

STATE TITLE V BLOCK GRANT NARRATIVE

STATE: MI

APPLICATION YEAR: 2005

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I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

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

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

The Assurances and Certifications can be found on file with the 2004 MCH Block Grant Application in paper and electronic form.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

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 four newspapers throughout the state (Detroit Free Press, Grand Rapids Press, Traverse City Record-Eagle, and Marquette Mining Journal).

Two comments were received from Wayne County Health Department and Detroit City Health Department. As a result of those comments, we did add information on Wayne County's Family Planning activities under SPM #6 and corrected Detroit's FIMR data (PM #17). Detroit also suggested the topic of childhood obesity for our next needs assessment.

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

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, employing local health departments and local collaborative bodies to determine the needs of their community and the best system for addressing those needs. Services are delivered 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, as well as with other state departments. 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, WIC, and injury prevention programs.

The public health functions of assessment and assurance are shared with 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 1990 U.S. Census, 70.5% of the state's population resides in urban areas. 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.

/2004/ 74.6% of the population live in urban areas. Per 2000 Census, 81% of Michigan's population resided in 26 counties designated as metropolitan.//2004//

Language is another potential barrier to access to care. An estimated 2.2% of persons age 5 and over do not speak English very well. Of these, 46,144 speak Spanish, 28,229 speak an Asian or Pacific Island language, and 114,289 speak other languages.

/2004/ 2000 Census data shows 8.4% of Michigan residents speak a language other than English (2.7% speak Spanish, 3.3% speak Other Indo/European, and 1.1% speak Asian and Pacific Island languages). 3.2% of Michigan residents speak English less than very well.//2004//

Also, according to the 1990 Census, there were 251,687 families, or 10.2% of all families, who were below the 100% poverty level. Of related children under 18 years of age, 18.6% lived in poverty. 22.1% of related children under 5 years were below poverty. Among the white population, 12.4% of children under 18 and 14.8% of children under 5 were below the poverty level. For black children under 18, 46.2% were below the poverty level, while 32.5% of American Indian, Eskimo and Aleut and 14.6% of Asian/Pacific Islander children under 18 were below poverty. For children under 5, 53.5% of blacks, 40.5% of American Indian, Eskimo and Aleut, and 15.4% of Asian/Pacific Islanders were

below poverty.

In 1998, the total estimated population in Michigan was 9,817,244 according to the Michigan Information Center. This includes 134,483 infants, 2,671,110 children between the ages of 1 and 20 years, and 2,205,426 women of childbearing age (15-44 years). Approximately 79% of infants were white, 18% black, 2% Asian and Pacific Islander, and less than 1% were American Indian. Of Michigan residents aged 1-20 years, 80% were white, 18% were black, 1.6% were Asian/Pacific Islander, and 0.8% 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.

/2003/ 2000 total population for Michigan was 9,938,444. This includes 131,188 infants, 2,752,877 children between the ages of 1 and 20 years and 2,116,289 were women of childbearing years. Approximately 76% of infants were white, 18% were black, .7% were Native American, 2.4% were Asian, .03% Pacific Islander, and 2.5% Other. Of Michigan residents aged 1-20 years, 78% were white, 18% were black, less than 1% were Pacific Islander, and 2% were Other. Among women of child bearing years, 80% were white, 16% were black, .6% were Native American, 2% were Asian, less than 1% were Pacific Islander, and 1.5% were Other.

/2004/ Total population in Michigan by 2000 Census was 9,938,444. This represented a 6.9% increase. This included 136,048 infants, 2,748,017 children between the ages of one and 20, and 2,155,403 women of childbearing age. Of the total population, 80.2% were White (increase of 2.7%), 14.2% were Black (increase of 9.4%), 0.6% were American Indian and Alaska native (increase of 5.1%), 1.8% were Asian (increase of 70.5%), less than one percent were Native Hawaiian and Other Pacific Islander (increase of 81.6%) and 1.3% were Some Other Race (increase of 49.1%). 3.3% of the population is Hispanic or Latino. 14.2% of people under age 18 in Michigan were in poverty in 2000. Of total White families with children under 18, 3.7% were in poverty. For Black families, this was 18.2%, for American Indian/Alaskan Native, 11.1%, Asian, 5.3%, Native Hawaiian & Other Pacific Islander, 11.3%, Some Other Race, 16.7%, Hispanic or Latino, 15.2%. Unemployment rates in certain metropolitan areas in Michigan exceeded those for the state as a whole impacting target populations. Flint, Jackson and Saginaw had rates of 8.8%, 7.3% and 7.8% respectively in March 1994, while Michigan's level was 6.3%. In March 2003, those same cities had levels of 9.7%, 8.1%, and 8.6% respectively.

