBLEMS

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

Percent of Children Ages 4 Months to 5 Years Determined to be at Moderate or High Risk for Developmental or Behavioral Problems based on Parents' Specific Concerns, Georgia and HRSA Region IV, National Survey of Children's Health 2003 and 2007



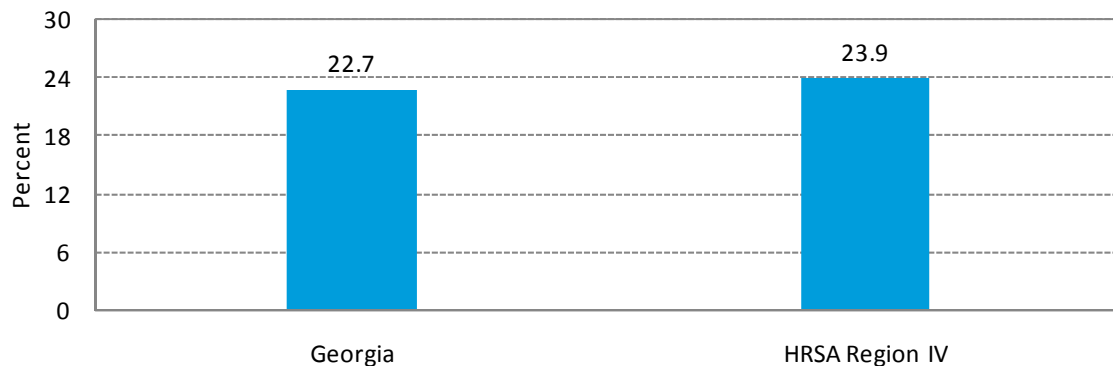
Percent of Children Ages 4 Months to 5 Years Determined to be at Moderate or High Risk for Developmental or Behavioral Problems based on Parents' Specific Concerns, Georgia, National Survey of Children's Health 2007



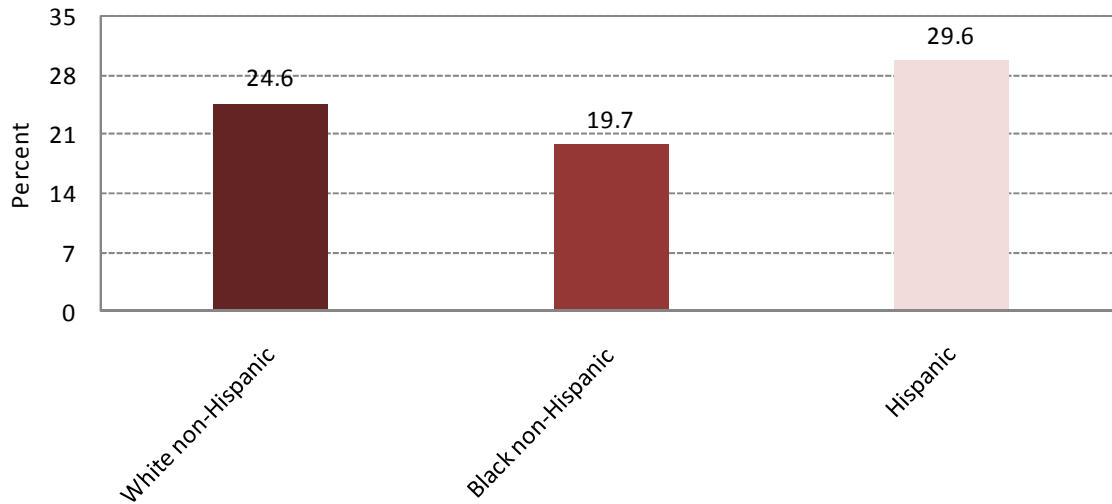
DEVELOPMENTAL SCREENING

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

Percent of Children Ages 10 Months to 5 Years Who Received a Standardized Screening for Developmental or Behavioral Problems, Georgia and HRSA Region IV, National Survey of Children's Health 2003 and 2007



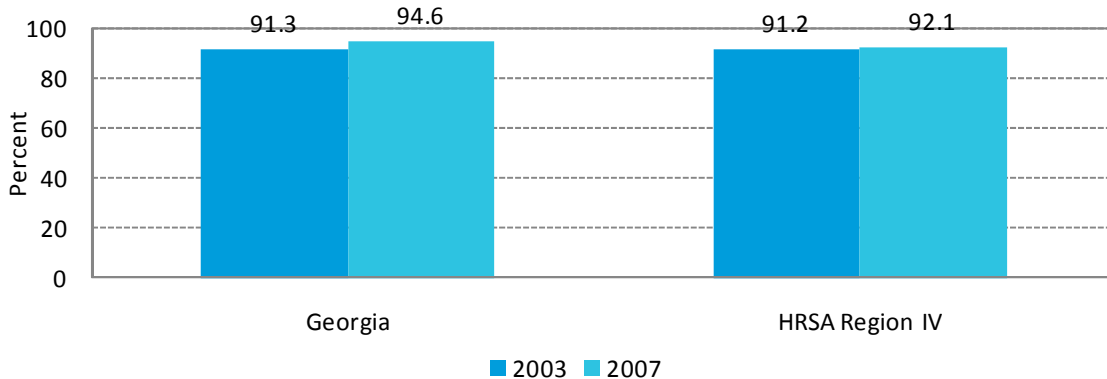
Percent of Children Ages 10 Months to 5 Years Who Received a Standardized Screening for Developmental or Behavioral Problems by Age and Race/Ethnicity, Georgia, National Survey of Children's Health 2007



POSITIVE SOCIAL SKILLS

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

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

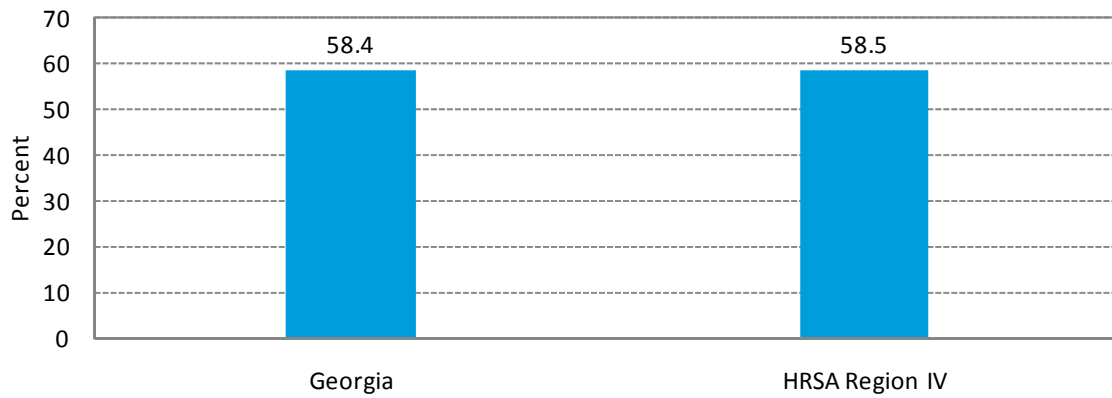


All children should receive medical care through a medical home. However, in Georgia and HRSA Region IV, about 58 percent of children received care that met the American Academy of Pediatrics' (AAP) definition of a medical home. Medical home refers to medical care for infants, children, and adolescents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

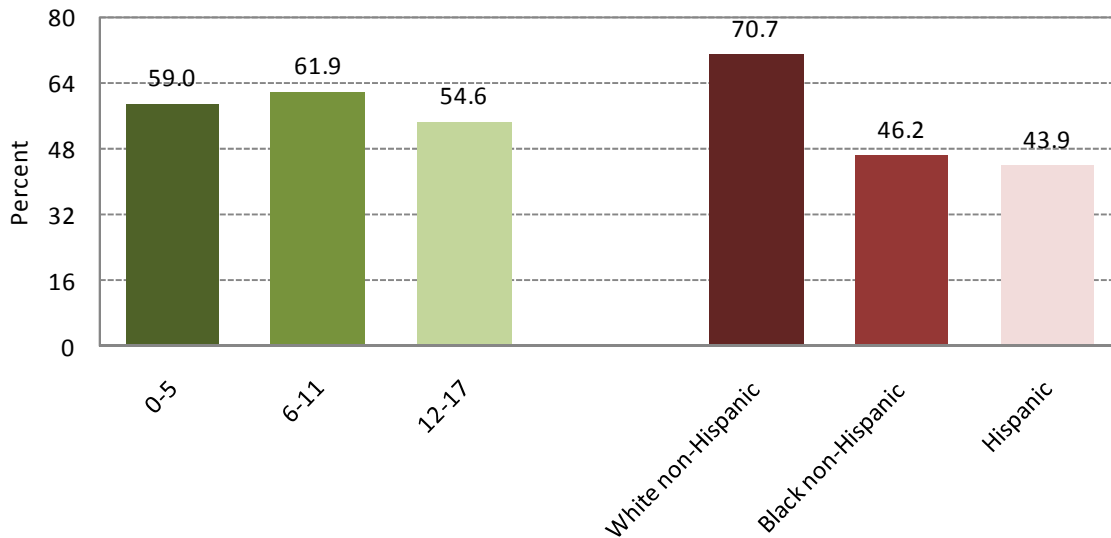
comprehensive primary pediatric care from infancy through young adulthood, with availability 24 hours a day, seven days a week, from a pediatrician or physician whom families trust."

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

Percent of Children Who Received Care within a Medical Home,
Georgia and HRSA Region IV, National Survey of Children's Health
2007



Percent of Children Who Received Care within a Medical Home by Age and Race/Ethnicity, Georgia, National Survey of Children's Health 2007



BIRTHS AMONG ADOLESCENT FEMALES AGES 15 TO 19 YEARS

The adolescent (15 to 19 years of age) birth rate declined from 1999 through 2005, but increased in 2006 and 2007. Even with these increases, the overall decline in the adolescent birth rate in Georgia was 14.2 percent between 1998 and 2007.

