Maternal and Child Health Services Title V Block Grant

State Narrative for Michigan

Application for 2011 Annual Report for 2009

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Table of Contents

I. General Requirements 4
A. Letter of Transmittal 4
B. Face Sheet 4
C. Assurances and Certifications 4
D. Table of Contents 4
E. Public Input 4
II. Needs Assessment 5
C. Needs Assessment Summary 5
III. State Overview 7
A. Overview 7
B. Agency Capacity 10
C. Organizational Structure 17
D. Other MCH Capacity 18
E. State Agency Coordination 19
F. Health Systems Capacity Indicators 22
Health Systems Capacity Indicator 01: 23
Health Systems Capacity Indicator 02: 24
Health Systems Capacity Indicator 03: 25
Health Systems Capacity Indicator 04: 25
Health Systems Capacity Indicator 07A: 26
Health Systems Capacity Indicator 07B: 27
Health Systems Capacity Indicator 08: 27
Health Systems Capacity Indicator 05A: 28
Health Systems Capacity Indicator 05B: 29
Health Systems Capacity Indicator 05C: 29
Health Systems Capacity Indicator 05D: 30
Health Systems Capacity Indicator 06A: 31
Health Systems Capacity Indicator 06B: 31
Health Systems Capacity Indicator 06C: 32
Health Systems Capacity Indicator 09A: 32
Health Systems Capacity Indicator 09B: 33
IV. Priorities, Performance and Program Activities 35
A. Background and Overview 35
B. State Priorities 35
C. National Performance Measures 37
Performance Measure 01: 37
Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated 39
Performance Measure 02: 39
Performance Measure 03: 42
Performance Measure 04: 45
Performance Measure 05: 47
Performance Measure 06: 50
Performance Measure 07: 52
Performance Measure 08: 55
Performance Measure 09: 56
Performance Measure 10: 58
Performance Measure 11: 60
Performance Measure 12: 62
Performance Measure 13: 63
Performance Measure 14: 64
Performance Measure 15: 66
Performance Measure 16: 67

Performance Measure 17: 69
Performance Measure 18: 70
D. State Performance Measures 73
State Performance Measure 1: 73
State Performance Measure 2: 75
State Performance Measure 3: 77
State Performance Measure 4: 80
State Performance Measure 5: 81
State Performance Measure 6: 84
State Performance Measure 7: 86
State Performance Measure 8: 88
E. Health Status Indicators 89
Health Status Indicators 01A: 89
Health Status Indicators 01B: 90
Health Status Indicators 02A: 91
Health Status Indicators 02B: 92
Health Status Indicators 03A: 92
Health Status Indicators 03B: 93
Health Status Indicators 03C: 94
Health Status Indicators 04A: 95
Health Status Indicators 04B: 96
Health Status Indicators 04C: 97
Health Status Indicators 05A: 98
Health Status Indicators 05B: 98
Health Status Indicators 06A: 99
Health Status Indicators 06B: 100
Health Status Indicators 07A: 100
Health Status Indicators 07B: 101
Health Status Indicators 08A: 101
Health Status Indicators 08B: 102
Health Status Indicators 09A: 103
Health Status Indicators 09B: 104
Health Status Indicators 10: 104
Health Status Indicators 11: 105
Health Status Indicators 12: 105
F. Other Program Activities 105
G. Technical Assistance 106
V. Budget Narrative 107
Form 3, State MCH Funding Profile 107
Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds 107
Form 5, State Title V Program Budget and Expenditures by Types of Services (II) 108
A. Expenditures 108
B. Budget 109
VI. Reporting Forms-General Information 110
VII. Performance and Outcome Measure Detail Sheets 110
VIII. Glossary 110
IX. Technical Note 110
X. Appendices and State Supporting documents 110
A. Needs Assessment 110
B. All Reporting Forms 110
C. Organizational Charts and All Other State Supporting Documents 110
D. Annual Report Data 110

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 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

Public input was invited all throughout the needs assessment and application development process. Input was solicited to an online survey of MCH needs in the first step of the needs assessment. The results were posted on the department's website and updated with each succeeding step of the needs assessment. Notice of the needs assessment and the website were also posted on the Maternal and Infant Health program's Twitter page. Participants of the online survey and the Needs Assessment Work Group included consumers, community agencies, providers, professional groups and advocacy organizations.

The draft application was also posted on the department's website with notice to all advisory groups, Needs Assessment Work Group, local health departments, and other state programs and agencies. Comments were also invited via the MIHP Twitter page.

Feedback on the needs assessment, priorities and draft application was received from local health departments, Healthy Start projects, other state agencies, DCH program staff, parents, private providers, advocacy agencies, and other stakeholders.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The needs assessment process was directed by the Bureau of Family, Maternal and Child Health and involved a large stakeholder group from state and local public agencies, private providers, consumers, advocacy groups, professional groups, community agencies and academic institutions. The process involved an online survey of approximately 400 stakeholders, analysis of data related to the top four priority areas identified by the survey, and input from a workgroup composed of representatives of the aforementioned groups.

The assessment of needs for the MCH population for 2011-2016 highlights the continuing need to focus on reducing infant mortality and the associated risk factors. Michigan's infant mortality rate remains above the national rate and significant disparities exist between indicators for the white population and for minority populations. To accomplish reductions in these indicators, a change in approach is necessary. Priorities for the 2011-2016 period will not only focus on the traditional risk factors associated with infant mortality, including low birth weight, preterm birth and unintended pregnancy, but also on the social determinants of health and the patterns of health established during the life course. Strategies will focus on improving the pre-conception and inter-conception health status of women of child-bearing age, including addressing chronic disease, obesity and domestic violence factors. Increasing the proportion of intended pregnancies, including reducing adolescent pregnancy, will also continue to be an important effort. With a grant from the Kellogg Foundation, the Department will develop and implement a training curriculum for state staff on multi-culturalism and the effects of racism in areas such as developing a common language, analysis and definition of racism, and understanding the connection of their work to institutional racism.

Addressing obesity will continue to be a priority for improving the health status of children and women of child-bearing age. Obesity increases the risk of many diseases and health conditions that affect pregnancy outcomes and children's health status. Obesity disproportionately affects Black residents of Michigan. Breastfeeding is included as one strategy for impacting obesity among children.

Childhood lead poisoning prevention is also a continuing environmental priority for the Department, along with asthma and second-hand smoke. While significant improvements in the number of children under age 6 with elevated blood lead levels have been made, there are still pockets of unacceptable rates of lead poisoning and disparity between the rates for white and black children. Asthma continues to be one of the top causes of preventable hospitalizations for children. The prevalence of high school students with asthma is increasing.

The needs assessment revealed an alarming trend in sexually transmitted diseases among teens, 15-19 years of age. The rates of infection for Chlamydia increased by 119.8% from 1997 to 2008, and by 36.7% for gonorrhea. In addition, rates of new HIV diagnoses among 13-19 year-olds more than doubled between 2003 and 2007.

Intimate partner and sexual violence has become an increasing concern for youth and pregnant women. Native Americans are disproportionately affected by dating violence and rape. Domestic violence is one of the risk factors associated with maternal depression.

Access to dental care has become a priority concern in terms of its availability to adults and

children including children with special health care needs, and in terms of the impact of oral health upon the general health of children and pregnant women.

In order to more effectively address the complex needs of CYSHCN, the establishment of a medical home is critical to the coordination of primary and specialty services. Efforts will continue to define and implement the medical home concept for CYSHCN in Michigan. Early intervention and developmental screening services will allow children to develop to their full potential and enhance their learning ability.

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. In accordance with the Public Health Code, local health departments are our main partner in fulfilling our Public Health Mission. 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 Department also works cooperatively with other State departments on issues of mutual responsibility.

The Title V program is operated by the Bureau of Family, Maternal and Child Health. The Title V Director is also the Director of the Bureau. The Bureau includes the Division of Family and Community Health, Children's Special Health Care Services Division, and the WIC Division. The Division of Family and Community Health manages all of the MCH programs besides CSHCN. The Title V Director reports to the Deputy Director for Public Health who reports to the Director of the Department of Community Health (see attached organization chart). The Department of Community Health is composed of five administrations which include Medicaid (Medical Services Administration) and Mental Health and Substance Abuse.

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.

The Title V program also works across state departments on initiatives that affect our mutual customers. The Title V Director serves on the Board of the Children's Trust Fund that serves as a voice for Michigan's children and families and promotes their health, safety, and welfare by funding effective local programs and services that prevent child abuse and neglect. Another inter-agency initiative is the Great Start Initiative which supports a comprehensive early childhood system of care (ECCS). This initiative began with a State Early Childhood Comprehensive Systems grant from HRSA in 2003 and now serves children and families statewide through local collaborative teams.

According to the U.S. Census Bureau, Michigan's population as of July 1, 2009 was 9,969,727. The state population has remained fairly steady over the past decade, ranging from 9,938,444, according to the April 1, 2000 Census, to a high of 10,090,554 in 2005. Births in Michigan have declined since 2000 by 14.3%. Michigan's rate of net migration to other states was 1.1 % in

2008. From 2000 to 2006, Michigan's out-migration rate was very close to the average for all states, but increased in 2007 and 2008. More than 80% of the state's population resides in the southern half of the Lower Peninsula; almost half of the population resides in southeastern Michigan. Approximately 3.1% of the state's population resides in the Upper Peninsula. About 19% of the state's population resides in rural areas.

According to the US Census Bureau, in 2009 Michigan's population was 81.1% white, 14.2% African American, 2.4% Asian/Pacific Islander, 0.6% Native American and 1.6% two or more races. 4.2% of the population was of Hispanic ancestry. The demographic profile of the state indicates significant increases over the last two decades in the percentage of residents that are Asian/Pacific Islander and Hispanic. From 1990 to 2009, the percentage of residents that were Asian/Pacific Islander increased 100%, and the percentage that were Hispanic ancestry increased 90.9%. Over the same time period, the proportion of the population that was white decreased by 3.6% and the proportion that was African American increased by 1.4%. The proportion of the population that was Native American remained the same.

In 2008, 23.9% of the population was under 18 years of age; 36.0% were 18-44 years; 27.1% were 45-64 years; and 13.0% were 65 years and older. From 1999 to 2008, the population under 18 years of age declined by 7.6%, and the population 45 years and older increased by 18.1%. Among the population under 18 years of age, 77.6% were white, 18.6% were Black, 0.9% were Native American, and 2.9% were Asian/Pacific Islander. 6.4% of the population under 18 years of age were Hispanic.

Among people 5 years of age or older, 9% spoke a language other than English at home. 34% of those spoke Spanish and 66% spoke some other language.

According to the Current Population Survey, 2008, 13.0% of the total population was below the federal poverty level, and 19.1% of children under 18 were below poverty level. In 2006-2008, 10.0% of all families and 31.0% of families with a female householder and no husband present had incomes below poverty. During the same three-year period, the median income of households in Michigan was $49,694. For the first half of fiscal year 2009, more than 20% of the population was receiving some form of public assistance benefits. The WIC program serves more than 50% of infants in Michigan.

Michigan's economy has suffered severely over the past two years. According to the U.S. Bureau of Labor Statistics, employment in Michigan in 2008 declined by 3.2%. Payroll jobs in transportation equipment manufacturing decreased by 36.5% from December 2007 through October 2009; durable goods manufacturing declined by 26.4%; and construction by 24.0%. The 2009 average annual unemployment rate was 14.0% compared to the U.S. rate of 9.2%. The unemployment rate reached a peak of 15.3% in September 2009. Job losses have slowed in the state as the economy generally improved and auto industry production resumed, albeit at lower levels. As of May 2010, the Michigan unemployment rate was 13.6% compared to the U.S. rate of 9.7%. Recovery will be slow as Michigan's economy evolves from heavy dependence on the auto industry to a service-based economy.

Due to the manufacturing history of Michigan and the strong presence of unions, the state has enjoyed a relatively high proportion of the population that was insured. However, with the decline of the auto industry and the general economic downturn, the number of uninsured residents is increasing. Overall, the uninsured population in Michigan increased from 1.04 million in 2006 to 1.15 million in 2007. Although Michigan had one of the lowest uninsured rates for children, a 2009 report by the Center for Healthcare Research and Transformation indicated that the percent of uninsured children (0-18 years of age) increased from 4.7% in 2006 to 6.2% in 2007, and the percent of uninsured young children (0-5 years) increased from 4.6% to 7.8% during the same period. African Americans and Hispanics were disproportionately represented in the uninsured population.

Distribution of health care resources is a significant factor in accessing health care. According to Michigan Strategic Opportunities for Rural Health Improvement: A State Rural Health Plan, 57 of the 83 counties in Michigan are defined as rural, containing 19% of the state's population. Rural Michigan has 165 physicians per 100,000 population, compared to 272.9 physicians per 100,000 population for the state as a whole. Two-thirds of the hospitals in Michigan are in metropolitan counties, and 40% are located in southeastern Michigan. Most of the specialty care for children is located in the southern portion of the lower peninsula of the state.

The leading causes of death for infants under age 1 in 2008 were certain conditions originating in the perinatal period, congenital malformations, accidents, SIDS and homicide. Black infants died at 2.7 times the rate of white infants; Hispanic infants at 1.6 times the rate for whites; and American Indian infants at 1.5 times the white rate. The five-year (2004-2008) average low birth weight rate (8.4) increased over the preceding five-year period (8.0). Black infants were more than twice as likely to have low birth weight as white infants. The pre-term birth rate was relatively unchanged from 2003 to 2008.

The overall infant mortality rate in Michigan in 2008 was 7.4. Of the 83 counties in Michigan, eleven counties had a higher infant mortality rate than the state rate -- Berrien (7.8), Calhoun (7.9), Genesee (8.1), Grand Traverse (8.2), Kent (7.5), Lenawee (9.6), Mecosta (20.5), Saginaw (10.2), Saint Joseph (11.0), VanBuren (10.2), and Wayne (10.7)

Among cities with populations greater than 40,000 and more than 200 average number of births, the following cities had the highest average rate of infant mortality in the state in 2008:

Detroit -	14.9	
Pontiac -		13.3
Saginaw -		12.7
Flint -	11.8	
Southfield -	11.5	
Wyoming -	10.1	
Taylor -	9.4	
Grand Rapids -	8.7	
Lansing -		8.5
Battle Creek -	8.0	

Wayne County (including Detroit), Genesee County (including Flint), and Saginaw County had the highest rates of low birth weight.

The Department's focus for addressing infant mortality over the next several years will be on improving the health of mothers, pre- and post-pregnancy. Programs to address chronic conditions, such as diabetes and obesity, will be pursued. Of the live births in 2008, 15.9% of mothers were exposed to second-hand smoke at home, 27.5% of mothers with singleton births had a body mass index above 29.0, 0.8% had pre-pregnancy diabetes, 3.8% had gestational diabetes, 1.2% had pre-pregnancy hypertension, and 4.4% had gestational hypertension. American Indian mothers had the highest rate of exposure to second-hand smoke. Asian/Pacific Islander mothers had the lowest rate of BMI greater than 29.0, but had the highest rate of gestational diabetes.

According to the County Health Rankings for Michigan , the following counties had the best rankings in both Health Outcomes and Health Factors: Livingston (central Lower Peninsula), Ottawa (southwestern Lower Peninsula), Leelenau (northern Lower Peninsula), Clinton (central Lower Peninsula), Washtenaw (southeastern Lower Peninsula), Grand Traverse (northern Lower Peninsula) and Marquette (Upper Peninsula). The only major city (population > 40,000) in this area is Ann Arbor (Washtenaw County).

The counties with the worst rankings in both categories were: Saginaw (central Lower Peninsula), Calhoun (southern Lower Peninsula), Gladwin (central Lower Peninsula), Genesee (central

Lower Peninsula), Lake (northern Lower Peninsula), Wayne (southeastern Lower Peninsula) and Clare (northern Lower Peninsula).

The leading causes of death among children ages 1-19 in 2008 were accidents, assault (homicide), cancer, suicide and congenital malformations. The leading causes of hospitalizations for children were females with deliveries, injury and poisoning, asthma, pneumonia and appendicitis. Births to teens aged 15 to 17 years declined from 2004 (18.7%) to 2007 (14.0%), but then increased significantly in 2008 (18.2%).

An attachment is included in this section.

B. Agency Capacity

The Division of Family and Community Health (DFCH) is responsible for assessing need, recommending policy, developing and promoting best practices and service models, and advocating for the development of capacity within communities to provide quality, accessible, culturally competent services. We focus on improving the health, well-being, functioning and/or quality of life for infants, children, adolescents, women of childbearing age, and their families. Maternal and child health programs, policy development and activities focus on assessment of health status, identification of priority health issues, and development and support of health care programs and systems to address these health issues in the context of health care reform and with culturally competent approaches to service delivery.

The life-course framework is the structural model for the organization of the division and its strategic plans to address the needs of the population served to meet the department's mission "to protect, preserve and promote health with special attention to the needs of the vulunerable and underserved." The division's organizational unit structures are based on life stages: reproductive/preconception/interconception, maternal/interconception, infant, child, adolescent and family (oral health -- crossing all life stages). The division continuously supports linkage to the adjacent life phase of which each individual grows and develops with the impact of the complex interplay of the social determinants of health.

The health of a woman prior to pregnancy has a significant impact on pregnancy outcome and the early health of the infant sometimes more than interventions during pregnancy. Priority is being placed on increasing health promotion and prevention activities including strategies to increase access to effective social-emotional, medical and dental health for women. Mental health service availablity and improvement of social determinants of health are addressed as a component of improving the overall health of women. Interconception care is a subset of preconception care, comprised of interventions that aim to identify and modify biomedical, behavioral, and social risks to a woman's health or pregnancy outcome through prevention and management, emphasizing those factors which must be acted on before conception or early in pregnancy to have maximum impact. It is more than a single visit and less than all well-woman care.

For all the life course stages we connect to and work with other organizational units of the Department and community partners who may be technical experts and/or are responsible for oversight of assessment, strategic planning and implementation of care systems and policies for other health care and/or social determinates of health (mental health; substance abuse; child development; early, middle and adolescent education; chronic disease development; healthy environments, etc.). Each unit within the DFCH addresses these factors, concentrating on the portion of the life course they are responsible for, but also by building on, coordinating and complementing the other life course stage immediately adjacent or relevant.

To support relevant and culturally sensitive planning efforts, the division uses advisory groups;

develops and holds work groups of diverse representatives; conducts focus groups; and supports, employs or contracts for ongoing parent or population representatives to have ongoing or episodic input into the planning and sometimes the monitoring process of our efforts. In addition, all managers have as a performance objective to value and secure a diverse work environment that ensures compliance with equal opportunity in hiring, training and assignments to assure diversity in the views brought to bear in our operations.

During the last year and a half there have been conducted division-wide cultural sensitivity trainings and the division's director and section managers have participated in cultural sensitivity trainings. One of our intents is to improve all staff's awareness for the need to gather and monitor appropriate data on the diversity of the state's population and the disparity in the health statistics in each life course stage. There are multiple representatives working on the Department's Health Disparities Work group. Some of this group's charges are to increase awareness of health disparity, and collect and disseminate relevant data to distribute information focusing on eliminating disparities and ensuring policies, programs, and implementing strategies that are culturally and linguistically tailored to reduce morbidity and mortality.

The Reproductive Health Unit is responsible for preconception and interconception health planning and promotion. The primary service area is the delivery of quality, equitable, scientifically safe contraception and reproductive health care services via the implementation of the Federal Title X Family Planning program. As the long-term single, state-wide grantee for Title X Federal funds, 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. Following Title X regulations services are delivered through a statewide network of local health departments, Planned Parenthood affiliates, hospitals and private non-profit agencies.

Michigan Department of Community Health (MDCH) received approval of its Mediciad Section 1115 Family Planning Waiver July 1, 2006, expanding Medicaid supported 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. MDCH is currently in the process of completing a continuation application for the Family Planning waiver, due in 2011.