During the '90's, three counties in the Detroit metropolitan area (Livingston, Washtenaw, and Lapeer) experienced rapid growth while Wayne County lost population. Six counties in the northern Lower Peninsula gained in population as did counties clustered in or near the Grand Rapids metropolitan area. Twelve of fifteen counties in Michigan's Upper Peninsula lost population as did nine counties along the Lake Huron shore.//2004//

/2005/ Estimated population for 2002 was 9,797,198./2005/

According to the Division for Vital Records and Health Statistics, MDCH, the ten leading causes of death in 1998 for Michigan were: heart disease; cancer; cerebrovascular diseases; chronic obstructive pulmonary diseases; unintentional injuries; pneumonia and influenza; diabetes mellitus; kidney disease; chronic liver disease and cirrhosis; and suicide. Mortality rate disparities between black male and white male population increased during the last 28 years. Michigan age-adjusted mortality rates for black males were 43% higher than their white counterparts in 1970. By 1998, the mortality rate for black males was 63% higher than rates for their white counterparts. Steady declines have generally occurred since 1970 both in Michigan and the United States in age-adjusted rates in each race-sex group. From 1970 to 1998, the age-adjusted mortality rates for black males and females declined 28% and 33%, respectively. During this period, the age-adjusted national mortality rates for black males and females declined by 31% and 34%, respectively. In comparison, the Michigan mortality rates for white males and females declined 36 and 28%, while the national rates dropped 36 and 29%, respectively. For Michigan children under 1 year of age, the leading cause of death in 1998 was conditions originated in the perinatal period. For Michigan children 1 year of age and over, the leading cause of death in 1998 was unintentional injuries.

/2004/ For 2001, the leading cause of death was conditions originating in the perinatal period for children under 1 year of age. For children 1 year of age and over, the leading cause of death was accidents.//2004//

There were 133,429 resident live births in 1999. Between 1990 and 1998, the number of live births declined by 13 percent. The racial composition of women having live births in Michigan changed over the period 1978 through 1998. The proportion of all live births born to white women declined from 82.6% in 1978 to 78.7% in 1998. The proportion of all live births born to minority women increased from 17.4% to 21.3% during the same time period. The fertility rate (per 1000 women) for women aged 15-17 years declined from 30.8 in 1995 to 25.4 in 1998. Although 65% of the births to teens are to white mothers, only about one in ten births to white women were born to women under the age of 20 years. Among Asian/Pacific Islander women and women of Arab ancestry, about one in 21 and one in 13 live births, respectively, occurred to women under 20 years of age. On the other hand, among black women, American Indian women and women of Hispanic ancestry, approximately one in five live births occurred to women under the age of 20 years.

/2003/ There were 136,048 resident live births in 2000.

/2004/ There were 133,247 births in 2001 and 128,624 in 2002. Between 1990-1999, fertility rates declined 10% for Caucasian women and 26% for African-American women. The very steep decline for African-American women resulted in a fertility rate for African-American women that was only 14% larger than for Caucasian women in 1999. Between 1990 and 1999, the number of live births declined by almost 13%. The largest decline occurred to African-American women (-25%) while the decline for Caucasian women was 12%. Between 1992 and 1999, births to Native Americans remained steady, averaging 765 births per year or .5% of total births. The percent of births (average 2,410 per year) to Asian/Pacific Island women increased from 1.0% to 2.6%. Births (average 2676 per year) to women of Arab ancestry increased from 1.6% to 2.4%, and births (average 4,918 per year) to women of Hispanic ancestry increased from 3.0% to 4.7% of total births during the period 1990-1999./2004//

Implementation of the statewide Medicaid managed care program and MICHild program (CHIP) are the top priorities of the Department. 1999 was the first full year of statewide operation of the Medicaid managed care program. The Title V MCH program works with the Medical Services Administration to develop/refine quality assurance standards, monitoring requirements and service delivery requirements/guidelines for the managed care plans. The Title V MCH program monitors the health status of the MCH population and identifies issues of access to and quality of services, including those issues resulting from implementation of welfare reform.