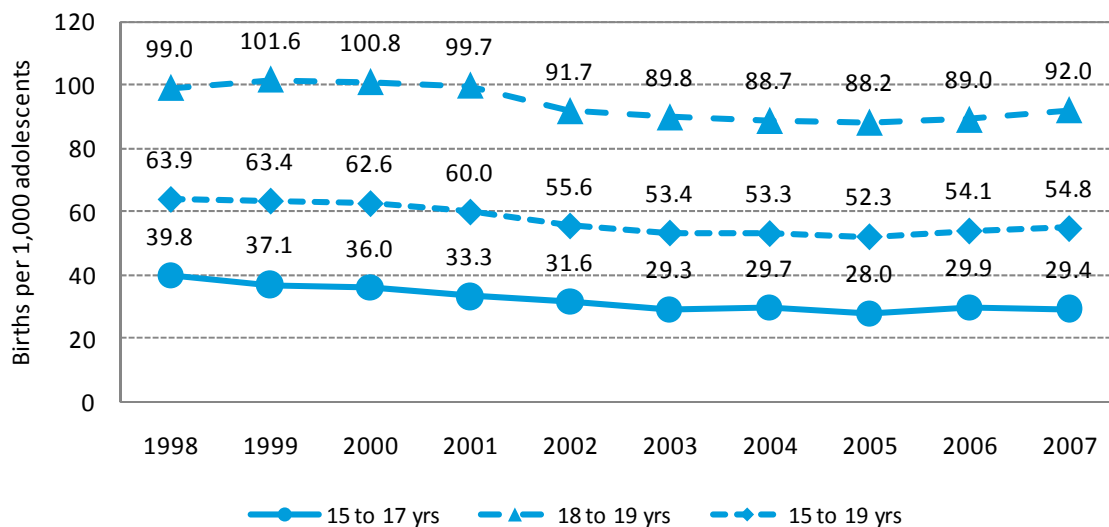
Among younger adolescents (15 to 17 years of age), there were declines in the birth rate from 1999 through 2003. From 2004 through 2007, the birth rate among younger adolescents fluctuated with no discernable pattern.

Among older adolescents (18 to 19 years of age), the birth rate declined from 2000 through 2005. The greatest decline occurred between 2001 and 2002 when the birth rate among older adolescents declined 8.0 percent. Among older adolescents, there was an increase in the birth rate from 2005 to 2006 and 2006 to 2007.

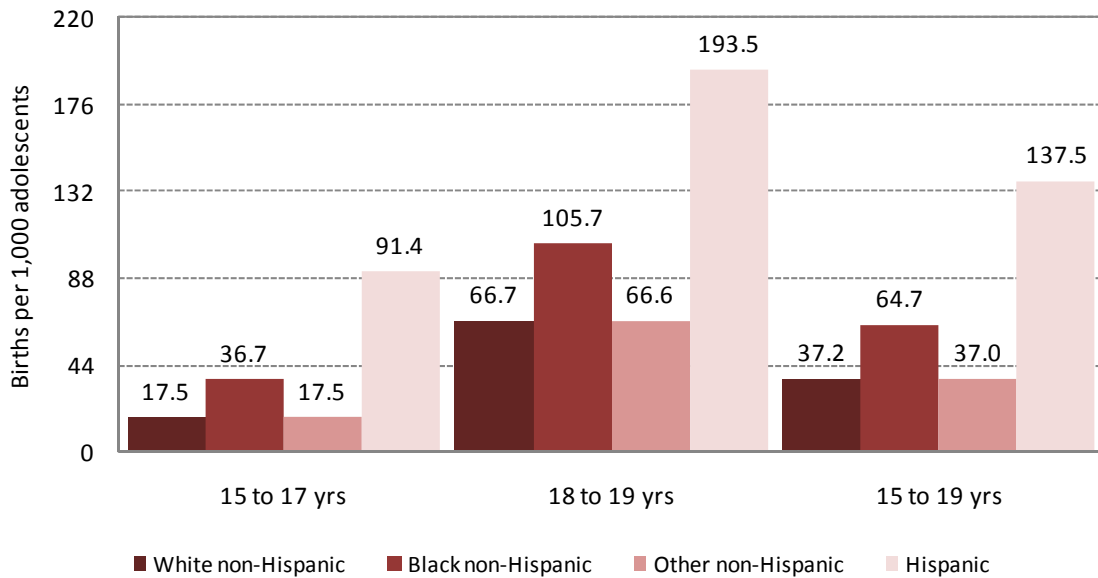
Regardless of age, Hispanic adolescents had the greatest adolescent birth rates among all racial/ethnic groups. Among adolescents 15 to 17 years of age, the birth rate among Hispanic adolescents was more than twice that of the next greatest group (Black adolescents, 36.7 births per 1,000 adolescents 15 to 17 years of age). Among adolescents 18 to 19 years of age, the birth rate among Hispanic adolescents was nearly 200 births per 1,000 adolescents 18 to 19 years of age.

Among Georgia's 18 public health districts, birth rates among adolescents 15 to 19 years of age exceeded 70 births per 1,000 adolescents 15 to 19 years of age in the South Public Health District, Southeast Public Health District, and Southwest Public Health District. In six of the 18 public health districts, the adolescent birth rate among this group was less than 50 births per 1,000 adolescents 15 to 19 years of age.

Adolescent Birth Rate per 1,000 by Year, Georgia, State Vital Records
1998 through 2007



Adolescent Birth Rate per 1,000 by Race/Ethnicity and Maternal Age, Georgia, State Vital Records 2007



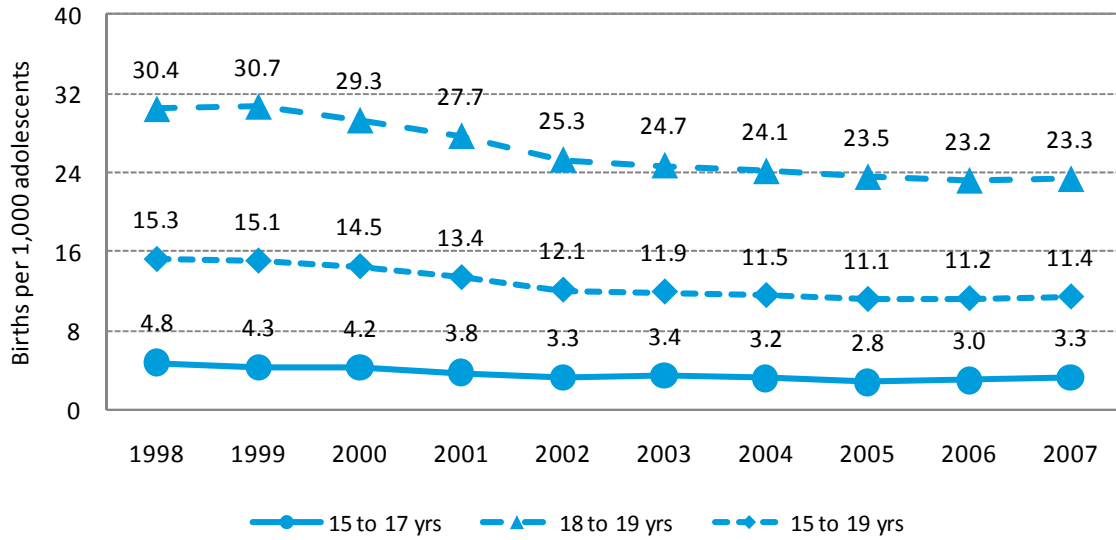
REPEAT BIRTHS AMONG ADOLESCENT FEMALES AGES 15 TO 19 YEARS

The rate of repeat adolescent birth declined in each year between 1998 and 2006. In 2007, the rate of repeat birth among adolescents 15 to 19 years of age increased. Among adolescents 15 to 17 years of age, the decline in the rate of repeat birth was 31.3 percent between 1998 and 2007. Among adolescents 18 to 19 years of age the decline was 23.4 percent. While this rate has declined, in 2007, there were 639 repeat births among adolescents 15 to 17 years of age and 3,114 repeat births among adolescents 18 to 19 years of age.

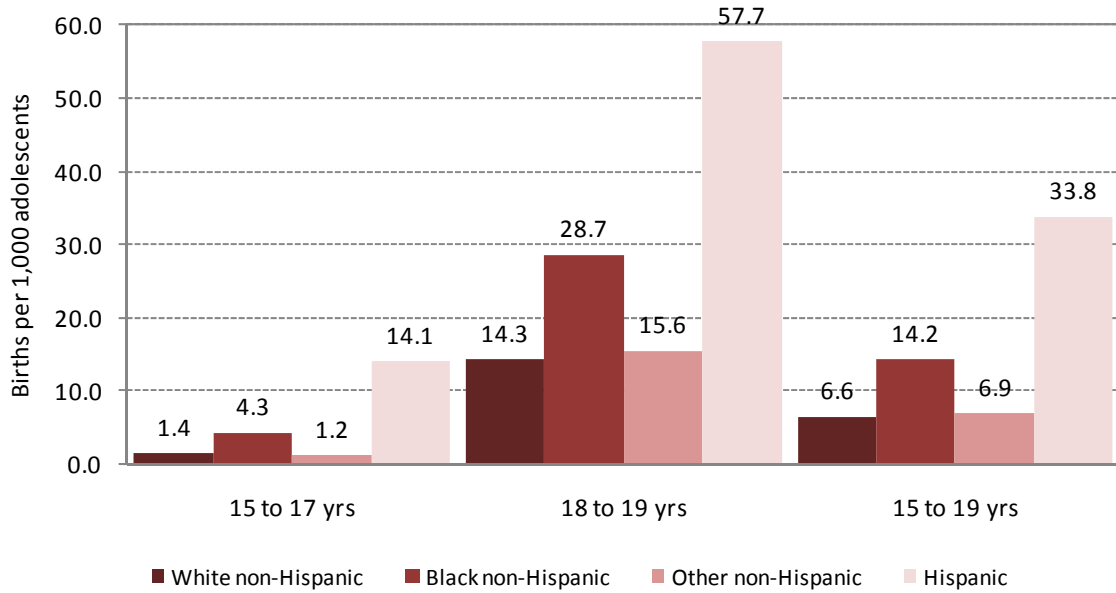
The greatest rate of repeat adolescent birth was found among Hispanic adolescents regardless of age. Among adolescents 15 to 17 years of age, the rate of repeat birth among Hispanic adolescents was ten times greater than the rate of repeat birth among White adolescents and more than three times greater than among Black adolescents. Among adolescents 18 to 19 years of age, the rate of repeat birth among Hispanic adolescents was more than double the rate of repeat birth among Black adolescents.

Among Georgia's 18 public health districts, the South Public Health District, Southeast Public Health District, and Southwest Public Health District each had rates of repeat birth among adolescents 15 to 19 years of age in excess of 4.5 per 1,000 adolescents 15 to 19 years of age. Examination of case counts revealed that a quarter of all cases of repeat birth among adolescents 15 to 17 years of age were found in DeKalb Public Health District, East Metro Public Health District, and Fulton Public Health District. Among adolescents 18 to 19 years of age, in addition to Fulton and East Metro Public Health Districts, the LaGrange Public Health District, Northwest Public Health District, and Southwest Public Health District each had more than 600 cases of repeat birth among adolescents 18 to 19 years of age.

