



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Michigan**

**Application for 2009
Annual Report for 2007**



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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.....	11
C. Organizational Structure.....	19
D. Other MCH Capacity	20
E. State Agency Coordination.....	22
F. Health Systems Capacity Indicators	25
Health Systems Capacity Indicator 01:	26
Health Systems Capacity Indicator 02:	27
Health Systems Capacity Indicator 03:	28
Health Systems Capacity Indicator 04:	29
Health Systems Capacity Indicator 07A:.....	30
Health Systems Capacity Indicator 07B:.....	31
Health Systems Capacity Indicator 08:	32
Health Systems Capacity Indicator 05A:.....	32
Health Systems Capacity Indicator 05B:.....	33
Health Systems Capacity Indicator 05C:.....	34
Health Systems Capacity Indicator 05D:.....	34
Health Systems Capacity Indicator 06A:.....	35
Health Systems Capacity Indicator 06B:.....	36
Health Systems Capacity Indicator 06C:.....	36
Health Systems Capacity Indicator 09A:.....	36
Health Systems Capacity Indicator 09B:.....	38
IV. Priorities, Performance and Program Activities	39
A. Background and Overview	39
B. State Priorities	40
C. National Performance Measures.....	44
Performance Measure 01:.....	44
Performance Measure 02:.....	45
Performance Measure 03:.....	48
Performance Measure 04:.....	50
Performance Measure 05:.....	52
Performance Measure 06:.....	54
Performance Measure 07:.....	57
Performance Measure 08:.....	59
Performance Measure 09:.....	60
Performance Measure 10:.....	61
Performance Measure 11:.....	63
Performance Measure 12:.....	65
Performance Measure 13:.....	67
Performance Measure 14:.....	68
Performance Measure 15:.....	70
Performance Measure 16:.....	71
Performance Measure 17:.....	73
Performance Measure 18:.....	75

D. State Performance Measures.....	77
State Performance Measure 1:	77
State Performance Measure 2:	78
State Performance Measure 3:	80
State Performance Measure 4:	82
State Performance Measure 5:	84
State Performance Measure 6:	86
State Performance Measure 7:	88
State Performance Measure 8:	90
E. Health Status Indicators	91
F. Other Program Activities.....	92
G. Technical Assistance	93
V. Budget Narrative	95
A. Expenditures.....	95
B. Budget	95
VI. Reporting Forms-General Information	97
VII. Performance and Outcome Measure Detail Sheets	97
VIII. Glossary	97
IX. Technical Note	97
X. Appendices and State Supporting documents.....	97
A. Needs Assessment.....	97
B. All Reporting Forms.....	97
C. Organizational Charts and All Other State Supporting Documents	97
D. Annual Report Data.....	97

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

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

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

D. Table of Contents

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

E. Public Input

Comments on the draft application narrative were invited from local health departments and other contract agencies, advisory groups, other areas of the department with overlapping interest and the general public. The draft document was posted on the department's web site (www.michigan.gov/mdch, click on Pregnant Women, Children and Families) and a notice was published in three newspapers throughout the state (Detroit Free Press, Grand Rapids Press, and Marquette Mining Journal) during the week of June 30. No comments were received from the public. Internal staff provided editorial comments.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

Michigan has designated 11 priorities. Seven are repeated from the 2001 needs assessment.

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

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

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

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

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

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

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

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

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

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

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

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

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

III. State Overview

A. Overview

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

The Title V program also works with other state departments on initiatives that affect our mutual customers. One current initiative is the development of a comprehensive early childhood system of care (ECCS). This initiative is funded in part by a grant from HRSA and is part of the Governor's Great Start Initiative which aims to get children to school ready to learn. The Title V Director is the project officer for this grant. The Great Start Initiative is guided by the Children's Cabinet, consisting of the Directors of the Departments of Community Health, Education, Human Services (formerly Family Independence Agency), and Labor and Economic Growth. The Children's Action Network (CAN) is appointed by the Children's Cabinet to focus on prevention and early intervention services for children 0-5 years of age. In addition to members of the Children's Cabinet, CAN includes representatives of advocacy groups and other key state staff. The ECCS project is now completing planning activities and has applied for an implementation grant that would start in September 2005. Through this network, the Title V program also works with interagency staff on the development of Family Resource Centers in schools that have been designated as "priority" based on their Annual Yearly Progress status under No Child Left Behind. //2007//The Department was awarded an ECCS Implementation grant in September 2005. With this grant, the state ECCS project will develop local collaboratives to assure access to the six critical components (physical and social-emotional health, parenting education, early care and education, basic needs, family support). //2007//

//2008//The Early Childhood Investment Corporation (ECIC) was created by the Governor as a public non-profit corporation to oversee the development of a statewide comprehensive early childhood system. This system includes local collaboratives, known as Great Start Collaboratives (GSCs), that are responsible for assessing needs, linking existing early childhood programs, and identifying and filling gaps in the system components. The GSCs are formed by intermediate school districts under an inter-local agreement with the Michigan Department of Human Services. Twenty-one GSCs have been implemented to-date and are receiving technical support and funding from the ECIC. The Department of Community Health contracts with the ECIC to implement its Early Childhood Comprehensive Systems grant. The grant funding supports a project coordinator, technical assistance activities and support for parents participating in the development of policies and standards for the system. The ECIC has also obtained substantial foundation funding and a state appropriation of \$1 million to expand the local Great Start collaboratives and to evaluate the system. This includes grants from the Building Connections project and from the Kellogg Foundation (\$6.5 million). //2008//

//2009//Eleven new Great Start Collaboratives were added in 2008.

The recent availability of funding to states for the LAUNCH initiative (SAMHSA), which could not be sought for Michigan, spurred development of a more proactive approach for

positioning the state to more aggressively move toward the development of a coordinated system of care for children.//2009//

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

According to the 2000 Census, Michigan has the eighth largest population in the United States. In 2003, the total estimated population in Michigan was 10,079,985 according to the US Census Bureau. This includes 126,553 infants, 521,204 children 1-4 years of age, 2,179,219 children 5-20 years of age, and 2,125,430 women of childbearing age (15-44 years). Approximately 78% of infants were white, 18.9% black, 2.7% Asian and Pacific Islander, and less than 1% were American Indian. Of Michigan residents aged 1-20 years, 78% were white, 18.7% were black, 2.4% were Asian/Pacific Islander, and 0.9% were American Indian. Among women of childbearing age, 82% were white, 16% were black, 1.7% were Asian/Pacific Islander, and 0.8% were American Indian. Minority populations are increasing in proportion to the total population of the state.

/2008/There were no significant changes in the State's population from 2004 to 2005 in terms of racial/ethnic composition. In 2005 (according to the American Community Survey), among infants, 77.6% were white, 18.7% were black, less than 1% were Native American and 3.3% were Asian/Pacific Islander. For children 1-20, 76.7% were white, 17.6% were black, .6% were Native American, and 2.3% were Asian/Pacific Islander. Among women of child-bearing age, 78.8% were white, 16.2% were black, .7% were Native American and 3.0% were Asian/Pacific Islander.//2008//

/2009/According to the American Community Survey, Michigan's total population declined slightly from 2005 (10,120,860) to 2006 (10,095,643); 79.5% were white, 14.1% were black, .5% were Native American, 2.3% were Asian, and 3.6% were Other. For children under 20 years of age, 74.0% were white, 17.3% were black, .48% were Native American, 2.3% were Asian, and 5.9% were Other.//2009//

There were 130,850 resident live births in 2003. Between 1998 and 2003, the number of live births declined by 2.1 percent. The fertility rate (per 1000 women) for women aged 15-19 years declined by 19.6% from 1999 to 2003, while the overall fertility rate increased for the same period by 2.2%.

/2008/From 2003 to 2005, the number of live births declined by 2.5%. Fertility rates for females 15-19 years of age and overall also declined (2.7% and 1.1%, respectively).//2008//

/2009/Live births in Michigan remained relatively stable at 127,537 in 2006. Overall fertility rates increased slightly from 60.9 per 1,000 live births in 2005 to 61.8 in 2006, and fertility rates for females 15-19 years of age increased from 32.4 in 2005 to 33.8 in 2006.//2009//

In 1999, over 3.2 million Michiganians were medically underserved and over 1.5 million were unserved. Rural residents had a slightly greater risk for being without health insurance than urban residents. However, almost nine out of ten residents (87.9%) without health insurance coverage live in urban areas. Michigan has a lower percentage of uninsured residents on average than the United States, but has over 1.1 million uninsured residents. Residents at greatest risk of being uninsured are young adults (particularly those ages 21-24), minorities and working poor (less than 200% of poverty).

/2007/The Michigan State Planning Project for the Uninsured conducted a Household Health Survey that revealed an estimated 800,000, or 7.8%, of the state's population are without health insurance coverage. More than half of the uninsured individuals live in families with incomes

below 200% FPL. Over half of the uninsured are non-disabled adults below the age of 65 who are not parents of minor children. 93,000 of the uninsured individuals are children and approximately 58,000 of these children are in families with incomes below 200% FPL.//2007//

/2008/In the final report of the Michigan State Planning Project for the Uninsured, most of the uninsured are identified as the working poor who are offered employer-based insurance but are unable to afford their share of the premium or whose employers do not offer insurance. Other uninsured are low-income children who have lost dependent coverage and adults who have lost their jobs and exhausted their unemployment benefits. The report recommended support for the Michigan First Healthcare Plan which would extend coverage to all the low-income uninsured. This plan, submitted to the US Department of Health and Human Services, would cover about half of the uninsured in the state. Approval of the plan is expected this Spring.//2008//

/2009/A concept paper for the Michigan First Healthcare Plan was submitted to DHHS in 2007. However, the proposal has been put on hold due to the state's continuing financial limitations.//2009//

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

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

According to the Division for Vital Records and Health Statistics, MDCH, the five leading causes of death in 2003 for Michigan were: heart disease; cancer; stroke; chronic lower respiratory diseases; and accidents. Among whites and blacks of both genders, the leading causes of premature death were predominantly due to chronic illnesses. However, homicide is the second leading cause of premature death and the third leading cause of overall death in black males. Heart and lung problems were among the four leading causes of preventable hospitalizations among Michigan residents. Over 19% of Michigan residents have some type of disability, which is higher than the United States. Detroit is estimated to have one in four persons with some type of disability. For Michigan children under 1 year of age, the leading causes of death are conditions originating in the perinatal period, congenital malformations, accidents, SIDS and diseases of the heart. The majority of postneonatal deaths are due to preventable causes. For Michigan children 1 year of age and over, the leading cause of death by far is unintentional injuries. Other leading causes for this age group are homicide and cancer.

Michigan has been facing severe socioeconomic challenges over the past few years, as illustrated by increasing unemployment rates. From 1992 to 2001, Michigan employment grew by only 16.8% compared to national employment growth of 22.3%. The state's 2003 average annual unemployment rate rose to 7.0%, up from 6.2% in 2002. From December 2002 to December 2003, Michigan wage and salary employment declined by 79,000, or 1.8%. Nationally, December wage and salary employment fell 0.1% from a year earlier.

/2008/According to the Bureau of Labor Statistics, Michigan had the third highest unemployment rate in the U.S, based on data for the first ten months of 2006. Michigan's manufacturing base continued to erode over the past year with layoffs and reductions in the automotive and related industries. Manufacturing jobs declined by 3.9% from March 2006 to March 2007 and construction jobs declined by 5.6%. Total non-farm employment decreased by 1.0%. A record number and percentage of the population were receiving public assistance as of March 2007. 1,770,000 people or 17.5% of the population received FIP (Family Independence Program), SER (state emergency services), SDA (State Disability Assistance), FAP (Food Assistance Program),

Energy Assistance, SSI and/or Medicaid. This is the highest number and percentage since 1983. The number of Medicaid recipients increased by almost 60% from 2000 to 2006.//2008//
/2009/Economic difficulties continued in FY 2008. While statewide unemployment declined by 3.1% from April 2007 to April 2008, payroll jobs fell by 72,000 (1.7%), mostly in manufacturing, construction and government. However, education and health services and professional and business services registered job growth during the same time period. The state's seasonally adjusted unemployment rate for April 2008 was 6.9%.//2009//

Since 2001, Michigan has had a cumulative deficit of over \$7.8 billion and has cut spending by approximately \$3 billion. Both a lagging economy and a structural imbalance between revenues and expenditures have contributed to the state's budget problems over the past four years. Manufacturing is a significant component of Michigan's economy and its recovery is lagging behind the overall economic recovery. Tax reductions have contributed to the decline in state revenues, even as the demand for public services has increased. Costs continue to rise annually for Corrections, health care for public employees and Medicaid. The Medicaid caseload has grown from just over 1 million in 1999 to almost 1.4 million in 2004.

/2007/According to the Michigan State Planning Project for the Uninsured Household Health Survey, Medicaid now covers 1.5 million Michigan residents, or 15% of the population. This is an increase of almost 400,000 from five years ago.//2007//

/2008/Again, the State of Michigan is facing a budget crisis as the Governor and Legislature negotiate on how to deal with an estimated \$700 million deficit for this fiscal year and \$3 billion for FY 2008. The Single Business Tax will phase out in December 2007, leaving a revenue imbalance of approximately \$1.9 billion. Funding for several MCH programs from tobacco settlement funds have been cut for FY 2007, including childhood lead poisoning prevention, family planning/pregnancy prevention, dental health, Early Hearing Detection and Intervention and infant mortality projects. Moratoriums and restrictions have been placed on purchases, travel, energy use and contractual services. Several proposals for restructuring Michigan's tax base are being analyzed and considered by the Legislature.//2008//

/2009/The State's budget crisis for FY 2008 was resolved by a combination of tax revisions and increases and spending cuts. The Single Business Tax was replaced by the Michigan Business Tax, and the state's personal income tax was increased to 4.35 percent. Approximately \$440 million in spending cuts were enacted. Restrictions remained on hiring, travel and other expenses.//2009//

According to the 2000 Census, there were 192,376 families, or 7.4% of all families, who were below the 100% poverty level. This is down from 10.2% of all families in the 1990 Census. In families with related children under 18 years of age (2000 Census), 11.3% lived in poverty and 14.7% of families with related children under 5 years were below poverty. Among the white population, 9.5% of children under 18 and 12.0% of children under 5 were below the poverty level. Among black children, 39.5% of children under 18 and 49.5% of children under age 5 were below the poverty level. For the American Indian and Alaska Native population, 39.0% of children under 18 and 16.1% of children under 5 were below poverty. For the Asian population, 12.3% of children under 18 and 7.5% of children under 5 were below poverty.

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

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

Services Administration to implement electronic reporting of blood lead analyses and a lead-safe rental housing registry, increase testing levels of children in the Medicaid program, establish and implement penalties for landlords who knowingly cause lead poisoning of children and to establish and appoint a state Lead Commission. The Title V program has been working with the Medical Services Administration to obtain a 1115 waiver from the Centers for Medicare and Medicaid Services to extend family planning services to women whose pregnancy and delivery were covered by Medicaid and have no other source of coverage. The Title V program also participates in the Department's health disparities reduction efforts through infant mortality initiatives and the childhood lead poisoning prevention program.

//2008//In the current economic situation, the Department's current priority is to protect, as much as possible, our most vulnerable citizens from the effects of the state's budget crisis. Benefits and eligibility levels have been maintained so far for pregnant women and children under Medicaid and MIChild. The Family Planning waiver was approved in 2006 and enrollment began July 1 2006. Although state funding for the Childhood Lead Poisoning Prevention Program was cut in FY 2007, efforts continue to improve testing levels of children enrolled in Medicaid and in general (see State Performance Measure #5).//2008//

//2009//Due to state budget fiscal problems in FY '07, Healthy Michigan funding (tobacco tax) was cut for the following programs: dental health, Family Planning, Local MCH grants, Pregnancy Prevention, Lead Poisoning Prevention, Infant Mortality-Nurse Family Partnership, and Early Hearing Detection and Screening. Most of the cuts were absorbed through unspent or unallocated funds. Some small reductions in local programs were made in Dental Health and Local MCH grants with across-the-board reductions. Unspent funds covered reductions in Family Planning (chlamydia testing savings and other unallocated funds), Pregnancy Prevention (colposcopy and sterilization savings), Early Hearing Detection and Infant Mortality (Nurse Family Partnership project did not start as planned). Special project contracts were reduced in Lead Poisoning Prevention. For the most part, local agency services were maintained. In FY '08, most of the funding was restored to these programs except in Pregnancy Prevention where savings from the colposcopy program again covered the reduction.//2009//

B. Agency Capacity

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

The Michigan Legislature passed P.A. 167 in 1997 supporting statewide development of child death review teams. The law also defined the composition of the teams, established reporting requirements, provided for training and technical assistance and exempted team meetings from FOIA. New legislation was passed in 2004 regarding lead poisoning. A package of six bills established a lead-safe rental housing registry and state lead commission appointed by the

Governor, mandated electronic reporting of blood lead analyses, required Medicaid providers to increase testing levels of children and established penalties for landlords who knowingly cause the lead poisoning of children.

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

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

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

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

/2007/The Newborn Screening panel was expanded to 49 disorders detectable by tandem mass spectrometry in 2005./2007//

/2009/Newborn screening for cystic fibrosis began on October 1, 2007, bringing the total number of disorders in the newborn screening panel to 50./2009//

The Hereditary Disorders Program (HDP) coordinates statewide services for genetic diagnosis and counseling, and provides information about birth defects and inherited diseases. Six regional coordinating centers are funded to provide a network of clinics for diagnosis, counseling and medical management, and to provide outreach education to community groups, including families, health professionals and teachers. HDP staff members and the Michigan Birth Defects Registry (MBDR) participate in a cooperative agreement with the Centers for Disease Control and Prevention (CDC) for birth defects surveillance and utilization of data for public health programs relating to prevention and intervention.

The Nurse Family Partnership is a nurse home visiting program, based on the Olds model, for first time, low-income pregnant women that has evidence of success addressing the family needs over approximately two and a half years. This service model has shown improved family outcomes, strengthening the environments of infants and young children, ultimately improving infant survival and young children's health. Services are provided through a team (four nurses and a part-time nurse supervisor). Each nurse maintains a caseload of 25 families. Nurses follow program guidelines that focus on the mother's personal health, quality of care giving for the

child, and parents' own life-course development. Nurses involve the mother's support system including family members, fathers when appropriate, and friends, and they help families use other health and human services they may need. Four communities with significant disparity are currently implementing this model. These communities had other related factors such as having at least 100 African American first time, low-income births, lower high school completion rates, a significant number of young children living in poverty, etc.