Other important focus areas of the Reproductive Health Unit are: promotion of "Prevention of Unintended Pregnancy in Adults 18 and Older" care recommendations, Maternal Child Health hotline oversight, prenatal smoking cessation promotion and training, and coordination with statewide sexually transmitted infection reduction efforts.

The Perinatal Health Unit is the area within DFCH that is responsible for program activities, health promotion and prevention that focuses on the woman who is pregnant, between pregnancies and their newborn infant. The Perinatal Health Unit has the following objectives that guide their activities: increase the interconception health of women including prenatal and postnatal; reduce infant mortality and morbidity; reduce maternal mortality and morbidity; eliminate disparities in infant and maternal birth outcomes; implement, support and evaluate a system of perinatal regionalization; increase the development of a medical home for women, particularly of child-bearing age; reduce untreated maternal depression; increase maternal/infant attachment for all women who give birth in Michigan; increase successful maternal health management for both women and their infants, including effective engagement in appropriate services and supports, particularly for women identified as being at-risk due to social/economic determinants of health; and increase screening for maternal alcohol use and implement prevention strategies to decrease the number of women who drink alcohol during pregnancy.

These objectives are accomplished by the provision of organized program, services and prevention activities. The following programs & services are coordinated within the Unit and incorporate culturally competent approaches:

Fetal Alcohol Spectrum Disorders (FASD) program provides prevention, awareness and access to services by: multidisciplinary teams called Centers of Excellence that diagnose children and provide initial care planning; community projects that provide local prevention and linking to services projects; and training and consultation that assist these agencies in their work. The outcome is to decrease this preventable disorder and enhance the quality of life for affected individuals /their families and lessen the social and economic impact of FASD in Michigan.

Infant Mortality and Morbidity activities are designed for prevention and reduction of infant mortality/morbidity and elimination of racial disparities in infant death rates. The creation and implementation of the MDCH Infant Mortality Strategic Plan will help drive this process.

Local Maternal and Child Health funds are flexible funds from the Federal Title V Maternal and Child Health Block Grant that are made available to local health departments to address locally identified health needs of women and children in their jurisdictions. Each local health department uses both a defined needs assessment process to determine/identify their MCH needs and also identifies which of the 18 priority MCH measures established by the MCH Bureau of the Department of Health and Human Services and eight measures established by MDCH that their plan addresses.

Michigan Maternal Mortality Surveillance is a program of case ascertainment, surveillance of maternal death data and trends, case reviews and development of prevention recommendations based on analysis of data and case review findings to reduce Michigan's maternal deaths, illness and complications and decrease the black/white mortality ratio.

Maternal and Infant Health Program provides case management and support services to pregnant women and infants enrolled in Medicaid to improve maternal and infant birth outcomes.

Medicaid Outreach/Access to Health Care allows for Federal match available to local health departments to support their local activities to facilitate outreach, public awareness, enrollment, access, monitoring and referrals for Medicaid services.

The Perinatal Health Unit has identified resources and methods to establish a formal perinatal care system as recommended by the Perinatal Regionalization Workgroup consistent with evidence based guidelines to clearly define levels of care designations and collaboration among regional hospitals providing services to women, neonates/infants and families to improve pregnancy outcomes. A nurse was recently hired to assume some of thes tasks required. The Unit collaborates and coordinates with many different groups to provide these services including: other State Departments; other Divisions within the Department of Community Health; local health departments; schools of medicine and public health; professional medical organizations; state wide organizations; hospitals; clinics; FQHCs; physicians; advocacy groups; culturally diverse community groups and interested stakeholders.

The Infant Health Unit is responsible for infant health promotion program & initiatives with objectives to:

Reduce fetal and infant deaths
Reduce racial disparity in infant mortality
Increase the percentage of infants sleeping in safe environments
Increase the proportion of mothers who breastfeed their babies and increase lactation period
Increase the percentage of employers who have worksite lactation programs
Promote "Routine preventive services for infants & children birth - 2 months
Promote screening and evidence based treatment for known chronic conditions in newborns
Increase the proportion of newborns that receive hearing screens no later than 1 month of age, audiologic evaluation no later than three months, and intervention services no later than six months

Increase early identification of physical, developmental and social-emotional issues and early linkage to appropriate follow up interventions

Programs services and initiatives in the unit are:

The Early Hearing Detection and Intervention program is a process of screening, diagnosis, and intervention for newborns with congenital hearing loss. Universal newborn hearing screening is hospital-based aligned with efforts to establish and maintain a local comprehensive community-based system that provides screening, diagnosis and intervention services by the age of six months for infants who have been identified as having a potential hearing loss. 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. Michigan Hands & Voices and the Guide By Your Side program, which provide support, resources and activities to families with a child who has hearing loss, are also supported under this program.

The Safe Delivery program, by state law, allows for anonymous surrender of an infant (within 72 hours of birth) to an Emergency Service Provider without the expressed intent to return for the newborn, per the Michigan Safe Delivery of Newborns Act. A toll-free hotline exists to provide information to the public regarding the law, resources for counseling and medical services, and information on adoption services.

Infant Death Prevention and Bereavement services are provided through a contract with the nonprofit agency Tomorrow's Child. Tomorrow's Child develops and promotes initiatives for human service professionals that work with high-risk families; and develops bereavement counseling, education, advocacy and support services for families who have experienced the death of a young child. These services are promoted to medical examiners, hospitals, local health departments, FIMR teams and local child death review teams. Tomorrow's Child also provides promotion, education, and publication distribution regarding infant safe sleep under this agreement.

The Infant Safe Sleep State Advisory Team is a public/private partnership that coordinates statewide efforts to implement Infant Safe Sleep and reduce infant deaths related to unsafe sleep environments. The Team includes representatives from the Department of Community Health, Department of Education, Department of Human Services, Michigan Public Health Institute and Tomorrow's Child. Formed in 2004 the Team works diligently to develop a statewide, consistent, comprehensive message and strategy to inform families and caregivers about unsafe sleep. An Infant Safe Sleep website was established, as well as an online training module.

The Infant Death Autopsy Reimbursement program provides financial incentive to local medical examiner's systems to perform autopsy as well as death scene investigation in cases of Sudden Unexpected Infant Death. This program also provides surveillance of preventable infant deaths, especially post-neonatal and sleep-related deaths. Program objectives include the reduction of infant mortality by correctly identifying cause, manner and significant risk factors contributing to infant death, and standardization of how medical examiners certify cause and manner of SUID.

Michigan's Fetal Infant Mortality Review (FIMR) program identifies and examines factors that contribute to fetal and infant deaths through the systematic evaluation of individual cases. Multidisciplinary teams throughout the state work together to find patterns of need in a community and gaps in the perinatal health delivery system. The state FIMR coordinator provides technical assistance, consultation, and training of local teams. A single, state supported data system serves the teams.

The Child Health Unit's purpose is to administer programs and initiatives that improve child wellness across all domains of development; increase family ability to understand and promote their child's wellness; support the development of an integrated and comprehensive early

childhood system that spans public/private organizations and includes promotion, prevention, and intervention activities; and collect and analyze data to improve systems and service outcomes.

Programs and initiatives supported within the unit include preschool and school-aged Hearing and Vision Screening programs; Childhood Lead Poisoning Prevention; the Parent Leadership in State Government parent training initiative; and Project LAUNCH. The unit serves as liaison between Public Health and Part C/Early On Michigan which is administered out of our state Department of Education; interagency efforts to reduce abuse and neglect with our Children's Trust Fund and Department of Human Services; and with the MDCH Medical Services Administration and Michigan AAP regarding implementation of EPSDT. The unit also collaborates with both internal and external partners on initiatives to improve early childhood systems coordination, improve and expand home visitation services, implement evidence-based practices and measure fidelity, support the integration of social-emotional well-being as a component of child wellness; expand developmental screening; and increase the flow of information to the public that can support family and child wellness.

The Adolescent and School Health (ASH) Unit has a strong foundation in addressing a range of adolescent and school health issues through direct services and programming. Among the multiple adolescent health-focused programs coordinated by this unit are: Child and Adolescent Health Centers (school based health centers), Michigan Model for Health K-12 Comprehensive School Health Curriculum, the School Wellness Program (school nursing and mental health), a comprehensive Teen Pregnancy Prevention Initiative and Coordinated School Health Programs (in collaboration with the Michigan Department of Education).

The mission of the ASH Unit is to improve the health and well-being of Michigan's school-aged youth and young adults. The vision for ASH is that school-aged youth and young adults will transition into adulthood physically, emotionally and socially healthy; equipped with the necessary knowledge and skills to make informed decisions regarding their health and well-being; and able to locate resources and be active consumers in their health. ASH has many core objectives that guide its work, including:

- Supporting parents in understanding adolescent health issues;
- Improving access to care and a medical home for adolescents and young adults;
- Providing all children and youth with medically accurate information and best practices around health promotion and skill development;
- Improving access to mental health information, services and supports;
- Promoting healthy and informed decision-making around sexual health, including preconception health; and
- Supporting the identification of health, developmental and social/emotional concerns, through an integrated adolescent system of care at both the state and local levels.

To achieve some of these objectives, ASH operates the following statewide initiatives aimed at school aged youth:

- Child & Adolescent Health Centers are designed for school aged children and youth 5 through 21 years of age. These centers provide comprehensive primary care services, health education, peer counseling, screening/case finding services, referral for specialty care, and Medicaid outreach activities across 69 locations in Michigan.
- Michigan Model for Health is a nationally acclaimed comprehensive school health education program that facilitates skills-based learning through lessons that include a variety of teaching and learning techniques, skill development and practice, and building positive lifestyle behaviors in students and families.
- Teen Pregnancy Prevention Initiative is a comprehensive pregnancy prevention program, whose goal is to reduce teen pregnancy in MI through the implementation of the evidence-based program, Safer Choices, in eight high need communities.
- Coordinated School Health Programs, in collaboration with the Michigan Department of Education, support an eight component model within the school district that includes school health, health education, physical education, health services, staff wellness, family and

community involvement, healthy school environment, nutrition services, and counseling, psychology and social services.

The ASH unit has many strong collaborative partners at both the state and local level. However one unique partnership has developed with the Michigan Department of Education's Coordinated School Health and Safety Programs Unit. Because both Department's have an enduring commitment to the importance of adolescent well-being particularly when it comes to mental health and promoting social/emotional health, the Departments have created a "shared" state-level public health consultant position to focus exclusively on improving the social/emotional health of school aged youth in Michigan. This is just one example of this unique partnership between the MDCH and MDE.

The Oral Health Program within the division is responsible for education, promotion and implementation of activities and improving oral health throughout the life span for Michigan residents through prevention. Improving access to oral health includes oral health education, prevention of dental disease and dental restorative treatment. Through the efforts of the Oral Health Program, community water fluoridation programs are monitored for safety and effectiveness in reducing dental disease. Fluoride varnish programs and sealant programs offer oral health surveillance on all age children by detecting oral disease, applying preventive treatments, and referring for continued oral care. With the Count Your Smiles and Senior Smiles data collection we will better understand the oral health needs of school children and aging adults. Educating the public, medical and dental professionals as well as collaborating with other sections of the department in oral health has spread the word that oral health is integral to overall health.

Dental Hygiene PA 161 Program Allows a dental hygienist to work under relaxed supervision rules to provide service to the underserved children and elderly populations; must be a local, state or federal grantee health agency for patients who are not assigned by a dentist.

Oral Health Education and Access Promotion is a statewide oral health education program designed to change behavior, create awareness and improve the oral health of persons through all stages of life by linking oral health to total body health.

Points of Light Oral Health Program supports the matching of a dentist with a pediatrician to provide dental care to infants by age one. Educating the physician to do a caries risk assessment, provide anticipatory guidance and early dental interventions can greatly reduce dental disease in this young population.

Dental Treatment for Developmentally Disabled provides limited funding to assist the severe developmentally disabled population to access dental services; clients accepted for funding is through referral basis only from client case managers.

SMILE! Michigan Dental Sealant Program is a preventive dental sealant program offered to limited 2nd and 6th graders in schools with a high percentage of children enrolled in the Free and Reduced School Lunch Program. The program included an oral screening, placement of dental sealants on all erupted molar teeth, fluoride application, oral health education and referral for dental care.

Varnish! Michigan Program promotes fluoride varnish programs to reduce incidence of dental decay in primary teeth. Services are available to low income, high-risk 0-5 age children in medical facilities, Head Start and other vulnerable groups. Training on Infant/Child Oral Health is provided for MI Medicaid providers.

Volunteer Dental Program (Donated Dental) is a network of volunteer dentists providing dental care to persons who are mentally and physically handicapped, who are medically compromised, or who are elderly and/or indigent.

The Oral Health Unit collaborates and coordinates with many groups to provide these services including: other state departments; other divisions within the Department; professional medical organizations; state wide organizations; clinics; dentists; advocacy groups; Schools of Dentistry; culturally diverse community groups and interested stakeholders; hospitals; Federally Qualified Health Centers; schools; universities; health insurance plans; and pharmaceutical companies.

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 sub-specialist in making a medical eligibility determination. The full range of CSHCS program elements and services includes: case-finding; application for CSHCS coverage, assessment of family service needs, 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.

The medical care and treatment covered by CSHCS includes a wide range of services such as physician specialist care, hospitalization, pharmaceuticals, special therapies, 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.

The payment agreement fee schedule has been changed to include all clients in a payment agreement on a sliding scale unless they have Medicaid, MIChild (CHIP) or WIC coverage if they choose to join CSHCS. This is a change from having those whose income is at or below 200% of the federal poverty level or for children adopted with a qualifying pre-existing condition being exempt from a payment agreement.

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 case-finding, the LHD system, the CSHCS Customer Support Section or the Family Center 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 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 Family Center has parent consultants on staff and payroll to work closely with CSHCS, and provides parent membership in the CSHCS Advisory Committee, and the Family Support Network to reinforce family-centeredness. 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.
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.

The CSHCS strategic planning meeting that engaged 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 resulted in the establishment of workgroups to begin to address the priorities that the strategic planning meeting identified. (See Needs Assessment, page 13.)

The Family Center 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 Family Center.

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 Title V program is administered by the Bureau of Family, Maternal and Child Health, Public Health Administration, Michigan Department of Community Health. The Bureau includes Divisions of Family and Community Health, WIC, and Children with Special Health Care Services. The Title V Director is the Director of the Bureau who reports to the Director of the Public Health Administration. The Public Health Administration also includes the Bureau of Epidemiology, the Bureau of Health Promotion and Disease Control and the Bureau of Laboratories. The Bureau of Epidemiology maintains the state's vital records system and provides the Title V program with data and analytical support. The Department of Community Health reports directly to the Governor.

The Division of Family and Community Health manages programs within the areas of reproductive health, perinatal health, infant health, child health, adolescent and school health and oral health. This includes Family Planning, Prenatal Smoking Cessation, Fetal Alcohol Syndrome Prevention, Infant Mortality and Morbidity, Maternal Mortality and Morbidity, Maternal and Infant Health Program, Pre/Interconception Health, Local Maternal & Child Health, Early Hearing Detection & Intervention, Medicaid Outreach/Access to Health Care, Safe Delivery, Safe Sleep, Fetal Infant Mortality Review, Child Lead Poisoning Prevention, Early On, Hearing Screening,

Vision, Screening, Parent Leadership in State Government, Child & Adolescent Health Centers, Coordianted School Health, Michigan Model for Health, Teen Pregnancy Prevention Initiative, Michigan Abstinence Program, and Oral Health.

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. More than half of the infants in the state are seved by the WIC program.

Children's Special Health Care Services provides medical care and treatment, care coordination, case-finding, assessment of family service needs, family support services 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.

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. Local health departments are units of local government. The 45 local health departments in Michigan employ over 5,500 staff including nurses, physicians, nutritionists, social workers, sanitarians, health educators and epidemiologists. Department staff provide training, consultation and technical assistance to local health departments and other community providers in various programs, certify providers of the Maternal and Infant Health Program, 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 maternal and child health programs are located in the Bureau of Family, Maternal and Child Health which includes the Divisions of Family and Community Health, WIC, and Children's Special Health Care Services. The Bureau Office has two professional and one clerical position. The Bureau is part of the Public Health Administration within the state Department of Community Health. All state staff are located centrally in Lansing.

Alethia Carr is the Title V Director and Director of the Bureau of Family, Maternal and Child Health. Ms. Carr has an MBA and a Bachelor of Science degree in hospital dietetics and is a registered Dietitian. She has ten years experience as a clinician and more than 25 years of management experience in various maternal and child health programs including childhood lead poisoning, MCH HIV/AIDS, and Women's and Reproductive Health.

In the Division of Family and Community Health, there are 56 established positions including four vacancies. In addition there are fourteen professional contractual staff working on numerous programs and projects. Professional staff is composed of nurses, public health consultants, hearing and vision consultants, nutrition consultant and managers. Brenda Fink, A.C.S.W., is the Director of the Division and has served in that capacity since 2003. Prior to that, she was a manager in the Long Term Care program, serving as Acting Director from 2000-2003; and served in several capacities with Kalamazoo Community Mental Health Services, including Chief Operating Officer and Deputy Director of Systems and Operations, Co-Acting Director, Director of Family Services, and Children's Services Coordinator.

The WIC Division administers the federal Supplemental Food Program for Women, Infants and Children and Project FRESH. The Division has 43 funded positions, including six vacancies. Staffing includes nutritionists, public health consultants, analysts and managers. Stan Bien is the Director of the WIC Division. Mr Bien has 25 years of management experience, including 22 years with the WIC Division. He has a Bachelor's of Science degree in Accounting and a Masters degree in Public Administration.

The Children's Special Health Care Services Division currently includes 46 funded full time positions including one vacancy. 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 Family Center for Youth and Children with Special Health Care Needs perform an advisory role to the department as well as developing support networks across the state for parents of special needs children. The Family Center currently employs eight staff total, five of whom are parents of children with special needs.

Kathleen Stiffler is the Director of the Children's Special Health Care Services Division. Ms. Stiffler has over 24 years of experience in various capacities within the Maternal and Child Health area, including over seven years as the director of Michigan's Children and Youth with Special Health Care Needs Program. As the CYSHCN Director, Ms. Stiffler has overseen a significant effort along with the Division's many partners, to move the state closer to meeting the 2010 objectives for CYSHCN. This included a comprehensive strategic planning effort in 2008 that included over 100 partners. Progress has been made since that time on all six 2010 objectives. Additionally, Ms. Stiffler oversees the operations of the CSHCS program that provides insurance coverage and support services to over 30,000 children and youth with special health care needs. Before accepting the CYSHCN position, 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 and is currently on the Board of Directors for the Association of Maternal and Child Health Programs.

The Office of Medical Affairs within the Medical Services Administration houses two full-time physician consultants dedicated specifically to CSHCS, and three 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.

The Bureau of Epidemiology, Division of Genomics, Perinatal Health and Chronic Disease Epidemiology includes a Maternal and Child Health Section with seven positions (three vacancies). This section works with staff of the Bureau of Family, Maternal and Child Health on data collection, analysis and evaluation. The Newborn Screening Unit has six professional staff. This unit follows up on newborn screening tests and results with hospitals, physicians and parents.

E. State Agency Coordination

The Michigan Department of Community Health includes the Medical Services Administration (responsible for the Medicaid and MIChild programs), Mental Health and Substance Abuse Administration, Public Health Administration, Services to the Aging, and Health Policy and Regulation Administration (responsible for 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, Corrections and Energy, Labor and Economic Growth meet on a regular basis to coordinate policy and discuss cross-cutting issues affecting our common clients. Most recently, each department has identified their top priorities that require interagency coordination of policy and activities. The Department of Community Health has identified infant mortality as our interagency priority; Human Services -- poverty; Corrections -- Michigan Prisoner Re-entry Initiative; Energy, Labor and Economic Growth -- No Worker Left Behind; and Education -- Education Reform.