The state's Child Health Insurance Program (CHIP), MICHild, was implemented in 1998. The Title V MCH program participated in development of outreach plans and materials and in training of local agencies on the program and application process. As of April 1, 2000, 12,388 children were enrolled in MICHild. /2002/ As of March 1, 2001, 27,977 children were enrolled in MICHild.

/2003/ As of March 1, 2002, 26,776 children <16 years and 25,010 16-18 year olds, receiving service through Healthy Kids were enrolled in MICHild.

/2005/As of June 1, 2004, there were 35,091 children enrolled in the MICHild program./2005//

/2004/In January, 2003 the first new governor of the state in twelve years was sworn in. Governor Jennifer Granholm acknowledged the serious budget challenges that faced the state (\$1.7 billion shortfall projected for FY 2004) but pledged to protect the most vulnerable populations -- children, elderly, poor and disabled -- in developing a balanced budget. The Executive Budget proposal presented to the legislature in March, 2003 included a combination of spending cuts and new revenues. While the general fund budgets of most state departments were reduced (2.4%-45.3%), the departments of Community Health and Education saw small increases in their general fund budgets. While Medicaid costs continued to rise, the Medicaid budget received relatively small reductions. The Medicaid budget for FY 2004 was reduced by \$174 million including elimination of coverages for podiatry, dental and chiropractic services for adults. Dental services for elderly and disabled adults is limited to emergency services only. At the same time, a federal waiver proposal was developed for a limited package of benefits for approximately 62,000 childless adults and caretaker relatives. This

waiver would restore some coverage for caretaker relatives whose Medicaid eligibility was eliminated by Executive Order in December, 2002. Medicaid eligibility and coverages for pregnant women and children would not be changed.

In her state of the state speech, the Governor announced the Great Start Initiative. This initiative focuses on early childhood and development of a comprehensive system of care. Great Start will be a collaborative effort involving public and private agencies, organizations, advocacy groups, citizens, the Ready to Succeed Partnership and the Healthy Child Care Michigan project (for more information go to www.greatstartforkids.org). The initiative will be guided by the Children's Action Network (CAN) composed of the directors of each state department having children and families within its purview. CAN is charged with the coordination and alignment of child and family programs and services across state agencies, as well as the implementation of a shared policy agenda that promotes health, social and emotional development and school readiness in all young children.//2004//

/2005/***During FY 2004, the Children's Action Network designated two priority projects for the Great Start Initiative: the establishment of Family Resource Centers in selected schools not meeting adequate yearly progress under No Child Left Behind, and the Early Childhood Comprehensive Systems Project funded by a grant from MCHB. A Children's Cabinet was appointed by the Governor in April, 2004 to provide leadership to the Children's Action Network and other state-led initiatives related to children that involve citizen, advocacy and similar groups in their make-up. Members of the Children's Cabinet are the directors of the Family Independence Agency, Department of Community Health and Department of Labor and Economic Growth and the Superintendent of Public Instruction.***

In 2003, Michigan's Surgeon General Dr. Kimberlydawn Wisdom led the effort to develop a status report on the health of Michigan residents with input from a team of MDCH experts. The Healthy Michigan 2010 report identifies critical health issues in ten focus areas, similar to Healthy People 2010, and sets the stage for development of a strategic plan for addressing these issues. An initial plan is under development and will focus on short term strategies. A longer term strategic plan will also be developed with input from citizens and partner agencies.//2005//

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 seven 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. Screening for congenital adrenal hyperplasia was designated as a required test in 1993. 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.

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 seven disorders: PKU, galactosemia, hypothyroidism, MSUD, biotinidase deficiency, sickle cell anemia, and congenital adrenal hyperplasia. 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. MDCH contracts with three medical centers to assure and/or provide comprehensive diagnostic and treatment services. A departmental Genetics Advisory Committee was restructured in the fall of 2001 and now includes a Newborn Screening Subcommittee. /2004/ Screening for MCAD and Homocystinuria was added in 2003./2004//

The Hereditary Disorders Program (HDP) coordinated 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. As part of this effort, folic acid education for prevention of neural tube defects will be expanded to target specific populations based on analysis of Pregnancy Risk Assessment Monitoring System (PRAMS), MBDR, and other data sets. An internal Birth Defects Steering Committee has been established and a birth defects surveillance and prevention subcommittee added to the Genetics Advisory Committee. A statewide needs assessment and draft state genetics plan has been completed and will be used as a blueprint for guiding program activities with an increased emphasis on the role of genetics in relation to the public health functions of assessment, policy development and assurance.