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

The Family Planning Program makes available general reproductive health assessment, comprehensive contraceptive services, related health education and counseling, and referrals as needed to Michigan residents. Services are available to anyone, but the primary target population is low-income women and men. Services are delivered through local health departments, Planned Parenthood affiliates, hospitals and private non-profit agencies.

/2007/Michigan Department of Community Health (MDCH) received approval of its Section 1115 Family Planning Waiver and will begin implementation July 1, 2006, expanding family planning services to women 19-44 years old with family incomes up to 185% of the Federal Poverty Level. The approved service cap is 200,000 women.//2007//

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

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

The Fetal-Infant Mortality Review (FIMR) Program is supported by state funds to build FIMR capacity through local team development, technical assistance, consultation, training, data collection, research design, and program evaluation. Currently, teams are operating in Berrien County, Branch County, Calhoun County, City of Detroit, Genesee County, Jackson County, Kalamazoo County, Kent County, Lapeer County, cities of Pontiac and Southfield in Oakland County, Saginaw County and Washtenaw County and a team to study Native American infant deaths statewide. No funds for local teams have been available since 9/30/2001.

/2009/ Currently, teams are operating in Berrien County, Branch County, Calhoun County, City of Detroit, Genesee County, Jackson County, Kalamazoo County, Kent County, cities of Pontiac and Southfield in Oakland County, Saginaw County, Out-Wayne County, Ingham County, Muskegon County, Macomb County and Washtenaw County. A team affiliated with the federal Healthy Start sites through the Intertribal Council of Michigan reviews Native American infant deaths statewide. A \$54,000 line item supported by Healthy Michigan Funds is available to local teams to supplement their ability to abstract medical records and obtain home interview for their case summaries.//2009//

Infant Support Services, funded by Medicaid, provide non-medical support services consisting of

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

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

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

/2008/The design phase of the Maternal and Infant Health Program has been completed and the project is now in the implementation phase. Screening tools for various aspects of the program have been developed and are being pilot-tested (e.g., maternal screening tool, postnatal risk screening).//2008//

/2009/The implementation phase of the MIHP continues. A database was developed for the MIHP Prenatal Risk Factor Eligibility Form. All MIHP providers will be required to enter each MIHP screen into the state's MIHP online database as of July 1 2008. Best practice interventions are being developed for the screening tool domains. An integrated MIHP/WIC tool was developed and implemented by some of the MIHP providers. WIC's program system will electronically share common data elements with MIHP of women screened.//2009//

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

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

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

The Maternal and Child HIV/AIDS Program assures that coordination of existing medical care and social support services exists for families living with HIV/AIDS in southeast Michigan. The program follows a family-centered approach to service delivery, employing a family case manager to link families with needed care across service systems. The target populations are women, adolescents, children and families with HIV, and sexually active women and youth. Clients receiving services from contracted agencies have access to primary and tertiary care for HIV

disease and may also receive the following services: comprehensive, coordinated, family-centered care and case management services; access to an emergency fund for eligible expenses; gynecological services; psychosocial services; information and access to available clinical trial participation; opportunities to participate in a community advisory board; child care resources; transportation; resources to enhance development of leadership skills in women and/or adolescents affected by HIV; and health education, information and referrals for other health and psychosocial services.

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

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

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

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

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

Preventive and Primary Care Services for Children

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

June 30 2007./2008//

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

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

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

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

/2008/A state-wide sealant program will begin October 1 2007 (see National Performance Measure #9)./2008//

The Hearing Screening Program supports local health department (LHD) screening of children at least once between the ages of three and five years and every other year between the ages of five and twelve years. A few LHDs also screen children younger than three utilizing a subjective behavioral technique which rules out a severe profound hearing loss. LHD staff are trained as either an EPSDT technician or a comprehensively trained school screening technician. Quality

assurance is provided for approximately 200 LHD threshold technicians by the MDCH audiology consultant, through field visits and required biennial skills update workshops. Over 680,000 children are screened per year in preschool and school programs, and between 40,000 and 50,000 referred for evaluation each year. Increasingly, agencies are utilizing otoacoustic emissions (OAE) technology, for screening young children and children who are difficult to test. Follow-up for all referred children is required to assure that needed care has been received, or assistance given to be seen at an Otology clinic provided through CSHCS. Most screenings are conducted in schools and day care centers. In 2005, funding for this program was cut in half by the legislature, which resulted in significantly reduced numbers of screenings, but the referral rate has remained stable.

/2009/ The frequency of screening has changed from ages 5 through 12 to 5 through 10. Subjective behavioral hearing screening is no longer conducted on the 0-3 age group, but programs with Otoacoustic Emissions (OAEs) will often screen children under 3 years of age as well as the developmentally delayed and difficult to test. Quality assurance is conducted by contracted audiologists. Since the 2005 budget cuts, the program is working to get our screening numbers back to where they were before the cuts were made. Last year, just under a half million children were screened and almost 20,000 medical referrals were made. Pre-budget cuts the total number of children screened was approximately 680,000 with over 40,000 referrals.//2009//

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

/2008/ Of the 149,445 children under six years of age tested in 2007, 2,031 (1.4%) had a venous blood lead level at or above 10 ?g/dL. Case management will be improved as a result of updated protocol, standardized forms and case management training.//2008//

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

/2009/"Grade 11 has been deleted from the frequency of screening. Screening, retesting and referral is done by the local health department. In 2007, 585,747 pre-school and school-age children were screened and 56,527 children were referred for follow-up.//2009//

Services for Children with Special Health Care Needs

The Michigan Public Health Code, Public Act 368 of 1978 as amended, defines a CSHCS-eligible person as someone under age 21 "...whose activity is or may become so restricted by disease or deformity as to reduce the individual's normal capacity for education and self-support." Persons over age 21 with cystic fibrosis or hereditary coagulation defects (e.g., hemophilia) also may be eligible for services. CSHCS covers chronic physical conditions that require care by medical or

surgical specialists. The program also evaluates severity, chronicity and the need to be seen at least once annually by an appropriate pediatric subspecialist in making a medical eligibility determination. The full range of CSHCS program elements and services includes: casefinding; application for CSHCS coverage, assessment of family service needs, and service coordination/case management, specialty medical care and treatment; family support services and opportunities for parent participation in policy development; and specialized home care supports. /2008/ The CSHCS division created the Early Adult Transition Task-Force in 2006 which serves as the official youth advisory council for the division. This has increased the opportunity for youth participation in policy development. //2008//

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

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

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

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

The CSHCS program operates according to the philosophies inherent in Family-Centered, Community-Based, Culturally Competent, Coordinated Care. This philosophy has been incorporated into all CSHCS strategies for program and policy development, and into the service delivery structure. CSHCS has built an infrastructure that assures both input and feedback with regard to these critical program characteristics. The Parent Participation Program (paid parent consultants to the program), parent membership in the CSHCS Advisory Committee, and the Family Support Network are program elements that reinforce family-centeredness. Formal relationships with local health departments, initiatives to strengthen home-based care, and provider standards all support a community-based approach. Coordinated care is facilitated by

state-level inter-agency planning (including coordination among state-level parent support initiatives); local relationships among and between other MCH colleagues and human service agency professionals; broad representation on the CSHCS Advisory Committee; and expectations of specialty clinic providers, primary care physicians, and local health department professionals.

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

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

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

C. Organizational Structure

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

The Public Health Administration includes the Bureau of Family, Maternal and Child Health (BFMCH), Bureau of Laboratories, Office of Public Health Preparedness, Bureau of Health Promotion and Disease Control, and the Bureau of Epidemiology. Responsibility for Michigan's Title V program is placed within the Public Health Administration, Bureau of Family, Maternal and Child Health. The Title V program works closely with the Epidemiology Bureau on maternal mortality and other MCH epidemiology studies using state vital records, PRAMS and other health statistics, newborn screening and hereditary disorders. BFMCH coordinates activities with the Division of Chronic Disease and Injury Control around childhood obesity, childhood injury, suicide and breast and cervical cancer. BFMCH works with the Bureau of Laboratories on childhood lead

poisoning, immunizations and sexually transmitted diseases. BFMCH also works closely with the Medical Services Administration on Medicaid and MICHild coverage of services to women and children and coordination of eligibility determination and payment for services to children with special health care needs.

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

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

D. Other MCH Capacity

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

In the Division of Family and Community Health, there are approximately 46 professional (including vacancies and contractual positions) and 7 support staff working on programs for pregnant women, mothers, infants, children and adolescents. Professional staff is composed of nurses, public health consultants, hearing and vision consultants, nutrition consultant and managers.

/2008/There are 52 established positions in the Division of Family and Community Health, including 42 professional and 10 support staff. The Division currently has 10 vacancies for positions that have been frozen due to state budget shortfalls.//2008//

/2009/There are currently 37.5 funded positions in the Division, including 9.5 vacancies.//2009//

The WIC Division administers the federal Supplemental Food Program for Women, Infants and Children and Project FRESH. The Division includes 29 professional and 11 support staff. Staffing includes nutritionists, analysts and managers.

/2008/The WIC Division currently has 42 established positions, including 31 professional and 11 support staff. The Division has 4 vacancies.

/2009/There are currently 43.0 funded positions in the WIC Division. including 32 professional staff and 11 clerical staff. This includes 6 vacancies.//2009//

The Children's Special Health Care Services Plan Division currently includes approximately 30 professional and 15 support staff. Professional staff is made up of doctors, nurses, nutritionists,

analysts and managers. Support staff perform clerical, technical and enrollment functions. Parents of children with special needs, working through the Parent Participation Program, perform an advisory role to the department as well as developing support networks across the state for parents of special needs children. The Parent Participation Program (PPP) employs 9 staff persons, 5 of whom are parents of children with special needs.

/2008/The CSHCS Division currently has 50 established positions, including 31 professional and 19 support staff. The Division currently has 4 vacancies that have been frozen due to state budget shortfalls. The Parent Participation Program has been re-named the Family Center for Youth and Children with Special Health Care Needs. The Center currently employs six parents.//2008//

/2009/The Division currently has 47 funded positions, of which 27 are professional positions and 20 are clerical. There are currently 5 vacancies. The Family Center has seven total staff, four of whom are parents.//2009//

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

Douglas M. Paterson is Director of the Bureau of Child and Family Programs within the Michigan Department of Community Health. In this capacity, he oversees the WIC Division, the Children's Special Health Care Services Division, and the Division of Family and Community Health. Mr. Paterson has 30 years of experience in Maternal and Child Health serving as the WIC Director and Division Director over several MCH Programs. He currently serves as the Title V MCH Director for the State of Michigan and Project Manager for the State MCH Early Childhood Comprehensive Systems Grant. Mr. Paterson has a Master's Degree in Public Administration. /2007/ Douglas Paterson retired in January 2006. Dr. Gary Kirk was appointed the new bureau and Title V Director in May 2006. Dr. Kirk is a pediatrician with Masters in Health Professions Education and Public Health. He has three years experience as attending physician at Michael Reese and Wyler Children's Hospitals in Chicago, four years experience as Director of inpatient pediatric services at University of Illinois and DeVos Children's Hospitals, two years as Director of Pediatric Residency Program at Spectrum Health in Grand Rapids, two years as Director of Sindecuse Health Center at Western Michigan University, and two years as Director of the Division of Immunization at MDCH.//2007//

/2008/Dr. Kirk will leave the Department of Community Health in July 2008. Alethia Carr, current Director of the WIC Division will assume the post of Acting Bureau Director and Title V Director. Ms. Carr has an MBA and a Bachelor of Science degree in hospital dietetics and is a registered Dietician. She has ten years experience as a clinician and 23 years of management experience in various maternal and child health programs including childhood lead poisoning, MCH HIV/AIDS, and Women's and Reproductive Health.//2008//

/2009/Alethia Carr was appointed Director of the Bureau of Family, Maternal and Child Health effective May 18, 2008. As such she is also the State's Title V Director.//2009//

The Office of Medical Affairs within the Medical Services Administration houses two full-time physician consultants dedicated specifically to CSHCS, and two physicians who dedicate a portion of their efforts toward CSHCS needs. Their role is determination of program eligibility, approval of CSHCS specialists, and approval of specific specialists to serve the CSHCS beneficiary. /2008/ The access to two full-time physician consultants changed significantly in 2006 because of illness. The division was left with one full-time physician and the part-time physicians to continue the vast amount of work that the physician consultants provide for the division. In the

absence of one full-time consultant three additional physicians were contracted to provide a portion of their time picking up the CSHCS workload. //2008//
/2009/The physician position was filled by Dr. Nina Mattarella effective October 15, 2007./2009//

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

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

E. State Agency Coordination

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

Directors of the Departments of Community Health, Education, Human Services, and Labor and Economic Growth meet on a regular basis to coordinate policy and discuss cross-cutting issues affecting their common target populations. In March, 2003 the Governor created the Children's Action Network (CAN) consisting of directors of all state departments that have services to children and families within their purview. The purpose of CAN is to coordinate child and family programs across state agencies and implement a shared policy agenda promoting health, social and emotional development and school readiness in all young children. In addition, the departments of Community Health, Human Services, Education and Labor and Economic Growth are collaborating on the Early Childhood Comprehensive Systems Planning Project, begun in 2003 with a grant from MCHB. Along with parents, providers, community representatives and advocacy organizations, this project is developing a plan for the structure, finance, performance measures and program strategies for implementing a comprehensive system of care for children 0-5 years of age that supports early brain development. Staff members from the human services agencies guide the project and report to the Children's Action Network on progress and products. The project is coordinated with the Governor's Great Start campaign to get children to school ready to learn.

/2008/ The activities of the Children's Action Network have been subsumed under the Governor's Children's Cabinet. The Children's Cabinet includes the directors of the Departments of Community Health, Human Services, Education and Labor and Economic Growth. In addition to the projects mentioned above, other interagency efforts include projects addressing healthcare workforce issues (Interagency Healthcare Workforce Coordinating Council, Michigan Opportunity Partnerships, Governor's Accelerated Health Career Training Initiative), Michigan Prisoner Re-entry Program (working with prisoners leaving institutions and their families), Autism Spectrum Disorder Workgroup, and Foster Youth Development Program. The workforce initiatives will address current and predicted critical health care worker shortages in the state, particularly nurses and physicians, by expanding educational opportunities and re-training workers and by offering online information to healthcare employers and career seekers. The Prisoner Re-entry Program will work with released offenders and their families to increase success rates in

transitioning to the community. The Autism Spectrum Disorder Workgroup has developed preliminary recommendations to the Directors in regard to early identification, appropriate treatment and education. The Foster Youth Development Program helps youth transitioning out of foster care to achieve independent living status by assisting them with education and employment goals, housing, and learning how to access and use the health care system.//2008//
/2009/In light of the impact of incarceration upon families, the Department of Corrections was added to the Interagency Directors group in 2008. The recommendations from the Autism Spectrum Disorders Workgroup began implementation in 2007. Two pilot sites to implement the recommendations on screening, assessment and evidence-based practice interventions and evaluation of results will begin in October 2008./2009//

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

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

/2007/ DCH and the Department of Education collaborate on school health programs and work together on the Early On Initiative (Part C of IDEA). The activities of the Early On program are directed by the State Interagency Coordinating Council and include technical assistance and training for local coordinating councils. Staff from the Division of Family and Community Health, the Division of Mental Health Services to Children and Families, and CSHCS participate on the state council.//2007//

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

The Michigan Public Health Institute, a non-profit corporation, was authorized by Public Act 264 of 1989 as a cooperative venture of the Michigan Department of Public (now Community) Health, the University of Michigan, Michigan State University and Wayne State University to plan, promote and coordinate public health research, evaluations and demonstrations. The Institute's board of directors includes representatives from each of the universities and the department. Since its creation, the Institute has worked with the department on several important initiatives including: evaluation (e.g., Maternal Support Services, Michigan Abstinence Partnership, Local

Public Health Accreditation Program); developing new programs and projects (e.g., Suicide Prevention, Safe Delivery, child death review teams); training and technical assistance activities (e.g., development of a standard tool for reporting death scene investigations of sudden and unexplained child deaths and training of local child death review team members); and data collection and reporting (e.g., child death review database, PRAMS).

With the statewide implementation of Medicaid managed care in 1998, EPSDT services were integrated into the qualified health plans (QHPs). Most local health departments no longer provide EPSDT services. The MCH program continues to work with the Medical Services Administration to develop standards of performance and quality for the plans and provides technical consultation. The MCH program also provides training for QHPs and local health departments on the hearing and vision components of EPSDT.

//2009/The Department of Community Health convened the Michigan State Leadership Workshop in January, 2008 to begin work with stakeholders to strengthen the infrastructure for and outcomes of the EPSDT program. This Leadership group includes a broad spectrum of stakeholders, including parents, school nurses, local public health leaders, the MI Chapters of the American Academy of Pediatrics and Academy of Family Physicians, the MI Primary Care Association, Head Start, Family Voices, the State's ABCD project, Early Childhood Investment Corporation (state ECCS project), and the state departments of Human Services and Education. The January meeting focused on early childhood health and development. The group identified sixteen topics of common concern: MI Care Improvement Registry (MCIR) augmentation; medical home QI project; ABCD to scale; CSHCN into managed care; community resources; improve linkages between medicine and public health; care coordination/case management; early childhood mental health; expand role of WIC; EPSDT coordinators in local health departments; telemedicine (CSHCN); fiscal analysis; care for parents; foster care; child health work group; and developmental services/Early On. For the short-term, six priority areas were identified: use data to help assure access and quality; using Medicaid managed care to serve CSHCN; assure appropriate information exchange across services and systems; implement and operationalize a common definition of the pediatric medical home; improve the Part C Early Intervention (Early On); and improve access to early childhood mental health services. Six workgroups will be formed to explore actions and recommendations in each of these areas.//2009//

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

Building Bridges is a collaborative effort between local health departments, Medicaid Health Plans and state MCH programs to coordinate outreach efforts to pregnant women and children by increasing access and adequacy of care. A second annual Building Bridges meeting of stakeholders was held in June 2003. The Building Bridges Project meets quarterly to discuss access to care issues between Medicaid Managed Care, health departments and Maternal

Support Services.

//2007/A small grant was awarded to Michigan in 2006 to enhance the coordination structure between state agencies and the local Great Start Collaboratives.//2007//

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

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

There are currently five Healthy Start programs in Michigan. The department initiated a collaborative network of all programs to share their experiences, discuss issues of mutual concern and interest, and to develop standardized evaluation criteria for the programs. The network meets approximately four times a year. The department also assists proposed new programs with their applications by providing data and technical assistance and supports an extensive program evaluation project in Detroit.

