

Building Capacity to Address Infant Mortality:
Atlanta Perinatal Region Strategic Plan
(2018-2021)



**HEALTHY MOTHERS,
HEALTHY BABIES**

Coalition of Georgia

Improving maternal and infant health in Georgia through advocacy, education and access to vital resources since 1974.

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HMHB is the only organization in Georgia that focuses on the full spectrum of maternal and child health concerns from prematurity to maternal mortality.

Our mission is to improve maternal and infant health in Georgia through advocacy, education and access to vital resources.

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REDUCING INFANT MORTALITY:
2018 - 2021 STRATEGIC PLAN FOR THE
ATLANTA PERINATAL REGION



BACKGROUND

In 2015, Georgia’s Infant Mortality Rate (IMR) stood at 7.8 per 1,000 live births. The state IMR has steadily increased since 2010 when it was the lowest it had been in recent history (6.5 per 1,000 live births). In Georgia the leading cause of infant mortality is disorders related to preterm birth and low birth weight. This plan aims to address these causes and other infant outcomes by addressing the facilitating factors.

The Georgia Department of Public Health (DPH) has been working to address the IMR in the state since its establishment as a separate agency in 2011. DPH established the Infant Mortality Task Force, which released a strategic plan in 2013 titled Reducing Infant Mortality in Georgia.

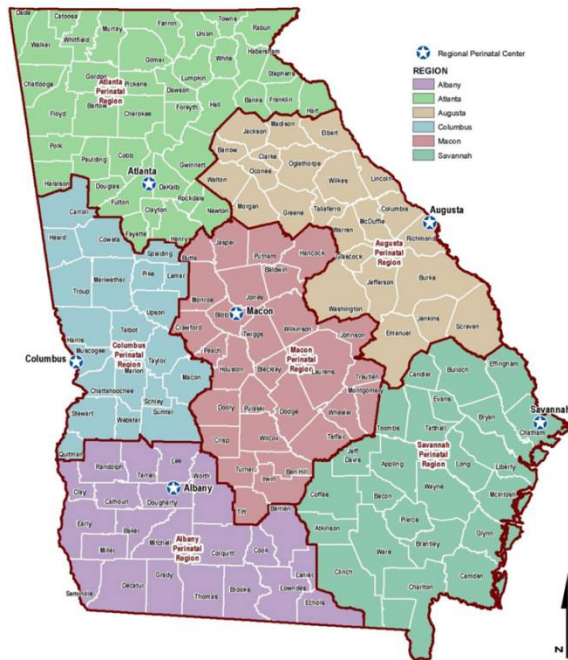


Figure 1: Map of Georgia's Regional Perinatal Centers

In line with the objectives of the 2013 strategic plan, the Georgia Department of Public Health’s (DPH), Maternal and Child Health Section awarded mini-grants to applicants committed to creating realistic and measurable plans of action to reduce infant mortality throughout the perinatal region. Healthy Mothers, Healthy Babies Coalition of Georgia (HMHB) was awarded a Building Capacity to Address Infant Mortality in Georgia grant award to address infant mortality in the Atlanta Perinatal Region in 2017. As a result, the planning process that informed this strategic plan to reduce infant mortality was developed with a focus on the communities and stakeholders of the 39 counties included in the northern most region of the state, the Atlanta Perinatal Region further referred to as the APR. See figure 1.¹

HMHB’s mission is to improve maternal and child health through advocacy, education and access to vital resources. In 2016, HMHB published its biennial State of the State of Maternal & Infant Health in Georgia report, which outlined the need for further action related to infant mortality, among other key measures. HMHB is dedicated to addressing the root causes of poor maternal and infant outcomes in Georgia by implementing evidence based practices and adapting innovative promising practices across the state. This following plan was developed by stakeholders serving communities in the APR as a call to action for agencies and organizations to commit to working together to reduce IMR in the APR by 2021 through collaborative efforts by addressing access to care, maternal health, and social determinants of health.

¹ “Regional Perinatal Centers | Georgia Department of Public Health,” accessed February 6, 2018, <https://dph.georgia.gov/RPC>.

METHODOLOGY:

Healthy Mothers, Healthy Babies Coalition of Georgia selected the Georgia Health Policy Center at Georgia State University to serve as the implementation partner for all activities related to the strategic planning process.

Stakeholder Survey:

The Georgia Health Policy Center worked with Healthy Mothers, Healthy Babies (HMHB) to design and implement a 25-question stakeholder survey. The survey asked stakeholders to offer their experience and perspective on topics related to infant mortality in the communities they serve (e.g., accelerating factors, the availability of services, anticipated service expansions, previous interventions, and recommendations about evidence informed interventions). Questions were adapted from survey evidence informed instruments used to assess community needs and assets related to infant mortality. The survey was administered in an online format to more than 70 stakeholders by HMHB in an email request. There were 49 surveys submitted during April 2017. Survey results were analyzed and referenced throughout the planning process. See appendix 1 for the survey results and tool.

Stakeholder Selection:

HMHB identified over 85 organizations to serve as stakeholders working in or serving the perinatal population within the 39 counties of the Atlanta Perinatal Region. The stakeholder list included organizations such as hospitals with neonatal intensive care units and/or delivery units, professional provider associations, experts from local, state and national groups focused on maternal and infant health, child protective services, state agencies, federal agencies, social service providers, private insurers, public health schools, and the four Care Management Organizations responsible for administering Medicaid in the State of Georgia (Amerigroup, CareSource, Peach State and WellCare), among others.

Secondary Data:

Secondary data related to infant mortality in the U.S., Georgia, and the 39-county Atlanta Perinatal Region were collected and summarized in order to provide stakeholders with a comprehensive look at infant mortality at the local, state and national levels. Sources included Centers for Disease Control and Prevention (CDC), Pregnancy Risk Assessment Monitoring System (PRAMS), World Health Organization (WHO); Georgia Department of Public Health, HMHB State of the State of Maternal & Infant Health in Georgia report (2016), and KidsCount Data Center. See appendix 2 for additional detail.

Landscape Scan:

In order to assess gaps in services, a landscape scan was completed using the resource directory maintained by Healthy Mothers, Healthy Babies (<https://www.resourcehouse.com/hmhb/>). Services were filtered and sorted into four categories: access to care, maternal health, infant outcomes, and social determinants of health (priorities identified by stakeholders during the initial planning meeting on May 3, 2017). The landscape scan showed that there were 70 unique types of services being provided by 992 agencies across the 39-county perinatal region. Areas of abundance and scarcity were identified, mapped, and summarized. See appendix 3 for additional detail.

Evidence Informed Interventions:

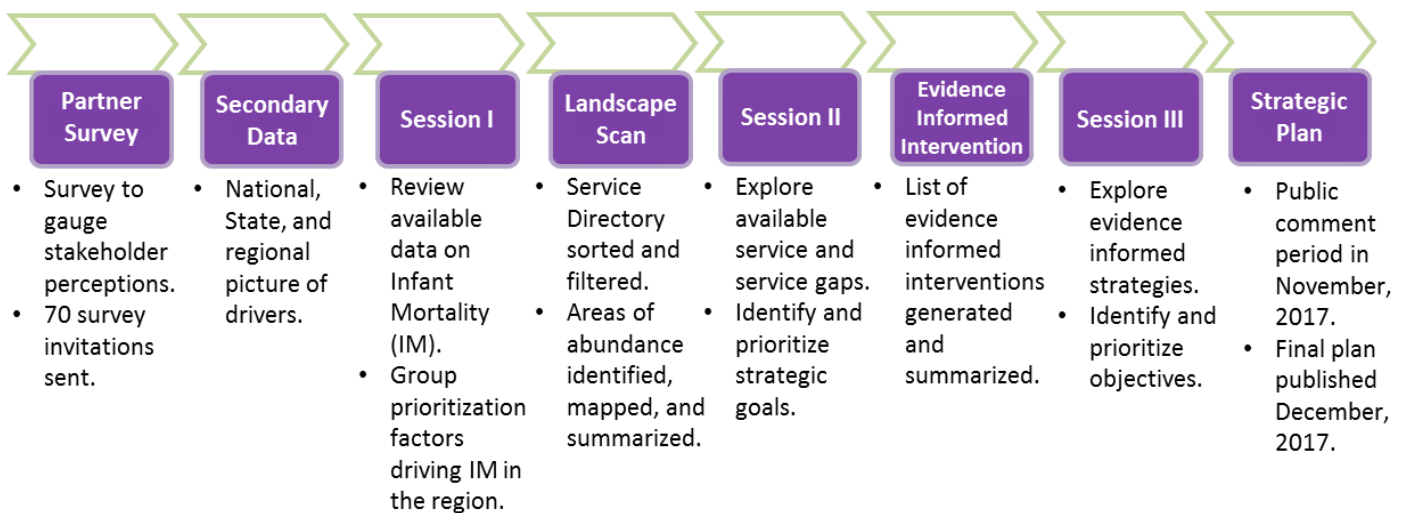
A list of evidence informed interventions was generated in May 2017 to share with stakeholders as they worked to finalize strategic goals and objectives. Evidence informed interventions were filtered and sorted into four categories: access to care, maternal health, infant outcomes, and social determinants of health (priorities identified by stakeholders during the initial planning meeting on May 3, 2017). The name, source, target perinatal period(s), evidence rating, and summary of intervention purpose were compiled and presented to stakeholders. Additionally, HMHB identified 25 unique interventions using the following sources: The National Healthy Start Association (NHTSA); The National Institute of Child Health and Human Development; The Community Preventive Services Task Force; Mental Health Innovation Network (MHIN); The Family Resource Network; SmokeFreeWomen; National Child and Maternal Health Education Program; U.S. Dept. of Health and Human Services; National Women’s Law Center; Nurse Family Partnership; WellPass (Text4Baby); Association of Maternal and child health programs (AMCHP); March of Dimes; The Centering Healthcare Institute; Moving Beyond Depression (MBD); The Preconception Health and Health Care Initiative (PCHHC); The Maternity Care Coalition (MCC); The Antenatal and Neonatal Guidelines, Education and Learning Systems (ANGELS); and The Homeless Prenatal Program (HPP). See appendix 5 for additional detail.