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), 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 Autism Spectrum Disorder Workgroup developed recommendations to the Directors in regard to early identification, appropriate treatment and education. Two pilot sites to implement the recommendations on screening, assessment and evidence-based practice interventions and evaluation of results began in October 2008. 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.

DCH and the Department of Human Services 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.

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 and in the design and implementation of the Michigan Model health education curriculum. DCH works with the Department of Education to develop plans for assisting schools not meeting performance expectations under No Child Left Behind.

DCH joins 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 Title V Director is the Department's liaison with the Michigan Women's Commission. The two agencies partner on issues affecting women in the state, such as infant mortality, unintended pregnancy and domestic violence. The Title V Director also serves as a member of the Michigan Pandemic Influenza Coordinating Committee (PICC) and Chair of the Human Health Committee. The PICC coordinates pandemic flu activities vertically and horizontally across state agencies.

The Title V program participates in an ad hoc workgroup that has been convened within the Department to coordinate and share information on several medical home projects in the department, including Chronic Disease, Medicaid and CSHCS.

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, 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.

In 2008, the Department of Community Health convened the Michigan State Leadership Workshop to begin work with stakeholders to strengthen the infrastructure for and outcomes of the EPSDT program. 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 were formed to explore actions and recommendations in each of these areas. Follow-up on priorities identified at the Michigan State Leadership Workshop is taking place through Michigan's Early Childhood Comprehensive Systems interdepartmental advisory body, the Great Start Systems Team. Medicaid has worked with the MI Care Improvement Registry (MCIR) to add fields to document delivery of EPSDT services.

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.

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 Health Program, 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. State and federal resources 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. In 2006, approval of a Section 1115 Family Planning Waiver expanded Medicaid-covered family planning services to women 19-44 years old with family incomes up to 185% of poverty. 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 six Healthy Start programs in Michigan - Kalamazoo, Flint, Detroit, Grand Rapids, Saginaw and Sault Sainte Marie. The department created 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 involving four of the projects (Detroit, Grand Rapids, Sault Sainte Marie and Flint).

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 Health Services Advisory Group, Inc. 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.

The Parent Leadership in State Government project identifies, trains and supports parent leaders from among families who utilize specialized public services provided through DCH, Education, Human Services and/or their local counterparts, with a focus on providing consumer voice and input on local, state and federal program planning and policy development that impacts children and families.

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 Title V program has been working with professional organizations, providers, March of Dimes and other state staff to re-establish a regional perinatal system in Michigan. Level of care standards were developed and published (based on AAP/ACOG Guidelines), and a plan for establishing the regional system was submitted to the legislature. This effort is being coordinated with plans for a regional trauma system. Enabling legislation is currently under consideration.

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.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	46.5	40.1	38.1	38.1	36.6
Numerator	3021	2560	2414	2414	2714
Denominator	650215	638195	633017	633017	742424
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

Narrative:

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, schools 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. For more information on the burden of asthma in Michigan, please go to http://www.getasthmahelp.org/main_stats_11.asp .

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. In January 2009, 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. As a result of the Summit recommendations, efforts are currently being made to develop an in-home case management program serving children in Detroit with moderate to severe asthma. The Asthma Mortality Review Report was also instrumental in the development and adoption of standard asthma emergency department discharge instructions called FLARE. There have been twelve emergency departments who have fully adopted FLARE and eight who have partially adopted FLARE. Additionally, three national software companies have committed to using FLARE in their electronic discharge instructions.

The Healthy School Action Tool (HSAT) is a set of online tools to help Michigan schools create healthier environments through assessment and policy development. Additionally, Asthma 1-2-3 is an education and training program designed by the American Lung Association of the Midland States (ALAMS), in collaboration with the Asthma Initiative of MI (AIM), to inform school personnel about the prevalence and severity of asthma, while teaching basic management techniques, including what to do in an asthma emergency. Since Sept 1, 2009, over fifteen trainings/in-services have been provided reaching over 600 school staff.

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 also under development in Saginaw.

MDCH Healthy Homes University Program works 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 emissions through education and/or upgrading of school buses.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	85.1	86.2	86.4	86.1	78.6
Numerator	56516	58927	59916	59561	56068
Denominator	66402	68352	69357	69152	71293
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 health plans set standards for screening children including defining the screening components of a periodic exam and requirements for referral for diagnostic or treatment 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 provider's assist beneficiaries in using health care services for which they are eligible. Outreach matched funds are available to local health departments and continued collaborative efforts have increased enrollments in publicly-funded programs and provided outreach to uninsured families. The MIChild (SCHIP) and Healthy Kids (Medicaid) programs have been able to maintain the level of coverage for children. MDCH continues to be involved in a number of inter-and intradepartmental efforts to improve access to services including adding fields to the Care Improvement Registry to document delivery of well child services; medical home projects; efforts to increase developmental screening, referrals, and subsequent communication among providers; and a special taskforce to address timely enrollment of infants in Medicaid.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	55.5	64.5	69.4	74.9	71.4
Numerator	201	216	238	236	235
Denominator	362	335	343	315	329
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:
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. MDCH continues to be involved in a number of inter-and intradepartmental efforts to improve access to services including adding fields to the Care Improvement Registry to document delivery of well child services; medical home efforts; and efforts to increase developmental screening, referrals, and subsequent communication between involved providers.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	76.6	75.9	73.9	70.8	72.1
Numerator	97437	96851	92503	85868	84061
Denominator	127122	127537	125172	121231	116610
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 percent of women 2007-2009 with a live birth whose prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index has remained relatively stable. The primary Health System initiative to improve this indicator is the redesign of the Maternal Infant Health Program (MIHP). During 2009-2010, the policies and guidelines for MIHP have been revised and are ready for implementation July 1, 2010. A comprehensive Operations Guide, which outlines program implementation details and includes standardized MIHP forms and interventions, will accompany the policy. It is now mandatory for Medicaid pregnant women to be enrolled in a Managed Care Health Plan and a requirement that all pregnant women be referred to the MIHP program to achieve total population screening.

Anticipated outcomes of the maternal & infant support redesign program include: (1) increased percent of women whose prenatal visits meet expectations identified in the Kotelchuck Index; (2) deliver full term, healthy babies (3) reduce infant death rates and sickness rates; (4) have developmentally healthy infants and (5) have physically, emotionally healthy mothers. Additional MIHP program focus for 2010-2011 will include quality assurance and data collection.

Collaboration and integration with other statewide initiatives involving the Perinatal Regionalization System and Medical Home initiatives for residents are also anticipated to have a positive impact on this health system indicator.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	83.6	84.3	85.4	86.2	81.3
Numerator	835005	924469	893739	923503	923503
Denominator	998680	1097269	1046771	1071516	1136252
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 health plans set standards for screening children including defining the screening components of a periodic exam and requirements for referral for diagnostic or treatment 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 provider's assist beneficiaries in using health care services for which they are eligible. Outreach matched funds are available to local health departments and continued collaborative efforts have increased enrollments in publicly-funded programs and provided outreach to uninsured families.

MDCH has been exploring the opportunity to implement ‘express lane' eligibility for publicly-funded programs with the same eligibility criteria. Several efforts are underway to reduce infant mortality, which will concurrently enhance enrollment and access to services for infants, for hard to reach women in the Corrections system, and for children and teens in the foster care system.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	45.7	45.9	48.2	49.2	50.5
Numerator	93697	97602	105000	109212	115850
Denominator	205246	212662	218064	221780	229388
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 continually works 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 the 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 Kinds Dental than for Children enrolled in the traditional Medicaid dental plan (2001 through 2005). Due to access to oral health care for children in Healthy Kids Counties being significantly more increased, the dental sealant program focuses on schools within non-Healthy Kids counties to increase access to prevention for children who reside in non-Healthy Kids counties.

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.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	24.2	23.8	19.7	17.5	15.2

Numerator	7568	7689	6406	5713	5232
Denominator	31336	32303	32449	32629	34363
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)	2009	payment source from birth certificate	9.3	7.6	8.4

Narrative:
With a stagnant infant mortality rate, the low birth weight and the black infant mortality rate remains high. Close to fifty percent of all births in Michigan are covered by Medicaid. The infant mortality rate for black births is three times 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 emphasis on prenatal smoking cessation, FAS prevention programs, social determinants of health, preconception education in the Title X Family Planning Clinics, and interconception counseling through the Maternal Infant Health Program (MIHP).

MDCH uses a lifecourse framework for developing strategies to improve pregnancy outcomes, particularly preterm birth. A SPRANS grant opportunity was sought to emphasize the identification and prevention of chronic illness, particularly heart disease, among young women that may impact their pregnancy with poor outcomes for the infant as well as the mother.

The redesign of MIHP calls for interventions that target issues that result in poor birth outcomes and interconception health promotion. MIHP has embedded standardized screening instruments into the maternal risk identifier. There are questions in the tool regarding previous pregnancy outcomes, chronic disease and other factors that may lead to low birth weight and other poor pregnancy outcomes. MDCH staff is working on more strategies to screen women who are abusing substances during pregnancy. Motivational interviewing and brief interventions and referral for more intense substance abuse treatment is also being used. Increased capacity for FAS screening, diagnosis and treatment is being demonstrated through collaboration of

community partners and state agencies. Further efforts to identify racial disparities in preconception findings are being added to program planning and care coordination expectations of the MIHP program for maternal support.

The Interconception Care Project (ICP) was active in eleven communities. Over 300 women were enrolled and case managed to reduce their risk for another poor pregnancy outcome. Due to state budget cuts, the program was eliminated in July, 2009.

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	2008	payment source from birth certificate	9.1	6	7.4

Narrative:
With a stagnant infant mortality rate, the low birth weight and the black infant mortality rate remains high. Close to fifty percent of all births in Michigan are covered by Medicaid. The infant mortality rate for black births is three times 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 emphasis on prenatal smoking cessation, FAS prevention programs, social determinants of health, preconception education in the Title X Family Planning Clinics, and interconception counseling through the Maternal Infant Health Program (MIHP). The Family Planning Waiver continues to improve access to contraception for low-income women. The mandatory enrollment of Medicaid pregnant women into a Medicaid Health Plan, effective October 1, 2008, has resulted in an increased number of women having the MIHP Risk Identifier completed, increased communication between the Health Plans, and MIHP providers. The MIHP redesign has been initially completed and incorporates Medicaid policy changes, standardized interventions and forms, an operation guide, trainings and information system activity. The effective date for the reengineered program is July 1, 2010 when the MSA Policy takes effect. The redesign of MIHP also calls for interventions that target issues that result in poor birth outcomes and interconception health promotion. The Nurse Family Partnership Programs have been able to continue in four of the five previously funded communities. Local funding, foundation support and Medicaid match dollar has provided for the continuance of the projects for the time being. Grant funding from the Kellogg Foundation was received by another community and start up for their NFP project will commence in the near future. The Bureau of Family, Maternal and Child Health, along with community stakeholders is moving forward to re-establish a regional perinatal care system. A comprehensive Infant Mortality Strategic Plan for the Department was created and will be a major focus in the next year.

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***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**

MCH populations in the State					
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2009	payment source from birth certificate	64.2	81.1	73.5

Narrative:
MIHP redesign effort with new Medicaid policy, procedures, forms and requirements began July 1, 2010. The program's evidence based, standardized interventions will focus on prenatal care and improving the life conditions affecting pregnancy outcomes. Anticipated results include: (1) early entry into MIHP and prenatal care (2) reduction of amenable risk factors (3) reduction of infant death rates and sickness rates; (4) delivery of full term, healthy babies; (5) developmentally healthy infants; (6) physically, emotionally healthy mothers; (7) conduct of timely quality assurance site reviews to enforce Medicaid policy; (8) evaluation and assurance of accountability for quality service delivery, and (9) provision of consultation and technical assistance to local providers. The MIHP redesign will continue with a plan to enhance data collection and quality assurance.

Early entry into prenatal care with support for compliance to prenatal visit schedule and requirements will be continued by the Nurse Family Partnership (NFP) projects where 91% of the pregnant women enrolled in the NFP program gave birth to full term babies.

The Medicaid Family Planning Waiver will continue. 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.

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])	2009	payment source from birth certificate	66.5	76.8	72.1

Narrative:
MIHP redesign effort with new Medicaid policy, procedures, forms and requirements began July 1, 2010. The program's evidence based, standardized interventions will focus on prenatal care and improving the life conditions affecting pregnancy outcomes. Anticipated results include: (1) early entry into MIHP and prenatal care (2) reduction of amenable risk factors (3) reduction of infant death rates and sickness rates; (4) delivery of full term, healthy babies; (5)

developmentally healthy infants; (6) physically, emotionally healthy mothers; (7) conduct of timely quality assurance site reviews to enforce Medicaid policy; (8) evaluation and assurance of accountability for quality service delivery, and (9) provision of consultation and technical assistance to local providers. The MIHP redesign will continue with a plan to enhance data collection and quality assurance.

Early entry into prenatal care with support for compliance to prenatal visit schedule and requirements will be continued by the Nurse Family Partnership (NFP) projects where 91% of the pregnant women enrolled in the NFP program gave birth to full term babies.

The Medicaid Family Planning Waiver will continue. 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.

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)	2009	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)	2009	200

Narrative:
Eligibility levels for Medicaid and MIChild remained unchanged in 2010. 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.

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)	2009	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	2009	

(Age range 1 to 19) (Age range to) (Age range to)		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 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	2009	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	2009	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.

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
	3	Yes

Annual linkage of birth certificates and newborn 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 - 2011

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 to update the Medicaid enrollment and payment system was completed in 2009. The new system includes 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 several 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. The State of Michigan continues 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.

The SSDI grant partially supports a MCH epidemiologist position in the Bureau of Epidemiology. This position provides technical support to MCH programs in collecting and interpreting relevant data, as well as managing the PRAMS survey and linking data from the State's Vital Records with other databases, including PRAMS, WIC, Newborn Screening and Medicaid.

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?	Does your MCH program have direct access to the state YRBS database for analysis?

	(Select 1 - 3)	(Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2011

Narrative:
Data from the YRBS are used to guide policy and program efforts that discourage tobacco use among high school-aged adolescents. Data from the YRBS is also used for surveillance and evaluation of Michigan's Five-Year Strategic Plan for Tobacco Use Prevention and Reduction 2008-2013. The plan includes five goal areas: 1)identify and eliminate disparities in tobacco use; 2) eliminate exposure to secondhand smoke; 3)increase tobacco dependence treatment among adults and youth; 4) prevent youth tobacco-use initiation; and 5) sustain tobacco control infrastructure and funding. On May 1 2010, a smoke-free air law for all worksites and public places, including bars and restaurants, became effective. Experience in other states demonstrate that such laws increase public perception (including youth) that tobacco use is not the norm and encourage smokers to quit. Other policy initiatives that impact a reduction in youth smoking include smoke-free high school campus policies and increases in tobacco taxes. Smoking among students has dropped statistically significantly since 1997, but has remained flat in the last several years.

Data collected from the 2009 Michigan YRBS indicates:

46% of Michigan students in grades 9-12 reported that they have tried smoking a cigarette, even if it was only one or two puffs

18.8% of Michigan students are current smokers, in that they have smoked at least one cigarette in the last 30 days.

11.7% of the Michigan students reported smoking regularly, in that they smoke at least 2 cigarettes per day within the past 30 days.

IV. Priorities, Performance and Program Activities

A. Background and Overview

For the 2011-2016 period, five of the previous priorities were retained (some wording changes):

Increase the proportion of intended pregnancies

Increase the proportion of CSHCN population that has access to a medical home and integrated care planning

Reduce obesity in children, including children with special health care needs, and women of child-bearing age.

Address environmental issues (asthma, lead poisoning and second-hand smoke) affecting children, youth and pregnant women.

Reduce African American and Native American infant mortality rates.

Little to no consistent progress on reducing infant mortality and its associated risk factors (low birth weight, preterm birth and unintended pregnancy) has been made over the last five years. In addition, there is still great disparity in infant mortality rates among racial and ethnic groups. Activities to address these indicators for the next five years will focus on pre- and inter-conception health, social determinants of health and health behaviors. See NPM #01, NPM #08, NPM #15, NPM #17, NPM #18, SPM #02, SPM #03, and SPM #04.

The Children's Special Health Care Services Division developed a 2010 Action Plan for Children with Special Health Care Needs which included, for each national performance measure, an identification of gaps in policies, analysis of quantity and quality of services, and prioritized recommendations for action. Implementation of the plan is ongoing, including several medical home pilot programs and transition planning for youth with special health care needs. See NPM #2-6.

Activities to improve the health status of children and youth will continue to include cooperation and coordination with other DCH programs (Chronic Disease, Injury Control, Mental Health and Substance Abuse, Medicaid), other state agencies (Education, Human Services, Corrections, and Energy, Labor and Economic Growth), and other stakeholders (Michigan Dental Association, Delta Dental of Michigan, Michigan State Medical Society, March of Dimes, Michigan State University, etc.). Three new priorities will focus on reducing rates of sexually transmitted diseases among youth, increasing access to early intervention services and developmental screening, and increasing access to dental care. See NPM #07, NPM #09, NPM #10, NPM #11, NPM #12, NPM #13, NPM #14, NPM #16, and SPM #05.

B. State Priorities

Increase the proportion of intended pregnancies

According to the Pregnancy Risk Assessment Monitoring Systems (PRAMS), less than half of the pregnancies in Michigan are intended. Intendedness of pregnancy has consequences for maternal health and pregnancy outcomes, as well as economic consequences. Services to support activities related to this priority include family planning (Title X and Medicaid) and Teen Pregnancy Prevention Initiative. Related Performance Measures are NPM #08 and SPM #01.

Increase the proportion of CSHCN population that has access to a medical home and integrated care planning

Children with special health care needs have complex medical problems that require care and services from multiple providers who are frequently not located in close proximity. Often, there is a lack of communication between providers and no focal point for coordination of care. Lack of coordination may cause the condition of already medically fragile children to deteriorate or fail to improve. Several projects are underway to develop or pilot medical home models, including the Department of Pediatrics Henry Ford Health System Cooperative Project, MCAAP Residents

Training, and the CSHCS State Implementation Grant. Related Performance Measure is NPM #03.

Reduce obesity in children and women of child-bearing age, including children with special health care needs.
Data for Michigan residents indicate that rates of obesity for children and adults are increasing. Programs to address this issue include nutrition education through Child and Adolescent Health Centers, Michigan Model, WIC and the Michigan Nutrition Network. The Michigan Steps Up and Generation with Promise programs, developed and operated by Michigan's Surgeon General, promotes healthy eating and physical activity in school-age children and the general population. The Department of Community Health and the Title V program are also partners in the Healthy Kids, Healthy Michigan initiative with the Michigan Chapter of the American Heart Association and approximately 100 other organizations to plan and implement activities designed to reduce and prevent childhood obesity. Related Performance Measure is NPM #14.

Address environmental issues (asthma, lead and second-hand smoke) affecting children, youth and pregnant women.
Lead poisoning is a continuing priority in Michigan, with Black children disproportionately affected. Asthma is one of the leading causes of preventable hospitalization for children. 15.9% of mothers statewide and 31.2% of Native American mothers were exposed to second-hand smoke at home. Programs to address these environmental issues include the Childhood Lead Poisoning Prevention Program, Child and Adolescent Health Centers, Michigan Model, and the Prenatal Smoking Cessation program. Other programs outside of the Title V program address asthma through the Asthma Coalitions in Detroit, West Michigan, Genesee and Saginaw and MDCH Healthy Homes University Program. Related Performance Measures are NPM #15 and SPM #05.

