Maternal and Child Health Services Title V Block Grant

State Narrative for Michigan

Application for 2010 Annual Report for 2008

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

A copy of the Assurances (Non-Construction Programs) and Certifications signed by the Director of the Department of Community Health may be obtained by contacting the Title V Director's Office at 517/335-8928.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Comments on the draft application narrative were invited from local health departments and other contract agencies, advisory groups, participants in the 2008 Infant Mortality Summit and Perinatal Regionalization Workgroups, other areas of the department with overlapping interest and the general public. The draft document was posted on the department's web site (www.michigan.gov/mdch, click on Pregnant Women, Children and Families) and a notice was published on the Department's Facebook page.

Comments were received from other programs within the department and from external partners. Comments from within the department provided additonal information that was added to the application. Comments from outside the department were from the Wayne County Health Department, Kent County Health Department, the Early Childhood Investment Corporation, Tomorrow's Child, and the Michigan Oral Health Coalition. The comments expressed support for the priorities and activities mentioned in the application, particularly those activities targeting infant mortality and the disparity between black and white and Native American and white infant mortality rates. Support was also noted for the Perinatal Regionalization effort, expansion of oral health services and the Michigan Care Improvement Registry (MCIR). Concern was also expressed with the economic conditions in the state and their impact upon services directed toward the target population. Comments also included a suggestion to organizational combine the Childhood Lead Poisoning Prevention and Healthy Homes programs.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Michigan has designated 11 priorities. Seven are repeated from the 2001 needs assessment.
1. Establish a system to better identify, screen and refer for maternal depression. New for 2006.
2. Increase the rate and duration of breastfeeding. This priority is continued from 2001 with specific focus on duration of breastfeeding.
3. Reduce the percentage of unintended and teen pregnancies. This priority is continued from 2001.
4. Reduce the percentage of preterm births and births with low birth weight. This priority is continued from 2001.
5. Establish a medical home and increase care coordination for children with special health care needs. This priority is continued from 2001.
6. Increase the number of CSHCS-enrolled youth who have appropriate adult health care providers. New for 2006
7. Reduce the proportion of children and adolescents who are obese. New for 2006
8. Reduce the incidence of teen suicide. New for 2006
9. Increase the testing rate of low-income children for lead poisoning. Continued from 2001
10. Reduce the racial disparity between black and white infant mortality and between Native American and white infant mortality. This priority continues from the last needs assessment with the addition of specific attention to the gap in infant mortality rates between the white and Native American population.
11. Reduce the number of maternal deaths in the black population. This priority is continued from the 2001 needs assessment but is not reported as one of the ten top priorities. Although the Needs Assessment Workgroup did not rank this as one of the top priorities, the Department continues to review maternal deaths for possible policy and programmatic strategies.

The selection of Michigan's Title V priority needs for 2006-2011 was based on input from a variety of stakeholders and analysis of the available data. Training in MCH needs assessment methods was conducted for local health department staff. Comments on maternal and child health priorities were invited from parent groups, advocacy organizations, advisory committees, providers, and other Department and state program staff. Data was compiled by MCH epidemiology staff and presented to a group of key stakeholders who reviewed the data analysis and comments provided by the aforementioned groups. The stakeholders workgroup then recommended ten priorities to the Title V Director. These recommendations were then adopted with a few revisions based on current Department priorities.

The needs assessment process was essentially the same as in 2001. Training of local health department staff was added to assist them in determining local priorities and provide input to state-level priorities.

As in the past, partners in the needs assessment process included representatives from other programs within the Department of Community Health, other federally funded programs such as WIC, other state departments, local health departments and other providers, advocacy organizations and parents.

Michigan continues to have one of the highest infant mortality rates in the country. The incidence of infant deaths as well as the prevalence of low birth weight fluctuated over the last five years but have remained high. Unintended pregnancy and preterm birth are contributing factors to infant mortality and continue to be a concern. The ratio of black infant mortality rate to white infant

mortality rate averages about 3.0 and the gap between Native American and white infant mortality has grown over the past five years. Breastfeeding rates continue to be low especially among African American women.

While progress has been made in testing of children for lead poisoning, there is still room for improvement. Recent legislation concerning testing and reporting along with penalties for landlords and the creation of a lead-safe housing registry should help to increase testing rates for all children.

Although data on overweight status is not available for young children, the rate for adolescents shows an increasing problem in Michigan. Based on samples from the Youth Risk Behavior Survey, Michigan children are similar to children across the nation in terms of patterns of increasing weight.

The suicide death rate for 15-19 year olds has fluctuated over the past five years from 6.7 to 8.8. The 2001 Michigan YRBS states that 18% of Michigan's 9th-12th graders seriously considered attempting suicide some time in the 12 months preceding the survey. One of ten students actually attempted suicide during that time.

Although there is very limited data for analysis, the percent of children with special health care needs whose care is coordinated within a medical home appears low and much more effort is needed to assist CSHCN youth transitioning out of the program to find adult health care providers and other support services.

/2008/There are no changes to the state's priority needs or needs assessment process from the last application. There may be significant changes in state capacity to meet those needs in the coming year due to the state's budget crisis. Proposals to cover a revenue shortfall in the current and next fiscal year include siginificant cuts in state funding for the lead, infant mortality, pregnancy prevention, and Early Hearing Diagnosis and Intervention programs. See Sections III. A and B for further discussion.//2008//

/2009/There are no changes to the state's priorities or needs assessment process. Due to state budget fiscal problems in FY '07, Healthy Michigan funding (tobacco tax) was cut for the following programs: dental health, Family Planning, Local MCH grants, Pregnancy Prevention, Lead Poisoning Prevention, Infant Mortality-Nurse Family Partnership, and Early Hearing Detection and Screening. Most of the cuts were absorbed through unspent or unallocated funds. Some small reductions in local programs were made in Dental Health and Local MCH grants with across-the-board reductions. Unspent funds covered reductions in Family Planning (chlamydia testing savings and other unallocated funds), Pregnancy Prevention (colposcopy and sterilization savings), Early Hearing Detection and Infant Mortality (Nurse Family Partnership project did not start as planned). Special project contracts were reduced in Lead Poisoning Prevention. For the most part, local agency services were maintained. In FY '08, most of the funding was restored to these programs except in Pregnancy Prevention where savings from the colposcopy program again covered the reduction.

The Lead Poisoning Prevention and Control Commission was reinstated by legislation in December 2007.//2009//

/2010/There were no significant changes to the state's demographic characteristics over the previous year. Michigan's economic situation continued to worsen in 2008-2009. As with the rest of the country, Michigan's economy was affected by the banking crisis and record mortgage foreclosures. In addition, the crisis in the American auto industry had a particularly negative impact on the State's economy. Michigan now has the highest unemployment rate in the country. On top of the last six tight budget years, the State was facing a $1.3 billion deficit for FY 2009. Several programs serving the MCH population have been cut.//2010//

III. State Overview

A. Overview

The Title V program in Michigan operates within the larger context of public health services as articulated in the Department of Community Health's mission statement: "...to promote access to the broadest possible range of quality services and supports; take steps to prevent disease, promote wellness and improve quality of life; and strive for the delivery of those services and supports in a fiscally prudent manner." To accomplish this mission, the department employs a variety of resources including federal, state and local funding to provide, arrange or assure access to a broad range of health and other social services. Services are arranged and delivered at the community level through a variety of public and private agencies, including local health departments, hospitals, clinics, private practices, schools, Planned Parenthood organizations, migrant health centers, and primary care centers. Cooperative efforts to achieve specific initiatives are arranged with the private sector, such as managed care plans, universities, Delta Dental of Michigan, Blue Cross/Blue Shield of Michigan, Michigan State Medical Society, and Michigan Association of Broadcasters. Within the Department of Community Health, Title V programs and planning and policy activities are coordinated with the Medicaid program, MIChild (state CHIP), mental health and substance abuse services, chronic disease programs, communicable disease programs, and injury prevention programs.

The Title V program also works with other state departments on initiatives that affect our mutual customers. One current initiative is the development of a comprehensive early childhood system of care (ECCS). This initiative is funded in part by a grant from HRSA and is part of the Governor's Great Start Initiative which aims to get children to school ready to learn. The Title V Director is the project officer for this grant. The Great Start Initiative is guided by the Children's Cabinet, consisting of the Directors of the Departments of Community Health, Education, Human Services (formerly Family Independence Agency), and Labor and Economic Growth. The Children's Action Network (CAN) is appointed by the Children's Cabinet to focus on prevention and early intervention services for children 0-5 years of age. In addition to members of the Children's Cabinet, CAN includes representatives of advocacy groups and other key state staff. The ECCS project is now completing planning activities and has applied for an implementation grant that would start in September 2005. Through this network, the Title V program also works with interagency staff on the development of Family Resource Centers in schools that have been designated as "priority" based on their Annual Yearly Progress status under No Child Left Behind.
/2007/The Department was awarded an ECCS Implementation grant in September 2005. With this grant, the state ECCS project will develop local collaboratives to assure access to the six critical components (physical and social-emotional health, parenting education, early care and education, basic needs, family support).//2007//
/2008/The Early Childhood Investment Corporation (ECIC) was created by the Governor as a public non-profit corporation to oversee the development of a statewide comprehensive early childhood system. This system includes local collaboratives, known as Great Start Collaboratives (GSCs), that are responsible for assessing needs, linking existing early childhood programs, and identifying and filling gaps in the system components. The GSCs are formed by intermediate school districts under an inter-local agreement with the Michigan Department of Human Services. Twenty-one GSCs have been implemented to-date and are receiving technical support and funding from the ECIC. The Department of Community Health contracts with the ECIC to implement its Early Childhood Comprehensive Systems grant. The grant funding supports a project coordinator, technical assistance activities and support for parents participating in the development of policies and standards for the system. The ECIC has also obtained substantial foundation funding and a state appropriation of $1 million to expand the local Great Start collaboratives and to evaluate the system. This includes grants from the Building Connections project and from the Kellogg Foundation ($6.5 million).//2008//
/2009/Eleven new Great Start Collaboratives were added in 2008.
The recent availability of funding to states for the LAUNCH initiative (SAMHSA), which could not be sought for Michigan, spurred development of a more proactive approach for positioning the

state to more aggressively move toward the development of a coordinated system of care for children.//2009//
/2010/Every county in the state has a Great Start Colloborative as of April 1, 2009. In an effort to broaden and strengthen the State Early Childhood Plan, a Great Start System Team, jointly convened by MDCH and ECIC, was formed to improve coordination and integration of publicly funded early childhood programs and services. Michigan also submitted a grant application for Project LAUNCH, focusing on Saginaw County as the pilot site for developing a model for the comprehensive wellness of children 0-8 years of age.//2010//

The public health functions of assessment and assurance are shared between the Department of Community Health and local health departments (LHD). Under the Public Health Code, all counties are required to provide for a local health department and are charged with: prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable populations; development of health care facilities and services delivery systems; and regulation of health care facilities and services delivery systems to the extent provided by law. There are 30 single county health departments, 14 district health departments covering multiple counties, and one city health department. See Section III.E below for further discussion of the role of local health departments.

According to the 2000 Census, Michigan has the eighth largest population in the United States. In 2003, the total estimated population in Michigan was 10.079,985 according to the US Census Bureau. This includes 126,553 infants, 521,204 children 1-4 years of age, 2,179,219 children 5-20 years of age, and 2,125,430 women of childbearing age (15-44 years). Approximately 78% of infants were white, 18.9% black, 2.7% Asian and Pacific Islander, and less than 1% were American Indian. Of Michigan residents aged 1-20 years, 78% were white, 18.7% were black, 2.4% were Asian/Pacific Islander, and 0.9% were American Indian. Among women of childbearing age, 82% were white, 16% were black, 1.7% were Asian/Pacific Islander, and 0.8% were American Indian. Minority populations are increasing in proportion to the total population of the state.
/2008/There were no significant changes in the State's population from 2004 to 2005 in terms of racial/ethnic composition. In 2005 (according to the American Community Survey), among infants, 77.6% were white, 18.7% were black, less than 1% were Native American and 3.3% were Asian/Pacific Islander. For children 1-20, 76.7% were white, 17.6% were black, .6% were Native American, and 2.3% were Asian/Pacific Islander. Among women of child-bearing age, 78.8% were white, 16.2% were black, .7% were Native American and 3.0% were Asian/Pacific Islander.//2008//
/2009/According to the American Community Survey, Michigan's total population declined slightly from 2005 (10,120,860) to 2006 (10,095,643); 79.5% were white, 14.1% were black, .5% were Native American, 2.3% were Asian, and 3.6% were Other. For children under 20 years of age, 74.0% were white, 17.3% were black, .48% were Native American, 2.3% were Asian, and 5.9% were Other.//2009//
/2010/According to the US Census Bureau 2008 Population Estimates, Michigan's total population continued to decline from 10,095,643 in 2007 to 10,003,422 in 2008. Of the total population, 81.2% were white, 14.2% were black, .6% American Indian, 2.4% Asian, less than 1% were Pacific Islander, and 1.5% were two or more races. The number of children 0-19 years of age also declined from 2,770,515 in 2007 to 2,685,515 in 2008.//2010//

There were 130,850 resident live births in 2003. Between 1998 and 2003, the number of live births declined by 2.1 percent. The fertility rate (per 1000 women) for women aged 15-19 years declined by 19.6% from 1999 to 2003, while the overall fertility rate increased for the same period by 2.2%.
/2008/From 2003 to 2005, the number of live births declined by 2.5%. Fertility rates for females 15-19 years of age and overall also declined (2.7% and 1.1%, respectively).//2008//
/2009/Live births in Michigan remained relatively stable at 127,537 in 2006. Overall fertility rates increased slightly from 60.9 per 1,000 live births in 2005 to 61.8 in 2006, and fertility rates for

females 15-19 years of age increased from 32.4 in 2005 to 33.8 in 2006.//2009//

In 1999, over 3.2 million Michiganians were medically underserved and over 1.5 million were unserved. Rural residents had a slightly greater risk for being without health insurance than urban residents. However, almost nine out of ten residents (87.9%) without health insurance coverage live in urban areas. Michigan has a lower percentage of uninsured residents on average than the United States, but has over 1.1 million uninsured residents. Residents at greatest risk of being uninsured are young adults (particularly those ages 21-24), minorities and working poor (less than 200% of poverty).
/2007/The Michigan State Planning Project for the Uninsured conducted a Household Health Survey that revealed an estimated 800,000, or 7.8%, of the state's population are without health insurance coverage. More than half of the uninsured individuals live in families with incomes below 200% FPL. Over half of the uninsured are non-disabled adults below the age of 65 who are not parents of minor children. 93,000 of the uninsured individuals are children and approximately 58,000 of these children are in families with incomes below 200% FPL.//2007//
/2008/In the final report of the Michigan State Planning Project for the Uninsured, most of the uninsured are identified as the working poor who are offered employer-based insurance but are unable to afford their share of the premium or whose employers do not offer insurance. Other uninsured are low-income children who have lost dependent coverage and adults who have lost their jobs and exhausted their unemployment benefits. The report recommended support for the Michigan First Healthcare Plan which would extend coverage to all the low-income uninsured. This plan, submitted to the US Department of Health and Human Services, would cover about half of the uninsured in the state. Approval of the plan is expected this Spring.//2008//
/2009/A concept paper for the Michigan First Healthcare Plan was submitted to DHHS in 2007. However, the proposal has been put on hold due to the state's continuing financial limitations.//2009//
/2010/According to a report from the University of Michigan Center for Healthcare Research and Transformation published in February 2009 entitled "Cover Michigan: The State of Health Care Coverage in Michigan," the number of uninsured in Michigan increased from 1.04 million in 2006 to 1.15 million in 2007. The percentage of children who were uninsured increased from 4.7% in 2006 to 6.2% in 2007. Twenty-three percent of African Americans are uninsured and 84% of the uninsured are in families with at least one adult working part time or full time. Medicaid and MIChild (SCHIP) enrollments are increasing: average monthly Medicaid enrollment increased 8.2% from FY08 (1,550,654) to the October 2008-April 2009 period (1,677,812); MIChild enrollment increased 11.5% from September 2007 to May 2009. According to the "Cover Michigan" report, the percentage of the state's private employers offering health coverage declined from 63.9% in 2000 to 53.4% in 2006 and the percentage of Michigan children covered by private insurance declined from 73.1% in 2006 to 69.2% in 2007. In addition, families are paying more for coverage - average family deductibles increased 25.3 % between 2002 and 2006.//2010//

According to the 2000 U.S. Census, 74.7% of the state's population resides in urban areas, up from 70.5% in 1990. However, only 25 of the state's 83 counties are classified as Metropolitan Statistical Counties. All specialized health care facilities are located only in urban areas, making it difficult for rural residents to access those facilities. Rural road conditions when it rains or snows heavily also create barriers to accessing care, particularly in the Upper Peninsula. Another access problem is created by the fact that the sole ground connection between the Upper and Lower Peninsulas is via the Mackinac Bridge which may be closed during windy, foggy and icy conditions.

Language is another potential barrier to access to care. An estimated 8.4% of persons age 5 and over speak a language other than English at home. Of these, 2.7% speak Spanish, 1.1% speak an Asian or Pacific Island language, and 3.3% speak other languages.

According to the Division for Vital Records and Health Statistics, MDCH, the five leading causes of death in 2003 for Michigan were: heart disease; cancer; stroke; chronic lower respiratory

diseases; and accidents. Among whites and blacks of both genders, the leading causes of premature death were predominantly due to chronic illnesses. However, homicide is the second leading cause of premature death and the third leading cause of overall death in black males. Heart and lung problems were among the four leading causes of preventable hospitalizations among Michigan residents. Over 19% of Michigan residents have some type of disability, which is higher than the United States. Detroit is estimated to have one in four persons with some type of disability. For Michigan children under 1 year of age, the leading causes of death are conditions originating in the perinatal period, congenital malformations, accidents, SIDS and diseases of the heart. The majority of postneonatal deaths are due to preventable causes. For Michigan children 1 year of age and over, the leading cause of death by far is unintentional injuries. Other leading causes for this age group are homicide and cancer.

Michigan has been facing severe socioeconomic challenges over the past few years, as illustrated by increasing unemployment rates. From 1992 to 2001, Michigan employment grew by only 16.8% compared to national employment growth of 22.3%. The state's 2003 average annual unemployment rate rose to 7.0%, up from 6.2% in 2002. From December 2002 to December 2003, Michigan wage and salary employment declined by 79,000, or 1.8 %. Nationally, December wage and salary employment fell 0.1% from a year earlier.
/2008/According to the Bureau of Labor Statistics, Michigan had the third highest unemployment rate in the U.S, based on data for the first ten months of 2006. Michigan's manufacturing base continued to erode over the past year with layoffs and reductions in the automotive and related industries. Manufacturing jobs declined by 3.9% from March 2006 to March 2007 and construction jobs declined by 5.6%. Total non-farm employment decreased by 1.0%. A record number and percentage of the population were receiving public assistance as of March 2007. 1,770,000 people or 17.5% of the population received FIP (Family Independence Program), SER (state emergency services), SDA (State Disability Assistance), FAP (Food Assistance Program), Energy Assistance, SSI and/or Medicaid. This is the highest number and percentage since 1983. The number of Medicaid recipients increased by almost 60% from 2000 to 2006.//2008//
/2009/Economic difficulties continued in FY 2008. While statewide unemployment declined by 3.1% from April 2007 to April 2008, payroll jobs fell by 72,000 (1.7%), mostly in manufacturing, construction and government. However, education and health services and professional and business services registered job growth during the same time period. The state's seasonally adjusted unemployment rate for April 2008 was 6.9%.//2009//
/2010/Michigan recorded the highest unemployment rate in the country in April 2009 (12.9%), a 63% increase over April 2008 rate. The umemployment rate reflects the massive restructuring of the auto industry. Michigan has lost over 400,000 manufacturing jobs since 2001. The recent bankruptcy filings of GM and Chrysler are expected to further increase unemployment. Half of the recently announced GM plant closings (7 out of 14) will be in Michigan. The number of persons receiving some form of public assistance (Family Independence Program, Food Assistance, Disability Assistance, Child Development and Care, and Medicaid) averaged 2,034,800 for the period October 2008 to April 2009, or 20.3% of the population.//2010//

Since 2001, Michigan has had a cumulative deficit of over $7.8 billion and has cut spending by approximately $3 billion. Both a lagging economy and a structural imbalance between revenues and expenditures have contributed to the state's budget problems over the past four years. Manufacturing is a significant component of Michigan's economy and its recovery is lagging behind the overall economic recovery. Tax reductions have contributed to the decline in state revenues, even as the demand for public services has increased. Costs continue to rise annually for Corrections, health care for public employees and Medicaid. The Medicaid caseload has grown from just over 1 million in 1999 to almost 1.4 million in 2004.
/2007/According to the Michigan State Planning Project for the Uninsured Household Health Survey, Medicaid now covers 1.5 million Michigan residents, or 15% of the population. This is an increase of almost 400,000 from five years ago.//2007//
/2008/Again, the State of Michigan is facing a budget crisis as the Governor and Legislature negotiate on how to deal with an estimated $700 million deficit for this fiscal year and $3 billion for

FY 2008. The Single Business Tax will phase out in December 2007, leaving a revenue imbalance of approximately $1.9 billion. Funding for several MCH programs from tobacco settlement funds have been cut for FY 2007, including childhood lead poisoning prevention, family planning/pregnancy prevention, dental health, Early Hearing Detection and Intervention and infant mortality projects. Moratoriums and restrictions have been placed on purchases, travel, energy use and contractual services. Several proposals for restructuring Michigan's tax base are being analyzed and considered by the Legislature.//2008//
/2009/The State's budget crisis for FY 2008 was resolved by a combination of tax revisions and increases and spending cuts. The Single Business Tax was replaced by the Michigan Business Tax, and the state's personal income tax was increased to 4.35 percent. Approximately $440 million in spending cuts were enacted. Restrictions remained on hiring, travel and other expenses.//2009//
/2010/The state budget has been impacted by the national economic recession and the crisis in the domestic auto industry. State revenues dropped by an unprecedented 20% since the adoption of the FY2009 budget. A deficit of $1.3 billion in FY'09 was estimated. As a result the Governor issued, and the Legislature adopted, an Executive Order to cut $304 million in this fiscal year, including elimination of funding for: Nurse Family Partnership projects, respite care for children with serious emotional disturbances, and Medicaid adult dental, optometric, chiropratic, podiatric, non-emergency transportation and hearing aid services; and reduction in funding for: child abuse prevention, community mental health services, local health department services, family planning, health disparities, immunization registry, infant mortality prevention, lead poisoning prevention and poison control. Medicaid reimbursement rates for providers will also be cut by 4% effective July 1 2009. In addition, non-essential state employees will be temporarily laid off for six days between June and September 2009. These reductions will likely be carried forward into FY 2010 budget. State revenue predictions for FY 2010 will, in large part, depend on whether and when GM and Chrysler emerge from bankruptcy. State departments have been asked to develop plans to cut expenditures by an additional 8% over revised 2009 levels.//2010//

According to the 2000 Census, there were 192,376 families, or 7.4% of all families, who were below the 100% poverty level. This is down from 10.2% of all families in the 1990 Census. In families with related children under 18 years of age (2000 Census), 11.3% lived in poverty and 14.7% of families with related children under 5 years were below poverty. Among the white population, 9.5% of children under 18 and 12.0% of children under 5 were below the poverty level. Among black children, 39.5% of children under 18 and 49.5% of children under age 5 were below the poverty level. For the American Indian and Alaska Native population, 39.0% of children under 18 and 16.1% of children under 5 were below poverty. For the Asian population, 12.3% of children under 18 and 7.5% of children under 5 were below poverty.
/2010/According to the American Community Survey 2005-2007 3-Year Estimates, the overall poverty rate in Michigan was 13.7%; 18.9% among children under 18 years; 30.6% among African Americans, 22.3% for American Indian, 12.3% for Asians and 10.3% for whites. Among those of Hispanic origin, the poverty rate was 23.3%.//2010//

While Michigan has high numbers of persons with insurance coverage, many residents are uninsured or underinsured and are unable to consistently access quality healthcare. Medicaid provides coverage for approximately 10% of Michigan's population, but residents still face other challenges in accessing healthcare. For example, recruitment and retention of medical personnel, particularly nurses, is a growing problem. The WIC program currently serves over 41% of all births in Michigan and over 70% of African American and Hispanic births.

The Department's current priorities include implementing the recommendations of the Mental Health Commission, reduction of health disparities, implementing legislative changes regarding childhood lead poisoning, promoting healthy lifestyles of Michigan residents through the Michigan Steps Up Initiative, and reducing unintended pregnancies and infant mortality. The Title V program has been working with the Governor's Office, the Bureau of Epidemiology and Medical

Services Administration to implement electronic reporting of blood lead analyses and a lead-safe rental housing registry, increase testing levels of children in the Medicaid program, establish and implement penalties for landlords who knowingly cause lead poisoning of children and to establish and appoint a state Lead Commission. The Title V program has been working with the Medical Services Administration to obtain a 1115 waiver from the Centers for Medicare and Medicaid Services to extend family planning services to women whose pregnancy and delivery were covered by Medicaid and have no other source of coverage. The Title V program also participates in the Department's health disparities reduction efforts through infant mortality initiatives and the childhood lead poisoning prevention program.
/2008/In the current economic situation, the Department's current priority is to protect, as much as possible, our most vulnerable citizens from the effects of the state's budget crisis. Benefits and eligibility levels have been maintained so far for pregnant women and children under Medicaid and MIChild. The Family Planning waiver was approved in 2006 and enrollment began July 1 2006. Although state funding for the Childhood Lead Poisoning Prevention Program was cut in FY 2007, efforts continue to improve testing levels of children enrolled in Medicaid and in general (see State Performance Measure #5).//2008//
/2009/Due to state budget fiscal problems in FY '07, Healthy Michigan funding (tobacco tax) was cut for the following programs: dental health, Family Planning, Local MCH grants, Pregnancy Prevention, Lead Poisoning Prevention, Infant Mortality-Nurse Family Partnership, and Early Hearing Detection and Screening. Most of the cuts were absorbed through unspent or unallocated funds. Some small reductions in local programs were made in Dental Health and Local MCH grants with across-the-board reductions. Unspent funds covered reductions in Family Planning (chlamydia testing savings and other unallocated funds), Pregnancy Prevention (colposcopy and sterilization savings), Early Hearing Detection and Infant Mortality (Nurse Family Partnership project did not start as planned). Special project contracts were reduced in Lead Poisoning Prevention. For the most part, local agency services were maintained. In FY '08, most of the funding was restored to these programs except in Pregnancy Prevention where savings from the colposcopy program again covered the reduction.//2009//
/2010/A budget shortfall for FY 2009 is estimated at $1.3 billion. The shortfall will be addressed by cuts in spending of $304 million and use of stimulus funds to cover the rest. The cuts include elimination of funding for Nurse Family Partnership projects in Kalamazoo, Detroit, Kent, Oakland and Berrien counties, reduction in funding for family planning services affecting approximately 4,900 persons, elimination of funding for a vision clinic in Saginaw County, and elimination of DCH funding for child abuse and prevention programming.//2010//

B. Agency Capacity

The primary authority for maternal and child health programs in the state is the Public Health Code (P.A. 368 of 1978, as amended). Part 23 of the Code requires the Department to identify priority health problems and develop a list of basic health services to be made available and accessible to all residents in need of the services without regard to place of residence, marital status, sex, age, race, or inability to pay. The current list of designated basic health services is: immunizations, communicable and sexually transmitted disease control, tuberculosis control, prevention of gonorrhea eye infection in newborns, newborn screening for eleven conditions, health/medical annex of the emergency preparedness plan, and prenatal care. Part 24 of the Code spells out the authority and responsibility of local health departments. Section 5431 requires screening of newborns for PKU, galactosemia, hypothyroidism, maple syrup urine disease, biotinidase deficiency, sickle cell anemia, and other treatable but otherwise handicapping conditions as designated by the department. Part 58 of the Code authorizes the department to establish and administer a program of services for children with special health care needs. Section 9101 requires the department to establish a plan for school health services in cooperation with the Department of Education. Section 9131 requires the department to publicize places where family planning services are available. Part 92 authorizes and sets certain requirements for immunization. Part 93 establishes a program of hearing and vision screening for children.

/2010/Section 333.5123 requires physicians and other health care professionals providing medical treatment to pregnant women to test for HIV, hepatitis B and syphilis at the time of initial prenatal screening and examination, unless the woman does not consent to be tested or the physician deems the tests are medically inadvisable. State guidelines further state that testing should be offered again during the third trimester, if a woman engages in behaviors that put her at risk; or at labor and delivery if the woman's test results are unknown or undocumented.//2010//

The Michigan Legislature passed P.A. 167 in 1997 supporting statewide development of child death review teams. The law also defined the composition of the teams, established reporting requirements, provided for training and technical assistance and exempted team meetings from FOIA. New legislation was passed in 2004 regarding lead poisoning. A package of six bills established a lead-safe rental housing registry and state lead commission appointed by the Governor, mandated electronic reporting of blood lead analyses, required Medicaid providers to increase testing levels of children and established penalties for landlords who knowingly cause the lead poisoning of children.

/2009/In 2007, the Public Health Code was revised to add language regarding racial and ethnic disparities and the associated department's responsibilities. This revision requires the Department of Community Health to: develop and implement a structure to address racial and ethnic disparities; monitor minority health progress; establish minority health policy; develop and implement a statewide strategic plan; utilize federal, state and private resources as available to fund minority health programs, research and other initiatives; provide interdepartmental coordination for data and technical assistance, establish measurable objectives, establish a webpage, support research within minority populations, provide a resource directory, and develop and implement recruitment and retention strategies to increase the number of minorities in the health and social services professions. The primary administrative responsibility for implementing this new section of the Code is in the Office of Minority Health.//2009//

Most programs are operated by local health departments, qualified health plan (managed care) providers, hospitals and other community health care providers. The department contracts with these agencies to provide services based upon needs identified at the state or local level, utilizing a combination of state funds, Title V, Medicaid and fees.

Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

The Newborn Screening Program currently screens for eleven disorders: PKU, galactosemia, hypothyroidism, MSUD, biotinidase deficiency, sickle cell anemia, congenital adrenal hyperplasia, MCAD deficiency, homocystinuria, citrullinemia and ASA. Blood samples are submitted by hospitals to the state laboratory which analyzes the samples and reports the results to the Newborn Screening Program. Program staff follow up on all positive or unsatisfactory test results with hospitals, family or family physician. MDCH contracts with three medical centers to assure and/or provide comprehensive diagnostic and treatment services. A statewide pilot was initiated in May, 2005 to expand newborn screening from the current panel of eleven disorders to 40 disorders, including fatty acid oxidation and organic acid disorders. The pilot will evaluate the feasibility of detecting disorders early and ensuring appropriate follow-up systems are in place to manage diagnosis and treatment.
/2007/The Newborn Screening panel was expanded to 49 disorders detectable by tandem mass spectrometry in 2005.//2007//
/2009/Newborn screening for cystic fibrosis began on October 1, 2007, bringing the total number of disorders in the newborn screening panel to 50.//2009//

The Hereditary Disorders Program (HDP) coordinates statewide services for genetic diagnosis and counseling, and provides information about birth defects and inherited diseases. Six regional coordinating centers are funded to provide a network of clinics for diagnosis, counseling and

medical management, and to provide outreach education to community groups, including families, health professionals and teachers. HDP staff members and the Michigan Birth Defects Registry (MBDR) participate in a cooperative agreement with the Centers for Disease Control and Prevention (CDC) for birth defects surveillance and utilization of data for public health programs relating to prevention and intervention.

The Nurse Family Partnership is a nurse home visiting program, based on the Olds model, for first time, low-income pregnant women that has evidence of success addressing the family needs over approximately two and a half years. This service model has shown improved family outcomes, strengthening the environments of infants and young children, ultimately improving infant survival and young children's health. Services are provided through a team (four nurses and a part-time nurse supervisor). Each nurse maintains a caseload of 25 families. Nurses follow program guidelines that focus on the mother's personal health, quality of care giving for the child, and parents' own life-course development. Nurses involve the mother's support system including family members, fathers when appropriate, and friends, and they help families use other health and human services they may need. Four communities with significant disparity are currently implementing this model. These communities had other related factors such as having at least 100 African American first time, low-income births, lower high school completion rates, a significant number of young children living in poverty, etc.