Stakeholder Convenings:

More than 100 stakeholders were invited to participate in three consecutive planning sessions:

- Session I - May 3rd, 2017 at the Gainesville Civic Center in Gainesville, GA
- Session II - May 31st, 2017 at Clayton State University in Morrow, GA
- Session III - June 21st, 2017 at Chattahoochee Technical College in Acworth, GA

Stakeholders were informed that the three planning sessions would build toward a final strategic plan to reduce infant mortality in the Atlanta Perinatal Region during a three-year period (2018-2021). The following road map was used to guide the planning sessions:



Georgia’s infant mortality rate (IMR) is among the highest in the nation. Georgia is ranked 47th in the nation for IMR. The IMR for Georgia is 7.8 per 1,000 live births, which is higher than the U.S. average (5.9 per 1,000 live births). It is important to note that while the national IMR has been decreasing, the rate in Georgia hit a 10 year low in 2012 (6.3 per 1,000 live births) and began to rise to the above average rates we see today.² The 39 counties included in the Atlanta Perinatal Region (APR) mimic the IMR trends of the U.S. more than state trends. According to the Georgia Online Analytical Statistical Information System (OASIS), the average IMR for the APR in 2015 was 6.5 per 1,000 live births. Though not yet achieving the IMR goal set by Healthy People 2020 of 6.0 deaths per 1,000 live births by the year 2020, the APR regional rate is better than the State (7.8) and has declined in recent years. While the largest number of infant deaths occurs in Fulton, DeKalb, Gwinnett, and Cobb Counties because of population density; the highest rates of infant mortality in 2015 occurred in Floyd, Rockdale, Banks, Dade, and Clayton Counties (10.4, 9, 8.5, 8.2, and 7.8 per 1,000 live births respectively). Since 2000, Rockdale has shown the highest increases across the region in both the number of infant deaths (from 74 to 107) and the IMR (from 6.1 to 9 per 1,000 live births).⁵

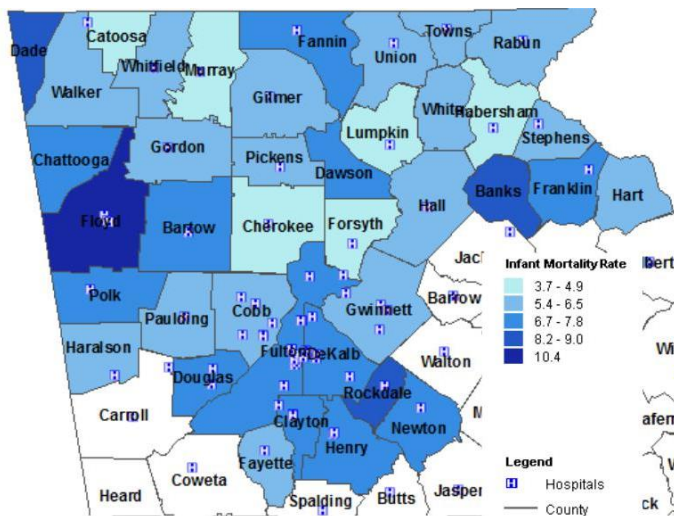


Figure 3: Atlanta Perinatal Region by IMR

Available Data Pertaining to the Leading Causes of Infant Mortality in 2015:

Congenital malformation and anomalies:⁵

- According to OASIS, the rate of infant mortality related to congenital malformation and anomalies in Georgia ranges from 1.1 to 1.5 per 1,000 live births.

Pre-term birth:⁵

- According to OASIS, the percentage of pre-term births (<37 weeks gestation) in 2015 was similar for the state (10.8%) when compared to the region (10.2%) and the nation (10%).
- There were 14 counties in the region showing higher percentages than the state – Bartow (13.3%), Rockdale (13.2%), Dade (13%), White (12.5%), Fannin (12.4%), Murray (11.8%), Whitfield (11.6%), Gordon (11.3%), Haralson (11.2%), Clayton (11.1%), Union (11.1%), Paulding (11%), Fulton (10.8%), and Newton (10.8%).

Low Birth Weight:⁶

⁵ “Georgia Department of Public Health, Office of Health Indicators for Planning OASIS,” accessed February 6, 2018, <https://oasis.state.ga.us/oasis/webquery/qryInfantDeath.aspx>.

⁶ “2016 HMHB State of the State Report,” HMHBGA, accessed February 6, 2018, www.hmhbga.org

- According to HMHB’s State of the State of Maternal & Infant Health in Georgia Report, between 2003 and 2014, the percentage of low birth weight births increased in the region (from 8.5% to 9.0%) and the state (from 9.0% to 9.5%), and the nation (from 7.9% to 8.0%).

Sudden Infant Death Syndrome (SIDS)/Sleep Environment:⁵

- According to OASIS, between 2010 and 2015, the percentage of infant deaths due to SIDS decreased in the region (from 16.8% to 9.6%) and the state (from 14.7% to 10.3%). This trend replicated nationally, and attributed to the safe sleep efforts (crib donations, education, in-home assessments, etc.)

During the planning process that was facilitated with stakeholders serving communities across the APR between April and June, 2017; planning participants recognized that while important, infant outcomes (i.e., infant mortality, low birth weight, SIDS, pre-term birth, and congenital malformations and abnormalities) would see the greatest improvement if facilitating factors are addressed as primary targets in the strategic plan. The strategic plan that follows offers a comprehensive roadmap for building capacity to address infant mortality in Georgia by focusing regional efforts on reducing the influence of the drivers of poor infant outcomes that were identified by stakeholders throughout the planning process. Specifically, stakeholders identified goals and objectives in three critically important focus areas: social determinants of health, access to care, and maternal health.



Images: Stakeholders attend three convening sessions to determine priority goals and objectives to address infant mortality in the Atlanta Perinatal Region.



ACCESS TO CARE

ACCESS TO CARE

The access to care priorities includes health equity, insurance status, availability and use of health services (e.g., prenatal care, preconception and interconception care and counseling). This cluster of priorities emerged in the initial planning session among stakeholders as they reviewed secondary data and survey results and discussed the forces driving higher rates of IM in the Atlanta Perinatal Region. Survey respondents most often noted the following facilitating factors restricting access to care for infants and expecting mothers: lack of Medicaid expansion, rural access issues (transportation, location of services, etc.), patient compliance, hospital closures, inequality, limited training for professionals, and limited care coordination.

There are several planned service expansions that should offer additional access to care for some areas in the region; though these are mostly in and around the City of Atlanta. The landscape scan related to these priorities indicated that resources are most scarce in the northern counties when compared to the rest of the region (see appendix 3 for included services).⁷ Most notably, there are several counties without hospitals that also show higher than average IMRs (Banks, Chattooga, Dade, Dawson, Hart, and Walker Counties).⁷ Some of the challenges to successful program implementation noted by survey respondents in this area were: lack of support in the community, limited staff capacity, low reimbursement rates, and limited funding.

Stakeholders recommended the following action to address barriers to accessing adequate care:

Strategic Goal: Increase the number of women in the Atlanta perinatal region that have access to the culturally relevant perinatal education, preconception, interconception, post-partum, and prenatal services they need to improve infant health outcomes.

Lack of health insurance

The health of mothers before they become pregnant has great influence on infant outcomes. In non-Medicaid expansion states, like GA, women that are of child bearing age may not have access to health insurance or a physician before they become pregnant. Additionally, undocumented immigrants may never have access to health insurance or a physician. According to PRAMS data, the percentage of mothers giving birth without health insurance increased from 2009 (31.8%) to 2011 (37.4%) in GA.⁴

Strategic Goal: Increase the number of women in the Atlanta perinatal region that have access to the culturally relevant perinatal education, preconception, interconception, post-partum, and prenatal services they need to improve infant health outcomes.

Objective:	Increase the utilization and number of existing treatment and referral services in underserved areas across the care continuum that are available to women of child-bearing age regardless of insurance status, as well as increase the number of women utilizing Medicaid-based services in the Atlanta Perinatal Region by 2021.
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⁷ “Healthy Mothers, Healthy Babies Coalition of Georgia,” accessed February 6, 2018, <https://www.resourcehouse.com/hmh/b/>.

Measures of Success:	Data from OASIS, DCH, and local health departments (e.g. vital statistics, birth certificates, birthing discharge summaries, county reports, OASIS, DCH, and local health departments).
Recommended Next Steps:	<ul style="list-style-type: none"> • Increase enrollment into Planning for Healthy Babies before and after pregnancy for eligible women. Move toward presumptive eligibility to Planning for Healthy Babies. • Increase referrals to the local health department and/or Federally Qualified Health Centers for low cost care. • Expand Medicaid or implement a Medicaid waiver program. • Increase provider participation in Medicaid network. • Evaluate the use of navigators in efforts to enroll women in health insurance coverage.

See appendix 4 for a list of relevant evidence informed practices.

Poor access/inadequate use of prenatal care

According to OASIS, between 2005 and 2015, the percentage of births to mothers receiving late or no prenatal care almost doubled in the Atlanta Perinatal Region (from 3.8% to 6.4%) and the state (from 3.8% to 5.7%), while there was a decrease nationally (from 8% to 6%).⁵ This makes some sense when considering that more than half (20) of the counties in the region (39) have three or less prenatal care providers listed in the HMHB directory and the counties with the most resources listed are in the Atlanta-metropolitan area. There are seven counties with one prenatal care provider listed (Chattooga, Haralson, Hart, Rabun, Towns, and White) and two with none listed (Dade and Polk Counties).⁷

Strategic Goal: Increase the number of women in the Atlanta perinatal region that have access to the culturally relevant perinatal education, preconception, interconception, post-partum, and prenatal services they need to improve infant health outcomes.	
Objective:	Increase the access to and use of prenatal care among expecting mothers in the Atlanta Perinatal Region by 2021.
Measures of Success:	Data from OASIS, DCH, and local health departments (e.g. vital statistics, birth certificates, birthing discharge summaries, county reports, OASIS, DCH, and local health departments).
Recommended Next Steps:	<ul style="list-style-type: none"> • Promote early prenatal care as well as prevention, smoking cessation, dental care, flu shots and TDAP during pregnancy through media campaigns, Care Management Organization programs for Medicaid participants, and community-based prenatal education. • Increase funding for home visiting programs.

See appendix 4 for a list of relevant evidence informed practices.

Preconception and interconception care and counseling

The literature shows that when births are adequately spaced (a minimum of 18 months apart), birth outcomes improve. According to OASIS, between 2010 and 2015, the percentage of births with less than 2 year intervals decreased in the Atlanta Perinatal Region (from 21.3% to 20.6%) and the state (from 22.9% to 21.6%).⁵ There remain 15 counties that show higher percentages of poor birth spacing than the state (Stephens, Towns, Rabun, Gilmer, Bartow, Hart, Lumpkin, Newton, Chattooga, Rockdale, Banks, Union, Floyd, Polk, and Gordon).⁷

Strategic Goal: Increase the number of women in the Atlanta perinatal region that have access to the culturally relevant perinatal education, preconception, interconception, post-partum, and prenatal services they need to improve infant health outcomes.	
Objective:	Increase the access to and use of preconception, interconception, post-partum care and counseling and education among those of childbearing age and their support systems in the APR by 2021.
Measures of Success:	Data from CDC, DCH, DPH (e.g. reimbursements for preconception and interconception services will increase, additional codes covering critical services are active, reduction of unintended pregnancy, lower teen pregnancies, and healthy pregnancy spacing).
Recommended Next Steps:	<ul style="list-style-type: none"> • Bolster incentive programs for women covered by both Medicaid and private insurance to receive preconception and interconception services. • Market and increase enrollment in Planning for Healthy Babies • Assess current billing codes for private insurance and Medicaid to recommend key changes or reimbursement increases for providers around key prenatal services. • Include families in prenatal counseling and education. • Promote policies and practices that aim to remove barriers to accessing affordable contraception for women that are childbearing age. • Increase access to 17P for pregnant women who have previously delivered a pre-term infant.

Health inequity

While data is not complete at the county level, the highest rates of IM are among African American births in the region, the state, and the nation. Also, survey respondents noted that there are disparities in birth outcomes, which they felt could be attributed to the absence of people of color in decision-making positions. Issues related to health inequity also fall partially under the Social Determinants of Health category.

Strategic Goal: Increase the number of women in the Atlanta perinatal region that have access to the culturally relevant perinatal education, preconception, interconception, post-partum, and prenatal services they need to improve infant health outcomes.
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Objective:	By 2021 identify and implement at least one evidence-informed practice in the Atlanta Perinatal Region aimed at narrowing racial and geographical disparities in birth outcomes.
Measures of Success:	Data from OASIS (e.g. change in IM by race overtime in APR) and a formal evaluation of the evidence-informed practice(s) identified and implemented.
Recommended Next Steps:	<ul style="list-style-type: none"> • Support initiatives to provide cultural competency training for healthcare professionals in Georgia. • Support initiatives to increase the number of providers of color participating in/and leading decision-making processes around healthcare delivery and access. • Encourage the inclusion of racially and ethnically diverse consumers in evaluation and decision-making processes regarding healthcare delivery and access.