Reduce African American and American Indian infant mortality rates.
According to Michigan Vital Records, Black infants died at 2.7 times the rate for white infants and Native American infants died at 1.5 times the rate for white infants. Black infants were more than twice as likely to have low birth weight as white infants and have higher preterm birth rates. Services to address issues impacting infant mortality include Medicaid-covered services (prenatal care, delivery, neonatal care), Medicaid Outreach, Maternal and Infant Health Program, Safe Delivery, Safe Sleep, FIMR and Maternal Mortality Surveillance. Related Performance Measures are NPM #17, NPM #18, SPM #02, SPM #03 and SPM #10.

Decrease the rate of sexually transmitted diseases among youth 15-24 years of age
Chlamydia rates for 15-19 year-olds increased by 110.6% from 2000 to 2008, and gonorrhea rates increased by 38.5% for the same age group and time period. In addition to the services administered by the Bureau of Epidemiology Communicable Disease Section, Family Planning, Child and Adolescent Health Centers and Teen Pregnancy Prevention Initiative offer services to address sexually transmitted diseases. Related Performance Measure is SPM #06.

Reduce intimate partner and sexual violence
One of the factors affecting maternal depression is exposure to intimate partner and sexual violence. According to the Youth Risk Behavior Survey (YRBS), 12.4 % of high school students experienced dating violence in 2007, and 10.3% were forced to have sexual intercourse they did not want. The incidence of violence is significantly higher among Native Americans. Title V services to address this priority are included in the Maternal and Infant Health Program and the Child and Adolescent Health Centers. Related Performance Measure is SPM #08.

Increase access to early intervention services and developmental screening within the context of a medical home for children
Early identification and treatment of health and development problems in young children can prevent or mitigate the lifelong affects and improve the child's chance of success upon entering school. Programs to address this priority include CSHCS multi-disciplinary clinics, regional perinatal system, Early On, Great Start Collaborative (Early Childhood Comprehensive System),

and the ABCD Project. Related Performance Measures are NPM #01, NPM #03, NPM #04, NPM #05, NPM #12, NPM #17 and SPM #09.

Increase access to dental care for pregnant women and children, including children with special health care needs
Oral health can affect other diseases/conditions and may place pregnant women at risk for pre-term births and low birth weight. In addition, other diseases, such as diabetes, can affect an individual's oral health. According to our Medicaid database, less than 50% of children 6 through 9 years of age received any dental service during 2008. Children with special health care needs especially have difficulty finding a provider. Thirty-nine of Michigan's 83 counties are designated dental Health Professional Shortage Areas. Related Performance Measure is NPM #09.

Reduce discrimination in health care services in publicly-funded programs.
All of the data indicators that were reviewed as part of the needs assessment demonstrated disparity between rates for the white population and other racial/ethnic groups. The Community Conversations series, hosted by the Health Disparities and Minority Health Section of the Public Health Administration, noted a distrust of health care professionals among minority communities and issues of cultural sensitivity and language barriers. A concerted effort to address these disparities must be made if we are to achieve improvements in health status indicators for the maternal and child health population. Related Performance Measures are NPM #08, NPM #11, NPM #13, NPM #15, NPM #18, SPM #01, SPM #02, SPM #03, SPM #04, SPM #05, SPM #06, SPM #07, SPM #08, SPM #10.

While the MCH program has lost significant state funding over the past two years for programs targeting infant mortality and pregnancy prevention, support is still provided to local programs in the form of data and consultation. In addition, the MCH program works with other MDCH programs and other state agencies to coordinate efforts aimed at our mutual target populations. Wherever possible, other funding sources are identified to maintain some level of service in these programs. For example, state funding support for five Nurse Family Partnership projects was eliminated in the FY 2009 budget. However, some of the local sponsors have been able to retain the Medicaid match with local funding sources. In addition, the Patient Protection and Affordable Care Act will enable us to restore and expand programs that address several of our priorities for the next five years.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	96.4	100.0
Numerator	208	189	203	190	220
Denominator	208	189	203	197	220
Data Source				NBS Program data	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?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

During 2009 115,619 newborns received at least one screen and 220 were diagnosed with one of 49 disorders. A system for monitoring collection and transport of specimens by courier from hospitals to the Newborn Screening Laboratory was implemented with a subsequent 23.2 % reduction in average transit time. Hospital staff were trained on how to add the newborn screening card number to the electronic birth record leading to a matching rate of 87.5% and early identification of a small number of newborns (primarily home births) that had not been screened. Training sessions for hospital newborn screening coordinators were conducted at seven regional sites throughout Michigan. Four contractual agreements were maintained for medical management of metabolic disorders, endocrine disorders, cystic fibrosis and Hemoglobinopathies.

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

Michigan is one of six states to receive funding from CDC for hemoglobinopathies surveillance and the newborn screening program is the primary focus for this inititive. As part of this project screening for Hemoglobin H disease was implemented on July 1, 2010. An expert committee on immunological disorders has been formed to develop a proposal for screening for Severe Combined Immunodeficiency (SCID) to be presented to the legislature via the Newborn Screening Quality Assurance Advisory Committee (NBSQAAC). If approved, screening for SCID would begin on October 1, 2010. A new NICU screening algorithm that expands repeat testing to all NICU newborns was implemented on July 1, 2010. It is expected that expanded NICU screening will provide early detection of an additional 20 newborns with congenital hypothyroidism. Performance measures for evaluation of each hospital's newborn screening procedures have been developed that include measures for number of unsatisfactory, late, early and batched specimens and number of cards recorded on the electronic birth certificate.

c. Plan for the Coming Year
Screening and quality control and improvement activities will be continued as described above.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**116226**					
Reporting Year:	**2009**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	115619	99.5	24	15	15	100.0
Congenital Hypothyroidism (Classical)	115619	99.5	676	67	67	100.0
Galactosemia (Classical)	115619	99.5	32	22	22	100.0
Sickle Cell Disease	115619	99.5	70	46	46	100.0
Biotinidase Deficiency	115619	99.5	139	15	15	100.0
Cystic Fibrosis	115619	99.5	507	32	32	100.0
MCAD	115619	99.5	10	9	9	100.0
Other Fatty Acid Oxidation Disorders	115619	99.5	37	8	8	100.0
Organic Acid Disorders	115619	99.5	43	1	1	100.0
Other Amino Acid Discorders	115619	99.5	41	3	3	100.0
Congential Adrenal Hyperplasia (CAH)	115619	99.5	612	2	2	100.0

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	61.3	61.3	61.3	56.4	56.4
Annual Indicator	61.3	61.3	56.4	56.4	56.4

Numerator					
Denominator					
Data Source				NS-CSHCN 2005/06	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	56.4	56.4	56.4	56.4	56.4

Notes - 2009
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 - 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.

a. Last Year's Accomplishments
The Family Center for Children and Youth with Special Health Care Needs (Family Center) 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 provides services to families statewide and serves as the collective voice for families around the state enrolled in CSHCS. The information the Family Center receives from families is used to provide consultation to Michigan Title V programs regarding policy and program development. All written materials intended for families created by CSHCS, as well as CSHCS policy and procedure, are reviewed by the Family Center for recommendations or revisions. Review, comment, and recommendations to policies, letters, and other documents by a parent representative are an ongoing activity for the CSHCS division. The Family Center also provides review of the federal MCH Block Grant application, as was provided in 2009.

One of the main services the Family Center provides to families is the toll-free Family Phone Line. The Family Phone Line is used by families throughout the state of Michigan, whether they are enrolled in CSHCS or not. The Family Phone Line is used to assist families in accessing providers, obtaining information on the CSHCS program, and general information and referral for families of children with special needs. In 2009 the phone lined handled 20,064 calls. The Family Phone Line subscribes to a Language Line and in 2009 approximately 66 calls used the language line, primarily for translation into Spanish and Arabic.

The Family Center continues to provide parent support through their Family Support Network of Michigan. The Family Support Network matches support parent volunteers with other parents in similar situations in need of support. In 2009 the Family Support Network made 109 parent matches and trained 123 support parents providing services across the state of Michigan for

parents with children with special health care needs.

The Family Center also provided conference scholarships for youth and family to attend conferences around the United States that pertain to their diagnosis. In 2009 the Family Center provided scholarships to 57 people. In addition to providing funding for families, the Family Center was able to provide funding to local health departments in the form of mini-grants to support local health in their efforts in partnering with families. This past year the mini grants were awarded to eight local health departments, increasing family participation at the local level. As a result eight parent networking events were hosted in four separate counties, financial support was provided for parent support groups, family forums were conducted, a parent liaison was hired, along with many educational opportunities for families.

Housed within the Family Center is the Family to Family Health Information Center. The Family to Family grant funded through HRSA has allowed the Family Center to focus on providing valuable trainings and other resources. In 2009 the Family to Family Health Information Resource Center trained 491 people on topics that included; Communication and Self-Advocacy, Health Resource Support Parent Training, Becoming a Family Support Network Parent, Helping Families and Young Adults Protect Their Rights, Bullying and Positive Behavior Reinforcement, Planning for a Child's Education Training, and Is Your Teen Ready for Adult Life. Multiple trainings were held on each topic throughout Michigan.

In 2009 the Family Center held its biennial conference "Relatively Speaking". Relatively Speaking is a one of a kind weekend conference focusing on the issues of siblings of children with special health care needs. This year 225 people attended the conference. With great feedback the conference is already planned to be held again in 2011.

CSHCS continues to focus on implementing its strategic planning objectives developed in April 2008. In 2009, each of the six groups focused on the MCHB core CSHCN outcomes convened workgroup meetings to discuss objectives. Also in 2009 an update meeting was held for all stakeholders to maintain interest and momentum toward the goals and objectives addressed by each workgroup.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued Family Center policy making activities.				X
2. Maintained the Family Phone Line.		X		
3. Provided insurance training seminars for families.		X		
4. Partnered with the Family Center on training activities through the Family to Family Health Information Center grant program.		X		
5. Provided mini grants to local health deparments for family participation activities.	X			
6. Held biennial Relatively Speaking conference.		X		
7. Provided conference scholarships to family and young adults		X		
8.				
9.				
10.				

b. Current Activities

The Family Center is partnering with Michigan's Integrated Community Systems of Care for Children and Youth with Special Health Care Needs grant project by working closely with the medical home pilot sites in getting input from the families they serve. The Family Center is

currently working with medical home partners to help host a "Medical Home Family Gathering". The gathering is an opportunity for families to share their thoughts about the medical home clinic, talk about suggestions for improvements and changes that could be made to improve the quality of care.

The Family Center is also sponsoring a large insurance training seminar for up to 100 persons. The day long session will include such information as Insurance Issues in Michigan Today for Consumers, Insurers, and Providers; Insurance Advocacy and working with families to access insurance both private and publicly funded; Insurance Skills and Knowledge for Families; What to do when insurance coverage changes; CSHCS and COBRA; CSHCS Coverage of Deductibles; Medicaid Eligibility; Applying for Healthy Kids; The Children's Waiver; TEFRA. Based on the feedback of the training other training locations are being planned, including a training in June 2010 for CSHCS employees.

c. Plan for the Coming Year

The Family Center will continue to provide consultation to the Michigan Title V programs, as well as keeping existing services to families that include:

•The Family Phone Line
•The statewide Family Support Network
•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 Information Resource Center.
•Continue to provide mini-grants for local health departments to increase family involvement at the local level.
•Partner with the Medical Home grant project to provide insurance training seminars and other family support activities with the help of each pilot practice site.

The biennial conference for siblings of children with special needs, Relatively Speaking, is already scheduled for October 7-9 2011 in Grand Rapids Michigan.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55.8	55.8	55.8	46	46
Annual Indicator	55.8	55.8	46	46	46
Numerator					
Denominator					
Data Source				NS-CSHCN 2005/06	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	46	46	46	46	46

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

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.

a. Last Year's Accomplishments
Michigan's Integrated Community Systems of Care for Children and Youth with Special Health Care Needs project is designed to support the implementation of the six core components of a system of services for children and youth with special health care needs (CYSHCN). Implementation is being supported through the establishment and regionalization of the medical home model throughout the State of Michigan. The medical home model provides an evidence-based vehicle to implement the six core components of a system of services in a culturally competent, coordinated, and comprehensive manner that can be applied across the state. 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.

Since the beginning of the second project year in June, 2009, we have successfully recruited and are working with seven new practices. We continue our close affiliation with the Michigan State University Pediatric Primary Care Clinic which has served CSHCS with practice-based Medical Home experience for several years. The seven new practices represent a range of practice types and settings across the State, and they have different histories in caring for children with special health care needs. They are also mixed in their history and implementation of aspects of the Medical Home practice model.

Seven practices identified as medical homes have completed the Medical Home Index and are developing/implementing quality improvement activities. After receiving each practice site's application and completed Medical Home Index, a visit with the practice team was scheduled at which the project objectives were discussed and the planned quality improvement activity. After the site visit, our evaluators from the University of Michigan Child Health Research and Evaluation unit contacted the practice about base line measures. All of these things have to be in place before we can start working with the practice on implementing focus groups and identifying parent partners to be part of the improvement teams. CSHCS stayed in touch with the sites and offered help and resources as they can use them.

CSHCS continues to focus on implementing its strategic planning objectives developed in April, 2008. In November, 2009, an update meeting was held to maintain interest and momentum. Progress toward each of the goals and objectives was addressed by the various work group teams.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Recruited seven new medical home practices to participated in HRSA Integrated Community System of Care grant project.	X			
2. Partnered with seven medical home practice sites to each to complete the Medical Home Index.				X
3. Partnered with seven medical home practice sites to develop and implement quality improvement activities based on the Medical Home Index.				X
4. Worked cooperatively with several growing medical home efforts in Michigan.				X
5. Launced a medical home website.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Children's Special Health Care Services (CSHCS) is also working with four other practices and expect to enroll them as Medical Home pilot sites before the end of 2010. These four sites will go through the same process as the previous seven practice sites with the completion of the Medical Home Index and submission of practice specific quality improvement projects.

Michigan State University (MSU) Pediatric Primary Care Clinic has been a declared Medical Home for several years through CSHCS. The Family Center, which is the parent-directed section of CSHCS, has helped them conduct focus groups in the past and is planning another with parents and providers. This "Medical Home Family Gathering" is an opportunity for families to share their thoughts about the clinic, talk about suggestions for improvements and changes that can be made to improve the quality of care. Having had a series of focus groups, MSU is now actively planning a parent advisory group, and we are working with them and parents to look at the role of parent partners with the practice through grant support. Each practice has different needs and resources so it is a different set of activities and approaches with each Medical Home setting.

CSHCS with support from Michigan's Integrated Community Systems of Care for Children and Youth with Special Health Care Needs project continues to work closely with and keep abreast on all the major medical home activity throughout the nation and across the state.

c. Plan for the Coming Year

In Michigan there are several growing efforts helping promote the Medical Home model of care, and as more and more practices take note of discussions about health care reform and systems of care, meaningful use of IT, etc, it is easier to work with practices as they become ready and interested in making changes. In addition to the Michigan Primary Care Consortium which is allied with the Patient Centered Primary Care Collaborative, Michigan Medicaid is working with several projects including the Robert Wood Johnson Foundation sponsored "Reducing Disparities at the Practice Site" which is supporting practice transformation at six practices in the Detroit area. They are helping practices that serve large numbers of Medicaid clients achieve NCQA Physician Practice Connections Patient Centered Medical Home (PPC PCMH) recognition.

The largest Medical Home initiative in Michigan was launched by Blue Cross Blue Shield of Michigan through its Physician Group Incentive Program (PGIP). Current areas of focus include

developing a sophisticated information infrastructure and using it to proactively manage chronic illness on a long-term basis.

Michigan's Integrated Community Systems of Care for Children and Youth with Special Health Care Needs project has its last project year in 2011. The project coordinator and all project partners are looking at ways to sustain the project. One area of sustainability is reimbursement for medical home. Medical home funding and reimbursement systems are being implemented. The new Medicaid processing system, CHAMPS, Community Health Automated Processing Systems, has the capacity to allow CSHCS to reimburse medical home providers. In February, 2010, we asked each of our medical home sites for the names of two children who were a part of their medical home practice, were enrolled in CSHCS, and who were enrolled in Medicaid to test the system. We have successfully enrolled six children and letters have been generated. Additional names have been given us and permission obtained from the parents to enroll the children as test cases. In addition, we are monitoring the system closely from a parent's perspective. An employee, a parent and parent trainer with the Family Center, enrolled her daughter in the MSU Medical Home through the CHAMPS System. She is monitoring and giving CSHCS feedback on the CHAMPS communications as to timing, accuracy, and usefulness for families.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	66.5	66.5	66.5	60.8	60.8
Annual Indicator	66.5	66.5	60.8	60.8	60.8
Numerator					
Denominator					
Data Source				NS-CSHCN 2005/06	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	60.8	60.8	60.8	60.8	60.8

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

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.

a. Last Year's Accomplishments

Children's Special Health Care Services (CSHCS) provides coverage for medical care and treatment for 2,500 different diagnoses. In 2009 the program provided services to 36,577 children. Children's Special Health Care Services also has the Insurance Premium Payment Benefit. This benefit has been in place for over 14 years, whereby the state pays the private health insurance premium for the eligible client. This benefit allows for the CSHCS client to maintain their private health insurance coverage that they may otherwise not be able to afford. This enables the state to prevent a shift in the 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. Cost effectiveness must be proven in order for CSHCS to pay premiums.

Because of the hard hit economy, particularly in Michigan's auto industry, many more CSHCS beneficiaries have taken advantage of the Insurance Premium Payment benefit. In 2009, the Insurance Premium Payment Benefit assisted 299 families with insurance premiums. This is a 48% increase from 2008.

CSHCS took a proactive approach to helping families as the economy continued to decline by providing outreach to families with other insurance showing in our database. A letter was mailed to approximately 11,000 CSHCS enrolled families in April of 2009 reminding them of the CSHCS Insurance Premium Payment benefit.

CSHCS also worked closely with our partners to provide up to date information on insurance to our clients. The CSHCS program partnered with the Family to Family Health Information Center and their educational training sessions to provide information on insurance in their Health Resource Support Parent Training sessions that were held throughout the state.

CSHCS continues to focus on implementing its strategic planning objectives developed in April 2008. In 2009, each of the six groups focused on the MCHB core CSHCN outcomes convened workgroup meetings to discuss objectives. Also in 2009 an update meeting was held for all stakeholders to maintain interest and momentum toward the goals and objectives addressed by each workgroup.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided insurance training seminars for families.		X		
2. Provided financial assistance to families who needed hlep paying for insurance premiums and COBRA coverage to maintian benefits.	X			
3. Supported local health departments efforts in assisting families who may be eligible for the Insurance Premuim Payment Benefit.		X		
4. Increased outreach for the the Insurance Premium Payment Benefit thought direct mailings to families and increased circulation of the brochure.		X		
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
CSHCS continues to assist families to 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.

A large Insurance training seminar was recently conducted in Grand Rapids, Michigan for both consumers and professionals. The day long session included such information as Insurance Issues in Michigan Today for Consumers, Insurers, and Providers; Insurance Advocacy and working with families to access insurance both private and publicly funded; Insurance Skills and Knowledge for Families; What to do when insurance coverage changes; CSHCS and COBRA; CSHCS Coverage of Deductibles; Medicaid Eligibility; Applying for Healthy Kids; The Children's Waiver; TEFRA. Based on evaluation and feedback the seminar will be replicated for other audiences and offered to various stakeholders.

c. Plan for the Coming Year
The CSHCS division will continue with the Insurance Premium Payment Benefit. Based on feedback from the 2008 Strategic Planning sessions, stakeholders encouraged CSHCS to provide further program outreach to publicize the program to enroll new clients with special health care needs. The Program will plan to systematically share information about the CSHCS program and its benefits at identified entry points. The program will do this by reaching out to Children's hospitals, Pediatric Regional Centers, children's multidisciplinary clinics and client organizations such as the United Cerebral Palsy foundation, hemophilia foundation and others.