Repeat Adolescent Birth Rate per 1,000 by Year, Georgia, State Vital Records 1998 through 2007



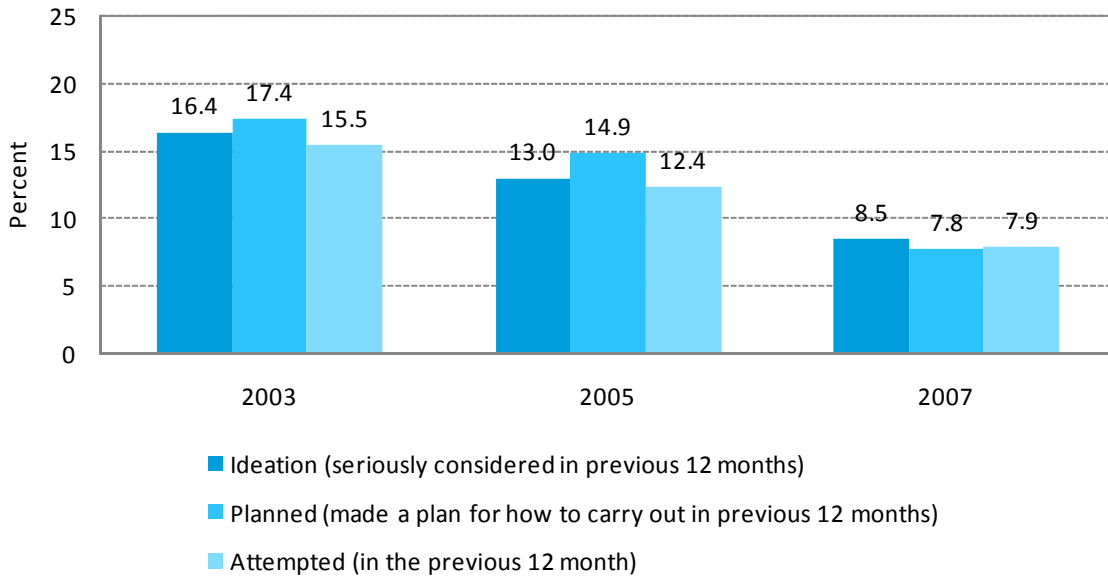
Repeat Adolescent Birth Rate per 1,000 by Race/Ethnicity, Georgia, State Vital Records 2007



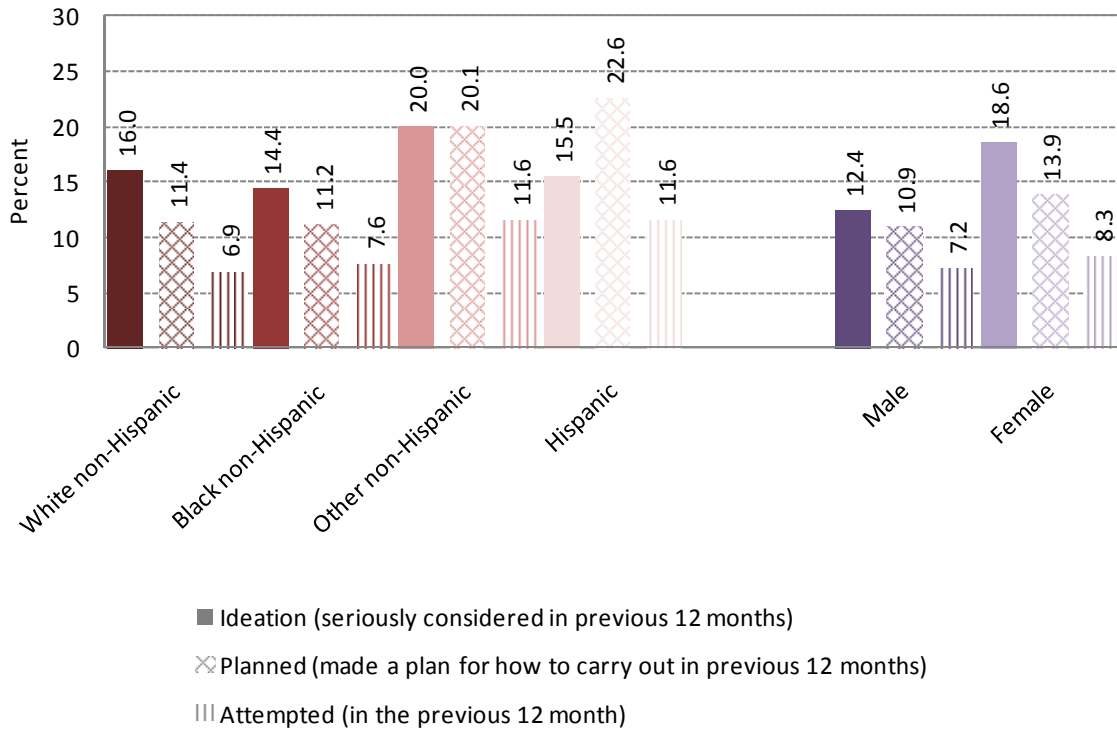
SUICIDAL IDEATION, SUICIDE PLANNING, AND SUICIDE ATTEMPTS IN THE PAST TWELVE MONTHS AMONG HIGH SCHOOL STUDENTS

There was a decline in suicidal ideation, suicide planning, and suicide attempts in 2007 compared to 2003 and 2005. The decline from 2005 to 2007 replicated a decline, though not as large, between 2003 and 2005. Greater than one in five Hispanic high school students reported having made a plan for how to carry out a suicide in the previous twelve months and more than one in ten Hispanic high school students reported attempting suicide in the previous twelve months. These rates were greater than those reported among White and Black high school students. Female high school students had greater rates of ideation, planning, and attempting suicide compared to male high school students.

Suicidal Ideation, Planning, and Attempts among High School Students by Year, Georgia, YRBS 2003, 2005, and 2007



Suicidal Ideation, Planning, and Attempts among High School Students by Race/Ethnicity and Sex, Georgia, YRBS 2007

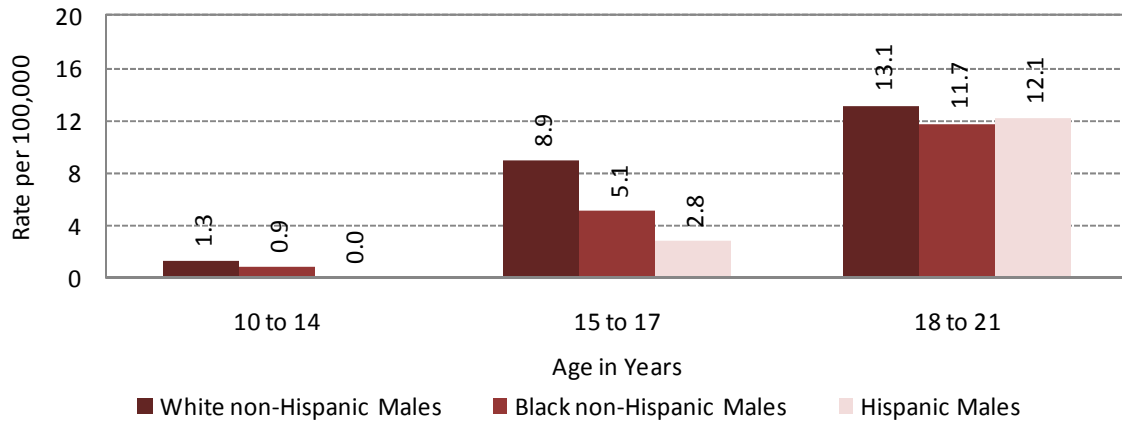


SUICIDE MORTALITY AMONG ADOLESCENTS 10 TO 21 YEARS OF AGE

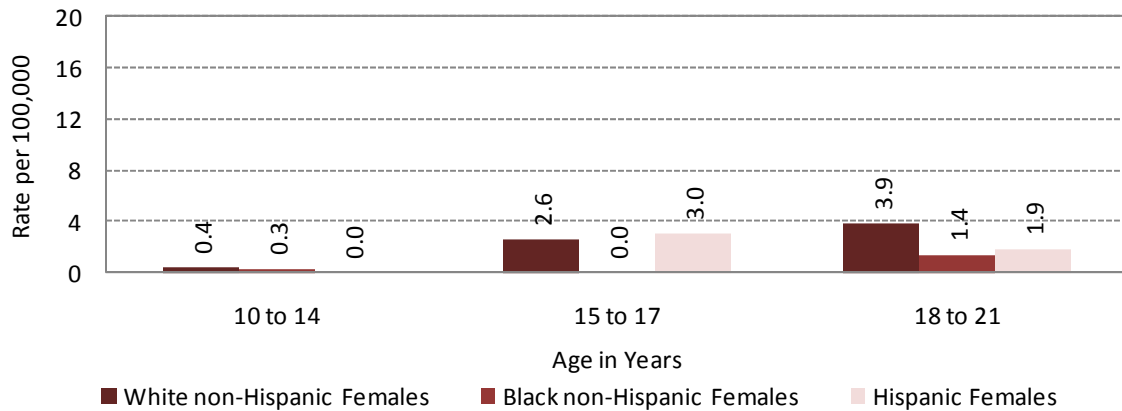
As noted earlier, in 2007, intentional self harm/suicide was the third leading cause of death among children 15 to 21 years of age. Suicide rates fluctuated between 1998 and 2007. Overall, suicide rates from 2002 through 2007 were generally lower than suicide rates between 1998 and 2001. The suicide rate among White children 15 to 17 years of age was greater than that among Black children 15 to 17 years of age and more than three times greater than the suicide rate among Hispanic children 15 to 17 years of age. While rates were similar between race/ethnic groups among children 18 to 21 years of age, the case counts are substantially different. Among children 18 to 21 years of age, there were 75 suicide deaths among children with White race/ethnicity. This compared to 37 suicide deaths among children with Black race/ethnicity and 11 suicide deaths among children with Hispanic race/ethnicity. Males had greater suicide rates than females for all age and racial/ethnic groups. Between 2005 and 2007, females accounted for 17 percent of all suicide deaths.