MATERNAL HEALTH

MATERNAL HEALTH

Maternal health priorities address the health status of mothers before during and after pregnancy and are impacted by substance abuse (including tobacco and alcohol), poor health status, obesity, poor mental health, and lack of breastfeeding. This cluster of priorities also emerged in the discussions stakeholders had about the driving forces of the higher rates of IM in their communities. Survey respondents most often noted the following facilitating factors driving poor maternal health: lack of insurance, rural access issues (transportation, location of services, etc.), patient compliance, culture/tradition/generational cycles, stigma, apathy, lack of child care, and limited training of professionals. Additionally, there is a link between the social determinants of health (cluster of priorities found below) and maternal health.

There are several planned service expansions that should offer additional services to address maternal health for some areas in the region; though these are mostly in and around the City of Atlanta. The resource directory that was used to build the landscape scan in this planning process shows few resources available (outside of the area surrounding the City of Atlanta) to address maternal health for uninsured women of childbearing age.

Stakeholders recommended the following action to address maternal health issues that are driving higher IMRs in the region:

Strategic Goal: Improve infant outcomes by improving maternal health and wellness in the Atlanta Perinatal Region through culturally appropriate community outreach and investment that provides education and resources related to the pregnancy continuum including assessment and care coordination.

Substance abuse

There are scant datasets in the public domain that depict the prevalence of substance abuse among expecting mothers, particularly for illegal substances. According to OASIS, the percentage of births with reported tobacco exposure has decreased from 2011 to 2015 in the region (4.5% to 4.4%), the state (6.0% to 5.7%), and the nation (9% to 8%).⁵ Underreporting is common for this behavior. The landscape scan revealed that almost half of the counties in the region (18/39) do not have substance abuse services.⁷ Survey results further support the findings of the landscape scan, in that respondents indicated a lack of resources in rural areas; and highlighted the need for more rehabilitation options for mothers and their infants.

Strategic Goal: Improve infant outcomes by improving maternal health and wellness in the Atlanta Perinatal Region through culturally appropriate community outreach and investment that provides education and resources related to the pregnancy continuum including assessment and care coordination.

Objective:	Reduce the use of harmful substances during pregnancy by increasing awareness, knowledge, and support related to the need to abstain from the use of tobacco, illegal substances, certain prescriptions, and alcohol
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	during pregnancy and among women of child bearing age in the Atlanta Perinatal Region by 2021.
Measures of Success:	Data from DBHDD, DFCS, DCH, DPH, SHBP, and CMO's (e.g. number of referrals and program participation).
Recommended Next Steps:	<ul style="list-style-type: none"> • Increase provider knowledge and access to resources. • Include all available measurements for assessing treatment outcomes for pregnant women in evaluation efforts. • Assure preferential admission for pregnant women into treatment. • Increase treatment options for pregnant women and women of childbearing age.

Poor health status and obesity

According to the CDC, the percentage of women entering pregnancy as obese has increased from 2011 to 2014 in the state (from 27.3% to 28.0%) and the nation (from 23.4% to 24.8%), with higher rates among Black and Hispanic women.⁴ Similarly, rate of births associated with hypertension has increased nationally from 39.9 to 56.0 per 1,000 live births from 2005 to 2015.⁶

Strategic Goal: Improve infant outcomes by improving maternal health and wellness in the Atlanta Perinatal Region through culturally appropriate community outreach and investment that provides education and resources related to the pregnancy continuum including assessment and care coordination.	
Objective:	Improve women's health by increasing awareness and behavioral changes regarding healthy choices and risk reduction among women of child bearing age to reduce poor health/obesity outcomes among women in the Atlanta Perinatal Region by 2021.
Measures of Success:	Data from ICD-10, WIC, DPH SHAPE, & SHBP (e.g. WIC utilization, BMI of women of reproductive age, chronic disease incidence overtime).
Recommended Next Steps:	<ul style="list-style-type: none"> • Provide evidence-based programming to school-aged children. • Increase access to affordable healthy food choices and to community health facilities. • Increase utilization of WIC services for eligible women and infants. • Use culturally appropriate teaching methods and support initiatives that use evidence-informed strategies to improve outcomes with Black and Hispanic populations.

Poor mental health

According to HMHB State of the State of Maternal & Infant Health in Georgia report (2016), postpartum depression affects 9-16% of postpartum women in the U.S.⁶ Survey respondents indicated that there is a need to increase screening and treatment for perinatal mood and anxiety disorders (PMADs) and adverse childhood experiences (ACES) among women that are childbearing age, pregnant, or new mothers.

Resources to accomplish this may not be readily available in Catoosa, Dawson, Murray, Polk, and Towns Counties.⁷

Strategic Goal: Improve infant outcomes by improving maternal health and wellness in the Atlanta Perinatal Region through culturally appropriate community outreach and investment that provides education and resources related to the pregnancy continuum including assessment and care coordination.	
Objective:	Assess communities for need and availability, reduce stigma and increase availability and use of behavioral health services for pregnant and postpartum in the Atlanta Perinatal Region by 2021.
Measures of Success:	Data from DBHDD, DCH, CDC, DPH, & DFCS (e.g. number of regional providers offering post-partum mental health services, number of referrals).
Recommended Next Steps:	<ul style="list-style-type: none"> • Implement mandatory mental health screenings at well-woman, pre-natal, postpartum, and infant’s pediatric visits. • Share mental health promotion among all programs that touch women of childbearing age. • Address stigma through awareness-raising campaigns. • Include perinatal and breastfeeding support professionals in depression screening • Increase the availability of services specific to perinatal mental health issues and providers with specific perinatal mental health training. • Expand the types of data collected by Georgia related to perinatal mood and anxiety disorders (PMADs). • Improve access to behavioral telehealth for those areas where in-person provider availability is absent.

Lack of breastfeeding

According to the HMHB State of the State of Maternal & Infant Health in Georgia report (2016), 31% of mothers do not initiate breastfeeding in GA compared to 18.9% nationally.⁶ One of the greatest challenges to increasing breastfeeding is the limited supply of trained professionals in the APR due to the lack of reimbursement by Medicaid. The northeast (Banks, Dawson, Fannin, Franklin, Gilmer, Hart, Lumpkin, Murray, Pickens, Rabun, Stephens, Towns, and Union Counties) and southern counties (Fayette, Henry, and Newton Counties) have fewer breastfeeding resources listed than the rest of the region.⁷

Strategic Goal: Improve infant outcomes by improving maternal health and wellness in the Atlanta Perinatal Region through culturally appropriate community outreach and investment that provides education and resources related to the pregnancy continuum including assessment and care coordination.	
Objective:	By 2021, increase breastfeeding initiation and duration in the Atlanta Perinatal Region by increasing awareness, knowledge and support of breastfeeding practices among women, families and providers.by 2021.
Measures of Success:	Data from DPH, hospital discharge records, WIC, (e.g. the number of hospitals that are Baby Friendly, and GA 5-Star).

Recommended Next Steps:	<ul style="list-style-type: none">• Increase access to qualified providers: IBCLC, CLC, LLLL, Doulas, CHWs, peer counselors, etc. (per Surgeon General report, WHO, CDC etc.)• Shared outreach by all organizations that reach women of child bearing age with a message about the benefits of breastfeeding• Collaborate with faith-based institutions to reach women.• Increase utilization of WIC services for eligible women and infants.• Address stigma through awareness-raising campaigns.
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SOCIAL DETERMINANTS OF HEALTH

SOCIAL DETERMINANTS OF HEALTH

Social determinants of health refer to the societal factors that impact health, including poverty, low educational attainment, stress and lack of support, and lack of housing. This cluster of priorities also emerged in the discussions of stakeholders about the driving forces of the higher rates of IM in their communities. The datasets point to a strong connection between infant outcomes and the social determinants of health defined by stakeholders. Survey respondents most often noted the following facilitating factors related to the social determinants of health: lack of resources, lack of awareness, limited care coordination, rural access issues (transportation, location of services, etc.), lack of education/poor education opportunities, culture/tradition/generational cycles, stigma and apathy. The landscape scan related to these priorities indicated that there are resources to address the social determinants of health listed here.

Strategic Goal: Increase knowledge, awareness, competence, and create opportunities within systems to reduce the influence of Social Determinants of Health that affect maternal and infant outcomes.

Poverty

According to the KidsCount Data Center, the percent of children in families that receive public support has increase between 2010 and 2015 in GA (from 29% to 31%) and the nation (from 27% to 28%).⁸ Between 2004 and 2011, PRAMS data shows an increase in the percent of respondents with an income less than \$10,000/yr. in the state (from 22.7% to 24.5%) and a slight decrease nationally (from 20.2% to 19.7%).⁴ Survey respondents indicated that employment opportunities, safety, financial support and nutritional support are the greatest needs in their communities.

Strategic Goal: Increase knowledge, awareness, competence, and create opportunities within systems to reduce the influence of Social Determinants of Health that affect maternal and infant outcomes.	
Objective:	Increase the implementation of evidence-informed practices that aim to improve birth outcomes among socio-economically disadvantaged women in the Atlanta Perinatal Region through increased funding and program support by 2021.
Measures of Success:	Data from KidsCount Data Center, PRAMS, and WIC (e.g. program outcomes and budget indicators).
Recommended Next Steps:	<ul style="list-style-type: none"> Partnership planning with the Department of Education, Department of Labor and technical colleges of Georgia. Incorporate strategies to address socioeconomic disparities in birth outcomes that remain constant throughout educational attainment.

⁸ "KIDS COUNT Data Center from the Annie E. Casey Foundation," accessed February 6, 2018, <http://datacenter.kidscount.org/>.

Low educational attainment

According to OASIS, between 2005 and 2015, the percent of births to mothers with less than a H.S. diploma has decreased in the region (from 22.9% to 14.3%), the state (from 23.7% to 15.1%), and the nation (from 24% to 15%).⁵ Survey respondents indicated that job training and educational opportunities are the greatest needs in the communities they serve.

Strategic Goal: Increase knowledge, awareness, competence, and create opportunities within systems to reduce the influence of Social Determinants of Health that affect maternal and infant outcomes.	
Objective:	By 2021, increase the number of evidence-informed practices implemented in the APR to improve educational attainment among expectant mothers, new mothers, and their families.
Measures of Success:	Data from OASIS, and DOE (e.g. women giving birth with less than high-school diploma, GED).
Recommended Next Steps:	<ul style="list-style-type: none"> • Partnership planning with the Department of Education and technical colleges of Georgia. • Incorporate strategies to address socioeconomic disparities in birth outcomes that remain constant throughout educational attainment. • Support early childhood education programs that seek to jumpstart learning, thereby increasing the likelihood for higher educational attainment of Georgia parents. • Job placement programs

Stress and lack of support

According to the PRAMS data, the percent of mothers reporting 3 or more stressors in the state has decreased from 30.3% in 2006 to 17.6% in 2011. There was a national decrease from 2006 to 2011 from 28.7% to 25.2%.⁴ Survey respondents indicated that the greatest needs in the communities they serve are related to affordability of services, appropriate birth spacing, availability of in-home services, safe sleep training, care coordination for mother and baby, and financial assistance for uninsured mothers.

Strategic Goal: Increase knowledge, awareness, competence, and create opportunities within systems to reduce the influence of Social Determinants of Health that affect maternal and infant outcomes.	
Objective:	By 2021, increase the number of evidence-informed practices implemented in the Atlanta Perinatal Region to improve culturally competent screening and social support structures for pregnant and postpartum women and their families.
Measures of Success:	Program outcome data (e.g. healthcare education programs report integration of evidence-based cultural competency training).
Recommended Next Steps:	<ul style="list-style-type: none"> • Increase visibility and awareness of available resources (EAP, support groups, etc.). • Provide cultural competency trainings for healthcare providers in Georgia.