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. In FY 2000, the Family Planning program, in cooperation with the Breast and Cervical Cancer Control Program (BCCCP), initiated a demonstration project to refer women with abnormal Pap tests to BCCCP agencies for further testing and diagnosis. See Section III.E below for further description.

The Prenatal Care Clinic program provides funding for a limited time to high-risk communities to address specific issues unique to that community. The program is currently supporting transportation and advocacy services in Oakland County.

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.

//2005/ MDCH received CDC funding for Fetal Alcohol Syndrome Prevention in Detroit in the Fall of 2003.//2005//

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.

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. The high-risk factors are: unstable or non-existent social support systems; history of child abuse/neglect; negative feelings/attitudes toward the pregnancy; unstable emotional status/inability to cope; educational/developmental deficits; dysfunctional family/domestic violence; and nutritional deficits.

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.

Maternal and Infant Health Advocacy Services were designed to outreach to pregnant women who are not in prenatal care, assist high-risk women in dealing with situations which may keep them from remaining in prenatal care, and support and reinforce the health education messages delivered by professionals.

//2004/In January, 2003 an Executive Order, issued to bring the state's budget for FY '02-'03 into balance with projected revenues, eliminated the MIHAS program. Some funding has been retained to develop outreach initiatives in high risk areas and to pilot approximately five projects in the state employing the Nurse/Family Partnership model.//2004//

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 December 2002, 101 of the 102 birthing hospitals

are participating in the screening program.

//2005/ In April, 2004, Henry Ford Hospital became the last of the birthing hospitals to participate in the screening program.//2005//

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 has expanded to cover 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.

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.

The Adolescent Health Program includes two models of service delivery -- adolescent health centers and alternative models. The adolescent health center model provides on-site primary health care, psychosocial, health promotion and disease prevention education, and referral services. The alternative model focuses on case finding, screening, referral for primary care, and providing health education services. The program administers 20 adolescent health centers and eight alternative health delivery sites that are located in 16 counties across the state. In November 2001, the program funding was cut as part of the Governor's Executive Order Budget Cuts.

//2004/ The Legislature restored funding for the Adolescent Health Centers with School Aid funds through the Department of Education. The Department of Education contracts with the centers and the Department of Community Health continues to provide monitoring, training, technical assistance and consultation. //2004//

The Michigan Teen Outreach Program (MTO) provides funding, training, technical assistance and consultation to five community projects aimed at 12-18 year old youth and their parents. The goal of the program is to increase the number of adolescents who are making positive choices to abstain from risky behaviors, including sexual activity and the use of alcohol, tobacco and other drugs. Components of the program are community service, group or small classroom discussion and parent education. Projects are located in Detroit (Arab-American and Chaldean Council), Muskegon, Genesee County, Shiawassee County and Kent County.

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 population 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. ***/2005/Non-emergency dental services for adults was eliminated from Medicaid coverage effective 10/1/2003 due to budget limitations./2005//***

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. 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.

The Division of Family and Community Health has a staff liaison to the Division of Immunization to promote timely vaccination. The liaison works with maternal and child health programs including Women Infants and Children (WIC) program, Maternal/Infant Support Services, teen health centers, migrant health centers and interagency programs providing services to children to integrate immunization assessment, referral, and/or administration of vaccines; collaborates with the Immunization Division and other interested organizations and agencies on the development of health care provider education materials; and collaborates with the Immunization Division and other interested organizations and agencies on outreach and education efforts to parents and the public.

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.

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.

Services for Children with Special Health Care Needs

The CSHCN Program in Michigan is known as "Children's Special Health Care Services". A variety of program components support core public health functions (e.g., collaboration with local agencies to develop community-based systems of care), population-based individual services (e.g., Children's Multidisciplinary Specialty Clinics), enabling and non-health support services (e.g., Parent Participation Program), and direct health care services (e.g., medical care and treatment services). 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.

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

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 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.

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.

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 (see also Section IV.E).

The Private Duty Nursing Benefit (PDNB) is designed to address the needs of medically fragile, technology-dependent children and their families by arranging for and reimbursing hourly nursing services provided in the home setting, rather than keeping children requiring skilled nursing interventions in a hospital or other institutional setting. It also provides for specialized community-based care coordination.