Age Group	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
10 to 14	6.3	5.7	4.9	6.7	4.8	5.8	5.4	3.2	2.8	4.7
15 to 17	27.7	25.8	21.4	28.5	24.8	27.7	16.5	22.3	19.7	21.0
18 to 21	34.3	29.3	26.8	35.3	22.3	22.0	22.7	24.6	28.5	28.2

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



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

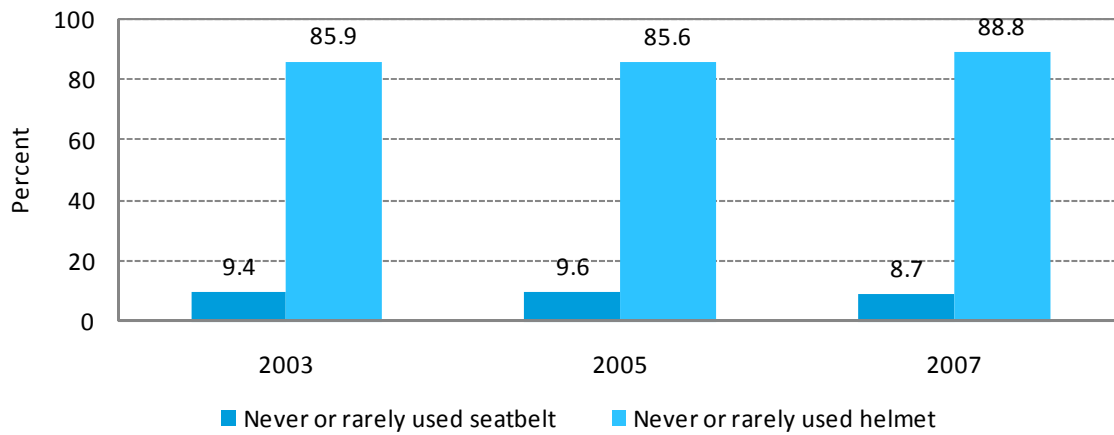


USE OF SAFETY DEVICES – SEAT BELTS AND HELMETS AMONG HIGH SCHOOL STUDENTS

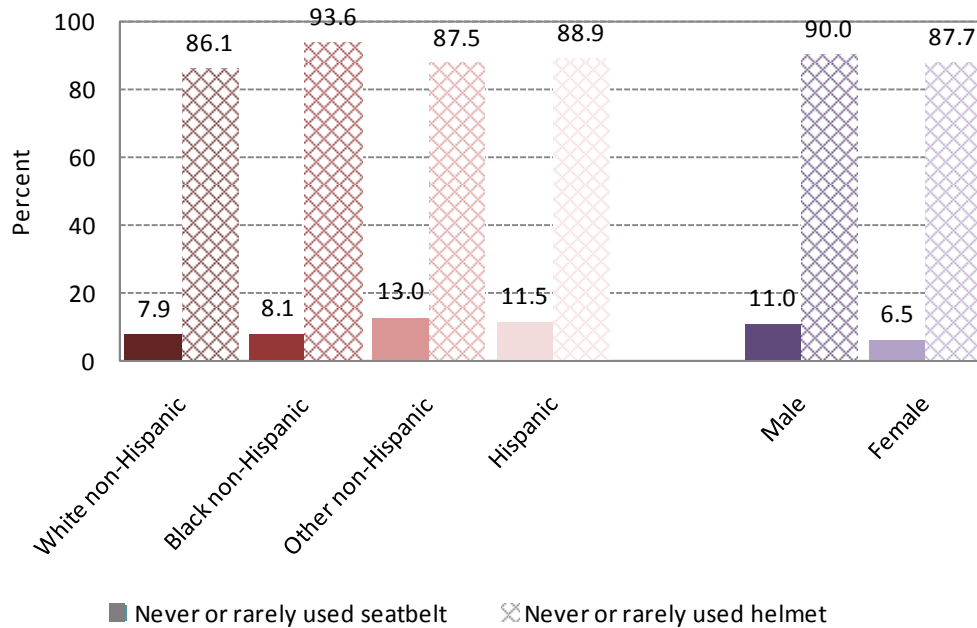
Less than 10 percent of high school students reported either never or rarely using their seat belt. The percent of male high school students who either never or rarely used their seat belts was nearly double that of female high school students.

Unlike seat belt use, nearly 90 percent of high school students either never or rarely used bicycle helmets. The percent of high school students who either never or rarely used bicycle helmets exceeded 90 percent among Black high school students and male high school students.

Seat Belt and Bicycle Helmet Use among Students in High School, Georgia, YRBS 2003, 2005, and 2007



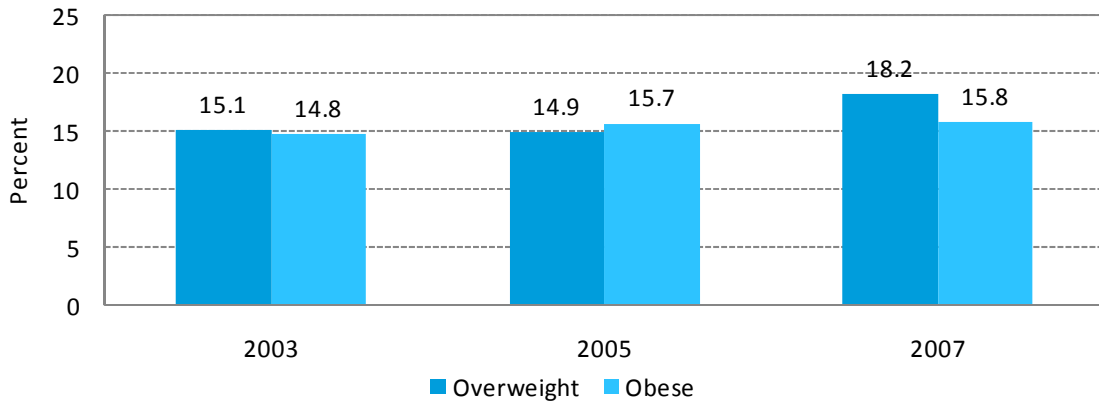
Seat Belt and Bicycle Helmet Use among Students in High School by Race/Ethnicity and Gender, Georgia, YRBS 2007



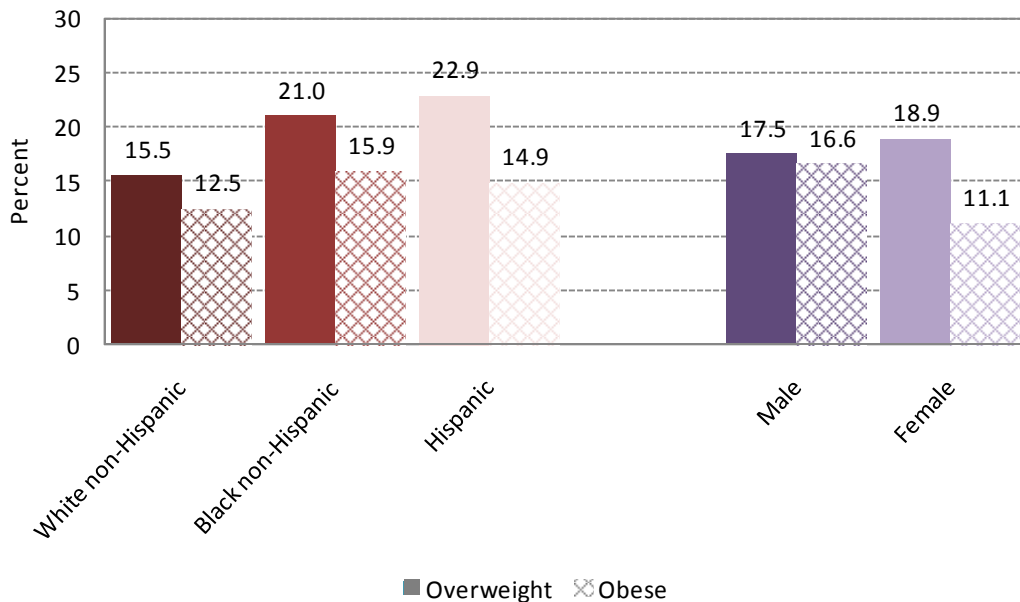
OBESITY AND OVERWEIGHT AMONG HIGH SCHOOL STUDENTS

In 2008, nearly one in five high school students in Georgia was overweight. This was approximately a three percentage point increase from previous years. Obesity rates have remained relatively constant between 2003 through 2007. Rates of overweight and obesity were greater among Black and Hispanic high school students compared to White high school students. The rate of overweight was greater among female high school students, but the rate of obesity was greater among male high school students.

Prevalence of Obesity and Overweight among Students in High School by Year, Georgia, YRBS 2003, 2005, and 2007



Prevalence of Obesity and Overweight among Students in High School by Race/Ethnicity and Gender, Georgia, YRBS 2007