	<ul style="list-style-type: none"> • Maintain and increase support groups for women of childbearing age. • Support initiatives that seek to empower women and families to address and prevent domestic violence, child abuse, and child neglect.
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Lack of housing

Affordable housing is a known issue within the state. According to KidsCount Data Center, the percent of children living in households with a high housing cost burden decreased between 2010 and 2015 in GA (from 41.0% to 33.0%) and the nation (from 41.0% to 33.0%).⁸ Survey respondents indicated that the greatest need in the communities they serve is related to stable housing. More than two-thirds of the counties in the region did not have identified housing services in the landscape scan completed for this priority cluster (Banks, Catoosa, Chattooga, Cherokee, Clayton, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Haralson, Hart, Henry, Lumpkin, Murray, Newton, Paulding, Pickens, Polk, Rockdale, Towns, Union, Walker, and White Counties). Moreover, requests for housing is a common problem/need of consumers utilizing the 1-800-300-9003, the maternal and child health referral line maintained by HMHB and supported by the Department of Public Health.

Strategic Goal: Increase knowledge, awareness, competence, and create opportunities within systems to reduce the influence of Social Determinants of Health that affect maternal and infant outcomes.	
Objective:	By 2021, increase the number of evidence-informed practices implemented in the Atlanta Perinatal Region to increase access to stable housing for pregnant and postpartum women.
Measures of Success:	Data from Georgia Housing and Urban Development (e.g. number of available and utilized units along with waiting list figures).
Recommended Next Steps:	<ul style="list-style-type: none"> • Include housing information in prenatal care welcome packets. • Identify partnerships with public and private agencies to provide affordable housing for expectant women and women with small children. • Assure State and agency-level data reflect utilization of housing services by pregnant and postpartum women.



ADDRESSING SUDDEN
INFANT DEATH
SYNDROME

ADDRESSING SUDDEN INFANT DEATH SYNDROME

According to OASIS, between 2010 and 2015, the percentage of infant deaths due to SIDS decreased in the region (from 16.8% to 9.6%) and the state (from 14.7% to 10.3%). This is a trend that was replicated nationally, and attributed to the promotion of safe sleep efforts (crib donations, education, in-home assessments, etc.). While Georgia has seen improvements toward reducing sleep-related deaths, it is still a leading cause of death among infants in the State. Additionally, there is a need to ensure the continued funding and support for safe sleep education interventions to sustain these outcomes and further reduce preventable sleep-related deaths. This issue does not fit specifically within the categories of access to care, maternal health or the social determinants of health, but is critical to highlight in any efforts to reduce infant mortality. Based on feedback received during the preliminary survey, during the planning sessions and during the public comment period, the following strategic goal was added to the framework:

Strategic Goal: Reduce the number of preventable sleep-related infant deaths to below the national average.

Objective:	By 2021, increase the implementation of evidence-informed practices that aim to reduce sleep-related infant deaths.
Measures of Success:	Data from DPH and DCH (e.g. state assessment of hospitals implementing programming, sleep-related infant deaths overtime).
Recommended Next Steps:	<ul style="list-style-type: none"> • Increase the number of hospitals actively implementing safe sleep education with parents and guardians of new infants prior to discharge. • Increase the number of in-home safety assessments conducted. • Maintain and enhance education and awareness raising programming targeting parents, providers and caregivers.

CONCLUSION

The recommendations provided in this report serve as a blueprint for prioritizing programming, funding and partnerships in the Atlanta Perinatal Region to address infant mortality. The next step in this process is to re-convene with stakeholders across the region to identify establish commitments and collaborations toward operationalizing the plan.

Questions about the process or strategic plan may be emailed to: thecoalition@hmbga.org.

Appendix 1: Survey Results

HMHB Stakeholder Survey Results to Inform Three Strategic Planning Sessions

(5/3, 5/31, and 6/21)

The following survey was developed with HMHB oversight and input. While raw data is available to review, this summary of results will help guide the meeting design session. What follows is a question by question summary of the survey responses.

Survey data will be accompanied by secondary data about the infant mortality rate in the Atlanta Perinatal Region, as well as service providers in each county.

Question 1-3: Information about survey respondents

There were 49 surveys submitted by 4/17/17; of those 34 were completed. The following results include the 34 complete surveys unless otherwise noted.

Of the 34 surveys included in the analysis:

- 50% of respondents (17) represented all 39 counties in the Atlanta Perinatal Region,
- Individual counties had no more than 6 respondents;
 - Gwinnett, Fulton, DeKalb, Cobb, and Habersham had 4-6 respondents;
 - Rabun, Rockdale, Hall, Stephens, Forsyth, Union, Dawson, Clayton, Hart, Lumpkin, and Newton had 2-3 respondents;
 - Chattooga, Bartow, Douglas, Henry, White, Polk, Floyd, Towns, Franklin, and Banks had 1 respondent each; and
 - Paulding, Dade, Pickens, Fayette, Whitfield, Walker, Gilmer, Gordon, Cherokee, Murray, Catoosa, Haralson, and Fannin were not individually represented in these survey result.
- There were a variety of organization types represented:
 - 74% represented non-profit/public health service providers (25)
 - 15% represented professional associations (5)
 - 6% represented for-profit health service providers (2)
 - 6% represented research/education (2)

Table: Survey Respondents Type of Organization and Service Area

County	Total	For Profit Health Service Provider	Non-Profit/Public Health Service Provider	Research/Education	Funder	Professional Association
Total	34	2	25	2	0	5
All 39 counties	17	1	9	2	0	5
Gwinnett	6	1	5	0	0	0
Fulton	6	1	5	0	0	0
DeKalb	5	1	4	0	0	0
Cobb	4	1	3	0	0	0
Habersham	4	0	4	0	0	0
Rabun	3	0	3	0	0	0

County	Total	For Profit Health Service Provider	Non-Profit/Public Health Service Provider	Research/Education	Funder	Professional Association
Rockdale	3	1	2	0	0	0
Hall	3	0	3	0	0	0
Stephens	3	0	3	0	0	0
Forsyth	2	0	2	0	0	0
Union	2	0	2	0	0	0
Dawson	2	0	2	0	0	0
Clayton	2	0	2	0	0	0
Hart	2	0	2	0	0	0
Lumpkin	2	0	2	0	0	0
Newton	2	0	2	0	0	0
Chattooga	1	0	1	0	0	0
Bartow	1	0	1	0	0	0
Douglas	1	0	1	0	0	0
Henry	1	0	1	0	0	0
White	1	0	1	0	0	0
Polk	1	0	1	0	0	0
Floyd	1	0	1	0	0	0
Towns	1	0	1	0	0	0
Franklin	1	0	1	0	0	0
Banks	1	0	1	0	0	0

Note: Paulding, Dade, Pickens, Fayette, Whitfield, Walker, Gilmer, Gordon, Cherokee, Murray, Catoosa, Haralson, and Fannin did not have individual representation outside of the 39 county representation

Question 4: Service growth/expansions planned over the next 12 months among respondent organizations

The majority of respondents (71%) are not planning to expand the services they offer in the next 12 months. Of the 10 providers planning to expand services in the next 12 months, there are:

- 2 Non-Profit/Public Health Service Providers and 1 Research/Education provider planning to expand Adolescent Reproductive healthcare, Behavioral health services, and Interconception Education/advocacy services throughout the 39-County Region
- A variety of additional service expansions are planned for Rockdale, Clayton, DeKalb, Fulton, Henry, Newton, Gwinnett, Habersham, Cobb, Floyd, Chattooga, Bartow, and Polk Counties
- Outside of any expansion planned in services provided across the 39-county region, there are no specific service expansions planned among respondents in Banks, Catoosa, Cherokee, Dade, Dawson, Douglas, Fannin, Fayette, Forsyth, Franklin, Gilmer, Gordon, Hall, Haralson, Hart, Lumpkin, Murray, Paulding, Pickens, Walker, Rabun, Stephens, Towns, Union, White, and Whitfield Counties.

Table: Service Expansion by Type of Provider and Counties Served

Service Expanding	Provider Type	Geographic Area
Adolescent Reproductive healthcare	2 Non-Profit/Public Health Service Providers	39-County Region, Rockdale, Clayton, DeKalb, Fulton, Henry, Newton, Gwinnett
Behavioral health services	1 Non-Profit/Public Health Service Provider	39-County Region
Breastfeeding education/support	1 Non-Profit/Public Health Service Provider	Habersham
Gestational Education/advocacy,	1 Non-Profit/Public Health Service Provider	Fulton
Postpartum Education/advocacy	2 Non-Profit/Public Health Service Provider	Fulton, DeKalb, Cobb, and Gwinnett
Social services to mothers (including expecting mothers)	1 Non-Profit/Public Health Service Provider	Fulton
Pre- and early-term births to prevent births before 39 weeks of gestation		
High-risk maternity services	1 Non-Profit/Public Health Service Provider	Floyd, Chattooga, Bartow, Polk
Interconception Education/advocacy	1 Research/Education provider	39-County Region
Seeking funding for housing, and job support for pregnant women	1 Non-Profit/Public Health Service Provider	DeKalb
Safe sleep practices for infants and newborns	1 Research/Education provider	Clayton and DeKalb

Question5: Top factors driving the IMR in respondents' areas

Top 10 Factors that impact IMR

1. Health inequity (15)
2. Medical complications (hypertension, diabetes, etc.) (13)
3. Substance abuse (12)
4. Poor access to or inadequate use of prenatal care (12)
5. Poverty (12)
6. Unintended pregnancy (10)
7. Stress and lack of support (8)
8. Absence of preconception/interconception care and counseling (7)
9. Lack of health insurance (7)
10. Age of mother (40 years) (6)

Questions 6-10: Respondents opinions about what mothers and infants need to improve birth outcomes, including the reasons those needs are not currently being met

When asked if mothers and infants that are at risk of poor outcomes are receiving what they need about one-quarter of 39 survey respondents (all non-profit/public health service providers) felt they were; whereas, approximately three-quarters of respondents felt they were not. More specifically:

- The non-profit/public health service providers that responded yes (mothers and babies are receiving what they need) represented the 39-County region (1/17), Rockdale (2/3), Banks (1/1),

Clayton (2/3), DeKalb (2/6), Dawson (1/3), Fulton (3/7), Douglas (1/1), Franklin (1/2), Henry (1/1), Newton (2/2), Hart (1/3), Cobb (2/4), Rabun (1/4), Union (2/4), Hall (2/5), Stephens (2/5), Gwinnett (4/7), White (1/2), Towns (1/2), Habersham (2/6), Lumpkin (2/4), and Forsyth (2/4)

Geographic Representation of Respondents non-profit/public health service providers that responded yes (mothers and babies are receiving what they need)

1. All 39 counties
2. Clayton
3. Fulton
4. Cobb
5. Union, Hall, Stephens, Gwinnett, Habersham, Lumpkin, Forsyth
6. DeKalb, Fulton, Gwinnett
7. DeKalb, Fulton, Gwinnett, Newton, Henry, Rockdale, Clayton
8. Banks, Dawson, Franklin, Hart, Rabun, Union, Hall, Stephens, White, Towns, Habersham, Lumpkin, Forsyth
9. Douglas, Cobb
10. Rockdale, Newton, Gwinnett

Table: Factors Driving the Infant Mortality Rate in the Atlanta Perinatal Region by Challenges and Facilitators Identified by Respondents