//2008/There are currently six Healthy Start projects in the state - Kalamazoo, Flint, Detroit, Grand Rapids, Saginaw and Sault Sainte Marie.//2008//

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

F. Health Systems Capacity Indicators

Introduction

The Michigan Title V program participates in policy development and planning activities for the health system capacity indicators and provides funding support for some of the services related to the indicators. Our capacity to provide services has been affected by state and federal funding reductions over the past five years. Funding for outreach services to connect women and children to appropriate services, including EPSDT and prenatal care, was eliminated in FY 2003 and only partially restored in FY 2005. However, coverages for children and pregnant women through the

Medicaid and MIChild programs have been maintained throughout these tough economic times. The Healthy Kids Dental program, providing dental care to Medicaid-eligible children under age 21, has been maintained and expanded through a public-private partnership between the Department of Community Health, Delta Dental, and the Michigan Dental Association. We continue to seek ways to partner with other organizations with common interests to maximize our resources and better serve our clients.

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

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	50.4	49.9	46.5	40.1	40.1
Numerator	3280	3243	3021	2560	2560
Denominator	651161	649842	650215	638195	638195
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2006

There is no data available yet for 2006.

Narrative:

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

The 2005 Asthma Mortality Review Report was published and released in FY 2007. The report can be viewed at <http://oem.msu.edu//AsthmaMort/05AsthmaMortality.pdf>

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

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

In FY 2007 the Asthma Coalition of West Michigan saw 305 asthma patients in their in home case management program.

Asthma coalitions in Genesee, Saginaw and the city of Detroit attended a national and in-state

Asthma Health Disparities Collaborative (AHDC) training. The AHDC is a national initiative that focuses on making system level changes within the practice. The Genesee County Asthma Network (GCAN) is partnering with Hamilton Community Health Network (a Federally Qualified Health Center) to participate in an AHDC. As part of the initiative, GCAN provided an in-service to 28 providers at Hamilton Community Health Network. The Tri-County Asthma Coalition (Saginaw) and the Detroit Alliance for Asthma Awareness (DAAA) both tried to engage their local FQHC to participate in an AHDC. There is only one FQHC in Saginaw and they declined participation due to being too busy with other initiatives. The FQHC that DAAA approached initially said that they wanted to participate in an AHDC. After approximately three months, the FQHC said that they didn't have the time and resources to continue participating. The DAAA is currently soliciting other FQHC to participate.

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

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

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

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	79.7	79.7	85.1	86.2	86.4
Numerator	49578	49578	56516	58927	59916
Denominator	62203	62203	66402	68352	69357
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:

The Bureau of Family, Maternal and Child Health continues to work with the Medical Services Administration (MSA) to improve services to Medicaid-enrolled children and families through setting standards and monitoring quality. Contracts with Medicaid managed care plans set standards for screening children including defining the screening components of a periodic exam and requirements for referral for diagnostic or 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 providers assist women in using health care services for which they are eligible. Outreach funds to local health departments were reinstated at a slightly reduced rate for 2005 and continued collaborative efforts have increased enrollments in publicly-funded programs and provided outreach to uninsured families. In spite of the State's continuing budget problems, the MIChild (SCHIP) and Healthy Kids (Medicaid) programs have been able to maintain the level of coverage for children, so far.

/2009/The Department of Community Health convened the Michigan State Leadership Workshop in January, 2008 to begin work with stakeholders to strengthen the infrastructure for and outcomes of the EPSDT program. This Leadership group includes a broad spectrum of stakeholders, including parents, school nurses, local public health leaders, the MI Chapters of the American Academy of Pediatrics and Academy of Family Physicians, the MI Primary Care Association, Head Start, Family Voices, the State's ABCD project, Early Childhood Investment Corporation (state ECCS project), and the state departments of Human Services and Education. The January meeting focused on early childhood health and development. The group identified sixteen topics of common concern: MI Care Improvement Registry (MCIR) augmentation; medical home QI project; ABCD to scale; CSHCN into managed care; community resources; improve linkages between medicine and public health; care coordination/case management; early childhood mental health; expand role of WIC; EPSDT coordinators in local health departments; telemedicine (CSHCN); fiscal analysis; care for parents; foster care; child health work group; and developmental services/Early On. For the short-term, six priority areas were identified: use data to help assure access and quality; using Medicaid managed care to serve CSHCN; assure appropriate information exchange across services and systems; implement and operationalize a common definition of the pediatric medical home; improve the Part C Early Intervention (Early On); and improve access to early childhood mental health services. Six workgroups will be formed to explore actions and recommendations in each of these areas.//2009//

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	2003	2004	2005	2006	2007
Annual Indicator	0.0	79.2	55.5	64.5	69.4
Numerator	0	486	201	216	238
Denominator	1	614	362	335	343
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:

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

Access to Medicaid and SCHIP information is available to the MCH program through the Data Warehouse. The Bureau of Family, Maternal and Child Health and the Medical Services Administration cooperate on policy development and outreach efforts concerning access to services for children and pregnant women. Outreach funding to local health departments were reinstated at a slightly reduced rate for 2005 and continued collaborative efforts have increased enrollments in publicly-funded programs and provided outreach to uninsured families. See also narrative for National Performance Measure #13.

/2009/The Department of Community Health convened the Michigan State Leadership Workshop in January, 2008 to begin work with stakeholders to strengthen the infrastructure for and outcomes of the EPSDT program. This Leadership group includes a broad spectrum of stakeholders, including parents, school nurses, local public health leaders, the MI Chapters of the American Academy of Pediatrics and Academy of Family Physicians, the MI Primary Care Association, Head Start, Family Voices, the State's ABCD project, Early Childhood Investment Corporation (state ECCS project), and the state departments of Human Services and Education. The January meeting focused on early childhood health and development. The group identified sixteen topics of common concern: MI Care Improvement Registry (MCIR) augmentation; medical home QI project; ABCD to scale; CSHCN into managed care; community resources; improve linkages between medicine and public health; care coordination/case management; early childhood mental health; expand role of WIC; EPSDT coordinators in local health departments; telemedicine (CSHCN); fiscal analysis; care for parents; foster care; child health work group; and developmental services/Early On. For the short-term, six priority areas were identified: use data to help assure access and quality; using Medicaid managed care to serve CSHCN; assure appropriate information exchange across services and systems; implement and operationalize a common definition of the pediatric medical home; improve the Part C Early Intervention (Early On); and improve access to early childhood mental health services. Six workgroups will be formed to explore actions and recommendations in each of these areas.//2009//

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	2003	2004	2005	2006	2007
Annual Indicator	77.5	75.2	76.6	75.9	74.6
Numerator	101456	97227	97437	96851	74066
Denominator	130850	129311	127122	127537	99303
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2007

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

Narrative:

This measure was virtually unchanged from 2005 to 2006. Referral pathways through the WIC program were created. Four Nurse/Family Partnership programs began enrolling clients in 2004 and offer early intervention for first time pregnancies. A re-design of the Maternal and Infant Support Services Program (now called Maternal and Infant Health Program or MIHP) was implemented in late 2005 with emphasis on early entry into prenatal care and early risk assessment. Expansion of eligibility for Medicaid family planning services will allow providers to connect women choosing to become pregnant to prenatal care providers, supporting earlier entry into care. Data collected from pilot sites (see NPM # 18) and the Nurse/Family Partnership program will be analyzed to learn best practices for improving this indicator. Our ability to maintain these efforts in the coming year will depend upon the outcome of budget deliberations now occurring between the Legislature and the Governor. Michigan's economic outlook continues to be weak and this may affect funding sources for several programs focusing on infant mortality and contributing factors.

/2009/The Michigan Infant Mortality Program: Interconception Care Project was initiated in 2005 to improve birth outcomes for women who are most at-risk of an infant or fetal loss, a preterm birth or a low birth weight baby. Funding uses a mix of Title V and Healthy Michigan (tobacco tax) Funds to provide consultation and technical assistance to projects in eleven local communities. Each project supports case management for women who have had a previous poor pregnancy outcome. Overall the project has the capacity to intervene with approximately 400 women, most of whom are African American. Over 100 women have been enrolled so far and an evaluation plan is underway to determine what works to improve many risk factors that are part of each woman's life course. A fifth Nurse Family Partnership Program was initiated in December 2007 in Kalamazoo County.//2009//

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	2003	2004	2005	2006	2007
Annual Indicator	82.5	80.2	83.6	84.3	85.4
Numerator	739523	792549	835005	924469	893739
Denominator	896104	988147	998680	1097269	1046771
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:

The Bureau of Family, Maternal and Child Health continues to work with the Medical Services Administration (MSA) to improve services to Medicaid-enrolled children and families through setting standards and monitoring quality. Contracts with Medicaid managed care plans set standards for screening children including defining the screening components of a periodic exam and requirements for referral for diagnostic or 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 providers assist women in using health care services for which they are eligible. Outreach funds to local health departments were reinstated at a slightly reduced rate for 2005 and continued collaborative efforts have increased enrollments in publicly-funded programs and provided

outreach to uninsured families.

//2009/The Department of Community Health convened the Michigan State Leadership Workshop in January, 2008 to begin work with stakeholders to strengthen the infrastructure for and outcomes of the EPSDT program. This Leadership group includes a broad spectrum of stakeholders, including parents, school nurses, local public health leaders, the MI Chapters of the American Academy of Pediatrics and Academy of Family Physicians, the MI Primary Care Association, Head Start, Family Voices, the State's ABCD project, Early Childhood Investment Corporation (state ECCS project), and the state departments of Human Services and Education. The January meeting focused on early childhood health and development. The group identified sixteen topics of common concern: MI Care Improvement Registry (MCIR) augmentation; medical home QI project; ABCD to scale; CSHCN into managed care; community resources; improve linkages between medicine and public health; care coordination/case management; early childhood mental health; expand role of WIC; EPSDT coordinators in local health departments; telemedicine (CSHCN); fiscal analysis; care for parents; foster care; child health work group; and developmental services/Early On. For the short-term, six priority areas were identified: use data to help assure access and quality; using Medicaid managed care to serve CSHCN; assure appropriate information exchange across services and systems; implement and operationalize a common definition of the pediatric medical home; improve the Part C Early Intervention (Early On); and improve access to early childhood mental health services. Six workgroups will be formed to explore actions and recommendations in each of these areas.//2009//

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	2003	2004	2005	2006	2007
Annual Indicator	44.2	44.5	45.7	45.9	48.2
Numerator	84001	84595	93697	97602	105000
Denominator	190029	190029	205246	212662	218064
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Narrative:

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

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	2003	2004	2005	2006	2007
Annual Indicator	23.7	24.3	24.2	23.8	19.7
Numerator	7293	7613	7568	7689	6406
Denominator	30808	31336	31336	32303	32449
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)	2007	payment source from birth certificate	9.6	7.1	8.2

Narrative:

In spite of a declining infant mortality rate, the low birth weight rate remains high, especially among black infants. Forty percent of all births in Michigan are covered by Medicaid. Typically, the rate for black births is twice the rate for white births. Studies to analyze birth data using Vital Records, PRAMS and FIMR to understand the factors involved in low birth weight births will continue. Programmatic efforts include continued emphasis on prenatal smoking cessation and FAS prevention programs, as well as preconceptional counseling through the Maternal Infant Health Program (formerly Maternal/Infant Support Services), Nurse Family Partnership Programs and the Kalamazoo Pilot Preconception Program. The Infant Mortality Initiative targets efforts in eleven communities with the highest rates of African American infant mortality. These local coalitions develop local education efforts and health system plans designed to decrease preterm delivery rates and improve pregnancy outcomes. Another strategy for reducing low birth weight and preterm birth is the implementation of the Family Planning Waiver to improve access to contraception for low-income women. The Bureau of Family, Maternal and Child Health is also

exploring the possibility of re-introducing a regional perinatal care system. Working with the MCH Epidemiologist, staff have looked at systems in other states and have talked with New York City in depth on their system, resources and legal authority. The Bureau will continue to analyze the experience of other states and the results of a survey of hospitals in this state for possible development of policy and funding proposal.

/2009/The Michigan Infant Mortality Program: Interconception Care Project was initiated in 2005 to improve birth outcomes for women who are most at-risk of an infant or fetal loss, a preterm birth or a low birth weight baby. Funding uses a mix of Title V and Healthy Michigan (tobacco tax) Funds to provide consultation and technical assistance to projects in eleven local communities. Each project supports case management for women who have had a previous poor pregnancy outcome. Overall the project has the capacity to intervene with approximately 400 women, most of whom are African American. Over 100 women have been enrolled so far and an evaluation plan is underway to determine what works to improve many risk factors that are part of each woman's life course. A fifth Nurse Family Partnership Program was initiated in December 2007 in Kalamazoo County./2009//

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2007	matching data files	9.3	6.2	7.8

Narrative:

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

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

women have been enrolled so far and an evaluation plan is underway to determine what works to improve many risk factors that are part of each woman's life course. A fifth Nurse Family Partnership Program was initiated in December 2007 in Kalamazoo County.//2009//

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

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	payment source from birth certificate	75	89.6	83.4

Narrative:

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

/2009/The Michigan Infant Mortality Program: Interconception Care Project was initiated in 2005 to improve birth outcomes for women who are most at-risk of an infant or fetal loss, a preterm birth or a low birth weight baby. Funding uses a mix of Title V and Healthy Michigan (tobacco tax) Funds to provide consultation and technical assistance to projects in eleven local communities. Each project supports case management for women who have had a previous poor pregnancy outcome. Overall the project has the capacity to intervene with approximately 400 women, most of whom are African American. Over 100 women have been enrolled so far and an evaluation plan is underway to determine what works to improve many risk factors that are part of each woman's life course. A fifth Nurse Family Partnership Program was initiated in December 2007 in Kalamazoo County.//2009//

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 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

State					
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	payment source from birth certificate	68.7	79.4	74.6

Notes - 2009

The data provided are not limited only to women 15 through 44 years old.

Narrative:

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

/2009/The Michigan Infant Mortality Program: Interconception Care Project was initiated in 2005 to improve birth outcomes for women who are most at-risk of an infant or fetal loss, a preterm birth or a low birth weight baby. Funding uses a mix of Title V and Healthy Michigan (tobacco tax) Funds to provide consultation and technical assistance to projects in eleven local communities. Each project supports case management for women who have had a previous poor pregnancy outcome. Overall the project has the capacity to intervene with approximately 400 women, most of whom are African American. Over 100 women have been enrolled so far and an evaluation plan is underway to determine what works to improve many risk factors that are part of each woman's life course. A fifth Nurse Family Partnership Program was initiated in December 2007 in Kalamazoo County.//2009//

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)	2007	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)	2007	200

Narrative:

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

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)	2007	150
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	200

Narrative:

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

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	2007	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	2007	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)

<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	2	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	1	No
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:

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

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

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

CSHCS program data is linked with the Michigan Birth Defects Registry (BDR) to study prevalent

conditions at enrollment. A new data work group has been established on child health data integration that would allow provider access to newborn screening results through the Internet-based Childhood Immunization Registry.

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

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2009

Narrative:

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

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

IV. Priorities, Performance and Program Activities

A. Background and Overview

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

For 2004 (or the latest year for which data is available), Michigan met or exceeded targets for the following performance measures:

NPM #1 Newborn Screening

NPM #8 Birth Rate for Teenagers 15-17

NPM #10 Deaths to children caused by motor vehicle crashes

NPM #11 Breastfeeding/2007/ Definition changed from at hospital discharge to at six months//2007//

NPM #13 Percent of children without health insurance

NPM #16 Suicide Deaths among youth 15-19

SPM #04 Preterm Births /2007/Changed to SPM #03//2007//

Other performance measures that showed improvement from the previous year but did not meet the target were:

NPM #9 Third grade children who have received protective sealants

NPM #15 VLBW Births

NPM #17 VLBW Deliveries at facilities for neonates and high risk deliveries

SPM #01 Infant Mortality /2007/ Changed to Women Screened for maternal depression//2007//

SPM #05 Unintended Pregnancy /2007/ Changed to SPM #04//2007//

SPM #08 CSHCS beneficiaries receiving dental care paid by CSHCS/2007/Deleted for 2007//2007//

SPM #09 Lead testing among Medicaid eligible children 0-6 /2007/Changed to SPM #06//2007//

Measures that did not show improvement and require further effort are:

NPM #7 Childhood Immunizations

NPM #12 Newborn Hearing Screening

NPM #14 Medicaid-eligible children received a service /2007/Changed to WIC children at or above 85%BMI//2007//

NPM #18 Infants born to pregnant women receiving care in first trimester

SPM #02 Maternal Mortality Ratio /2007/Changed to SPM #6//2007//

SPM #03 LWB among live births /2007/Changed to SPM #2//2007//

SPM #06 Repeat live births to unwed mothers 15-19 years of age /2007/Discontinued//2007//

/2007/Several changes were made to the State Performance Measures and a couple National Performance Measures for 2007 as a result of the five-year needs assessment. The 2005 (or latest available) data indicates that Michigan met or exceeded targets for 4 performance measures (NPM #1, 10, 13 and 16), improved but did not meet target for 6 measures (NPM #12, 17, 18, SPM #2, 4 and 5), and did not improve for 5 measures (NPM #7, 8, 9, SPM #3 and 6). NPM #11, 14 and 15 and SPM #1, 7 and 8 are new for 2006.//2007//

/2008/Improvements were shown in National Performance Measures #8, 9, 10, 11, 12, 13, 16, 17 and 18 and in State Performance Measures #3, 4, 5 and 7. No change was noticed in National Performance Measures #1-7 and 14 and in State Performance Measure #2. A decline in actual indicators for National Performance Measure #15 and State Performance Measure #6 was noted. No data is currently available for State Performance Measure #1 (maternal depression).//2008//

/2009/The following Performance Measures showed improvement over the previous year: NPM #8, 10, 12, 13, 15, 16, 17 and 18; SPM #2, 4 and 5. Performance indicators for NPM #1, 9 and 11 and SPM #3 and 7 were the same compared to the previous year. Performance indicators for NPM #7 and SPM #6 were worse than the year before.//2009//

National Performance Measures 2-6 are related to Children's Special Health Care Services. The only source of data for these performance measures is the SLAITS survey which is only conducted every other year. Data has not been updated since the original survey which indicated that Michigan's data for NPM #2-5 were above the national average for 2001 and slightly below the national average for NPM #6 (Percent of youth with special health care needs who received services necessary for transition to adult life).