/2009/In December 2007, Kalamazoo County became the fifth implementation site in Michigan for the Nurse-Family Partnership program.//2009//

/2010/ Due to state budget cuts, funding for the Nurse Family Partnership programs will be ended as of 6/30/09. State staff are working with Local Health Departments on possible federal matching of local funds allocated to the NFP during FY 08/09. If possible, this will allow some additional money for closeout or other health department activities. Berrien is anticipating continuing with their program even with State money removed, while the others are uncertain right now. //2010//

The Family Planning Program makes available general reproductive health assessment, comprehensive contraceptive services, related health education and counseling, and referrals as needed to Michigan residents. Services are available to anyone, but the primary target population is low-income women and men. Services are delivered through local health departments, Planned Parenthood affiliates, hospitals and private non-profit agencies.
/2007/Michigan Department of Community Health (MDCH) received approval of its Section 1115 Family Planning Waiver and will begin implementation July 1, 2006, expanding family planning services to women 19-44 years old with family incomes up to 185% of the Federal Poverty Level. The approved service cap is 200,000 women.//2007//

The Fetal Alcohol Syndrome (FAS) program has three main components: 1) five multidisciplinary teams called Centers of Excellence diagnose children and provide initial care planning; 2) eleven community projects provide community outreach and education; and 3) training and consultation to assist collaborative agencies in their work. This work is guided and assisted by FAS steering committees and community networking to increase awareness of FAS and the importance of its prevention, do outreach, screening and referrals to diagnostic services, and assist with providing therapeutic and social supportive services to families and children with FAS. These projects vary in their delivery method, but include working extensively with other programs such as Early On, WIC, foster care, substance abuse programs, Infant Support Services, Family Independence Agency case workers, as well as community partners such as liquor stores, restaurants, media companies, etc. The Department provides funding for the projects, training and assistance with building community awareness.

/2009/ A state FASD Task Force was formed in 2005 to advise the program. Strategic planning was done in 2006 and the task force has met quarterly since then to implement goals and objectives of the plan. Task Force members consist of representatives from MDCH, DOE, DHS,

Corrections, various advocacy organizations and parents.//2009//
/2010/During the first quarter of 2009, The Michigan Department of Community Health issued an RFP entitled Fetal Alcohol Spectrum Disorders (FASD) Prevention and Intervention Grants and awarded ten community agency planning grants to further expand statewide programs. These projects will expand prevention and identification of various populations at risk for FASD (e.g. women in substance abuse treatment centers, children in foster care). The projects provide additional momentum and progress necessary to achieve goals identified in Michigan's FASD 2006-2011 strategic plan, including: further integration and advocacy with other state public health programs (e.g. WIC, HIV); education of clients about FASD; and to gain support of key private sector groups to facilitate changes related to FASD prevention and services (e.g., employment, warning labels, new product development).

CDC funding for the Detroit FAS Prevention Project has demonstrated the success of work with women who are at-risk of an alcohol exposed pregnancy because of heavy alcohol use and limited use of birth control. Brief Motivational Interviewing was used with 404 women and over 80% reduced their risk.

A new RFP for community projects was released this year and 8-9 programs across the state was funded for planning activities until September 30, 2009.

The FASD Program is collaborating with the Office of Drug Control Policy on a SAMHSA funded Parent-Child Assistance Program in Southwest Michigan. This project identifies women in substance abuse treatment who are pregnant or parenting an infant that used alcohol during the pregnancy. A knowledgeable peer provides intensive home visiting and linking with resources with the goal of preventing another alcohol exposed pregnancy. The project will enroll 60 women and work with them for a period of 3 years.//2010//

The Fetal-Infant Mortality Review (FIMR) Program is supported by state funds to build FIMR capacity through local team development, technical assistance, consultation, training, data collection, research design, and program evaluation. ***/2010/ Currently, teams are operating in 15 counties and cities in Michigan. A team affiliated with the federal Healthy Start sites through the Inter-tribal Council of Michigan reviews Native American infant deaths statewide. A $54,000 line item supported by Healthy Michigan Funds is available to local teams to supplement their ability to abstract medical records and obtain home interview for their case summaries.//2010//***

Infant Support Services, funded by Medicaid, provide non-medical support services consisting of health education, parenting education, breast-feeding education, counseling in appropriate infant care, nutrition, social casework, infant mental health, transportation, care coordination, referral and follow-up. Services are targeted to high-risk Medicaid-eligible infants and their families. Infants are referred when one or more of the following risk factors is present: abuse of alcohol or drugs or smoking; mother is under the age of 18 and has no family support; family history of child abuse/neglect; low birth weight; mother with cognitive, emotional or mental impairment; homeless or dangerous living situation; or any other condition that may place the infant at risk of death, significant impairment or illness. A team of professionals including a nurse, nutritionist and social worker provide the services. An infant mental health specialist is an optional member of the team.

The Maternal Support Services program provides nutrition, psychosocial, nursing and transportation services to Medicaid-eligible, high-risk pregnant women. Pregnant women are screened in specific domains to determine if they are at risk. These domains include prenatal care, smoking, alcohol, drug use, stress depression, social support, abuse/violence and basic needs. Interventions are provided based on the risks and needs identified.

/2007/The Maternal and Infant Support Services Programs, now called the Maternal and Infant Health Program, is undergoing a re-design that emphasizes early entry into prenatal care and

early risk assessment.//2007//
/2008/The design phase of the Maternal and Infant Health Program has been completed and the project is now in the implementation phase. Screening tools for various aspects of the program have been developed and are being pilot-tested (e.g., maternal screening tool, postnatal risk screening).//2008//
/2009/The implementation phase of the MIHP continues. A database was developed for the MIHP Prenatal Risk Factor Eligibility Form. All MIHP providers will be required to enter each MIHP screen into the state's MIHP online database as of July 1 2008. Best practice interventions are being developed for the screening tool domains. An integrated MIHP/WIC tool was developed and implemented by some of the MIHP providers. WIC's program system will electronically share common data elements with MIHP of women screened.//2009//
/2010/Implementation of the MIHP redesign is on the fast track. Effective October 1, 2008, the Medical Services Administration mandated enrollment of all newly eligible Medicaid pregnant women into managed care. Managed care was then directed to refer all pregnant beneficiaries to MIHP. Care coordination agreements became required May 1, 2009 which define the responsibilities and relationship between the MIHP providers and the managed care plans. The agreements provide guidance around communication and assure prenatal and postpartum care is coordinated. //2010//

Maternal and infant domain enhancement has moved forward and standardized interventions are being crafted. Forms have been designed and workgroups have met to address topics relevant to strengthening the coordination and working relationships between MIHP providers and the Health Plans.

/2009/The Michigan Infant Mortality Program: Interconception Care Project was initiated in 2005 to improve birth outcomes for women who are most at-risk of an infant or fetal loss, a preterm birth or a low birth weight baby. Funding uses a mix of Title V and Healthy Michigan (tobacco tax) Funds to provide consultation and technical assistance to projects in eleven local communities. Each project supports case management for women who have had a previous poor pregnancy outcome. Overall the project has the capacity to intervene with approximately 400 women, most of whom are African American. Over 100 women have been enrolled so far and an evaluation plan is underway to determine what works to improve many risk factors that are part of each woman's life course.

This project is an outcome of strategic planning for infant mortality reduction that began in 2004. Other outcomes include a statewide Infant Mortality Summit held in May 2008 that brought together key stakeholders from across the state to share lessons learned and set goals for the future.

Strategic planning has also resulted in some reorganization of staff so that a Perinatal Health Unit is now dedicated to working with preconception issues of childbearing age women.//2009//

/2010/ The Michigan Department of Community Health's Infant Mortality Program continues to support 11 local Interconception Care Projects (ICP) in communities disproportionately affected by infant mortality. The primary audience continues to be African American women at risk of having repeat poor pregnancy outcomes. Nevertheless, women of all racial/ethnic groups are served in this program. Since its implementation, the ICP has served a total of 332 women during the inter-pregnancy period. Currently, 205 clients are actively enrolled in the ICP. However, due to state budget cuts, the ICP will be eliminated effective July 1, 2009. //2010//

The Maternal and Child HIV/AIDS Program assures that coordination of existing medical care and social support services exists for families living with HIV/AIDS in southeast Michigan. The program follows a family-centered approach to service delivery, employing a family case manager to link families with needed care across service systems. The target populations are women,

adolescents, children and families with HIV, and sexually active women and youth. Clients receiving services from contracted agencies have access to primary and tertiary care for HIV disease and may also receive the following services: comprehensive, coordinated, family-centered care and case management services; access to an emergency fund for eligible expenses; gynecological services; psychosocial services; information and access to available clinical trial participation; opportunities to participate in a community advisory board; child care resources; transportation; resources to enhance development of leadership skills in women and/or adolescents affected by HIV; and health education, information and referrals for other health and psychosocial services.
/2010/ The Perinatal Prevention Workgroup partnered with the MDCH Perinatal Hepatitis B Program to survey Michigan's birthing hospitals & prenatal care providers on their maternal HIV and Hepatitis B testing practices. In response to survey results, each hospital was sent information on Michigan's Public Health Code, which requires HIV, hepatitis B, & syphilis testing be offered at the first prenatal care visit, again during the third trimester (if a woman engages in behaviors that put her at risk), or at labor & delivery if the woman's test results are unknown or undocumented. As follow-up to the surveys, chart abstractions were done to collect baseline data on hospitals' compliance with the Public Health Code. In response, many hospitals have begun to review their HIV testing policies & procedures. The workgroup also worked with MDCH Title V & substance abuse programs to distribute consumer-focused brochures on the importance of maternal HIV testing to their program participants, community based organizations, local health departments, private prenatal care providers, and hospitals across the state. The Perinatal Prevention Workgroup is working toward routinized perinatal HIV testing in Michigan birthing hospitals. Chart reviews will continue through 2012. Technical assistance to birthing hospitals will remain on going.//2010//

The Newborn Hearing Screening Program is a hospital-based, voluntary program to screen newborns for hearing loss by one month of age, assure diagnosis by the age of three months, and, when appropriate, assure intervention services by the age of six months. The department provides education to local health care facilities on the importance of newborn hearing screening, the need for a collaborative local team for infants requiring follow-up, and maintains a statewide database for tracking screening and follow-up activities. As of April, 2004, all Michigan birthing hospitals are participating in the screening program.

The Prenatal Smoking Cessation Program works with low-income pregnant smokers who are receiving health services in public prenatal programs. Intervention is based on a stages of change model.

/2010/ A Smoke Free for baby and Me on line course has been established and active since November 2007. Agencies who implement the program provide MDCH a quarterly report of unduplicated women served. In the CY 2008, 1,236 women were served.

During 2008, MDCH received an AMCHP mini-grant to implement the SWIM (Smokefree Women In Michigan) program at 3 pilot sites. The SWIM program was designed to increase utilization of the state's tobacco quit-line among women of reproductive age, 18-44 years//2010//

The Michigan Sudden Infant Death Services Program covers all sudden infant deaths during the postneonatal period, which are not trauma, homicide or chronic illness. To improve the capacity to provide bereavement services, new cases are being reported to the Michigan SIDS Alliance which sends a grief literature packet and makes referrals for grief support. Bereavement support education is provided. A Family Services Committee of bereaved parents acts as an advisory group to the Family Support Coordinator. To help coordinate infant mortality reduction efforts, the SIDS Alliance staff were given positions on the state Fetal-Infant Mortality Review Network, the state Infant Mortality Network and the local FIMR and Child Death Review teams.

/2009/The Michigan Sudden Infant Death Services Program covers all sudden infant deaths during the postneonatal period, which are not trauma, homicide or chronic illness. To improve the capacity to provide bereavement services, referrals are sent to Tomorrow's Child/MI SIDS. A packet of grief literature is sent to families, and if desired, they are connected to local staff for bereavement home visits and grief support. A Family Services Committee of bereaved parents acts as an advisory group to the Family Support Coordinator. Autopsy and scene investigation reimbursement is offered to local medical examiner offices to provide incentive to getting accurate cause and manner of death.

Services provided by the SIDS/OID program include: bereavement support for grieving parents, payment for infant autopsy and death scene investigation, and public education on safe sleep. A study of causes of infant death was begun in 2007 comparing a cohort who died in 2003-2004 compared with a cohort from 1998-1999. Results should be available in 2008 and are expected to help in understanding the variety of labels given to unexpected infant deaths.//2009//

/2010/An Infant Safe Sleep web site has been established, and in 2008 an on-line training on Infant Safe Sleep was created for professionals, parents, and all infant care-givers. //2010//

Preventive and Primary Care Services for Children

The Michigan Abstinence Partnership aims to positively impact adolescent health problems through promoting abstinence from sexual activity and the related risky behaviors such as the use of alcohol, tobacco, and other drugs. A comprehensive approach targeting 9 to 17 year old children and their parents is used and includes coalition development, community activities, media, and educational and promotional items. Educational materials promote the abstinence message and efforts of the partnership. The media campaign has been developed targeting 9 to 17 year old children through television, radio, and posters. Technical assistance is provided to assist with local partnership activities, coalition building, program development and evaluation. /2008/ State and federal funding for this program has been eliminated and the program will end June 30 2007.//2008//

/2009/ Federal funding for this program is currently being authorized on a quarterly basis. Current funding ends June 30, 2008 unless the fourth quarter authorization passes Congress.//2009//

/2010/ Nine agencies throughout Michigan were funded to provide abstinence-only education from January 1, 2009-September 30, 2013. Federal funding for this program is currently being authorized on a quarterly basis. Current funding ends June 30, 2009 unless the fourth quarter authorization passes Congress. Four agencies were funded to provide comprehensive evidence-based pregnancy prevention programs from May 1, 2009-September 30, 2012. //2010//

The Child and Adolescent Health Center (CAHC) Program includes two models of service delivery -- school based or linked clinical health centers serving either elementary age students (5-10 years) or adolescents (10-21 years) and non-clinical alternative health models. The clinical child and adolescent health center model (also referred to as school based/linked health centers) provides on-site primary health care, psychosocial services, health promotion and disease prevention education, and referral services in either a school or community setting. The nonclinical health model focuses on case finding, screening, referral for primary care, and providing health education services. The program provides base funding support to 45 clinical child and adolescent health centers and 12 non-clinical centers. In November 2001, the program funding source was shifted to the School Aid Fund in the Department of Education. The Department of Education transfers the CAHC funding to the Department of Community Health, which continues to be responsible for contract oversight, agency monitoring, training, technical assistance and consultation.

/2010/ In FY 2009, $1.2 million additional dollars were allocated to the CAHC program bringing the total state funding to $4.9 million. This state funding is used to draw down Federal Medicaid match Outreach dollars. The FY 2009 match is estimated at $8 million.

A statewide RFP was issued by the Michigan Department of Community Health and Michigan Department of Education in October 2008 to expand the CAHC program. The Departments awarded grants to 17 communities in Michigan to start up a school based or linked Child & Adolescent Health Center, bringing the total number of state-funded centers to 74.//2010//

The Michigan Model For Comprehensive School Health Education Program is a planned, age appropriate, sequential K-12 health curriculum, which has been in many Michigan schools since 1984. The major goal of this program is to create a partnership between homes, schools community groups and government to educate young people about current health risks. The Model gives children the information and skills that they need to make healthy choices now and in the future. Since 1984 health information has changed in many areas. The Michigan Model has updated and revised materials and curriculum to address the changes. At this point in time over 95% of the public school districts provide Michigan Model to their students. Health education was provided to more than 1,000,000 students this past school year. Twenty-six local coordinators train teachers to make this program available to all of the public and private schools in the state.

The Oral Health Program provides consultation, technical assistance, and statewide coordination for oral health programs to local health departments (LHDs) and other community agencies. Forty-six local agencies, including LHDs, primary care centers, migrant health clinics, and Indian Health Services (IHS) conduct public health dental programs. Forty-three provide direct clinical services and three programs refer to private dental offices. One LHD program is supported by funding from the MCH block grant to provide dental care to dentally underserved children in a five county area. Other programs are funded locally, through fee-for-service collection, Medicaid, private foundation funds, and federal funding (IHS, primary care, and migrant health). A network of volunteer dentists provides dental care to persons who are mentally and physically handicapped, who are medically compromised, or who are elderly, through the Donated Dental Services Program, supported by the Healthy Michigan Fund. The department provides dental services to the developmentally disabled populations who are not eligible for Medicaid, cannot access a Medicaid provider, do not have other dental coverage, and cannot afford dental care. Services provided are limited to the treatment of those conditions that would lead to generalized disease due to infection or improper nutrition. Through a CDC Cooperative Grant the Oral Health Program is investigating the development of a state-wide sealant program to provide the required provision of sealants on 3rd grade children in the MCH Block grant.
/2008/A state-wide sealant program will begin October 1 2007 (see National Performance Measure #9).//2008//

/2010/The MCH Block grant provides funding for the SMILE! Michigan state-wide school-based/school-linked dental sealant program targeting second grade children. Over 13,000 children received dental sealants in 2009. Forty-six local agencies, including LHDs, primary care centers, migrant health clinics, and Indian Health Services (IHS) conduct public health dental programs. A network of volunteer dentists provides dental care to persons who are mentally and physically handicapped, who are medically compromised, or who are elderly. The Developmentally Disabled Dental Fund provides limited funding for the developmentally disabled populations to receive dental services. A State Water Fluoridation Committee created the State Community Water Fluoridation Work Plan to direct the program. In collaboration with the DEQ, CDC recommendations are implemented to monitor monthly fluoride levels in water systems, encourage water systems to begin fluoridating and training in the oral health benefits of fluoridation. New Medicaid policies allow pediatricians and nurses to provide oral screenings, home care instructions to parents and the application of fluoride varnish during ESPDT well-baby

checks. The Varnish! Michigan program is expected to provide fluoride varnish, oral health education, and dental referral to over 17,000 children from age 0 to 5 in 2009.//2010//

The Hearing Screening Program supports local health department (LHD) screening of children at least once between the ages of three and five years and every other year between the ages of five and twelve years. A few LHDs also screen children younger than three utilizing a subjective behavioral technique which rules out a severe profound hearing loss. LHD staff are trained as either an EPSDT technician or a comprehensively trained school screening technician. Quality assurance is provided for approximately 200 LHD threshold technicians by the MDCH audiology consultant, through field visits and required biennial skills update workshops. Over 680,000 children are screened per year in preschool and school programs, and between 40,000 and 50,000 referred for evaluation each year. Increasingly, agencies are utilizing otoacoustic emissions (OAE) technology, for screening young children and children who are difficult to test. Follow-up for all referred children is required to assure that needed care has been received, or assistance given to be seen at an Otology clinic provided through CSHCS. Most screenings are conducted in schools and day care centers. In 2005, funding for this program was cut in half by the legislature, which resulted in significantly reduced numbers of screenings, but the referral rate has remained stable.
/2009/ The frequency of screening has changed from ages 5 through 12 to 5 through 10. Subjective behavioral hearing screening is no longer conducted on the 0-3 age group, but programs with Otoacoustic Emissions (OAEs) will often screen children under 3 years of age as well as the developmentally delayed and difficult to test. Quality assurance is conducted by contracted audiologists. Since the 2005 budget cuts, the program is working to get our screening numbers back to where they were before the cuts were made. Last year, just under a half million children were screened and almost 20,000 medical referrals were made. Pre-budget cuts the total number of children screened was approximately 680,000 with over 40,000 referrals.//2009//

The Childhood Lead Poisoning Prevention Program (CLPPP) supports the coordination of lead poisoning prevention and surveillance services for children in Michigan and the funding of pilot sites for primary prevention of lead poisoning through the identification of lead hazards in housing. Infants, children under six years, and pregnant women are priorities for screening and testing. Program service components are education and outreach, blood screening and testing, tracking, reporting, primary prevention activities, policy development and program management, quality assurance, and evaluation. Of the nearly 133,000 children tested 2008, or 2.4%, had blood lead levels at or above 10 ug/dL.

/2008/ Of the 149,445 children under six years of age tested in 2007, 2,031 (1.4%) had a venous blood lead level at or above 10 ug/dL. Case management will be improved as a result of updated protocol, standardized forms and case management training.//2008//
/2010/ Special populations for screening and testing were expanded to include foreign adoptees, refugee, migrant, immigrant, and foster care. 153,248 children less than six years of age were tested in 2008.//2010//

Vision screening of pre-school children is conducted by local health department (LHD) staff at least once between the ages of three and five years, and school-age children are screened in grades 1,3,5,7,9,11 or in grades 1,3,5,7, and in conjunction with driver training classes. Screening, re-testing and referral is done. The battery of vision screening tests is administered by LHD staff trained by the Vision Consultant in the Division of Family and Community Health at MDCH. Consultation and quality assurance is provided for the approximately 200 LHD school screening technicians by the MDCH Vision Consultant and a cadre of specially trained individuals, through field visits and skills update workshops provided yearly in at least three regional sites. Follow-up for all screening is required which assures that care is received. More than 850,000 preschool and school-age children are screened each year and more than 70,000 referrals are made to eye doctors annually.

/2009/Grade 11 has been deleted from the frequency of screening. Screening, retesting and

referral is done by the local health department. In 2007, 585,747 pre-school and school-age children were screened and 56,527 children were referred for follow-up.//2009//
/2010/ Over 682,810 children were screened in 2007-2008. Over 67,330 children were referred for vision exams and follow-up care.

New technicians from Local Health Departments were trained during one of two comprehensive trainings offered in the fall of 2008. Twenty two technicians completed the training designed to provide both didactic and clinical experience in the screening of preschool and school-age children. The large number of trainees represents the new hires of vision programs seeking to re-staff since the budget cuts of 2005-2006.

The Vision Program continues to serve all children of Michigan at no cost to families. With approximately 10% of all children screened requiring follow-up, this service impacts learning and life-long education opportunities for those requiring vision care.//2010//

Services for Children with Special Health Care Needs

The Michigan Public Health Code, Public Act 368 of 1978 as amended, defines a CSHCS-eligible person as someone under age 21 "...whose activity is or may become so restricted by disease or deformity as to reduce the individual's normal capacity for education and self-support." Persons over age 21 with cystic fibrosis or hereditary coagulation defects (e.g., hemophilia) also may be eligible for services. CSHCS covers chronic physical conditions that require care by medical or surgical specialists. The program also evaluates severity, chronicity and the need to be seen at least once annually by an appropriate pediatric subspecialist in making a medical eligibility determination. The full range of CSHCS program elements and services includes: casefinding; application for CSHCS coverage, assessment of family service needs, and service coordination/case management, specialty medical care and treatment; family support services and opportunities for parent participation in policy development; and specialized home care supports. /2008/ The CSHCS division created the Early Adult Transition Task-Force in 2006 which serves as the offical youth advisory council for the division. This has increased the opportunity for youth participation in policy development. //2008//

Medical care and treatment includes a wide range of services such as physician specialist care, hospitalization, pharmaceuticals, special therapies and durable medical equipment, respite, and orthotics/prosthetics. In addition to making payment for these services, CSHCS assures quality in the services provided. Physicians, hospitals, and clinics must meet established criteria in order to qualify as CSHCS "approved" providers. The criteria focus on the demonstration of expertise and willingness to provide pediatric specialty services. Along with the approval of providers, CSHCS authorizes specific providers for each child, so that specialty expertise is appropriate for the child's condition. Provider reimbursement policies and rates are the same for both CSHCS and Medicaid.

There are no fees assessed for families whose income is at or below 250% of the federal poverty level or for children adopted with a qualifying pre-existing condition. All other families or clients are required to have their income evaluated. Families can choose to participate in the program, subject to a payment agreement established on a sliding-fee scale. /2007/ The federal poverty level was reduced to 200% January 2006 and the sliding fee scale was changed to a five-tiered set of fees. //2007//

CSHCS is a statewide program, although certain program components may not be located in every county. For example, children's multidisciplinary clinics are associated with tertiary care centers, and family support coordinators may serve more than one county.

Local health departments (LHDs) serve as a community resource to assist families in accessing needed services, both from CSHCS and other local agencies. LHD CSHCS professionals are encouraged to work closely with their MCH colleagues and with other agencies to identify

community service needs from the perspective of children with special health needs and their families. These local collaborative efforts are supported by the state-level approach to community needs assessment and are reflected in efforts to remove artificial, categorical barriers to services. Local efforts are focused on the earliest intervention possible to prevent, cure or minimize the impact of handicapping conditions on children. In addition to program representation activities for the purpose of casefinding, the LHD system or the CSHCS Customer Support Section helps families to obtain needed program information and services. Families are offered a Family Service Needs Summary by the LHD when the family requests assistance in understanding the CSHCS program and other services available in their communities. During the service needs summary, LHD professionals help to identify the needs of all family members. Service coordination (formerly case management) can then be provided if the family decides it wants further help in developing self-advocacy skills, problem-solving, or in obtaining needed services.

The CSHCS program operates according to the philosophies inherent in Family-Centered, Community-Based, Culturally Competent, Coordinated Care. This philosophy has been incorporated into all CSHCS strategies for program and policy development, and into the service delivery structure. CSHCS has built an infrastructure that assures both input and feedback with regard to these critical program characteristics. The Parent Participation Program (paid parent consultants to the program), parent membership in the CSHCS Advisory Committee, and the Family Support Network are program elements that reinforce family-centeredness. Formal relationships with local health departments, initiatives to strengthen home-based care, and provider standards all support a community-based approach. Coordinated care is facilitated by state-level inter-agency planning (including coordination among state-level parent support initiatives); local relationships among and between other MCH colleagues and human service agency professionals; broad representation on the CSHCS Advisory Committee; and expectations of specialty clinic providers, primary care physicians, and local health department professionals.

/2009/ In 2007, a large scale strategic planning meeting was planned to engage stakeholders in the process of preparing a five-year plan for the CSHCS program to address the implementation of the MCHB Healthy People 2010 objectives. The meeting was planned and participants were invited. Because of state budget constraints the strategic planning meeting had to be cancelled. The meeting was rescheduled to take place in 2008.//2009//

The Parent Participation Program has three major areas of responsibility: 1) development of a statewide, community-based network of parent-to-parent support, 2) provision of parental input to CSHCS administration regarding programs and policies; and 3) facilitation of timely responses to families in need. As a core component of the CSHCS organization, the program is headed by a parent of a child with special health needs. The program is unique in that it is inclusive of all families of children with special health care needs, whether or not they are enrolled in CSHCS. The Children's Special Health Care Services hotline is operated through the Parent Participation Program. /2008/ In October of 2006 the Parent Particpation Program re-named themselves the Family Center for Youth and Children with Special Health Care Needs (Family Center). The name was changed to reflect the broader scope of services the Family Center offers that includes serving all youth and children with special health care services as opposed to CSHCS clients only. //2008//

All children eligible for SSI are also eligible for Medicaid in Michigan. Therefore rehabilitation services are typically provided under Title XIX, often in the school under Medicaid-Reimbursed School-Based Services. Michigan Medicaid has a very extensive benefit package, and the need for further coverage would be rare. CSHCS provides medical services as needed based upon the CSHCS qualifying diagnosis. Therefore, CSHCS would provide medically necessary services not covered under Title XIX for children enrolled in CSHCS as the circumstance arises.

C. Organizational Structure

The Michigan Department of Community Health is the state public health agency, responsible directly to the Governor. The Department is organized into six administrations, five programmatic and one administrative support: Medical Services Administration, Health Policy, Regulation and Professions Administration, Public Health Administration, Mental Health and Substance Abuse Administration, Office of Services to the Aging, and Administrative Operations. The Medical Services Administration has primary responsibility for the Medicaid and state CHIP program, MIChild. The Health Policy, Regulation and Professions Administration includes licensing functions for health care professions and health care facilities which were transferred into the Department by Executive Order in December, 2003.

The Public Health Administration includes the Bureau of Family, Maternal and Child Health (BFMCH), Bureau of Laboratories, Office of Public Health Preparedness, Bureau of Health Promotion and Disease Control, and the Bureau of Epidemiology. Responsibility for Michigan's Title V program is placed within the Public Health Administration, Bureau of Family, Maternal and Child Health. The Title V program works closely with the Epidemiology Bureau on maternal mortality and other MCH epidemiology studies using state vital records, PRAMS and other health statistics, newborn screening and hereditary disorders. BFMCH coordinates activities with the Division of Chronic Disease and Injury Control around childhood obesity, childhood injury, suicide and breast and cervical cancer. BFMCH works with the Bureau of Laboratories on childhood lead poisoning, immunizations and sexually transmitted diseases. BFMCH also works closely with the Medical Services Administration on Medicaid and MIChild coverage of services to women and children and coordination of eligibility determination and payment for services to children with special health care needs.

The Bureau of Family, Maternal and Child Health includes the Division of Family and Community Health, Children's Special Health Care Services Division, and the WIC Division. Because the WIC program reaches so many low-income families, it is integral to many of our MCH efforts including promotion of immunization, lead poisoning screening, nutrition and breastfeeding. Children's Special Health Care Services provides medical care and treatment, care coordination and other ancillary services for children with special health care needs and works closely with the Medical Services Administration in providing specialty services for Medicaid-eligible families and coordinating with primary care services. The Division of Family and Community Health (DFCH) includes several programs targeting birth outcomes and child health including childhood lead poisoning prevention, adolescent health centers, Michigan Abstinence Partnership, School Health, Oral Health, Newborn Hearing Screening, Nurse/Family Partnership projects, Maternal and Infant Support Services, Family Planning, SIDS and Other Infant Deaths, Fetal-Infant Mortality Review projects, Fetal Alcohol Syndrome and Prenatal Smoking Cessation. DFCH works with the Medical Services Administration on Maternal and Infant Support Services and coverages for other maternal and child health services. The divisions contract with local health departments, private clinics and physicians, FQHCs and other providers to implement maternal and child health services at the community level.

/2008/ There were no organizational changes in the Department over the past year.//2008//

D. Other MCH Capacity

The department does not provide direct services, but contracts with local health departments and other community health agencies to provide MCH services. Department staff provide training, consultation and technical assistance to local staff in various programs, certify providers of Maternal and Infant Support Services, determine eligibility for CSHCS program, plan and develop programs, projects and new initiatives, and monitor the performance of local programs. Most of the staff at the state level working on Title V programs are located in the divisions of Family and Community Health and Children's Special Health Care Services.

In the Division of Family and Community Health, there are approximately 46 professional (including vacancies and contractual positions) and 7 support staff working on programs for pregnant women, mothers, infants, children and adolescents. Professional staff is composed of nurses, public health consultants, hearing and vision consultants, nutrition consultant and managers.
/2008/There are 52 established positions in the Division of Family and Community Health, including 42 professional and 10 support staff. The Division currently has 10 vacancies for positions that have been frozen due to state budget shortfalls.//2008//
/2009/There are currently 37.5 funded positions in the Division, including 9.5 vacancies.//2009//
/2010/There are 51 established state positions in the Division including 5 vacancies. In addition to these state positions, the Division has 14 professional contractual staff working on numerous programs and projects.//2010//

The WIC Division administers the federal Supplemental Food Program for Women, Infants and Children and Project FRESH. The Division includes 29 professional and 11 support staff. Staffing includes nutritionists, analysts and managers.
/2008/The WIC Division currently has 42 established positions, including 31 professional and 11 support staff. The Division has 4 vacancies.
/2009/There are currently 43.0 funded positions in the WIC Division. including 32 professional staff and 11 clerical staff. This includes 6 vacancies.//2009//
/2010/There are currently 43 funded positions with three vacancies in the Division.//2010//

The Children's Special Health Care Services Plan Division currently includes approximately 30 professional and 15 support staff. Professional staff is made up of doctors, nurses, nutritionists, analysts and managers. Support staff perform clerical, technical and enrollment functions. Parents of children with special needs, working through the Parent Participation Program, perform an advisory role to the department as well as developing support networks across the state for parents of special needs children. The Parent Participation Program (PPP) employs 9 staff persons, 5 of whom are parents of children with special needs.
/2008/The CSHCS Division currently has 50 established positions, including 31 professional and 19 support staff. The Division currently has 4 vacancies that have been frozen due to state budget shortfalls. The Parent Participation Program has been re-named the Family Center for Youth and Children with Special Health Care Needs. The Center currently employs six parents.//2008//
/2009/The Division currently has 47 funded positions, of which 27 are professional positions and 20 are clerical. There are currently 5 vacancies. The Family Center has seven total staff, four of whom are parents.//2009//
/2010/ The division currently has 46 funded full time positions. 45 of these positions are filled and there is one vacancies. The Family Center for Youth and Children with Special Health Care Needs currently employs eight staff total, five of whom are parents of children with special needs. //2010//

Kathleen Stiffler is the Director of the Children's Special Health Care Services Division. Ms. Stiffler has 17 years of experience in various capacities within the Maternal and Child Health area. Most recently she served as the Unit Director for Adolescent Health for over eight years. In that capacity she was responsible for directing program and policy development, program implementation and monitoring, quality assurance, evaluation and program improvement for Michigan's adolescent health programs. The focus of adolescent health programming in Michigan includes school-based/school-linked teen health centers (primary care programs designed to address the unique needs/strengths of the adolescent-aged population) and teen pregnancy prevention. Prior to that, Ms. Stiffler was the Chief of the Prenatal and Infant Care Section. Ms. Stiffler holds a Master's Degree in Health Education from Central Michigan University.