/2004/ PDN was added to the State Plan and implemented through the policy promulgation process February 2002 and is therefore a Medicaid benefit. The beneficiary must have Medicaid coverage to be eligible, and may also have CSHCS or other program coverage. Most of these children are eligible to qualify for Medicaid at home as a family-of-one due to their medical circumstances. Funding for "specialized community based care coordination" (SCBCC) was eliminated in 2003. The department quickly informed the local health departments of how to continue the care coordination as needed while decisions and processes are put into place to provide for care coordination as needed on an on-going basis. //2004// **/2005/Specific policy regarding Case Management and Care Coordination will be in effect as of October 1, 2004. //2005//**

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.

Culturally Competent Care

The Department of Community Health addresses the cultural differences in our MCH population through involvement of appropriate representatives on advisory groups and task forces, training, translated materials, and working with local agencies that have a cultural connection with specific groups. The Department does not provide services directly, but contracts with local public and non-profit agencies for delivery of services. Some of these agencies, such as the Arab-American and Chaldean Council and Migrant Health Centers provide translation and culturally sensitive services to their target populations. The Department assists these agencies with training and materials that incorporate the language and cultural issues specific to each group. Advisory groups include participation that is representative of the different cultural groups across the state. Some examples are:

The Maternal and Child HIV Program uses health advocates who work with the families served in this program. These individuals are people who are affected by HIV (either because of their own health status, or their direct experience with people who are HIV infected). Staff help clients negotiate the system to assure their needs are met, while at the same time working with our system to better respond to the needs of our target population.

The Migrant Camp Aide Program trains migrant farm workers in advocacy and health education to help assure that migrant camp workers, particularly women, pregnant women and children, access available health services. Migrant camp aides help to connect workers to services and help migrant farmers understand the relevant issues that offer challenges to their workers and families. Many of the migrant workers and camp health aides share language (Spanish) and culture. The camp health aides

also help DCH better understand the needs of the clients we are serving and areas where program revision or enhancements are needed.

The Parent Participation Program in Children's Special Health Care Services has developed a program fully staffed by parents of children with special needs as an effort to assure a heightened level of cultural competence for working with those families. Through this program, issues related to barriers in service and needs of the families are identified and addressed.

Information from the Infant Mortality Summit indicated that the acceptability of some providers and institutions is a problem related to racism, simple ignorance of cultural practices, and other cultural issues. Local coalitions are being encourage

C. ORGANIZATIONAL STRUCTURE

The Michigan Department of Community Health is the state health agency, responsible directly to the Governor. In 1997, a major reorganization of state departments combined the former departments of Public Health, Mental Health, Medical Services Administration (Medicaid) and Office of Services to the Aging. The new department was organized into administrations. The Community Living, Children and Families (CLCF) Administration included MCH programs, children's mental health services, WIC and residential programs for persons with mental illness or developmental disabilities. The director of the CLCF Administration is the state Title V Director. In 1999, the WIC program was separated from CLCF and established as a separate administration reporting to the department director. The Medical Services Administration includes Children's Special Health Care Services.

/2004/ In her State-of-the-State speech, Governor Granholm announced the creation of a new Surgeon General position in the Department of Community Health. Dr. Kimberly Dawn Wisdom was appointed to this new position in February 2003. The new department administration began a reorganization planning process in February 2003 involving all staff within the department. Though incomplete at this time, the Director announced the re-creation of a Medical Services Administration with responsibility for the Medicaid program effective April, 2003. Further reorganization is expected pending approval by the Governor's Office. See attached copy of department organization chart.//2004//

/2005/The reorganization in 2004 resulted in the re-creation of the Public Health, Mental Health & Substance Abuse, and Medical Services (Medicaid) Administrations. Other major organizational units are the Operations Administration, Health Policy Regulation and Professions Administration, Drug Control Policy and the Office of Services to the Aging. Licensing functions for health care professions and health care facilities were transferred to the Department of Community Health in December, 2003.//2005//

The CLCF Administration is organized into the Division of Family and Community Health, the Division of Mental Health Services to Children and Families, the Division of Program Administration and Consumer Resources, the Office of Multi-Cultural Services, the African American Male Health Initiative, and the Self-Determination Initiative. The Division of Family and Community Health administers most of the MCH programs, including: Adolescent Health, the Michigan Abstinence Partnership, Oral Health, Family Planning, Hearing and Vision Screening for pre- and school-age children, Newborn Hearing Screening, Childhood Lead Poisoning Prevention, Fetal-Infant Mortality Review, Maternal and Child HIV/AIDS, Maternal and Infant Health Advocacy Services, Prenatal Smoking Cessation, and SIDS. The division also maintains a liaison with the state's immunization program, administered by the Public Health Administration, and participates in inter- and intra-agency initiatives, such as Part C of IDEA and the Child Death Review Program. In addition, the division participates in quality assurance and issue identification activities concerning Medicaid-funded MCH services, including EPSDT, and Maternal and Infant Support Services.