//2009/The data for NPM #2-6 were updated based on the 2006 National Survey. Due to wording changes in the survey questions, the indicator data for NPM #3, 5 and 6 are not comparable to data from the 2001 survey. Data for NPM #2 and 4 indicate a decline in these performance indicators from the 2001 survey.//2009//

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

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

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

B. State Priorities

Establish a system to better identify, screen and refer for maternal depression: Postpartum depression (PPD) occurs anytime during the first year after delivery with an estimated prevalence of almost 12%. The onset of PPD usually takes place after baby blues and ranges from mild to severe depression. Postpartum psychosis is the extremely severe form in which the mother loses touch with reality and has thoughts of suicide and or homicide. It affects about 1 in 1,000 women. PPD affects a woman's ability to function as a new mother and can impair the cognitive and

language development of the newborn.

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

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

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

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

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

Establish a medical home and increase care coordination for children with special health care

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

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

Reduce the proportion of children and adolescents who are obese: No current baseline percentages exist regarding Michigan children and adolescents who are overweight, obese and/or lacking opportunities for physical activity. Baseline data will be gathered during 2005 so future comparisons and percentages can be determined. During 2005, professional associations, standard-setting organizations (i.e., M-QIC) and public agencies will develop and reach consensus on guidelines for the prevention and management of overweight in children in clinical settings. Guidelines for nutrition and physical activity will be widely disseminated to primary health care providers, educators and other school personnel and the public. WIC and other maternal and child health staff will work with staff in the Community Public Health Administration to develop and implement a plan to enhance breastfeeding among program participants and address healthy weight and feeding issues. Training for WIC and other maternal and child health program staff will be implemented as part of the plan. Efforts will also be focused in increasing the number of Michigan schools that make changes to policies, programs and practices focused on making school environments more supportive of healthy eating and physical activity. Nutrition and physical activity content of the Michigan Model for School Health Education will be reviewed and revised as necessary to provide consistency with Michigan consensus guidelines for healthy eating and physical activity. Legislation has recently been introduced that would make nutrition education and physical activity mandatory in all Michigan schools.

Reduce incidence of teen suicide: In Michigan, suicide is the third leading cause of death for 15-19 year olds and the second leading cause of death for college age young people. Suicide rates, methods, risk factors and at-risk populations in Michigan closely parallel national trends and

statistics. An analysis of the 2003 Michigan Youth Risk Behavior Survey data found that 18% of Michigan's 9th-12th graders seriously considered attempting suicide at some point during the 12 months preceding the survey. More than one out of every ten students indicated they actually attempted suicide during that time. The number of young people in the state who die by suicide increases dramatically over the adolescent years.

//2007//An analysis of the 2005 Michigan Youth Risk Behavior Survey data found that 16% of Michigan's 9th-12th graders seriously considered attempting suicide at some point during the 12 months preceding the survey. Nearly one out of every ten students indicated they actually attempted suicide during that time.//2007//

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

Reduce the racial disparity between black and white infant mortality and between Native American and white infant mortality: In 2004 the white rate was 5.2 (the lowest rate in state history) and the black rate was 17.3 demonstrating a worsening of the disparity, 3.3, due to the stagnant black infant mortality rate and the improving white rate. Ninety eight percent of the black infant deaths occur in eleven urban communities that are now being targeted for study and coalition building to improve health care systems to reduce the problem. Since 1997 the Native American rates have risen from 8.7 to 12.4 using three-year averages. Over the same period the white rates have increased from 5.9 to 6.7 and dropped significantly in 2004 to 5.2 using annual rates. Native American infant deaths are few in number and scattered across the state making targeted efforts difficult. Eight of the 12 recognized tribes in Michigan are part of the HRSA Healthy Start Project and have benefited by education and nursing services at the local reservations.

//2008//In 2006, the white infant mortality rate was 5.4, slightly higher than the 2004 rate of 5.2, but slightly lower than the 2005 rate of 5.5. The 2006 black infant mortality rate of 14.8 represented a significant decline from the respective 2004 and 2005 rates of 17.3 and 17.9. Despite a considerable decline in the black infant death rate, the disparity between the black and white rates remains substantial at 2.7. In an effort to reduce this racial disparity, 11 communities (with the greatest number of African American infant deaths) are conducting pilot projects that focus on improving interconception health among women who have experienced poor pregnancy outcomes (i.e., fetal deaths, preterm births low birth weight infants, and infant deaths).

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

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

Increase the percentage of third grade children who have received protective sealants on at least one permanent molar. The Healthy People 2010 target for dental sealants on molars is 50% for 8-year-olds and 14-year-olds. Michigan has a sealant placement rate of 23% on 3rd grade

children and no data for 14-year-olds. Third grade children have a 58% rate of active decay. This rate of current dental decay is 15% higher than the national average. Development of school-based/school-linked sealant programs is critical to meet the Healthy People 2010 objectives and to reduce the oral disease burden of Michigan's children. Regular surveillance of decay rates and sealant placement on 8 and 14-year-olds is necessary to document measurable progress towards meeting the objectives of Healthy People 2010.

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	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	196	183	208	189	203
Denominator	196	183	208	189	203
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
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

During 2007, 123,368 newborns received at least one screen and 207 were diagnosed with one of 49 disorders. Screening for cystic fibrosis began on October 1, 2007 and 7 newborns with cystic fibrosis were detected in the first three months of screening. A courier system for same day delivery of newborn screening specimens was implemented. Three contractual agreements were maintained for medical management of metabolic disorders, endocrine disorders and Hemoglobinopathies. A new contractual agreement for medical management of cystic fibrosis was established in conjunction with the University of Michigan. A new metabolic clinic was opened in Grand Rapids in conjunction with Spectrum Health. HRSA contracts for implementing a web-based data management system for sickle cell anemia and evaluation of region 4 screening for congenital hypothyroidism and congenital adrenal hyperplasia were continued. The first newborn screening hospital coordinators meeting was held at MDCH on September 27, 2007. The purpose of the meeting was to review the expanded newborn screening program and to reinforce the importance of the coordinator's role in assuring that all newborns are screened in accordance with established newborn screening guidelines. At a news conference at the capitol on March 25, 2007, Michigan was recognized as one of the leaders in the United States in newborn screening by the March of Dimes for having made great strides in advocacy and awareness for newborn screening.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Screened 123,368 newborns			X	
2. Diagnosed 207 infants with one of forty-nine disorders			X	
3. Contracted for medical management of metabolic disorders	X			
4. Screening panel expended to include cystic fibrosis			X	
5. Contracted for genetic evaluation and counseling services	X			
6. Contracted for medical management of cystic fibrosis	X			
7.				
8.				
9.				
10.				

b. Current Activities

A family recognition day for parents and children diagnosed through newborn screening will be held on September 6, 2008. The purpose is to assist families in providing and receiving parent-to-parent support and to establish an ongoing interaction between the newborn screening program and parents regarding how the program is perceived by parents and how the program can be improved to better serve families. The newborn screening hospital coordinator network will be re-organized on a regional basis for more efficient provision of education and training programs. A six-day workweek will begin in June 21, 2008 to improve the turn-around-time for diagnosis and treatment of children detected through newborn screening.

c. Plan for the Coming Year

There will be on-going evaluation of implementation of newborn screening programs for Severe Combined Immunodeficiency Disorder and the Lysosomal Storage Disorders. Screening for these disorders has begun in several states but there is not yet a national or regional consensus on the efficacy of nation wide screening for these disorders.

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	2003	2004	2005	2006	2007
Annual Performance Objective	61.3	64	61.3	61.3	61.3
Annual Indicator	61.3	61.3	61.3	61.3	56.4
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	56.4	56.4	56.4	56.4	56.4

Notes - 2007

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

Notes - 2006

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

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 National Survey of CSHCN reported 56.4% success for the this outcome. The National Survey reported the positive response to "Doctors usually or always made family feel like a partner" was 87.8%. Positive response to "Family was very satisfied with services received" was 56.4%. Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed.

The Family Center remains in contact with families statewide, using the information obtained to provide consultation to the Michigan Title V programs regarding program and policy development. The Family Center is an integral part of the CSHCS division and is treated as a section within the division. All written materials intended for families, as well as CSHCS policy and procedure, are reviewed by the Family Center for recommendation and revision as needed. Family participation is a constant regarding CSHCS policy and program development. Proposed policies, letters to families, procedural and other documents undergo review, comment, and recommendation by parent representatives as a regular course of events. Review of the federal MCH Block Grant application was also provided by the Family Center in 2007.

In 2007, the Family Center had continued with their volunteer Family Support program in various communities in Michigan. The Family Center continues to staff the Family Phone Line that assists families in accessing their providers, other families with similar circumstances, and assistance in obtaining information regarding the status of their child's CSHCS coverage. The Family Center provided 13 regular scholarships for parents to attend conferences that pertain to their child's diagnosis. In 2007 the Family Center also held the bi-annual "Relatively Speaking" conference, which is a family oriented conference for parents and siblings of children with special health care needs. The Family Center awarded 24 scholarships for families to attend Relatively Speaking. Also in 2007 the Family Center expanded on the availability of conference scholarships to include youth with special health care needs to receive scholarships.

Along with the Family Center, the CSHCS division has eight parent representatives on the CSHCS Advisory Committee, which regularly makes policy and program recommendations. In addition to parent representatives, the CSHCS Advisory Committee has had youth/consumer representation since 2006. A representative from the CSHCS youth advisory council known as the Early Adult Transition Task-Force (EATT) provides youth participation in the CSHCS Division decision making process.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Incorporate requirement to address families as partners in decision making into the medical home model		X		
2. Continue to conduct the Early Adult Transition Task-Force		X		
3. Continue the activities of the Family Center in policy making		X		
4. Include families in the implementation process of strategic planning recommendations				X
5. Include families in the development and spread of the medical home model that will be piloted through the HRSA State				X

Implementation Grant				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Michigan's Family Center is an excellent resource for obtaining family input and determining problem areas in need of being addressed. Based on the large number of calls the Family Center receives per year from families, we are able to keep abreast of current and rising issues in the special needs "community".

In 2008, the CSHCS division embarked on a strategic planning process that will be integral in the way the division moves forward in implementing performance measures. The Family Center has worked hand in hand with the division to make sure that families are represented in the strategic planning process. 27 family representatives took part in the initial two day planning meeting and many will continue to play an important role in the implementation of the recommendations brought forth by the planning group. More of these recommendations will be discussed in our Plan for the Coming Year.

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:

1. The Family Phone Line that provides information
2. A statewide Family Support Network that offers family "matches" between families dealing with similar circumstances and emotional support
3. A biennial conference for siblings of children with special needs.
4. Conference scholarships for parents and young adults to learn more about diagnosis, care, and advocacy.
5. In-service trainings for families, Pediatric Regional Centers, Medicaid HMO's, local health departments, and other various agencies.
6. Provide trainings to parents and professionals through the Family to Family Health Resource Center.

In 2008 the CSHCS division embarked on a Strategic Planning process. The process included a two-day planning meeting to discuss and create an implementation plan for the six MCHB outcomes for CYSHCN. The topic of family participation was included in the discussion and prioritized recommendations were created. Workgroups will be convened to work on implementing these recommendations. Per the results of the meeting the high priority recommendations are:

- Collaborate with partners and build coalitions to assure that all families have full access to consistent and complete information on program benefits, information on the benefits of family partnership; conduct outreach to fathers, grandparents, youth and diverse populations, improve shared awareness of benefits of partnering organizations, develop, translate, and communicate information in multiple formats, languages, and literacy levels

- Subpriority: Send letters to families with infants on the birth defect registry

- New regional structures are required to have family advisors that will develop guidance to prepare, recruit and engage families to become advisors. Composition of family advisory structure will be reflective of community served and inclusive of youth. Each region will have a face-to-face family liaison. Provide minimal standards for financial support for family participation.

The CSHCS division also received grant funding to implement the MCHB outcomes through the HRSA State Implementation Grant to develop and spread a medical home model and medical

home certification as a mechanism to implement all six outcomes. Families will be included throughout the entire development and medical home spread process and will be instrumental in developing a mechanism for family participation and feedback within the medical home model that will be a requirement in the certification process for regional spread.

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	2003	2004	2005	2006	2007
Annual Performance Objective	55.8	58	55.8	55.8	55.8
Annual Indicator	55.8	55.8	55.8	55.8	46
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	46	46	46	46	46

Notes - 2007

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

Notes - 2006

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

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The National Survey of CYSHCN (2005/2006) reported the following: 45.9% of parents of CYSHCN in Michigan reported that their children have a medical home; and 48% indicated a positive response to "effective care coordination was received when needed." Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed.

In 2006 Michigan completed the Child with Chronic Condition Survey. The Survey randomly selected 1,500 CSHCS enrollees. The Survey included recently added questions related to medical home. Of the respondents, 62.7% said that their child received care from more than one provider or health care service, while 38.7% indicated that someone helped coordinate care among different providers or services. When rated by the child's health status (based on parent perception), the group receiving the most assistance with coordination of care was the group whose health status was rated as Fair/Poor (49.7%). The group receiving the least amount of assistance with coordination of care was the group whose health status was rated Excellent/Very

Good (32.7%). The age group with the greatest amount of coordinated care was the 0-4 age group with 45.5% of respondents indicating that someone helped coordinate care among different providers or services.

The CSHCS program continued to partner in the coordinated effort with the Metabolic Screening, Genetics, and the Early Health Detection and Intervention (EHDI) programs to further develop the Medical Home concept. The CSHCS program also created a system to provide in-state care as opposed to out of state care as part of the medical home efforts. The CSHCS Nurse Consultants worked toward this effort.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Implement medical home model and activities as proposed in the HRSA State Implementation Grant.	X			
2. Finalize consensus definition in collaboration with the MI chapter of the AAP.				X
3. Expand telemedicine awareness and use as a method of maintaining or increasing communication with the medical home.		X		
4. Convene workgroups to implement the medical home priorities as identified from the strategic planning process.				X
5. Participate in the on-going workgroup with the Metabolic Screening, Heredity Disorders, and the Early Hearing Detection and Intervention programs to develop the medical home concept.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In a collaborative effort to develop consensus of the medical home, an interest group of the Michigan Chapter of the American Academy of Pediatrics (MCAAP) is working with CSHCS to carry out the continued work of the Medical Home Learning Collaborative (MHLC). Activities include, further work on a consensus medical home definition, research and creation of a reimbursement mechanism for providers, and a regionalized support system for medical home providers and families.

An outgrowth of the MHLC activities is a cooperative project with the Department of Pediatrics Henry Ford Health System. The project is specifically targeted at assisting the state to increase physician capacity to provide medical homes for CYSHCN. Another medical home project is directed toward training residents in the precepts of the medical home. The MCAAP has proposed a joint effort with the residency directors of four Michigan State University (MSU) affiliated programs. The joint effort seeks to create a curriculum content in the area of medical home.

A project with MSU that began in 2006 continues on today as the only State funded medical home pilot project. The project works with two MSU pediatric practices and the funding provides an on-site coordinator to provide care coordination. The Medical Home Index and the Medical Home Family Index are being used to evaluate the effectiveness of the nurse coordinator intervention.

c. Plan for the Coming Year

In 2008 the CSHCS division embarked on a Strategic Planning process. The process included a two-day planning meeting to discuss and create an implementation plan for the six MCHB outcomes for CYSHCN. The topic of medical home was included in the discussion and prioritized recommendations were created. Workgroups will be convened to work on implementing these recommendations. Per the results of the meeting the high priority recommendations are:

- Develop consensus definition for CYSHCN family-centered medical home and all subsets of medical home such as care coordination in Michigan and method to operationalize that fully involves family representation in each group and process throughout start to finish
- Address the funding and reimbursement issues allowing for multiple strategies

The CSHCS division also received grant funding to implement the MCHB outcomes through the HRSA State Implementation Grant to develop and spread a medical home model and medical home certification as a mechanism to implement all six outcomes. This grant project will not only be a source of funding for creating medical homes but will provide a basis for expansion and the expansion of this model across the state.

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	2003	2004	2005	2006	2007
Annual Performance Objective	66.5	50	66.5	66.5	66.5
Annual Indicator	66.5	66.5	66.5	66.5	60.8
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	60.8	60.8	60.8	60.8	60.8

Notes - 2007

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

Notes - 2006

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

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

According to the 2005/2006 National Survey of CYSHCN, Michigan data indicated that: 64.3% of CYSHCN had adequate insurance compared to 66.9% nationally, 35.7% of the insured have insurance that is not adequate, and 6.7% were without insurance at some point in the past year. Currently, 2.7% of families surveyed were uninsured.

CSHCS has had an Insurance Premium Payment benefit in place for over 12 years whereby the state pays the private health insurance premium for the CSHCS eligible client. One reason CSHCS has this benefit is that it maintains private health care coverage for families that could not afford it. This enables the state to prevent a shift in cost of medical services from the private health insurance company to CSHCS state funding. The majority of the premiums paid by CSHCS are when COBRA coverage is offered to a family when the policyholder loses a job or when a young adult is no longer a dependent. CSHCS also pays for a client's premium for a private health insurance policy they purchased themselves or a reimbursement of insurance premium that is payroll deducted out of the paycheck of a CSHCS parent or client. Cost-effectiveness must be proven in order for CSHCS to pay premiums. It is a well-established benefit, and the number of families CSHCS has assisted in paying insurance premiums has remained fairly constant over the years. In 2007 the Insurance Premium Payment Benefit assisted 182 families with insurance premiums, saving the CSHCS program 1.8 million dollars.

In an attempt to assist families in accessing more coverage, CSHCS continues to send a specific mailing, letter and application, to families with CSHCS coverage when it appears they may be eligible for the MICHild/Healthy Kids programs to invite them to apply.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Build upon outreach efforts to families who may need assistance paying for insurance premiums.		X		
2. Support local health departments efforts of proactively assisting families who might be eligible for premium payment assistance with the application process.	X			
3. Maintain mailing to applicants encouraging they also apply for MICHild if they seem to meet the general eligibility criteria.			X	
4. Create and support health insurance options family training in partnership with the Family to Family Health Information Center as proposed in the HRSA State Implementation Grant.	X	X		
5. Convene workgroups to implement the insurance status priorities as identified from the strategic planning process.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

We continue to monitor the CSHCS population regarding their access to other insurance, either private or public. See Form number 7 for a more detailed breakout of coverage.