Douglas M. Paterson is Director of the Bureau of Child and Family Programs within the Michigan Department of Community Health. In this capacity, he oversees the WIC Division, the Children's

Special Health Care Services Division, and the Division of Family and Community Health. Mr. Paterson has 30 years of experience in Maternal and Child Health serving as the WIC Director and Division Director over several MCH Programs. He currently serves as the Title V MCH Director for the State of Michigan and Project Manager for the State MCH Early Childhood Comprehensive Systems Grant. Mr. Paterson has a Master's Degree in Public Administration. /2007/ Douglas Paterson retired in January 2006. Dr. Gary Kirk was appointed the new bureau and Title V Director in May 2006. Dr. Kirk is a pediatrician with Masters in Health Professions Education and Public Health. He has three years experience as attending physician at Michael Reese and Wyler Children's Hospitals in Chicago, four years experience as Director of inpatient pediatric services at University of Illinois and DeVos Children's Hospitals, two years as Director of Pediatric Residency Program at Spectrum Health in Grand Rapids, two years as Director of Sindecuse Health Center at Western Michigan University, and two years as Director of the Division of Immunization at MDCH.//2007//
/2008/Dr. Kirk will leave the Department of Community Health in July 2008. Alethia Carr, current Director of the WIC Division will assume the post of Acting Bureau Director and Title V Director. Ms. Carr has an MBA and a Bachelor of Science degree in hospital dietetics and is a registered Dietician. She has ten years experience as a clinician and 23 years of management experience in various maternal and child health programs including childhood lead poisoning, MCH HIV/AIDS, and Women's and Reproductive Health.//2008//
/2009/Alethia Carr was appointed Director of the Bureau of Family, Maternal and Child Health effective May 18, 2008. As such she is also the State's Title V Director.//2009//

The Office of Medical Affairs within the Medical Services Administration houses two full-time physician consultants dedicated specifically to CSHCS, and two physicians who dedicate a portion of their efforts toward CSHCS needs. Their role is determination of program eligibility, approval of CSHCS specialists, and approval of specific specialists to serve the CSHCS beneficiary. /2008/ The access to two full-time physician consultants changed significantly in 2006 because of illness. The division was left with one full-time physician and the part-time physicians to continue the vast amount of work that the physician consultants provide for the division. In the absence of one full-time consultant three additional physicians were contracted to provide a portion of their time picking up the CSHCS workload. //2008//
/2009/The physician position was filled by Dr. Nina Mattarella effective October 15, 2007.//2009//

The Newborn Screening and Hereditary Disorders Program within the Bureau of Epidemiology has seven professional and two support staff. Professional staff includes a public health consultant who directs the NBS Follow-up Program component and a public health consultant who serves as State Genetics Coordinator. In addition, the program contracts with 2.5 FTE nursing/genetics professionals for projects related to birth defects, newborn screening, and adult genetics, as well as two parent consultants funded through grants on an hourly basis. /2007/The Department added a public health genomics unit to address chronic disease/genomics and birth defects. The newborn screening unit remains and will be expanded as needed to manage the workload associated with expanded newborn screening.//2007//

The Bureau of Epidemiology also includes 2 epidemiologist positions (one vacancy) dedicated to maternal and child health issues and work with the Bureau of Family, Maternal and Child Health on data collection and analysis and evalutation.

E. State Agency Coordination

The Michigan Department of Community Health includes administrations responsible for the Medicaid and MIChild programs, Mental Health and Substance Abuse, Public Health, Services to the Aging, and licensing of health professionals and facilities. In administering the Medicaid and MIChild programs, DCH works closely with the Department of Human Services, the state agency responsible for eligibility determination for Medicaid and other assistance programs.

Directors of the Departments of Community Health, Education, Human Services, and Labor and Economic Growth meet on a regular basis to coordinate policy and discuss cross-cutting issues affecting their common target populations. In March, 2003 the Governor created the Children's Action Network (CAN) consisting of directors of all state departments that have services to children and families within their purview. The purpose of CAN is to coordinate child and family programs across state agencies and implement a shared policy agenda promoting health, social and emotional development and school readiness in all young children. In addition, the departments of Community Health, Human Services, Education and Labor and Econimc Growth are collaborating on the Early Childhood Comprehensive Systems Planning Project, begun in 2003 with a grant from MCHB. Along with parents, providers, community representatives and advocacy organizations, this project is developing a plan for the structure, finance, performance measures and program strategies for implementing a comprehensive system of care for children 0-5 years of age that supports early brain development. Staff members from the human services agencies guide the project and report to the Children's Action Network on progress and products. The project is coordinated with the Governor's Great Start campaign to get children to school ready to learn.
/2008/ The activities of the Children's Action Network have been subsumed under the Governor's Children's Cabinet. The Children's Cabinet includes the directors of the Departments of Community Health, Human Services, Education and Labor and Economic Growth. In addition to the projects mentioned above, other interagency efforts include projects addressing healthcare workforce issues (Interagency Healthcare Workforce Coordinating Council, Michigan Opportunity Partnerships, Governor's Accelerated Health Career Training Initiative), Michigan Prisoner Re-entry Program (working with prisoners leaving institutions and their families), Autism Spectrum Disorder Workgroup, and Foster Youth Development Program. The workforce initiatives will address current and predicted critical health care worker shortages in the state, particularly nurses and physicians, by expanding educational opportunities and re-training workers and by offering online information to healthcare employers and career seekers. The Prisoner Re-entry Program will work with released offenders and their families to increase success rates in transitioning to the community. The Autism Spectrum Disorder Workgroup has developed preliminary recommendations to the Directors in regard to early identification, appropriate treatment and education. The Foster Youth Development Program helps youth transitioning out of foster care to achieve independent living status by assisting them with education and employment goals, housing, and learning how to access and use the health care system.//2008//
/2009/In light of the impact of incarceration upon families, the Department of Corrections was added to the Interagency Directors group in 2008. The recommendations from the Autism Spectrum Disorders Workgroup began implementation in 2007. Two pilot sites to implement the recommendations on screening, assessment and evidence-based practice interventions and evaluation of results will begin in October 2008.//2009//

DCH and the Department of Human Services (formerly the Family Independence Agency) continue to work together on outreach activities to low-income families eligible for public programs. The Department of Human Services (DHS) provides information and helps families apply for Medicaid and MIChild, determines Medicaid eligiblity and updates relevant information for Medicaid beneficiaries. DCH and DHS collaborate on policies and processes for making low-income families aware of their eligibility for public assistance programs through various state and local sources, particularly families leaving the TANF program due to increased income or noncompliance with work requirements. DCH and DHS also collaborate on family preservation efforts, the Safe Delivery program targeting new mothers who may want to surrender their babies, and the Child Death Review Program. Both departments maintain representation on the State Child Death Review Team. In addition, WIC and DHS coordinate annual outreach campaigns for the WIC nutrition and TANF programs. WIC and DHS also co-locate services in the Detroit and Wayne County area to increase enrollment of the eligible population in those areas.

DCH and the Department of Education collaborate on school health programs and work together on the Early On initiative (Part C of IDEA). The activities of the Early On program are directed by the State Interagency Coordinating Council and include technical assistance and training for local

coordinating councils. Staff from the Division of Family and Community Health, the Division of Mental Health Services to Children and Families, and CSHCS participate on the state council. The departments also cooperate in administering the Youth Risk Behavior Survey and the School-based Health Centers. Through the Children's Action Network, DCH works with the Department of Education to develop plans for assisting schools not meeting performance expectations under No Child Left Behind.
/2007/ DCH and the Department of Education collaborate on school health programs and work together on the Early On Initiative (Part C of IDEA). The activities of the Early On program are directed by the State Interagency Coordinating Council and include technical assistance and training for local coordinating councils. Staff from the Division of Family and Community Health, the Division of Mental Health Services to Children and Families, and CSHCS participate on the state council.//2007//

DCH joined with the Departments of Agriculture and Environmental Quality in developing and implementing the Michigan Local Public Health Accreditation Program. This program institutes a baseline standard for characteristics and services that define a local health department. The program includes a self-assessment and on-site review components and is operated on a three-year cycle. DCH contracts with the Michigan Public Health Institute to house, staff and coordinate the program. More information on this program can be found at www.accreditation.localhealth.net.

The Michigan Public Health Institute, a non-profit corporation, was authorized by Public Act 264 of 1989 as a cooperative venture of the Michigan Department of Public (now Community) Health, the University of Michigan, Michigan State University and Wayne State University to plan, promote and coordinate public health research, evaluations and demonstrations. The Institute's board of directors includes representatives from each of the universities and the department. Since its creation, the Institute has worked with the department on several important initiatives including: evaluation (e.g., Maternal Support Services, Michigan Abstinence Partnership, Local Public Health Accreditation Program); developing new programs and projects (e.g., Suicide Prevention, Safe Delivery, child death review teams); training and technical assistance activities (e.g., development of a standard tool for reporting death scene investigations of sudden and unexplained child deaths and training of local child death review team members); and data collection and reporting (e.g., child death review database, PRAMS).

With the statewide implementation of Medicaid managed care in 1998, EPSDT services were integrated into the qualified health plans (QHPs). Most local health departments no longer provide EPSDT services. The MCH program continues to work with the Medical Services Administration to develop standards of performance and quality for the plans and provides technical consultation. The MCH program also provides training for QHPs and local health departments on the hearing and vision components of EPSDT.
/2009/The Department of Community Health convened the Michigan State Leadership Workshop in January, 2008 to begin work with stakeholders to strengthen the infrastructure for and outcomes of the EPSDT program. This Leadership group includes a broad spectrum of stakeholders, including parents, school nurses, local public health leaders, the MI Chapters of the American Academy of Pediatrics and Academy of Family Physicians, the MI Primary Care Association, Head Start, Family Voices, the State's ABCD project, Early Childhood Investment Corporation (state ECCS project), and the state departments of Human Services and Education. The January meeting focused on early childhood health and development. The group identified sixteen topics of common concern: MI Care Improvement Registry (MCIR) augmentation; medical home QI project; ABCD to scale; CSHCN into managed care; community resources; improve linkages between medicine and public health; care coordination/case management; early childhood mental health; expand role of WIC; EPSDT coordinators in local health departments; telemedicine (CSHCN); fiscal analysis; care for parents; foster care; child health work group; and developmental services/Early On. For the short-term, six priority areas were identified: use data to help assure access and quality;using Medicaid managed care to serve CSHCN; assure appropriate information exchange across services and systems; implement and operationalize a

common definition of the pediatric medical home; improve the Part C Early Intervention (Early On); and improve access to early childhood mental health services. Six workgroups will be formed to explore actions and recommendations in each of these areas.//2009//
/2010/Medicaid has worked with the MI Care Improvement Registry (MCIR) to add fields to document delivery of EPSDT services. Follow-up on priorities identified at the Michigan State Leadership Workshop is taking place through Michigan's ECCS interdepartmental advisory body, the Great Start Systems Team.//2010//

The protection of the public's health under the Public Health Code is a partnership between the state and local health departments (LHDs). The state health department has responsibility for general supervision of the interests of the health and life of the people of Michigan, promoting an adequate system of community health services throughout the state, and developing and establishing arrangements and procedures for the effective coordination and integration of all public health services, including effective cooperation between public and non-public entities to provide a unified system of statewide health care. With the responsibility for many personal care services including maternal and child health services shifted from local public health to qualified health plans, the role of local health departments has changed somewhat to emphasize assurance of community capacity to provide needed services and accountability for the health status of the community. LHDs continue to carry out the core functions and to provide services aimed at communicable disease control, protection of food and water supply, casefinding and service coordination and planning for children with special health care needs, health education and public information. In addition, the LHDs provide a link to other social and public services. The state health department supports the local health system with funding, training, technical assistance and data resources.

Building Bridges is a collaborative effort between local health departments, Medicaid Health Plans and state MCH programs to coordinate outreach efforts to pregnant women and children by increasing access and adequacy of care. A second annual Building Bridges meeting of stakeholders was held in June 2003. The Building Bridges Project meets quarterly to discuss access to care issues between Medicaid Managed Care, health departments and Maternal Support Services.
/2007/A small grant was awarded to Michigan in 2006 to enhance the coordination structure between state agencies and the local Great Start Collaboratives.//2007//

WIC is part of the Bureau of Family, Maternal and Child Health and continues to be an important component of strategies to improve the health of pregnant women, mothers and children. WIC clinics routinely make referrals for lead screening, maternal and infant support services, and prenatal smoking cessation. The clinics also routinely check immunization status and either refer or provide immunizations on site. Outreach activities are coordinated through the MCH hotline.

Availability and accessibility of family planning services is a key strategy for reducing unintended pregnancy and teen pregnancy. Resources of Title X, Preventive Block Grant and state funds are combined to assure that women and men in need of family planning services have access to them through a provider of their choosing and through referral arrangements with prenatal care providers, WIC and substance abuse programs. Family planning services are a required component of capitated funding for Medicaid enrollees in qualified health plans. The QHPs are also required to reimburse other publicly funded family planning clinics for family planning services provided to any QHP enrollee. The Division of Family and Community Health provides continuing education and training to Title X family planning clinics and managed care providers. The Family Planning program also works with the Breast and Cervical Cancer Control Program (BCCCP) to provide follow-up diagnosis and testing for women who had an abnormal Pap test from Family Planning services. This group of women is too young for the services of the traditional BCCC program.

There are currently five Healthy Start programs in Michigan. The department initiated a collaborative network of all programs to share their experiences, discuss issues of mutual

concern and interest, and to develop standardized evaluation criteria for the programs. The network meets approximately four times a year. The department also assists proposed new programs with their applications by providing data and technical assistance and supports an extensive program evaluation project in Detroit.
/2008/There are currently six Healthy Start projects in the state - Kalamazoo, Flint, Detroit, Grand Rapids, Saginaw and Sault Sainte Marie.//2008//

The implementation of Medicaid managed care has significantly changed the role of local health departments and the MCH program in assuring access to prenatal care. Qualified health plans are held accountable by contract for providing prenatal services in accordance with standards set by the Medicaid program. A separate organization is contracted to conduct enrollment activities. The Medical Services Administration is responsible for administering the managed care contracts, establishing performance standards, monitoring and evaluating performance. MSA contracts with the Michigan Peer Review Organization to conduct annual performance reviews of all plans. Many local health departments (LHDs) and community agencies continue to provide enrollment and outreach services to low-income women either through agreement with the QHP(s) in their area or with their own resources. Several have had to limit their activity due to funding constraints by reducing staff dedicated solely to enrollment and outreach or by concentrating on the non-Medicaid eligible low-income population. Local health departments are encouraged to partner with community agencies to extend the scope of their efforts.

F. Health Systems Capacity Indicators

Introduction

The Michigan Title V program participates in policy development and planning activities for the health system capacity indicators and provides funding support for some of the services related to the indicators. Our capacity to provide services has been affected by state and federal funding reductions over the past five years. Funding for outreach services to connect women and children to appropriate services, including EPSDT and prenatal care, was eliminated in FY 2003 and only partially restored in FY 2005. However, coverages for children and pregnant women through the Medicaid and MIChild programs have been maintained throughout these tough economic times. The Healthy Kids Dental program, providing dental care to Medicaid-eligible children under age 21, has been maintained and expanded through a public-private partnership between the Department of Community Health, Delta Dental, and the Michigan Dental Association. We continue to seek ways to partner with other organizations with common interests to maximize our resources and better serve our clients.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	49.9	46.5	40.1	38.1	38.1
Numerator	3243	3021	2560	2414	2414
Denominator	649842	650215	638195	633017	633017
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006

There is no data available yet for 2006.

Narrative:
Title V dollars are not used in direct suppport of the asthma activities in Michigan. People with asthma in Michigan, including children in childcare settings and schools, do not have appropriate support systems to allow for effective self-management of their condition. Lack of diagnosis, inadequate prescription and use of inhaled medications, and continued exposure to allergens and irritants in homes, day care and other settings increase the number of urgent physician and emergency department visits and hospitalizations due to asthma. The 0-4 age group has some of the highest hospitalizations rates of any age group, and large racial and economic disparities exist in these rates.

The 2005 Asthma Mortality Review Report was published and released in FY 2007. The report can be viewed at http://oem.msu.edu//AsthmaMort/05AsthmaMortality.pdf
/2010/The 2006 Asthma Mortality Review Report was published and released in FY 2008. The report can be viewed at http://oem.msu.edu//AsthmaMort/06AsthmaMortality.pdf . Findings from these reports have been used to raise awareness and inform planning in a number of ways. Most recently, the Detroit Asthma Mortality Summit brought together over 70 health care and community decision makers in Detroit to better understand the causes of asthma mortality and develop a policy agenda for preventing future deaths. This work continues, with MDCH supporting a full time position next year in the Detroit Department of Health and Wellness Promotion. This position will work to implement the Summit recommendations, develop case management capacity in the city, work with three FQHCs on developing an asthma medical home for patients, and build a collaborative asthma initiative between the health department, local asthma coalition, health care systems, schools, managed care institutions, and others.//2010//

The Healthy School Action Tool (HSAT) is a set of online tools to help Michigan schools create healthier environments through assessment and policy development. In 2007 HSAT was overhauled, which included the development and addition of asthma questions. The HSAT revisions were completed and it was launched in September 2007. As a part of the development and finalization of the asthma question, Stark Elementary in Detroit and their Coordinated School Health Team conducted an asthma HSAT pilot and revised their asthma policy to improve the school's asthma management.

Other asthma in schools activities conducted by asthma coalitions include 23 coalition members trained in HSAT, five asthma related school policies have been created or revised and Alpena Public Schools has adopted a school bus anti-idling policy.

In FY 2007 the Asthma Coalition of West Michigan saw 305 asthma patients in their in home case management program.
/2010/In FY 2008, the successful case management model developed by Asthma Coalition of West Michigan was spread to Genesee and Washtenaw counties, with multiple health plans reimbursing for asthma services. A program is under development in Saginaw County as well. MDCH, qualified Medicaid health plans, and case management organizations have developed and agreed to a comprehensive evaluation of the program to better understand impact.//2010//
Asthma coalitions in Genesee, Saginaw and the city of Detroit attended a national and in-state Asthma Health Disparities Collaborative (AHDC) training. The AHDC is a national initiative that focuses on making system level changes within the practice. The Genesee County Asthma Network (GCAN) is partnering with Hamilton Community Health Network (a Federally Qualified Health Center) to participate in an AHDC. As part of the initiative, GCAN provided an in-service to 28 providers at Hamilton Community Health Network. The Tri-County Asthma Coalition (Saginaw) and the Detroit Alliance for Asthma Awareness (DAAA) both tried to engage their local FQHC to participate in an AHDC. There is only one FQHC in Saginaw and they declined participation due to being too busy with other initiatives. The FQHC that DAAA approached initially said that they wanted to participate in an AHDC. After approximately three months, the

FQHC said that they didn't have the time and resources to continue participating. The DAAA is currently soliciting other FQHC to participate.

Asthma coalitions have worked with hospitals promote the adoption of standard asthma emergency department discharge instructions (FLARE). As a result, three emergency departments have fully adopted the discharge instructions and one adopted a portion. A barrier to implementation/adoption of the FLARE has been electronic discharge systems that hospital staff is, or perceive they are, unable to change. To address this barrier national electronic discharge systems companies have been contacted and asked to incorporate the FLARE. As a result of this contact, three of them are now committed to using the FLARE.

The MDCH Healthy Homes University Program worked to eliminate, reduce, or control asthma triggers in the homes of low-income families with children with asthma. Three school districts, with support from AIM, reduced exposure to school bus diesel emissions through education and/or upgrading of school buses. Asthma program staff collaborated with MSU Department of Epidemiology and the UM School of Public Health to assess the effects of exposure to air pollutants on children with asthma in Detroit and Dearborn.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	79.7	85.1	86.2	86.4	86.1
Numerator	49578	56516	58927	59916	59561
Denominator	62203	66402	68352	69357	69152
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
The Bureau of Family, Maternal and Child Health continues to work with the Medical Services Administration (MSA) to improve services to Medicaid-enrolled children and families through setting standards and monitoring quality. Contracts with Medicaid managed care plans set standards for screening children including defining the screening components of a periodic exam and requirements for referral for diagnostic or treament services. In addition, Health plans are required to provide or arrange for outreach services to Medicaid beneficiaries who are due or overdue for well-child visits. A report on the performance overall and by individual health plan is published annually and a consumer satisfaction survey is conducted annually. Other programs funded by MDCH that serve Medicaid-eligible populations include requirements that providers assist women in using health care services for which they are eligible. Outreach funds to local health departments were reinstated at a slightly reduced rate for 2005 and continued collaborative efforts have increased enrollments in publicly-funded programs and provided outreach to uninsured families. In spite of the State's continuing budget problems, the MIChild (SCHIP) and Healthy Kids (Medicaid) programs have been able to maintain the level of coverage for children, so far.

/2009/The Department of Community Health convened the Michigan State Leadership Workshop in January, 2008 to begin work with stakeholders to strengthen the infrastructure for and outcomes of the EPSDT program. This Leadership group includes a broad spectrum of stakeholders, including parents, school nurses, local public health leaders, the MI Chapters of the American Academy of Pediatrics and Academy of Family Physicians, the MI Primary Care Association, Head Start, Family Voices, the State's ABCD project, Early Childhood Investment Corporation (state ECCS project), and the state departments of Human Services and Education. The January meeting focused on early childhood health and development. The group identified sixteen topics of common concern: MI Care Improvement Registry (MCIR) augmentation; medical home QI project; ABCD to scale; CSHCN into managed care; community resources; improve linkages between medicine and public health; care coordination/case management; early childhood mental health; expand role of WIC; EPSDT coordinators in local health departments; telemedicine (CSHCN); fiscal analysis; care for parents; foster care; child health work group; and developmental services/Early On.For the short-term, six priority areas were identified: use data to help assure access and quality;using Medicaid managed care to srve CSHCN; assure appropriate information exchange across services and systems; implement and operationalize a common definition of the pediatric medical home; improve the Part C Early Intervention (Early On); and improve access to early childhood mental health services. Six workgroups will be formed to explore actions and recommendations in each of these areas.//2009//
/2010/Medicaid has worked with the MI Care Improvement Registry (MCIR) to add fields to document delivery of EPSDT services. The ECIC (state ECCS project) coordinated with Michigan AAP and the Head Start State Collaboration Office to convene a Medical Home summit attended by stakeholders from across government, health care providers, and early childhood providers. Michigan completed its pilot of the Assuring Better Child Health & Development project (ABCD), focused on improving developmental screening in the primary care provider's office, and has undertaken a spread initiative. Follow-up on priorities identified at the Michigan State Leadership Workshop is taking place through Michigan's ECCS interdepartmental advisory body, the Great Start Systems Team. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	79.2	55.5	64.5	69.4	74.9
Numerator	486	201	216	238	236
Denominator	614	362	335	343	315
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
Data for this population first became available in 2004. This program is administered by the Medical Services Administration within MDCH in conjunction with the Medicaid Healthy Kids program. A single application is used for determining eligibility for both programs. The majority of applicants are determined to be eligible for, and referred to, Medicaid. With continued high unemployment in Michigan, more people, including dependent children, are becoming eligible for some form of public assistance. Outreach efforts are coordinated between the two programs. Access to Medicaid and SCHIP information is available to the MCH program through the Data Warehouse. The Bureau of Family, Maternal and Child Health and the Medical Services

Administration cooperate on policy development and outreach efforts concerning access to services for children and pregnant women. Outreach funding to local health departments were reinstated at a slightly reduced rate for 2005 and continued collaborative efforts have increased enrollments in publicly-funded programs and provided outreach to uninsured families. See also narrative for National Performance Measure #13.
/2009/The Department of Community Health convened the Michigan State Leadership Workshop in January, 2008 to begin work with stakeholders to strengthen the infrastructure for and outcomes of the EPSDT program. This Leadership group includes a broad spectrum of stakeholders, including parents, school nurses, local public health leaders, the MI Chapters of the American Academy of Pediatrics and Academy of Family Physicians, the MI Primary Care Association, Head Start, Family Voices, the State's ABCD project, Early Childhood Investment Corporation (state ECCS project), and the state departments of Human Services and Education. The January meeting focused on early childhood health and development. The group identified sixteen topics of common concern: MI Care Improvement Registry (MCIR) augmentation; medical home QI project; ABCD to scale; CSHCN into managed care; community resources; improve linkages between medicine and public health; care coordination/case management; early childhood mental health; expand role of WIC; EPSDT coordinators in local health departments; telemedicine (CSHCN); fiscal analysis; care for parents; foster care; child health work group; and developmental services/Early On.For the short-term, six priority areas were identified: use data to help assure access and quality;using Medicaid managed care to srve CSHCN; assure appropriate information exchange across services and systems; implement and operationalize a common definition of the pediatric medical home; improve the Part C Early Intervention (Early On); and improve access to early childhood mental health services. Six workgroups will be formed to explore actions and recommendations in each of these areas.//2009//
/2010/Medicaid has worked with the MI Care Improvement Registry (MCIR) to add fields to document delivery of EPSDT services. The ECIC (state ECCS project) coordinated with Michigan AAP and the Head Start State Collaboration Office to convene a Medical Home summit attended by stakeholders from across government, health care providers, and early childhood providers. Michigan completed its pilot of the Assuring Better Child Health & Development project (ABCD), focused on improving developmental screening in the primary care provider's office, and has undertaken a spread initiative. Follow-up on priorities identified at the Michigan State Leadership Workshop is taking place through Michigan's ECCS interdepartmental advisory body, the Great Start Systems Team. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	75.2	76.6	75.9	73.9	73.9
Numerator	97227	97437	96851	92503	92503
Denominator	129311	127122	127537	125172	125172
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

The denominator is based on data from the new Electronic Birth Certificate system and appears to under-represent the actual number of births in the state for 2007. Corrected data is not yet available.

Narrative:
This measure was virtually unchanged from 2005 to 2006. Referral pathways through the WIC program were created. Four Nurse/Family Partnership programs began enrolling clients in 2004 and offer early intervention for first time pregnancies. A re-design of the Maternal and Infant Support Services Program (now called Maternal and Infant Health Program or MIHP) was implemented in late 2005 with emphasis on early entry into prenatal care and early risk assessment. Expansion of eligibility for Medicaid family planning services will allow providers to connect women choosing to become pregnant to prenatal care providers, supporting earlier entry into care. Data collected from pilot sites (see NPM # 18) and the Nurse/Family Partnership program will be analyzed to learn best practices for improving this indicator. Our ability to maintain these efforts in the coming year will depend upon the outcome of budget deliberations now occurring between the Legislature and the Governor. Michigan's economic outlook continues to be weak and this may affect funding sources for several programs focusing on infant mortality and contributing factors.
/2009/The Michigan Infant Mortality Program: Interconception Care Project was initiated in 2005 to improve birth outcomes for women who are most at-risk of an infant or fetal loss, a preterm birth or a low birth weight baby. Funding uses a mix of Title V and Healthy Michigan (tobacco tax) Funds to provide consultation and technical assistance to projects in eleven local communities. Each project supports case management for women who have had a previous poor pregnancy outcome. Overall the project has the capacity to intervene with approximately 400 women, most of whom are African American. Over 100 women have been enrolled so far and an evaluation plan is underway to determine what works to improve many risk factors that are part of each woman's life course. A fifth Nurse Family Partnership Program was initaited in December 2007 in Kalamazoo County.//2009//
/2010/The MIHP redesign continues with standardized interventions aimed at addressing maternal and infant biological, psychological and social risk domains including early entry into prenatal care and birth outcome improvement. In October 2008, it became mandatory for Medicaid pregnant women to be enrolled in a Managed Care Health Plan. With this mandate also came the requirement that all pregnant women be referred to the MIHP program. These requirements will help assure that all Medicaid pregnant women have a health care provider and that she will be assisted in obtaining the visits necessary for a healthy outcome. The Interconception projects, in the 11 targeted communities, continued to see women who had an adverse birth outcome but with the state budget difficulties, the funding for all projects ends as of June 30, 2009. It is encouraged that these women be referred to other appropriate community services for continued interventions. The Nurse Family Partnership has been established in five communities but the state funding for these programs will also be eliminated June 30, 2009. There may be some local continuation in one or two communities after the state funding is removed. The Perinatal Regionalization System of Care has received more attention this past year, with OB, Neonatal and Pediatric workgroups established and a combined report and guidelines being developed. The report was provided to the legislature April 1 and has received positive support from the health care community. MDCH is exploring creative ways to implement the use of the guidelines and to move forward with the Perinatal Regionalization System in light of the financial difficulties in the state. A comprehensive Infant Mortality Strategic Plan is in development to address the Perinatal Periods of Risk areas. The initial version has been created and is to be presented to internal stakeholders in June 2009. The Plan would be MDCH's course of action for the 2009-2013.//2010//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	80.2	83.6	84.3	85.4	86.2
Numerator	792549	835005	924469	893739	923503
Denominator	988147	998680	1097269	1046771	1071516
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
The Bureau of Family, Maternal and Child Health continues to work with the Medical Services Administration (MSA) to improve services to Medicaid-enrolled children and families through setting standards and monitoring quality. Contracts with Medicaid managed care plans set standards for screening children including defining the screening components of a periodic exam and requirements for referral for diagnostic or treament services. In addition, Health plans are required to provide or arrange for outreach services to Medicaid beneficiaries who are due or overdue for well-child visits. A report on the performance overall and by individual health plan is published annually and a consumer satisfaction survey is conducted annually. Other programs funded by MDCH that serve Medicaid-eligible populations include requirements that providers assist women in using health care services for which they are eligible. Outreach funds to local health departments were reinstated at a slightly reduced rate for 2005 and continued collaborative efforts have increased enrollments in publicly-funded programs and provided outreach to uninsured families.
/2009/The Department of Community Health convened the Michigan State Leadership Workshop in January, 2008 to begin work with stakeholders to strengthen the infrastructure for and outcomes of the EPSDT program. This Leadership group includes a broad spectrum of stakeholders, including parents, school nurses, local public health leaders, the MI Chapters of the American Academy of Pediatrics and Academy of Family Physicians, the MI Primary Care Association, Head Start, Family Voices, the State's ABCD project, Early Childhood Investment Corporation (state ECCS project), and the state departments of Human Services and Education. The January meeting focused on early childhood health and development. The group identified sixteen topics of common concern: MI Care Improvement Registry (MCIR) augmentation; medical home QI project; ABCD to scale; CSHCN into managed care; community resources; improve linkages between medicine and public health; care coordination/case management; early childhood mental health; expand role of WIC; EPSDT coordinators in local health departments; telemedicine (CSHCN); fiscal analysis; care for parents; foster care; child health work group; and developmental services/Early On.For the short-term, six priority areas were identified: use data to help assure access and quality;using Medicaid managed care to srve CSHCN; assure appropriate information exchange across services and systems; implement and operationalize a common definition of the pediatric medical home; improve the Part C Early Intervention (Early On); and improve access to early childhood mental health services. Six workgroups will be formed to explore actions and recommendations in each of these areas.//2009//
/2010/Medicaid has worked with the MI Care Improvement Registry (MCIR) to add fields to document delivery of EPSDT services. The ECIC (state ECCS project) coordinated with Michigan AAP and the Head Start State Collaboration Office to convene a Medical Home summit attended by stakeholders from across government, health care providers, and early childhood providers. Michigan completed its pilot of the Assuring Better Child

Health & Development project (ABCD), focused on improving developmental screening in the primary care provider's office, and has undertaken a spread initiative. Follow-up on priorities identified at the Michigan State Leadership Workshop is taking place through Michigan's ECCS interdepartmental advisory body, the Great Start Systems Team. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	44.5	45.7	45.9	48.2	49.2
Numerator	84595	93697	97602	105000	109212
Denominator	190029	205246	212662	218064	221780
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
Although the Medicaid program continues slow progress in increasing dental services for children, the major problems have been with recruiting dentists who will accept Medicaid clients and the Medicaid fee screens. The Department has been working with the Michigan Dental Association (MDA) and Delta Dental of Michigan to increase the availability of services for Medicaid-eligible children. In March, 2006, the Governor announced the expansion of the Healthy Kids (Medicaid) Dental Program beginning in May 2006 to an additional 22 counties in the Upper Peninsula and northern Lower Peninsula in partnership with MDA and Delta Dental. Effective July 1, 2008 Saginaw and Genesee counties were added to the list of counties with access to the Healthy Kids Dental program. In total, residents of 61 counties have access to the Healthy Kids Dental Program, serving more than 240,000 children. According to a study conducted by Dr. Stephen A. Eklund of the University of Michigan, dental visits were 50% higher for children enrolled in Healthy Kids Dental than for children enrolled in the traditional Medicaid dental plan (2001 through 2005).