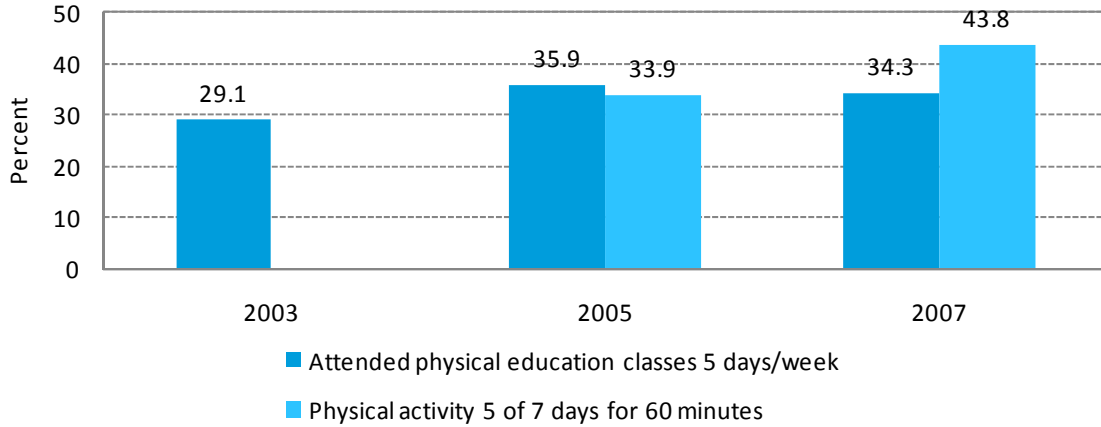


PHYSICAL ACTIVITY AMONG HIGH SCHOOL STUDENTS

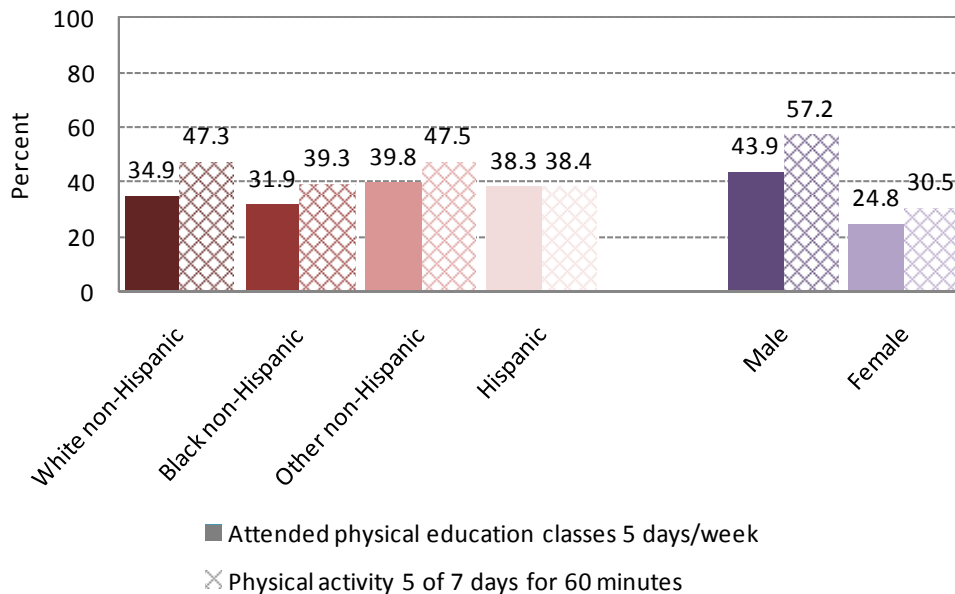
In 2005 and 2007, more than a third of high school students attended physical education class daily. However, while this was an increase from 2003, the *Healthy People 2010* objective for daily physical education class was 50 percent. While there was limited variation in daily physical education class attendance by race/ethnicity, the percent of male high school students attending physical education class daily was 77.0 percent greater than the same rate among female high school students.

The percent of high school students who participated in 60 minutes of physical activity on five of seven days in a week increased ten percentage points between 2005 and 2007. White high school students and high school students of other race/ethnicity had greater rates than Black or Hispanic high school students. The percent of male high school students participating in 60 minutes of physical activity on five of seven days in a week was 87.5 percent greater than among female high school students.

Physical Education Class Attendance and Physical Activity Prevalence among Students in High School, Georgia, YRBS 2003, 2005, and 2007



Physical Education Class Attendance and Physical Activity Prevalence among Students in High School by Race/Ethnicity and Gender, Georgia, YRBS 2007

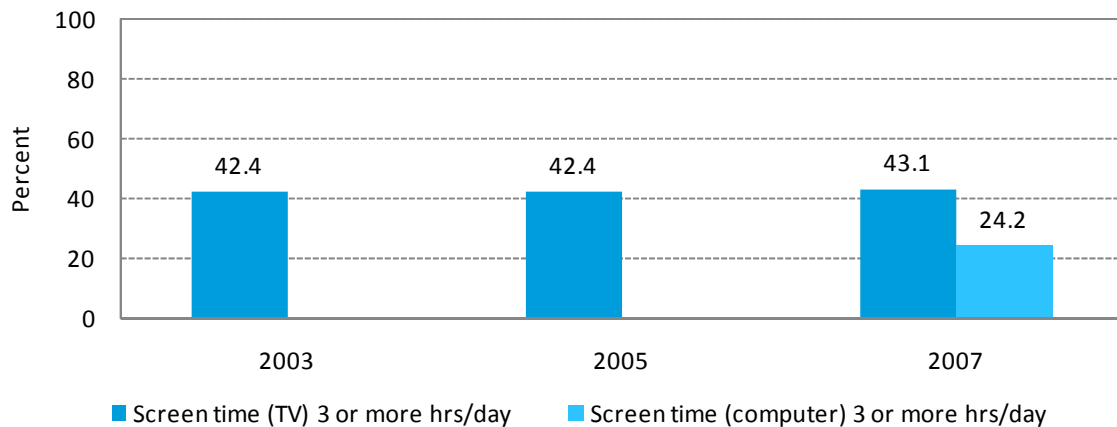


TELEVISION AND COMPUTER SCREEN TIME FOR THREE HOURS OR MORE PER DAY AMONG HIGH SCHOOL STUDENTS

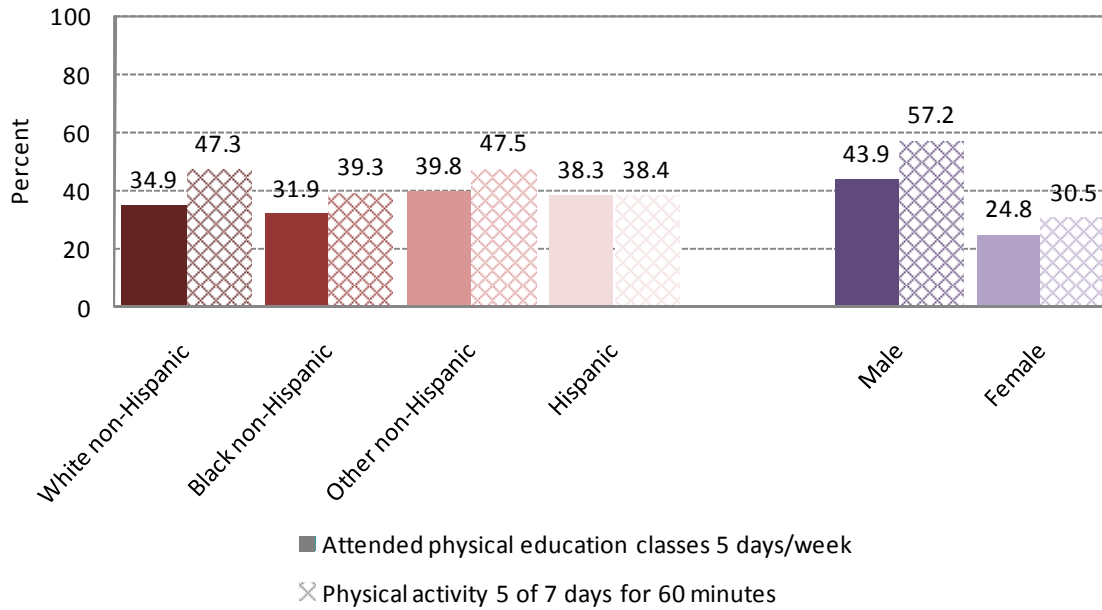
More than 40 percent of high school students watch three or more hours of television per day. In 2007, the rate in Georgia was 72.4 percent higher than the *Healthy People 2010* objective. In 2007, the first year computer screen time was assessed on Georgia's YRBS, nearly a quarter of High school students reported spending three or more hours of computer screen time per day.

The percent of Black high school students who reported viewing three or more hours of television daily exceeded 60 percent. Fewer than 30 percent of White High school students reported viewing three or more hours of television daily. While the variation in television viewing by gender was limited, a greater percent of male high school students reported three or more hours of computer screen time daily.

Television and Computer Time for Three or More Hours per Day among Students in High School, Georgia, YRBS 2003, 2005, and 2007



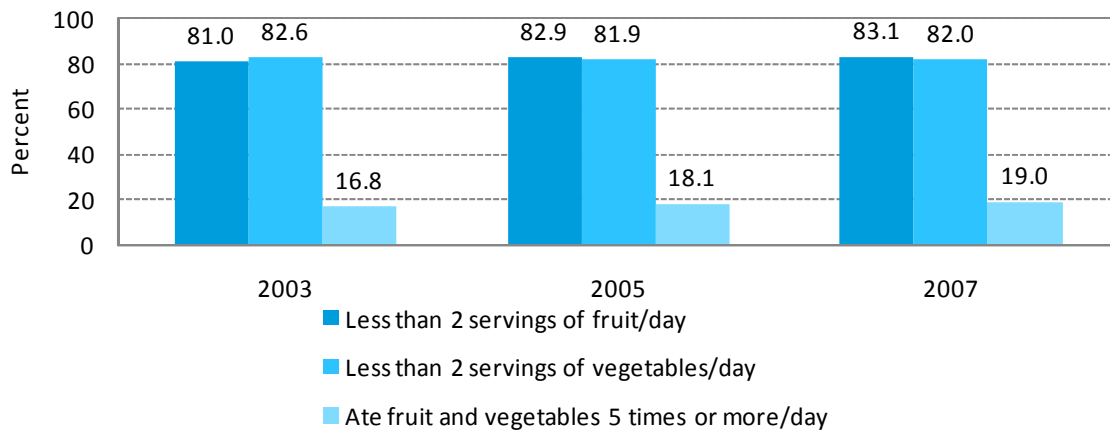
Physical Education Class Attendance and Physical Activity Prevalence among Students in High School by Race/Ethnicity and Gender, Georgia, YRBS 2007



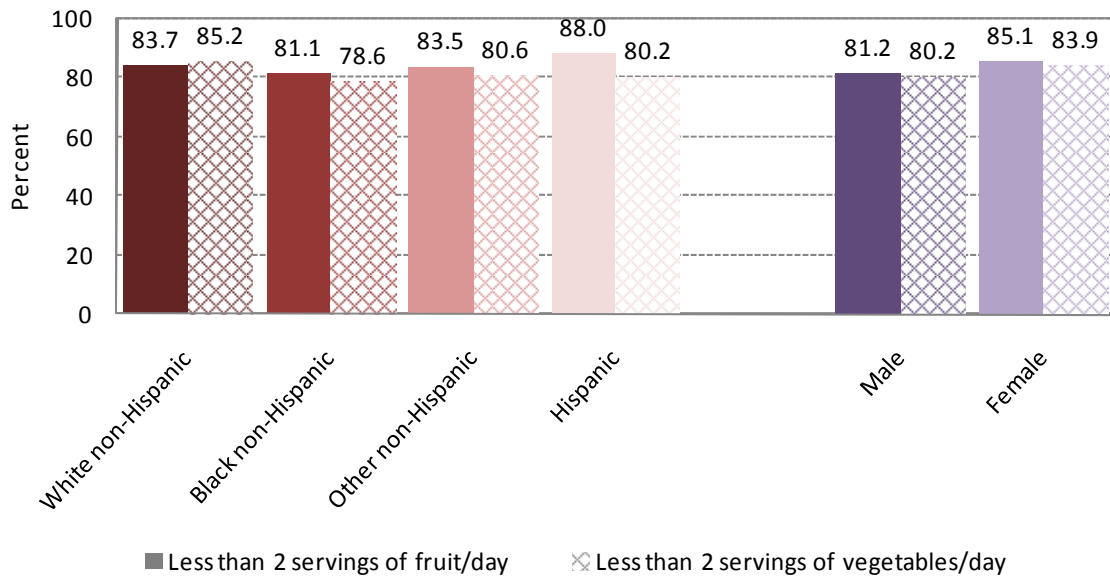
NUTRITION BEHAVIORS AMONG HIGH SCHOOL STUDENTS

Less than 20 percent of high school students report consuming two or more servings of fruits or vegetables daily. Two related *Healthy People 2010* objectives for nutrition are for 75 percent of people 2 years of age and older to consume at least two servings of fruits and vegetable daily and to increase the percent of children 2 years of age and older who consume at least three servings of vegetables daily to 50 percent. The low fruit and vegetable consumption reported in the high school population did not contribute to achieving these objectives. Analysis by race/ethnicity revealed that nearly twice the percent of Hispanic high school students consumed five or more servings of fruits and vegetables per day compared to White high school students.