Factors Driving the Infant Mortality Rate in the Atlanta Perinatal Region	
What is missing?	Why?
HEALTH INEQUITY (15)	
	Absence of people of color in decision-making positions
MEDICAL COMPLICATIONS (HYPERTENSION, DIABETES, ETC.) (13)	
<ul style="list-style-type: none"> • Relevant health education for expecting mothers • Medical management • Additional training and awareness for first responders 	<ul style="list-style-type: none"> • Culture • Poor compliance with follow-up directives • Lack of access to care (transportation and provider location) • Lack of insurance
SUBSTANCE ABUSE (12)	
<ul style="list-style-type: none"> • Smoking cessation resources for pregnant women • Rehabilitation options (Maternal and infant programs) • Foster care options 	<ul style="list-style-type: none"> • Lack of resources in rural areas, in particular • Lack of funding and limited reimbursement
POOR ACCESS TO OR INADEQUATE USE OF PRENATAL CARE (12)	
<ul style="list-style-type: none"> • Increased access/participation in prenatal care • In-home follow-up options • Affordable midwife services • Specific prenatal wrap around services for high risk populations • Prenatal oral health services • Prenatal classes 	<ul style="list-style-type: none"> • No programs in rural areas (e.g., Polk and Chattooga) • Poor compliance with follow-up directives • Insurance eligibility after pregnant • Inequality • Transportation
POVERTY (12)	
<ul style="list-style-type: none"> • Housing (stable, affordable, safe) 	<ul style="list-style-type: none"> • Lack of resources

Factors Driving the Infant Mortality Rate in the Atlanta Perinatal Region	
<ul style="list-style-type: none"> • Employment opportunities/ • Job training /Educational opportunities for mothers • Safety • Financial support • Nutritional support (mother and baby) 	<ul style="list-style-type: none"> • Lack of programs/options • Low awareness of what is available • Systemic oppression • Lack of buy-in from legislators • Limited accountability for disparities • No human rights framework
UNINTENDED PREGNANCY (10)	
STRESS AND LACK OF SUPPORT (8)	
<ul style="list-style-type: none"> • Parent support/education (e.g., nutrition, exercise, calm crying baby, child neglect/abuse, infant stimulation, child development, maternal bonding, stress reduction, safety, breastfeeding, language stimulation, etc.) • Maternity leave • Paternal inclusion and support • Social Services for pregnant women (in-home parenting assessments) • 	<ul style="list-style-type: none"> • Lack of resources/reimbursement • Illegal status • Isolation • Generational cycles • Low awareness of what is available • Poor attendance of existing programs • Limited awareness of importance/value • Inconsistent messaging and lack of information
<ul style="list-style-type: none"> • Behavioral health services for pregnant and postpartum women • Screening and counseling for perinatal mood disorders (postpartum depression) • Presences of ACEs 	<ul style="list-style-type: none"> • Lack of resources/reimbursement • Lack of programs/options • Isolation • Transportation issues • Lack of child care offered • Stigma/apathy • Generational cycles • Referral resources for positive screening • Poor attendance of existing programs • Limited awareness of importance/value
ABSENCE OF PRECONCEPTION/INTERCONCETION CARE AND COUNSELING (7)	
<ul style="list-style-type: none"> • Affordable doula services • Appropriate spacing of pregnancies • Postpartum check-ups at home • Safe sleep training • Breastfeeding training/education/support (IBCLC lactation services in the hospital and at home, training for breast pumps and how to maintain a mother's milk supply for all mothers undergoing any mother/baby separation, ,etc.) • Care coordination for mother and baby • Financial assistance for PPBTL for uninsured mothers 	<ul style="list-style-type: none"> • Lack of resources/reimbursement - Medicaid does not cover lactation care by an IBCLC (GA can choose to change) • Not all communities/hospitals have access to lactation consultants (Habersham) • Home visitors are not always trained to support breastfeeding • Limited social support in the community for mothers breastfeeding • Programs are not aware of a systemic way to coordinate care
LACK OF HEALTH INSURANCE (7)	

Factors Driving the Infant Mortality Rate in the Atlanta Perinatal Region	
<ul style="list-style-type: none"> • Access to affordable health care coverage for women of child bearing age before conception, postpartum, and between pregnancies • Continuous insurance for infants (emergency Medicaid after birth, until age 2 years without reenrollment) 	<ul style="list-style-type: none"> • Lack of Medicaid expansion in GA • Maternity units and hospitals have closed • Institutional racism embedded in the health care system
AGE OF MOTHER (40 YEARS) (6)	
<ul style="list-style-type: none"> • Lack of education for high-risk pregnancy 	

Questions 11-18: List of past interventions that respondents felt were effective at reducing IMR in their area

When asked if they were aware of past interventions that they felt reduced the IMR, 56% said they were unaware and 44% offered the following list of interventions:

Table: Previous Interventions by Target Population, Service Area, and Duration

Purpose	Target Population	Geography Represented	Date Range	Responsible Party
Increase access Centering pregnancy	Women of reproductive age.	All 39 counties	--	Fed government MOD/ United Way
Babies Can't Wait and Children First	high risk for developmental delays	All 39 counties	--	DPH
Improve preventive health services for infants and children - the adoption of the Bright Futures periodicity schedule allowing the detection of health issues during scheduled preventive health visits.	All Medicaid and CHIP kids	All 39 counties	Ongoing	Medicaid
Babies Born Healthy, Pregnancy Related Services, Perinatal Case Management	Pregnant, low income women	All 39 counties	2002-2008	HMHB and Georgia Public Health
To reduce poor birth outcomes.	1000+	Fulton	1989- Ongoing	Center for Black Women's Wellness
Safe to Sleep - bassinets given to mothers with Medicaid; "This Side Up" onesie and board book with safe sleep messages provided to all upon discharge	Postpartum families	DeKalb, Fulton, Gwinnett	2016- Ongoing	U.S. DHHS
Good prenatal care that includes not just physical health of the mother and unborn, but frank discussions about what to expect when the baby arrives to include, lack of sleep, crying babies, illness, safe sleep environments, medical checkups etc.	expectant mothers	All 39 counties	--	DFCS CM's
The old Medical payed PRS services that are no longer paid for or available. Postpartum home visits up to 1 year of age.	All Medicaid postpartum	Douglas, Cobb	-20+ yrs - 2007	Public Health

Purpose	Target Population	Geography Represented	Date Range	Responsible Party
	women and their babies.			
Video in Spanish to encourage language stimulation.	mothers	Hall	2015-Ongoing	Department of Public Health and Emory
"linking children and families at risk of poor health and developmental outcomes to appropriate Public Health and community services" "assist individuals in determining the number and spacing of their children"	birth-3, Birth - 5 Birth - 21y.o.	Rockdale, Newton, Gwinnett	--	Children First, Children's Medical Services, Babies Can't Wait and the Family Planning Program
Parent education and prevention of LBW - longitudinal home visitation programs. Parent education and prevention of a variety of poor birth outcomes - Centering Pregnancy		All 39 counties	--	--
Safe Sleep Initiatives	All birthing hospitals	All 39 counties	?? - Ongoing	GA Department of Public Health
parenting education	at-risk mothers and infants	Fulton	2015-Ongoing	Healthy Start - Atlanta program
Because I work with a variety of communities, I am uncertain how to answer this question. There are a number of interventions focused on reducing LBW that I believe have or can effectively address LBW and IM.		All 39 counties	--	--
Initiative to prevent elective deliveries prior to 39 weeks.	Medicaid	All 39 counties	2016-Ongoing	GA Medicaid, March of Dimes
M.O.R.E.--Mothers Offering Resources and Education-MCH program targeted towards infant mortality and positive birth outcomes	Expecting/new mothers	DeKalb	2005-Ongoing	DeKalb County Board of Health
Reduction in sudden infant death	All Georgians	DeKalb, Fulton, Cobb, Gwinnett	--	State Department of Community Health and Public Health
One on one nursing intervention in educating pts on obesity and healthy nutrition, WIC programs.	mothers & infants	Hall	--	WIC & Hall County PHD
Encourage imitation of breastfeeding in the immediate postpartum period.	Medicaid	All 39 counties	2016-Ongoing	Amerigroup Georgia
Planning for Healthy Babies	Medicaid w/birth weight < 1500 grams	DeKalb, Fulton, Cobb, Gwinnett	--	GA Medicaid
Hall County HD's prenatal and endo clinic	GDM mothers	Hall	--	The Longstreet Clinic (TLC) and Mandy Moore, TLC pharmacist.

Purpose	Target Population	Geography Represented	Date Range	Responsible Party
reduce low birthweight	Medicaid	All 39 counties	2016- Ongoing	Amerigroup- GA Medicaid- March of Dimes

Questions 16 -24: Recommendations about evidence informed practices to reduce IMR regionally:

When asked for recommendations for evidence based practices respondents believed would reduce IMR in their area, --% said they were unaware and --% offered the following list of interventions:

Table: Previous Interventions by Target Population, Service Area, and Duration

Counties Served	Name of program/practice	Purpose	Challenges for successful implementation
All 39 counties listed	P4HB	Access to FP services and care for high risk moms with a history of preterm births	Poor community uptake due to lack of support and poor marketing
All 39 counties listed	Improved rates of influenza immunization during pregnancy.	Reduce preterm births	reimbursement rate
Clayton	Parents As Teachers	Home Visitation Curriculum	Funding
All 39 counties listed	Baby LUV	care management for high risk African American pregnant women	funding
All 39 counties listed	Breastfeeding education, support and education around safe sleep practices and child spacing	health of mother, health of baby	resources, funding
Hart, Rabun, Stephens, Habersham	Back to sleep.	Encourages parents to place infant in their own bed and on their back to sleep. Reduces SIDS	Parents often want to hold infants and co-sleep
DeKalb, Fulton, Gwinnett	Postpartum depression screening	To identify mothers with postpartum psychosis	Work flow and follow up. Who would administer the questionnaire? How would follow-up occur for at-risk mothers?
All 39 counties listed	Baby Luv	bring social services to those in need	cost, availability of social workers
Douglas, Cobb	Nurse Family Partnership	Screening assessment referrals education and support that is longer term for pregnant women as soon as they become pregnant that lasts for 1 year after birth.	Lack of funds to implement.
All 39 counties listed	Centering Pregnancy	empowering PNC	adopting a new model for care

Counties Served	Name of program/practice	Purpose	Challenges for successful implementation
Fulton	Family Planning	to support pregnancy spacing	availability; accessibility
Floyd, Chattooga, Bartow, Polk	Healthy families	screen at risk and follow in homes postpartum	money
All 39 counties listed	A door to door awareness and training program regarding unsafe sleep	prevent sleep related infant deaths	funding
All 39 counties listed	Amerigroup Continued Care OB Management	Follow OB members who are at high risk on a continued basis.	Continued reaching out to members and insuring that they are keeping their prenatal visits.
DeKalb	MORE program--please see previous description	--	funding
All 39 counties listed	MOMS PROGRAM IN Clayton county	Care and Services to high risk pregnant women-AA WOMEN	Small pop served
All 39 counties listed	"Increase cost of tobacco products	--	--