/2010/Michigan has had a state-wide school-based/school-linked dental sealant program since 2007. The program focuses on providing dental sealants to children ages 6 to 9 in schools with greater than 50% student participation in free and reduced lunch programs. Through a CDC software data base, the number of dental sealants applied per child is captured.//2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	24.3	24.2	23.8	19.7	17.5
Numerator	7613	7568	7689	6406	5713
Denominator	31336	31336	32303	32449	32629
Check this box if you cannot report the numerator					

because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
All children eligible for SSI are also eligible for Medicaid in Michigan. Therefore rehabilitation services are typically provided under Title XIX, often in the school under Medicaid-Reimbursed School-Based Services. Michigan Medicaid has a very extensive benefit package, and the need for further coverage would be rare. CSHCS provides medical services as needed based upon the CSHCS qualifying diagnosis. Therefore, CSHCS would provide medically necessary services not covered under Title XIX for children enrolled in CSHCS as the circumstance arises.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	10.1	7.6	8.7

Narrative:
In spite of a declining infant mortality rate, the low birth weight rate remains high, especially among black infants. Forty percent of all births in Michigan are covered by Medicaid. Typically, the rate for black births is twice the rate for white births. Studies to analyze birth data using Vital Records, PRAMS and FIMR to understand the factors involved in low birth weight births will continue. Programmatic efforts include continued emphasis on prenatal smoking cessation and FAS prevention programs, as well as preconceptional counseling through the Maternal Infant Health Program (formerly Maternal/Infant Support Services), Nurse Family Partnership Programs and the Kalamazoo Pilot Preconception Program. The Infant Mortality Initiative targets efforts in eleven communities with the highest rates of African American infant mortality. These local coalitions develop local education efforts and health system plans designed to decrease preterm delivery rates and improve pregnancy outcomes. Another strategy for reducing low birth weight and preterm birth is the implementation of the Family Planning Waiver to improve access to contraception for low-income women. The Bureau of Family, Maternal and Child Health is also exploring the possibility of re-introducing a regional perinatal care system. Working with the MCH Epidemiologist, staff have looked at systems in other states and have talked with New York City in depth on their system, resources and legal authority. The Bureau will continue to analyze the experience of other states and the results of a survey of hospitals in this state for possible development of policy and funding proposal.

/2009/The Michigan Infant Mortality Program: Interconception Care Project was initiated in 2005 to improve birth outcomes for women who are most at-risk of an infant or fetal loss, a preterm birth or a low birth weight baby. Funding uses a mix of Title V and Healthy Michigan (tobacco tax) Funds to provide consultation and technical assistance to projects in eleven local communities. Each project supports case management for women who have had a previous poor pregnancy outcome. Overall the project has the capacity to intervene with approximately 400 women, most

of whom are African American. Over 100 women have been enrolled so far and an evaluation plan is underway to determine what works to improve many risk factors that are part of each woman's life course. A fifth Nurse Family Partnership Program was initiated in December 2007 in Kalamazoo County.//2009//
/2010/Automatic enrollment of pregnant Medicaid recipients into managed care (est. October 2009) has resulted in an increase in women referred to the MIHP and an improvement in care coordination. It is anticipated that early enrollment in MIHP will facilitate improvement in birth outcomes and a decrease in low birth weight babies. The Interconception projects, in the 11 targeted communities, continued to see women who had an adverse birth outcome but with the state budget difficulties, the funding for all projects ends as of June 30, 2009. It is encouraged that these women be referred to other appropriate community services for continued interventions. The Nurse Family Partnership has been established in five communities but the state funding for these programs will also be eliminated June 30, 2009. There may be some local continuation in one or two communities after the state funding is removed. The Perinatal Regionalization System of Care has received more attention this past year, with OB, Neonatal and Pediatric workgroups established and a combined report and guidelines developed. The report was provided to the legislature April 1 and has received positive support from the health care community. MDCH is exploring creative ways to implement the use of the guidelines and to move forward with the Perinatal Regionalization System in light of the financial difficulties in the state. A comprehensive Infant Mortality Strategic Plan is in development to address the Perinatal Periods of Risk areas. The initial version has been created and was presented to internal stakeholders in June 2009. The Plan would be MDCH's course of action for the 2009-2013. The Fetal Infant Mortality Review (FIMR) continues to be active in 17 areas of the state to assess and evaluate the deaths and the maternal and infant factors. //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	payment source from birth certificate	9.3	6.6	8

Narrative:
Although the overall infant mortality rate declined in 2005, the ratio of black to white infant mortality remained unacceptably high (3.3). Unintended pregnancies are highest among socio-economically vulnerable groups: women under the age of 20, uninsured, low income (Medicaid as a proxy), and racial/ethnic minorities. Unintended pregnancies are associated with inadequate prenatal care, low birth weight, and infant mortality. Expansion of eligibility for Medicaid family planning services will allow providers to connect women choosing to become pregnant to prenatal care providers, supporting early entry in care. The Maternal and Infant Health Program which serves high-risk low-income mothers and their infants has been re-designed to emphasize early entry into prenatal care and early risk assessment. Four Nurse/Family Partnership programs offer early intervention for first time pregnancies. The Infant Mortality Initiative reached full capacity in 2006. The eleven participating communities developed local education efforts and health system plans to decrease preterm delivery rates and improve pregnancy outcomes. Emphasis on prenatal smoking cessation and FAS prevention programs will continue. Data collected from pilot sites (see NPM #18) and the Nurse/Family Partnership program will be analyzed to learn best

practices for improving adequate prenatal care. The Bureau of Family, Maternal and Child Health is studying the experience in other states with regional perinatal care systems for possible development of a policy and funding proposal for Michigan.

/2009/The Michigan Infant Mortality Program: Interconception Care Project was initiated in 2005 to improve birth outcomes for women who are most at-risk of an infant or fetal loss, a preterm birth or a low birth weight baby. Funding uses a mix of Title V and Healthy Michigan (tobacco tax) Funds to provide consultation and technical assistance to projects in eleven local communities. Each project supports case management for women who have had a previous poor pregnancy outcome. Overall the project has the capacity to intervene with approximately 400 women, most of whom are African American. Over 100 women have been enrolled so far and an evaluation plan is underway to determine what works to improve many risk factors that are part of each woman's life course. A fifth Nurse Family Partnership Program was initiated in December 2007 in Kalamazoo County.//2009//
/2010/ Anticipated outcomes of the MIHP redesign process are quantitative, qualitative and administrative and include: (1) reduce infant death rates and sickness rates; (2) deliver full term, healthy babies; (3) have developmentally healthy infants; (4) have physically, emotionally healthy mothers; (5) conduct timely quality assurance site reviews to enforce Medicaid policy; (6) evaluate and assure accountability for quality service delivery, and (7) provide consultation and technical assistance to local providers. In October 2008, it became mandatory for Medicaid pregnant women to be enrolled in a Managed Care Health Plan. With this mandate also came the requirement that all pregnant women be referred to the MIHP program. These requirements will help assure that all Medicaid pregnant women have a health care provider and that she will be assisted in obtaining the visits necessary for a healthy outcome. The Interconception projects, in the 11 targeted communities, continued to see women who had an adverse birth outcome but with the state budget difficulties, the funding for all projects ends as of June 30, 2009. It is encouraged that these women be referred to other appropriate community services for continued interventions. The Nurse Family Partnership has been established in five communities but the state funding for these programs will also be eliminated June 30, 2009. There may be some local continuation in one or two communities after the state funding is removed. The Perinatal Regionalization System of Care has received more attention this past year, with OB, Neonatal and Pediatric workgroups established and a combined report and guidelines developed. The report was provided to the legislature April 1 and has received positive support from the health care community. MDCH is exploring creative ways to implement the use of the guidelines and to move forward with the Perinatal Regionalization System in light of the financial difficulties in the state. A comprehensive Infant Mortality Strategic Plan is in development to address the Perinatal Periods of Risk areas. The initial version has been created and was presented to internal stakeholders in June 2009. The Plan would be MDCH's course of action for the 2009-2013. The Fetal Infant Mortality Review (FIMR) continues to be active in 17 areas of the state to assess and evaluate the deaths and the maternal and infant factors. //2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving	2007	payment source from birth certificate	77.2	85.4	81.5

prenatal care beginning in the first trimester					

Narrative:
This indicator showed slight improvement in 2005, although the gap between the Medicaid and non-Medicaid populations was unchanged. Despite efforts to create new pathways to early entry to prenatal care, a significant proportion of women refuse or are unable to receive care in the first trimester. Four Nurse/Family Partnership programs began enrolling clients in 2004 and offer early intervention for first time pregnancies. A re-designed Maternal and Infant Support Services Program was implemented in late 2005 and is continuing with emphasis on early entry into prenatal care and early risk assessment. Expansion of eligibility for Medicaid family planning services allows providers to connect women choosing to become pregnant to prenatal care providers, supporting earlier entry into care. Data collected from pilot sites (see NPM # 18) and the Nurse/Family Partnership program will be analyzed in conjunction with the Bureau of Epidemiology to learn best practices for improving this indicator.

/2009/The Michigan Infant Mortality Program: Interconception Care Project was initiated in 2005 to improve birth outcomes for women who are most at-risk of an infant or fetal loss, a preterm birth or a low birth weight baby. Funding uses a mix of Title V and Healthy Michigan (tobacco tax) Funds to provide consultation and technical assistance to projects in eleven local communities. Each project supports case management for women who have had a previous poor pregnancy outcome. Overall the project has the capacity to intervene with approximately 400 women, most of whom are African American. Over 100 women have been enrolled so far and an evaluation plan is underway to determine what works to improve many risk factors that are part of each woman's life course. A fifth Nurse Family Partnership Program was initiated in December 2007 in Kalamazoo County.//2009//
/2010/The enhancement of the MIHP program has continued in 2009 with expansion of the network of providers--particularly in the City of Detroit. The program's evidence based/standardized interventions (in development) focus on early access to prenatal care in addition to improving the life conditions that affect pregnancy outcomes. Interventions will be reviewed, approved and rolled out statewide this year. In October 2008, it became mandatory for Medicaid pregnant women to be enrolled in a Managed Care Health Plan. With this mandate also came the requirement that all pregnant women be referred to the MIHP program. These requirements will help assure that all Medicaid pregnant women have a health care provider and that she will be assisted in obtaining the visits necessary for a healthy outcome. The WIC Program and services such as Healthy Kids for Pregnant Women and the Maternity Outpatient Medical Services also encourage early access to prenatal care. The Nurse family Partnership Program, in five communities, also encourages early entry into prenatal care but the state funding for these programs will be eliminated June 30, 2009. There may be some local continuation in one or two communities after the state funding is removed.
The Perinatal Regionalization System of Care has received more attention this past year, with OB, Neonatal and Pediatric workgroups established and a combined report and guidelines developed. The report was provided to the legislature April 1 and has received positive support from the health care community. MDCH is exploring creative ways to implement the use of the guidelines and to move forward with the Perinatal Regionalization System in light of the financial difficulties in the state. A comprehensive Infant Mortality Strategic Plan is in development to address the Perinatal Periods of Risk areas. The initial version has been created and was presented to internal stakeholders in June 2009. The Plan would be MDCH's course of action for the 2009-2013. The Fetal Infant Mortality Review (FIMR) continues to be active in 17 areas of the state to assess and evaluate the deaths and the maternal and infant factors including entry into prenatal care and number of visits. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	70.9	76.7	73.9

Narrative:
This measure showed slight improvement in 2005. State program strategies continued in 2006 and 2007. Four Nurse/Family Partnership programs began enrolling clients in 2004 and offer early intervention for first time pregnancies. A re-designed Maternal and Infant Support Services Program (now Maternal and Infant Health Program) was implemented in late 2005 and is continuing with emphasis on early entry into prenatal care and early risk assessment. Expansion of eligibility for Medicaid family planning services allows providers to connect women choosing to become pregnant to prenatal care providers, supporting earlier entry into care. Data collected from pilot sites (see NPM # 18) and the Nurse/Family Partnership program will be analyzed to learn best practices for improving this indicator.

/2009/The Michigan Infant Mortality Program: Interconception Care Project was initiated in 2005 to improve birth outcomes for women who are most at-risk of an infant or fetal loss, a preterm birth or a low birth weight baby. Funding uses a mix of Title V and Healthy Michigan (tobacco tax) Funds to provide consultation and technical assistance to projects in eleven local communities. Each project supports case management for women who have had a previous poor pregnancy outcome. Overall the project has the capacity to intervene with approximately 400 women, most of whom are African American. Over 100 women have been enrolled so far and an evaluation plan is underway to determine what works to improve many risk factors that are part of each woman's life course. A fifth Nurse Family Partnership Porgram was initiated in December 2007 in Kalamazoo County.//2009//
/2010/All beneficiaries in the MIHP program are provided prenatal care information and referral to the health care provider network. The program's evidence based/standardized interventions (in development) focus on early and ongoing acc ess to OB providers. In October 2008, it became mandatory for Medicaid pregnant women to be enrolled in a Managed Care Health Plan. With this mandate also came the requirement that all pregnant women be referred to the MIHP program. These requirements will help assure that all Medicaid pregnant women have a health care provider and that she will be assisted in obtaining the visits necessary for a healthy outcome. The Interconception projects, in the 11 targeted communities, continued to see women who had an adverse birth outcome but with the state budget difficulties, the funding for all projects ends as of June 30, 2009. It is encouraged that these women be referred to other appropriate community services for continued interventions. The Nurse Family Partnership has been established in five communities but the state funding for these programs will also be eliminated June 30, 2009. There may be some local continuation in one or two communities after the state funding is removed. The Perinatal Regionalization System of Care has received more attention this past year, with OB, Neonatal and Pediatric workgroups established and a combined report and guidelines developed. The report was provided to the legislature

April 1 and has received positive support from the health care community. MDCH is exploring creative ways to implement the use of the guidelines and to move forward with the Perinatal Regionalization System in light of the financial difficulties in the state. A comprehensive Infant Mortality Strategic Plan is in development to address the Perinatal Periods of Risk areas. The initial version has been created and was presented to internal stakeholders in June 2009. The Plan would be MDCH's course of action for the 2009-2013. The Fetal Infant Mortality Review (FIMR) also assesses and evaluates the deaths and the maternal and infant factors including entry into prenatal care and number of visits. The Michigan Maternal Mortality Surveillance also reviews the circumstances and factors related to the death of the woman including the adequacy of prenatal care. //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Narrative:
Eligibility levels for Medicaid and MIChild remained unchanged in 2007 and 2008. The Governor has made protection of vulnerable populations a priority in her budget proposals, in spite of increases in the number of persons becoming eligible for Medicaid and the state's continuing revenue and budget problems.

/2010/There is no change to eligibility levels for FY 2008 and 2009.//2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	150
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2008	200

Narrative:

Michigan has been able to maintain services to the most vulnerable members of the population despite significant budget cuts in other areas and continuing problems with the state's revenue picture. As unemployment continues at a high rate and fewer workers are able to afford their share of employer-offered coverage for themselves and their dependents, a larger number of applicants are determined to be eligible for Healthy Kids (Medicaid) than for MIChild. Eligibility levels remained the same for FY 2007.
/2010/ Eligibility remains the same.//2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	200

Narrative:
The same level of eligibility has been maintained over the past several years despite significant state budget restrictions. Coverage of pregnant women has been maintained as part of the Governor's priority for maintaining services to the most vulnerable citizens of Michigan and emphasis on giving children a healthy start in life.

/2010/Eligibility levels for pregnant women were unchanged in FY 2008 and FY 2009.//2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	No
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn	3	Yes

screening files		
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
Michigan has the benefit of an Executive Information System/Decision Support System and a data warehouse with multiple years of data from Medicaid, WIC, CSHCS, and Vital records, all on similar platforms. These data sets are uploaded weekly, monthly and annually to be of the greatest benefit for epidemiological studies. The warehouse provides the ability to link different data sets and thus track the impact of participation in MCH programs on a population basis. A major project beginning this year and continuing to January 2009 is the update of the Medicaid enrollment and payment system to include online provider services, real time claims adjudication and improved services to clients. State vital records (live births records, death certificates, linked infant mortality file either by using the birth or the death cohort, fetal deaths) remain the main source for monitoring pregnancy outcomes. The Michigan Maternal Morbidity Database (MMMDB), a claims-based file consisting of linked data from the Michigan Inpatient file and resident birth records, is the basis for studying maternal morbidity.

Over the past five years, Michigan has increased its capacity and gained access to the majority of the database resources identified in the MCH Block Grant. The most recent addition was access to the Michigan Hospital Discharge database. During FY 05-06, Michigan continued to utilize this database for analysis of maternal mortality and morbidity, perinatal mortality and other maternal and child health indicators.

PRAMS is Michigan's only source of data on unintended live births. PRAMS has been used to monitor the health status of mothers and infants as well as of services sought and received, and in developing public health policy such as the family planning waiver request.

CSHCS program data is linked with the Michigan Birth Defects Registry (BDR) to study prevalent conditions at enrollment. A new data work group has been established on child health data integration that would allow provider access to newborn screening results through the Internet-based Childhood Immunization Registry.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2010

Narrative:
Data from the YRBS are used to guide policy and program efforts on school-based health centers and the Michigan Model Program. In addition, data from the YRBS will be used for surveillance and evaluation of Tobacco-Free Michigan, A Five-Year Strategic Plan for Tobacco Use Prevention and Reduction 2003-2008. The plan includes four goal areas: identify and eliminate disparities in tobacco use; eliminate exposure to secondhand smoke; increase cessation among adults and youth; and prevent youth tobacco-use initiation. Smoking among students has dropped statistically significantly since 1997. Data collected in the 2005 Michigan YRBS indicates:

52% of Michigan students reported ever smoking;
17% of Michigan students reported smoking recently (in the last 30 days);
14% of Michigan students reported smoking regularly (2 or more cigarettes per day in the last 30 days; and
23% of Michigan students used any form of tobacco during the past 30 days (cigarettes, smokeless or cigars).

/2010/ According to the 2007 YRBS, Michigan rates are comparable to U.S. rates for the following:

51.2% of Michigan students reported ever smoking;
18.0% of Michigan students reported smoking recently (in the last 30 days);
8.9% of Michigan students reported current smokeless tobacco use.//2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

For the 2004 reporting year, the state's priorities remain unchanged from the 2001 needs assessment. Michigan's focus continues to be on improving birth outcomes, reducing racial disparities in health indicators and improving child health including children with special health care needs.

For 2004 (or the latest year for which data is available), Michigan met or exceeded targets for the following performance measures:
NPM #1 Newborn Screening
NPM #8 Birth Rate for Teenagers 15-17
NPM #10 Deaths to children caused by motor vehicle crashes
NPM #11 Breastfeeding/2007/ Definition changed from at hospital discharge to at six months//2007//
NPM #13 Percent of children without health insurance
NPM #16 Suicide Deaths among youth 15-19
SPM #04 Preterm Births /2007/Changed to SPM #03//2007//

Other performance measures that showed improvement from the previous year but did not meet the target were:
NPM #9 Third grade children who have received protective sealants
NPM #15 VLBW Births
NPM #17 VLBW Deliveries at facilities for neonates and high risk deliveries
SPM #01 Infant Mortality /2007/ Changed to Women Screened for maternal depression//2007//
SPM #05 Unintended Pregnancy /2007/ Changed to SPM #04//2007//
SPM #08 CSHCS beneficiaries receiving dental care paid by CSHCS/2007/Deleted for 2007//2007//
SPM #09 Lead testing among Medicaid eligible children 0-6 /2007/Changed to SPM #06//2007//

Measures that did not show improvement and require further effort are:
NPM #7 Childhood Immunizations
NPM #12 Newborn Hearing Screening
NPM #14 Medicaid-eligible children received a service /2007/Changed to WIC children at or above 85%BMI//2007//
NPM #18 Infants born to pregnant women receiving care in first trimester
SPM #02 Maternal Mortality Ratio /2007/Changed to SPM #6//2007//
SPM #03 LWB among live births /2007/Changed to SPM #2//2007//
SPM #06 Repeat live births to unwed mothers 15-19 years of age /2007/Discontinued//2007//

/2007/Several changes were made to the State Performance Measures and a couple National Performance Measures for 2007 as a result of the five-year needs assessment. The 2005 (or latest available) data indicates that Michigan met or exceeded targets for 4 performance measures (NPM #1, 10, 13 and 16), improved but did not meet target for 6 measures (NPM #12, 17, 18, SPM #2, 4 and 5), and did not improve for 5 measures (NPM #7, 8, 9, SPM # 3 and 6). NPM #11, 14 and 15 and SPM #1, 7 and 8 are new for 2006.//2007//
/2008/Improvements were shown in National Performance Measures #8, 9, 10, 11, 12, 13, 16, 17 and 18 and in State Performance Measures #3, 4, 5 and 7. No change was noticed in National Performance Measures #1-7 and 14 and in State Performance Measure #2. A decline in actual indicators for National Performance Measure #15 and State Performance Measure #6 was noted. No data is currently available for State Performance Measure #1 (maternal depression).//2008//
/2009/The following Performance Measures showed improvement over the previous year: NPM #8, 10, 12, 13, 15, 16, 17 and 18; SPM #2, 4 and 5. Performance indicators for NPM #1, 9 and 11 and SPM #3 and 7 were the same compared to the previous year. Performance indicators for NPM #7 and SPM #6 were worse than the year before.//2009//

/2010/For FY2008, the following performance measures showed improvement over 2007: NPM #07, 09, and 18, and SPM #4 and 6. The following performance measures showed no change from 2007: NPM #10. Performance for the following measures declined from 2007 to 2008: NPM #01, 08, 11, 12,13, 14, 15, 16 and 17, and SPM #2, 3, 5, 7 and 8.//2010//

National Performance Measures 2-6 are related to Children's Special Health Care Services. The only source of data for these performance measures is the SLAITS survey which is only conducted every other year. Data has not been updated since the original survey which indicated that Michigan's data for NPM #2-5 were above the national average for 2001 and slightly below the national average for NPM #6 (Percent of youth with special health care needs who received services necessary for transition to adult life).
/2009/The data for NPM #2-6 were updated based on the 2006 National Survey. Due to wording changes in the survey questions, the indicator data for NPM #3, 5 and 6 are not comparable to data from the 2001 survey. Data for NPM #2 and 4 indicate a decline in these performance indicators from the 2001 survey.//2009//

Although the data for 2004 for SPM #07 (CSHCS Beneficiaries enrolled in SHP) indicates an improvement, the Specialized Health Plans were discontinued as of October 1, 2004.

The strategies and activities described in Section IV. C and D are planned in the context of state initiatives proposed by the Governor and the Department of Community Health and the state's budget picture. The Title V program is actively involved in the Great Start Initiative focusing on children 0-6 years of age. See Section III.A for further description of the Great Start Initiative. The Department of Community Health has developed a state health status report building on the Healthy People 2010 format entitled "Healthy Michigan 2010." Healthy Michigan 2010 profiles the state's demographic, socioeconomic and healthcare status and, like Healthy People 2010, includes a focus area for maternal and child health. Following that, the state Surgeon General issued "Prescription for a Healthier Michigan" which included a set of recommendations for improving the health of Michigan citizens. The recommendations include unintended pregnancy, infant mortality and childhood lead poisoning. The Title V program is also implementing new infant mortality strategies, has developed, in cooperation with the Medicaid program, a waiver request to extend family planning services, is re-engineering the Maternal/Infant Support Services program and is implementing new legislation regarding childhood lead poisoning.

The CSHCS program is making significant strides in increasing its access to CSHCS pertinent data through the development of the MDCH Data Warehouse project. We are working very closely with department systems staff and staff of other MCH programs for the purpose of linking the available data to gather comprehensive data regarding our overlapping populations. The work between the various programs is expected to result in even more meaningful collaboration in assessing needs and providing services and resources in a more efficient manner for families and for the programs themselves. Collaboration has begun at a more detailed level than before with the Bureau of Epidemiology, Division for Vital Records and Health Statistics (Michigan Birth and Death registry), the Michigan Central Immunization Registry, the Childhood Lead Poisoning Prevention Program. The purpose of the collaboration is to gather and cross reference data to determine where Michigan is most and least successful in assisting families regarding multiple health care circumstances and needs. This process in turn will drive the decision making toward the greatest needs, and how best to address it. /2008/ After extensive revisions to the CSHCS Data warehouse project in 2006, the model went into the testing phase of production. //2008// /2009/ The CSHCS data warehouse is live, functional, and available for use for those with authorized access. //2009//

B. State Priorities

Establish a system to better identify, screen and refer for maternal depression: Postpartum depression (PPD) occurs anytime during the first year after delivery with an estimated prevalence

of almost 12%. The onset of PPD usually takes place after baby blues and ranges from mild to severe depression. Postpartum psychosis is the extremely severe form in which the mother loses touch with reality and has thoughts of suicide and or homicide. It affects about 1 in 1,000 women. PPD affects a woman's ability to function as a new mother and can impair the cognitive and language development of the newborn.

Increase the rate and duration of breast-feeding: The Healthy Michigan 2010 Goal for breastfeeding mirrors the national Healthy People 2010 Goal of increasing the breastfeeding initiation rate to 75% and the 6-month duration rate to 50%. While making progress, the Michigan breastfeeding rates are well short of the goal. According to the most recent Ross Laboratories survey (2002), the U.S. breastfeeding initiation rate in the hospital was 70.1% and the 6-month duration rate was 33.2%. College educated mothers exclusively breastfeed at a rate that is 50% higher than mothers without a college degree. White mothers exclusively breastfeed at a rate double that of black mothers. The survey reported Michigan figures as 65.5% initiation in hospital and 28.0% for 6-month duration. With the many reported benefits, increasing the breast-feeding initiation and duration rates in Michigan will have a positive impact on the health status of Michigan infants. The promotion and protection of breast-feeding among Michigan WIC eligible and black mothers is an even more important public health goal.

Reduce the percentage of unintended and teen pregnancies: In 2003, 40.5% of women who delivered a live birth had an unintended pregnancy, with about 74.2% of those reported as mistimed. When stratified by race/ethnicity, unintended pregnancy was found to be the highest in Non-Hispanic Black and Hispanic women (63.3% and 46.0% respectively), followed by Non-Hispanic Whites and Asian/Pacific Islanders (35.7% and 30.9%, respectively) Women over 35 years of age were five times more likely to have an intended pregnancy compared to those less than 18 years of age. Women with either Medicaid or no insurance were less likely to report an intended pregnancy compared to women with private insurance. This calls for renewed effort to address access and barriers to care issues for women in this population. Michigan has enjoyed a steady decline in teen pregnancy and birth rates across all subsets of the teen population for more than a decade. While Michigan has seen significant progress in this area, reducing the rate further remains a high priority as Michigan continues to have an alarming number of youth who experience the serious health, emotional and financial consequences of pregnancy, childbirth, and engagement in sexual activity and other risky behaviors. The teen pregnancy rate for Michigan is 54.6 per thousand (ages 15-19, 2004). In Michigan during 2003, 17.6% of teens who had previously given birth experienced a repeat birth. This is a reduction from a high of 26.7% in 1992. Racial disparities continue with 22.6% of black teens under the age of 20 years experiencing a repeat unwed birth while 14.7% of white teens experienced a repeat unwed birth.

Reduce the percent of pre-term births and births with low birth weight with emphasis on the black population: The percentage of pre-term births to all races has remained relatively steady from 1999 (10.8) to 2004 (10.0). The percentage of births with low birth weight has also remained about the same. Both indicators continue to be 2 to 3 times more likely for black babies. Low birth weight is more common in women giving birth in their teens and women who are over 40 years of age, in women who are not married, women with less than 12 years of education, women who receive inadequate prenatal care, women who smoke or drink alcohol, and in multiple births. Pre-term births are less affected by younger age in black women. Pre-term births are less prevalent in women with more education, more prenatal care, women who don't smoke or drink alcohol and in singleton births.

/2009/ In 2006, the percentage of pre-term births to all races fell to 9.6, down from 10.0 in 2004 and 2005//2009//

/2009/ Despite much programming effort, the racial disparity remains for low birth weight in 2006 (Black -- 14.3%; White 7.2%). In 2006, 9.6% of babies were born prior to 37 weeks gestation. The introduction of preconception care for all childbearing age women offers the best hope for improving the risks for low birth weight and preterm births. This remains a challenge for health

care systems across the state to fund such services.//2009//
/2010/ The MIHP redesign process is focused on standardization of screening and assessment of Medicaid eligible pregnant women and their infants including use of the Edinburgh for PPD identification. The program's evidence based interventions (in development) address maternal and infant biological, psychological and social risk domains including increasing breast feeding, reducing future unintended pregnancies and improving birth outcomes. Interconception Health Projects continued in the 11 targeted communities this year but with state budget difficulties, funding will be ending June 30, 2009. These communities are being encouraged to refer the program women to other community services and attempt to include Interconception health into their remaining programs. Pre and interconception health promotion continues to be addressed in other state programs.//2010//

Establish a medical home and increase care coordination for children with special health care needs: Children with special health care needs (CSHCN) have complex medical problems that require care and services from multiple providers who are frequently not located in close proximity. More importantly, there is often times a lack of communication between providers and no focal location for great concern as medically fragile CSHCN are already at significant health risk because their medical conditions may fail to improve, or even deteriorate. Discussion is underway regarding the definition and criteria for determining medical practices as "medical homes" and how best to assist practices in achieving that designation. Michigan is considering ways and means to work with the concept of a medical home. Efforts are underway to implement and study a model for private practices to determine how to expand the medical home concept. Michigan has received training and technical assistance through the Federal Medical Home Learning Collaborative supported by MCHB. Initially Michigan was developing the medical home model through the CSHCS Special Health Care Plans (SHP). CSHCS does not have the resources to accommodate the federal requirements that have been newly applied to the SHPs (already standard for Medicaid Health Plans) or to administer the two separate models of the traditional CSHCS and SHPs. CSHCS has incorporated the assistance of the MI AAP and the on-going assistance of the Federal Medical Home Learning Collaborative in establishing medical homes for this population. CSHCS will apply the best of what was learned from the SHP model to the traditional FFS model as is feasible.

Increase the number of CSHCS enrolled youth who have appropriate adult health care providers: Increasing the number of CSHCS enrolled youth who have appropriate adult health care providers is a priority because there currently is a need for an adequate number of physicians who are able, willing and comfortable serving the ever-increasing adult population who have had many kinds of special health care needs since childhood. Historically, there has been less need for knowledgable adult health care providers for many special needs conditions because the children with those conditions often did not survive into adulthood. More of the children with complicated and life-endangering conditions are now surviving into adulthood than ever before. Adult providers need to be recruited, trained and supported in learning how to care for adults with these conditions./2007/ While increasing the number of appropriate adult providers, CSHCS is also working toward putting a system in place that can accurately identify adult providers on the CSHCS computer database. //2007// /2008/ CSHCS has looked into ways in which to identify adult providers on the computer database in 2006. It has been determined that more time and effort is needed to successfully implement such a system.//2008//

Reduce the proportion of children and adolescents who are obese: No current baseline percentages exist regarding Michigan children and adolescents who are overweight, obese and/or lacking opportunities for physical activity. Baseline data will be gathered during 2005 so future comparisons and percentages can be determined. During 2005, professional associations, standard-setting organizations (i.e., M-QIC) and public agencies will develop and reach consensus on guidelines for the prevention and management of overweight in children in clinical settings. Guidelines for nutrition and physical activity will be widely disseminated to primary health care providers, educators and other school personnel and the public. WIC and

other maternal and child health staff will work with staff in the Community Public Health Administration to develop and implement a plan to enhance breastfeeding among program participants and address healthy weight and feeding issues. Training for WIC and other maternal and child health program staff will be implemented as part of the plan. Efforts will also be focused in increasing the number of Michigan schools that make changes to policies, programs and practices focused on making school environments more supportive of healthy eating and physical activity. Nutrition and physical activity content of the Michigan Model for School Health Education will be reviewed and revised as necessary to provide consistency with Michigan consensus guidelines for healthy eating and physical activity. Legislation has recently been introduced that would make nutrition education and physical activity mandatory in all Michigan schools.

Reduce incidence of teen suicide: In Michigan, suicide is the third leading cause of death for 15-19 year olds and the second leading cause of death for college age young people. Suicide rates, methods, risk factors and at-risk populations in Michigan closely parallel national trends and statistics. An analysis of the 2003 Michigan Youth Risk Behavior Survey data found that 18% of Michigan's 9th-12th graders seriously considered attempting suicide at some point during the 12 months preceding the survey. More than one out of every ten students indicated they actually attempted suicide during that time. The number of young people in the state who die by suicide increases dramatically over the adolescent years.
/2007/An analysis of the 2005 Michigan Youth Risk Behavior Survey data found that 16% of Michigan's 9th-12th graders seriously considered attempting suicide at some point during the 12 months preceding the survey. Nearly one out of every ten students indicated they actually attempted suicide during that time.//2007//
/2010/An analysis of the 2007 Michigan Youth Risk Behavior Survey data found that 15% of Michigan's 9th-12th graders seriously considered attempting suicide at some point during the 12 months preceding the survey. One out of every eleven students indicated they actually attempted suicide during that time. See NPM #16 for further discussion.//2010//

Increase the screening (testing) rate of low-income children for lead poisoning: Michigan residents are exposed to lead in their environment from sources such as lead-based paint, dust, soil, food, and water. The exposures are cumulative in children, especially those under six years of age, because they are more vulnerable to the toxic effects of lead and show greater effects upon the blood forming and central nervous systems. Children living in poverty are most at risk. In 2005, lead testing was reported on 132,913 children below age 6. Of those children tested, 96,887 were Medicaid-eligible. Of the total children tested, 2,008 (2.4%) had levels greater than or equal to 10 micrograms per deciliter. Because of 1) the existence of significant numbers of old houses in Michigan, 2) the fact that the percentages of children living in poverty are increasing, and 3) there are medical and public health interventions that are available to prevent and lower blood lead levels in children identified with elevated lead levels, this is a public health priority in Michigan.