CSHCS continues to assist families maintain other health insurance through the Insurance Premium Payment Benefit. The mailing also continues for new applicants who appear to be eligible for MICHild/Healthy Kids at the time of CSHCS application.

c. Plan for the Coming Year

In 2008 the CSHCS division embarked on a Strategic Planning process. The process included a two-day planning meeting to discuss and create an implementation plan for the six MCHB outcomes for CYSHCN. The topic of insurance status was included in the discussion and prioritized recommendations were created. Workgroups will be convened to work on implementing these recommendations. Per the results of the meeting the high priority recommendations are:

- Work with partners from Medicaid to discuss the Family Opportunity Act and the Medicaid Buy-in program for the state of Michigan.
- Improve communication, collaboration, and education about health care and insurance to all stakeholders of the CSHCS program.

The CSHCS division also received grant funding to implement the MCHB outcomes through the HRSA State Implementation Grant to develop and spread a medical home model and medical home certification as a mechanism to implement all six outcomes. This grant project will provide funding to partner with the Family to Family Health Information Center in Michigan to provide parent and professional training series on the topic of Public and Private Insurance Options.

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

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	75.7	79	75.7	75.7	75.7
Annual Indicator	75.7	75.7	75.7	75.7	90.9
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012
Annual Performance Objective	90.9	90.9	90.9	90.9	90.9

Notes - 2007

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

Notes - 2006

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

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The 2005/2006 National Survey for CYSHCN indicated that 75.7% of Michigan families report that community-based systems are organized so they can use them easily; this is above the national average of 74.3%. 17.3% reported having problems getting a referral for specialty care; this is below the national average of 21.9%, while 14.6% had at least one unmet need for specific health care services; this is also below the national average of 17.7%. Persons beyond those with Michigan CSHCS coverage and eligibility were interviewed.

Michigan relies heavily on the local health department partners (LHD) to assist families in locating additional resources within their community. The CSHCS efforts to increase the success of this role has been to work much more collaboratively with the LHDs.

Because CSHCS relies so heavily on the LHDs it is crucial that the division provides them with the most up to date information and streamlined processes to handle clients needs. Historically the CSHCS program has maintained all medical records in central office in paper form and central office has had sole access to important client databases, leaving the LHDs to constantly rely on central office staff for information that is typically copied and mailed to them. One of the main accomplishments of the CSHCS division in the last year was scanning all of the medical records housed by the program and making them into electronic files that the LHDs will have protected access to. This was a major undertaking and was completed in record time. This will surely increase the client and family access to community based services in the second phase of the project that will give LHDs remote access to these files to have the information needed at the ready.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to establish closer relations with local health departments with support through the public health nurse consultants.		X		
2. Maintain updates in the Transition Resource Manual and the Guidance Manual that are available to support local health departments.		X		
3. Actively pursue in-state providers and facilities for services that are currently obtained out of state.	X			X
4. Convene workgroups to implement the community-based service priorities as identified from the strategic planning process.				X
5. Implement the activities of the medical home model and spread regionally for community-based medical home services through the HRSA state implementation grant.	X			
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CSHCS nurse consultants have taken on an increasingly active role in working closely with local health departments to identify areas of need and to provide training and technical assistance in many areas. This work has greatly strengthened the partnership between the CSHCS central office and the community based local health department staff. In the continued effort to assist

locally based services to assist CSHCS clients the division has made all of the manuals electronic for quick on-line access, this includes the CSHCS Guidance manual and the Transition Resource manual.

To increase community based access to information the CSHCS Division has undertaken the task of partnering with the Department of Information Techonology to make the CSHCS database a web-based application that can be accessed remotely in each local health department around the state. This, along with the addition of the filenet system which will house the electronic medical case file will provide for much more efficient work at the community level.

c. Plan for the Coming Year

CSHCS will continue in its efforts to work collaboratively with local health departments to provide community based services. This collaborative effort i echoed in the strategic planning process that was put together to address this objective along with the five other MCHB objectives. The process included a two-day planning meeting to discuss and create an implementation plan for the six MCHB outcomes for CYSHCN. The topic of community based services was included in the discussion and prioritized recommendations were created. Workgroups will be convened to work on implementing these recommendations. Per the results of the meeting the high priority recommendations are:

- Increase System efficiency (transportation, streamline documentation, webpage directions, who's/who list, Statewide Plan incentive/reward collaboration, hours of operation)
- Increase health communication technology including; telemedicine, infomatics, family controlled portable health records

This is a large idea that requires not only the CSHCS program but all parts of a system of care that families, children, and youth with special health care needs must access for care.

The CSHCS division also received grant funding to implement the MCHB outcomes through the HRSA State Implementation Grant to develop and spread a medical home model and medical home certification as a mechanism to implement all six outcomes. The very concept of the medical home is that it is community based. With the efforts of this project the medical home model will be spread regionally across the state for community based services.

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	2003	2004	2005	2006	2007
Annual Performance Objective	5.8	6	5.8	5.8	5.8
Annual Indicator	5.8	5.8	5.8	5.8	40.8
Numerator					
Denominator					
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
	2008	2009	2010	2011	2012

Annual Performance Objective	40.8	40.8	40.8	40.8	40.8
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Notes - 2007

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

Notes - 2006

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

Notes - 2005

The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments

The National Survey of CSHCN (2005/2006) indicated that 44.7% of parents in Michigan reported that "Doctors or other health care providers have talked to you or your child about his/her health needs as he/she becomes an adult." This is slightly below the national average of 46.2%. Persons beyond those with CSHCS eligibility were interviewed.

CSHCS has made great effort since 2005 to coordinate efforts to assess and assure youth with special health care needs receive services necessary to make the transition to adult life including health care, employment, and independent living. To address the needs of local health department (LHD) staff who wanted more information and resource materials CSHCS created a transition resource manual. The Transition Resource Manual was created to serve as a single point at which LHDs could maintain reference information, handouts for youth and families, and planning material on the topic of transition to adulthood. The manual contains over 100 pages of information on the topic of transition, divided into easy to use topical sections and is available electronically on the CSHCS website. Feedback from LHD staff has been positive. Further education and training has been provided to them through semi-annual meetings and teleconference training calls. Technical assistance is always available to LHDs on any topic related to transition through the division's Transition Analyst.

The CSHCS Youth Advisory Council called the EATT (Early Adult Transition Task-Force) continued in its efforts by continuing the EATT newsletter. Three newsletters have been created and mailed to over 4600 young adults on the CSHCS program ranging on topics such as health insurance and health care skills. CSHCS also educates young adults and family members on transition through anticipatory guidance in the form of letters. Four anticipatory letters have recently been developed and are currently being sent to clients and to family members. These letters provide guidance to youth and their family members with detailed information about steps throughout the transition process, steps such as planning for your child's future as an adult, reaching the Age of Majority, HIPAA privacy laws after the age of 18, as well as guidance on health care skills and health insurance. This guidance addresses the concerns that were voiced by youth and families that included comments such as "tell us where we are going" and "we need to know what is next."

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to train local health departments to work with the aging out population with medicaid to assist with the medicaid		X		

managed care rules.				
2. Continue to increase the collection and development of resources professionals and families/clients need to assist clients during the transition process.		X		X
3. Update the Transition Resource Manual for local health department staff.		X		
4. Maintain the Early Adult Transition Task-Force and all its activities including the EATT newsletter.		X	X	
5. Continue to create and provide anticipatory guidance for families and youth regarding the transition process.		X	X	
6. Partner with the Birth Defects program to further research and provide education to young woman with special health care needs about health and pre-conception issues.		X	X	
7. Develop transition planning packets and provide electronic devices for portable medical summaries for clients through the HRSA state implementation grant.	X	X	X	
8. Convene workgroups to implement the transition to adulthood priorities as identified from the strategic planning process				X
9.				
10.				

b. Current Activities

CSHCS continues to work with local health departments to provide them with the most up to date resources on the topic of transition. The Transition Analyst for the CSHCS division is able to provide technical assistance and take the time to help local health departments gather community based transition resources for young adults.

The Early Adult Transition Task Force will be maintained for the CSHCS division along with the support for the creation and mailing of the EATT quarterly newsletter.

HIPAA concerns are also being addressed that will also assist young adults in being able to take more responsibility for their health care once the age of majority has been reached. Mailings outlining the change in responsible party will continue and release of information forms will be available to young adults and their families if they need assistance.

In 2008 more resources are in the works that will include diagnosis specific information for clients aging out of the program. Specifically for the large population that ages off the program with diabetes. Resource materials will also be created for providers, to assist them in guiding youth and family through the transition process.

c. Plan for the Coming Year

In 2008 the CSHCS division embarked on a Strategic Planning process. The process included a two-day planning meeting to discuss and create an implementation plan for the six MCHB outcomes for CYSHCN. The topic of transition to adulthood was included in the discussion and prioritized recommendations were created. Workgroups will be convened to work on implementing these recommendations. Per the results of the meeting the high priority recommendations are:

- Create additional services to cover adults: health care, insurance coverage, CSHCS buy-in, pharmacy coverage, and mental health services.
- Create standard requirements and training for transition planning. Begin transition plan for all youth with special health care needs at age 14. Review at least annually and expand who would be eligible to bill for care coordination for transition planning.

The CSHCS division also received grant funding to implement the MCHB outcomes through the HRSA State Implementation Grant to develop and spread a medical home model and medical home certification as a mechanism to implement all six outcomes. The transition activities of the grant project will serve as a guide for expansion and spread of transition planning activities. Each client receiving services within the medical home will have to have a transition plan of care by the age of 14 that is updated annually. The project also allows for funding of electronic portable medical summary devices for youth and families to have control of a portable medical summary to assist in the transition process.

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	2003	2004	2005	2006	2007
Annual Performance Objective	85	87	89	91	91
Annual Indicator	81.5	81.2	82.7	81.2	81.8
Numerator	158336	152922	157364	154510	154222
Denominator	194277	188328	190283	190283	188535
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
	2008	2009	2010	2011	2012
Annual Performance Objective	91	91	91	91	91

Notes - 2006

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

a. Last Year's Accomplishments

Pandemic Flu preparedness activities are ongoing. MCIR has been enhanced to meet the needs of data collection during an all-hazards event.

MCIR has created an interface which displays lead data on children who have been accessed in the MCIR. Lead screening results are displayed and interpreted based on the most recent results to assist health care providers. Enhancing MCIR with other child health data will ensure that Michigan's children receive necessary preventive, screening, therapeutic and follow-up services as needed.

Immunization completion rates for children in MCIR continue to be assessed and tracked. MCIR rates for 19 to 36 months of age for a 4-3-3-1-3-1 series is at 71% statewide with many counties attaining 80% or higher coverage rates. Assessment, Feedback, Incentive, and eXchange (AFIX) is a process to determine provider immunization completion rates and provide input into ways their practice can be improved. AFIX assessments were implemented in MCIR. MCIR has now become the tool used to do these AFIX assessments. Over 1 million adult immunization records have been added to MCIR since June 5, 2006. New immunization assessment schedules are being added to MCIR to meet the requirements of adolescent and adult immunizations.

New Vaccine Inventory Module (VIM) is being developed to track and account for vaccines within

the MCIR. This new VIM system will meet the needs of the new vaccine centralized distribution system being implemented by the CDC.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCIR enhanced to include lead screening results				X
2. Maintained the MI Care Improvement Registry (formerly MI Childhood Immunization Registry)				X
3. AFIX (Assessment, Feedback, Incentive and eXchange) assessments implemented				X
4. New Vaccine Inventory Module (VIM) under development				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Pandemic flu preparedness activities are ongoing, MCIR has been enhanced to meet the needs of data collection during an all-hazards event.

MCIR has created an interface which displays lead data on children who have been accessed in MCIR. Lead screening results are displayed and interpreted based on the most recent results to assist health care providers. Enhancing MCIR with other child health data will ensure that Michigan's children receive necessary preventive, screening, therapeutic and follow-up services as needed.

Immunization completion rates for 10 to 36 months of age for 4-3-3-1-3-1 series is at 74% statewide with many counties attaining 80% or higher coverage rates.

The transition to the new Vaccine Inventory Module (VIM) in the MCIR has been partially implemented. We are planning to complete the transition by the end of 2008 to all 1,600 VFC provider offices. In late 2008, the immunization program will be adding functionality into the MCIR to allow for electronic ordering and approval of all VFC vaccine. This system will interface with the CDC software to electronically order vaccines.

c. Plan for the Coming Year

With the release of the new electronic birth record system, MCIR will have the capability of capturing the newborn kit number. Adding this number in MCIR will allow for MCIR to link with the newborn screening database and display newborn blood test results to providers in Michigan. In 2008, EPSDT data is displayed through MCIR and TB skin test results were added to MCIR. MCIR has a new vaccine inventory module with vaccine ordering capability. This module will become a quality assurance tool for local health departments and the VFC program. With the enhancement of a sickle cell case reporting tool in MCIR, the infrastructure will be created in the MCIR to allow the development of a case management tool for the Perinatal Hepatitis B Program. Evaluation strategies for FY 08 include:

1. Monitor number of provider users enrolled in the MCIR and immunization completion rates for children provided services.
2. Monitor the number of AFIX assessments and the change in immunization rates with repeat assessments among public and private providers.
3. Monitor the utilization of MCIR adult immunization providers statewide.

4. Monitor the number of educational presentations to providers and their staff.
5. Monitor the amount of vaccine being ordered and accounted for in the new VIM.

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	2003	2004	2005	2006	2007
Annual Performance Objective	18	18	17.8	17.6	17.4
Annual Indicator	18.1	18.7	17.6	17.0	14.0
Numerator	3894	4049	3934	3802	3127
Denominator	214590	216657	222960	223398	223398
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
	2008	2009	2010	2011	2012
Annual Performance Objective	17.4	17.2	17.2	17	17

a. Last Year's Accomplishments

During FY07 Michigan's primary teen pregnancy prevention program addressing the rate of birth to teenagers in the 15-17 year old age bracket was the Michigan Abstinence Program (MAP). MAP provides youth ages 9-17 years of age with intensive education regarding the benefits of abstinence from sexual activity and related risky behaviors such as the use of alcohol, tobacco and other drugs. Parents/guardians receive education regarding the importance of communicating with youth about sex and developing close, connected relationships with youth in order to positively influence youth decision-making. During FY 07 eleven funded community agencies provided 11,233 youth with abstinence education. Of that number, 10,037 youth participated in at least 14 hours of intervention. Parent Education programming saw 954 parents/guardians participating in MAP parent education.

Local coalitions, representative of the community, provide oversight and direction for the programs. These coalitions also develop and implement community awareness activities designed to help the local community understand the benefits of abstinence for youth. A statewide media campaign with public service announcements (PSAs) for television and radio along with print media targets youth and parents in separate PSAs. Extensive technical assistance is provided to funded MAP communities. MAP programming meets the definition of abstinence education as outlined in both Section 510 of Title V of the Social Security Act and the MDCH appropriation boilerplate.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided abstinence education to 11,233 youth		X		
2. Provided parent education to 954 parents		X		
3. Supported local coalitions through the Michigan Absitenice				X

Program				
4. Conducted statewide media campaign			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

MAP continues in the current year with the 11 community agencies funded.

c. Plan for the Coming Year

Continuing funding for the Section 510, Title V Abstinence Education programs is questionable as the funds are being authorized on a quarterly basis at the federal level. Funding will end June 30, 2008 unless the fourth quarter is authorized.

This performance measure will also continue to be addressed by Family Planning Programs, (Title X) and education by Adolescent Health Centers (clinical & non-clinical). The adolescent and School Health Unit also plans to issue a teen pregnancy prevention RFP that will work towards these goals in FY 09.

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	2003	2004	2005	2006	2007
Annual Performance Objective	39	41	33.6	25	25
Annual Indicator	33.4	33.4	22.5	23.4	23.4
Numerator	41889	41889	28170	29350	29350
Denominator	125417	125417	125417	125417	125417
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
	2008	2009	2010	2011	2012
Annual Performance Objective	30	35	40	45	50

Notes - 2006

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

a. Last Year's Accomplishments

The Michigan Department of Community Health/Oral Health program utilized the data from the 2006 Basic Screening Survey titled "Count Your Smiles" of 3rd grade children in Michigan to implement a state-wide dental sealant program for second grade children on October 1, 2007. The SMILE! Michigan dental sealant program provides dental sealants to second grade students in schools that have greater than 50% or more participation in free and reduced lunch programs.