Appendix 2: Secondary Data, Dashboards, Tables, and Charts

FOCUS AREA	Priority						Special Populations
	Condition	Type	Year	APR	GA	US	Disparities /Geographic notes/Racial Data
Access to Care	Lack of health insurance ¹	% Pop.	2009		31.8%		
			2011		37.4%		
	Prenatal care ²	% Births with late or no prenatal care	2005	3.8%	3.8%	8.0%	
			2015	6.4%	5.7%	6.0%	
	Preconception/interconception care ²	% Births with <2 year Interval	2010	21.3%	22.9%		
2011-2015			20.6%	21.6%			
Health inequity ²	IMR race/ethnicity by county					Highest rates among African American groups	
Maternal Health	Substance abuse ²	% Births with reported tobacco use	2011	4.5%	6.0%	9.0%	
			2015	4.4%	5.7%	8.0%	
	Poor health status Hypertension (Preg) ³	Rate per 1,000 live births	2005			39.9	
			2015			56.0	
	Poor health status Obesity ³	% of women entering pregnancy obese	2011		27.3%	23.4%	African American and Hispanic communities have higher percent of women entering pregnancy overweight or obese
			2014		28.0%	24.8%	
Poor mental health ⁴	% of mothers with postpartum depression	2009		11.6%	9-16%	In GA, teen mothers, Non-Hispanic Black mothers, and mothers with less than a High School education are most at-risk for depression	
		2011		8.1%	9-16%		
Lack of breastfeeding ⁴	% of women who don't initiate breastfeeding	2014		31%	18.9%		
Infant Health	Infant Mortality Rate ²	Rate 1,000 live births	2000-10	7.0	8.1	6.14	Infant Mortality rate is highest among Black or African American infants (13.3)
			2005-15	6.5	7.5	5.9	
	Low Birth Weight ⁴	% of live births	2003	8.5%	9.0%	7.9%	Rural mothers delivered 15.5% of LBW babies in GA (had 15.5% of births)
			2014	9.0%	9.5%	8.0%	
	Sudden Infant Death Syndrome ²	% of Infant Deaths due to SIDS	2010	16.8%	14.7%		
			2015	9.6%	10.3%		
Pre-term birth ⁴	% of births that are premature births	2008	11.6%	11.9%	12%	GA rural mothers- 16.7% of premature babies (had 15.5% of births) (2015) preterm birth non-Hispanic Black women (13%) was about 50% higher than among non-Hispanic White women (9%).	
		2015	10.2%	10.8%	9.57%		
Congenital malformation and anomalies ³	Rate per 100,000 live births	2005			11.3		
		2015			10.3		
Social Determinants of Health	Poverty ¹	% with an income less than \$10,000	2004		22.7%	20.2%	
			2011		24.5%	19.7%	
	Low Educational Attainment ²	% of births with educational level less than high school	2005	22.9%	23.7%	24.0%	
			2015	14.3%	15.1%	15.0%	
	Stress and Lack of Support ¹	% of mothers reporting 3 or more stressors	2006		30.3%	28.7%	
			2011		17.6%	25.2%	
Lack of housing ⁵	% of children living in households with a high housing cost burden	2010		41.0%	41.0%		
		2015		33.0%	33.0%		

¹PRAMS: <https://www.cdc.gov/prams/pramstat/index.html>; ²OASIS: <https://oasis.state.ga.us>; ³CDC: https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01_tables.pdf; and https://www.cdc.gov/nchs/data/nvsr/nvsr65/nvsr65_06.pdf; and https://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_01_tables.pdf; ⁴(SOS Presentation); ⁵Kids Count

2000-2015 IMR COUNTY-BY-COUNTY WITH REGIONAL, STATE, AND NATIONAL COMPARISON HANDOUT

Rank	Counties in the Atlanta Perinatal Region	Births	% GA Pop.	Infant Deaths 2000-2010	IMR 2000-2010	Infant Deaths 2005-2015	IMR 2005-2015	2010-2015 Change
1	Floyd	15,280	1.0	168	11.0	148	10.4	0.6
2	Rockdale	12,085	0.8	74	6.1	107	9.0	2.9
3	Banks	2,335	0.2	20	8.6	19	8.5	0.1
4	Dade	1,875	0.1	15	8.0	15	8.2	0.2
5	Clayton	51,887	3.4	458	8.8	394	7.8	1.0
STATE GA Total						11,333	7.8	--
6	Chattooga	3,567	0.2	31	8.7	26	7.7	1.0
7	Fannin	2,606	0.2	19	7.3	18	7.5	0.2
8	Bartow	15,791	1.0	104	6.6	111	7.4	0.8
9	DeKalb	124,380	8.1	1,019	8.2	924	7.4	0.8
10	Dawson	2,702	0.2	17	6.3	19	7.2	0.9
11	Fulton	145,512	9.5	1,111	7.6	1029	7.2	0.4
12	Douglas	18,989	1.2	134	7.1	143	7.1	0
13	Franklin	3,089	0.2	25	8.1	22	7.1	1.0
14	Henry	27,273	1.8	208	7.6	195	7.0	0.6
15	Newton	15,343	1.0	106	6.9	109	7.0	0.1
16	Polk	7,527	0.5	52	6.9	47	6.7	0.2
17	Hart	3,122	0.2	21	6.7	20	6.5	0.2
18	Walker	8,500	0.6	65	7.6	55	6.5	1.1
Atlanta Perinatal Region Total						5885	6.5	--
19	Haralson	4,215	0.3	33	7.8	26	6.4	1.4
20	Cobb	115,784	7.5	736	6.4	690	6.2	0.2
21	Rabun	1,957	0.1	14	7.2	11	6.2	1
22	Union	2,033	0.1	13	6.4	12	6.1	0.3
23	Paulding	21,080	1.4	134	6.4	130	6.0	0.4
NATION U.S. Total						--	5.9	--
24	Hall	32,479	2.1	221	6.8	181	5.9	0.9
25	Stephens	3,655	0.2	23	6.3	21	5.9	0.4
26	Pickens	3,801	0.2	31	8.2	21	5.8	2.4
27	Fayette	9,966	0.6	53	5.3	54	5.7	0.4

Rank	Counties in the Atlanta Perinatal Region	Births	% GA Pop.	Infant Deaths 2000-2010	IMR 2000-2010	Infant Deaths 2005-2015	IMR 2005-2015	2010-2015 Change
28	Gwinnett	139,449	9.1	842	6.0	790	5.7	0.3
29	White	3,079	0.2	22	7.1	17	5.7	1.4
30	Whitfield	19,293	1.3	121	6.3	96	5.5	0.8
31	Gilmer	4,166	0.3	38	9.1	21	5.4	3.7
32	Gordon	8,976	0.6	70	7.8	46	5.4	2.4
33	Towns	935	0.1	7	7.5	5	5.4	2.1
34	Cherokee	32,843	2.1	163	5.0	161	4.9	0.1
35	Catoosa	8,180	0.5	54	6.6	39	4.8	1.8
36	Murray	6,795	0.4	43	13.5	29	4.7	8.8
37	Habersham	6,214	0.4	29	4.7	26	4.4	0.3
38	Lumpkin	3,556	0.2	13	3.7	14	3.9	0.2
39	Forsyth	25,398	1.7	106	4.2	94	3.7	0.5

Source: Oasis, Department of Public Health, Office of Health Indicators for Planning (OHIP)

Higher than GA Rate (7.8 per 1,000 live births): Floyd, Rockdale, Banks, Dade, and Clayton

Higher than Regional Rate (6.5 per 1,000 live births): Chattooga, Fannin, Bartow, DeKalb, Dawson, Fulton, Douglas, Franklin, Henry, Newton, Polk, Hart, and Walker

Higher than U.S. Rate (6.0 per 1,000 live births): Haralson, Cobb, Rabun, Union, and Paulding

Additional Secondary Data Related to Infant Mortality:

- Infant Mortality (IM) is the death of children under the age of one year.
- The measure of IM is the Infant Mortality Rate (IMR) (deaths per 1,000 births).

In 2015:

- GA ranked 47th in the nation for our IMR
- IMR was much higher in GA than the U.S. (7.8 compared to 5.9 per 1,000 live births)
- The Atlanta Perinatal Region County IMR was higher than the U.S. (6.5 and 6.0 per 1,000 live births respectively)

Across the 39 Counties included in the Atlanta Perinatal Region (APR):

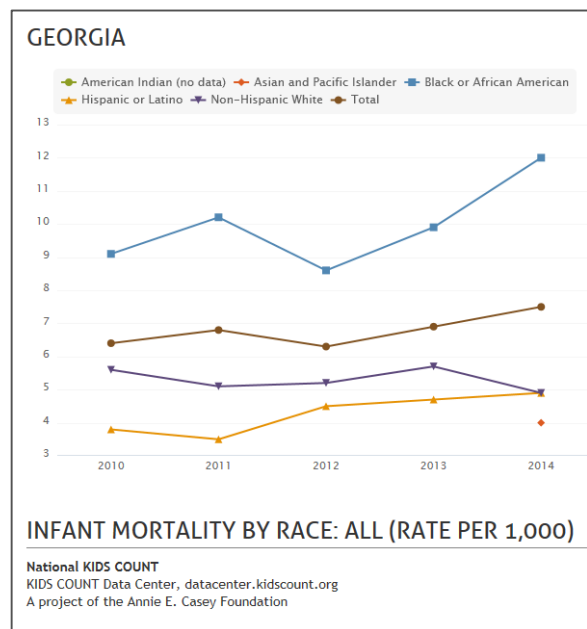
- There were 5885 deaths (6.5 per 1,000 live births)
- 31 counties decreased IMR, 9 counties saw increases in IMR
- 5 counties have higher IMR than GA (Reflected in Red cells on IMR county by county handout)
- 14 have higher IMR than the region (Reflected in orange cells on IMR county by county handout)
- 5 counties have higher IMR than the U.S. (Reflected in yellow cells on IMR county by county handout)

APR Since 2010:

- 9 counties have seen increases
- 30 counties have seen decreases

Infant Mortality: Health Inequity

- Infant Mortality Rate (per 1,000) by race:
 - Black: 13.3
 - White: 5.5
 - Hispanic: 4.9
- Of the 1,004 infant deaths in 2014:
 - 61% were African-American
 - 31% were white
 - 6% were Hispanic



Infant Mortality: State Plan (2013-2016):

Reducing Infant Mortality in Georgia (2013) - *Infant Mortality Task Force*

- IMR improved in GA from 2007-2011 (8.4 to 7.3 per 1,000 live births)
- 6 Clusters of high IMR*
 - Fulton, Douglas, Cobb and Clayton
 - Bibb, Twiggs, Houston and Jones
 - Muscogee and Chattahoochee
 - Lowndes
 - Richmond
 - Chatham
- Three objectives
 1. Strengthen the regional perinatal system of care
 2. Develop targeted educational campaigns on infant mortality related issues
 3. Develop external collaborations to support infant mortality initiatives

Infant Mortality: Medical Complications

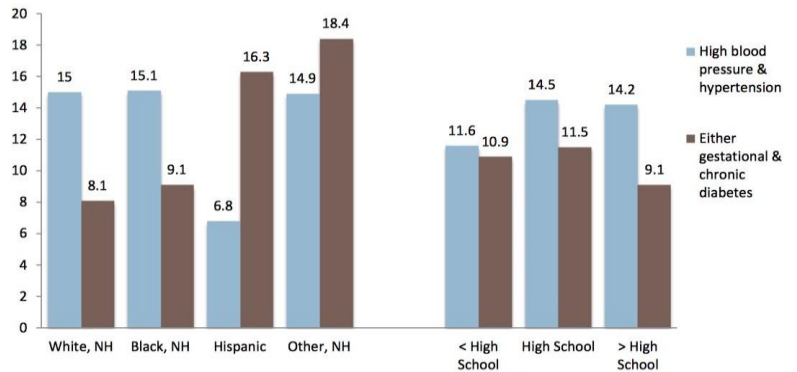
Maternal hypertension (HTN) and diabetes increase risk to both mother and baby.

- Women with a history of preeclampsia are at 2x the risk of heart disease, stroke or thromboembolic event in the 5-15 years following pregnancy.^{iv}

GA PRAMS data by race for HTN in pregnancy:

- Black 15.1%
- White 15%
- Hispanic 6.8%

Percent of women reporting high blood pressure, hypertension, preeclampsia, toxemia or diabetes during pregnancy by race/ethnicity and education, Georgia, 2009 to 2011



Infant Mortality: Substance Abuse and Smoking

Georgia shows better rates than the nations for mothers’ use of alcohol and illicit drugs:

- Alcohol consumption (GA- 6.2% compared to U.S. 7.5%)
- Illicit drugs (GA compared to U.S. 3.1 and 8.2 per 1,000 live births respectively)

Maternal Smoking is usually underreported and associated with increase risk of: Placental abruption, LBW babies, SGA babies, Nonsyndromic heart defects, Oral clefts, and Tourette syndrome

Of the 1,004 infant deaths in 2014:

- 52 (33%) had prenatal maternal tobacco exposure

Birth certificates indicate that about 6% of GA mothers are smoking in pregnancy (7,500+)

- GA PRAMS maternal smoking by race (2009-2012):
 - 10.3% White
 - 3.7% Black
 - 0.9% Hispanic
 - Rome, GA (Floyd County) has one of the highest maternal smoking rates in GA.