/2010/Increase the screening (testing) rate of low-income children for lead poisoning: Michigan residents are exposed to lead in their environment from sources such as lead-based paint, dust, soil, food, and water. The exposures are cumulative in children, especially those under six years of age, because they are more vulnerable to the toxic effects of lead and show greater effects upon the blood forming and central nervous systems. Children living in poverty are most at risk. In 2008, 153,248 children less than six years of age were tested for lead poisoning. Of those children tested, 108,249 (71%) were Medicaid-eligible. Of the total children tested, 1,686 (1.1%) had venous blood lead levels greater than or equal to 10 micrograms per deciliter. Because of 1) the existence of a significant number of pre-1950 homes in Michigan, 2) the escalation of children living in poverty, and 3) the availability of medical and public health interventions to prevent and lower blood lead levels in children identified with elevated lead levels, lead poisoning remains a public health priority in Michigan.//2010//

Reduce the racial disparity between black and white infant mortality and between Native

American and white infant mortality: In 2004 the white rate was 5.2 (the lowest rate in state history) and the black rate was 17.3 demonstrating a worsening of the disparity , 3.3, due to the stagnant black infant mortality rate and the improving white rate. Ninety eight percent of the black infant deaths occur in eleven urban communities that are now being targeted for study and coalition building to improve health care systems to reduce the problem. Since 1997 the Native American rates have risen from 8.7 to 12.4 using three-year averages. Over the same period the white rates have increased from 5.9 to 6.7 and dropped significantly in 2004 to 5.2 using annual rates. Native American infant deaths are few in number and scattered across the state making targeted efforts difficult. Eight of the 12 recognized tribes in Michigan are part of the HRSA Healthy Start Project and have benefited by education and nursing services at the local reservations.
/2008/In 2006, the white infant mortality rate was 5.4, slightly higher than the 2004 rate of 5.2, but slightly lower than the 2005 rate of 5.5. The 2006 black infant mortality rate of 14.8 represented a significant decline from the respective 2004 and 2005 rates of 17.3 and 17.9. Despite a considerable decline in the black infant death rate, the disparity the between the black and white rates remains substantial at 2.7. In an effort to reduce this racial disparity, 11 communities (with the greatest number of African American infant deaths) are conducting pilot projects that focus on improving interconception health among women who have experienced poor pregnancy outcomes (i.e., fetal deaths, preterm births low birth weight infants, and infant deaths).

/2009/In 2006, the Native American infant death rate was 11.0, up from 9.6 in 2005.

The racial disparity in infant mortality rates continued in 2006 (Black -- 14.8; White -- 5.4; Other -- 10.6). Most infant deaths are associated with very low birth weight and preterm births. The second largest group of infant deaths is those that occur in the postneonatal period due to sudden unexpected deaths, accidents, and infections. The number of actual SIDS deaths was 51(5% of the total).//2009//

/2010/The racial disparity in infant mortality rates continues to be a challenge in Michigan. Since 2006, Michigan had begun to address poor birth outcomes and infant mortality by improving interconception health for high-risk women. A broader approach to improving maternal and infant health is now being implemented--the life course perspective. This approach aims to promote and keep women healthy throughout their lifespan, not just during pregnancy. Strategies for supporting the life course perspective are being implemented through Michigan's Strategic Plan to Reduce Infant Mortality. Sudden Unexpected Infant Deaths (SUIDS) continues to be addressed through Safe Sleep awareness via community, hospital, and provider education.//2010//

Increase the percentage of third grade children who have received protective sealants on at least one permanent molar. The Healthy People 2010 target for dental sealants on molars is 50% for 8-year-olds and 14-year-olds. Michigan has a sealant placement rate of 23% on 3rd grade children and no data for 14-year-olds. Third grade children have a 58% rate of active decay. This rate of current dental decay is 15% higher than the national average. Development of school-based/school-linked sealant programs is critical to meet the Healthy People 2010 objectives and to reduce the oral disease burden of Michigan's children. Regular surveillance of decay rates and sealant placement on 8 and 14-year-olds is necessary to document measurable progress towards meeting the objectives of Healthy People 2010.
/2010/In 2009 over 8,000 third grade children have received dental sealants through a state-based dental sealant program. Over 6 school-based dental clinics within child and adolescent school settings are increasing access to underserved children.//2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	96.4
Numerator	183	208	189	203	190
Denominator	183	208	189	203	197
Data Source					NBS Program data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

During 2007, 119,327 newborns received at least one screen and 226 were diagnosed with one of 49 disorders. Screening for cystic fibrosis began on October 1, 2007 and 39 newborns with cystic fibrosis were detected in the first year of screening. A courier system for same day delivery of newborn screening specimens was completed and the NBS laboratory, follow-up and medical management programs expanded to include Saturday operations. Four contractual agreements were maintained for medical management of metabolic disorders, endocrine disorders, Cystic Fibrosis and Hemoglobinopathies. HRSA contracts for implementing a web-based data management system for sickle cell anemia and evaluation of region 4 screening for congenital hypothyroidism and congenital adrenal hyperplasia were completed. A family recognition day for parents and children diagnosed through newborn screening was held on September 6, 2008. The newborn screening hospital coordinators network was organized into seven regions for annual education and training programs.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screening for cystic fibrosis began October 1, 2007			X	
2. Courier system for same-day delivery of specimens completed				X
3. Laboratory, follow-up and medical management programs expanded to include Saturday operations.				X
4. Medical management contracts maintained				X
5. Family recognition Day held on September 6, 2008			X	
6. Newborn screening hospital coordinators network organized into seven regions				X
7.				
8.				
9.				
10.				

b. Current Activities

The second annual family recognition day for parents and children diagnosed through newborn screening will be held in September 2009. The purpose is to assist families in providing and receiving parent-to-parent support and to establish an ongoing interaction between the newborn screening program and parents regarding how the program is perceived by parents and how the program can be improved to better serve families. Seven regional newborn screening coordinator educational programs will be completed during 2009. Four quality assurance committees made up of medical specialists have been established to review all program operations and protocols for cystic fibrosis and the metabolic, hemoglobin and endocrine disorders. A pilot project to screen for Tyrosinemia Types II and III will be implemented in June, 2009

c. Plan for the Coming Year

There will be continued review of pilot projects in other states for newborn screening for Severe Combined Immunodeficiency Disorder and the Lysosomal Storage Disorders. Michigan will implement a pilot project to screen for Alpha and Beta Thalassemia in conjunction with an application for CDC funding of a comprehensive hemoglobinopathies surveillance system

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	64	61.3	61.3	61.3	56.4
Annual Indicator	61.3	61.3	61.3	56.4	56.4
Numerator					
Denominator					
Data Source					NS-CSHCN 2005/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	56.4	56.4	56.4	56.4	56.4

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
The Family Center for Children and Youth with Special Health Care Needs is a section of the Children's Special Health Care Services division (CSHCS). The Family Center is an integral part of the division. The Family Center remains in contact with families statewide, using the information obtained to provide consultation to the Michigan Title V programs regarding policy and program development. All written materials intended for families, as well as CSHCS policy and procedure, are reviewed by the Family Center for recommendation and revision as needed. Because of the integral nature of the Family Center, family participation is a constant in the CSHCS division. Review, comment, and recommendations to policies, letters, and other documents by a parent representative is an on-going activity for the CSHCS division. The Family Center also provides a review of the federal MCH Block Grant application, as was provided in 2008.

The Family Center continued with their volunteer Family Support Network in various communities in Michigan. The Family Support network matches support parent volunteers with other parents in need of support. In 2008, the program had a total of 34 parent volunteers and 93 family matches.

In 2008, the Family Center handled 21,441 calls from parents through the Family Phone Line to assist families in accessing providers, obtaining information on the CSHCS program, and general information and referral. Their conference scholarship program also allowed 15 parents to attend conferences around the United States that pertained to their child's diagnosis. The new youth conference scholarships that began in 2008 also allowed one young adult to attend a conference related to their disability. The Family Center also holds a grant to serve as a Family to Family Health Information and Resource Center. In 2008, 477 families were trained on various topics through the Resource Center.

The Family Center also played an important role in recruiting and sponsoring family participation during the CSHCS division's strategic planning meeting and subsequent workgroup activities. Because of their support 27 family representatives were able to attend the two day strategic planning meeting in Lansing Michigan on April 16 and 17, 2008. The Center also heads up the workgroup to continue work on the recommendations that came forth at the two day meeting related to family participation. The work of the group continues into 2009.

In addition to the above activites the Family Center offered funding to local health department CSHCS offices for mini-grants. The purpose of the mini-grants was to increase family participation in policy and procedure at the local level. Seven local health departments received mini-grants for this purpose. As a result of the mini grants 168 families attended various educational and support opportunites. Two of these families are now members of the CSHCS Strategic Planning workgroups. One county was able to hire a parent to create a database of e-mail addresses for local families to inform them of upcoming community opportunities and local resources. The e-mail list in that county is now at 275 families. Examples of activites that were accomplished because of the mini grants include:

-Increasing the use of parents as paid staff to perform various functions.
-Building e-mail address databases for educational and support outreach.
-Conducting surveys to assess program effectiveness.
- Conducting family forums.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement family participation activities as outlined in the HRSA State Implementation Grant.				X
2. Continue Family Center policy making activities		X		

3. Provide support to include families in the Strategic Planning process		X		
4. Work collaboratively with partners to reach Strategic Planning objectives				X
5. Maintain the Family Phone Line	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Family Center continues to be an excellent resource for obtaining family input and determining problem areas in need of being addressed. They continue to provide financial support for family involvement in CSHCS program activities through stipends.

Because of the success of the mini grants the Family Center was able to offer them in 2009. Eight mini grants were awarded.

In 2009, the CSHCS division continues to work with the recommendations put forth by our strategic planning partners. Work continues in workgroups for each national performance measure. The Family Center leads the workgroup for Family Participation. The following are the recommendations the Family Center is working on:

•Collaborate with partners and build a coalition to assure that all families have full access to consistent and complete information on program benefits and develop, translate, and communicate information in multiple formats, languages, and literacy levels.
•Explore the possibilities of utilizing the Birth Defects Registry to inform families of the CSHCS program who may have need for it.
•Establish regional structures to create new family advisories that will develop guidance to prepare, recruit, and engage families to become advisors.

The Family Center is also currently working with the division on family participation related activities as outlined in the division's HRSA State Implementation grant to develop and spread the medical home model in Michigan.

c. Plan for the Coming Year
The Family Center will continue to provide consultation to Michigan Title V programs, as well as keeping existing services to families that include:
•The Family Phone Line
•A statewide Family Support Network
•A biennial conference for siblings of children with special needs
•Conference scholarships for parents and young adults to learn more about diagnosis, care and advocacy.
•In-service training for families, Pediatric Regional Centers, Medicaid HMO's, Local Health Departments, and other agencies
•Trainings to parents and professionals through the Family to Family Health Resource Center

With the continued success of the local CSHCS mini grants, the Family Center will continue to award grants to local health departments in the coming year. The mini grants will increase interaction between local health and families, enabling them to work together to make program improvements at the local level.

The Family Center will also continue to work on the following CSHCS Strategic Plan

recommendations and activities
•Collaborate with partners and build a coalition to assure that all families have full access to consistent and complete information on program benefits and develop, translate, and communicate information in multiple formats, languages, and literacy levels.

Activities identified:1) identify partners and expand work group and /or bring in additional expertise as needed; 2) develop consistent look and theme for CSHCS informational media; 3) identify cultural brokers to participate and advise regarding development of materials "that are culturally sensitive and at literacy levels and languages used by" enrolled families; 4) seek expertise on coalition building and build on Family to Family Health Education and Information Center model.

•Explore the possibilities of utilizing the Birth Defects Registry to inform families of the CSHCS program who may have need for it.

Activities Identified: 1)Learn more about Birth Defects Registry and invite key persons to meeting. 2)Conduct joint meeting and consider overlaps with Screening Work Group. 3)Consider HIPPA issues. 4)Look at costs and linking data sources.

•Establish regional structures to create new family advisories that will develop guidance to prepare, recruit, and engage families to become advisors.

Activities Identified: 1)Link to Medial Home Work Group; 2)identify existing family structures and identify financial supports for family advisor in each region; 3)establish criteria for family advisor selection, training and compensation; 4)obtain grant funding to conduct educational conference for family advisors; 5) train for family advisors.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	58	55.8	55.8	55.8	46
Annual Indicator	55.8	55.8	55.8	46	46
Numerator					
Denominator					
Data Source					NS-CSHCN 2005/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	46	46	46	46	46

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
In 2008 the CSHCS division was awarded grant funding through the HRSA State Implementation Grant to develop and spread the medical home model in Michigan. The purpose of the grant is designed to support the implementation of the six core components of a system of services for CYSHCN. Implementation will be supported through the establishment and regionalization of the medical home model throughout the State of Michigan. The project supports the long term goal of sustaining medical home sites in Michigan for children and youth with special health care needs to receive comprehensive health care services, while simultaneously addressing the need to include the six core components of services for CYSHCN. A full-time project coordinator was hired to oversee the grant project and coordinate the activities.

In 2008, the division continued work that began in 2006 with Michigan State University as the only State funded medical home pilot project. The project works with two MSU pediatric practices and the funding provides an on-site coordinator to provide care coordination. The Medical Home Index and the Medical Home Family Index are being used to evaluate the effectiveness of the practices. This pilot practice at MSU also provides valuable information and experience to the work that is being done through the HRSA State Implementation Grant, and works as a close partner with the grant.

Medical Home also played a large role in the CSHCS division's two day strategic planning meeting and recommendations were put forth for the strategic plan that organized workgroup members continue to work on into 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implement medical home model and activities as proposed in the HRSA State Implementation Grant.	X			
2. Convene workgroups to implement the medical home objectivies as identified from the strategic planning process.				X
3. Participate in on-going workgroup with the metabolic screening, heredity disorders, and the early hearing detection and intervention programs to coordinate medical home concept.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The division continues to focus its efforts in the area of medical home on the work that is being done for the HRSA State Implementation grant. Work is being done to reach the following objectives:

Objective 1: One medical home site in each of the ten regions is certified by 6/1/10
Objective 2: In each certified medical home site, 75% of families report satisfaction with the method and response to input they have provided by 5/31/11
Objective 3: In each certified medical home site, 75% of families report having access to information on public and private health insurance options by 5/31/11
Objective 4: In each certified medical home 90% of children will have been screened according to AAP screening guidelines by 5/31/11
Objective 5: In each medical home site 90% of families report having access to care coordination by 5/31/11
Objective 6: In each medical home site 60% of transition aged youth have a transition plan and a portable medical summary by 5/31/11

Work on the State Implementation grant coincides with the recommendations that came out of the strategic planning Process:
•Develop mechanisms to educate the public and train professionals on the topic of medical home.
•Develop consensus definition for CYSHCN family-centered medical home and all subsets of medical home such as care coordination in Michigan and involve family representation throughout the process.
•Address medical home funding and reimbursement issues allowing for multiple billing strategies.

c. Plan for the Coming Year
The CSHCS division will continue to work on the following CSHCS Strategic Plan recommendations and activities

•Develop mechanisms to educate the public and train professionals on the topic of medical home.

Activities Identified: 1)Survey what it already happening and what is needed to train professionals and educate the public about the medical home model. 2)Find out what is happening with physicians, nurses, allied health programs, state screening programs, Region IV genetics collaborative, Early On, Great Start, Family to Family Health Education Center, Federally Qualified Health Centers, Primary Care Collaborative Patient Centered Medical Home, Early Childhood Investment Corporation (ECIC) and MI-AAP Medical Home Summit, etc.

•Develop consensus definition for CYSHCN family-centered medical home and all subsets of medical home such as care coordination in Michigan and involve family representation throughout the process.

Activities Identified: 1)Adopt the Joint Principles of Patient Centered Medical Home with Michigan Footnotes and AAP definition of Medical Home as a working definition to build from.

•Address medical home funding and reimbursement issues allowing for multiple billing strategies.

Activities Identified: 1)Review of web sites, programs, and literature to understand various payment mechanisms used to support medical home. 2)Investigate the payment combinations that are in place: Fee for service, enhanced fee for service, capitation, pay for performance, grant support.

The CSHCS division will also continue to work towards the objectives outlined in the HRSA State Implementation grant that are on-going until 2011.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	50	66.5	66.5	66.5	60.8
Annual Indicator	66.5	66.5	66.5	60.8	60.8
Numerator					
Denominator					
Data Source					NS-CSHCN 2005/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	60.8	60.8	60.8	60.8	60.8

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
According to the 2005/2006 National Survey of CYSHCN, Michigan data indicated that: 64.3% of CYSHCN had adequate insurance compared to 66.9% nationally, 35.7% of the insured have insurance that is not adequate, and 6.7% were without insurance at some point in the past year.

The Children's Special Health Care Services program (CSHCS) provides coverage for medical care and treatment for 2,500 different diagnoses. In 2008 the program provided services for 37,709 clients enrolled in the program.

CSHCS has the Insurance Premium Payment benefit. This benefit has been in place for over 13 years, whereby the state pays the private health insurance premium for the CSHCS eligible client. The reason for this benefit is that it maintains private health care coverage for families that could not otherwise afford it. This enables the state to prevent a shift in cost of medical services from the private health insurance company to CSHCS state funding. The majority of the premiums paid by the benefit are when COBRA coverage is offered to a family when the policyholder loses

a job or a young adult is no longer a dependent. CSHCS also pays for a client's premium for a private health insurance policy they purchased themselves or a reimbursement of insurance premiums that is payroll deducted. Cost effectiveness must be proven in order for CSHCS to pay premiums.

In 2008, the Insurance Premium Payment benefit assisted 202 families with insurance premiums, saving the CSHCS program $2.468 million.

Access to Insurance also played a large role in the CSHCS divisions two day strategic planning meeting and recommendations were put forth for the strategic plan that workgroup members continue to work on into 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide financial assistance to families who may need help paying for insurance premiums.	X			
2. Support local health departments efforts of assisting families who might be eligible for the Insurance Premium Payment Benefit.		X		
3. Convene workgroups to implement the insurance status priorites as identified from the strategic planning process.				X
4. Maintain and increase dissemination of Insurance Premium Payment brochure and outreach materials		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCS continues to assist families maintain other health insurance through the Insurance Premium Payment benefit. CSHCS has developed a specific brochure for families that explains the benefit and how to request assistance. The brochures are now widely distributed to families enrolled in CSHCS through our application renewal process.

Because of the increasingly difficult economic times in Michigan and the high numbers of jobs being lost throughout the state the division is trying to reach more CSHCS enrollees to inform them of this benefit. A letter is being prepared to be mailed to all individuals on the CSHCS program who have private health insurance. The letter will outline the benefit and the application process.

In 2009, the CSHCS division also continues to work with the recommendations put forth by our strategic planning partners. Work continues in workgroups for each national performance measure. The recommendations being worked on for Access to Insurance are:

•Improve communication, collaboration, and education to all CSHCS stakeholders on the CSHCS program and the Insurance Premium Payment benefit.

•Pursue the Medicaid buy-in option available for children with special health care needs through the Family Opportunity Act.

•Expand the Insurance Premium Payment benefit and increase enrollment.

c. Plan for the Coming Year
Work on this performance measure will continue through the recommendations put forth by the designated strategic planning workgroup. A focus of the workgroup is to get a clear and concise message out about the CSHCS program and the Insurance Premium Payment benefit to those who may have need throughout Michigan.

The CSHCS division also works towards this performance measure through the HRSA State Implementation grant project. The grant project will provide funding to partner with the Family to Family Health Information Center in Michigan to provide parent and professional training series on the topic of public and private insurance options.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	79	75.7	75.7	75.7	90.9
Annual Indicator	75.7	75.7	75.7	90.9	90.9
Numerator					
Denominator					
Data Source					NS-CSHCN 2005/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90.9	90.9	90.9	90.9	90.9

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
Michigan relies heavily on our Local Health Department (LHD) partners to be the community based arm of the CSHCS program. CSHCS relies on the LHDs to assist families in locating additional resources within their community. CSHCS effort to increase the success of this role has been to work even more collaboratively with the LHDs.

Because CSHCS relies so heavily on the LHDs it is crucial that the division provides them with the most up to date information and streamlined process to handle client's needs. In 2007 the division went through the process of converting all medical records into an electronic format. In 2008 the work continues in utilizing a program called Filenet to access all medical records. Other system improvements include the transformation of the CSHCS database to an on-line version. The benefit of having the CSHCS database on-line will allow our LHD partners to have access to up to date information on the clients they are working with at the community level, increasing efficiency for the family and client. While the CSHCS on-line database is not ready to be rolled out to all LHDs, it is currently in the works.

Access to Community Based Services played a large role in the CSHCS division's two day strategic planning meeting and recommendations were put forth for the strategic plan that workgroup members continue to work on into 2009.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to provide technical assistance to local health departments through the public health nurse consultants.		X		
2. Convene workgroups to implement the community-based services objectives a identified through the strategic planning process.				X
3. Implement the activities of the HRSA State Implementation Grant to provide access to medical homes at the community level.	X			
4. Continue to roll out Information Technology and system improvments to increase efficacy at the local level.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2009, the CSHCS division continues to work with the recommendations put forth by our strategic planning partners. Work continues in workgroups for each national performance measure. The recommendations being worked on for Community Based Services are:

•Implement health communications technology including the statewide utilization of telemedicine and the use of Informatics such as flash drive portable health records.

•Increase efficiency across multiple areas such as transportation, inter-agency documentation/communication and accessibility.

System improvements continue that will allow for the CSHCS Local Health Department partners to work more efficiently at the community level to provide services to clients and families. The

division will continue to work towards the roll out of the CSHCS on-line database and other information technology improvements.

The CSHCS nurse consultants are also taking an increasingly active role in working closely with local health departments to identify areas of need and to provide training and technical assistance in many areas. The work has greatly strengthened the partnership between CSHCS central office and the community based local health department staff. Currently the nurse consultants hold a monthly conference call with the local public health nurses. The teleconference provides a great opportunity to share information and provide training on issues identified at the local level.

c. Plan for the Coming Year

CSHCS will continue in its efforts to work collaboratively with local health departments to provide community based services. The collaborative approach will also be echoed in the work done for the strategic planning recommendations. Workgroup members representing various stakeholders will continue their work on the recommendations for increasing community based services for families.

The CSHCS division also works towards this performance measure through the HRSA State Implementation grant project. The grant project aims to develop and spread the medical home model in Michigan. The very concept of Medical Home is that it is community based. With the efforts of the grant project, the CSHCS division hopes to spread the medical home concept that will provide services to children and youth with special health care needs in their local community.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6	5.8	5.8	5.8	40.8
Annual Indicator	5.8	5.8	5.8	40.8	40.8
Numerator					
Denominator					
Data Source					NS-CSHCN 2005/06
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40.8	40.8	40.8	40.8	40.8

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

a. Last Year's Accomplishments
CSHCS has made great effort to assess and assure youth with special health care needs receive the services necessary to make the transition to adulthood. The division works closely with our community based local health department partners in this effort. The Transition Resource Manual serves as a single point at which LHDs can maintain reference information, handouts for youth and families, and planning material on the topic of transition. The manual contains over 100 pages of information on the topic of transition and it is available on-line for increased access. Further education and training has been provided to LHD staff through semi-annual meetings and teleconference training calls. Technical assistance is always available to local health partners on any topic related to transition through the division's Transition Specialist.

CSHCS continued to educate our clients and families on transition though anticipatory guidance in the form of letters. Four anticipatory letters are being sent to clients and family members. These letters provide guidance to youth and their family members with detailed information about steps to take throughout the transition process. Steps are outlined such as planning for your child's future as an adult, reaching the age of Majority, HIPAA privacy laws after the age 18, as well as guidance on health care skills and health insurance.

Transition to adulthood was discussed during the CSHCS division's two day strategic planning meeting and recommendations were put forth for the strategic plan that organized workgroup members continue to work on into 2009. Through Early Adult Transition Task-Force (EATT), the youth advisory council for CSHCS, the division was able to have a youth representative participate in the two day meeting.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase the collection/development of resources professionals and families/clients needs to assist in the transition process.		X		
2. Continue to create and provide anticipatory guidance material for families and youth regarding the transition process.		X	X	
3. Convene workgroups to implement the transition to adulthood priorities as identified through the strategic planning process.				X
4. Implement the activities of the HRSA State Implementation grant for transition. Disseminate Transition Guidebook and portable flash drives.	X	X	X	
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
In 2009, the CSHCS division continues to work with the recommendations put forth by our strategic planning partners. Work continues in workgroups for each national performance measure. The recommendations being worked on for Transition are:

•Create additional services to cover young adults including, health care coverage, a CSHCS buy-in program, pharmacy coverage, and mental health services.

•Create standard requirements and training for transition planning with plans that begin at age 14 and are reviewed annually. Expand who would be eligible to bill for care coordination for such services.

•Identify all available transition services and establish a single point of entry.

•Enhance collaboration between organizations and agencies that serve youth and adults.

There is a transition component to the HRSA State Implementation grant as well. With grant funding and support the division is putting together a Transition Guidebook for young adults and their families. It covers many topics related to transition and will be distributed throughout the pilot medical home practice sites as designated by the grant project. In addition to the Transition Guidebook, grant funds will also help the division purchase portable flash drives to distribute to clients to use as a portable medical summary with the support of their medical home provider.

c. Plan for the Coming Year
The CSHCS division will continue to work on the following CSHCS Strategic Plan recommendations and activities

•Create additional services to cover young adults including, health care coverage, a CSHCS buy-in program, pharmacy coverage, and mental health services.

Activities Identified: 1)Investigate the possibility of partnering with a private health insurance company for CSHCS buy-in coverage, 2)Produce CSHCS data on the transition population, Obtain information/data on costs associated with this group for medical services, pharmacy, etc., 3)Investigate prescription assistance programs and look into the possibility of partnering for expanded prescription coverage

•Create standard requirements and training for transition planning with plans that begin at age 14 and are reviewed annually. Expand who would be eligible to bill for care coordination for such services.

Activities Identified: 1)Review all transition plans of care that local health departments currently use, Review Transition Individualized Education Plan from the Department of Education for their requirements, 2)Work closely on this objective with the Medical Home Model and workgroup, 3)Examine the feasibility of opening/expanding CSHCS care coordination, 4)Create and implement standard requirements.

•Identify all available transition services and establish a single point of entry.

Activities Identified: 1)Investigate the possibility of using an on-line approach for a single point of entry. Research the current Michigan Assistance and Referral Service (MARS) run through the Department of Human Services.

•Enhance collaboration between organizations and agencies that serve youth and adults.

Activities Identified: 1)Bring more partners to the workgroup table, Recruit young adults for workgroup, and 2)use the single point of entry technology to enhance collaboration

The division will also continue to partner with the HRSA State Implementation grant project on the topic of transition. The transition specialist will work closely with the project coordinator to be sure the Transition Guidebooks and Portable Medical Summary flash drives are disributed and pilot medical home practice sites are trained in topics related to transition.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	87	89	91	91	91
Annual Indicator	81.2	82.7	81.2	81.8	82.0
Numerator	152922	157364	154510	154222	152195
Denominator	188328	190283	190283	188535	185604
Data Source					Nat'l Imm. Survey, MCIR
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	85	86	87	88	89

Notes - 2006
The 2006 National Immunization Survey data is not yet released. However, we have updated numbers for 2005.

a. Last Year's Accomplishments
The Michigan Care Improvement Registry (MCIR) was enhanced to allow for data collection of relevant information occurring during an all-hazards event. The interface previously established in MCIR providing for the display of lead data addressing children accessed in MCIR allowed for future incorporation of additional integration enhancements involving newborn screening (NBS) the early periodic screening diagnostic tool (EPSDT) and early hearing detection intervention (EHDI). Lead screening results continued to be displayed and interpreted which proved to be a valuable tool for health care providers.

Immunization completion rates for children in MCIR were assessed and tracked. Statewide MCIR rates for children 19 to 36 months of age for the 4-3-3-1-3-1 series was 71% with many counties

experiencing coverage rates in excess of 80%. The Assessment, Feedback, Incentive, and eXchange (AFIX) process was incorporated into MCIR and was used to determine provider immunization completion rates as well as to provide input into ways that provider practice methods could be improved. During 2008, MCIR became the tool used to complete AFIX assessments. Since June 2006 (the inception of MCIR as a life-span registry) over one million adult immunization records have been added. New immunization assessment schedules were constantly added to MCIR to address changing immunization requirements of children, adolescents, and adults. The Vaccine Inventory Module (VIM) was also implemented which allowed for tracking of vaccines within MCIR. The VIM has proven to be a highly effective tool for monitoring vaccine storage as well as administration. Provider vaccine inventories are pre-populated in the MCIR with vaccine shipment data.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enhanced MCIR to collect information occurring during an all-hazards event				X
2. Enhancements for future incorporation of newborn screening, EPSDT and early hearing detection information				X
3. Lead screening results displayed				X
4. AFIX (Assessment, Feedback, Incentive and eXchange) process incorporated into MCIR				X
5. New immunization schedules incorporated into MCIR				X
6. Vaccine Inventory Module implemented				X
7.				
8.				
9.				
10.				

b. Current Activities

Pandemic flu preparedness activities continue. MCIR is incorporating additional enhancements to address data collection requirements of an all-hazards event. The MCIR enhancements regarding the lead data interface have allowed incorporation of additional integration tools regarding NBS, EPSDT and EHDI. These enhancements ensure that Michigan's children receive necessary preventive, screening, therapeutic and follow-up services. Geo-coding has also been added to ensure that address and county mapping is more accurate. This allows MCIR to more accurately measure immunization coverage rates. Statewide immunization completion rates for children 19 to 36 months of age regarding the 4-3-3-1-3-1 series are currently 74% with many counties attaining coverage rates greater than 80%.

Transition to the new VIM in the MCIR has been substantially completed. Currently the majority of VFC providers (1,600) have been integrated into the VIM with the exception of a minimal number who have experienced technical problems involving electronic data transfer. In the later part of 2009, the immunization program will add functionality into the MCIR allowing providers to submit vaccine orders electronically (e-ordering) for subsequent approval by a local health department (LHD). E-ordering will interface with CDC software allowing uploading of electronic vaccine orders.

c. Plan for the Coming Year

MCIR implementation plans for 2010 include integration of a Hepatitis B Case Management Module. This module will modify the current sickle cell case management component to include

fields necessary to address the tracking of children born to mothers who were hepatitis B surface antigen positive (HBsAg+). Included in this implementation will be training of MCIR users regarding how to use MCIR profiles to assess hepatitis B coverage at STD clinics, HIV clinics, correctional facilities, and/or other high risk facilities. It should be noted that the Hepatitis B Immune Globulin (HBIG) field will also be added to the new Vital Records System.

The MCIR will also be enhanced to include the creation of an employee health module to enhance vaccines and TB skin test results for occupational health reasons. In many hospital settings across the country, healthcare workers must have the follow vaccinations or tests:

1. Tuberculosis (TB) Skin Test (PPD) and/or chest x-ray;
2. Measles/Mumps/Rubella (MMR) immunization;
3. Measles and Rubella antibody testing;
4. Tetanus/Diphtheria (Td) immunization;
5. Hepatitis-B immunizations;
6. Hepatitis B antibody testing; and
7. Chickenpox antibody testing and immunizations

The moved or gone elsewhere (MOGE) component will also be implemented into the MCIR in 2010. The MOGE is a valuable tool to ensure the accuracy and reliability of immunization coverage level reports. Implementation of MOGE will allow for a consistent method of determining who is responsible for an individual's immunization status. Information of this nature allows for accurate coverage assessments and increases the efficacy of reminder/recall activities.

The MCIR will also be upgraded to include edit checks. This upgrade focuses on the validation of electronic data received by MCIR. Accuracy of immunization records is a critical factor in improving the health of patients, the operation of healthcare clinics, and public health decision making. It is the responsibility of the MCIR and those who provide information to the MCIR to ensure that data is reliable. Data is received by the MCIR from variety of external sources and it is crucial that standards be established to validate this incoming data. The best practice document developed by American Immunization Registry Association (AIRA) which addresses the national standards for data quality will form the basis for development of these standards.

MDCH will also be working with Altarum Institute Childhood Prevention Mission Project to expand MCIR to include fields to track Body Mass Index (BMI) measurements.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	18	17.8	17.6	17.4	17.4
Annual Indicator	18.7	17.6	17.0	14.0	16.8
Numerator	4049	3934	3802	3127	3629
Denominator	216657	222960	223398	223398	216619
Data Source					MI vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot					

be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17	17	16.9	16.9	16.8

a. Last Year's Accomplishments
Moving Toward Solutions: Addressing Teen Pregnancy Prevention in Michigan conference was held August 26-27, 2008 in Dearborn, Michigan. Approximately 150 professionals (educators, social workers, counselors, nurses, faith-based leaders, etc.) were in attendance.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided abstinence education to 11,233 youth		X		
2. Provided parent education to 954 parents		X		
3. Supported local coalitions through the Michigan Abstinence Program				X
4. Conducted statewide media campaign			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Moving Toward Solutions: Addressing Teen Pregnancy Prevention in Michigan conference will be held May 5-6, 2009 in Kalamazoo, Michigan. Approximately 225 professionals (educators, social workers, counselors, nurses, faith-based leaders, etc.) will be in attendance.