A full time dental sealant coordinator was hired in January 2007 to develop, implement and evaluate the program. A statewide dental sealant advisory board was formed and the oral health program worked closely with the Michigan Oral Health Coalition to implement the project. A grant process resulted in 10 local public health agencies, federally qualified health centers and non-profit agencies funded to implement the first SMILE! Michigan dental sealant program. Training on sealant placement and SEALS data collection was provided to all grantees. 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 HHealth Kids Dental	X		X	
6. Implement a State-Wide Sealant Program				X
7.				
8.				
9.				
10.				

b. Current Activities

The MDCH/Oral Health Program is currently working with the Oral Health Coalition and the Sealant Advisory Committee to implement the SMILE! Michigan dental sealant program. The dental sealant coordinator monitors all grant recipient activities and provides technical and consulting services to the grantees and other local health agencies to support dental sealant placement. Four school based health centers have established a dental component which includes dental sealants. Work continues to expand the number of dental clinics within school-based health centers to increase dental sealant rates. The SMILE! Michigan program is being internally and externally evaluated to determine the effectiveness and efficiency of the program and to determine barriers that need to be addressed for continual program enhancement. The oral health program is working diligently to increase the capacity and infrastructure of the SMILE! Michigan. As a result of this work, additional funding for dental sealants was provided through the Healthy Michigan Fund to address racial disparities within the city of Detroit.

c. Plan for the Coming Year

Provide technical assistant to dental sealant programs. Continue to build support for additional funding to support the dental sealant program and to increase capacity. Evaluate and monitor the SMILE! Michigan program and utilize the evaluation data for program enhancement. Conduct the "Count Your Smiles Survey" on 3rd grade and 6th grade children. Analyze the results and compare the results to the 2005 "Count Your Smiles" Survey. Publish and disseminate the findings.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007

Annual Performance Objective	3.5	4.1	4.1	3.4	3.2
Annual Indicator	4.6	3.5	3.1	2.5	2.3
Numerator	96	73	65	50	47
Denominator	2098595	2098595	2066272	2019667	2019667
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	3	2.5	2.4	2.3	2.2

Notes - 2007

The population estimates for 2007 are not available.

a. Last Year's Accomplishments

MDCH continued to lead a statewide program for child passenger safety (CPS) training and public education including information on best practices/benefits of proper restraint use, MI law, and the dangers of airbags to unrestrained occupants and children. Programs focused on the needs of at-risk populations. MDCH conducted the Nationally Standardized CPS Technician Certification Course to certify individuals as CPS Technicians (CPST). CPST conducted public events to provide CPS education on restraint correct use/installation. MDCH 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. MDCH continues to implement strategies from its CPS Strategic Plan that includes recommendations in: law enforcement, legislation, education, health care & family service providers, and funding. MDCH finalized work on a 4-year cooperative agreement with CDC to develop interventions to reduce motor vehicle-related injuries to children. The Michigan Child Passenger Safety Coalition met quarterly to assist in activities of the campaign, including the development of two community interventions to increase booster seat use. The University of Michigan Transportation Research Institute (UMTRI) conducted all evaluation activities of the CDC project which included: a booster seat observation study in each pilot community and a control site, a process evaluation of each site to determine the successful and unsuccessful components of each community program, and a statewide booster seat usage observational study and a statewide telephone survey. In conjunction with the Michigan State Police (MSP) Office of Highway Safety Planning, MDCH developed and is distributing educational materials through the MSP distribution center.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducted CPS Technical Certification courses				X
2. Conducted CPS education on restraint correct use/installation		X		
3. Provided technical assistance to the public and direction to fitting stations around the state that provide a specific time/place where parents can have a car seat inspected	X			
4. Developed two 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

MDCH continues to lead the program for child passenger safety (CPS) training & public education. MDCH coordinates & conducts the Nationally Standardized CPS Technician Certification Course for healthcare providers (HCP) and law enforcement (LE) to certify them as CPS Technicians (CPST). CPST conduct public events to provide education on restraint correct use/installation. MDCH also coordinates the CPS Instructor Team. There are over 950 CPST & 46 CPS Instructors in Michigan. MDCH provides 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 is developing an educational campaign and materials on Michigan's new booster seat law in effect July 1, 2008. The materials will be available through the MSP distribution center. Finally, MDCH is working toward expanding its motor vehicle injury prevention program to include injury prevention activities directed toward older children ages 8-15.

c. Plan for the Coming Year

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 will continue to provide technical assistance and award car seats to Michigan hospitals that adopt or strengthen CPS hospital discharge policies. MDCH will continue coordinating and conducting the Nationally Standardized CPS Technician Certification Course for healthcare providers (HCP) and law enforcement to certify them as CPS Technicians (CPST). MDCH will continue to coordinate the Michigan CPS Instructor Network and will provide funding for Instructors to conduct the CPS in EMS and CPS in Buses courses in their local communities. MDCH will work in conjunction with the Michigan State Police (MSP) Office of Highway Safety Planning to implement an educational campaign on Michigan's new booster seat law in effect July 1, 2008. MDCH will also continue to work to expand its motor vehicle injury prevention program to include children 8 to 15 years of age.

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	2003	2004	2005	2006	2007
Annual Performance Objective				35	40
Annual Indicator			14.6	15.8	15.8
Numerator			6345	6618	6619
Denominator			43459	41890	41890
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

	2008	2009	2010	2011	2012
Annual Performance Objective	20	25	30	35	40

a. Last Year's Accomplishments

The WIC Division offers Breastfeeding Basics (BFB), Breastfeeding Coordinator (BFC) and Milk Expression (ME) training. In FY 2006 -- 2007 117 local agency (LA) staff and other health care providers attended BFB, 15 LA Breastfeeding Coordinators attended BFC training and 13 of those same individuals attended ME Training

The Mother-to-Mother Program Breastfeeding Initiative (BFI) expanded and now provides breastfeeding peer counselor services in 35 counties.

Benton Harbor Project: Focus groups recommended an additional breastfeeding peer counselor to help serve the needs of the African American population. A breastfeeding peer counselor continued to work in that WIC clinic.

The WIC Division worked with a representative from the Maternal Infant Health Program (MIHP) to incorporate the two programs' data needs under one umbrella. Breastfeeding needs were addressed in this joint effort.

Within the WIC Division, we began the work of developing a new data system to track breastfeeding promotion and support, services of our pregnant and lactating women and breastfeeding infants. This project will complement data collected by our partners such as MSUE/BFI and MIHP. We introduced and implemented the LAs to the new breastfeeding policies.

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

The WIC Division continues to participate & provide leadership in a multi-state Nutrition Education on the Internet Project. The Breastfeeding Module developed by Michigan WIC & the local agency Breastfeeding Workgroup continues to get used by breastfeeding mothers. Feedback continues to be good.

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Offer Breastfeeding Basics, Breastfeeding Coordinator and Milk Expression training				X
2. Conduct Mother-to-Mother Program Breastfeeding Initiative		X		
3. Initiate development of new data system to track breastfeeding promotion and support				X
4. Continue Build Breastfeeding Friendly Community in Bay County project				X
5. Participate in multi-state Nutrition Education on the Internet project		X		

6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

During FY '08, WIC has continued to: provide training for local agency staff which includes a 5 day intensive lactation course for 100 LA 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; focus on social marketing methods to reach African American women; strengthen and improve breastfeeding workgroups, the Michigan Breastfeeding Network and local breastfeeding coalitions; and implement breastfeeding policies within WIC.

c. Plan for the Coming Year

Continue activities as described above

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	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	90.6	90.9	95.4	96.7	97.1
Numerator	116135	117619	121640	121898	119770
Denominator	128126	129387	127518	126015	123407
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
	2008	2009	2010	2011	2012
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Michigan EHDI has continued to have 100% of birthing hospital participation in universal newborn hearing screening. Pass and referral rates have remained fairly stable at roughly 96% pass and 3.5% referred in 2007. The average age of identification has remained stable at 2.9 months in 2006. Of the infants identified with hearing loss, all with parent consent were referred to Part C services. Obtaining documentation of early intervention services continues to be problematic due to FERPA (Family Education Rights and Privacy Act) but for those cases that are reported, the average age of enrollment in early intervention continues to decrease from 5.2 months in 2005 to 3.7 months in 2006.

EHDI continues to provide resources and consultation to hospitals, increase public awareness through exhibiting and presenting, promote county collaborations through funding EHDI county brochure development, provide training consortiums and educational meetings. EHDI continues to maintain providers lists for hospital, rescreen, diagnostic, and early intervention sites. Physician education and family support continues as a priority for EHDI staff time and resources. EHDI is continuing to develop and implement various stages of database development. Database development includes building a comprehensive follow-up system, linking with other data systems, and provider Web base access. EHDI continues to receive referrals for a family support program called "Guide- By-Your-Side". This program links families with newly identified infants with hearing loss to other hearing loss families in order to provide family support through the initial stages of diagnosis to intervention.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Achieved 100% participation of Birthing hospitals				X
2. Screened 121,902 infants	X			
3. Referred infants identified 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

EHDI is currently developing a training module for hearing screeners, hospital nurse coordinators, and audiologists that would be available online. Database development continues to be a priority, EHDI is proceeding with developing a linkage to the Electronic Birth Certificate System and initializing a web-based reporting system for hearing screening and diagnostic hearing testing. EHDI has continued to maintain the follow-up system. EHDI continues to support the parent programs Guide-By-Your-Side and Michigan Hands & Voices.

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. EHDI will integrate with the Michigan Care Improvement Registry and hearing results will be displayed for providers. 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	2003	2004	2005	2006	2007
Annual Performance Objective	6.8	6.7	5.6	3.7	3.5
Annual Indicator	5.8	5.8	3.7	5.0	4.7
Numerator	147257	147257	93000	128000	116049
Denominator	2538920	2538920	2513514	2554000	2445601
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
	2008	2009	2010	2011	2012
Annual Performance Objective	4.5	4.4	4.3	4.2	4.1

Notes - 2006

Data from the US Census American Community Survey

Notes - 2005

Data is based on 2005 Household Survey conducted by the State Planning Project for the Uninsured

a. Last Year's Accomplishments

The most current statistics on children below age 18 living in poverty continues to hover between 15 and 20 percent. As expected, Detroit has one of the highest overall poverty rates among metropolitan areas in the country. The number of Michigan children who are enrolled in Medicaid and MICHild continues to increase, primarily due to sustained community outreach for the MICHild Program, which identified and enrolled many Medicaid-eligible children. So despite significant cuts in health programs, Michigan has made important efforts to provide coverage to uninsured children. 5.2 percent of the pediatric population in Michigan is uninsured compared to 9.1 percent for the nation. The dual enrollment procedure utilized to bring children into the Medicaid and MICHild programs continues, and funding for outreach by local health departments was restored. Between 8,000-9,000 children are enrolled per month with between 2,000-3,000 enrolled in MICHild and the remainder enrolled in Healthy Kids (Medicaid). The use of alternate sites for enrollment and continuing collaboration with other human services agencies supports the outreach to families with uninsured children. Families completing the dual enrollment are also able to self-report income, rather than being required to provide pay stubs or other proof of income before applications can be completed. Program enrollments and re-enrollments have remained fairly constant for the last year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued Medicaid and MICHild enrollment through community outreach for the MICHild program				X
2. Continued dual enrollment procedure to bring children into the Medicaid and MICHild program				X

3. Use of alternative sites for enrollment and continued collaboration with other human service agencies for outreach to families with uninsured children				X
4. Local Public Health Outreach continues				X
5. HSA outreach activities related to program enrollment being carefully monitored				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Outreach funds available to local health departments have been promoted by the Department. The continued collaborative efforts have increased enrollments in publicly-funded programs & provided outreach to uninsured families. The development of Family Resource Centers in schools not meeting Adequate Yearly Progress will also serve as enrollment sites for children from families that are uninsured or underinsured, & the number of resource centers has increased. Nurse Family Partnership programs in Detroit, Pontiac, Grand Rapids, Berrien County & Kalamazoo are identifying & serving families who need coverage for their children, these programs assist with enrollments in publicly-funded programs, as well as the general outreach conducted by local health departments. MDCH's State Planning Project for the Uninsured recommendations have been reviewed & efforts to follow up/initiate them is underway.

c. Plan for the Coming Year

Outreach funding to local health departments will continued along with consultation and technical assistance. The department will be seeking additional community-based partners to assist in the outreach efforts to assure that children currently uninsured or underinsured obtain coverage for health care. Links with interagency programs such as WIC, MSS/ISS and Early On are already established, as are networks with Early Head Start, the Children's Action Network, schools, employers and the counties funded for development of birth to five services through the Early Childhood Investment Corporation - a public/private collaborative established by the Governor. Dual program enrollment continues, and additional partners identified that are able to assist with outreach and/or provide direct enrollment on site. Collaboration will be expanded with day care centers, emergency food and shelter programs and a number of school programs to assure that families are aware of the MICHild and Healthy Kids programs. Assistance for on-site enrollment will also be encouraged whenever possible. The greatly expanded number of school-based health centers will also be a source of outreach efforts since outreach will be important for school-age children and adolescents, groups that are currently less reflected in the MICHild and Medicaid programs. Enrollment efforts will also be focused on underrepresented groups and subgroups having high rates of uninsured individuals.

Closer scrutiny of outreach activities will be continued in 2008. Reporting by local health departments regarding outreach and enrollment activities will produce greatly improved substantiation of outreach efforts.

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	2003	2004	2005	2006	2007
Annual Performance Objective				16	15.8
Annual Indicator			16.1	16.2	29.5
Numerator			15434	15516	28255
Denominator			95863	95780	95780
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
	2008	2009	2010	2011	2012
Annual Performance Objective	29.5	29	28.5	28	27.5

Notes - 2007

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

a. Last Year's Accomplishments

WIC-Breastfeeding-Obesity Partnership: WIC has been engaged in discussions with chronic disease about how best to provide the message and to what audiences, related to the excellent evidence that breastfeeding in infancy decreases the incidence of obesity in later life.

Local WIC nutrition educators meet three times a year and were provided with lesson plans for clients related to obesity and physical activity for children. For WIC participants, the Internet Education Project, www.wichealth.org, is an alternative form of nutrition education. The site offers several topics on feeding children using Stages of Change and Division of Responsibility concepts which promote healthy parenting around meals, supporting the prevention of overweight in children. Also, a module titled "Happy, Healthy, Active Children" on the [wichealth.org](http://www.wichealth.org) site is used by clients to learn how to promote physical activity in their children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct WIC-Breastfeeding-Obesity Partnership		X		
2. Provide nutrition education through Internet Education Project		X		
3. Provide lesson plans for nutrition educators on obesity and physical activity for children				X
4. Include a module on "Happy, Healthy, Active Children" for clients to learn how to promote physical activity in their children		X		
5. C				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Use of and continued development of nutrition education modules for wichealth.org include 12 modules currently in use (4 in Spanish) and 3 new modules being developed on fruits and vegetables and whole grains.

Continued activities as stated above.

c. Plan for the Coming Year

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				14.6	13.6
Annual Indicator			15.6	17.5	13.6
Numerator			19851	22281	13505
Denominator			127249	127537	99303
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
	2008	2009	2010	2011	2012
Annual Performance Objective	12.6	11.6	10.6	10.6	10.6

Notes - 2006

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

Notes - 2005

Data from the PRAMS system, not from the birth certificate.

a. Last Year's Accomplishments

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

increase in the percentage of pregnant women who smoke during the last trimester of pregnancy, 15.6% and 15.8% respectively.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

A web-based Smoke Free for Baby and Me training has been developed and was launched November 2006. This web-based training is accessible and required for providers in the state's Maternal Infant Health Program and offers nursing continuing educational credits. It can also be accessed by any prenatal provider.

In FY2006-2007 500, Continuing Educational Credits (CEUs) were awarded to Nurses who completed and passed the online course.

The Maternal Infant Health Program (MIHP) will have an intensive focus on prenatal smoking cessation in this redesigned MCH population based, home visiting support service for Medicaid enrollees. Providers will have required intervention protocols, reporting requirements and performance evaluation measures to follow. MIHP aims for a systematic approach to address smoking risk in pregnant women and mothers of infants in this low-income population.

c. Plan for the Coming Year

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

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	8.7	8.4	8.1	7.9	7.8

Annual Indicator	6.7	8.2	8.2	7.9	7.0
Numerator	49	60	61	59	52
Denominator	728381	735634	745736	745908	745908
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
	2008	2009	2010	2011	2012
Annual Performance Objective	7.7	7.6	7.5	7.4	7.3

a. Last Year's Accomplishments

MDCH, working with the Michigan Suicide Prevention Coalition (MiSPC) developed and successfully applied for a three-year, \$1.2 million youth suicide prevention cooperative agreement from the federal Substance Abuse and Mental Health Services Administration (SAMSHA). The first year of funding started on October 1, 2006. The grant will allow the state to conduct a health communication campaign, provide a training of trainers for clinicians and community gatekeepers, offer technical assistance to all interested communities in the state, build state infrastructure around suicide prevention, provide limited grants to communities, and conduct extensive evaluation of efforts.

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

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

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

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Successfully applied for federal youth suicide prevention funding				X
2. Participated in Yellow Ribbon Campaign		X		
3. Continued implementation of Michigan Model for Comprehensive School Health			X	
4. Implementation of the state suicide prevention plan				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

MDCH and MiSPC are continuing to work cooperatively on implementation of the state plan.

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

Implementation of the Michigan Model is ongoing.

c. Plan for the Coming Year

- Continue implementation of the SAMHSA funded youth suicide prevention activities
- Complete an action plan for full implementation of the state suicide prevention plan.
- Secure support for implementation of high priority objectives of the suicide prevention plan.
- Establish a state government suicide prevention cross-systems work group.
- Provide ongoing support to local and regional suicide prevention coalitions.
- Expand participation in symposiums held within the state on suicide prevention in partnership with the Michigan Association of Suicidology, the Michigan Chapter of the Suicide Prevention Action Network, and other public and private entities.
- Work with the Department of Education to develop voluntary guidelines for schools.

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

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	88	88	88.2	88.2	88.4
Annual Indicator	84.8	86.0	86.4	85.9	87.8
Numerator	1896	1848	1849	1796	1422
Denominator	2235	2148	2140	2090	1620
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
	2008	2009	2010	2011	2012
Annual Performance Objective	88.4	88.6	88.6	88.8	88.8

a. Last Year's Accomplishments

The findings of the 2005 survey of birthing hospitals were shared with different partners to further engage them in understanding and challenging the updating of the state perinatal system. The Department worked with Grand Valley State University to develop feedback for each hospital surveyed. A fact sheet with information on live births at their respective hospitals was provided to them.

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

Plans to conduct a perinatal survey every other year had to be put on hold due to current state budget constraints. On May 5, 2008, a statewide summit on infant mortality was held in Lansing, including a session on perinatal regionalization. Participants included staff/health care professionals from hospitals, managed care plans, universities, professional associations, local health departments and community clinics. Commitments to follow-up action pursuant to the Summit were obtained from 20 stakeholders.

An internal work group was formed and met few times to discuss the MCH/Life Cycle Quality Care frame work that will be used to integrate the other state collaborative efforts and programs targeted to MCH population. The members of this group are leaders from different areas from within MDCH from programs and epidemiology to Medicaid and Certificate of Needs.

As a result of all of the above, a plan was drafted to address the health care and the related outcomes as well as the program services that might serve the quality assurance/improvement. Objectives of this plan would be to: 1/ develop level of care guidelines based on the latest AAP/ACOG recommendations (health care specific quality assessment/improvement built in); 2/ assess and adopt regions boundaries in concordance with other state wide initiatives; 3/ assess and use different programs in developing new objectives and specific strategies related to the perinatal system of care quality assessment and improvement.

c. Plan for the Coming Year

The Department will be using the plan drafted for a coordinated perinatal system of care to further engage different stakeholders to address the perinatal health care system in Michigan. The Department will also follow-up on discussions and commitments from the Infant Mortality Summit in the coming year.

A state leader is invited to join the Vermont Oxford Network (VON) Neonatal Quality Improvement initiative. Twelve out of the existing 24 centers with NICU licensed beds are already part of this initiative and three more will soon join. This offers the unique opportunity to strengthen the existing collaboration between MDCH and neonatologists and work together towards improving the perinatal system of care in Michigan.

Other projects with obstetricians and gynecologists as well as pediatricians that are targeted

towards the coordination of perinatal care are on the way.

There are always barriers to overcome and the lack of funding for these activities makes the process more difficult and slows it down. However, there is interest and commitment from MDCH and providers as well as few other stakeholders to developing a coordinated perinatal system of care.