Infant Mortality: Prenatal Care

Data regarding prenatal care is often outdated and incomplete in GA:

- Access to prenatal care in rural areas is a challenge
- Babies born to mothers who received no prenatal care are
 - Three times more likely to be born at low birthweight, and
 - Five times more likely to die, than those whose mothers received prenatal care.
- DPH provided HMHB the latest data 2008-2014:

Prenatal Care, Georgia, 2008-2014					
Year	Total Births	Prenatal Care Data Missing	% of Total Births	“No Prenatal Care”	% of Total Births
2008	146,464	44,014	30.1%	2,034	1.4%
2009	141,332	34,064	24.1%	2,181	1.5%
2010	133,668	28,858	21.6%	1,851	1.4%
2011	132,239	23,413	17.7%	1,903	1.4%
2012	130,112	17,988	13.8%	1,633	1.3%
2013	128,511	20,702	16.1%	2,437	1.9%
2014	130,776	21,995	16.8%	960	0.7%

Source: GA DPH (Vital Records)

Infant Mortality: Maternal Factors

Unintended pregnancy

- In 2010, 60% pregnancies were unintended (national average was 45% in 2011)

Age of mother - Mothers <25 and >34 years old:

- have higher rates of premature babies
- have higher rates of LBW babies

Infant Mortality: LOW BIRTHWEIGHT AND VERY LOW BIRTHWEIGHT

- Low Birthweight (LBW): Babies weighing less than 2500gms (5.5 pounds)*
 - ~ 9.5% of GA births, but 70% of GA's infant deaths**
 - Very Low Birthweight (VLBW): Babies weighing less than less than 1.5 kg*
 - ~ 2% of GA births, but 50% of GA's infant deaths**
 - Costs \$27,000 per pound to raise a baby to normal weight
- Risk factors: small maternal stature, poor nutrition, smoking, illicit drug use, hypertension, and short inter-pregnancy interval (inadequate birth spacing)
- For the last five years of data (as noted in the table below), consistently, babies born to mothers utilizing Medicaid have had lower rates of low birthweight than the overall state rate.

Infant Mortality: PRE-TERM BIRTHS

Preterm is defined as babies born alive before 37 weeks of pregnancy are completed.

Beginning with 2014 birth data, the OB estimate of gestation on the birth certificate is now being used to calculate prematurity instead of the previous estimate using the LMP. This is a national change and is lowering prematurity rates by about 2% here in Georgia.

- 2014 GA: 10.8% (National average - 9.57%)
- GA currently ranks 38th (perhaps 43rd)
- Risk factors: History of pre-term births, carrying multiples, uterus or cervix problems, maternal medical condition, certain infections during pregnancy, and substance use (including tobacco)

Infant Mortality: SUDDEN INFANT DEATH SYNDROME (SIDS)

Sudden death is non-violent, unexpected death occurring less than 24 hours from the onset of symptoms.

- From 2005 through 2014, the (national) IMR for sudden infant death syndrome declined 29%
- Of the 1,004 infant deaths in 2014, 158 (15%) were sleep related.

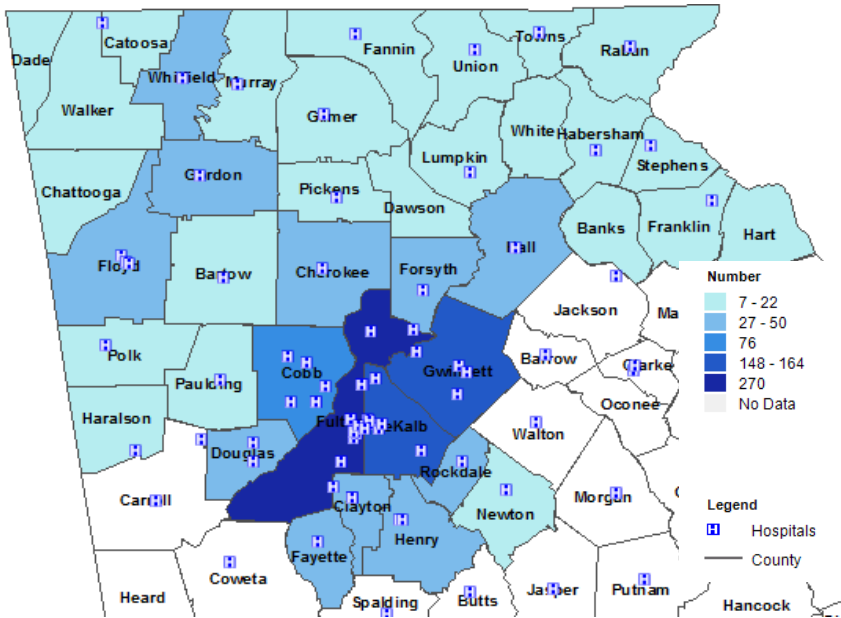
Appendix 3: Landscape Scan - Directory of Resources to Address Infant Mortality in Atlanta Perinatal Region

Types of Services Included in the Landscape Scan Generated from HMHB Directory

70 Services 39 Counties 992 Agencies 2382 Locations

Access to Care HMHB Directory Map:

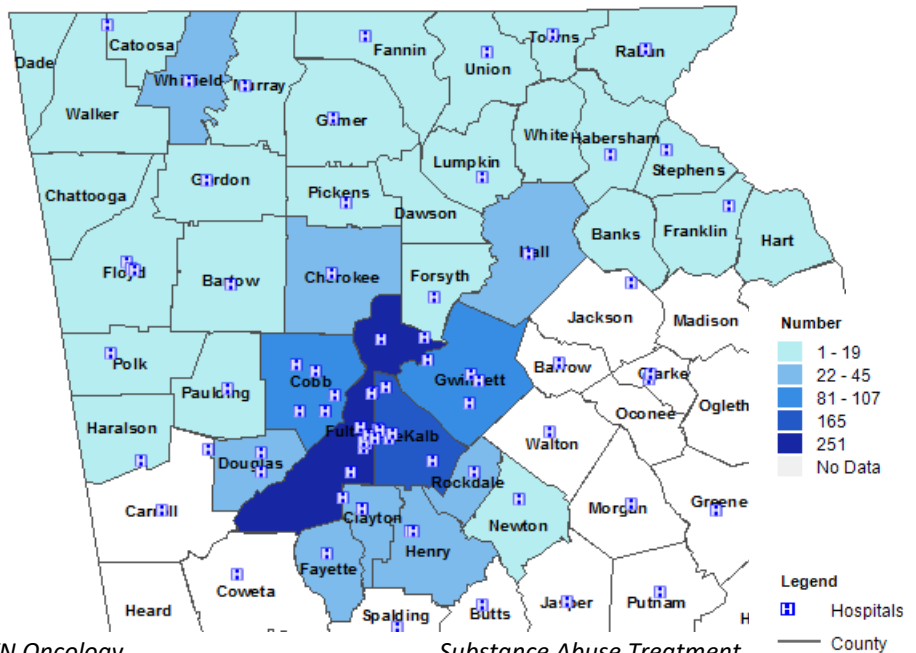
- Birth Control / Contraception
- Breastfeeding / Lactation Services
- Care Management Organization (CMO)
- Child Birth Classes
- Children's State Health Insurance
- Community Health Clinics
- Dentist
- Diabetes Treatment
- Endocrinologist
- Family Planning
- Financial Counseling / Assistance
- Government Benefits / Assistance
- Gynecologist
- Health Education and Information
- Hospitals
- In-Home Care
- Insurance / Pre-Existing Conditions
- Medicaid Main Number / Information
- Medicaid Pharmacy
- Certified Midwifery
- Neonatal Specialist
- Newborn Screening
- Nurse Hotline / Medical Advice Line
- OB/GYN & OB/GYN Oncology



- Obstetrician
- Pediatrician
- Planning for Healthy Babies
- Pregnancy Related Services (counseling, tests)
- Prenatal Care
- Right from the Start Medicaid
- Social Services Information and Referral
- Transportation Assistance
- Women's Health Clinics
- Women's Health Medicaid

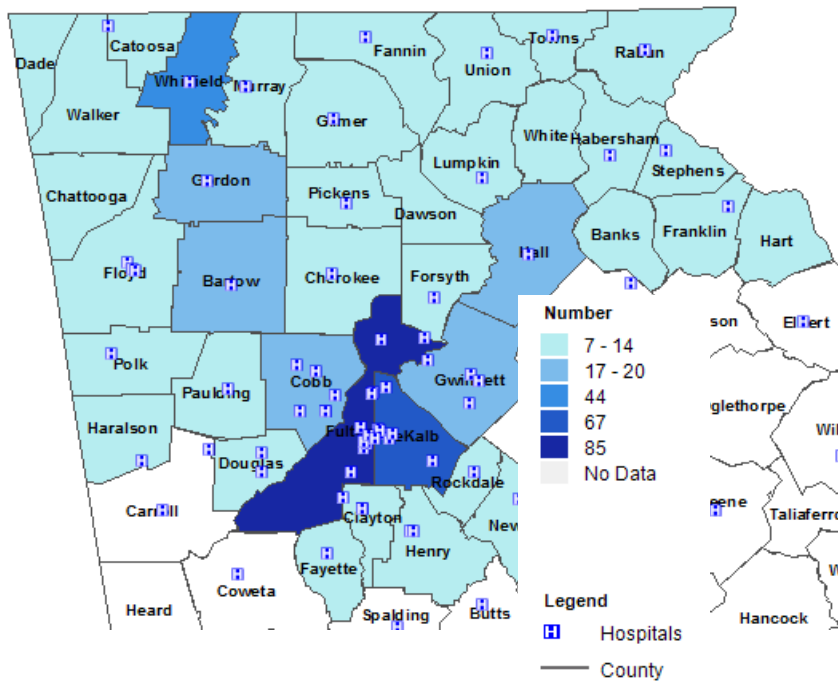
Maternal Health HMHB Directory Map:

- Birth Control / Contraception
- Breast Pumps
- Breastfeeding / Lactation Services
- Community Health Clinics
- Dentist
- Diabetes Treatment
- Domestic Violence Hotline / Shelter
- Domestic Violence Services
- Endocrinologist
- Family Planning
- Gynecologist
- Health Education and Information
- High Risk Pregnancy
- Hospitals
- Hypertension / Blood Pressure
- Mental Health Counseling
- Mental Health Information & Advocacy
- Nurse Hotline / Medical Advice Line
- Nutrition Services
- OB/GYN



- OB/GYN Oncology
- Parenting Education
- Postpartum Depression
- Stop Smoking / Tobacco Addiction
- Substance Abuse Treatment
- Support Groups
- Women & Children Emergency Shelters
- Women's Health Clinics