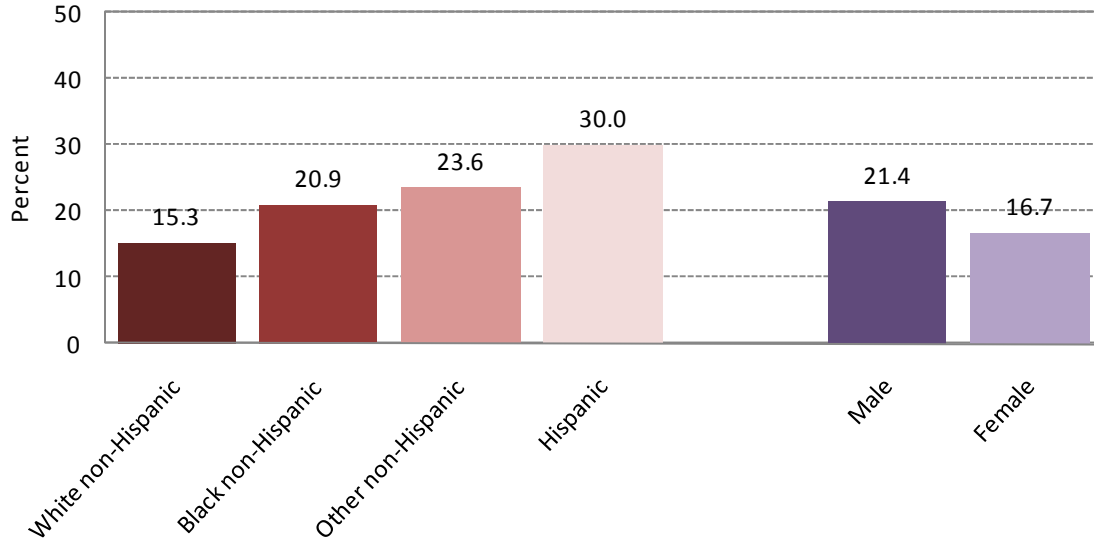
Nutrition Behavior among Students in High School, Georgia, YRBS
2003, 2005, and 2007



Consumption of Two or More Servings of Fruits and Two or More Servings of Vegetables by Race/Ethnicity and Gender, Georgia, YRBS
2007



Consumption of Fruits and Vegetables Five Times or More per Day among Students in High School by Race/Ethnicity and Gender, Georgia, YRBS 2007

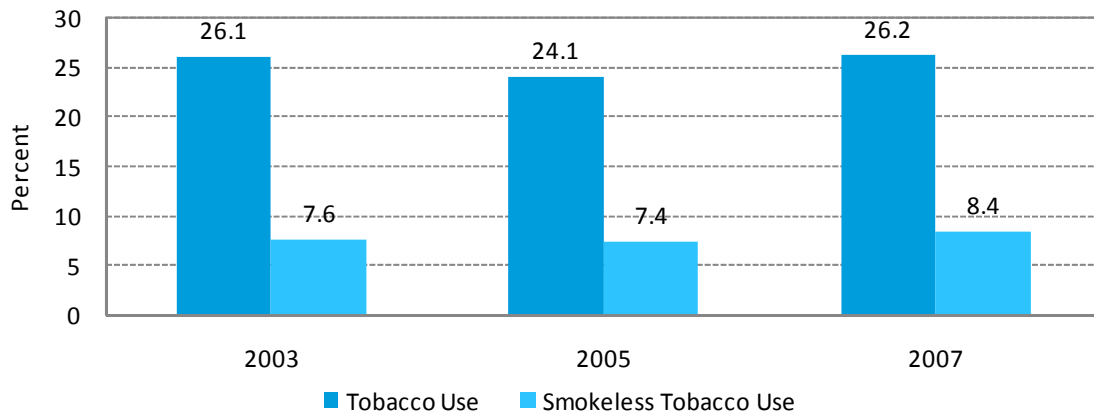


TOBACCO USE AMONG HIGH SCHOOL STUDENTS

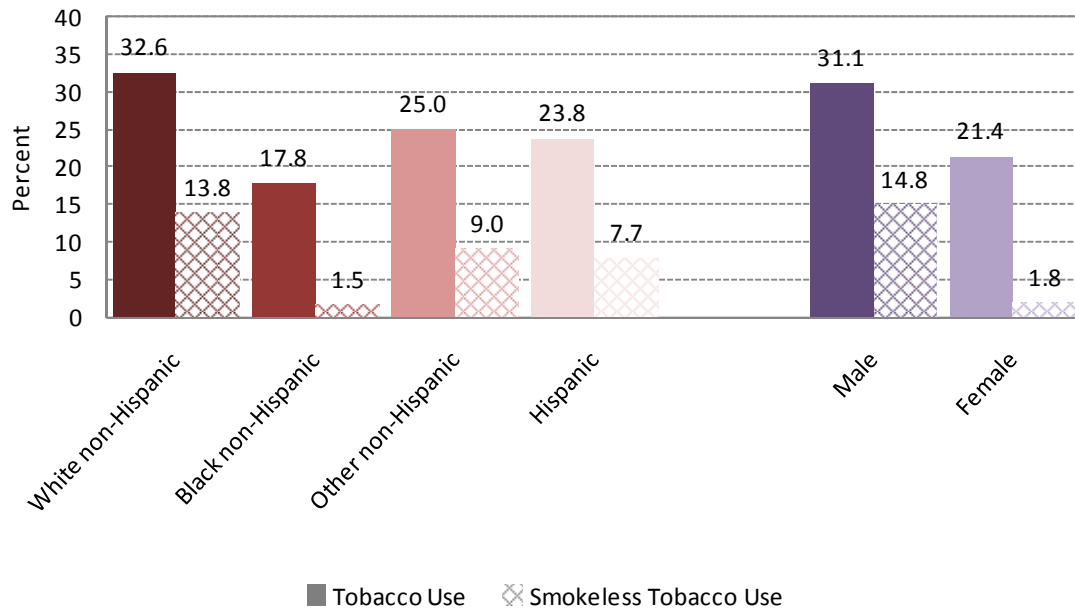
The *Healthy People 2010* objective for adolescent tobacco use is 21 percent and 1 percent for adolescent smokeless tobacco use. In Georgia, among high school students, the tobacco use prevalence rate was approximately 26 percent annually. The average smokeless tobacco rate in 2003, 2005, and 2007 exceeded the *Healthy People 2010* objective by 680 percent.

Tobacco use was greater among White high school students compared to other racial/ethnic groups and greater among male high school students compared to female high school students. Smokeless tobacco use was lower among Black high school students and female high school students.

Tobacco and Smokeless Tobacco Use among Students in High School
by Year, Georgia, YRBS 2003, 2005, and 2007



Tobacco and Smokeless Tobacco Use among Students in High School
by Race/Ethnicity and Gender, Georgia, YRBS 2007



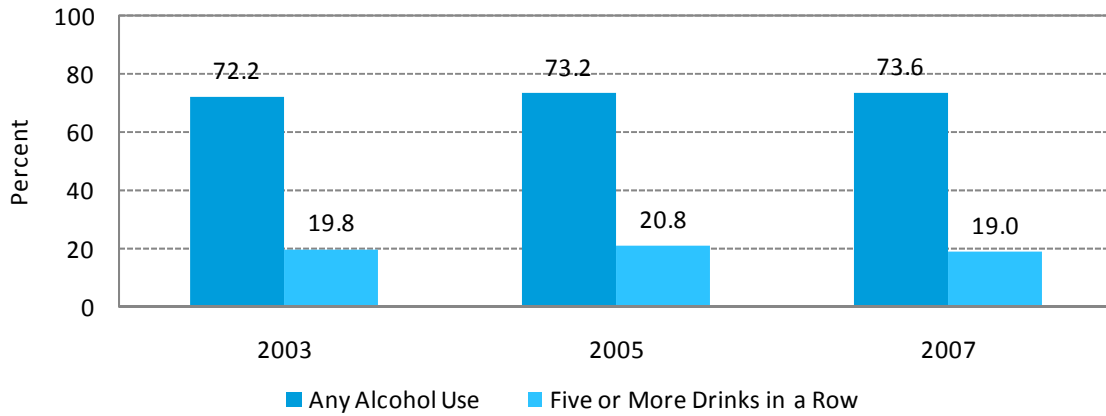
ALCOHOL USE AND BINGE DRINKING AMONG HIGH SCHOOL STUDENTS

Healthy People 2010 set a target of 29 percent of high schools seniors having never used alcohol. In Georgia, across all high school students, approximately 17 percent have never used alcohol. Lifetime alcohol use prevalence exceeded 70 percent among both male and female high school students and high school students of all racial/ethnic groups except Black high school students.