We will continue to work on developing and implementing different strategies that will meet the state goals related to perinatal system of care.

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	2003	2004	2005	2006	2007
Annual Performance Objective	85.9	85.9	86.6	87.8	89
Annual Indicator	84.1	82.7	83.3	83.3	83.4
Numerator	110019	107283	106238	106188	82849
Denominator	130850	129710	127518	127537	99303
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
	2008	2009	2010	2011	2012
Annual Performance Objective	90.3	90.3	90.3	90.3	90.3

a. Last Year's Accomplishments

The final 2005 data on this indicator shows a slight increase to 83.3% of mothers who received early prenatal care. Despite emphasis on creating new pathways to care through early referral from WIC, there continue to be a significant proportion of women who refuse or are unable to receive care in the first trimester. Provisional 2006 data is suggesting a slow return to a higher percentage of women entering care earlier. The redesigned Medicaid support services program implementation began in late 2005, and emphasis is being placed on early entry and early risk assessment.

During 2006 the Maternal Infant Health Program (MIHP) implemented the Prenatal Risk Factor Eligibility Risk Factor Screening form and Prenatal Services Assessment. The Prenatal Risk Factor Eligibility Risk Factor Screening form will stratify the Medicaid Beneficiary into low, moderate or high risk. During 2007, the MIHP domain workgroups continued to develop best practice interventions for each of the specific risk domains on the Prenatal Risk Factor Eligibility Screening form. Once implemented into the MIHP, these best practice interventions will help assure a health pregnancy and birth.

During 2006, a MIHP medical home workgroup developed communication forms to be used by the MIHP staff and the Medicaid medical providers. These communication forms will assist both the MIHP staff and medical care providers with communicating in a timely manner so the MIHP beneficiary gets services in a timely manner, thereby assuring a healthy pregnancy and birth.

During 2007, the MIHP database workgroup continued to assist the Department of Information

Technology (DIT) with development of an on-line electronic MIHP Prenatal Risk Factor Eligibility Screening form. All MIHP Coordinators and staff were trained on use of the electronic screener. Once implemented the on-line screener will begin to provide a profile of screened needs of the MIHP beneficiaries, provide an efficient way to screen MIHP beneficiaries and prevent duplicative services.

During 2007, the MIHP medical home workgroup completed its work on the communication forms to be used by the MIHP staff and the Medicaid medical providers.

MIHP providers continue work collaboratively with the WIC programs in their community. During 2007, a MIHP/WIC workgroup developed an integrated MIHP/WIC screening tool which is being used by some of the MIHP providers. This collaboration of WIC and MIHP services enhances each entry into MIHP services.

In the 11 counties that are funded to address infant mortality, activities to promote early prenatal care included:

- Engaging key community representatives, including churches, health insurance plans, hospitals, and parents in local efforts to reduce infant mortality.
- Identifying and linking high-risk pregnant women and mothers with young children to relevant systems of care and services (e.g., Healthy Start, Medicaid, MIHP, WIC, etc.).
- Improving coordination (e.g., referrals, screening, etc.) between systems that serve pregnant women.

The Nurse Family Partnership projects enrolled women and offered early intervention for first time pregnancies. The Medicaid Family Planning Waiver was initiated.

Table 4a, National Performance Measures Summary Sheet

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

b. Current Activities

During 2008, the on-line electronic MIHP Prenatal Risk Factor Eligibility Screening form was implemented and became mandatory. All MIHP providers must enter all MIHP beneficiary screens into the state's database.

The MIHP domain intervention workgroups continue to complete their work. At least two of the domain interventions will be implemented next year.

The 4 Nurse Family Partnership (NFP) projects are continuing to enroll clients & offer early intervention for first time pregnancies. An additional NFP project was funded in Kalamazoo County. The Medicaid Family Planning Waiver has continued. With many more low income child bearing age women receiving regular reproductive care, as they choose to become pregnant, family planning providers, especially Title X Family Planning providers, will connect her to prenatal care providers supporting earlier entry into care.

c. Plan for the Coming Year

The plan for 2009 is to continue to analyze data collected from the pilot prenatal projects and the NFP sites to learn best practices for improving early entry to prenatal care. The department will also look at ways to study how much substance abuse in childbearing age women and how inadequate contraception affects the timing of entry to care. Additional influence is needed to affect Medicaid and health plan policies to reward early entry to care. The Medicaid Family Planning Waiver will continue with access to regular reproductive care, and if pregnancy does occur, then the connection to prenatal care providers will support earlier entry into care. The database for the Prenatal Risk Factor Eligibility Risk Factor Screening form will be completed. In 2009, the Infant Mortality Reduction Coalitions will continue implementing and evaluating their Interconception Care Programs. The NFP Programs will continue to look for funding to expand the number of projects within the state. Work will be completed on the MIHP infant screener. Two of the domain workgroup interventions will be implemented next year. Reports will be developed for the MIHP providers and the state utilizing data from the MIHP database. The name of the MIHP Prenatal Risk Factor Eligibility form will change to Prenatal Risk Identifier.

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	2003	2004	2005	2006	2007
Annual Performance Objective				25	30
Annual Indicator				100.0	
Numerator				1	
Denominator				1	
Is the Data Provisional or Final?				Provisional	
	2008	2009	2010	2011	2012
Annual Performance Objective	35	40	45	50	50

Notes - 2007

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

Notes - 2006

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

Notes - 2005

This measure was new for 2006

a. Last Year's Accomplishments

The MIHP screener contains a depression screening section based on the Edinburgh depression tool. Since December 2005, MIHP providers began to systematically screen all clients for perinatal depression using this screener. As for intervention, it was agreed minimally all women, regardless of risk status, would be given information regarding signs of perinatal depression and treatment, and level of severity, evidence based interventions will be developed and implemented. Our measures of success are the percentage of pregnant women who receive MIHP services screened for depression during pregnancy; percent of women receiving MIHP services screened for depressions after delivery; percentage of women receiving MIHP services and screening positive who are referred for treatment broken out by mild, moderate and severe; and percentage of women receiving MIHP services screening positive who receive treatment. It is expected this group will not have measurable data until 2010.

Table 4b, State Performance Measures Summary Sheet

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

b. Current Activities

The Perinatal Depression Work Group will strategize this year on how to implement their recommendations and their goal "to recommend a referral process, interventions, and systems changes in order to improve access to services and the quality of services for MIHP clients who screen positive for mild, moderate or severe depression."

c. Plan for the Coming Year

The Perinatal Depression Work Group will strategize this year on how to implement their recommendations and their goal "to recommend a referral process, interventions, and systems changes in order to improve access to services and the quality of services for MIHP clients who screen positive for mild, moderate or severe depression."

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	2003	2004	2005	2006	2007
Annual Performance Objective	8.1	7.9	7.8	8.2	8.1

Annual Indicator	8.2	8.4	8.4	8.4	8.2
Numerator	10778	10867	10665	10720	8100
Denominator	130850	129710	127518	127537	99303
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	8	7.9	7.8	7.8	7.7

Notes - 2006

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

a. Last Year's Accomplishments

Final data from 2004 shows a total LBW rate of 8.4%. Typically the rate for black births is twice the rate for white births. Measures to reduce this rate have failed to be successful in the last 10 years. Some interest has been focused on substance abuse related to low birth weight. Smoking cessation and FAS prevention programs are active in recruiting pregnant women to reduce their risks. Preconception counseling after the infant's delivery was also recommended for MIHP clients and those in Nurse Family Partnership to reduce LBW before pregnancy begins. The Infant Mortality Coalitions accomplished the following to reduce LBW infants:

- Engaged key community representatives, including churches, health insurance plans, hospitals, and parents in local efforts to increase awareness.
- Identified and linked high-risk pregnant women and mothers with young children to relevant systems of care and services (e.g., Healthy Start, Medicaid, MIHP, WIC, etc.).
- Improved coordination (e.g., referrals, screening, etc.) between systems that serve pregnant women.
- Implemented pilot Interconception Care Projects. Through this program, registered nurses provide home-based education and case management services to improve the health of high-risk women prior to subsequent pregnancies. The program serves women who have had one of the following: a fetal death, a preterm infant, a low birth weight infant, or an infant death. The goal is to prevent the recurrence of preterm births, low birth weight infants, and infant deaths.

The CDC-funded Fetal Alcohol Syndrome Prevention Program in Detroit hired staff and had grantees meetings to collaborate on strategies for prevention. A lot of outreach was done in Detroit with agencies to identify more at-risk women for the project. The pilot Preconception Project had good acceptance with women who have had an early pregnancy loss. The goals are to provide grief support and preconception counseling for subsequent pregnancies.

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

Each coalition has developed an Interconception Program in which 20-25 women who have had either a fetal loss, an infant loss, a preterm delivery, or a low birth weight infant will receive case management services for up to two years. Nurses and social workers will assess, educate, and assist these women in addressing behavioral, economic, grief, medical, and social issues in order to improve subsequent birth outcomes. The program objectives are to: a) reduce the number of subsequent preterm births (births < 37 weeks gestation); b) reduce the number of subsequent low birth weight infants (births < 2500 grams, or 5lbs 5 oz); c) increase the number of planned pregnancies among program participants; d) increase 18 month pregnancy intervals among program participants.

The MIH Program is well on its way and is seeing good 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. Prenatal Smoking cessation training for providers will be available on-line, improving information access.

c. Plan for the Coming Year

The Infant Mortality Initiative will continue to address reducing black infant mortality based on the needs identified by using the Perinatal Periods of Risk analytical model for improving the health system of local communities. Each area will use collaboration between agencies and consumers to develop a plan appropriate for their community. In fiscal year 2008, the coalitions will continue implementing and evaluating their Interconception Programs.

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	2003	2004	2005	2006	2007
Annual Performance Objective	11.2	11.1	11	11	10.9
Annual Indicator	11.2	10.0	10.0	9.6	9.6
Numerator	14651	12939	12794	12297	9536
Denominator	130850	129710	127518	127537	99303
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	10.2	10.2	10.1	10.1	10

a. Last Year's Accomplishments

A fifth Nurse Family Partnership site was newly established in Kalamazoo County. The Infant Mortality Coalitions (IMCI) implemented pilot Interconception Care Projects. The projects utilize registered nurses to provide case managed inter-pregnancy services to high-risk women. The program serves women who have had one of the following: a fetal death, a preterm infant, a low

birth weight infant, or an infant death. The goal is to improve subsequent birth outcomes by preventing the recurrence of preterm births, low birth weight infants and infant deaths.

Table 4b, State Performance Measures Summary Sheet

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

b. Current Activities

The IMCI continues charging the local communities with assessing the gaps in service for the health care system for prenatal care & delivery. Focus group evaluation of local consumer & providers' needs of issues such as prematurity & early infant loss were completed & are being used to improve local perinatal systems of care. Emphasis has shifted to optimizing women's health prior to & between pregnancies with these 4 goals: Fewer preterm births; Fewer low birth weight births; More planned pregnancies; More pregnancies with 18 month pregnancy intervals. The SIDS/OID program continues to provide home visiting bereavement services to families experiencing a sudden loss of an infant unexpectedly at home. Components of interconception care have been incorporated into the 6 reimbursed home visits. An annual professional training addresses common problems associated with infant mortality, such as prematurity. The 2006 training hosted over 100 nurses & social workers across the state. Similar topics are covered in conferences held annually by the Healthy Mothers Healthy Babies Coalition. MIHP continues to be redesigned to place emphasis on early entry into care, early risk assessment, & interconception care. Five Nurse/Family Partnership projects provide early intervention for first time pregnancies. The Smoking Cessation Program launched on line training courses for providers to improve information access & to help women reduce or stop smoking during pregnancy.

c. Plan for the Coming Year

The Infant Mortality Coalitions will continue to implement and evaluate their Interconception Care Projects. The program provides case management services to women who have had poor pregnancy outcomes, such as a preterm infant. The goal is to improve the outcome of subsequent pregnancies.

The Medicaid Family Planning Waiver will be expanded. The program will improve access to

contraception for low income women. Reducing the number of unintended pregnancies is part of the overall strategy to improve the interconceptional periods and reduce the percent of preterm births.

Implementation of recommendation for re-designing the MIHP program will continue.

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	2003	2004	2005	2006	2007
Annual Performance Objective	39.6	39.2	38.7	38.7	38.3
Annual Indicator	40.6	39.6	41.8	40.7	38.3
Numerator	53093	51402	53330	51909	38033
Denominator	130850	129710	127518	127537	99303
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	37.8	37.3	37.3	37.3	37.3

Notes - 2006

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

Notes - 2005

PRAMS data was used to estimate the number of unintended pregnancy in Michigan. We just adjust the weighted number from PRAMS to the number of live births to Michigan's residents reported by the Vital Records office.

We were able to provide the final numbers for 2004 and 2005.

a. Last Year's Accomplishments

Most recent available PRAMS data (2005) indicates 41.3% of women who delivered a live birth had an unintended pregnancy. Several programs in Michigan are working to reduce this number. All prenatal programs have a service component that connects women postnatally to family planning services, either the Title X program or their medical provider. Prevention of unintended pregnancy is the responsibility of both partners. Many programs highlight the responsibility of the male. Contraception services are available to males in Michigan's Title X Family Planning services.

All methods of contraception are available through Medicaid and Michigan's Title X Family Planning program. In the Title X program, permanent contraception is available to both sexes through a cost efficient centralized project site. There were 80 for women and 104 procedures provided for men in CY 2007.

Reflecting the adolescent population where greater than 70% of pregnancies are unintended, an objective of the Family Planning Program is to assure that the percentage of teens served in the program compared to total users is at least 28% of the caseload in 2007; this objective was met last year. In 2007, 40,622 male and female teens were served in Family Planning Clinics.

The Michigan Abstinence Program (MAP) provides youth ages 9-17 years of age with intensive education regarding the benefits of abstinence from sexual activity and related risky behaviors such as the use of alcohol, tobacco and other drugs. Parents/guardians receive education regarding the importance of communicating with youth about sex and developing close, connected relationships with youth in order to positively influence youth decision-making. During

FY 07 eleven funded community agencies provided 11,233 youth with abstinence education. Of that number, 10,037 youth participated in at least 14 hours of intervention. Parent Education programming saw 954 parents/guardians participating in MAP parent education. MAP programming meets the definition of abstinence education as outlined in both Section 510 of Title V of the Social Security Act and the MDCH appropriation boilerplate.

School-based/linked Child & Adolescent Health Centers continue to be included in strategies to reduce unintended pregnancies. Michigan currently funds 45 school based/linked teen health centers to provide comprehensive primary health care, behavioral health services, health promotion/disease prevention education, and referral services to youth 10-21 years of age.

Table 4b, State Performance Measures Summary Sheet

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

b. Current Activities

Began implementation of segments of the redesigned Maternal Infant Health Program (formerly Maternal Support Services and Infant Support Services).

In 2007, 142,432 women and 4,697 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.

The Michigan Abstinence Program (MAP) and Child & Adolescent Health Center program continue in the current year. In calendar year 2007, over 30,000 adolescents were provided primary health care services and over 100,000 youth received health education services through the CAHC program.

c. Plan for the Coming Year

Maximize the use of Title X Family Planning Program and the Medicaid Waiver funds to serve as many individuals as possible to meet the contraception needs of the state's residents. MDCH has implemented a media campaign to assure everyone becomes aware of the expanded availability for family planning services in the state.

Continue to assure access to family planning services for teens by assuring that Family Planning clinics are held at times convenient for teens and upholding Title X regulations assuring their access.

MAP funding (Section 510, Title V Abstinence Education) has not been reauthorized at the federal level for the fourth quarter of FY 08. As a result, MAP funded projects will no longer be operational after June 30, 2008.

Through increased funding obtained through federal Medicaid matching dollars, use additional centers funded by the Child & Adolescent Health Center program to provide primary medical services to an increased number of at-risk children and adolescents.

Continue rolling out implementation (sections of the program at a time) of the newly designed Maternal Infant Health Program (formally the Maternal Support Services and Infant Support Services programs) with a strengthened family planning service component; continue the five Nurse Family Partnership sites, both programs including components to provide reproductive health information and assisting women served to make choices about birth control methods.

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	2003	2004	2005	2006	2007
Annual Performance Objective	25	25	60	70	80
Annual Indicator	18.8	24.3	27.1	28.9	29.2
Numerator	65078	86088	96887	105514	107856
Denominator	346239	354928	357527	364858	369615
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	30	35	40	45	50

a. Last Year's Accomplishments

There was an increase in the number of children 0-6 who were tested in 2007 over 2006. 8,434 more children were tested in 2007 with 278 fewer children poisoned. 2,031 children were found to have blood lead levels at or equal to 10 µg/dL, which represents 1.4% of children tested, and remains slightly above the national average. An additional 16,566 children between birth and 6 years of age had blood lead levels between 5-9 µg/dL. During 2007 the Lead Initiative Coordinators received additional training on case management. The objective of the training was to improve each local health department's ability to define and provide comprehensive, coordinated, family-centered case management services for children with lead poisoning. Training components included review of the revised case management protocol, use of the newly developed standardized chart forms and individual plan of care, and review of standard of care/best practices for LHDs.

Lead Initiative Coordinators have three major responsibilities: comprehensive case management of any child with a blood lead level at or above 20 µg/dL; identification and implementation of strategies to increase testing; and development and implementation of a primary prevention plan addressing the needs of the community/county.

In addition to special consultation with the City of Detroit Department of Health and Wellness Promotion, twelve other communities (in 11 counties), chosen based on age of housing and other variables are identified as high risk and receive additional consultation and technical assistance. In addition to the activities listed above, funding from the Centers for Disease Control and Prevention and the Healthy Michigan Fund (state fund) supports lead activities in five high-risk counties, elevated blood lead level investigations, housing abatement, the lead-safe housing registry, grant development, a public awareness campaign and a Governor's Commission that is

charged with identifying all state agency activities related to lead and evaluating how the agencies work together to address lead hazards in communities. The annual report of the Governor's Lead Poisoning Prevention and Control Commission was sent to the Governor and the legislature in June 2007. The report is available online at www.michigan.gov/leadsafe.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Increased the testing percentage of children enrolled in managed care to 80%.			X	
2. Provided consultation to high-risk communities.				X
3. Began planning for first statewide lead conference.				X
4. Testing benchmarks include a 10% increase in testing of < 6 years old and a 25% increase in testing children 1 and 2 years of age.			X	
5. State prevalence rate goal is 1.5%			X	
6. Blood lead level results avail. on the (MCIR) to help assure appro. med. f/up of children w/ elev. blood lead levels, decrease the # of missed opport., and limit unnecessary testing. Also provides recom. for f/up testing and trtmnt as needed.				X
7. Developed and a new Statewide Public Awareness Campaign			X	
8. Provided follow-up for all children at BLL 20ug/dL or above		X		
9. Participated with Healthy Housing Solutions to provide case management training to local health department staff on the revised protocol and new chart forms.				X
10.				

b. Current Activities

The statewide average for children in Medicaid tested by three years of age, including Managed Care enrolled, fee-for-service and Children's Special Health Care Services (CSHCS) dual enrolled is 70%.