CSHCS is also looking into the feasibility to begin identifying clients on the CSHCS system with no other private health insurance and assisting them in the process of obtaining health insurance in the individual market, with CSHCS paying the cost of the premium to help offset costs. In addition the program is staying up to date on all aspects of health care reform that will effect the CSHCS population. The program is particularly interested in the how Michigan's high risk pool will be formed and how that might assist with the adult population on the program with hemophilia and cystic fibrosis.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75.7	75.7	75.7	90.9	90.9
Annual Indicator	75.7	75.7	90.9	90.9	90.9
Numerator					
Denominator					
Data Source				NS-	NS-

				CSHCN 2005/06	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90.9	90.9	90.9	90.9	90.9

Notes - 2009
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

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.

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. 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 2009, the program rolled out online access to the CSHCS database to our local health department partners. Online access to the CSHCS database allows local health department staff working with CSHCS families to have the most up to date information on eligibility and enrollment, authorized providers, and other information incoming to CSHCS Central Office.

Another technological improvement that has benefited our communication with our local partners is the use of an online paperless fax system called EZ-Link. While before local health departments, hospitals, and providers had been faxing in updates and medical information, these documents were faxed traditionally and reached us in paper form, causing the headache of logging in each fax and managing all the paper documents coming in. Once the division converted our medical records into electronic files it made no sense to continue to receive faxes in paper form. With the use of EZ-Link the division's fax line now uses this system to automatically convert the paper document into an electronic file. EZ-Link also allows the document to follow a certain workflow and can be moved around from person to person electronically. This has virtually eliminated the problem of lost faxes and paper shuffling from desk to desk. It has made CSHCS Central Office more efficient in communicating back and forth with our local partners such as local health departments and medical providers.

In 2009, the CSHCS Outreach/Publicity group finalized plans for and acquired posters for the CSHCS program, display boards with CSHCS information, and new brochures have been printed and distributed across the state to provide program and contact information relative to the CSHCS program. All materials that were created utilized a new CSHCS logo and have a consistent appearance. The step of creating outreach materials and streamlining the look of our

materials was brought forth by our strategic planning partners.

The CSHCS program's Nurse Consultants have also proved a valuable resource for our local partners. The Nurse Consultants each work with a specified region on the state and have provided technical assistance to our local health department partners in the form of site visits and monthly conference calls.

CSHCS continues to focus on implementing its strategic planning objectives developed in April 2008. In 2009, each of the six groups focused on the MCHB core CSHCN outcomes convened workgroup meetings to discuss objectives. Also in 2009 an update meeting was held for all stakeholders to maintain interest and momentum toward the goals and objectives addressed by each workgroup.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Trained hosptials and discharge planners for referrels to and working with the CSHCS program.		X		
2. Partnered with local health departments to implement secure on-line access to the CSHCS database for increased community based support.		X		
3. Developed and distributed streamlined marketing materials for the CSHCS program into the community.				X
4. Provided techinical assistance to local health departments through public health nurse consultants.		X		
5. Recruited seven new medical home practices to participated in HRSA Integrated Community System of Care grant project.	X			
6. Implemented the use of EZ Link for faxes and messages to local partners.				X
7.				
8.				
9.				
10.				

b. Current Activities

The division is working closely with the Family Center to provide increased outreach and information to hospitals and discharge planners on referral to and working with the CSHCS program. The program is also using its Michigan's Integrated Community Systems of Care for Children and Youth with Special Health Care Needs project to increase access to community based services for children and youth with special health care needs and their families through the use of the medical home model. There are currently eight medical homes throughout the state supported by this project. With the Integrated System on Care grant this is being increased to eleven medical home practice sites this year.

The CSHCS nurse consultants are 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.

In 2010, the Family Center will conduct 10 training seminars to hospitals across Michigan to teach

CSHCS basics and provide further outreach for enrollment.

c. Plan for the Coming Year

Since the program relies heavily on the local health departments as our local arm, we will continue to provide them with the most recent up to date CSHCS information possible. The CSHCS database is currently in the process of being rewritten. The new CSHCS database will be more user-friendly and technologically up to date. One of the barriers to full implementation of the CSHCS online database at the local level was technical issues such as compatibility with operating systems. With the new online database these issues should be resolved and our local partners will all be able to have timely and consistent information. The planned implementation date for the new CSHCS online database is approximately June 2011.

For the coming year the CSHCS program will continue to partner with the Family Center to provide further outreach to the community with trainings and information distribution to hospitals and medical providers. The program is also planning to share information about the CSHCS program and its benefits at identified entry points. The program will do this by reaching out to Children's hospitals, Pediatric Regional Centers, children's multidisciplinary clinics and client organizations such as the United Cerebral Palsy foundation, hemophilia foundation and others.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.8	5.8	40.8	40.8
Annual Indicator	5.8	5.8	40.8	40.8	40.8
Numerator					
Denominator					
Data Source				NS-CSHCN 2005/06	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40.8	40.8	40.8	40.8	40.8

Notes - 2009

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

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.

a. Last Year's Accomplishments
As part of Michigan's Integrated Community Systems of Care for Children and Youth with Special Health Care Needs project a pilot was created to provide medical homes and CSHCS clients with USB flash drives for transition planning. Flash drives were used based on the "Consensus Statement on Health Care Transitions for Young Adults with Special Health Care Needs". The consensus statement names six steps for successfully transitioning to adult oriented health care. Two of those steps include "Create a written health care transition plan by age 14" and "Prepare and maintain an up to date medical summary that is portable and accessible". Technologies now support these goals and allow patients to take control of their health information and keep their own records with the use of a USB flash drive. Health care transition plans as well as other medical information can be saved and used on the flash drive, and will be portable and accessible.

Along with the flash drives, CSHCS created a new resource for young adults and their families on the topic of transition. The guidebook titled "Transition Planning: A Guidebook for Young Adults and Family", is a 15 page guide divided into 5 main sections; Health Care Transition , Educational Transition, Adult Living, Bringing it All Together, and Community Agencies: Navigating the Maze. Each section provides background information and tips, tools, and strategies to assist in the process of transition planning. The flash drives CSHCS are using have been pre-loaded with a copy of the Transition Guidebook for Young Adults and Families along with transition planning worksheets.

Another major milestone was the automation of CSHCS program's transition anticipatory guidance letters. In previous years the anticipatory guidance letters were hand generated and mailed. With the new Medicaid Management system called CHAMPS the program was able to build in the automatic creation and mailing of the anticipatory guidance letters. Each month the CHAMPS system identifies clients based on their birthdates to create five client/family specific letters for ages 16, 17, 18, and 21. Additionally, monthly, any CSHCS authorized provider with a client turning 16, 18, and 21 will receive a letter reminding them of the importance to discuss transition planning with them at their next visit.

CSHCS continues to focus on implementing its strategic planning objectives developed in April 2008. In 2009, each of the six groups focused on the MCHB core CSHCN outcomes convened workgroup meetings to discuss objectives. Also in 2009 an update meeting was held for all stakeholders to maintain interest and momentum toward the goals and objectives addressed by each workgroup.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Created "Transition Guidebook" to medical home practices, families, and community partners.		X		
2. Obtained and distributed USB flash drives for piloted use in medical homes to provide youth with accessible and portable medical information	X	X		

3. Automated process for creation and mailing of transition related anticipatory guidance letters to youth with special health care needs.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Current transition activities include the distribution of both the transition guidebook and the transition USB flash drives. While part of the Michigan's Integrated Community Systems of Care grant, each resource will be provided to our partnering medical home practice sites. We are also in the process of distributing guidebooks and flash drives to other CSHCS families on the program, with outreach to clients through the Family Center's monthly Heart to Heart memo and partnering with our local health departments and other local partners such as hospitals and medical providers.

The CSHCS division also monitors closely the creation and distribution of the transition anticipatory guidance letters through the CHAMPS system to monitor defects and other system problems and to ensure that all clients who should be receiving the anticipatory guidance are in fact receiving them.

c. Plan for the Coming Year
For the upcoming year CSHCS hopes to revitalize its Youth Advisory Committee and other youth leadership activities. The Committee, named the Early Adult Transition Task Force (EATT), hit a snag with low youth involvement and problems in recruitment. These problems will be addressed and with the support of the Family Center will work to provide a compensated and diverse Youth Advisory Committee.

The CSHCS division will continue to monitor the USB transition flash drive pilot project by following up with recipients, with a survey, to gain information on their experience with and the usefulness of the flash drive in transition planning. Follow up will provide the program with information on whether or not this is a valuable transition planning activity and how to proceed with the project.

While the Transition guidebook is being distributed to many partners we are working within the department to have the guidebook translated in both Spanish and Arabic. Once in a translated format the new versions will be available electronically to those who need it. If funding is available the translated document will be printed.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	89	91	91	91	85

Annual Indicator	82.7	81.2	81.8	82.0	74.9
Numerator	157364	154510	154222	152195	139832
Denominator	190283	190283	188535	185604	186692
Data Source				Nat'l Imm. Survey, MCIR	National Immunization
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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	86	87	88	89	90

a. Last Year's Accomplishments

The immunization rates for Michigan show a drop from 82% to 74.9% for the 4:3:1:3:3 series. The reason for the drop in Immunization coverage rates for Michigan is because of a National shortage of Hib vaccine and the recommendation from the CDC to suspend the booster dose of Hib vaccine. The National Immunization Survey (NIS) also assessed the vaccination level for 4:3:1:0:3:1 that did not include Hib but also added in 1 dose of varicella vaccine. The rate for this series was 84.6% and Michigan had the second highest immunization rates in the country and recieved national recognition for having the second best rates in the country. According to the same NIS, Michigan had the highest coverage rates in the country for 4 doses of DTaP vaccine and second highest coverage rates in the country for birth dose Hepatitis B.

In 2009 and 2010 the Immunization program ordered and distributed over 2.7 million doses of 2009 H1N1 influenza vaccine. The Division was responsible for enrolling additional providers into the program and assuring that the vaccine was administered appropriately and accounted for. There were 3,628 provider practices enrolled in the H1N1 program to administer the vaccine. The Immunization program activated the All Hazard module in the Michigan Care improvement Registry. All H1N1 vaccine inventories and publically purchased antivirals were added to provider inventories. Vaccine and antiviral medications were tracked in the MCIR. Over 1.6 million doses of vaccine were tracked in the MCIR system. The immunization program developed immunization nurse education training modules for H1N1 vaccine information.

All VFC providers in MCIR were trained to use the Vaccine Inventory Module (VIM) in the MCIR system. Implementing the VIM allows MDCH to better track all publicly purchased vaccines and provide for current inventories of vaccine throughout the state. As doses of vaccine are administered, vaccine inventories are reduced which provide for better vaccine accountablility. Better forcasting of vaccine can be done since vaccine eligibility is now recorded on vaccine administered.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to enhance the Vaccine Inventory Module in the MCIR to better account for and track vaccine inventories in provider offices.			X	
2. Implement the electronic ordering of vaccines in the MCIR.			X	
3. Implement an electronic interface using HL7 messages in the			X	

MCIR to make reporting of immunization data to the MCIR more accurate, more timely, and more efficient.				
4. Continue to track immunization levels statewide to identify pockets of need and identify areas with low immunization rates.			X	
5. Continue to track the impact of the Hib vaccine shortage and work with local health departments and provider offices to assure children are appropriately vaccinated and caught up now the at the shortage is resolved.			X	
6. Work with local heatlh departments and private provider offices to gain acceptance and promote the new Pneumococcal Conjugate 13 valent vaccine in all children less than 5 years of age.			X	
7.				
8.				
9.				
10.				

b. Current Activities
MCIR has a module which allows schools and childcare centers to assess and report the immunization status on all the children enrolled in their programs. This system was first deployed several years ago but is currently being updated to support the implementation of new administrative rules for schools. On Jan. 1, 2010 the new requirements became effective to be first reported by schools in Nov. 2010. These new rules require a 2nd dose of varicella vaccine and age appropriate adolescents 1 dose of meningococcal vaccine and one dose of Tdap vaccine.

A pilot program is underway to implement an electronic vaccine ordering system in the MCIR which will allow providers and local health departments to order vaccine using the MCIR. This electronic vaccine ordering system will be used by all LHDs and participating private providers. MDCH has also been chosen by the CDC to pilot the submission of electronic vaccine orders to CDC using the MCIR.

Planning for an electronic data exchange between the MCIR and private provider electronic medical record systems using HL7 messages is currently underway. This transparent transfer of data between EMRs and the MCIR will greatly enhance the efficiency of data exchange between EMRs and MCIR. This upgrade focuses on the validation of electronic data received by MCIR.

c. Plan for the Coming Year
The Immunization program will fully implement the electronic vaccine ordering funtionality in the MCIR and deploy that funtionality to all enrolled clinics after the pilot is completed. This coupled with an electronic data interface with a electronic data system being developed by the CDC to accept these vaccine orders will greatly increase the efficiency and processing of vaccine orders in the state. MDCH has been asked to be the pilot project with the CDC on the electronic data exchange with CDC.

MCIR will be working with clinics across the the state that have Electronic Medical Records (EMR's) to create an electronic interface using HL7 messaging so data can be transmitted directly from EMR's to the MCIR. Not only will this process improve the efficency of uploading records to the MCIR, it will also have many more data quality monitoring funtionality built into the system so we will have improved data quality for the MCIR.

The immunization program will continue to monitor the uptake of the new vaccine requirements for schools and child care centers. The new requirements for 2nd dose varicella vaccine and one

dose of Tdap and meningococcal vaccines will first be reported by schools in November of 2010. Michigan is one of the first states in the country to require these two vaccines for adolescents.

The Immunization program has been working with individuals from the chronic disease area to add Body Mass Index (BMI) measurements in MCIR. The majority of the programming in the MCIR to implement this funtionality is completed and work is being done to modify the administrative rules to allow for the recording of this information in the MCIR.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	17.8	17.6	17.4	17.4	17
Annual Indicator	17.6	17.0	14.0	16.8	15.5
Numerator	3934	3802	3127	3629	3354
Denominator	222960	223398	223398	216619	216619
Data Source				MI vital Records	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?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	16	15.9	15.8	15.7	15.6

a. Last Year's Accomplishments
MDCH's Teen Pregnancy Prevention Initiative funded 4 community organizations to implement Safer Choices, an evidence-based teen pregnancy prevention program in their communities for youth 10-18 to delay the initiation of sexual intercourse or increase condom use for those who are already sexually active. The overall goal of TPPI is to decrease the rate of teen pregnancy and the associated risk behaviors. Last year was a pilot year. Data from the pilot year is being analyzed, but preliminary data shows success via several indicators.

The Michigan Abstinence Program funded 9 organizations to implement an abstinence-only until marriage curriculum in their communities for youth 12-18 to delay the initiation of sex until marriage. The overall goal is to decrease the rate of teen pregnancy and the associated risk behaviors. However, due to the expiration of Title V funding, the MAP is no longer in existence.

The second annual Moving Toward Solutions: Addressing Teen Pregnancy Prevention Conference in Michigan drew over 200 participants from throughout the state, including health care professionals, health educators, teachers, social workers/counselors, youth, administrators, etc.. The conference focus included several sessions on male involvement and understanding the male image of girls and women in this country.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Provided abstinence education to 5,100 youth		X		
2. Provided parent education to 2,000 parents		X		
3. Supported local coalitions and programs through the Michigan Abstinence Program				X
4. Conducted a statewide media campaign			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Teen Pregnancy Prevention Initiative is currently funding the same 4 organizations to implement Safer Choices, an evidence-based teen pregnancy prevention program in high-risk communities for youth 10-18 to delay the initiation of sexual intercourse or increase condom use for those youth that are already sexually active. The overall goal is to decrease the rate of teen pregnancy and the associated risk behaviors. So far, results are showing a positive impact on students' knowledge, skills, and attitudes.

The third annual Moving Toward Solutions (MTS): Addressing Teen Pregnancy Prevention Conference in Michigan is currently being planned. The conference will take place next year with Elizabeth Schroeder and Kwian Bryant as keynote speakers. Participants will include health care professionals, health educators, teachers, social workers/counselors, youth, administrators, etc.

The Adolescent Clinical Guideline for the Prevention of Pregnancies Among Adolescents 12-17 has been approved by the Michigan Quality Improvement Consortium and is being prepared for wide dissemination throughout MI to primary care providers and physicians. As far as we are aware, MI is the first state to develop an evidence based clinical guideline for the prevention of adolescent pregnancies. As a supplement to the guideline, MDCH has developed an online toolkit for providers, parents and youth. The toolkit can be located at www.michigan.gov/teenpregnancy.

c. Plan for the Coming Year
Next year, it's expected that MDCH will have multiple teen pregnancy prevention initiatives, including the Teen Pregnancy Prevention Initiative, Michigan Abstinence Program (Title V funding restored), Personal Responsibility and Education Program (newly created program). The Department is in the process of applying for both Tier 1 and Tier 2 HHS-Office of Adolescent Health, Teen Pregnancy Prevention funding to replicate evidence based programs in high need, underserved areas of the State.

The third annual MTS conference will Occur in October with a theme of "bridging the gap". The conference and all of its sessions will focus in some manner on the issues of gaps, whether in disparities, funding or others. We anticipate 200-250 participants.