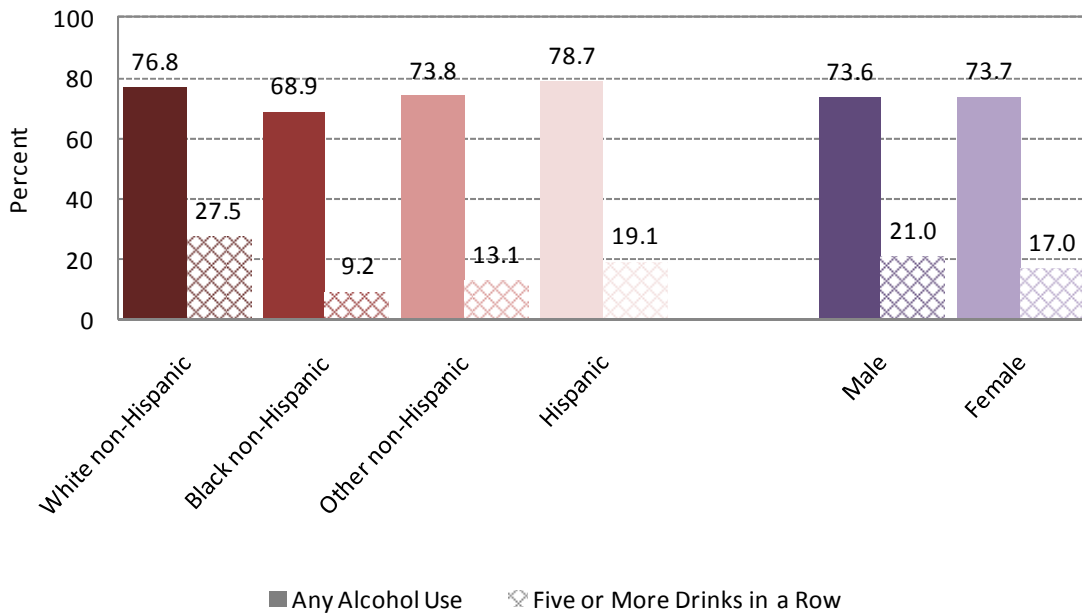
Approximately one-fifth of Georgia's high school students reported binge drinking (having five or more drinks in a row). The average binge drinking prevalence in 2003, 2005, and 2007 was 19.7 percent. The

average binge drinking prevalence was 885 percent greater than the *Healthy People 2010* objective for binge drinking of two percent. More than one-quarter of White high school students in Georgia reported binge drinking. This compared to less than 10 percent among Black high school students and less than 20 percent among Hispanic high school students. The prevalence of binge drinking was four percentage points greater among male high school students compared to female high school students.

Alcohol Consumption among Students in High School by Year, Georgia, YRBS 2003, 2005, and 2007



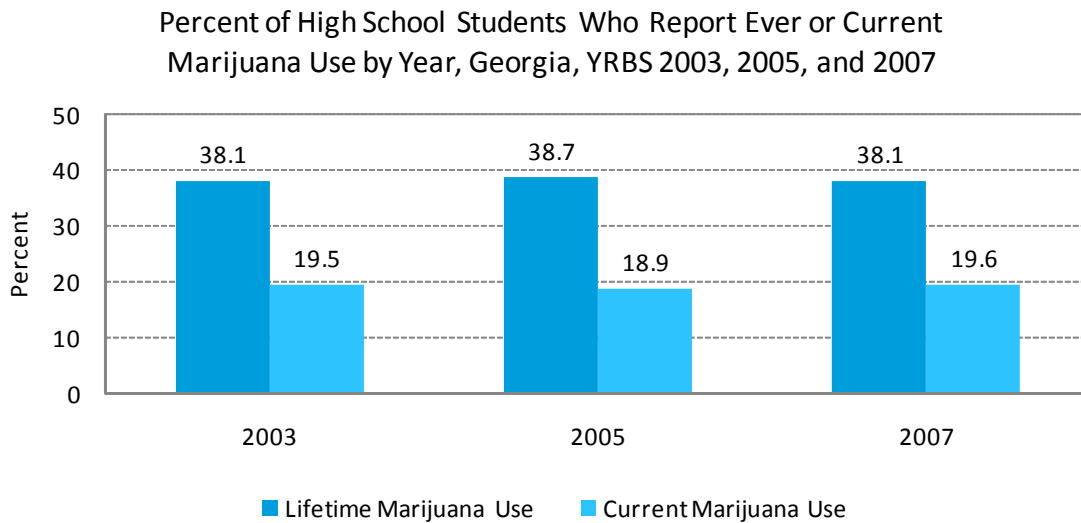
Alcohol Consumption among Students in High School by Race/Ethnicity and Gender, Georgia, YRBS 2007



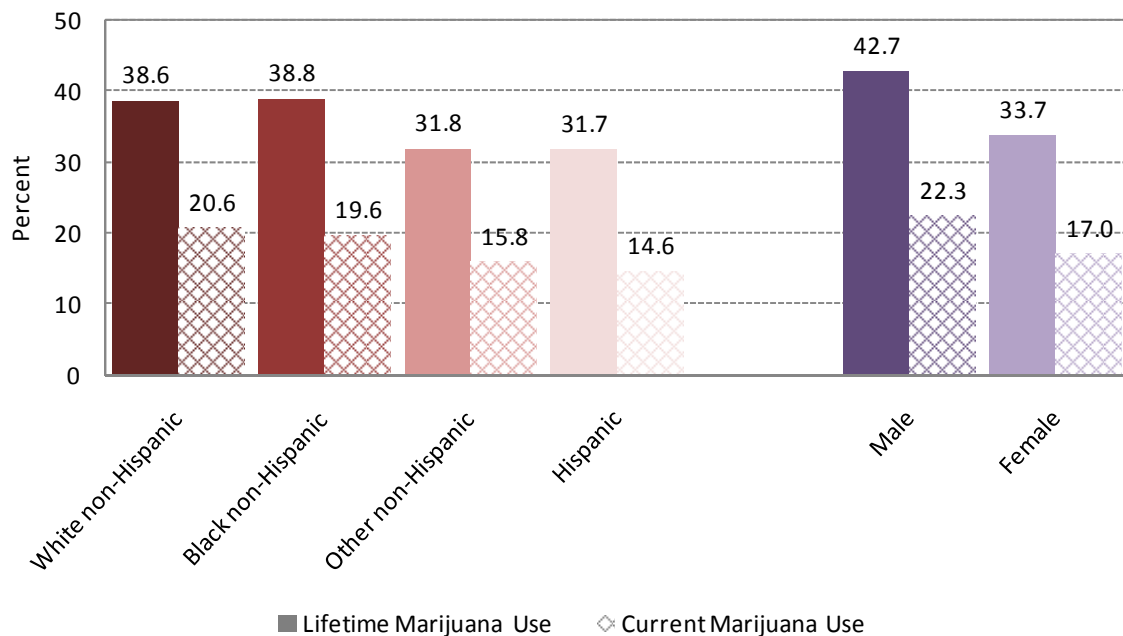
LIFETIME AND CURRENT MARIJUANA USE AMONG HIGH SCHOOL STUDENTS

Healthy People 2010 set a target of 56 percent of high schools seniors having never used illicit substances. Adolescents in Georgia fail to meet this objective when considering marijuana use alone. Nearly 40 percent of Georgia high school students reported lifetime marijuana use. The prevalence of lifetime marijuana use was greater for White and Black high school students than Hispanic high school students or students of other race/ethnicity. The prevalence of lifetime marijuana use was approximately ten percentage points greater among male high school students than female high school students.

Nearly one-fifth of all Georgia high school students reported current marijuana use (use in the past 30 days). The average rate of current marijuana use for 2003, 2005, and 2007 was 38.1 percent. This average rate was more than 5,000 percent greater than the *Healthy People 2010* objective for current marijuana use of 0.7 percent. Among White high school students, 20.6 percent reported current marijuana use as did 19.6 percent of Black high school students. Current marijuana use was greater among male high school students than female high school students.



Percent of High School Students Who Report Ever or Current Marijuana Use by Race/Ethnicity and Gender, Georgia, YRBS 2007



CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

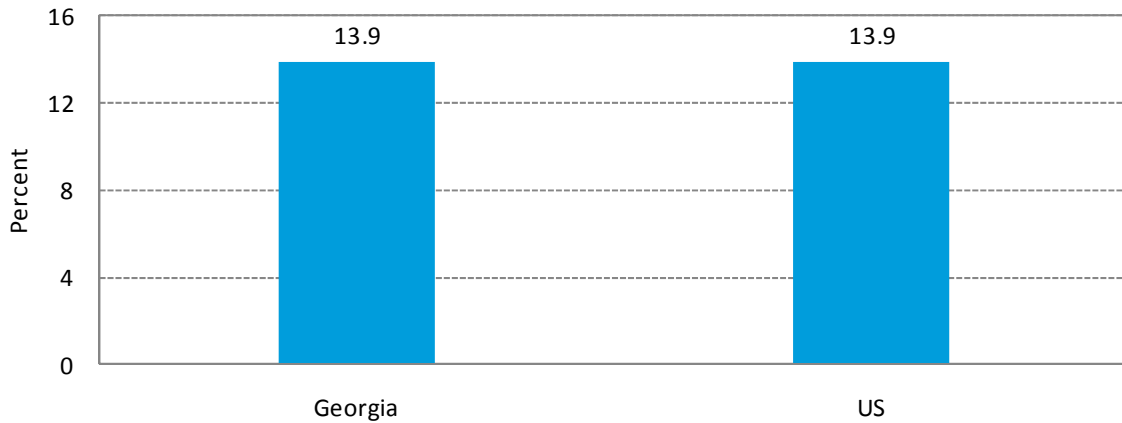
QUANTITATIVE ANALYSES

DESCRIBING THE CSHCN POPULATION IN GEORGIA

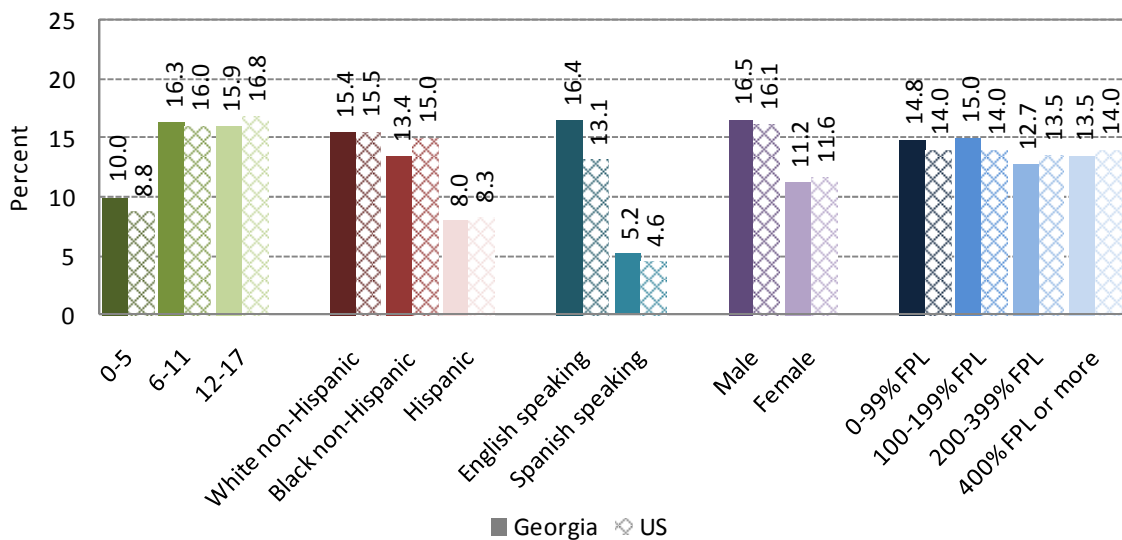
According to the 2005/2006 National Survey of Children with Special Health Care Needs, there were approximately 334,420 children in Georgia with special health care needs for a prevalence of 13.9

percent, which was identical to the nationwide prevalence. When stratifying by sociodemographic characteristics, the prevalence of children with special health care needs was similar between Georgia and the US. The prevalence of children with special health care needs was greater for male children than female children and greater for English speaking Hispanic children than Spanish speaking Hispanic children. The prevalence among English-speaking Hispanic children was approximately three times the prevalence among Spanish-speaking Hispanic children.