Nine (9) agencies serving 14 counties throughout Michigan were funded to conduct abstinence-only education programs through the Michigan Abstinence Program from October 1, 2009-September 30, 2013.

Map Orientation was held February 10-11, 2009 and the MAP Coordinators Dinner will be held May 4, 2009. Another MAP Coordinators meeting will be held in the year, probably Setember/October.

c. Plan for the Coming Year
Moving Toward Solutions: Addressing Teen Pregnancy Prevention in Michigan conference will be held again in 2010.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	41	33.6	25	25	30
Annual Indicator	33.4	22.5	23.4	23.4	31.3
Numerator	41889	28170	29350	29350	41094
Denominator	125417	125417	125417	125417	131500

Data Source					SEALS Data
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	40	45	50	55

Notes - 2006
Data source for 2006 survey is the "Count Your Smiles" survey, a Basic Screening Survey conducted on a statistical sampling of 3rd grade children in Michigan

a. Last Year's Accomplishments
The Michigan Department of Community Health/Oral Health program implemented the first state-wide dental sealant program for second grade children on October 1, 2008. The SMILE! Michigan dental sealant program provided funding to 11 grantees who provided dental sealants to over 13,000 children. Eligible children were enrolled in schools that have greater than 50% or more participation in free and reduced lunch programs. Children were required to receive oral health education, dental sealants and referral for emergency dental needs. Data on the program included the number of children screened, the number of sealants placed, and a myriad of other socioeconomic and demographic factors. The program used the CDC SEALS data system for data collection. The sealant coordinator monitors all grant recipient activities and provides technical and consulting services to the grantees and other local health agencies to support dental sealant placement.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Oral Health Coalition				X
2. Oral Health Burden Document				X
3. Oral Health Coordinator				X
4. State Oral Health Plan				X
5. Increased Healthy Kids Dental	X		X	
6. Implement a State-Wide Sealant Program				X
7.				
8.				
9.				
10.				

b. Current Activities
The MDCH/Oral Health Program has implemented the SMILE! Michigan dental sealant program to second grade children in schools with a minimum of 50% participation in a free and reduced lunch program. The program provides dental sealants to approximately 13,000 children annually. The dental sealant coordinator monitors all grant recipient activities and provides technical and consulting services to the grantees and other local health agencies to support dental sealant placement. Work continues to expand the number of dental clinics within school-based health centers to increase dental sealant rates. The SMILE! Michigan program is being internally and externally evaluated to determine the effectiveness and efficiency of the program and to determine barriers that need to be addressed for continual program enhancement. The oral

health program is working diligently to increase the capacity and infrastructure of SMILE! Michigan. Results of the SMILE! Michigan program is used to gain administrative and legislative support for the SMILE! Michigan program.

c. Plan for the Coming Year
Provide technical assistant to dental sealant programs. Continue to build support for additional funding to support the dental sealant program and to increase capacity. Evaluate and monitor the SMILE! Michigan program and utilize the evaluation data for program enhancement. Conduct the "Count Your Smiles Survey" on 3rd grade children in 2010. Analyze the results and compare the results to the 2005 "Count Your Smiles" Survey. Publish and disseminate the findings.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	4.1	4.1	3.4	3.2	3
Annual Indicator	3.5	3.1	2.5	2.3	2.3
Numerator	73	65	50	47	44
Denominator	2098595	2066272	2019667	2019667	1945927
Data Source					MI Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	2.3	2.2	2.2	2.1	2.1

Notes - 2007
The population estimates for 2007 are not available.

a. Last Year's Accomplishments
MDCH continued to lead the program for child passenger safety (CPS) training & public education. MDCH coordinated & conducted the Nationally Standardized CPS Technician Certification Course for healthcare providers (HCP), law enforcement and fire fighters to certify them as CPS Technicians (CPST). CPST conducted public events to provide education on restraint use. MDCH also coordinated the CPS Instructor Team. MDCH provided technical assistance to the public & direction to fitting stations that provide a specific time/place where parents can have a car seat inspected. In conjunction with the Michigan State Police (MSP) Office of Highway Safety Planning, MDCH developed an educational campaign and materials on Michigan's new booster seat law in effect July 1, 2008. The materials are available through the MSP distribution center.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted CPS Technical Certification courses				X
2. Conducted CPS education on restraint correct use/installation		X		
3. Provided technical assistance to the public and direction to fitting stations around the state that provide a specific time/place where parents can have a car seat inspected	X			
4. Developed community interventions to increase booster seat use				X
5. Continued work on a hospital discharge policy program for infants				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The main goal of the MDCH CPS program is to conduct activities recommended in the five-year state CPS Strategic Plan that will supplement, enhance, and expand current CPS programs in Michigan. These activities include CPS training, child safety seat check up events, dissemination of educational materials for parents and caregivers, and coordinating and compiling pertinent information on child safety seat advocates and resources. MDCH continues to provide technical assistance and award car seats to Michigan hospitals that adopt or strengthen CPS hospital discharge policies. MDCH will continue to coordinate and conduct the Nationally Standardized CPS Technician Certification Course for healthcare providers (HCP) and law enforcement to certify them as CPS Technicians (CPST). MDCH continues to coordinate the Michigan CPS Instructor Network and provides funding for Instructors to conduct the CPS in EMS and CPS in Buses courses in their local communities.

c. Plan for the Coming Year
Continue activities as mentioned above.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			35	40	20
Annual Indicator		14.6	15.8	15.8	15.3
Numerator		6345	6618	6619	6652
Denominator		43459	41890	41890	43476
Data Source					PNSS/PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20	20	22	23	25

a. Last Year's Accomplishments

The WIC Division offers Breastfeeding Basics (BFB), Breastfeeding Coordinator (BFC) and Milk Expression (ME) training. In FY 2007 -- 2008, 130 local agency (LA) staff and other health care providers attended BFB, 17 LA Breastfeeding Coordinators attended BFC training and 10 of those same individuals attended Milk Expression Training.

The Mother-to-Mother Program Breastfeeding Initiative (BFI) expanded and now provides breastfeeding peer support services in 38 counties.

Within the WIC Division, we worked intensively to complete the design and report elements of the new MI-WIC data system. It tracks breastfeeding promotion, support services, and education of our pregnant and lactating women and breastfeeding infants. This project will complement data collected by our partners such as MSUE/BFI and MIHP.

Michigan Breastfeeding Awareness Month (August) was celebrated with: a proclamation from the Governor; press releases for the state & local agencies; development & distribution of breastfeeding promotion displays & materials for use by the local WIC & MSUE agencies & activities such as breastfeeding walks, billboards, & rock & rest tents at local festivals.

The WIC Division continues to participate & provide leadership in a multi-state nutrition education internet project, WICHealth.org. The Breastfeeding Module developed by Michigan WIC & the local agency Breastfeeding Workgroup continues to get used by breastfeeding mothers. Feedback continues to be good.

The USDA/Loving Support Grant efforts to Build a Breastfeeding Friendly Community in Bay County continues beyond the grant funding. The Bay Area Breastfeeding Coalition is using materials purchased &/or developed through the grant to continue to educate the community. The coalition continues to meet and work with the community to promote breastfeeding as normal infant feeding. Cooperation continues between Bay Regional Medical Center, Bay County WIC & MSU Extension to provide breastfeeding nutrition education & peer support services to breastfeeding moms & dads of breastfed babies.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Breastfeeding Basics, Breastfeeding Coordinator and Milk Expression training offered				X
2. Mother-to-Mother Breastfeeding Initiative expanded to 38 counties				X
3. Completed the design and report elements of the new MI-WIC data system				X
4. Participated and provided leadership in multi-state nutrition education internet project				X
5. Continued support to Build a Breastfeeding Friendly Community in Bay County				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

While WIC supports and promotes breastfeeding, there remain many challenges to increasing initiation and duration rates. Resources are limited, local hospital policies often run contrary to supporting breastfeeding, employers are reluctant to provide time and appropriate private space for breastfeeding moms to pump breastmilk, federal regulations and state policies prompt postpartum women on public assistance to return to work early and without regard for breastfeeding needs such as an appropriate breast pump or time and space for expressing milk, and both Medicaid and it's contracted providers breast pump policies are often inconsistent in terms of providing pumps to mothers whose infants are either in the NICU or are discharged from the NICU still unable to nurse at the breast. The expansion of peer counseling services is limited by funding.

During FY '09, WIC has continued to: provide training for local agency staff; hold joint training and conference calls for local agency WIC and MSUE staff involved in the Breastfeeding Initiative; explore new ways to provide peer counselor services; develop new breastfeeding packages for lactating women and their breastfed babies; train WIC staff on these new packages; provide breastfeeding coordinator training utilizing MI-WIC; strengthen and improve breastfeeding workgroups such as the Michigan Breastfeeding Network and local breastfeeding coalitions; and implement breastfeeding policies within WIC.

c. Plan for the Coming Year

We will continue most of the activities as described above. In addition, we will provide: another Lactation Management Specialist Course; Glow & Grow in WIC, a hands-on training to increase WIC staff's ability to support our breastfeeding clients; we will pilot a new breastfeeding peer counselor model at the local agency level and we will continue to transition our policies to reflect our newfound data recording, tracking and reporting abilities in MI-WIC.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	90.9	95.4	96.7	97.1	96.7
Numerator	117619	121640	121898	119770	116318
Denominator	129387	127518	126015	123407	120240
Data Source					EHDI Database
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Michigan EHDI has continued to have 100% of birthing hospital participation in universal newborn hearing screening. Pass and referral rates have remained fairly stable at roughly 96% pass and 3.9% referred in 2007. The average age of identification has remained stable at 4.7 months in 2007. Of the infants identified with hearing loss, all with parent consent were referred to Part C services. Obtaining documentation of early intervention services continues to be problematic due to FERPA (Family Education Rights and Privacy Act) but for those cases that are reported, the average age of enrollment in early intervention was 6.3 months in 2007.
EHDI continues to provide resources and consultation to hospitals, increase public awareness through exhibiting and presenting, providing an annual EHDI conference, and providing an online hearing screener training module for hearing screeners, hospital nurse coordinators, and audiologists. EHDI continues to maintain provider lists for hospital, rescreen, diagnostic, and early intervention sites. Physician education and family support continues as a priority for EHDI staff time and resources. EHDI is continuing to develop and implement various stages of database development. Database development includes building a comprehensive follow-up system, linking with other data systems, and provider Web base access. EHDI continues to receive referrals for a family support program called "Guide- By-Your-Side". This program links families with newly identified infants with hearing loss to other hearing loss families in order to provide family support through the initial stages of diagnosis to intervention.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Achieved 100% particiaption of birthing hospitals				X
2. Screened 116,318 infants	X			
3. Referred infants indentified with hearing loss to Part C services		X		
4. Provided training consortiums and educational meetings				X
5. Provided family support		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Database development continues to be a priority, EHDI is proceeding with developing a linkage to the Electronic Birth Certificate System and initializing a web-based reporting system for hearing screening and diagnostic hearing testing. EHDI has continued to maintain the follow-up system. EHDI continues to support the parent programs Guide-By-Your-Side and Michigan Hands & Voices. EHDI has linked with the Michigan Care Improvement Registry and hearing results will be displayed for providers.

c. Plan for the Coming Year
EHDI will continue with the database development to ensure tracking and surveillance of infants through screening, diagnostic, and intervention services. The program will continue providing hospitals with quarterly reports on screening efforts. EHDI materials will continue to be distributed for family and provider use. EHDI staff will make efforts to work closer with primary care providers to ensure follow-up care. The EHDI program will hold advisory meetings and obtain provider/family input into program operations and activities.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6.7	5.6	3.7	3.5	4.5
Annual Indicator	5.8	3.7	5.0	4.7	5.9
Numerator	147257	93000	128000	116049	150970
Denominator	2538920	2513514	2554000	2445601	2579250
Data Source					State Health Facts
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	6	5.9	5.9	5.8

Notes - 2006
Data from the US Census American Community Survey

a. Last Year's Accomplishments
The number of children below age 18 living in poverty rose to 19 percent in 2007. The state's growing economic problems of rising unemployment and declining wages are the most likely contributors to the increase. As expected, Detroit has one of the highest overall poverty rates among metropolitan areas in this country. Community outreach for the MIChild program has continued, which identifies and enrolls many Medicaid-eligible children. Michigan continues to make health coverage for uninsured children a priority. According to 2008 MDCH report, Characteristics of the Uninsured and Individuals with Select Health Insurance Coverage in Michigan, the number of uninsured Michigan children, under age 18, is 5.2% compared to 11% for the nation. The dual enrollment procedure utilized to bring children into the Medicaid and MIChild programs continued throughout the year. Average monthly MIChild enrollment for calendar year 2008 was 30,148 while average Medicaid enrollment for persons through 18 years of age for calendar year 2008 was 921,633. This increase in enrollment reflects significant growth from the beginning to the end of the year. Efforts have continued to follow-up or initiate recommendations from the MDCH's State Planning Project for the Uninsured.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued Medicaid and MIChild enrollment through community outreach for the MIChild program		X		
2. Continued dual enrollment procedure to bring children into the Medicaid and MIChild program		X		
3. Use of alternative sites for enrollment and continued collaboration with other human service agencies for outreach to families with uninsured children		X		
4. Local Public Health Outreach continues		X		
5. HSA outreach activites related to program enrollment being			X	

carefully monitored				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MDCH continues to make outreach funds available to local public health departments. This collaboration has resulted in an increased number of enrollments as well as providing much-needed outreach to uninsured families. MDCH continues to work towards identifying additional community-based partners to assist in the outreach efforts to uninsured and underinsured children with dual program enrollment continuing. MDCH continues to focus efforts on underrepresented groups, which often have higher numbers of uninsured individuals.

MDCH has improved monitoring of outreach activities.

c. Plan for the Coming Year
Outreach funding to local public health will continue along with consultation and technical assistance from MDCH. As always, additional community based partners will be identified and encouraged to participate in outreach and enrollment efforts. Dual program enrollment will be continued. Lastly, MDCH will continue to pursue implementation of the recommendations of the Advisory Council of the State Planning Project for the Uninsured.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			16	15.8	29.5
Annual Indicator		16.1	16.2	29.5	30.1
Numerator		15434	15516	28255	29469
Denominator		95863	95780	95780	97905
Data Source					PNSS/PedNSS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29	28.5	28	27.5	27.5

Notes - 2007
The change from 2006 to 2007 is primarily due to a correction in the data reported previously. Data for 2005 and 2006 reflected only those children with a BMI between the 85th and 95th percentile.

a. Last Year's Accomplishments

WIC-Breastfeeding-Obesity Partnership: WIC has worked with chronic disease to provide messages related to the evidence that breastfeeding in infancy decreases the incidence of obesity in later life. Local WIC nutrition educators receive information for clients related to obesity and physical activity for children. For WIC clients, the Internet Education Project, www.wichealth.org, is an alternative form of nutrition education. The site offers several topics on feeding children using Stages of Change and Division of Responsibility concepts which promote healthy parenting around meals, supporting the prevention of overweight in children. Also, a module titled "Happy, Healthy, Active Children" on the wichealth.org site is used by clients to learn how to promote physical activity in their children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC worked with Chronic Disease programs to provide messages about the relationship between breastfeeding and obesity in later life				X
2. Provided lesson plans related to obesity and physical activity for children to local WIC nutrition educators				X
3. Provided nutrition education to clients via the Internet Education Project		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Use of and continued development of nutrition education modules for wichealth.org include 16 modules currently in use (6 in Spanish). New modules are developed each year.
Continued activities as stated above.

c. Plan for the Coming Year
By October of 2009, all WIC mothers and children will have a new food package based on Institute of Medicine recommendations for foods that will help fight the obesity that occurs in the WIC participant population. This package places a stronger emphasis on breastfeeding by increasing the foods available to the breastfeeding woman-infant dyad. The package will also provide whole grain bread and cereal and a cash value benefit for fruits and vegetables.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			14.6	13.6	12.6
Annual Indicator		15.6	17.5	17.1	17.5

Numerator		19851	22281	21371	21120
Denominator		127249	127537	125172	120601
Data Source					PRAMS
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16.8	16.7	16.7	16.6	16.5

Notes - 2006
We used 2005 PRAMS data to estimate the number of women who smoke in the third trimester in 2006.

a. Last Year's Accomplishments
Michigan has addressed prenatal smoking cessation as a part of perinatal health and overall general population smoking cessation efforts. The Smoke Free for Baby and Me (SFBM) is a provider training program for which 11 face to face "Smoke Free for Baby and Me" trainings have been conducted in the last two years. The program is based on providers assessing and counseling prenatal smokers using the Five A's, Five R's process that has shown wide acceptance and efficacy among clients. The department has made Prenatal Quit Kits available to consumers and providers by calling the "iCanQuit" or the MCH hotlines. The Michigan Smoker's Quit Kit which includes a pamphlet "Quit Smoking for You and Your Baby" has been updated and was published November 2006. This is a collaborative project of MCH programs and the Tobacco Section of the department to make educational tools available. The 2005 Michigan Pregnancy Risk Assessment and Monitoring Survey (PRAMS), the most current survey, shows a slight increase in the percentage of pregnant women who smoke during the last trimester of pregnancy, 15.6% and 15.8% respectively.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Developed a web-based Smoke Free for Baby and Me Training				X
2. Provided nursing continuing education credits to participants completing and passing the web-based training				X
3. Made Prenatal Quit Kits available to consumers adn providers through the "ICanQuit" or the MCH hotlines		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
A web-based Smoke Free for Baby and Me training has been developed and was launched November 2006. This web-based training is accessible and required for providers in the state's

Maternal Infant Health Program and offers nursing continuing educational credits. It can also be accessed by any prenatal provider.
In FY2006-2007, 500 Continuing Educational Credits (CEUs) were awarded to Nurses who completed and passed the online course.
The Maternal Infant Health Program (MIHP) will have an intensive focus on prenatal smoking cessation in this redesigned MCH population based, home visiting support service for Medicaid enrollees. Providers will have required intervention protocols, reporting requirements and performance evaluation measures to follow. MIHP aims for a systematic approach to address smoking risk in pregnant women and mothers of infants in this low-income population.

c. Plan for the Coming Year
The program will continue to expand its reach to users of the web based Smoke Free for Baby and Me training, and will require quarterly and annual reports of the number of hits and the number of individuals who are awarded nursing continuing education credits to MDCH. Michigan is in the early stages of crafting a preconception and inter conception plan to promote readiness for pregnancy. One of the primary messages will be for all women contemplating pregnancy to cease smoking before becoming pregnant, and if pregnant to cease early. Upon the implementation of the tobacco assessment and cessation intervention of the MIHP, the department will monitor and evaluate the outcomes to assure we continue reducing the percentage of pregnant women smoking the last three months of pregnancy.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	8.4	8.1	7.9	7.8	7.7
Annual Indicator	8.2	8.2	7.9	7.0	7.3
Numerator	60	61	59	52	54
Denominator	735634	745736	745908	745908	739588
Data Source					MI Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7.3	7.3	7.2	7.2	7.2

a. Last Year's Accomplishments
MDCH continued to work on activities related to it's 3 year youth suicide prevention cooperative agreement from the federal Substance Abuse and Mental Health Services Administration (SAMSHA). The first year of funding started on October 1, 2006. The grant allows the state to conduct a health communication campaign, provide a training of trainers for clinicians and community gatekeepers, offer technical assistance to all interested communities in the state, build state infrastructure around suicide prevention, provide limited grants to communities, and conduct

extensive evaluation of efforts.

A grassroots movement in Michigan, the Yellow Ribbon Campaign continued to work with young people in specific areas of the state to assist them in reaching out to an adult when they are in need of help. The campaign goes into schools and talks to young people and provides a "card" that they present to an adult as a signal that the young person needs to have a "conversation."

The Michigan Model for Comprehensive School Health Education(r) continued to be used in over 90% of Michigan's public schools and more than 200 private and charter schools. The Curriculum promotes life skills for children, K-12, in areas such as problem solving/decision making, resolving conflict, anger management, healthy lifestyles, listening skills, and feelings.

MDCH and MiSPC continued to work jointly to implement the Suicide Prevention Plan for Michigan, which was issued in September of 2005.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Implementation of activities funded under the SAMHSA Youth Suicide Prevention cooperative agreement.				X
2. Participated in Yellow Ribbon Campaign		X		
3. Continued implementation of Michigan Model for Comprehensive School Health			X	
4. Implementation of the state suicide prevention plan				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Department has a 0.75 FTE working specifically on the activities funded under the SAMHSA youth suicide prevention grant.

MDCH and the Michigan Suicide Prevention Coalition are continuing to work cooperatively on implementation of the state plan.

The Department continues to work with the local human services collaborative bodies and community mental health agencies across the state to develop local suicide prevention coalitions and plans.

Implementation of the Michigan Model is ongoing.

c. Plan for the Coming Year
Applied for an additional three years of youth suicide prevention funding from SAMHSA. If received, will continue to support training and programming activities across the state.
Secure support for implementation of high priority objectives of the suicide prevention plan.
Establish a state government suicide prevention cross-systems work group.
Provide ongoing support to local and regional suicide prevention coalitions.
Expand participation in symposiums held within the state on suicide prevention in partnership with

the Michigan Association of Suicidology, the Michigan Chapter of the Suicide Prevention Action Network, and other public and private entities.
Work with the Department of Education to develop voluntary guidelines for schools.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	88	88.2	88.2	88.4	88.4
Annual Indicator	86.0	86.4	85.9	85.0	78.6
Numerator	1848	1849	1796	1826	1716
Denominator	2148	2140	2090	2147	2183
Data Source					MI Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	81	82	85

a. Last Year's Accomplishments
Michigan has not had a regionalized perinatal system since the early 1990s; since that time, health system changes have resulted in decreased numbers of high-risk pregnancies delivered at hospitals with neonatal intensive care units. Michigan PA 246 of 2008 was signed into law, mandating the MDCH to "convene appropriate stakeholders to determine the efficacy and impact of restoring a statewide coordinated regional perinatal system in Michigan."

In May, 2008, MDCH convened a statewide infant mortality summit meeting to discuss Michigan's infant mortality issue, with particular attention to racial disparities. From that meeting, one of the topics recommended for further review was a regional perinatal system of care. Late in 2008, stakeholders from the neonatal, obstetric and pediatric fields were identified to participate in workgroups that would be charged with developing level of care guidelines for Michigan.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Monitored data of low birth weight infants delivered at high-risk facilities to assure system of referral is working				X
2. Developed hospital survey to capture information about the level of service delivery, staff preparation, referral patterns, etc				X
3. FIMR program continues to share information about access to appropriate health system services				X
4. Determined communities with racial disparities in infant mortality have significant percentages of VLBW infants born in hospitals without a NICU				X

5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In response to PA 246 regarding a regionalized perinatal system in Michigan, MDCH convened a group of subject matter experts and stakeholders comprised of obstetric, neonatal, and pediatric physicians and nurses; representatives from the Early Childhood Investment Corporation (ECIC); managed care plans; the Michigan Public Health Institute; and others to address these requirements. The goal of this group was to develop Michigan level of care guidelines based on the AAP/ACOG Guidelines for Perinatal Care and recommendations for implementing a regional system of care. A report was produced by this group that included LOC guidelines, including NICU follow-up, and recommendations for a method of authoritative recognition of Level I, II and III units. This report was presented to the Legislature on April 1st. A state leader was invited to join the Vermont Oxford Network (VON) Neonatal Quality Improvement initiative. Fifteen out the 24 centers with NICU licensed beds are already part of this initiative. This offers the unique opportunity to stregthen the existing collaboration between MDCH and neonatologists and work together towards improving the perinatal system of care in Michigan.

c. Plan for the Coming Year
The regional perinatal system planning committee will make revisions to their plan and begin the implementation process. A nurse consultant position is purposed to work with and support the perinatal regionilization. It may be a struggle to acquire the needed funding, but some steps that are independent of hiring staff may be continued. Essential buy in from hospital systems across the state will be the critical step to complete in this year of operation.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	85.9	86.6	87.8	89	90.3
Annual Indicator	82.7	83.3	83.3	81.5	85.0
Numerator	107283	106238	106188	102050	102050
Denominator	129710	127518	127537	125172	120112
Data Source					MI Vital Records
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90.3	90.3	90.3	90.3	90.3

a. Last Year's Accomplishments
Standardized interventions were crafted in MIHP, forms were designed and workgroups met to address topics relevant to strengthening the coordination and working relationships between MIHP providers and the Health Plans to improve birth outcomes.

Anticipated outcomes are quantitive, qualitative and administrative and include: (1) reduce infant death rates and sickness rates; (2) deliver full term, healthy babies; (3) have developmentally healthy infants; (4) have physically, emotionally healthy mothers; (5) conduct timely quality assurance site reviews to enforce Medicaid policy; (6) evaluate and assure accoutnability for quality service delivery, and (7) provide consultation and technical assistance to local providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Created referral pathway through WIC				X
2. Initated redesign project for MSS/ISS with emphasis placed on early entry and early risk assessment tailored to the clients needs				X
3. The MIHP (formerly MSS/ISS) redesign includes plans to pilot projects to test the feasibility of WIC Program integration to improve outreach		X		
4. The four Nurse family Partnership projects have been enrolling clients and offer early intervention for first time pregnancies	X			
5. Plans to analyze data collected from the pilot prenatal projects and the NFP sites to learn best practices for improving early entryto prental care				X
6. Plans for the department to look at ways to study how much substance abuse occurs in childbearing age women and how inadequate contraception affects the timing of entry to care and ways to affect Medicaid and health plan policies to reward early.				X
7.				
8.				
9.				
10.				

b. Current Activities
Standardized interventions are being crafted in MIHP, forms are being designed and workgroups are meeting to address topics relevant to strengthening the coordination and working relationships between MIHP providers and the Health Plans to improve birth outcomes. Anticipated outcomes include: (1) reduce infant death rates and sickness rates; (2) deliver full term, healthy babies; (3) have developmentally healthy infants and (4) have physically, emotionally healthy mothers.

The 4 Nurse Family Partnership (NFP) projects are continuing to enroll clients & offer early intervention for first time pregnancies. An additional NFP project was funded in Kalamazoo County. In Michigan, 91% of the pregnant women enrolled in the NFP program gave birth to full term babies and 91% of babies had no visits to the ER or hospitalizations due to injury or ingestion by 12 months of age.

The Medicaid Family Planning Waiver has continued. With many more low income child bearing

age women receiving regular reproductive care, as they choose to become pregnant, family planning providers, especially Title X Family Planning providers, will connect her to prenatal care providers supporting earlier entry into care.

The enhancement of the MIHP program has continued in 2009 with expansion of the network of providers--particularly in the City of Detroit. The program's evidence based/standardized interventions will focus on prenatal care and improving the life conditions affecting pregnancy outcomes.

c. Plan for the Coming Year
Due to 2009 state budget reductions the NFP programs in the state have been identified for elimination, effective July 1, 2009. The five existing NFP communities programs will continue to look for funding within their local communities. The city of Battle Creek is also currently exploring funding to support implementation of an NFP program in their community.

The evidence-based standardized MIHP interventions will be reviewed, approved and rolled out statewide this next year.

Title X Family Planning and Medicaid Family Planning Waiver activities will continue in FY 2010.

D. State Performance Measures

State Performance Measure 1: *Percent of Medicaid-enrolled women who are screened for maternal depression*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			25	30	35
Annual Indicator			100.0		
Numerator			1		
Denominator			1		
Data Source					
Is the Data Provisional or Final?					
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	40	45	50	50	50

Notes - 2008
Notes - 2009 No current data. Will have data next year after the algorithym has been corrected and we have one year of MIHP risk identifier information in system.

Notes - 2007
Due to technical problems with the reporting system, data will not be available until next year. All providers will be required to begin reporting screens as of July 1, 2008.

Notes - 2006
No current data available. The Perinatal Depression workgroup expects to have data in 2008.

a. Last Year's Accomplishments
All beneficiaries in the MIHP program are screened for depression using the Edinburgh tool. System's change is being addressed in several communities focusing on enhancing the perinatal depression continuum of care and increasing the provider network available to Medicaid beneficiaries.

The provider network of MIHP providers has expanded with several new programs open in the City of Detroit. The program's evidence based/standardized interventions (in development) focus on prenatal care in addition to improving the life conditions that affect pregnancy outcomes.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Participation in the maternal depression work group				X
2. Surveying state providers to determine what services are available for women who are identified in need of care.				X
3. Initiated pilot testing of a screening tool based on the Edinburgh depression tool				X
4. Encourage depression screening by prenatal providers				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The program's evidence based/standardized interventions (in development) focus on depression/stress in pregnancy, the interconception period and postpartum and are stratified by anticipated service intensity level. Recommendations from the Perinatal Depression Workgroup have been incorporated.

Standardized interventions are being crafted, forms are being designed and workgroups are meeting to address topics relevant to strengthening the coordination and working relationships between MIHP providers and the Health Plans to improve birth outcomes.

In addition MIHP quality assurance site visits resumed this year. Given that there is much technical assistance needed in the field, relative to previous program expectations and emerging redesign requirements, it is not possible for one person to do this. Four part-time experienced reviewers have been added, all with local MIHP provider experience.

c. Plan for the Coming Year
The Perinatal Depression Workgroup has held statewide conferences to inform providers and enhance the service delivery continuum. Their work will continue in the next year.

The evidence-based standardized interventions will be reviewed, approved and rolled out statewide this next year.

State Performance Measure 2: *Percent of low birthweight births (<2500 grams) among live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Performance Objective	7.9	7.8	8.2	8.1	8
Annual Indicator	8.4	8.4	8.4	8.4	8.7
Numerator	10867	10665	10720	10550	10543
Denominator	129710	127518	127537	125172	120601
Data Source					MI Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7.9	7.8	7.8	7.7	7.6

Notes - 2006
The annual performance objective has remained around the same since 2003, with minor variances, When Kids Count's Right Start data is looked at for 2003-05 births, it shows that the higher the percent of Medicaid births in a locale the higher the rate of LBWs. Locations with over 40 percent Medicaid births, the rate is 11.2; those areas with 20-40 percent, Medicaid the rate is 8.0; and for locales with less than 20 percent Medicaid births, the rate is 7.1

a. Last Year's Accomplishments
The Infant Mortality Program's Interconception Care Project (ICP) collaborated with multiple community resources to generate referrals, including the Fetal and Infant Mortality Review (FIMR) program, Healthy Start, hospital NICUs, the Maternal and Infant Health Program (MIHP), and the Women, Infant and Children (WIC) program. The program currently has 205 actively enrolled clients (FY 2009). Since its implementation, the ICP has served a total of 332 women at risk of having repeat poor pregnancy outcomes. During FY 2009, nurses (and social workers) developed individualized care plans with program participants to address a range of issues including pregnancy planning, management of chronic illnesses, weight management, nutrition, etc.

The provider network of MIHP providers has expanded with several new programs open in the City of Detroit. The program's evidence based/standardized interventions (in development) focus on improving access to prenatal care, smoking cessation, improving nutrition and improving the life conditions that affect pregnancy outcomes.

A statewide Infant Mortality Summit was held in May 2008 bringing together state and local decision makers, providers and key stakeholders. The common denominators of the state perspective are race, poverty, access to health care, funding availability and accessibility, building coalitions, data and measuring outcomes. Race and disparity were major issues under discussion with the following activities as the framework: 1) Mobilizing the community, 2) Changing the stigma of Poverty, 3) Cultural competency training, 4) Providing simple/clear messages, 5) Providing access to psychosocial support, 6) Appropriate use of data, 7) Making bench knowledge applicable to the field. Common threads throughout the meeting were: 1) Increase early entry into public health programs through Medicaid, WIC, MIHP, Family Planning and Healthy Start; 2) Reducing premature birth & LBW; 3) Promote/support breastfeeding; 4) Increase immunization rates; 5) Coordinate maternal and infant care; 6) Universal health coverage to improve prenatal care and maternal morbidity; 7) Safe sleep; 8) Fatherhood initiatives. The goal of consensus building and networking around these issues, common denominators and common threads was an important step to reducing low birth weight.
A report was completed on the work of the Michigan Families Medicaid Project, a collaborative effort between Michigan Department of Community Health (MDCH) and Michigan State University to improve services for Medicaid-insured pregnant women and new mothers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Provided smoking cessation services and supported tobacco quitline		X		
2. Implemented and monitored the progress of FAS prevention program to target high-risk families		X		
3. Continued MIHP program that targets high-risk pregnant women and infants		X		
4. Continued MIHP collaboration with WIC to identify clients and improve nutrition and weight gain		X		
5. Continued redesign process with the goal of a more effective Maternal Infant Health Program				X
6. Piloted the Preconception program in Kalamazoo		X		
7. The Infant Mortality Initiative will continue to address the disparity in African American infant mortality rates in Michigan. Through cont. of the Interconception Care Project. The program aims to primarily serve high-risk African American women.				X
8. Nurse Family Partnership program continues to enroll and serve low-income, first-time pregnant women.		X		
9.				
10.				

b. Current Activities

The Maternal Infant Health Program (MIHP) is testing the new screening tools and beginning to implement new chronic disease standards for support services to Medicaid eligible pregnant women. The goal is to serve more women at risk for low birth weight and other poor pregnancy outcomes.