The Adolescent Clinical Guideline will continue to be disseminated to primary care providers throughout the state, and the toolkit will be updated with the latest resources, statistics, and information.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	33.6	25	25	30	35
Annual Indicator	22.5	23.4	23.4	31.3	26.0
Numerator	28170	29350	29350	41094	33579
Denominator	125417	125417	125417	131500	129152
Data Source				SEALS Data	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	45	50	55	60

Notes - 2009
A school-based dental sealant coordinator was recently hired to work with grantees on their data collection and reporting, as well as resolving discrepancies in the reports.

a. Last Year's Accomplishments
The Michigan Department of Community Health-Oral Health Program continued the state-wide dental sealant program in 2008-2009, targeting the first permanent molars for second grade students. Eligible schools were those that have greater than 50% or more participation in free and reduced lunch programs. The SMILE! Michigan dental sealant program provided funding to six (6) grantees that placed over 10,000 dental sealants. They served a minimum of 198 schools. In addition to dental sealants the students received oral health education, fluoride varnish, and referrals for emergent dental care. 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 uses 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 MI Dept of Community Health- Oral Health Program currently has five (5) grantees under the Title V funding. The program is growing and the current year provides dental sealants to first,

second, sixth, and seventh graders. The grantees are serving more schools, thus more students and serving more grades (the program began with only placing dental sealants on second graders and now serves first, second, sixth, and seventh graders), therefore grantees request more funding. Eligible schools were those that have greater than 50% or more participation in free and reduced lunch programs. In addition to dental sealants the students received oral health education, fluoride varnish, and referrals for emergent dental care. Data on the program included the number of children screened, the number of sealants placed, and a myriad of other socioeconomic and demographic factors. Grantees are currently in a minimum of 150 schools placing dental sealants. It is anticipated that 13,000 dental sealants will be placed this grant year. Retention checks to ensure the dental sealants retained are performed on 20% of the children within each school and grantees are required to have a 90% retention rate on occlusal surfaces. The Count your Smiles Survey is a survey on the oral health status of the third graders in Michigan. The survey will provide new dental sealant information on third graders in Michigan and will be used to direct the future of the dental sealant program

c. Plan for the Coming Year

The Michigan Department of Community Health -- Oral Health Program had 11 proposals in response to the request for funds proposal (RFP) for grant year 2010-2011. Of those 11, there will be five (5) grantees funded. The grantees are all growing and establishing their programs to ensure future sustainability of their programs. The grantees will provide dental sealants to first, second, sixth and seventh grade students. Eligible schools enrolled will be schools that have greater than 50% or more participation in free and reduced lunch programs. In addition to dental sealants the students received oral health education, fluoride varnish, and referrals for emergent dental care. Retention checks to ensure the dental sealants retained are performed on 20% of the children within each school and grantees are required to have a 90% retention rate on occlusal surfaces. The program will continue to be evaluated to further shape the needs of the grantees and students in Michigan. The dental sealant program will have a name change from SMILE! Michigan to SEAL! Michigan on October 1, 2010.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.1	3.4	3.2	3	2.3
Annual Indicator	3.1	2.5	2.3	2.3	1.9
Numerator	65	50	47	44	36
Denominator	2066272	2019667	2019667	1945927	1945927
Data Source				MI Vital Records	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	2.2	2.2	2.1	2.1	2

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

a. Last Year's Accomplishments
Activities of the MDCH Injury & Violence Prevention Program:

>> Three Child Passenger Safety (CPS) Technician CEU trainings were held to recertify eighty-six technicians.
>> Three CPS Technician Certification trainings were conducted for fifty-seven technicians.
>> Three CPS for School Buses trainings were conducted for sixty-one school bus drivers.
>> Two CPS for Emergency Medical Services (EMS) trainings were conducted for seventeen EMS personnel.
>> One CPS Technician Renewal course was conducted to recertify ten technicians whose certifications had expired.
>> A CPS for Special Health Care Needs training was conducted for eighteen healthcare staff.
>> The CPS for Law Enforcement training curriculum was completed.
>> Six community car seat check events were held in underserved counties. At the events, 138 child safety seats were inspected with an average misuse rate of 94 percent. Seventy-six seats were replaced.
>> Three CPS education and car seat events were held with Migrant Head Start agencies where 146 child safety seats were inspected with an average misuse rate of 95.3 percent. A total of 132 seats were replaced or provided to families in need.
>> More than 700 child safety seats were purchased for distribution at various community events.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted CPS Technical Certification and education 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 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
Plans for FY 11 will be very similiar to the FY 10 plans. An Occupant Protection Assessment will be conducted by the National Highway Traffic Safety Administration for the Michigan CPS Program in the Fall of 2010. The results from this assessment will help drive future planning and activities for this program.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		35	40	20	20
Annual Indicator	14.6	15.8	15.8	15.3	18.5
Numerator	6345	6618	6619	6652	8302
Denominator	43459	41890	41890	43476	44879
Data Source				PNSS/PedNSS	PNSS/Ped/NSS
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	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	20	22	23	25	25

a. Last Year's Accomplishments
The WIC Division offers Breastfeeding Basics (BFB), Breastfeeding Coordinator (BFC) and Milk Expression (ME) training. In FY 2008 -- 2009, 140 local agency (LA) staff and other health care providers attended BFB, 20 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, staffed by peer counselors employed by Michigan State University Extension (MSUE).

The WIC Division's intensive effort resulted in completion, testing and rolling out the new MI-WIC data system, which has the capability of improved tracking of breastfeeding promotion and support services, as well as recording breastfeeding education provided to pregnant and lactating women. Michigan Breastfeeding Awareness Month (August) was celebrated with: a proclamation from the Governor; press releases for the state and local agencies; development and distribution of breastfeeding promotion displays and materials for use by the local WIC & MSUE agencies and activities such as breastfeeding walks, billboards, rock & rest tents at local festivals.

The WIC Division continues to provide leadership in a multi-state nutrition education internet project, www.wichealth.org. The on-line wichealth.org breastfeeding module continues to be utilized by breastfeeding mothers, with positive feedback.

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 and/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 and peer support services to breastfeeding moms and fathers 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 provided in 38 counties				X
3. Implemented new 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 Breastfeeding Friendly Community in Bay County				X
6. Celebrated MI Breastfeeding Awareness Month (August)				X
7.				
8.				
9.				
10.				

b. Current Activities

During FY '10, 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; 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. New breastfeeding training, Glow and Grow, has been provided to WIC staff statewide. Grow and Glow is a hands-on training to increase WIC staff ability to support breastfeeding clients. Certified Lactation Specialist training was provided to local agency staff to increase the number of trained lactation professionals in local WIC agencies. Genesee County received technical assistance via a USDA grant application, in addition to subsequent WIC funding, to develop community support for breastfeeding. A county breastfeeding coalition was developed as a result of this technical assistance; a peer counselor grant has been submitted by Genesee County for funding in FY 2011. An RFP for a new breastfeeding counseling services model was issued this year to local WIC agencies to provide clinic-based peer counseling services to WIC clients. MSUE will continue to provide home-based peer counseling services.

c. Plan for the Coming Year

We will continue most of the activities as described above. In addition, the peer counseling funding for local WIC agencies will be implemented, expanding the number of peer counselors trained to provide services to WIC mothers and infants.

In the redesign of the Maternal Infant Health Program, interventions that educate, support and encourage breast feeding are included in the maternal packet which is received by every pregnant Medicaid woman who has had a completed maternal risk assessment. The benefits of breast feeding are explained to the women and referral to the WIC program in their area is

mandated by Medicaid Policy. Breast feeding is also discussed in the infant nutrition interventions. Encouragement and support for this activity is expected by MIHP professionals to women who choose this method of infant feeding.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	95.4	96.7	97.1	96.7	97.3
Numerator	121640	121898	119770	116318	112464
Denominator	127518	126015	123407	120240	115576
Data Source				EHDI Database	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?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
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 4% referred in 2008. Of infants diagnosed with hearing loss, 54% were identified prior to 3 months of age. 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, 18% received services prior to 6 months of age.
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. Newborn hearing screening results are now displayed online for provider access via the Michigan Care Improvement Registry (MCIR). 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 112,464 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
Collaboration with the MCIR continues to be a priority. EHDI is proceeding with developing 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.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.6	3.7	3.5	4.5	6
Annual Indicator	3.7	5.0	4.7	4.7	4.7
Numerator	93000	128000	116049	113000	110445
Denominator	2513514	2554000	2445601	2390198	2349892
Data Source				2008 CPS	2008 CPS
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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6	5.9	5.9	5.8	4.5

a. Last Year's Accomplishments
MDCH continued to make outreach funds available to local public health departments. This collaboration resulted in an increased number of enrollments as well as providing much-needed outreach to uninsured families. MDCH continued to work towards identifying additional

community-based partners to assist in the outreach efforts to uninsured and underinsured children with dual program enrollment continuing. Efforts continued to focus on underrepresented groups, which often have higher numbers of uninsured individuals.

2009 data for the uninsured are not yet available from the Current Population Survey. Data for Michigan is expected to show an increase in the percentage of uninsured children as a result of the loss of jobs and their associated benefits. Enrollment in publicly-insured programs increased in 2009.

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		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. Continued local public health outreach		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Outreach funding to local public health continues along with consultation and technical assistance from MDCH. As always, outreach and enrollment efforts will include identification and participation of community based partners. The policy of dual program enrollment is continued. Despite dramatic state revenue reductions and budget cuts, the Department continues to advocate for maintenance of current benefits and eligibility for Medicaid and MIChild.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		16	15.8	29.5	29

Annual Indicator	16.1	16.2	29.5	30.1	30.3
Numerator	15434	15516	28255	29469	34690
Denominator	95863	95780	95780	97905	114489
Data Source				PNSS/PedNSS	PNSS/Ped/NSS
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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	28.5	28	27.5	27.5	31

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 works with chronic disease to deliver client and professional messages about decreased later-life incidence of obesity by infants being breastfed. Local WIC nutrition educators receive client information related to obesity and physical activity for children. The Internet Nutrition Education Project, www.wichealth.org, provides WIC clients with several topics on feeding children using Stages of Change and Division of Responsibility, concepts which promote healthy parenting around meals. These educational modules support 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 with their children.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Worked with chronic disease to deliver messages about decreased later-life incidence of obesity by breastfed infants				X
2. Provided information to local WIC nutrition educators on obesity and physical activity				X
3. Provided client education via Internet Nutrition 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 22 modules currently in use (8 in Spanish). New modules are developed each year to support parent and child information related to good nutrition, the dietary guidelines and physical activity,

Continued activities as stated above.

c. Plan for the Coming Year
By October of 2010, all modules on wichealth.org will be translated into Spanish. Also, several whole grain foods are being added to the WIC Food Package which was changed in August 2009 to reflect more whole grain foods and fruits and vegetables for WIC clients. These additions follow Institute of Medicine recommendations for foods that will help fight obesity that occurs in the WIC participant population. This package also places a strong emphasis on breastfeeding by increasing the foods available to the breastfeeding woman-infant dyad.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		14.6	13.6	12.6	16.8
Annual Indicator	15.6	17.5	17.1	17.5	17.5
Numerator	19851	22281	21371	21120	20407
Denominator	127249	127537	125172	120601	116610
Data Source				PRAMS	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	16.7	16.7	16.6	16.5	16.5

a. Last Year's Accomplishments
Michigan continues to integrate prenatal smoking cessation into all perinatal programs. A mainstay in the prenatal smoking cessation efforts has been the Smoke Free For Baby and Me (SFBM) evidence-based program which has been supported with continued collaboration between the Chronic Disease Tobacco Section and the Women, Infant and Family Health Section. Statewide efforts to decrease smoking tobacco in the general population claimed a significant victory when Michigan became the 38th state to ban smoking in public places. The legislative bill became effective May 1, 2010.

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 and providers		X		

through the "I Can Quit" or the MCH hotlines				
4. SFMB web-based online requirement for all MIHP providers statewide		X		
5. State legislation to ban smoking in public places, effective May 1, 2010			X	
6. Development of MIHP home visiting program policy requirements for intervention on both tobacco use and exposure to second-hand smoke.				
7.				
8.				
9.				
10.				

b. Current Activities

The Smoke Free for Baby and Me (SFBM) training has continued to be offered as a web-based online requirement for all MIHP providers statewide. The SFBM program is designed to address the risk of smoking tobacco in pregnant women and mothers of infants in order to decrease the percentage of women who smoke during pregnancy and expose their infants to second-hand smoke. During 2009-2010, intensified efforts to accelerate progress toward decreasing the percentage of women who smoke during the last 3 months of pregnancy included statewide policy and system changes: (1) legislation, effective May 1, 2010, to ban smoking in public places and (2) the development of MIHP home visiting program policy requirements for intervention on both tobacco use and exposure to second-hand smoke.

c. Plan for the Coming Year

Expansion plans for the Smoke Free Baby and Me (SFBM) program for 2010-2011 will include the collection and monitoring of data on the number of women smoking during pregnancy to identify potential gaps and/or barriers in service delivery and to inform the program of potential changes needed for further development. An additional web-based training on tobacco in pregnancy will be promoted to MIHP providers statewide. Completion of the update online training will provide both Nursing and Social Work continuing education credits.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.1	7.9	7.8	7.7	7.3
Annual Indicator	8.2	7.9	7.0	7.3	7.8
Numerator	61	59	52	54	58
Denominator	745736	745908	745908	739588	739588
Data Source				MI Vital Records	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.3	7.2	7.2	7.2	7.2

a. Last Year's Accomplishments
The MDCH Injury and Violence Prevention Program completed the final year of activities related to its three year youth suicide prevention cooperative agreement from the federal Substance Abuse and Mental Health Services Administration (SAMSHA). The grant allowed 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, work on building state infrastructure around suicide prevention, provide limited grants to communities, and conduct evaluation of efforts. The MDCH Injury and Violence Prevention Program also applied for and received an additional three years of funding, which will take the Transforming Youth Suicide Prevention in Michigan program through September of 2013.

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 0.5 FTE working specifically on the activities funded under the SAMHSA youth suicide prevention grant.

MDCH and the Michigan Association for Suicide Prevention are working 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
Continue to support training and programming activities across the state.
Secure support for implementation of high priority objectives of the suicide prevention plan.
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 Suicide Prevention and other public and private entities.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88.2	88.2	88.4	88.4	80
Annual Indicator	86.4	85.9	85.0	78.0	85.2
Numerator	1849	1796	1826	1708	1646
Denominator	2140	2090	2147	2191	1931
Data Source				MI Vital Records	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	80	81	82	85	86

a. Last Year's Accomplishments
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 (LOC) 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. Eighteen 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.

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

The Regional Perinatal System did not experience a lot of activity this pass year as funding was an issue in its implementation. Legislation was in process for a Regional Trauma System for Michigan that was tied to a funding mechanism. It was decided to work collaboratively with the Emergency Medical Services section of MDCH, which would be responsible for the Regional Trauma System, to help in the development of the Perinatal Regional System. The funding for the Perinatal Nurse Consultant, that would support the Perinatal Regionalization System was also determined. It is anticipated that the position will be filled as of August 1 2010. MDCH will be convening a work group to outline our next steps of action to implement the recommendations for a perinatal care system. A survey of birthing hospitals was issued in June to obtain baseline information to compare to the recommended perinatal LOC guidelines. This information will be collected and analyzed over the next several months by MCH epidemiologists working with the Michigan Health and Hospital Association and Michigan Certificate of Need areas to assure response submissions.

c. Plan for the Coming Year

The Perinatal Nurse will be in place and will be working with the Regional Trauma System, health care systems and physicians to obtain buy-in on the Perinatal Regionalization System and the guidelines. It is expected that a lot of meetings and presentations will be required to obtain the support of the various stakeholders in the state. The regional perinatal system planning committee will also make revisions to their plan as necessary and begin the implementation process. A notice with go out to those who participated in the original work to invite them to be part of the on-going Michigan Perinatal Care Interest Group.

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	2005	2006	2007	2008	2009
Annual Performance Objective	86.6	87.8	89	90.3	90.3
Annual Indicator	83.3	83.3	81.5	73.2	73.5
Numerator	106238	106188	102050	88791	85762
Denominator	127518	127537	125172	121231	116610

Data Source				MI Vital Records	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
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90.3	90.3	90.3	90.3	90.3

a. Last Year's Accomplishments
Standardized interventions, forms, trainings, risk identification and developmental screening and operation procedures created for MIHP. The coordination and working relationships between MIHP providers and the Health Plans was formalized with care coordination agreements. The MIHP program also saw an expansion of the network of providers--particularly in the City of Detroit.

The five Nurse Family Partnership (NFP) projects had their state funding eliminated last year but four of the five projects continued services with funding from Medicaid match, foundations and local contributions.

The Medicaid Family Planning Waiver continued with increased outreach and assistance for FQHCs and other providers.

Redesign of the Maternal Infant Health Program (MIHP) has continued. The MIHP chapter of the Medicaid Policy Manual has been revised; and was implemented July 1, 2010. The comprehensive MIHP Operations Guide, which outlines program implementation detail and includes standardized MIHP forms and interventions, will accompany the policy.

A series of training videos, providing baseline information on the maternal and infant domains have been filmed and are available on the MIHP website www.michigan.gov/mihp. The website has been enhanced to include extensive resources for MIHP providers and beneficiaries. A twitter site has also been established to provide up to date information about concerns affecting pregnant woman, infants and their families http://twitter.com/MyMIHP.

Anticipated outcomes of the redesign 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.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The four Nurse family Partnership projects will continue enrolling clients and offer early intervention for first time pregnancies	X			
2. Plans to analyze data collected from the pilot prenatal projects and the NFP sites to learn best practices for improving early entryto prenatal care				X
3. Plans for the department to look at ways to study how much				X

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.				
4. Completion and final roll-out of all redesign components of the Maternal Infant Health Program (MIHP) including: policy documents; program database and technology software; opportunities for public comment as well as health care provider & stakeholde		X		
5. Collaboration with multiple referral pathways through women & family programs to promote access & encourage early prenatal care being in the first trimester: MIHP, WIC, Plan First, MOMS, NFP, Healthy Kids for Pregnant Women, LIF				X
6. Revision of MQIC Guidelines For Unintended Pregnancy that emphasize connection and referral to primary care providers, local health department, family planning clinics, Plan First, and federally qualified health centers (FQHCS).				X
7.				
8.				
9.				
10.				

b. Current Activities

The MIHP redesign was completed with increased emphasis on communication with the medical care provider and the Medicaid Health Plans. Training was completed for all of the coordinators on the new forms, policy, operation guide, training and philosophy. Efforts to address the delay in the Medicaid application approval for pregnant women have been undertaken and multi-department cooperation has been seen.

Calhoun County has received a Kellogg Foundation Grant award to support implementation of an NFP program in their community. The four current NFP projects are continuing services awaiting possible funding assistance though health care reform's home visiting allocation.

Title X Family Planning and Medicaid Family Planning Waiver activities continued this year.

Healthy Kids For Pregnant Women Program that provides comprehensive health care for pregnant women of any age is also available.

The MOMS Program (Maternity Outpatient Medical Services) provides immediate prenatal care while a Medicaid application is pending and is available to teens who chose not to apply for Medicaid.

c. Plan for the Coming Year

MIHP redesign effort with new Medicaid policy, procedures, forms and requirements began July 1, 2010. The program's evidence based, standardized interventions will focus on prenatal care and improving the life conditions affecting pregnancy outcomes. Anticipated results include: (1) early entry into MIHP and prenatal care (2) reduction of amenable risk factors (3) reduction of infant death rates and sickness rates; (4) delivery of full term, healthy babies; (5) developmentally healthy infants; (6) physically, emotionally healthy mothers; (7) conduct of timely quality assurance site reviews to enforce Medicaid policy; (8) evaluation and assurance of accountability for quality service delivery, and (9) provision of consultation and technical assistance to local providers. The MIHP redesign will continue with a plan to enhance data collection and quality assurance.

Early entry into prenatal care with support for compliance to prenatal visit schedule and requirements will be continued by the NFP projects where 91% of the pregnant women enrolled in the NFP program gave birth to full term babies.