Prevalence of Children with Special Health Care Needs, Georgia and the United States, National Survey of Children's Health 2007



Prevalence of Children with Special Health Care Needs, Georgia and the United States by Age, Race/Ethnicity, Language, Sex, and Poverty, National Survey of Children's Health 2007



OUTCOME 2: COORDINATED AND COMPREHENSIVE CARE IN A MEDICAL HOME

The percent of families of children with special health care needs that received coordinated ongoing comprehensive care within a medical home declined in the US and Georgia between 2001 and 2005/2006. Among all measures, the gap between the percent in the US and Georgia was minimal. There was little variation in the percent changes for each measure when comparing percent changes in the US and Georgia between 2001 and 2005/2006.

Coordinated and Comprehensive Care in a Medical Home, Georgia and the US, National Survey of Children with Special Health Care Needs 2001 and 2005/2006						
	2001 CSHCN Survey			2005/2006 CSHCN Survey		
	Valid #	% Success	US/GA Gap	Valid #	% Success	US/GA Gap
Outcome 2. CSHCN will receive coordinated ongoing comprehensive care within a medical home.*						
Georgia	704	49.4	(3.2)	759	47.3	0.2
US	36,710	52.6		38,886	47.1	
The child has a usual source of care.						
Georgia	742	91.1	0.9	792	92.2	(0.7)
US	38,628	90.5		40,551	92.9	
The child has a usual source for sick care.						
Georgia	745	91.5	0.9	793	94.1	(0.2)
US	38,744	90.6		40,614	94.3	
The child has a usual source for preventive care.*						
Georgia	744	98.9	0.1	792	96.5	(0.6)
US	38,737	98.8		40,626	97.1	
The child has a personal doctor or nurse.*						
Georgia	745	86.7	(2.3)	790	91.1	(2.4)
US	38,711	89.0		40,658	93.5	
The child has no problems obtaining referrals when needed.						
Georgia	389	77.0	(1.1)	266	82.6	3.7
US	20,042	78.1		13,358	78.9	
The child receives effective care coordination.*						
Georgia	65	48.4	8.6	585	59.5	0.3
US	4,356	39.8		30,971	59.2	
Family usually or always gets sufficient help coordinating care, if needed.*						
Georgia	65	81.3	(0.6)	335	67.2	(0.2)
US	4,527	81.9		17,803	67.4	
Family is very satisfied with doctors' communication with each other.*						
Georgia	51	48.6	(5.8)	501	62.1	(1.7)
US	3,710	54.4		26,706	63.8	
Family is very satisfied with doctors' communication with other programs.*						
Georgia	45	46.8	9.7	171	50.2	(1.9)
US	3,196	37.1		11,077	52.1	

Coordinated and Comprehensive Care in a Medical Home, Georgia and the US, National Survey of Children with Special Health Care Needs 2001 and 2005/2006

	2001 CSHCN Survey			2005/2006 CSHCN Survey		
	Valid #	% Success	US/GA Gap	Valid #	% Success	US/GA Gap
The child receives family-centered care.						
Georgia	695	64.4	(2.4)	757	65.0	(0.8)
US	36,018	66.8		38,242	65.8	
Doctors usually or always spend enough time.						
Georgia	717	79.0	(4.7)	754	77.3	(1.5)
US	36,799	83.7		38,765	78.7	
Doctors usually or always listen carefully.						
Georgia	716	86.5	(1.6)	756	87.6	(1.2)
US	36,872	88.1		38,809	88.8	
Doctors are usually or always sensitive to values and customs.						
Georgia	704	83.0	(3.9)	750	87.2	(1.8)
US	36,425	86.9		38,555	89.0	
Doctors usually or always provide needed information.						
Georgia	712	81.9	1.0	755	81.9	(1.2)
US	36,734	80.9		38,773	83.1	
Doctors usually or always make the family feel like a partner.						
Georgia	717	87.4	1.5	756	86.0	(1.7)
US	36,837	85.9		38,825	87.7	

* Indicates that the question has been revised between 2001 and 2005/2006. This makes individual comparison between years difficult. However, changes in the question should not influence the comparison of absolute changes between the US and Georgia as the question change would have had equal impact on each population.

OUTCOME 5: ORGANIZATION OF COMMUNITY-BASED SYSTEMS

More than 90 percent of children with special health care needs in Georgia reported the availability of community-based service systems organized so that families can use them easily. The percent in Georgia was 1.9 percentage points greater than in the US. While there were significant changes to the question between 2001 and 2005/2006, the percent change between the two surveys was similar between Georgia (21.5 percent) and the US (19.9 percent).

Organization of Community-Based Systems, Georgia and the US, National Survey of Children with Special Health Care Needs 2001 and 2005/2006						
	2001 CSHCN Survey			2005/2006 CSHCN Survey		
	Valid #	% Success	US/GA Gap	Valid #	% Success	US/GA Gap
Outcome 5. Community-based service systems are organized so families can use them easily.*						
Georgia	346	74.9	0.6	789	91.0	1.9
US	15,310	74.3		40,344	89.1	

* Indicates that the question has been revised between 2001 and 2005/2006. This makes individual comparison between years difficult. However, changes in the question should not influence the comparison of absolute changes between the US and Georgia as the question change would have had equal impact on each population.

QUANTIFICATION

Third party coverage issues are identified as a major health concern for children with special health care needs by all seven CSHCN needs assessment community focus groups, the steering committee of the Early Childhood Comprehensive System (ECCS), and six of nine roundtables at the focus group of non-governmental maternal and child health provider and advocacy groups.

DESCRIPTION OF HEALTH CONCERN

Child health provider and advocacy group representatives cite their concern about system-level realities, and several groups forward their interest in macro-level issues: “Insurance reform (Medicaid, SCHIP, private),” “health care financing,” “health concerns created by the changes in Medicaid/CMO,” and “lack of adequate private health insurance coverage.”

Three major themes that emerged from focus groups are concerns around coverage gaps, reimbursement and definition of medical necessity.

“Gaps in insurance and coverage of services” are a major health concern expressed in all of the consumer and stakeholder groups contributing to the needs assessment. The steering committee of ECCS forwards their concerns about the “limited or lack of Medicaid coverage for Title V programs and services, and lack of continuous coverage under Medicaid.” Additionally, there is great concern about the “lack of adequate private health insurance coverage.”

The result, as heard repeatedly in community focus groups, is “certain medical services are not covered by Medicaid or third party.” Consumers and other stakeholders noted the following.

- “Insurance and Medicaid do not cover all of the developmental and medical services, therapies and supplies for children with certain conditions such as hearing loss, PKU and autism;”
- “Medicaid is unavailable for acute transportation. You have to make your reservation at least three days in advance;”
- There are “difficulties in getting durable medical equipment covered under Medicaid after client has been approved for waiver;”
- “Medicaid denials of head CT scans for patients with VP shunts” are a problem; and
- “The hearing equipment (FM system and hearing aid) is not covered by either Medicaid or CMS.”

Parents/stakeholders share some of their personal stories about how they have worked, sometimes successfully, to get their child’s health needs met.

- “Babies Can’t Wait came to my rescue. We didn’t know for the first two years what was wrong with my child. He had severe hearing disabilities. CMS is my lifesaver; they were there to cover what insurance would not. We had to go three to six months with no insurance so they would pick him up and cover him;”
- “You have to give up one service to get another service. To get respite care at home we had to give up CMS to get Source;”

- “I needed a new hearing aid and Medicaid did not help. I called other people, and they said they could not help. I called CMS and they helped, they helped with my son’s walker and hearing aid;” and
- “My insurance was exhausted and thankfully CMS was there to help.”

Tiredness is also evident in some of the parent/caretaker comments heard in the focus group.

- “You fill out a lot of papers just to be turned down. In other states, you get more therapy and nursing hours. Here your child has to be at the last breath before you get nursing care;”
- “It’s a lot of fighting to get therapy services;” and
- “You have to fight for everything you get. I’m tired of fighting.”

Another aspect of the issues with third party coverage is captured in the suggested priorities forwarded by child health provider and advocacy group representatives to “provide adequate reimbursement for services.”

- “Cost of providing services has increased while reimbursement rates have been stagnant or have decreased;”
- “Medicaid is not paying enough for deaf services. CMS helps a lot;”
- “Medicaid did not pay for the medicine the doctor prescribed; they gave me the generic drug;”
- “Adequate Medicaid reimbursement for G-tubes, pledgets. saline tubes, and MIC-KEY tubes?” is needed; and
- “Reimbursement of positioning chairs” is a problem.

Differences defining medical necessity are noted as an associated problem.

- “Families are frustrated because insurance companies and CMO’s are not telling them that their child does not qualify for therapy services or no longer qualifies. They are frustrated and don’t know what to do;” and
- “[Physicians] need more flexibility in determining what is medically necessary.”

IDEAS ABOUT WHAT IS NEEDED TO IMPROVE CHILDREN WITH SPECIAL HEALTH CARE NEEDS’ HEALTH

CSHCN stakeholders forwarded various ideas on what is needed to improve the physical and mental health of children with special health care needs. Suggestions around third party coverage issues follow.

- Address problem with “limited funding to provide CMS care for uninsured and/or undocumented children;”
- “The wish list would be to fill the gaps in insurance coverage. Funding for rehabilitative services;”
- “Funding assistance with purchase of needed equipment” is needed;
- “Health insurance coverage for all children” is needed;
- Provide “access to medical coverage for children and young adults not eligible for Medicaid and Peach Care due to citizenship and/or age;”
- We need “continuity of Medicaid services;”
- We need “easy access to waiver funds for respite and durable medical equipment;”

- “Improve access to funding sources;”
- “Affordable health insurance for children with special needs over the age of 18 who are low income and not eligible for SSI or Medicaid (i.e., diabetic students)” is needed;
- “For the self employed or self insured, [we need] access to medication at a decent cost. We pay \$300/month just for maintenance medication;” and
- Health Care providers say that they “need more flexibility in determining what is medically necessary.”