The Nurse Family Partnership (NFP) program, active in 5 urban areas, is providing intense case management and home visiting to first time mothers to improve pregnancy outcomes and educate young women on prenatal care and parenting.

Collaboration between MIHP, WIC and NFP is helping to improve nutrition support for pregnant women.

MCH staff is working more collaboratively with Office of Drug Control Policy to learn more effective strategies for working with women who are abusing substances during pregnancy, including screening for alcohol use, motivational interviewing and brief interventions and referral for more intense substance abuse treatment.

The CDC grant providing FAS prevention services in Detroit will be completed and new grant funding is being sought to build capacity within the Detroit and Wayne County health departments for FAS prevention in STD clinic participants

The MIH Program has continued collaboration with WIC to identify clients and to improve nutrition and weight gain, two factors associated with low birth weight. The Smoking Cessation program continues to support a tobacco Quitline that helps many women reduce or stop smoking during pregnancy.

c. Plan for the Coming Year

The Interconception Care Project will be eliminated effective July 1, 2009 due to state budget cuts. Due to state budget reductions, the NFP projects have been identified for complete elimination, effective July 1, 2009.

The evidence-based standardized MIHP interventions will be reviewed, approved and rolled out statewide this next year and will address risk factors that contribute to low birth weight and very

low birth weight. MIHP will continue to train personnel on chronic disease standards and on substance abuse strategies to improve options for women at risk because of disease and health behaviors.

Funding for NFP and ICP was cut as a result of budget cuts during 2009; so strategic planning may be needed to find other funding or to find ways to target first time mothers and those with an adverse birth outcome within MIHP at a higher level of service.
Cross program collaboration will be increased to strengthen the positive support from each program for women who receive services from multiple programs.

Increased capacity for FAS prevention, FAS screening, diagnosis and treatment will be sought through collaboration of community partners and state agencies.

State Performance Measure 3: *Percent of preterm births (<37 weeks gestation) among live births*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	11.1	11	11	10.9	10.2
Annual Indicator	10.0	10.0	9.6	10.0	10.9
Numerator	12939	12794	12297	12523	13141
Denominator	129710	127518	127537	125172	120601
Data Source					MI Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10.2	10.1	10.1	10	9.9

a. Last Year's Accomplishments
The Interconception Care Projects continued to work with women at increased risk of having subsequent poor pregnancy outcomes. Nurse home visitors (and social workers) developed individualized care plans for program participants and provided education, referrals, and support for bereavement, health, pregnancy planning, and other important issues prior to pregnancy. Program participants were linked to community resources such as county health plans, Federally Qualified Health Centers, dental care providers, family planning services, and mental health resources.

In addition, barriers and gaps in services that negatively impact preterm births and low birth weight rates were identified through the program. Please refer to State Performance Measure #2 (Percent of Low Birth Weight Births; A. Last Year's Accomplishments) for a list of the barriers and service gaps identified during the previous year.

The MDCH interconception care project reported at the Interconception Care Conference in Sacramento in 2008. Preliminary findings demonstrated that 104 women were enrolled: 60% had preterm births, 14% had fetal deaths, 14% had miscarriages and 9% had a neonatal death. The mean age was 22.7years; 72% were African American; 71% had a high school education; 84% were Medicaid eligible and 20% were married. The target births had a mean birth weight of 1698 grams, mean gestational age of 27.5 weeks, 54% had a NICU admission, the mean number of prenatal visits was 4.9 and 79% began care in the first trimester.

The Early Childhood Investment Corporation formed an Infant Mortality Reduction Committee that began work in 2008 on strategies to reach the Title V goals for reducing preterm births.

The Michigan Quality Improvement Consortium completed the Guideline for Prevention of Unintended Pregnancy in Adults 18 years and Older in 2007.

The provider network of MIHP providers has expanded with several new programs open in the City of Detroit. The program's evidence based/standardized interventions (in development) focus on prenatal care in addition to improving the life conditions that affect pregnancy outcomes.

During 2008, 91% of the pregnant women enrolled in the NFP program gave birth to full term babies in Michigan. The four Nurse Family Partnership program sites located in selected high risk Michigan cities: Benton Harbor, Detroit, Grand Rapids, and Pontiac. NFP served 582 pregnant women and their families in Michigan and 71% of those enrolled were African American.

A fifth Nurse Family Partnership site was established in Kalamazoo during 2007-2008 and began enrolling clients.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided technical assistance to Healthy Start projects				X
2. Continued the MIHP (formerly MSS) program that targets high-risk pregnant women	X			
3. Piloted the Preconception program with emphasis on adequate pregnancy intervals		X		
4. Nurse Family Partnership encouraged early enrollment to provide education on preterm birth		X		
5. Continued to analyze statewide FIMR data and inform programs on characteristics associated with prematurity				X
6. Sponsored and supported trainings and conferences that address problems associated with prematurity				X
7. The Infant Mortality Initiative implemented the Interconception Care Project to address health, mental, and social issues that impact preterm delivery rates.				X
8. Continue the redesign of MIHP (formerly MSS/ISS) with the goal of a more effective maternal and infant health program				X
9. Implement the Medicaid Family Planning Waiver program to reduce unintended pregnancies	X			
10.				

b. Current Activities

MDCH began an intensive strategic planning process earlier in 2009 to organize and evaluate efforts to reduce infant mortality in Michigan. The primary goals of the plan relate to each of the four Periods of Risk: 1) Improve the health of women of childbearing age to assure a healthy pregnancy and healthy newborn. 2) Increase the percentage of women who begin prenatal care in the 1st trimester. 3) Implement a system of Perinatal Regionalization for high-risk delivery & neonatal intensive care. 4) Improve infant health and development relative to known risk conditions for adult disease. Measurable evaluation methods objectives are being developed.

The Interconception Care project continues with activities in 11 communities. Over 200 women were enrolled effective July 1, 2009, the ICP program will be eliminated due to state budget cuts and case managed to reduce their risks for another poor pregnancy outcome.

MIHP continues to be redesigned to place emphasis on early entry into care, early risk assessment, & interconception care with standardized interventions being developed. Five Nurse/Family Partnership projects provide early intervention for first time pregnancies. Effective July 1, 2009, state funding for these projects have been eliminated. The Smoking Cessation Program launched on line training courses for providers.

In addition MIHP quality assurance site visits resumed this year.

c. Plan for the Coming Year

A fifth Nurse Family Partnership site was established in Kalamazoo during 2007-2008 and began enrolling clients.
However, due to state budget reductions, the NFP programs have all been identified for elimination, effective July 1, 2009.

The evidence-based standardized MIHP interventions will be reviewed, approved and rolled out statewide this next year.

The regional perinatal system planning committee will make revisions to their plan and begin the implementation process. It may be a struggle to acquire the needed funding, but some steps that are independent of hiring staff may be continued. Essential buy in from hospital systems across the state will be the critical step to complete in this year of operation.

Activities that relate to 2010 of the new Infant Mortality Strategic Plan will be implemented. Specific data collection tools will be put into place and program management steps to monitor activities will begin.

The Interconception Care project, in its current form, will be ending by June 30 2009, having come under budget cuts. Steps will be taken to compile the lessons learned from the project and continue dialogue with the health departments that participated in the hopes of translating successful activities into other programs.

Effective July 1, 2009, the Interconception Care Project will be eliminated due to state budget cuts.

State Performance Measure 4: *Percent of live births resulting from unintended pregnancies.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	39.2	38.7	38.7	38.3	37.8
Annual Indicator	39.6	41.8	40.7	40.2	39.6
Numerator	51402	53330	51909	50284	47770
Denominator	129710	127518	127537	125172	120601
Data Source					PRAMS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	37.3	37.3	37.3	37.3	37.1

Notes - 2006

PRAMS data was used to estimate the number of unintended pregnancy in Michigan. A rate of 41.3 (as an estimated rate based on the previous years of PRAMS data) was applied to the 2006 preliminary total number of live births reported by the Vital Records office.

a. Last Year's Accomplishments
All methods of contraception are available through Medicaid and Michigan's Title X Family Planning program. In the Title X program, permanent contraception is available to both sexes through a cost efficient centralized project site. There were 92 procedures for women and 99 procedures provided for men in CY 2008.

Reflecting the adolescent population where greater than 70% of pregnancies are unintended, an objective of the Family Planning Program is to assure that the percentage of teens served in the program compared to total users is at least 28% of the caseload in 2007; this objective was not met last year. In 2008 27% of the caseload served were teens, 33,817 male and female teens were served in Family Planning Clinics.

All beneficiaries in the MIHP program are provided family planning information and referral to the reproductive health provider network. The program's evidence based/standardized interventions (in development) focus on reducing unintended pregnancy as well.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided Family Planning services statewide	X			
2. Implemented Michigan Abstinence Program		X		
3. Provided education and referral services through school based/linked health services		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
MIHP's evidence based/standardized interventions focus on family planning in pregnancy as well as in the interconception period.

In 2008, 120,756 women and 4286 men were served in the Title X Family Planning Clinics. Michigan Department of Community Health (MDCH) received approval of its Section 1115 Family Planning Waiver and began implementation July 1, 2006, expanding family planning services to women 19-44 years old with family incomes up to 185% of the Federal Poverty Level. The approved service cap is 200,000 women.

c. Plan for the Coming Year
The evidence-based standardized MIHP interventions will be reviewed, approved and rolled out statewide this next year.

State Performance Measure 5: *Increase the percent of Medicaid enrolled children, 0-6 years of age, who receive lead screening*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**

Annual Performance Objective	25	60	70	80	30
Annual Indicator	24.3	27.1	28.9	29.2	28.6
Numerator	86088	96887	105514	107856	108249
Denominator	354928	357527	364858	369615	377921
Data Source					MDCH Data Warehouse
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	40	45	50	55

a. Last Year's Accomplishments

There was an increase in the number of children less than six years of age who were tested in 2008 over 2007. 3,803 more Michigan children were tested in 2008 with 345 fewer children poisoned. In 2008, 1,686 children were identified with blood lead levels equal to or greater than 10 ug/dL, which represents 1.1% of the children tested, which is near the national average of 1.2% in 2006 (the latest national average data available). In 2008, an additional 12,778 children less than six years of age had blood lead levels between 5-9 ug/dL, which decreased from 16,566 in 2007.

The case management training provided to all the Lead Initiative Coordinators in 2007 was expanded and in 2008 four additional trainings were provided and were attended by 27 nurses from eight local health departments. To date, at least one nurse from 25 of Michigan's 45 total local public health departments has participated in case management training. The objective of the training is to improve each local health department's ability to define and provide comprehensive, coordinated, family-centered case management services to children with lead poisoning.

The first statewide Lead and Healthy Homes Conference was held in April 2008 with over a 180 attendees. The conference included national, state, and local experts and received very positive reviews.

During 2008, a funding formula was developed with input from the health officers representing the 10 local public health agencies that receive funding from CLPPP. This funding methodology was re-visited since it had been a period of time since such an evaluation of level of need based on current priority risk factors had been conducted. It was determined that the same 10 local public health agencies would continue to receive funding with a minimum award being provided to assure that every grantee agency has sufficient base funding for program operations. As a result of these discussions, four need factors (number of elevated blood lead levels (EBLL) greater than or equal to 20 ug/dL for children under six years of age, estimated number of children with EBLL in 2007 aged one and two years, number of pre-1950 housing units, and number of children insured by Medicaid aged one and two years in April 2008), weighted and applied equally, were identified and agency allocations were determined based on the jurisdiction's need points.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Increase the testing percentage of children enrolled in managed care to 80%			X	
2. Provided consultation to high-risk communities		X		
3. Held first statewide Lead and Healthy Homes Conference		X		
4. Testing benchmarks include a 20% increase (over previous year) in testing of one and two year olds in the target communities.			X	

5. State Prevalence rate goal is 1.0%			X	
6. Blood lead level results available on the (MCIR) to help assure appro. testing. MCIR also provides recommendations for follow-up testing and treatment as needed.				X
7. Developed and launched a new print public awareness campaign		X		
8. Assured follow-up for all children with blood lead levels at 20 ug/dL or greater			X	
9. Provided case management training to local health department staff on the revised protocol and new chart forms.				X
10.				

b. Current Activities

The statewide average for children enrolled in Medicaid tested at least one time by three years of age, including those enrolled in managed care, fee-for-service and Children's Special Health Care Services (CSHCS) dual enrolled is 72.2%.

The Childhood Lead Poisoning Prevention and Control Commission was re-established and met twice during the year. The Commission has established priorities related to testing, sustainable funding, rental property owner protections and liabilities, and housing abatement. Commission activities include the formation of subcommittees to address each of the priority issues, aligning Commission activities with MDCH work plans, and development of a mechanism to assure that lead poisoning is addressed throughout any state program that deals with housing, environment, and children.

Case management training will be offered to nurses in a few remaining areas of the state including the southwest, northeast, and northwest portion of the Lower Peninsula. These trainings will help assure that case management services, are coordinated, comprehensive, and family centered. CLPPP will continue to assure that all Michigan children with blood lead levels greater than or equal to 20 ug/dL receive appropriate and timely case management services.

CLPPP, in collaboration with CLEARCorps Detroit, will continue the LESS (Lead Education & Safety Source) LEAD Program. CLEARCorps will continue to provide a variety of primary prevention services.

c. Plan for the Coming Year

CLPPP will continue to monitor data related to elimination. Data to be monitored includes: testing rates for children under six years of age, testing rates for children one and two years of age, and prevalence of poisoning in Michigan and the 14 target communities. The testing goals for both the state and the target communities will represent a 5% increase (over 2008) in testing among children one and two years of age. The prevalence of lead poisoning for the entire state for calendar year 2009 will decrease to 0.6%. In order to achieve the goals stated above, each of the funded agencies with a target community in their jurisdiction will develop a plan to increase testing within the target community. The basis of each plan will be the MDCH Statewide Testing/Screening Plan and each plan will be detailed and specific with measureable outcomes.

A web-based training module on point of service capillary specimen collection will be developed. This training module provides step-by-step instructions for obtaining capillary lead specimens and is intended to increase the number of providers, especially those seeing a large percentage of at-risk children, who perform point of service testing.

CLPPP will further develop partnerships with other department/agencies, both internal and external, whose primary focus is young children and housing including but not limited to: Department of Human Services, Michigan State Housing Development Authority, educational

providers, and schools of social work, nursing, and medicine.

CLPPP will strengthen its collaborative efforts with key partners on primary prevention strategies. These strategies will focus on residents of pre-1950 housing in target communities, pregnant women, women of childbearing age, families with young children, and special populations.

Lastly, CLPPP will begin to explore and implement Healthy Home concepts into a variety of program components.

State Performance Measure 6: *Maternal mortality ratio in Black women*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	26.4	25.7	90	90	89
Annual Indicator	80.1	98.4	52.5	87.0	44.2
Numerator	18	22	12	19	10
Denominator	22484	22365	22873	21848	22619
Data Source					MI Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88	86	84	82	82

a. Last Year's Accomplishments
Case ascertainment methods continue to be used & contributed to ascertainment of the majority of maternal deaths in Michigan. Both pregnancy & non-pregnancy related cases were reviewed by committees with expertise regarding the causes of death under review.

2008 Recommendations:
Injury Committee
1. Develop a brief report on the pregnancy outcomes of maternal deaths that meet the criteria for surveillance that would be used as a white paper for future study and recommendations
2. Convene subcommittee to review the issues of substance abuse, domestic violence, mental health services and data collection in maternal deaths
3. Re-examine the issue and encourage Medical Examiners to conduct autopsies for all maternal deaths; Draft a letter with minimum guidelines.
4. Encourage the use of the Michigan Automated Prescription system (MAPS)

Medical Committee
1. Review a percentage of maternal cancer deaths.
2. Find and evaluate alternative funding sources for submission of a proposal for the Cardiac Disease Registry project.
3. Send information to ACOG from the Ectopic Pregnancy Maternal Mortality Study in Michigan.
   a) Access to prenatal care should be available to all women at the first sign of pregnancy, i.e., after the first missed menses or if any suspicion of pregnancy.
   b) Provide education about early pregnancy complications, such as ectopic pregnancy, to all medical providers.
   c) Screening tests for ectopic pregnancy, i.e., serial beta HCG's and vaginal ultrasounds should be available to all who provide care to women in their reproductive years.
4. Review the reporting forms for preventability, categories and data collected.
5. Identify an individual champion located in each major institution for grand rounds and create a folder with education materials related to maternal mortality.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Case ascertainment methods continue to be used				X
2. Continued work on the development and maintenance of the maternal mortality database				X
3. Developed a linked file of 1995-2001 Michigan Hospital discharge data with Michigan's residents' live births records				X
4. Publish Interdisciplinary recommendations				X
5. Distribute Annual Maternal Mortality Report				X
6. 2010 Reprints of 2007 Anesthesia Study distributed to all birthing hospitals and department directors of obstetrics and anesthesia statewide, January 2009.				
7. Recommendations from the Ectopic Pregnancy Maternal Mortality Study in Michigan presented to the ACOG Practice Committee in 2008.				
8. Michigan Automated Prescription System (MAPS) outcome data for 2006-2008 presented to the Medical and Injury Committees. Plans are underway for statewide dissemination.				
9. Linkage and correlation of the cause & effect of maternal and infant deaths and possible ways to share information between FIMRs and MMMS is being explored.				
10.				

b. Current Activities

Maternal deaths since 1999 are identified through the linked file. The overall maternal mortality rate in 2006 for MI was approximately 66 per 100,000 live births; 28 Black maternal mortality ratio of 122.4 and the maternal mortality ratio for White women was 34.5. The Black/White maternal mortality ratio for 2006 is 3.5. The new Pregnancy Seatbelt brochures were distributed state wide.

The Interdisciplinary Committee met in Oct. 2008 and Recommendations for the 2009 year were identified as stated above.

c. Plan for the Coming Year

Case reviews by the Medical Committee and by the Injury Committee as described earlier will continue. Findings from reviews will continually be entered in the MMMS database developed (mentioned in section a), thus allowing for further epidemiological studies to better understand and address the Michigan specific issues. The process of identifying recommendations will continue. Recommendations that were not acted upon will be evaluated for follow up and additional recommendations will be elicited from the Committee members. A biannual newsletter will be developed about maternal mortality in Michigan and released to increase the awareness among women's health care providers. An updated analysis of maternal morbidity by using the MIDB data set is underway. Also, the Division of Genomics, Perinatal Health and Chronic Disease Epidemiology Director has initiated the work on an annual report of women of reproductive age. The work is in progress and multiple data sources are being used to thus offer a comprehensive picture of the women's health status in Michigan. The program staff from MCH as well as chronic disease will be involved during the process leading. Besides strengthening the collaboration between epidemiology and programs, this report will also bridge the maternal child health and chronic disease areas that have more in common nowadays.

State Performance Measure 7: *Rate of breastfeeding at six months*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			35	40	20
Annual Indicator		14.6	15.8	15.8	15.3
Numerator		6345	6618	6619	6652
Denominator		43459	41890	41890	43476
Data Source					PNSS/PedNSS
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	25	30	35	40	25

a. Last Year's Accomplishments

The WIC Division offers Breastfeeding Basics (BFB), Breastfeeding Coordinator (BFC) and Milk Expression (ME) training. In FY 2007 -- 2008, 130 local agency (LA) staff and other health care providers attended BFB, 17 LA Breastfeeding Coordinators attended BFC training and 10 of those same individuals attended Milk Expression Training.

The Mother-to-Mother Program Breastfeeding Initiative (BFI) expanded and now provides breastfeeding peer support services in 38 counties.

Within the WIC Division, we worked intensively to complete the design and report elements of the new MI-WIC data system. It tracks breastfeeding promotion, support services, and education of our pregnant and lactating women and breastfeeding infants. This project will complement data collected by our partners such as MSUE/BFI and MIHP.

Michigan Breastfeeding Awareness Month (August) was celebrated with: a proclamation from the Governor; press releases for the state & local agencies; development & distribution of breastfeeding promotion displays & materials for use by the local WIC & MSUE agencies & activities such as breastfeeding walks, billboards, & rock & rest tents at local festivals.

The WIC Division continues to participate & provide leadership in a multi-state nutrition education internet project, WICHealth.org. The Breastfeeding Module developed by Michigan WIC & the local agency Breastfeeding Workgroup continues to get used by breastfeeding mothers. Feedback continues to be good.

The USDA/Loving Support Grant efforts to Build a Breastfeeding Friendly Community in Bay County continues beyond the grant funding. The Bay Area Breastfeeding Coalition is using materials purchased &/or developed through the grant to continue to educate the community. The coalition continues to meet and work with the community to promote breastfeeding as normal infant feeding. Cooperation continues between Bay Regional Medical Center, Bay County WIC & MSU Extension to provide breastfeeding nutrition education & peer support services to breastfeeding moms & dads of breastfed babies.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Breastfeeding Basics, Breastfeeding Coordinator and Milk Expression training offered				X
2. Mother-to-Mother Breastfeeding Initiative expanded to 38 counties				X
3. Completed the design and report elements of the new MI-WIC data system			X	
4. Participated and provided leadership to multi-state nutrition education internet project				X

5. Continued to support Building a Breastfeeding Friendly Community in Bay County				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
While WIC supports and promotes breastfeeding, there remain many challenges to increasing initiation and duration rates. Resources are limited, local hospital policies often run contrary to supporting breastfeeding, employers are reluctant to provide time and appropriate private space for breastfeeding moms to pump breastmilk, federal regulations and state policies prompt postpartum women on public assistance to return to work early and without regard for breastfeeding needs such as an appropriate breast pump or time and space for expressing milk, and both Medicaid and it's contracted providers breast pump policies are often inconsistent in terms of providing pumps to mothers whose infants are either in the NICU or are discharged from the NICU still unable to nurse at the breast. The expansion of peer counseling services is limited by funding.

During FY '09, WIC has continued to: provide training for local agency staff; hold joint training and conference calls for local agency WIC and MSUE staff involved in the Breastfeeding Initiative; explore new ways to provide peer counselor services; develop new breastfeeding packages for lactating women and their breastfed babies; train WIC staff on these new packages; provide breastfeeding coordinator training utilizing MI-WIC; strengthen and improve breastfeeding workgroups such as the Michigan Breastfeeding Network and local breastfeeding coalitions; and implement breastfeeding policies within WIC.

c. Plan for the Coming Year
We will continue most of the activities as described above. In addition, we will provide: another Lactation Management Specialist Course; Glow & Grow in WIC, a hands-on training to increase WIC staff's ability to support our breastfeeding clients; we will pilot a new breastfeeding peer counselor model at the local agency level and we will continue to transition our policies to reflect our newfound data recording, tracking and reporting abilities in MI-WIC.

State Performance Measure 8: *Percent of WIC-enrolled children who are overweight (BMI greater than or equal to 95th Percentile)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			12.3	12.1	12
Annual Indicator		13.2	13.2	12.4	30.1
Numerator		29252	29252	27982	29469
Denominator		221604	221604	225665	97905
Data Source					PNSS/PedNSS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29	28.5	28	27.5	27.5

Notes - 2008
The change from 2007 to 2008 is primarily due to a correction in the data reported previously. Data for prior years reflected all children in WIC, 0-5 years of age (denominator).

a. Last Year's Accomplishments
WIC-Breastfeeding-Obesity Partnership: WIC has worked with chronic disease to provide messages related to the evidence that breastfeeding in infancy decreases the incidence of obesity in later life. Local WIC nutrition educators receive information for clients related to obesity and physical activity for children. For WIC clients, the Internet Education Project, www.wichealth.org, is an alternative form of nutrition education. The site offers several topics on feeding children using Stages of Change and Division of Responsibility concepts which promote healthy parenting around meals, supporting the prevention of overweight in children. Also, a module titled "Happy, Healthy, Active Children" on the wichealth.org site is used by clients to learn how to promote physical activity in their children.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WIC worked with Chronic Disease programs to provide messages regarding the relationship between breastfeeding and obesity later in life				X
2. Provided leason plans related to obesity and physical activity for children to local WIC nutrition educators.				X
3. Provided nutrition education to clients via Internet Education Project		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Use of and continued development of nutrition education modules for wichealth.org include 16 modules currently in use (6 in Spanish). New modules are developed each year.
Continued activities as stated above.

c. Plan for the Coming Year
By October of 2009, all WIC mothers and children will have a new food package based on Institute of Medicine recommendations for foods that will help fight the obesity that occurs in the WIC participant population. This package places a stronger emphasis on breastfeeding by increasing the foods available to the breastfeeding woman-infant dyad. The package will also provide whole grain bread and cereal and a cash value benefit for fruits and vegetables.

E. Health Status Indicators

Introduction
Beginning with a Center for Healthy Infants and Pregnancy Surveillance (CHIPS) grant in the mid-1990's, Michigan has been developing epidemiological capacity in MCH. What began as one full-time MCH epidemiologist position (usually a CDC-assignee and a high turn-over rate) has now been developed into a MCH Section within the Bureau of Epidemiology. The MCH Epidemiology Section works closely with the Bureau of Family, Maternal and Child Health to translate the data into policy and strategic program plans.

Michigan has the benefit of an Executive Information System/Decision Support System and a data warehouse with multiple years of data from Medicaid, WIC, CSHCS, and Vital Records all on similar platforms. These data sets are uploaded weekly, monthly and annually to be of the greatest benefit for epidemiological studies. The warehouse provides the ability to link different data sets and thus track the impact of participation in MCH programs on a population basis. However, the use of the data sets and the linked files from the data warehouse is time consuming and it still requires guidance from the data warehouse staff sometimes.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.4	8.4	8.4	8.4	8.7
Numerator	10867	10665	10720	10550	10485
Denominator	129710	127518	127537	125172	120601
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
The denominator is based on data from the new Electronic Birth Certificate system and appears to under-represent the actual number of births in the state for 2007. Corrected data is not yet available.

Narrative:
The Bureau routinely monitors data for HSI #1A from the state's Vital Records. The rate of low birth weight has not varied over the last five years despite existing program efforts. The rate of low birth weight continues to be 2 to 3 times more likely for black babies. According to the Kids Count Right Start data, the higher the percent of Medicaid births, the higher the rate of low birth weights. Locations with over 40% Medicaid births had a LBW rate of 11.2%; areas with 20-40% Medicaid births had a rate of 8.0%; and areas with less than 20% Medicaid births had a rate of 7.1%.

Low birth weight is more common in women giving birth in their teens and women who are over 40 years of age, in women who are not married, women with less than 12 years of education, women who receive inadequate prenatal care, women who smoke or drink alcohol, and in multiple births. Preterm births also impact the low birth weight rate. Preterm births are less affected by younger age in black women and are less prevalent in women with more education, more prenatal care, women who don't smoke or drink alcohol and in singleton births. Although the

preterm births have declined from 10.8% in 1999 to 10.0 in 2008, the rate of low birth weight has not changed.

Despite much programming effort, the racial disparity remains for low birth weight in 2006 (Black -- 14.3%; White 7.2%). In 2006, 9.6% of babies were born prior to 37 weeks gestation. The introduction of preconception care for all childbearing age women offers the best hope for improving the risks for low birth weight and preterm births. This remains a challenge for health care systems across the state to fund such services in the current economic climate. See also narrative discussion of NPM #17 and 18 and SPM #2 and 3.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	6.4	6.5	6.5	6.3	6.9
Numerator	7985	7941	7987	7905	7987
Denominator	124911	122970	122796	125172	116280
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
The denominator is based on data from the new Electronic Birth Certificate system and appears to under-represent the actual number of births in the state for 2007. Corrected data is not yet available.

Narrative:
The Bureau routinely monitors data for this indicator from the state's Vital Records. The rate of low birth weight has not varied over the last five years despite existing program efforts. The rate of low birth weight continues to be 2 to 3 times more likely for black babies. According to the Kids Count Right Start data, the higher the percent of Medicaid births, the higher the rate of low birth weights. Locations with over 40% Medicaid births had a LBW rate of 11.2%; areas with 20-40% Medicaid births had a rate of 8.0%; and areas with less than 20% Medicaid births had a rate of 7.1%.

Low birth weight is more common in women giving birth in their teens and women who are over 40 years of age, in women who are not married, women with less than 12 years of education, women who receive inadequate prenatal care, women who smoke or drink alcohol, and in multiple births. Preterm births also impact the low birth weight rate. Preterm births are less affected by younger age in black women and are less prevalent in women with more education, more prenatal care, women who don't smoke or drink alcohol and in singleton births. Although the preterm births have declined from 10.8% in 1999 to 10.0 in 2008, the rate of low birth weight has not changed.

Despite much programming effort, the racial disparity remains for low birth weight in 2006 (Black -- 14.3%; White 7.2%). In 2006, 9.6% of babies were born prior to 37 weeks gestation. The introduction of preconception care for all childbearing age women offers the best hope for improving the risks for low birth weight and preterm births. This remains a challenge for health

care systems across the state to fund such services in the current economic climate. See also narrative discussion of NPM #17 and 18 and SPM #2 and 3.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.7	1.7	1.6	1.7	1.8
Numerator	2148	2140	2090	2147	2183
Denominator	129710	127518	127537	125172	120601
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
The denominator is based on data from the new Electronic Birth Certificate system and appears to under-represent the actual number of births in the state for 2007. Corrected data is not yet available.

Narrative:
The Bureau routinely monitors data for this indicator from the state's Vital Records. The rate of low birth weight has not varied over the last five years despite existing program efforts. The rate of low birth weight continues to be 2 to 3 times more likely for black babies. According to the Kids Count Right Start data, the higher the percent of Medicaid births, the higher the rate of low birth weights. Locations with over 40% Medicaid births had a LBW rate of 11.2%; areas with 20-40% Medicaid births had a rate of 8.0%; and areas with less than 20% Medicaid births had a rate of 7.1%.

Low birth weight is more common in women giving birth in their teens and women who are over 40 years of age, in women who are not married, women with less than 12 years of education, women who receive inadequate prenatal care, women who smoke or drink alcohol, and in multiple births. Preterm births also impact the low birth weight rate. Preterm births are less affected by younger age in black women and are less prevalent in women with more education, more prenatal care, women who don't smoke or drink alcohol and in singleton births. Although the preterm births have declined from 10.8% in 1999 to 10.0 in 2008, the rate of low birth weight has not changed.

Despite much programming effort, the racial disparity remains for low birth weight in 2006 (Black -- 14.3%; White 7.2%). In 2006, 9.6% of babies were born prior to 37 weeks gestation. The introduction of preconception care for all childbearing age women offers the best hope for improving the risks for low birth weight and preterm births. This remains a challenge for health care systems across the state to fund such services in the current economic climate. See also narrative discussion of NPM #17 and 18 and SPM #2 and 3.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	1.2	1.2	1.2	1.2	1.4
Numerator	1482	1521	1508	1550	1678
Denominator	124911	122970	122796	125172	116280
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
The denominator is based on data from the new Electronic Birth Certificate system and appears to under-represent the actual number of births in the state for 2007. Corrected data is not yet available.

Narrative:
The Bureau routinely monitors data for this indicator from the state's Vital Records. The rate of low birth weight has not varied over the last five years despite existing program efforts. The rate of low birth weight continues to be 2 to 3 times more likely for black babies. According to the Kids Count Right Start data, the higher the percent of Medicaid births, the higher the rate of low birth weights. Locations with over 40% Medicaid births had a LBW rate of 11.2%; areas with 20-40% Medicaid births had a rate of 8.0%; and areas with less than 20% Medicaid births had a rate of 7.1%.

Low birth weight is more common in women giving birth in their teens and women who are over 40 years of age, in women who are not married, women with less than 12 years of education, women who receive inadequate prenatal care, women who smoke or drink alcohol, and in multiple births. Preterm births also impact the low birth weight rate. Preterm births are less affected by younger age in black women and are less prevalent in women with more education, more prenatal care, women who don't smoke or drink alcohol and in singleton births. Although the preterm births have declined from 10.8% in 1999 to 10.0 in 2008, the rate of low birth weight has not changed.

Despite much programming effort, the racial disparity remains for low birth weight in 2006 (Black -- 14.3%; White 7.2%). In 2006, 9.6% of babies were born prior to 37 weeks gestation. The introduction of preconception care for all childbearing age women offers the best hope for improving the risks for low birth weight and preterm births. This remains a challenge for health care systems across the state to fund such services in the current economic climate. See also narrative discussion of NPM #17 and 18 and SPM #2 and 3.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	9.1	9.3	8.8	9.1	9.5
Numerator	191	192	178	184	184
Denominator	2088878	2066272	2019667	2019667	1945927
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
We don't have population estimates for 2007 so 2006 data were used for denominator.