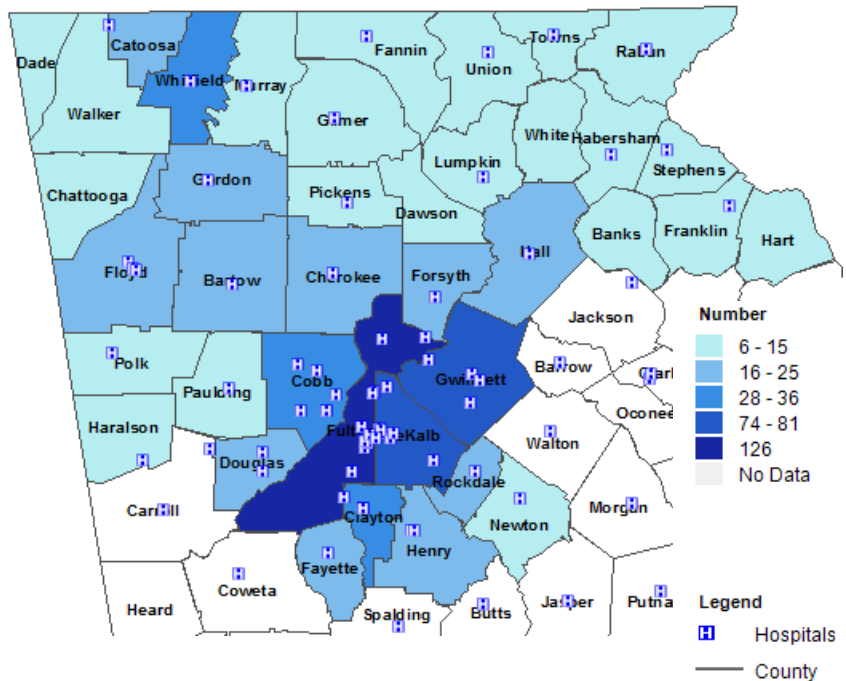
SDOH HMHB Directory Map:



- Baby/Infant Items & Supplies*
- Child Advocacy Center*
- Child Care Resources*
- Children at Risk*
- Domestic Violence Hotline / Shelter*
- Domestic Violence Services*
- Family and Children Services Dept*
- Family Resource Programs*
- Financial Counseling / Assistance*
- Government Benefits / Assistance*
- Homeless Services*
- Housing Services*
- Nutrition Services*
- Social Services Information and Referral*
- Transportation Assistance*
- Women & Children Emergency Shelters*

Infant Outcomes HMHB Directory Map:

- Breastfeeding / Lactation Services*
- Care Management Organization (CMO)*
- Child Abuse Prevention*
- Child Advocacy Center*
- Children at Risk*
- Children's State Health Insurance*
- Family and Children Services Dept*
- Foster Care*
- Hospitals*
- Neonatal Specialist*
- Newborn Hearing/Metabolic/HIV Screening*
- Nurse Hotline / Medical Advice Line*
- Nutrition Services*
- Parenting Education*
- Pediatrician*
- Planning for Healthy Babies (P4HB) - P4HBabis*



Find resources in your region at: <https://www.resourcehouse.com/hmhb/>

Appendix 4: Evidence Informed Strategies

	Infant Outcomes (Infant mortality, low birth weight, SIDS, pre-term birth, and congenital malformation and anomalies): Improve infant outcomes in the Atlanta Perinatal Region using Evidence Informed practices to address accomplish the following goals:												
	Access to Care				Maternal Health					Social Determinants of Health			
	Goal A from Session 2: Identify and ensure that women in the Atlanta perinatal region access needed preconception and postnatal services early		Goal B from Session 2: Increase the number of communities receiving: perinatal education, preconception, interconception, prenatal (1st trimester) care in the region		Goal A from Session 2: Increase community outreach that provides education and resources related to the pregnancy continuum by 5% in (region).		Goal B from Session 2: Improve mom's health and wellness in the Atlanta Perinatal Region through assessment and care coordination			Goal A from Session 2: To create opportunities and increase knowledge of available community resources to improve maternal and child health outcomes.		Goal B from Session 2: Create collaborative partnership within the community that develops a healthcare system that responds positively to social barriers that affect maternal outcomes.	
	Region Goal: Identify and ensure that women and families in the Atlanta perinatal region have access to the perinatal education, preconception, interconception, and prenatal services they need.				Region Goal: Improve maternal health and wellness in the Atlanta Perinatal Region through community outreach that provides education and resources related to the pregnancy continuum including assessment and care coordination.					Region Goal: Increase knowledge and awareness and create opportunities within systems to reduce the influence of SDOH that affect maternal and child health outcomes.			
	Priority Areas				Priority Areas					Priority Areas			
Evidence Informed Practices By Purpose	<i>Lack of health insurance</i>	<i>Poor access/ inadequate use of prenatal care</i>	<i>Preconception/ interconception care and counseling</i>	<i>Health inequity</i>	<i>Substance abuse</i>	<i>Poor health status</i>	<i>Obesity</i>	<i>Poor mental health</i>	<i>Lack of breastfeeding</i>	<i>Poverty</i>	<i>Low Educational Attainment</i>	<i>Stress and Lack of Support</i>	<i>Lack of housing</i>
Increase prenatal home visitation by registered nurses that remains engaged for up to two years for expecting and new mothers Evidence Informed Practices: 1. Nurse Family Partnership (Evidence of reduction in IMR and LBW) 2. Early Intervention Program (EIP) for Adolescent Mothers 3. MoMobile		X	X		X	X		X	X	X	X	X	X

Evidence Informed Practices By Purpose	Lack of health insurance	Poor access/ inadequate use of prenatal care	Preconception/ interconception care and counseling	Health inequity	Substance abuse	Poor health status	Obesity	Poor mental health	Lack of breastfeeding	Poverty	Low Educational Attainment	Stress and Lack of Support	Lack of housing
<p>Increase health assessments, prenatal education, and support of expecting and new mothers facilitated by practitioners</p> <p><u>Evidence Informed Practices:</u></p> <p>4. Centering Pregnancy 5. The Antenatal and Neonatal Guidelines, Education and Learning Systems (ANGELS)</p>		X		X		X						X	
<p>Increase awareness about risk reduction and healthy choices to improve maternal and infant health.</p> <p><u>Evidence Informed Practices:</u></p> <p>6. Text4Baby 7. New Benefits for Breastfeeding Moms 8. Show Your Love Preconception Health 9. La Vida Sana, La Vida Feliz (Healthy Life, Happy Life)</p>	X		X	X	X	X	X	X	X				

Evidence Informed Practices By Purpose	<i>Lack of health insurance</i>	<i>Poor access/ inadequate use of prenatal care</i>	<i>Preconception/interconception care and counseling</i>	<i>Health inequity</i>	<i>Substance abuse</i>	<i>Poor health status</i>	<i>Obesity</i>	<i>Poor mental health</i>	<i>Lack of breastfeeding</i>	<i>Poverty</i>	<i>Low Educational Attainment</i>	<i>Stress and Lack of Support</i>	<i>Lack of housing</i>
<p>Increase awareness, knowledge and support of women that are or may become pregnant about abstaining from the use of harmful substances like tobacco, illegal substances, certain prescriptions, and alcohol during pregnancy</p> <p><u>Evidence Informed Practices:</u> 10. ACOG Fetal Alcohol Spectrum Disorders (FASD) Prevention Program 11. SmokefreeMOM 12. The Parent Child Assistance Program 13. Project Link (Specifically targets reduction in LBW and pre-term birth)</p>					X			X			X		

Evidence Informed Practices By Purpose	<i>Lack of health insurance</i>	<i>Poor access/ inadequate use of prenatal care</i>	<i>Preconception/interconception care and counseling</i>	<i>Health inequity</i>	<i>Substance abuse</i>	<i>Poor health status</i>	<i>Obesity</i>	<i>Poor mental health</i>	<i>Lack of breastfeeding</i>	<i>Poverty</i>	<i>Low Educational Attainment</i>	<i>Stress and Lack of Support</i>	<i>Lack of housing</i>
<p>Increase support and available services for expecting and new mothers to address mood disorders and behavioral health issues through increased awareness, knowledge, and normalization of behavioral health symptoms and available resources.</p> <p><u>Evidence Informed Practices:</u> 14. Thinking Healthy: A manual for psychosocial management of perinatal depression 15. Moms' Mental Health Matters 16. Moving Beyond Depression</p>								X				X	

Evidence Informed Practices By Purpose	Lack of health insurance	Poor access/ inadequate use of prenatal care	Preconception/interconception care and counseling	Health inequity	Substance abuse	Poor health status	Obesity	Poor mental health	Lack of breastfeeding	Poverty	Low Educational Attainment	Stress and Lack of Support	Lack of housing
Improve birth outcomes related to social determinants of health (Poverty, low educational attainment, stress and lack of support, and lack of housing) <u>Evidence Informed Practices:</u> 17. Baby Basics 18. National Healthy Start Association (Targets reduced IMR, and LBW in communities of color) 19. Homeless Prenatal Program (Targets reduced IMR, LBW, and pre-term)		X		X	X			X		X	X	X	X
Increase breastfeeding initiation and duration <u>Evidence Informed Practices:</u> 20. The HealthConnect One Community Based Doula Program (Evidence of reduced LBW) 21. The Surgeon General's Call to Action to Support Breastfeeding 22. Community-Based Family Resource and Support (CBFRS) program (Specifically targets reduction in IMR, LBW, and pre-term birth)	X	X		X					X				

Evidence Informed Practices By Purpose	<i>Lack of health insurance</i>	<i>Poor access/ inadequate use of prenatal care</i>	<i>Preconception/interconception care and counseling</i>	<i>Health inequity</i>	<i>Substance abuse</i>	<i>Poor health status</i>	<i>Obesity</i>	<i>Poor mental health</i>	<i>Lack of breastfeeding</i>	<i>Poverty</i>	<i>Low Educational Attainment</i>	<i>Stress and Lack of Support</i>	<i>Lack of housing</i>
<p>Improve Infant outcomes (Infant mortality, low birth weight, SIDS, pre-term birth, and congenital malformations and anomalies)</p> <p><u>Evidence Informed Practices:</u></p> <p>23. Safe to Sleep Campaign (Formerly, Back to Sleep) (Reduce IMR and SIDS)</p> <p>24. CDC Community Guide: Prevention of Birth Defects: Community-Wide Campaigns to Promote the Use of Folic Acid Supplements (Reduce congenital malformations and anomalies)</p>													
<p>Reduce the impact of preterm birth on poor birth outcomes.</p> <p><u>Evidence Informed Practices:</u></p> <p>25. Healthy Babies are Worth the Wait (Evidence of positive impact on preterm births)</p> <p>26. Antenatal Corticosteroid Treatment (ACT) (Evidence of positive impact on preterm births)</p>													

Appendix 5: List of Participating Organizations

Atlanta Healthy Start Initiative
Amerigroup
CareSource
Center for Black Women’s Wellness
Center for Children’s Health, the Environment, the Microbiome, and Metabolomics (C-CHEM2), Emory University
Children’s Healthcare of Atlanta
Clayton County Perinatal and Infant Health Coalition
Clayton State University
DeKalb Medical Center
DPH District 1-1
DPH District 1-2
DPH District 2
DPH District 3-1
DPH District 3-2
DPH District 3-3
DPH District 3-5
DPH Maternal & Child Health Section
Emory University, Nell Hodgson Woodruff School of Nursing
Emory University, Rollins School of Public Health
Feminist Women's Health Center
Fulton County Government
Fulton County Board of Health
Georgia Bureau of Investigation
Georgia Breastfeeding Coalition
Georgia Chapter, American Academy of Pediatrics
Georgia Department of Community Health
Georgia Department of Public Health (Health Promotion, STD Prevention)
Georgia Division of Family and Children Services
Georgia Health Policy Center, Georgia State University
Georgia Perinatal Association
Georgia WIC
Grady Health
Habersham County Medical Center
Hall County Health Department
Healthy Mothers, Healthy Babies Coalition of Georgia
Medical Association of Georgia Alliance
March of Dimes Georgia
Northside Hospital
Northeast Georgia Medical Center
Peach State Health Plan
Prevent Child Abuse Georgia
Reaching Our Sisters Everywhere
Georgia General Assembly
Stephanie V. Blank Center for Safe and Healthy Children
Southern Lactation Consultants Association
Stephens County Hospital
WellCare
YWCA of Greater Atlanta