The Medicaid Family Planning Waiver will continue. 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 plans for the upcoming year include: (1) final planning & development of the state perinatal regionalization strategic plan; (2) further integration and collaboration of public health programs at the local community and state level; (3) enhanced data collection and stakeholder dissemination to increase knowledge, identify gaps, monitor service delivery, and improve quality early prenatal care.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25	30	35	40
Annual Indicator		100.0			173.0
Numerator		1			20024
Denominator		1			11576
Data Source					Medicaid Database
Is the Data Provisional or Final?					Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	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.

a. Last Year's Accomplishments
Over 31,000 pregnant women with Medicaid insurance were screened for perinatal risk factors in Michigan's Maternal Infant Health Program (MIHP) prior to the beginning of FY 09/10. The tool utilized by the program to screen pregnant women (the MIHP Maternal Risk Identifier) has the Edinburgh Postnatal Depression Scale (EPDS), the Perceived Stress Scale (PSS) and the T-ACE screening tools embedded in the questions. Of the women screened, initial reports indicated that 64% scored low risk for depression on the Edinburgh, 5% scored moderate and 30% scored high risk for depression. This result did not match the anecdotal information received from MIHP programs and led (among other screening results) the team to work with Michigan State University and the State of Michigan Department of Technology to adjust the screening algorithm. Another issue that was identified and addressed was the fact that Michigan Medicaid provides up to 20 outpatient mental health visits to beneficiaries through the services of the Medicaid Health Plan--but--due to delay in processing Medicaid applications and delay in assignment to a

Medicaid Health Plan, many beneficiaries have not been able to access mental health treatment until very late in their pregnancies. A "Mental Health Services for MIHP Beneficiaries" committee formed which will work to address issues around statewide access to needed mental health services.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Stress Scale (PSS) and T-ACE which are embedded in the MIHP Maternal Risk Identifier			X	
2. Plans to improve service access for pregnant Medicaid recipients enrolled in the MIHP		X		
3. Provide videotaped training sessions for MIHP providers on perinatal depression, infant mental health, domestic violence, motivational interviewing, maternal trauma and bonding and other perinatal risk domains				X
4. Provide perinatal mood disorder resources on MIHP website www.michigan.gov/mihp and MIHP twitter feed http://twitter.com/MyMIHP			X	
5. Convene "Mental Health Services for MIHP Beneficiaries" committee to address systems issues in the state around access to mental health services for pregnant women with Medicaid				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In Februray 2010, a Medicaid Mental Health Substance Abuse Authorization and Payment Responsibility Grid was established to determine which mental health and substance abuse services the Community Mental Health System is responsible for and which services the MIHP beneficiary's Medicaid Health Plan must authorize and reimburse. The grid provides guidance to MIHP providers regarding services available and with whom to coordinate MIHP beneficiary clinical care. The Maternal Risk Identifier algorithm was also adjusted in 2010. It now accurately reflects the level of the pregnant Medicaid beneficiary's mental health risk based on response to the standarized tools (Edinburgh, PSS and T-ACE) embedded in the MIHP Maternal Risk Identifier. Also, the statewide committee established to evaluate the systems response to mental health needs of pregnant Medicaid beneficiaries has been meeting. They are examining the role of the Social Worker and Infant Mental Health Specialist on the team and have informed the development of the standardized mental health and substance abuse interventions that will became effective July 1, 2010. Discussion continues around ways to improve access to mental health and substance abuse services for pregnant women and infants. Finally, links to mental health and substance abuse services that are available in communities throughout Michigan were posted on the MIHP website www.michigan.gov/mihp

c. Plan for the Coming Year

As standardized interventions are utilized in the statewide Maternal Infant Health Program (MIHP) and access to both mental health and substance abuse services are improved, it is anticipated that the number of pregnant Medicaid beneficiaries that appropriately engage in mental services will increase. Reports will be developed to analyze data collected from administration of the MIHP Maternal Risk Identifier and information gleaned from those reports will inform program development. CEU's will be available in the next year for MIHP Registered Nurses and Social

Workers for completion of the video series on maternal domains. The series includes sessions on motivational interviewing, maternal trauma and the affect on bonding with baby, domestic violence and infant mental health, among others. The statewide committee addressing mental health services for pregnant Medicaid beneficiaries will continue to identify and address systems issues related to access to care and payment for services.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.8	8.2	8.1	8	7.9
Annual Indicator	8.4	8.4	8.4	8.5	8.4
Numerator	10665	10720	10550	10339	9771
Denominator	127518	127537	125172	121231	116610
Data Source				MI Vital Records	MI Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	7.8	7.8	7.7	7.6	

a. Last Year's Accomplishments
The provider network of MIHP providers has continued to expand (76 providers as of June 2010). The program's evidence based/standardized interventions, which focus on improving access to prenatal care, smoking cessation, improving nutrition and improving the life conditions that affect pregnancy outcomes, have been rolled out to the state.

A series of training videos, containing baseline information on the maternal and infant domains, have been filmed and are available for MIHP professionals in the field to view. In the videos, which are available on the MIHP website www.michigan.gov/mihp, experts address topics such as tobacco use and exposure to second hand smoke, chronic disease in pregnancy, domestic violence, mental health, substance use and interconception health.

The MIHP website has been enhanced to include extensive resources for providers and beneficiaries. A Twitter site has also been established to provide up to date information about concerns affecting pregnant woman, infants and their families: http://twitter.com/MyMIHP.

The evidence-based standardized Maternal Infant Health Program (MIHP) interventions were developed to address risk factors that contribute to low birth weight and very low birth weight. MIHP continues 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.

MIHP 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.

Funding for the Interconception Care Project (ICP) ended effective July 1, 2009 due to state budget cuts. The ICP collaborated with multiple community resources to generate referrals, including the Fetal and Infant Mortality Review (FIMR) program, Healthy Start, hospital NICUs, the MIHP, and the Women, Infant and Children (WIC) program. 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.

State funding for the five Nurse Family Partnerships ended also on June 30, 2009. The projects were able to continue the rest of the fiscal year with the use of foundation, local and Medicaid match funds.

MDCH convened work groups of clinical experts in neonatal, obstetrical, and pediatric specialties in early 2009. These work groups were charged with modifying the current, evidence-based levels of care guidelines published by ACOG and AAP to reflect Michigan specific standards of perinatal care as a foundation for the State's coordinated perinatal system. Findings included: optimal delivery of a high risk neonate (750 -- 1250 grams birth weight) is in a tertiary care center; and in-utero transfers are optimal (due to lower morbidity & mortality). This extends to birth weight less than 2000 grams, where mortality was higher if delivered in hospital with no NICU (odds ratio (OR) 2.38), intermediate NICU (OR 1.92), or community NICU (OR 1.42). Other factors contributing to mortality and morbidity include maternal socio-behavioral risk which accounted for 73 percent of the variation in hospital fetal death rates and 38 percent of hospital neonatal mortality rates. Inborn VLBW and neonatal transport had significant, independent effects on both hospital fetal death rate and hospital neonatal mortality rate. One of the intents of this process is to provide a framework to define and evaluate the level of perinatal care delivered by hospitals and to ensure that care meets specific level of care criteria.

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

MIHP has embedded standardized screening instruments into the maternal risk identifier. There are questions in the tool regarding previous pregnancy outcomes, chronic disease & other factors that may lead to low birth weight & other poor pregnancy outcomes. MIHP maternal interventions are now standardized.

The Nurse Family Partnership (NFP) programs, have continued in 4 of the 5 communities. Cross program collaboration has been increased to strengthen the positive support from each program for women who receive services from multiple programs.

MDCH staff is working on more strategies to screen women who are abusing substances during pregnancy. Motivational interviewing & brief interventions & referral for more intense substance abuse treatment is also being used. Increased capacity for FAS screening, diagnosis & treatment is being demonstrated through collaboration of community partners & state agencies.

MDCH has implement the CDC recommendation to use a life course perspective for programming framework.

MDCH will continue to meet with their partners to implement the recommendations to reestablish a Perinatal Regionalization system and to: adopt the MI Perinatal Level of Care Guidelines; develop a method of authoritative recognition of levels of NICU care & establish a statewide mechanism to oversee & enforce adherence to the MI guidelines; require level III NICUs should have a NICU Follow-up Clinic & receive home visits; and develop a system to follow-up on NICU graduates

c. Plan for the Coming Year

With implementation scheduled July 1, the MIHP team is focusing on assisting providers in the field with the transition to the new standardized program model.

Planning for the implementation of recommendations of the Perinatal Regionalization Team is underway. Fiscal resources will be the biggest challenge. An initial step will be the hiring of MDCH staff to coordinate the implementation process. Further work on organizing a leadership team to manage communication, training and project oversight will be a goal for 2011.

Federal funding opportunities for home visiting will be pursued.

Training for MIHP providers and others on the need for preconception and interconception care to address the risks for preterm and low birthweight births will be emphasized in goals for 2011. More evaluation of the MIHP program to determine its efficacy and fidelity to design will be conducted in 2011, especially as new risk assessment and additional strategies for mothers during the first year of infant life are begun.

Emphasis will be placed on subrecipient monitoring, quality assurance and quality improvement activities.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	11	11	10.9	10.2	10.2
Annual Indicator	10.0	9.6	10.0	10.8	10.5
Numerator	12794	12297	12523	13037	12295
Denominator	127518	127537	125172	121231	116610
Data Source				MI Vital Records	MI Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10.1	10.1	10	9.9	

a. Last Year's Accomplishments

MDCH began an intensive strategic planning process early 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(ICP) was active in 11 communities. Over 300 women were enrolled and case managed to reduce their risks for another poor pregnancy outcome. On July 1, 2009, the ICP program was eliminated due to state budget cuts.

MIHP continued 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 provided early intervention for first time pregnancies. Effective July 1, 2009, state funding for these projects was eliminated. The Smoking Cessation Program launched on line training courses for providers. In addition MIHP quality assurance site visits resumed in 2009.

MDCH partnered with health systems and local health organizations on the Detroit Regional Infant Mortality Reduction Task Force that meets quarterly in Detroit. The group has combined information to produce an inventory of local services, to hold trainings on infant mortality reduction and to plan for community systems change to improve the social determinants of health.

The Perinatal Regionalization work groups met and completed work on recommendations for a new system in Michigan to improve the quality of care for very preterm infants. A report was completed in 2009 with a set of recommendations for implementing a new regional system of NICU care.

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 program that serves all Medicaid	X			
3. Re-establish the Perinatal Regional System of care				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. Develop, implement the MDCH Infant Mortality Strategic plan to address health, mental, and social issues that impact preterm delivery rates.				X
8. Continue the redesign of MIHP with the goal of a more effective maternal and infant health program				X
9. Continue the Medicaid Family Planning Waiver program to reduce unintended pregnancies	X			
10.				

b. Current Activities

MDCH uses a lifecourse framework for developing strategies to improve pregnancy outcomes, particularly preterm birth. A SPRANS grant opportunity was sought to emphasize the identification and prevention of chronic illness, particularly heart disease, among young women that may impact their pregnancy with poor outcomes for the infant as well as the mother.

Further efforts to identify racial disparities in preconception findings are being added to program planning & to care coordination expectations of the MIHP program for maternal support. MIHP mininmal maternal interventions are now standardized & have an emphasis on early entry into care, early risk assessment, & interconception care.

Further data analysis was started regarding Right Start, PRAMS, and YRBS to help understand the social determinants of health that relate to preterm birth.

The recommendations of the Regional Perinatal Work Group are being disseminated across the state especially to potential and existing tertiary care centers.

Several counties have continued to provide home visitation for women with poor pregnancy outcomes such as preterm birth during the interconception period despite the loss of state funding.

MDCH is submitting a grant application to support infant mortality reduction efforts in the state. The purpose of this grant is to increase public awareness of resources available in MI for women preparing for childbirth & new parents through advertising campaigns & other media methods.

c. Plan for the Coming Year

MDCH will continue to develop strategies to identify effects of social determinants of health, such as inadequate economic resources, poor quality environments and unsupportive social environments. Because these factors seem to influence the outcome of pregnancies and are not addressed routinely in existing health care, more emphasis will be directed in public programs to find solutions.

MDCH will continue to work with the Detroit Regional Infant Mortality Reduction Task Force to find locally based strategies to improve pregnancy outcomes, and particularly to improve access to preconception and interconception care.

MDCH will begin the implementation process for a Perinatal Regional system using the recommendations of the work group that was published in April 2009.

Funding will be sought for federal home visitation dollars to supplement home visiting programs in the state.

A final report of the evaluation of the pilot Interconception Care program (ICP) will be completed. The objectives of the ICP will be translated to existing programs so that parts or all of the components of care between pregnancies can be adopted for the most at-risk women.

More collaboration will be sought between MCH, Mental Health, Substance Abuse, Chronic Disease, Minority Health, Primary Care and Medicaid programs to understand other stressors on women's health and to develop strategies to affect health behavior change.

The MIHP redesign will continue with a plan to enhance data collection and quality assurance. The MIHP redesign team will continue to work with the Department of Technology and Budget to convert the standardized MIHP program forms to electronic documents. Once the conversion is complete and the forms are functional, then the field can enter beneficiary risk, intervention and outcome information directly into the state data base and reports can be run to evaluate the collective risks of the population and inform program enhancement. Currently the maternal risk

identifier is in electronic format. The infant risk identifier and discharge summaries are next.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	38.7	38.7	38.3	37.8	37.3
Annual Indicator	41.8	40.7	40.2	39.6	39.6
Numerator	53330	51909	50284	47770	46178
Denominator	127518	127537	125172	120601	116610
Data Source				PRAMS	PRAMS
Is the Data Provisional or Final?				Provisional	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	37.3	37.3	37.3	37.1	

a. Last Year's Accomplishments
Per Medicaid policy, all beneficiaries in the MIHP program are provided family planning information and referral to the reproductive health provider network. With implementation of the new evidence based/standardized interventions, comes an expectation that post pregnancy family planning is discussed early and often in the pregnancy and an application for Plan FIRST! the Medicaid waiver program, is facilitated.

Until 2010 all methods of contraception are available through Medicaid and Michigan's Title X Family Planning program, including permanent contraception for both sexes. Medicaid recipients were able to get sterilization through their health care provider and the Title X Family Planning program offered the service through a cost efficient centralized project site. There were 92 procedures for women and 99 procedures provided for men in CY 2008. To manage the dwindling fiscal resources of the program for the new calendar year 2010, we found it necessary to terminate the centralized sterilization service. Medicaid recipients still are able to access this service through a private health care provider.

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 2008; this objective was not met last year. In 2009, 26% of the caseload served was teens; 31,882 male and female teens were served in Family Planning Clinics.

All beneficiaries in the MIHP program are provided family planning information and referral to a reproductive health provider network. The program's evidence based/standardized interventions 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. Provided Family Planning services statewide	X			

5. Implemented Michigan Abstinence Program		X		
6. Provided education and referral services through school based/linked health services		X		
7.				
8.				
9.				
10.				

b. Current Activities
MIHP maternal interventions are now standardized and work to improve options for women at risk. The program has an emphasis on family planning which includes discussion of contraception alternatives early in pregnancy & during the interconception period.

MIHP's evidence based/standardized interventions focus on family planning in pregnancy as well as in the interconception period. Through out pregnancy family planning discussion/planning is required at each reimbursable visit.

In 2009, 120,577 women and 4,144 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
With implementation scheduled July 1, the MIHP team will focus on assisting providers in the field with the transition to the new program model.

The evidence-based standardized MIHP interventions requirement has an effective date of July 1, 2010.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	60	70	80	30	35
Annual Indicator	27.1	28.9	29.2	28.6	28.6
Numerator	96887	105514	107856	108249	114018
Denominator	357527	364858	369615	377921	398990
Data Source				MDCH Data Warehouse	MDCH Data Warehouse
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	40	45	50	55	

a. Last Year's Accomplishments

The percentage of Medicaid children tested for lead poisoning did not increase in 2009. The actual number of Medicaid enrolled children tested did increase by over 5700 children. This increase corresponds to the increase in the number of children enrolled in Medicaid. Recent MMWR suggested that in many states, Medicaid enrollment was no longer an indicator of risk for lead poisoning. A review of Michigan data, however, indicates a higher prevalence still exists among Medicaid enrolled children. Michigan's statewide testing/screening plan continues to list Medicaid as a criterion for testing.

While the state performance measure calls for data related to Medicaid enrolled children, CLPPP monitors testing data for all children less than six years of age. There was an increase in the number of children less than six years of age who were tested in 2009 over 2008. 1,043 more Michigan children were tested in 2009 with 283 fewer children poisoned. In 2009, 1,403 children were identified with blood lead levels equal to or greater than 10 ug/dL, which represents 0.9% of the children tested, which is near the national average of 1.2% in 2006 (the latest national average data available). In 2009, an additional 11,341 children less than six years of age had blood lead levels between 5-9 ug/dL, which decreased from 12,778 in 2008.

The Childhood Lead Poisoning Prevention Program (CLPPP) coordinator co-taught a Case Management track at the CDC National Lead Poisoning Prevention Training Center in collaboration with the National Center for Healthy Housing. Several participants from Michigan attended this training. The objective of the training is to improve states' abilities to define and provide comprehensive, coordinated, family-centered case management services to children with lead poisoning.
Both CLPPP nurse consultants were trained and credentialed as Healthy Homes Specialists through the National Center for Healthy Housing.

Despite state economic constraints in 2009, 10 local public health agencies continued to receive funding with a minimum award being provided to assure that every grantee agency has sufficient base funding for program operations. The funding formula continues to be based on 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 2008 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 2009), that were weighted and applied equally. 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. Updated web-based Lead poisoning training modules.		X		
4. Testing benchmarks include a 5% increase (over previous year) in testing of one and two year olds in the target communities.			X	
5. State Prevalence rate goal is 0.6%			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. Collaborated with Ad council on new 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		X		

department staff on the revised protocol and new chart forms.				
10.				

b. Current Activities
The statewide percentage is 73% of children enrolled in Medicaid who have been tested at least one time by three years of age. This includes those enrolled in managed care, fee-for-service and Children's Special Health Care Services (CSHCS) dual enrolled.

The Childhood Lead Poisoning Prevention and Control Commission 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 development of a program designed to educate rental property owners about the need for lead hazard remediation, drafting of a position paper on implementing a tax on paint sold in Michigan, development of a letter to pediatric providers to increase lead testing in their practices, and assuring compliance with the new EPA Renovating, Remodeling and Painting (RRP) Rule.

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. Services were provided to 46 families in 2009. Funding was also made available to expand these primary prevention services to the west side of Michigan. CLPPP and CLEARCorps will be working with the Healthy Homes Coalition of West Michigan to provide these services.

CLPPP submitted a CDC grant proposal to fund a conference to be held in 2010 to build on the conference conducted in 2008.

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. CLPPP will collaborate with the CDC to transition to the new Healthy Homes and Lead Poisoning Surveillance System (HHLPSS) database. The testing goals for both the state and the target communities will represent a 5% increase (over 2009) in testing among children one and two years of age. The prevalence of lead poisoning for the entire state for calendar year 2010 will decrease to 0.2%. 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 measurable outcomes.

If funds allow, the 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 and implementation of healthy homes concepts. 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 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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25.7	90	90	89	88
Annual Indicator	98.4	52.5	87.0	44.1	49.4
Numerator	22	12	19	10	11
Denominator	22365	22873	21848	22695	22270
Data Source				MI Vital Records	MI Vital Records
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	86	84	82	82	

a. Last Year's Accomplishments
The method for case ascertainment continued to involve collaboration between the MCH epidemiology team and the Division for Vital Records and Health Statistics to create an electronic linked file of maternal deaths. In addition, reports of maternal deaths were also submitted on a voluntary basis by health care providers, health care facilities and/or individuals aware of a maternal death. An annual analysis of maternal morbidity was completed. Both pregnancy & non-pregnancy related cases are reviewed by two maternal mortality surveillance committees, the Michigan Mortality Surveillance (MMMS) Medical Committee and the Michigan Maternal Mortality Surveillance (MMMS) Injury Committee. MMMS committees consist of members with expertise regarding the causes of death under review and a total of six meetings were convened during FY'09-10 to identify interventions and strategies for preventability. A third committee, the Interdisciplinary Committee is comprised of members from the Medical and Injury committees met in September 2009 and identified the following recommendations to reduce maternal mortality in Michigan.

2009-2010 Interdisciplinary Injury Committee Recommendations:
1) Increase early screening, diagnosis, and referrals to specialists & relevant community resources for follow up among women (preconception, during pregnancy, postpartum and interconception) who screen positive or have known history of mental health, substance abuse, and/or domestic violence.
Goal: Decrease 'missed opportunities' for improved mental, physical and social healthcare among women of reproductive age.
2) Match injury-related MMMS case reviews to the decision/policy makers from local community or state agencies to advise about current ordinances, regulations, and/or policies -- for example: fire marshal, housing authority for apartment buildings, human services, health plans, court systems, etc. related to issues identified.
Goal: Increase impact and success of MMMS Injury Committee preventability recommendations.
3) Utilize existing data sources: MMMS, PRAMS, BRFSS, SAMSHA to identify the highest-risk populations who have most significant correlations between mental health, substance abuse, domestic violence and maternal mortality.
4) Develop a two-track jointly sponsored communication campaign with MSMS, ACOG, and CNM organizations:
Track #1: Professional communication/academic detailing to increase healthcare provider knowledge in Michigan.
Track #2: Public Service Announcement (PSA) to raise general public awareness.

Goal: Decrease injury-related maternal mortality in Michigan using 3 important principles:

- Injury-related maternal mortality is a Real problem
- Recognize the problem
- Respond to the problem

FY 2009-2010 Interdisciplinary Medical Committee Recommendations:

1) Work with State of Michigan Cancer Registry to ensure:
   - All maternal deaths w/cancer diagnosis are reported.
   - Analyze all cancers deaths for women of reproductive age (12-44 years or 15-44 years).