Three pieces of legislation relating to lead in toys and other children's products, lunch boxes, and jewelry were passed in December 2007. A fourth piece of legislation, reinstating the Childhood Lead Poisoning Prevention and Control Commission also passed in December 2007.

Case management training will be provided to nurses in several areas of the state including the Upper Peninsula and the Thumb region. These trainings will help assure that case management services are comprehensive and family centered. CLPPP will continue to assure that all Michigan children with blood lead levels > 20 µg/dL receive appropriate and timely case management services.

CLPPP, in collaboration with CLEARCorps Detroit, will continue the Interim Controls Project. CLEARCorps will continue to conduct risk assessments on homes where children under 6 years of age or pregnant women reside and will conduct interim controls on these homes. Interim control measures include lead specific "supercleaning" and addressing identified lead hazards, especially in windows.

Lastly, training and educational opportunities will continue to be made available to various stakeholders including health care professionals, parents, childcare providers, and a variety of other stakeholders.

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, children 1 and 2 years of age, and prevalence of poisoning in the target communities. The testing benchmarks for each of the target communities will represent a 10% increase (over 2007) in testing among 1 & 2 year olds and a 25% increase in testing among children <6 years of age. The prevalence of lead poisoning for the entire state for calendar year 2008 will decrease to 1.0%. Additionally a testing strategy for each target community will be developed. The basis of each plan will be the MDCH Statewide Testing/Screening Plan and each plan will be detailed, specific and have measurable outcomes.

CLPPP will further develop partnerships with other departments/agencies, both internal and external, whose primary focus is young children and housing.

A mid-elimination report will be published and distributed to all stakeholders. The report will assure that stakeholders are fully informed regarding progress toward elimination in Michigan.

Lastly, CLPPP will design and implement, in collaboration with strategic partners, primary prevention strategies focusing on residents of pre-1950 housing in target communities, pregnant women, women of childbearing age, families with young children, and special populations.

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	2003	2004	2005	2006	2007
Annual Performance Objective	16	26.4	25.7	90	90
Annual Indicator	35.7	80.1	98.4	52.5	88.9
Numerator	8	18	22	12	16
Denominator	22380	22484	22365	22873	17991
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	89	88	86	84	82

a. Last Year's Accomplishments

Case ascertainment methods described in 2007 continue to be used & contributed to ascertainment of the majority of maternal deaths in Michigan. Both pregnancy & non-pregnancy related cases were reviewed by committees with expertise regarding the causes of death under review. The Medical Committee has representation from the schools of medicine in Michigan, large birthing hospitals, anesthesiology, midwifery, private practice, MEs & emergency medicine. While the Medical Committee continues to review the pregnancy related deaths, non-pregnancy related deaths are done by the Injury Committee. The Injury Committee, convened in 2004, has membership including state & local police, highway safety, urban public health nursing, domestic violence, substance abuse representation as well as obstetricians, emergency room physician, nursing educators & local public health representation. De-identified case information is used in conducting the reviews. Cause of death & contributing circumstances were identified for each case during the reviews with the focus on health care system, civic & personal contribution. Each review is followed by recommendations for prevention. De-identified findings are also used for medical education & presentations. Continued work occurred on the development & maintenance of the maternal mortality database offering more comprehensive case information for retrospective analysis.

2007 recommendations were: 1. Mandatory thorough autopsy for each case of maternal death. 2. Form a depression subcommittee to look at screening and interventions. 3. Develop a Cardiac

Disease Case Registry. 4. Establish a public campaign on ectopic pregnancy. 5. Send reprints of the Anesthesia Study to hospital obstetrics & anesthesia with questionnaire. 6. Establish a pregnancy seatbelt use subcommittee. The Autopsy Subcommittee presented at the annual Michigan Medical Examiner's meeting held in the fall of 2007. The Depression Subcommittee recommended screening women in the prenatal and post partum periods. The Medical Chair presented the recommendation of screening to the Michigan Section of ACOG. Members of the Medical Committee are exploring ways to accomplish the Cardiac Disease Registry. A public campaign regarding ectopic pregnancy was still in the process of development. The Anesthesia Study was published in the June 2007 issue of Anesthesiology. The Seatbelt Subcommittee met and developed a public education strategy including a brochure for distribution to pregnant women.

For years, the primary indicator of maternal health has been the maternal mortality ratio (MMR). However, mortality is the ultimate outcome of uncontrolled morbidity & women who deliver a live birth experienced either a new medical condition or the aggravation of a previous condition, which influence long-term health & mortality. The initial linked file of 1995-2001 Michigan Hospital discharge (Michigan Inpatient Data Base=MIDB) data with Michigan's residents' live births records that was developed has been updated every year. MIDB is a claims-based file, which uses International Classification of Diseases, Ninth Revision (ICD-9). Clinically related ICD-9 codes were grouped into pregnancy-related & non pregnancy-related categories. In our preliminary analysis, 384,179 women met the inclusion criteria. The most prevalent non pregnancy-related conditions & their racial distribution (black/white ratio) include asthma (ratio=1.72), hypertension (ratio=1.73), & cardiac diseases (ratio=0.67). Among the pregnancy-related conditions, the most prevalent & their racial distribution were hypertensive disorders of pregnancy (ratio=1.41), gestational diabetes (ratio=0.88), & abruptio placentae (ratio=1.41).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Case ascertainment methods continue to be used				X
2. Continued work on the development and maintenance of the maternal mortality database				X
3. Developed a linked file of 1995-2001 Michigan Hospital discharge (Michigan Inpatient Data Base=MIDB) data with Michigan's residents' live births records				X
4. Publish Interdisciplinary recommendations				X
5. Distribute Annual Maternal Mortality Report				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

The Interdisciplinary Committee met in Oct. 2007 and Recommendations for the 2008 year were identified: Develop a brief report on the pregnancy outcomes of maternal deaths. (i.e, review the cause/effect or assoc. between maternal deaths and fetal/infant deaths and possible sharing of info with interested groups; Review of maternal cancer deaths to understand /determine any patterns in diagnosis & treatment; Review existing depression screening questionnaires/tools,

their validity and frequency of use; Review the issues of substance abuse, domestic violence, mental health services and data collection in maternal deaths; Find and evaluate alternative funding sources for submission of a proposal for the Cardiac Disease Registry project; Send info to ACOG from the Ectopic Pregnancy Maternal Mortality Study in MI; Send reprints of the Anesthesia Study to each hospital department of obstetrics/anesthesia in the state.

New topics this year are related to maternal morbidity & included diabetes & obesity, the EPI Division is in the process of developing a Women's Health Report of reproductive age.

c. Plan for the Coming Year

Case reviews by the Medical Committee and by the Injury Committee as described earlier will continue. Findings from reviews will continually be entered in the MMMS database developed (mentioned in section a), thus allowing for further epidemiological studies to better understand and address the Michigan specific issues. The process of identifying recommendations will continue. 2007 Recommendations that were not acted upon will be evaluated for follow up and additional recommendations will be elicited from the Committee members. A biannual newsletter will be developed about maternal mortality in Michigan and released to increase the awareness among women's health care providers. An updated analysis of maternal morbidity by using the MIDB data set s underway. Also, the Division of Genomics, Perinatal Health and Chronic Disease Epidemiology Director has initiated the work on an annual report of women of reproductive age. The work is in progress and multiple data sources are being used to thus offer a comprehensive picture of the women's health status in Michigan. The program staff from MCH as well as chronic disease will be involved during the process leading. Besides strengthening the collaboration between epidemiology and programs, this report will also bridge the maternal child health and chronic disease areas that have more in common nowadays.

State Performance Measure 7: Rate of breastfeeding at six months

Tracking Performance Measures

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

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				35	40
Annual Indicator			14.6	15.8	15.8
Numerator			6345	6618	6619
Denominator			43459	41890	41890
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	20	25	30	35	40

a. Last Year's Accomplishments

The WIC Division offers Breastfeeding Basics (BFB), Breastfeeding Coordinator (BFC) and Milk Expression (ME) training. In FY 2006 -- 2007 117 local agency (LA) staff and other health care providers attended BFB, 15 LA Breastfeeding Coordinators attended BFC training and 13 of those same individuals attended ME Training

The Mother-to-Mother Program Breastfeeding Initiative (BFI) expanded and now provides breastfeeding peer counselor services in 35 counties.

Benton Harbor Project: Focus groups recommended an additional breastfeeding peer counselor to help serve the needs of the African American population. A breastfeeding peer counselor continued to work in that WIC clinic.

The WIC Division worked with a representative from the Maternal Infant Health Program (MIHP)

to incorporate the two programs' data needs under one umbrella. Breastfeeding needs were addressed in this joint effort.

Within the WIC Division, we began the work of developing a new data system to track breastfeeding promotion and support, services of our pregnant and lactating women and breastfeeding infants. This project will complement data collected by our partners such as MSUE/BFI and MIHP. We introduced and implemented the LAs to the new breastfeeding policies.

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

The WIC Division continues to participate & provide leadership in a multi-state Nutrition Education on the Internet Project. The Breastfeeding Module developed by Michigan WIC & the local agency Breastfeeding Workgroup continues to get used by breastfeeding mothers. Feedback continues to be good.

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

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Offer Breastfeeding Basics, Breastfeeding Coordinator and Milk Expression training				X
2. Conduct Mother-to-Mother Program Breastfeeding Initiative		X		
3. Initiated development of new data system to track breastfeeding promotion and support				X
4. Participate in multi-state Nutrition Education on the Internet project		X		
5. Continue Build a Breastfeeding Friendly Community in Bay County project				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

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

by funding. All of these factors negatively impact breastfeeding initiation and duration rates.

During FY '08, WIC has continued to: provide training for local agency staff which includes a 5 day intensive lactation course for 100 LA 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; focus on social marketing methods to reach African American women; strengthen and improve breastfeeding workgroups, the Michigan Breastfeeding Network and local breastfeeding coalitions; and implement breastfeeding policies within WIC.

c. Plan for the Coming Year

Continue Activities as described above

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	2003	2004	2005	2006	2007
Annual Performance Objective				12.3	12.1
Annual Indicator			13.2	13.2	12.4
Numerator			29252	29252	27982
Denominator			221604	221604	225665
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	12	11.8	11.7	11.7	11.7

a. Last Year's Accomplishments

MI WIC Health Outcome Indicator: Decrease the prevalence of early childhood overweight, in children 2 to 5 years of age, from 12.4% to 12.0%.

2007 Accomplishments:

WIC-Breastfeeding-Obesity Partnership: WIC has been engaged in discussions with chronic disease about how best to provide the message and to what audiences, related to the excellent evidence that breastfeeding in infancy decreases the incidence of obesity in later life.

Local WIC nutrition educators meet three times a year and were provided with lesson plans for clients related to obesity and physical activity for children. For WIC participants, the Internet Education Project, www.wichealth.org, is an alternative form of nutrition education. The site offers several topics on feeding children using Stages of Change and Division of Responsibility concepts which promote healthy parenting around meals, supporting the prevention of overweight in children. Also, a module titled "Happy, Healthy, Active Children" on the wichealth.org site is used by clients to learn how to promote physical activity in their children.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct WIC-Breastfeeding-Obesity Partnership		X		
2. Provide nutrition education through Internet Education project		X		
3. Provide lesson plans for nutrition educators on obesity and physical activity for children				X
4. Included a module on "Happy, Healthy, Active Children" for				X

clients to learn how to promote physical activity in their children				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Use of and continued development of nutrition education modules for wichealth.org include 12 modules currently in use (4 in Spanish) and 3 new modules being developed on fruits and vegetables and whole grains.

Continued activities as stated above

c. Plan for the Coming Year

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

Continue other activities as stated above

E. Health Status Indicators

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

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

Using the state's Vital Records, the Bureau of Family, Maternal and Child Health routinely monitors data for HS Indicators # 01A, 01B, 02A, 02B, 07A and 07B. This information is available on the department's website which also provides county and some city level profile data for local planning and policy development. The data provides a basis for developing plans and resource allocations for such initiatives as Infant Mortality Coalitions, Unintended Pregnancy Prevention, Michigan Abstinence Program and Nurse/Family Partnership projects. /2008/Data for indicators 01A, 01B, 02A and 02B have remained basically unchanged over the last five years. See also narratives for National Performance Measures #15 and #18 and State Performance Measures # 02 and #03. The number of live births in Michigan declined by 6.3% from 2000 to 2005 with no significant change in the racial/ethnic composition (see also

demographics on Page 8).//2008//

The primary administrative responsibility for programs addressing HSI #03A, 03B, 03C, 04A, 04B and 04C is outside the MCH program. The Bureau of Health Promotion and Disease Control includes an Injury Control Program which addresses deaths and injuries resulting from motor vehicle crashes and other types of causes. The primary source of information for planning and policy development is the Hospital Discharge Database.

/2008/There has been a significant decrease in the rate of deaths and injuries due to motor vehicle crashes over the last five years (see discussion under National Performance Measure #10).//2008//

HSI #05A and 05B are primarily monitored by the Bureaus of Epidemiology and Laboratories. This information is used to target education, prevention and testing efforts to appropriate subpopulations and geographic areas. The Family Planning Program in the Bureau of Family, Maternal and Child Health coordinates planning and services with the Communicable Disease Programs.

/2008/While the rate of chlamydia cases increased from 2002, there was a slight decline from 2004 to 2005.//2008//

The demographic data (HSI # 06A, 06B, 08A, 08B, 09A, 09B, 10, 11 and 12) do not vary significantly from year to year (see also Overview section and Needs Assessment). These data are used primarily for long-range planning. Child death statistics are made available to local Child Death Review Teams (covering all Michigan counties) for analysis and development of community policies or strategies to address specific needs in their areas. This data is summarized on a statewide basis annually and reviewed by the Michigan Child Death State Advisory Team. The State Advisory Team makes recommendations for policy and practice to prevent child deaths to the Children's Cabinet which includes the Departments of Community Health, Human Services, and Education. Data on fetal and infant deaths are used by state and local planners (including Infant Mortality Coalitions and FIMR Teams) to develop strategies for addressing the causes of deaths within communities and across the state. Data on enrollment in WIC, Medicaid and MICHild (SCHIP) inform outreach efforts and monitor performance targets for agencies. Data on households headed by a single parent, TANF, foster home care, enrollment in food stamp programs, juvenile crime arrests and high school drop-out rates are not used specifically for MCH program development or monitoring but are part of interagency efforts (such as the Great Start Collaborative) to coordinate policy and services for children and their families. Poverty statistics inform planning for most human service programs for Michigan families.

F. Other Program Activities

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

1-800-26-BIRTH is staffed by health or social service professionals to answer both information as well as crisis calls of pregnant women and parents. The staff are updated, quarterly, on the availability of services, eligibility requirements, and contact persons for local prenatal care and WIC providers and assist the client in identifying these and other providers in the client's community. Counselors are trained to respond to a broad range of health care needs. The hotline is marketed by local and state agencies through pamphlets, posters and public service announcements. Several times a year a flyer describing this service is mailed with every Medicaid

identification card to each recipient and in AFDC warrants. In FY 2004, 7,730 calls were handled by the 1-800-26-BIRTH hotline.

/2007/In 2005, 7,322 calls were handled by the hotline.//2007//

/2008/In FY 2006, 7,100 calls were handled by the 1-800-26BIRTH hotline.//2008//

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

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

G. Technical Assistance

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

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

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

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

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

V. Budget Narrative

A. Expenditures

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

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

On Form 4, the decrease from the budgeted amount to the expended amount in 2004 for Children 1 to 22 years old is due to the transfer of funds for the MOMS program to the Medical Services Administration (prenatal services for low-income women who do not qualify for Medicaid). Also on Form 4, the difference between Budgeted and Expended amounts for "Others" reflects the difference between the draft appropriations bill and the final actual appropriations.

//2007//The major difference between budget and expenditures for 2005 is in the CSHCS program. Medical care and treatment costs can vary significantly from estimates based on fluctuations in types and amount of services required by recipients.//2007//

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

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

B. Budget

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

The projected match for FY '06 is \$38,993,900. In addition to state general fund monies, the federal-state block grant partnership includes program income from the WIC and newborn

screening programs, and Children's Trust Fund monies supporting the CSHCS program.

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

On Form 3 line 3 and Form 4 line I.d, the budget amount for 2006 reflects the increase in caseload and funding for Medical Care and Treatment and the elimination of services for adults in CSHCS (hemophilia and cystic fibrosis) as contained in the Executive Budget. On Form 3 line 6, the increase in Program Income includes additional funding from the WIC formula rebate and an increase in fees for newborn screening. On Form 4 line I.c, the 2006 budget reflects the transfer of the MOMS program (prenatal care services for women who do not qualify for Medicaid) to the Medical Services Administration. Finally, on Form 5 line III, the 2006 budget figure includes the increases in WIC formula rebate and newborn screening fees.

//2007/The budget for FY 2007 reflects the decrease in federal allocation to Michigan and the exhaustion of federal carryforward funds (Form 3).//2007//

//2008/The budget for Children's Special Health Care Services for 2008 (Form 4) reflects the estimated actual expenditures for Medical Care and Treatment in FY 2007, a reduction of approximately \$8,000,000. These expenditures can vary widely, depending on claims submitted by providers. The budget change is also reflected on Form 3, Line 3 and Form 5, Line I. The budget for Infants on Form 4 (also Form 3, Line 6 and Form 5, Line II) reflects the re-negotiated WIC formula rebate amount with Mead Johnson. This change was effective October 2006. At this point in time, the state budget for FY 2008 is not determined. Based on cuts proposed for FY 2007, there may be significant changes for the FY 2008 budget as well, particularly as it affects services for children and pregnancy prevention/family planning.//2008//

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

VI. Reporting Forms-General Information

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

VII. Performance and Outcome Measure Detail Sheets

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

VIII. Glossary

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

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

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

C. Organizational Charts and All Other State Supporting Documents

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

D. Annual Report Data

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