Narrative:
Unintentional injuries are the leading cause of death for children ages 1-14 in Michigan. Motor vehicle traffic crashes are the most common cause of unintentional injury death to this age group; fire/burn was the second leading cause of death; and drowning was the third leading cause of death. Although unintentional injury death rates for Michigan and U.S. children were nearly equivalent during 1999-2005, rates for Michigan Hispanic and African-American children exceeded their national counterparts by 26% and 15%, respectively. During this period in Michigan, the death rate for African-American children due to fires was nearly four times the rate for white children. Boys have higher drowning rates than girls and for both sexes the highest rates are among ages 1-4 years.
MDCH is addressing this issue by providing leadership, training, public education, data collection and analysis, funding support and technical assistance related to the leading cause of injuries. A Child Passenger Safety (CPS) strategic planning process was coordinated by MDCH, resulting in a five-year plan. The Department is expanding its CPS program to include injury prevention activities directed toward the 9-18 year-old population. See also NPM #10.
Safe Kids Worldwide is a non-profit organization with the mission of preventing accidental injury to children age 14 and under. MDCH is the lead agency for Safe Kids in Michigan, a state coalition comprised of local coalitions and chapters. Currently, there are 22 local Safe Kids coalitions and chapters that address major risk areas for children (motor vehicle crashes, bicycle-related injuries, pedestrian injuries, fire/burn injuries, drowning, scald burns, poisoning, choking and falls).
See also NPM #10

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	3.5	3.1	2.5	2.6	2.3
Numerator	73	65	50	52	44
Denominator	2088878	2066272	2019667	2019667	1945927
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
We don't have population estimates for 2007 so 2006 data were used for denominator.

Narrative:
Data are from Michigan Vital Records. The data reflects legal and policy changes over the past five years requiring appropriate car seats and booster seats and training and public education programs on the proper installation and use of safety seats.

MDCH continued to lead the program for child passenger safety (CPS) training & public education. MDCH coordinated & conducted the Nationally Standardized CPS Technician Certification Course for healthcare providers (HCP), law enforcement and fire fighters to certify them as CPS Technicians (CPST). CPST conducted public events to provide education on restraint use. MDCH also coordinated the CPS Instructor Team. MDCH provided technical assistance to the public & direction to fitting stations that provide a specific time/place where parents can have a car seat inspected. In conjunction with the Michigan State Police (MSP) Office of Highway Safety Planning, MDCH developed an educational campaign and materials on Michigan's new booster seat law in effect July 1, 2008. The materials are available through the MSP distribution center.

See also discussion of NPM #10.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	21.9	17.5	17.1	19.1	19.5
Numerator	316	254	247	276	276
Denominator	1441132	1447779	1441512	1441512	1418751
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
We don't have population estimates for 2007 so 2006 data were used as denominator.

Narrative:
Three out of five accidental deaths for teenagers and young adults (15-24) are due to motor vehicle crashes. Of the 1,558 drivers involved in fatal crashes in 2007, 13.4% were under 21 years of age and 23.4% of all drivers involved in fatal crashes were under 25 years of age. Licensed drivers age 18 have the highest crash rate. Of those killed in traffic crashes, the majority were male. Of those injured in traffic crashes in 2007, the majority were female. The trend for motor vehicle deaths has improved since 1996; by 2006, the age-adjusted death rate had decreased by 31%.

Responsibility for the injury prevention program is outside of the MCH program; the Division of Chronic Disease and Injury Control provides leadership, training, public education, data collection and analysis, funding support and technical assistance related to the leading causes of injuries.

With statewide stakeholders, several injury prevention plans have been developed over the past few years addressing key injury issues in Michigan. One such plan is the Michigan Plan for Injury Prevention which contains recommendations to build the core capacity of the state injury program as well as impact the top four priority causes of injury in Michigan (motor vehicle crashes, firearms, falls and poisonings).

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	210.9	209.7	196.4	269.4	279.6
Numerator	4405	4341	3966	5440	5440
Denominator	2088878	2069997	2019667	2019667	1945927
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
We don't have either hospital discharge data or population estimates for 2007. We used 2006 population data as denominator and calculated the numerator for an annual indicator of 210 based on the prior years.

Narrative:
Unintentional injuries are the leading cause of death for children ages 1-14 in Michigan. Motor vehicle traffic crashes are the most common cause of unintentional injury death to this age group; fire/burn was the second leading cause of death; and drowning was the third leading cause of death. Although unintentional injury death rates for Michigan and U.S. children were nearly equivalent during 1999-2005, rates for Michigan Hispanic and African-American children exceeded their national counterparts by 26% and 15%, respectively. During this period in Michigan, the death rate for African-American children due to fires was nearly four times the rate for white children. Boys have higher drowning rates than girls and for both sexes the highest rates are among ages 1-4 years.

Except for newborns and neonates, injury and poisoning was the leading diagnoses for hospitalization for children under 18 years of age. According to the Michigan Child Health and Safety Risk Survey, 2001, conducted by the Office for Survey Research at the Institute for Public Policy and Social Research, Michigan State University, 14.3 %of children aged 1-14 years reported an injury during the previous 12 months that limited the child's activities for at least one day or that required medical attention. Children aged 10-14 years had the highest rate of injury (25.4%) among children ages 1-14 years. Falls and supervised sports were the leading causes of injury.

MDCH is addressing unintentional injuries by providing leadership, training, public education, data collection and analysis, funding support and technical assistance related to the leading cause of injuries. A Child Passenger Safety (CPS) strategic planning process was coordinated by

MDCH, resulting in a five-year plan. The Department is expanding its CPS program to include injury prevention activities directed toward the 9-18 year-old population. See also NPM #10.

Safe Kids Worldwide is a non-profit organization with the mission of preventing accidental injury to children age 14 and under. MDCH is the lead agency for Safe Kids in Michigan, a state coalition comprised of local coalitions and chapters. Currently, there are 22 local Safe Kids coalitions and chapters that address major risk areas for children (motor vehicle crashes, bicycle-related injuries, pedestrian injuries, fire/burn injuries, drowning, scald burns, poisoning, choking and falls).

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	27.1	25.2	12.1	18.8	18.8
Numerator	566	522	245	379	379
Denominator	2088878	2069997	2019667	2019667	2019667
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
We don't have hospital discharge data nor the population estimates for 2007. Therefore we decided to just use as preliminary info the 2006 data as the trends are not linear and thus any estimates may not be accurate. Furthermore, the annual indicator for 2006 is more than 50% lower compared to 2005.

Narrative:
According to the Michigan Child Health and Safety Risk Survey (2001), auto accidents are the third leading cause of hospitalization of children aged 1-14 (4.1%), after falls and supervised sports.

The Chronic Disease and Injury Control Program is responsible for activities addressing unintentional injuries and is administratively located outside of the MCH program.

The main goal of the MDCH Child Passenger Safety (CPS) program is to conduct activities recommended in the five-year state CPS Strategic Plan that will supplement, enhance, and expand current CPS programs in Michigan. These activities include CPS training, child safety seat check up events, dissemination of educational materials for parents and caregivers, and coordinating and compiling pertinent information on child safety seat advocates and resources. MDCH continues to provide technical assistance and award car seats to Michigan hospitals that adopt or strengthen CPS hospital discharge policies. MDCH will continues to coordinate and conduct the Nationally Standardized CPS Technician Certification Course for healthcare providers (HCP) and law enforcement to certify them as CPS Technicians (CPST). MDCH continues to coordinate the Michigan CPS Instructor Network and provides funding for Instructors

to conduct the CPS in EMS and CPS in Buses courses in their local communities.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	129.7	112.0	92.7	117.4	117.4
Numerator	1872	1622	1337	1693	1693
Denominator	1443173	1447759	1441512	1441512	1441512
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007
We don't have hospital discharge data nor population estimates for 2007. The annual indicator for 2006 is lower comapred to 2005 and the trend is not linear. Therefore, we decided to use 2006 data as very preliminary for 2007.

Narrative:
Unintentional injuries are the leading cause of death to Michigan residents who are at least one year of age but under age 35. Motor vehicle traffic crashes are the most common cause of unintentional injury deaths.

Three out of five accidental deaths for teenagers and young adults (15-24) are due to motor vehicle crashes. Of the 1,558 drivers involved in fatal crashes in 2007, 13.4% were under 21 years of age and 23.4% of all drivers involved in fatal crashes were under 25 years of age. Licensed drivers age 18 have the highest crash rate. Of those killed in traffic crashes, the majority were male. Of those injured in traffic crashes in 2007, the majority were female. The trend for motor vehicle deaths has improved since 1996; by 2006, the age-adjusted death rate had decreased by 31%.

21.5% of all bicycle crashes and 20.4% of all pedestrian crashes were to persons age 16-24.

Responsibility for the injury prevention program is outside of the MCH program; the Division of Chronic Disease and Injury Control provides leadership, training, public education, data collection and analysis, funding support and technical assistance related to the leading causes of injuries. With statewide stakeholders, several injury prevention plans have been developed over the past few years addressing key injury issues in Michigan. One such plan is the Michigan Plan for Injury Prevention which contains recommendations to build the core capacity of the state injury program as well as impact the top four priority causes of injury in Michigan (motor vehicle crashes, firearms, falls and poisonings).

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	33.4	34.6	33.8	45.8	44.6
Numerator	11984	12403	12305	16769	16122
Denominator	358671	358671	363674	366257	361443
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
Data are from the Michigan Sexually Transmitted Diseases Database and are monitored by the Bureau of Epidemiology and Laboratories. The total 4-year average rates increased 38% from 1998-2002 to 2003-2007. These increases follow national trends. Almost half (44.3%) of the cases in 2008 were in Wayne County, including Detroit.

The highest rates of chlamydia are found among the 15-19 and 20-24 year old age cohorts. The rates are highest among women in this age range, especially black women. The rate among blacks is 9.6 times higher than that of whites. The rate among black women is eight times higher than for white women. The overall rate among women is 3.2 times higher than in men, largely due to targeted screening towards females.

MDCH participates in the National Infertility Prevention Project (IPP) which targets adolescents and young adults (15-24 year olds). The IPP provides chlamydia screening in STD and family planning clinics, as well as school-based clinics, juvenile detention centers, and alternative adolescent sites, such as runaway shelters and alternative schools. Increased screening is encouraged as part of local health department reviews, Health Plan Employer Data and Information Set (HEDIS) reports, and IPP program evaluation. The Family Planning program in the Bureau of Family, Maternal and Child Health coordinates planning and services with the Communicable Disease programs in the Bureau of Epidemiology.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	11.2	9.6	9.1	13.6	11.0
Numerator	19570	16831	15681	23095	17970
Denominator	1754267	1754267	1730557	1696896	1640831
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:
Data are from the Michigan Sexually Transmitted Diseases Database and are monitored by the Bureau of Epidemiology and Laboratories. The total 4-year average rates increased 38% from 1998-2002 to 2003-2007. These increases follow national trends. Almost half (44.3%) of the cases in 2008 were in Wayne County, including Detroit.

The highest rates of chlamydia are found among the 15-19 and 20-24 year old age cohorts. The rates are highest among women in this age range, especially black women. The rate among blacks is 9.6 times higher than that of whites. The rate among black women is eight times higher than for white women. The overall rate among women is 3.2 times higher than in men, largely due to targeted screening towards females.

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Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	127680	94225	23546	996	3643	71	5199	0
Children 1 through 4	497846	378474	83654	3433	14854	418	17013	0
Children 5 through 9	641124	492969	104904	4069	17812	478	20892	0
Children 10 through 14	679277	519669	117631	4754	16491	304	20428	0
Children 15 through 19	739588	566862	135831	5408	14852	292	16343	0
Children 20 through 24	679163	541472	103835	5330	15524	276	12726	0
Children 0 through 24	3364678	2593671	569401	23990	83176	1839	92601	0

Notes - 2010

Narrative:
The population of children 0-24 years of age decreased by 4.6% from 2004 to 2008, reflecting the declining birth rate. Decreases were noted in all racial categories and in all age groups except the 15-19 age group.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	118048	9632	0
Children 1 through 4	459363	38483	0
Children 5 through 9	597315	43809	0
Children 10 through 14	640269	39008	0
Children 15 through 19	703808	35780	0
Children 20 through 24	646343	32820	0
Children 0 through 24	3165146	199532	0

Notes - 2010

Narrative:
The Hispanic population increased as a proportion of the total population 0-24 years by 13.3%. Increases were noted in all age groups except 20-24 years.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	144	35	95	1	2	0	1	10
Women 15 through 17	3629	1774	1597	21	16	1	129	91
Women 18 through 19	8319	4938	2859	60	52	2	263	145
Women 20 through 34	92568	70508	15354	392	3095	32	1624	1563
Women 35 or older	15935	12462	2148	57	793	6	220	249
Women of all ages	120595	89717	22053	531	3958	41	2237	2058

Notes - 2010

Narrative:
The number of live births continued to decline in 2008. From 2000 to 2008, the total number of live births decreased by 11.7%. Decreases were in all race categories, but some differences are due to changes in reporting between race categories. The largest decrease was in live births to mothers less than 15 years of age (31.4%). Programs addressing unintended pregnancy and teen pregnancy in particular include the Michigan Abstinence Program, the Title X Family Planning program and school-based/linked child and adolescent health centers. See also National Performance Measure #08 and State Performance Measure #4.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	125	19	0
Women 15 through 17	3139	477	13
Women 18 through 19	7507	764	48
Women 20 through 34	85665	6448	455
Women 35 or older	14931	945	59
Women of all ages	111367	8653	575

Notes - 2010

Narrative:
Whilte the total number of live births declined again in 2008, the number of births to Hispanic mothers increased by more than 11% from 2004 to 2008. Increases were in all age categories except in Hispanic mothers less than 15 years of age. Programs addressing teen pregnancy include the Michigan Abstinence Program, Title X Family Planning program and school-based/linked child and adolescent health centers. See also National Performance Measure #08 and State Performance Measure #4.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	880	483	332	6	15	2	0	42
Children 1 through 4	125	77	41	2	1	0	0	4
Children 5 through 9	62	48	10	1	1	0	0	2
Children 10 through 14	114	67	43	0	2	0	0	2
Children 15 through 19	384	244	124	7	3	0	0	6
Children 20 through 24	574	380	176	4	5	0	0	9
Children 0 through 24	2139	1299	726	20	27	2	0	65

Notes - 2010

Narrative:
From 2004 to 2008, the total number of deaths to children 0-24 years of age declined by 9%. The number of deaths decreased for white, Black, Native Hawaiian/Other Pacific Islander and Other/Unknown, but increased for American Indian and Asians. Deaths to Black children accounted for 33.9% of total deaths, while the population of Black children represented only 16.9% of the population 0-24 years of age. By comparison, white children were 77.1% of the population 0-24 years but accounted for only 60.7% of the deaths.

The leading causes of death by age group were: under age 1 - Conditions originating in the perinatal period and congenital malformations; 1-4 years - accidents and congenital malformations; 5-14 years - accidents and cancer; 15-24 years - accidents and intentional injuries (homicide and suicide). Programs addressing these causes are: for under age 1 - see National Performance Measures #01, 08, 17, 18 and State Performance Measure #2, 3 and 4; for 1-4 years - see NPM #01 and 10; for 5-15 years - see NPM #10; and for 15-24 years - see NPM #10 and 16.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	798	74	8
Children 1 through 4	119	6	0
Children 5 through 9	56	5	1
Children 10 through 14	107	7	0
Children 15 through 19	369	15	0
Children 20 through 24	560	14	0
Children 0 through 24	2009	121	9

Notes - 2010

Narrative:
Deaths to Hispanic children 0-24 years increased by 28.7%, mostly in children under one year of age. Hispanic children represented 5.9% of the population 0-24 years of age, and experienced 5.7% of the deaths in that age group.

See discussion under National Performance Measures #01, 08, 10, 16, 17 and 18 and State Performance Measures #2, 3, and 4.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**

All children 0 through 19	2685515	2052199	465566	18660	67652	1563	79875	0	2008
Percent in household headed by single parent	16.6	13.2	37.4	24.7	9.2	17.2	25.2	28.2	2007
Percent in TANF (Grant) families	5.5	2.2	19.5	3.0	0.0	0.0	0.0	6.1	2008
Number enrolled in Medicaid	1081824	615391	360557	5991	0	0	0	99885	2008
Number enrolled in SCHIP	50476	37611	5697	613	0	0	0	6555	2008
Number living in foster home care	18396	9260	8771	218	36	33	0	78	2008
Number enrolled in food stamp program	566391	283724	239311	2815	0	0	0	40541	2008
Number enrolled in WIC	237338	125298	62781	787	3649	0	11739	33084	2008
Rate (per 100,000) of juvenile crime arrests	1212.4	981.0	2479.5	496.2	258.7	0.0	0.0	858.2	2007
Percentage of high school drop-outs (grade 9 through 12)	15.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2007

Notes - 2010
For the first time, the graduation rate is based on a four-year cohort graduation rate, in compliance with the No Child Left Behind (NCLB) Act of 2001.

Narrative:
According to the US Bureau of Census, the population of children 0-19 in Michigan continued to decline in 2008. Over the past five years, the total number has declined by 4.9%; the largest declines were in the black and American Indian populations.

According to program data from the Michigan Department of Human Services, the number of children in families receiving some public assistance increased from 2007 to 2008, reflecting the state of Michigan's economy. The WIC caseload is also increasing. According to the American Community Survey 2005-2007 3-year Estimates, the poverty rate for children under 18 years was 18.9%.

The rate of juvenile arrests increased from 1095.5 in 2006 to 1212.4 in 2007. The Departments of Human Services and State Police implement programming to address juvenile crime.

Due to a change in reporting methodology, it is not possible to compare previous year dropout rates to 2007 (see note). The Department of Education implements programs to address the dropout rate in accordance with No Child Left Behind requirements.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	2518776	166739	0	2008
Percent in household headed by single parent	73.1	26.9	0.0	2007
Percent in TANF (Grant) families	94.7	5.3	0.0	2008
Number enrolled in Medicaid	1011463	70361	0	2008
Number enrolled in SCHIP	49121	1355	0	2008
Number living in foster home care	17193	991	212	2008
Number enrolled in food stamp program	531394	34700	297	2008
Number enrolled in WIC	204254	33084	0	2008
Rate (per 100,000) of juvenile crime arrests	1261.7	504.3	0.0	2007
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	15.1	2007

Notes - 2010

Narrative:
According to the US Census Bureau, the Hispanic population of children in Michigan has increased 7.6% between 2004 and 2008.

The number of children receiving some form of public assistance and WIC services are increasing, reflecting the current economic situation in Michigan.

Juvenile arrests of children of Hispanic ethnicity declined from 2006 to 2007.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	2228977
Living in urban areas	1987281
Living in rural areas	698234
Living in frontier areas	0
Total - all children 0 through 19	2685515

Notes - 2010

Narrative:
According to the U.S. Census Bureau, the distribution of the population among metropolitan, urban and rural areas in Michigan has remained stable since the 2000 census.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	10003422.0
Percent Below: 50% of poverty	4.5
100% of poverty	10.9
200% of poverty	28.3

Notes - 2010

Narrative:
According to the U.S. Census Bureau, the percent of the total population below 50% of poverty declined by 25% from 2006 to 2007; the percent of population below 100% of FPL declined by 19.3%; and the percent of the population below 200% of FPL declined only slightly from 29.0 to 28.3. However, these figures do not reflect Michigan's current economic situation with the highest unemployment rate in the country and the crisis in the auto industry.

The number of persons receiving some form of public assistance for the period October 2008 to April 2009 averaged 2,034,800, or 20.3% of the population.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	2685515.0
Percent Below: 50% of poverty	6.6
100% of poverty	15.9
200% of poverty	37.3

Notes - 2010

Narrative:
According to the U.S. Census Bureau, the percentage of children below 50% of poverty fell by 22.4% from 2006 to 2007 and the percentage of children below 100% of FPL fell by 13.1% over 2006 rate. The percent of children in families with income below 200% increased slightly from 37.0 in 2006 to 37.3 in 2007. These rates can be expected to increase given Michigan's current economic climate.

F. Other Program Activities

The Department of Community Health provides a toll-free hotline for pregnant women (1-800-26-BIRTH and 961-BABY in Detroit-Metro area) and for children with special health care needs (1-800-359-DSCC; T.D.D. #1-800-788-7889). 1-800-26-BIRTH is the primary source of information about health care services available under Titles V and XIX and WIC. This line includes information on immunizations and referral to local health departments and other providers for service. All numbers are coordinated interdepartmentally both at the state and local level. /2008/ The Family Phone Line no longer uses a T.D.D. number. The Family Phone Line uses Michigan

Relay. //2008//

1-800-26-BIRTH is staffed by health or social service professionals to answer both information as well as crisis calls of pregnant women and parents. The staff are updated, quarterly, on the availability of services, eligibility requirements, and contact persons for local prenatal care and WIC providers and assist the client in identifying these and other providers in the client's community. Counselors are trained to respond to a broad range of health care needs. The hotline is marketed by local and state agencies through pamphlets, posters and public service announcements. Several times a year a flyer describing this service is mailed with every Medicaid identification card to each recipient and in AFDC warrants. In FY 2004, 7,730 calls were handled by the 1-800-26-BIRTH hotline.
/2007/In 2005, 7,322 calls were handled by the hotline.//2007//
/2008/In FY 2006, 7,100 calls were handled by the 1-800-26BIRTH hotline.//2008//
/2010/ FY 2008, 6244 calls were handled by the 1-800-26BIRTH Hotline.//2010//

The Children's Special Health Care Services Family Phone line, operated out of the Parent Participation Program (PPP), is a toll free number for families to communicate with CSHCS staff (at state and local levels), other agencies serving children with special needs (e.g.; genetics counseling centers, newborn screening), providers and other families. The Family Phone Line can be used to: obtain general information about CSHCS, contact the Family Support Network, resolve problems related to CSHCS, contact the Michigan SIDS Center for support services or information, and ascertain the status of their application or renewal paperwork. This number is used to refer families to local health departments. The number is also publicized at local parent group meetings, CSHCS presentations throughout the state, and is included in the CSHCS brochure, Family Support Network brochure, and the newborn hearing brochure. PPP published a new Family Guide of CSHCS which also includes the toll free number. Family Phone Line calls are compiled and analyzed by PPP quarterly to determine areas of special concern to families and to identify needed policy or procedural changes. In 2004, there were 31,934 calls handled by the Family Phone Line. /2007/ In 2005, there were 31,053 calls handled by the Family Phone Line.//2007// /2008/ In 2006, there were 22,856 calls handled by the Family Phone Line. //2008// /2009/ In 2007, there were 17928 calls handled by the Family Phone Line. //2009// ***/2010/ In 2008 21,441 calls were handled by the Family Phone Line. //2010//***

The Count Your Smiles Survey was conducted in Fall 2005 to determine sealant placement rates and oral disease prevalence in third grade children in Michigan. A statistical sampling included 65 schools and approximately 3,000 children. This was the first survey done in Michigan to provide accurate disease prevalence information for this age group. The survey followed the format of the Basic Screening Survey, a national survey developed by the Association of State and Territorial Dental Directors. The Michigan Department of Community Health Oral Health Program and the Department of Environmental Quality (Water) collaborate to promote community water fluoridation. This collaboration has proven success as demonstrated by the reestablishment of community water fluoridation in an additional 3 communities within the state. /2008/The Michigan Department of Community Health/Oral Health program utilized the data from the 2006 Basic Screening Survey titled "Count Your Smiles" of 3rd grade children in Michigan to gain administrative support to develop a state-wide dental sealant program for 2nd grade high risk children. Beginning October 1, 2007, the Seal! Michigan program will begin.//2008//

/2010/ The second Count Your Smiles Survey will be conducted in 2009-2010 to determine sealant placement rates and oral disease prevalence in third grade children in Michigan. A statistical sampling will include approximately 78 schools and approximately 3,000 children. The first survey was conducted in 2005 to provide accurate disease prevalence information for this age group. The survey will follow the format of the Basic Screening Survey, a national survey developed by the Association of State and Territorial Dental Directors. The Michigan Department of Community Health Oral Health Program and the Department of Environmental Quality (Water) collaborate to promote community water fluoridation. This collaboration has proven success as demonstrated by the

reestablishment of community water fluoridation in an additional 3 communities within the state.//2010//

G. Technical Assistance

The MDCH Public Health Administration/Bureau of Family, Maternal and Child Health is working with the University of Michigan Prevention Research Center to develop a summit meeting focusing on infant mortality issues. This one-day summit is tentatively scheduled for Spring of 2008. Technical assistance would be desirable with securing expert speakers and small group facilitators for the meeting. Some possible speakers are David Williams, Harvard University Norman Professor of Public Health, and Michael Lu, MD, MPH, UCLA Center for Healthier Children, Families and Communities.

Technical assistance is also requested to identify evidence-based models working with pregnant and post-partum women with depression. In the course of re-designing the Maternal and Infant Health Program, maternal depression was an issue identified as needing specific attention. Assistance is needed with identification of best practice models that could be employed by the program to address maternal depression.

Michigan is studying the possibility of re-instituting a perinatal regionalization system as one means of addressing the state's high infant mortality rate and disparity between the white and black IM rates. We would like to identify regional perinatal models that other states have implemented to address their infant mortality and access to care issues.

/2009/The Infant Mortality Summit meeting was held on May 5, 2008 in Lansing. Dr. Michael Lu was our keynote speaker. The MCH Bureau assisted with the cost of the meeting, along with Blue Cross Blue Shield of Michigan, Genesee REACH Project, and the W. K. Kellogg Foundation.

This year's technical assistance request is for assistance with the organization and facilitation of the public input process for the 2010 Needs Assessment.//2009//

/2010/The 2011 needs assessment process has begun with a general survey of a broad group of stakeholders regarding priorities in MCH. Information from this survey will be used to develop specific questions for focus groups around the state. Technical assistance is requested to help with the design of the focus group format and with the collection and analysis of the information gained from the focus group sessions.//2010//

V. Budget Narrative

A. Expenditures

On Form 3 line 3, Form 4 line I.d and Form 5 line II, Expenditures in 2004 reflect the increased caseload and expenditures for Medical Care and Treatment for Children with Special Health Care Needs.

An increase in expenditures for 2004 is due to increased fees approved for Newborn Screening to fund the updated technology and additional tests and increased formula rebate in the WIC program (form 3 line 6, Form 4 line I.b, and Form 5 line III).

On Form 4, the decrease from the budgeted amount to the expended amount in 2004 for Children 1 to 22 years old is due to the transfer of funds for the MOMS program to the Medical Services Administration (prenatal services for low-income women who do not qualify for Medicaid). Also on Form 4, the difference between Budgeted and Expended amounts for "Others" reflects the difference between the draft appropriations bill and the final actual appropriations. /2007/The major difference between budget and expenditures for 2005 is in the CSHCS program. Medical care and treatment costs can vary significantly from estimates based on fluctuations in types and amount of services required by recipients.//2007//

/2008/FY 2006 expenditures were, for the most part, close to budget estimates. Collections in the CSHCS Trust Fund were below estimates (Form 3, Line 5). Expenditures from the federal allocation (Form 3 , Line 1) were close to the state's final allocation, as opposed to the appropriated level. The difference between budgeted and expenditure levels for "Others" (Form 4, Line I.e) is in Pregnancy Prevention ($800,000) and Family Planning ($500,000) services. The budget estimates were high in relation to final appropriations.//2008//

/2009/Expenditures in FY 2007 reflect funding shifts from state funds to other sources, where appropriate (most significantly Title XIX), reduction in contributions to the Children's Trust Fund (Form 3, line 5), cuts in programs receiving Healthy Michigan Funds, and reduction in WIC Infant Formula Rebate due to negotiation of a new vendor contract. The funding shifts are also reflected on Form 4 (CSHCS) and Form 5 (Direct Health Care Services). The change in WIC formula rebate is reflected on Form 4 (Infant <1 year old) and Form 5 (Enabling Services). Reductions shown on Form 4, line I.e and Form 5, line II include reductions in the Family Planning and Pregnancy Prevention programs. Due to state fiscal problems in FY '07, Healthy Michigan funds (tobacco tax) was cut for the following programs: Dental Health, Family Planning, Local MCH grants, Pregnancy Prevention, Lead Poisoning Prevention, Infant Mortality-Nurse Family Partnership, and Early Hearing Detection and Screening. Most of the cuts were absorbed through unspent or unallocated funds. Some small reductions in local programs were made in Dental Health and Local MCH grants with across-the-board reductions. Unspent funds covered reductions in Family Planning (chlamydia testing savings and other unallocated funds), Pregnancy Prevention (colposcopy and sterilization savings), Early Hearing Detection, and Infant Mortality (Nurse Family Partnership project did not start as planned). Special project contracts were reduced in Lead Poisoning Prevention. For the most part, local agency services were maintained.//2009//

/2010/In 2008, expenditures for CSHCS Medical Care and Treatment exceeded the amount projected in the budget by approximately $8.6 million. (See Form 3, Line 3; Form 4, line I.d; and Form 5, line I). Increases in the WIC Infant Formula Rebate and Newborn Screening fees are reflected on Form 3, Program Income; Form 4, line I.b; and Form 5, line II. The difference between the budgeted figure and expenditures for Other Funds on Form 3 is due to decreased contributions to the Children's Trust Fund. On Form 4, the difference between the budgeted figure and expenditures for "Others" (line I, e) reflects cuts in the Pregnancy Prevention and Family Planning programs.//2010//

B. Budget

In FY ‘89, the maintenance of effort amount was $13,507,900. This amount represented state funds spent for Children with Special Health Care Needs, family planning, adolescent health, local MCH programs, and WIC.

The projected match for FY ‘06 is $38,993,900. In addition to state general fund monies, the federal-state block grant partnership includes program income from the WIC and newborn screening programs, and Children's Trust Fund monies supporting the CSHCS program.

Other funding sources that contribute to our MCH priorities include Medicaid (not included in this partnership agrement), Abstinence Education, WIC, Ryan White funding, Title X of the Public Health Service Act, and other grants from CDC and HRSA.

On Form 3 line 3 and Form 4 line I.d, the budget amount for 2006 reflects the increase in caseload and funding for Medical Care and Treatment and the elimination of services for adults in CSHCS (hemophilia and cystic fibrosis) as contained in the Executive Budget. On Form 3 line 6, the increase in Program Income includes additional funding from the WIC formula rebate and an increase in fees for newborn screening. On Form 4 line I.c, the 2006 budget reflects the transfer of the MOMS program (prenatal care services for women who do not qualify for Medicaid) to the Medical Services Administration. Finally, on Form 5 line III, the 2006 budget figure includes the increases in WIC formula rebate and newborn screening fees.
/2007/The budget for FY 2007 reflects the decrease in federal allocation to Michigan and the exhaustion of federal carryforward funds (Form 3).//2007//
/2008/The budget for Children's Special Health Care Services for 2008 (Form 4) reflects the estimated actual expenditures for Medical Care and Treatment in FY 2007, a reduction of approximately $8,000,000. These expenditures can vary widely, depending on claims submitted by providers. The budget change is also reflected on Form 3, Line 3 and Form 5, Line I. The budget for Infants on Form 4 (also Form 3, Line 6 and Form 5, Line II) reflects the re-negotiated WIC formula rebate amount with Mead Johnson. This change was effective October 2006. At this point in time, the state budget for FY 2008 is not determined. Based on cuts proposed for FY 2007, there may be significant changes for the FY 2008 budget as well, particularly as it affects services for children and pregnancy prevention/family planning.//2008//

/2009/The budget figures for FY 2008 and 2009 are based on the Governor's Executive Budget released in January of those years. This included projected revenue reductions and cuts in programs due to the state's fiscal crisis. The final budget for FY 2008, however, restored Healthy Michigan Funds to Dental Health, Local MCH grants, Lead Poisoning Prevention, Infant Mortality-Nurse Family Partnership, and Early Hearing Detection and Screening. The budget figures for FY 2009 are again based on the Executive Budget which recognizes the revenue "fixes" that the Legislature and Governor agreed upon in 2008. The FY 2009 budget revises estimates of revenue for Newborn Screening fees (Form 3, line 6; Form 4, line IIb; Form 5, line III), and for the WIC formula rebate contract (Form 3, line 6; Form 4, line IIb; Form 5, line III). The shift in funding sources for CSHCS is also reflected in the 2009 budget (Form 3, line 3; Form 4, line IId; Form 5, line I). //2009//

/2010/The budget figures for FY2010 are based on the House appropriations bill, as of June 17, 2009. The State Funds shown on Form 3 line 3, Form 4 line I.d, and Form 5 line I reflect proposed funding shifts for CSHCS Medical Care and Treatment to Title XIX. An increase in budgeted Newborn Screening fees is reflected on Form 5, line III. //2010//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.