   Goal: Determine any patterns in diagnosis and treatment of cancers that occur in women of reproductive age.

2) Complete retrospective hemorrhage-related study of maternal mortality in Michigan: 1985-2005.

   Goal: Publish policy and/or system recommendations regarding 'lessons learned' from hemorrhage-related maternal mortality cases in Michigan.

3) Develop methodology to utilize MI-PPCM database for all cardiomyopathy case reviews beginning FY 09-10.

   Goal: Identify possible funding sources and submit proposal for MI-PPCM study.

4) Develop a series of MMMS slides in collaboration with MDCH -- include appropriate acknowledgements such as state staff contact names.

   Goals:
   - -Use as reference for educational purposes by committee members at 'Grand Rounds', continuing education and conferences with external stakeholders.
   - -Accurate identification of data sources.

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. Publish Interdisciplinary recommendations				X
4. Distribute Annual Maternal Mortality Report				X
5. Plans are under way for statewide dissemination of Michigan Automated Prescription System (MAPS) outcome data for 2006-2008.				X
6. 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.				X
7. Research study of hemorrhage-related maternal mortality completed. Peripartum Cardiomyopathy subcommittee developed database.				X
8. Medical Examiner Letters for statewide dissemination to increase awareness and notify county medical examiners of the value of pathology information for all maternal deaths..				X
9. HIPPA-compliant teaching synopses of MMMS case reviews presented at statewide Women's Primary Care Conference.				X
10. Injury subcommittee to identify types injury-related data to monitor, parameters of preventability and dissemination of finding for co-occurring disorders involving substance abuse, mental health and domestic violence.				X

b. Current Activities
Medical Examiner template letters were developed for statewide dissemination to county medical examiners to increase awareness and value of pathology information for all maternal deaths.

Educational presentations about Michigan Automated Prescription Service (MAPS) were provided statewide to educate, increase awareness and encourage utilization of MAPS by all providers who prescribe controlled substances. A new process has been approved to review MAPS reports for maternal deaths involving substance abuse.

HIPPA-compliant teaching synopses of MMMS case reviews were presented as a breakout session December 2009 at the statewide Women's Primary Care Conference.
Peripartum Cardiomyopathy Subcommittee developed a specific database for review of all cardiomyopathy maternal death reviews & feasibility of funding opportunities were explored.
Injury Committee subcommittee met to discuss: 1) monitoring Injury-related data for the non-pregnancy related maternal mortality cases; 2) parameters of preventability; 3) possible dissemination of findings to provider and advocacy organizations to increase awareness of co-occurring disorders involving substance abuse, mental health and domestic violence.
Research study of hemorrhage-related maternal mortality was completed.

The Annual Michigan Maternal Mortality Surveillance Status Report was published and disseminated statewide.

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 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. An updated analysis of maternal morbidity by using the MMMS data set will be completed each year. The collaboration between epidemiology, maternal child health, genomics and chronic disease programs will continue.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		35	40	20	25
Annual Indicator	14.6	15.8	15.8	15.3	18.5
Numerator	6345	6618	6619	6652	8302
Denominator	43459	41890	41890	43476	44879
Data Source				PNSS/PedNSS	PNSS/PedNSS
Is the Data Provisional or Final?				Provisional	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	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 2008 -- 2009, 140 local agency (LA) staff and other health care providers attended BFB, 20 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, staffed by peer counselors employed by Michigan State University Extension (MSUE).

The WIC Division's intensive effort resulted in completion, testing and rolling out the new MI-WIC data system, which has the capability of improved tracking of breastfeeding promotion and support services, as well as recording breastfeeding education provided to pregnant and lactating women.

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

The WIC Division continues to provide leadership in a multi-state nutrition education internet project, www.wichealth.org. The on-line wichealth.org breastfeeding module continues to be utilized by breastfeeding mothers, with positive feedback.

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 and/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 and peer support services to breastfeeding moms and fathers 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 provided in 38 counties				X
3. Implemented new 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 Breastfeeding Friendly Community in Bay County				X
6. Celebrated MI Breastfeeding Awareness Month (August)				X
7.				
8.				
9.				
10.				

b. Current Activities

During FY '10, 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; 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. New breastfeeding training, Glow and Grow, has been provided to WIC staff statewide. Grow and Glow is a hands-on training to increase WIC staff ability to support

breastfeeding clients. Certified Lactation Specialist training was provided to local agency staff to increase the number of trained lactation professionals in local WIC agencies. Genesee County received technical assistance via a USDA grant application, in addition to subsequent WIC funding, to develop community support for breastfeeding. A county breastfeeding coalition was developed as a result of this technical assistance; a peer counselor grant has been submitted by Genesee County for funding in FY 2011. An RFP for a new breastfeeding counseling services model was issued this year to local WIC agencies to provide clinic-based peer counseling services to WIC clients. MSUE will continue to provide home-based peer counseling services. Plans exist to annually celebrate Michigan Breastfeeding Awareness Month.

c. Plan for the Coming Year
We will continue most of the activities as described above. In addition, the peer counseling funding for local WIC agencies will be implemented, expanding the number of peer counselors trained to provide services to WIC mothers and infants.

In the redesign of the Maternal Infant Health Program, interventions that educate, support and encourage breast feeding are included in the maternal packet which is received by every pregnant Medicaid woman who has had a completed maternal risk assessment. The benefits of breast feeding are explained to the women and referral to the WIC program in their area is mandated by Medicaid Policy. Breast feeding is also discussed in the infant nutrition interventions. Encouragement and support for this activity is expected by MIHP professionals to women who choose this method of infant feeding.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12.3	12.1	12	29
Annual Indicator	13.2	13.2	12.4	30.1	30.3
Numerator	29252	29252	27982	29469	34690
Denominator	221604	221604	225665	97905	114489
Data Source				PNSS/PedNSS	PNSS/Ped/NSS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	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 works with chronic disease to deliver client and professional messages about decreased later-life incidence of obesity by infants being breastfed. Local WIC nutrition educators receive client information related to obesity and physical activity for children. The Internet Nutrition Education Project, www.wichealth.org, provides WIC clients with several topics on feeding children using Stages of Change and Division of Responsibility, concepts which promote healthy parenting around meals. These educational modules support 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 with their children.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Worked with chronic disease to deliver messages about decreased later-life incidence of obesity by breastfed infants				X
2. Provided information to local WIC nutrition educators on obesity and physical activity				X
3. Provided client education via Internet Nutrition 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 22 modules currently in use (8 in Spanish). New modules are developed each year to support parent and child information related to good nutrition, the dietary guidelines and physical activity, Continued activities as stated above.

c. Plan for the Coming Year
By October of 2010, all modules on wichealth.org will be translated into Spanish. Also, several whole grain foods are being added to the WIC Food Package which was changed in August 2009 to reflect more whole grain foods and fruits and vegetables for WIC clients. These additions follow Institute of Medicine recommendations for foods that will help fight the obesity that occurs in the WIC participant population. This package also places a strong emphasis on breastfeeding by increasing the foods available to the breastfeeding woman-infant dyad.

E. Health Status Indicators

Introduction
Most of the data for the Health Status Indicators comes from the state's Vital Records and the U.S. Census Bureau. MDCH implemented an Electronic Birth Certificate System in 2007. Other sources are the Michigan Department of Human Services (foster care, food stamps and TANF), Michigan State Police (juvenile arrests), the Center for Educational Performance and Information (drop-out rate), and the WIC program.

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	2005	2006	2007	2008	2009
Annual Indicator	8.4	8.4	8.4	8.5	8.4
Numerator	10665	10720	10550	10339	9771
Denominator	127518	127537	125172	121231	116610
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.

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.

Despite much programming effort, the racial disparity remains for low birth weight in 2008 (Black -- 14.4%; White 7.0%). In 2008, 12.5% 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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	6.5	6.5	6.3	6.7	6.5
Numerator	7941	7987	7905	7799	7311
Denominator	122970	122796	125172	116882	112315
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 low birth weight 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.

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.

Despite much programming effort, the racial disparity remains for low birth weight in 2008 (Black -- 14.4%; White 7.0%). In 2008, 12.5% 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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.7	1.6	1.7	1.8	1.7
Numerator	2140	2090	2147	2191	1931
Denominator	127518	127537	125172	121231	116610
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 low birth weight 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.

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.

Despite much programming effort, the racial disparity remains for low birth weight in 2008 (Black -- 14.4%; White 7.0%). In 2008, 12.5% 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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.2	1.2	1.2	1.4	1.3
Numerator	1521	1508	1550	1688	1408
Denominator	122970	122796	125172	116882	112315
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 low birth weight 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.

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.

Despite much programming effort, the racial disparity remains for low birth weight in 2008 (Black -- 14.4%; White 7.0%). In 2008, 12.5% 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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.3	8.8	9.1	8.2	8.0

Numerator	192	178	184	159	153
Denominator	2066272	2019667	2019667	1945927	1918752
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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	3.1	2.5	2.6	2.4	1.9
Numerator	65	50	52	47	36
Denominator	2066272	2019667	2019667	1945927	1918752
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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	17.5	17.1	19.1	15.2	12.3
Numerator	254	247	276	215	176
Denominator	1447779	1441512	1441512	1418751	1426370
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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	209.7	196.4	269.4	279.6	183.9
Numerator	4341	3966	5440	5440	3579
Denominator	2069997	2019667	2019667	1945927	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?				Provisional	Provisional

Notes - 2009
Based on 2008 data; number is undercounted because hospitals did not assign E-codes for all hospitalizations in that year.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	25.2	12.1	18.8	18.8	17.0
Numerator	522	245	379	379	331
Denominator	2069997	2019667	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?				Provisional	Provisional

Notes - 2009
Based on 2008 hospitalization data; number is undercounted because hospitals did not assign E-codes for all hospitalizations in that year.

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:
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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	112.0	92.7	117.4	117.4	87.7
Numerator	1622	1337	1693	1693	1244
Denominator	1447759	1441512	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?				Provisional	Provisional

Notes - 2009
Based on 2008 hospitalization data; number is undercounted because hospitals did not assign E-codes for all hospitalizations in that year.

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	34.6	33.8	45.8	44.6	54.9
Numerator	12403	12305	16769	16122	19834
Denominator	358671	363674	366257	361443	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	Provisional

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	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.6	9.1	13.6	11.0	11.6
Numerator	16831	15681	23095	17970	18557
Denominator	1754267	1730557	1696896	1640831	1604392

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

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.

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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	123960	91099	22831	997	3868	90	5075	0
Children 1 through 4	492095	372047	83290	3505	15828	397	17028	0
Children 5 through 9	637842	490508	103006	3996	19447	564	20321	0
Children 10 through 14	664855	509116	112705	4627	17097	380	20930	0
Children 15 through 19	733158	558153	135694	5294	16163	315	17539	0
Children 20 through 24	693212	545166	108583	5475	20015	355	13618	0
Children 0 through 24	3345122	2566089	566109	23894	92418	2101	94511	0

Notes - 2011

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	114536	9424	0
Children 1 through 4	452677	39418	0
Children 5 through 9	592577	45265	0
Children 10 through 14	625018	39837	0
Children 15 through 19	695030	38128	0
Children 20 through 24	657478	35734	0
Children 0 through 24	3137316	207806	0

Notes - 2011

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	133	39	80	1	0	0	7	6
Women 15 through 17	3354	1648	1426	32	13	1	127	107
Women 18 through 19	8302	4742	2973	53	48	1	272	213
Women 20 through 34	89982	67670	15115	390	3006	32	1756	2013
Women 35 or older	116908	113411	2080	58	787	8	230	334
Women of all ages	218679	187510	21674	534	3854	42	2392	2673

Notes - 2011

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	116	14	3
Women 15 through 17	2925	410	19
Women 18 through 19	7495	775	32
Women 20 through 34	83458	6137	387
Women 35 or older	13872	886	80
Women of all ages	107866	8222	521

Notes - 2011

Narrative:
While 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	864	460	350	10	18	1	0	25
Children 1 through 4	115	62	41	3	2	0	0	7
Children 5 through 9	91	62	24	1	3	0	0	1
Children 10 through 14	101	64	32	1	2	0	0	2
Children 15 through 19	395	229	151	3	3	0	0	9
Children 20	561	363	166	7	10	1	0	14

through 24								
Children 0 through 24	2127	1240	764	25	38	2	0	58

Notes - 2011

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	786	73	5
Children 1 through 4	100	15	0
Children 5 through 9	82	9	0
Children 10 through 14	96	4	1
Children 15 through 19	373	21	1
Children 20 through 24	538	23	0
Children 0 through 24	1975	145	7

Notes - 2011

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	2651910	2020923	457526	18419	72403	1746	80893	0	2009
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	5.8	3.0	19.7	3.8	1.4	9.2	0.0	0.0	2009
Number enrolled in Medicaid	1140963	655540	361702	6859	0	0	0	116862	2009
Number enrolled in SCHIP	53687	41369	5915	430	0	0	0	5973	2009
Number living in foster home care	15258	8106	6832	199	30	16	0	75	2009
Number enrolled in food stamp program	751320	445366	280917	4413	8348	962	0	11314	2009
Number enrolled in WIC	260728	135295	66571	657	3715	0	17039	37451	2009
Rate (per 100,000) of juvenile crime arrests	13976.6	12038.7	25578.7	9642.6	1701.6	0.0	0.0	10523.6	2008
Percentage of high school drop-outs (grade 9 through 12)	11.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2009

Notes - 2011

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	2479838	172072	0	2009
Percent in household headed by single parent	73.1	26.9	0.0	2007
Percent in TANF (Grant) families	5.8	5.7	0.0	2009
Number enrolled in Medicaid	1040390	75032	25541	2009
Number enrolled in SCHIP	49519	1935	2233	2009
Number living in foster home care	13816	1415	27	2009
Number enrolled in food stamp program	700188	46942	4190	2009
Number enrolled in WIC	223277	37451	0	2009
Rate (per 100,000) of juvenile crime arrests	14957.1	444.9	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	11.3	2009

Notes - 2011

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	2058266
Living in urban areas	1835080
Living in rural areas	644758
Living in frontier areas	0
Total - all children 0 through 19	2479838

Notes - 2011

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	9969727.0
Percent Below: 50% of poverty	6.3
100% of poverty	14.0
200% of poverty	29.9

Notes - 2011

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	2479838.0
Percent Below: 50% of poverty	8.9
100% of poverty	19.0
200% of poverty	37.4

Notes - 2011

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 Count Your Smiles (CYS) survey was designed to address dental outcomes in Michigan that pertain to those HP2010 objectives. In addition, CYS will contribute to Michigan's oral health

surveillance system. The purpose of the program is to spotlight oral disease prevalence in third grade children and address oral health disparities among children for both dental disease and access to dental care. The report also determines the use of sealants and community water fluoridation. The survey followed the format of the Basic Screening Survey, a national survey developed by the Association of State and Territorial Dental Directors. The Count Your Smiles was conducted in fall 2005 to determine sealant placement rates and oral disease prevalence in third grade children in Michigan. A statistical sampling included 76 elementary schools and approximately 1586 children participated in the program.

The Michigan Department of Community Health Oral health program and 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 additional 3 communities within the state. MDCH utilized the data from the 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.

The second Count Your Smiles 2009-2010 started in September 2009. The survey was planned to wrap up by 30th April 2010 but, due to increased recognition of the program, the time line is extended as more schools are interested in taking part in the survey. The purpose of the survey is similar to the previous survey conducted in 2005-2006, but now also focuses on issues such as the effect of dental insurance in obtaining dental treatment, and ethnicity-related oral disease prevalence and the occurrence rate. The statistical sample this time includes 78 schools with 1,989 children to date, expecting a few more schools to participate in the program.

1-800-26-BIRTH is staffed by health or social service professionals to answer both information as well as 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 2009, 6,771 calls were handled by the hotline, not including 194 wrong number calls and 861 undetermined calls.

Promising Practices for Reducing Racial Disparities in Infant Mortality in Michigan (WKKF Grant) -- The Department has received a grant from the Kellogg Foundation to develop a model curriculum and tool-kit that MDCH and local/state health departments may use to address disparities in health outcomes. The tool-kit will include strategies and tools to promote continuous quality improvement, collaboration and accountability, and public sharing of measurable outcomes that reflect racial and health equity. The project goals are to identify and eliminate institutionalized discriminatory policies and practices in MDCH MCH and to focus more of MCH funding, policy and practice on monitoring and addressing social determinants of racial disparities in infant mortality.

G. Technical Assistance

At this time, we have no technical assistance requests.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	19686900	18899435	19711600		19039800	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	39107300	45141449	24841100		34492500	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	1000000	726249	1000000		1000000	
6. Program Income *(Line6, Form 2)*	57488700	60771728	57646300		63054900	
7. Subtotal	117282900	125538861	103199000		117587200	
8. Other Federal Funds *(Line10, Form 2)*	266261699	256363615	335264693		361244156	
9. Total *(Line11, Form 2)*	383544599	381902476	438463693		478831356	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	0	0	0		0	
b. Infants < 1 year old	57488700	60771728	57646300		63054900	

c. Children 1 to 22 years old	8453700	8066932	8453700		8453700	
d. Children with Special Healthcare Needs	43068100	49280510	28835300		41988500	
e. Others	7784600	7250369	7784600		3895500	
f. Administration	487800	169322	479100		194600	
g. SUBTOTAL	117282900	125538861	103199000		117587200	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		94644	
c. CISS	140000		140000		140000	
d. Abstinence Education	0		1417131		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	154791400		189952600		206159200	
h. AIDS	1212495		1212495		1212495	
i. CDC	2202360		1719623		1799117	
j. Education	0		0		0	
k. Other						
HRSA	150000		150000		300000	
Preventive Block	416600		416600		416600	
Title X	7133200		7133200		7133200	
Title XIX	100121000		133028400		143988900	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	57647500	63397467	43414700		52739800	
II. Enabling Services	53346200	56406050	53346200		58645100	
III. Population-Based Services	5801400	5566022	5959000		6007700	
IV. Infrastructure Building Services	487800	169322	479100		194600	
V. Federal-State Title V Block Grant Partnership Total	117282900	125538861	103199000		117587200	

A. Expenditures

Expenditures for FY 2009 reflect changes in federal and state appropriation amounts. On Form 3, Line 5, the difference between the budgeted amount for FY2009 and the expenditures is due to decreased donations to the Children's Special Health Care Fund. The decreased amount in federal funding (Form 3, line 1) is the actual final Title V allocation.

On Form 4, the difference between 2009 budget and expenditures for "Others" represents the cut in state funds to family planning and pregnancy prevention programs. The difference in Line I.f. between budget and expenditures is the elimination of invoice processing charges for CSHCS (also shown on Form 5, Line IV).

In a unique situation, expenditures in the CSHCS program were significantly higher than the budgeted figure due to one complicated hemophilia case (Form 3, line 3; Form 4, line I.d; Form 5, line I).

B. Budget

The maintenance of effort level from 1989 is $13,507,900. This amount represented state funding for Children with Special Health Care Needs, Family Planning, Adolescent Health, Local MCH and WIC. Current MOE level is maintained by expenditures for CSHCS.

The projected match for FY 2011 is $34,492,500. In addition to state general funds, the federal-state partnership includes program income from the WIC and newborn screening programs and Children's Trust Fund monies supporting CSHCN.

Other funding sources that support MCH programs include Title X (Family Planning), WIC, Medicaid and grants from other federal and foundation sources.

The change in budgeted funds from 2010 to 2011 reflects an increase in Program Income for Newborn Screening fees and WIC Rebate (Form 3, line 6; Form 4, line I.b; Form 5, lines I and III), cuts in state funding for Family Planning and Pregnancy Prevention (Form 3, line 3; Form 4, line I.e; Form 5, line I), and elimination of invoice processing charges for CSHCS (Form 3, line 3; Form 4, line I.f; Form 5, line IV).

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.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

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.