/2003/ A reorganization of Michigan Department of Community Health effective 2/01/02 placed Mental Health Services to Children & Families, Children's Special Health Care Plan Division, the Division of Family and Community Health, and the WIC Program in the Bureau of Children and Family Programs, now a unit within the Health Services Administration.

The Division of Program Administration and Consumer Resources administers the Newborn

Screening and Hereditary Disorders Program, in addition to the Office of Specialized Nursing Homes/OBRA Program, and housing programs and residential contracts for persons with mental illness or developmental disabilities. The Newborn Screening and Hereditary Disorders Program became part of the Bureau of Epidemiology, a unit within Health Administration, effective 2/01/02.//2003//

/2005/The reorganization of 2003 combined the Division of Family and Community Health, the WIC Division and Children's Special Health Care Services Division in to the Bureau of Family, Maternal and Child Health within the Public Health Administration. The Division of Children's Mental Health Services became part of the Mental Health and Substance Abuse Administration.//2005//

The Medical Services Administration (MSA) administers the state's Medicaid program, Children's Special Health Care Services, and the state's Child Health Insurance Program, MICHild. The Children's Special Health Care Services Plan Division is part of the Plan Administration Bureau in MSA.

/2003/Children's Special Health Care Services Plan Division became part of the Bureau of Children and Family Programs, a unit within the Health Services Administration, effective 2/01/02.//2003//

In addition, there are two MCH epidemiologists in the Bureau of Epidemiology, Community Public Health Administration who provide epidemiology expertise in support of MCH programs.

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 30 professional and 11 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. The Data, Evaluation and Surveillance Unit includes seven staff who collect, analyze and disseminate program information.

/2003/ There are 36 professional staff and 6 support staff.

/2004/ There are currently 33 professional and 11 support staff. //2004//

/2005/ There are currently 24 professional and 9 support staff.//2005//

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.

The Children's Special Health Care Services Plan Division currently includes approximately 37 professional and 25 support staff. Professional staff is made up of doctors, nurses, nutritionists, analysts and managers. Support staff perform clerical, technical and enrollment functions.

/2004/ On 2-01-02, the operations portion (Customer Support Section (CSS)) of CSHCS was moved to the Medical Services Administration operations (Review and Evaluation Division). All CSS staff persons are still dedicated solely to the CSHCS program operations. The number of persons serving CSHCS has decreased due to an early retirement opportunity offered to State employees to assist with the State budget difficulties. CSS consists of 28 staff persons. The remaining staff in the CSHCS Plan Division consists of 12 staff persons. The Office of Medical Affairs houses two full-time physician consultants dedicated specifically to CSHCS, and two physicians who dedicate a portion of their

efforts toward CSHCS needs, upon whom CSHCS depends for program eligibility determination, approval of CSHCS specialists, and approval of specific specialists to serve the CSHCS beneficiary. The Parent Participation Program (PPP), providing technical assistance and recommendations regarding policy and procedures, employs 14 staff persons, 9 of whom are parents of children with special needs.//2004// **/2005/ In FY 03 CSS was returned to the CSHCS division. The Children with Special Need Fund was also returned to CSHCS. The division lost 10 positions but currently has 43 staff (28 professional and 15 support staff)./2005//**

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 (see previous section for a description of the Parent Participation Program). The department employs nine parents in this program.

The Newborn Screening and Hereditary Disorders Program has three professional (1 vacancy currently) and three support staff. Professional staff includes a genetic consultant and two public health consultants.

/2003/ 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.

Virginia Harmon is the deputy director for the Community Living, Children and Families Administration within the Michigan Department of Community Health. In this capacity, she is responsible for the direction of mental health services to children and families as well as family and community public health services. Ms. Harmon also oversees plans of the public mental health system for the return of persons residing in state-operated institutions to their home communities, providing technical assistance as needed to the responsible community mental health service programs; establishes policy, assures the availability of TA resources and best practices in areas of housing, supports and community living; and serves as liaison with other state systems in the coordination/integration of services and supports. Ms. Harmon has 25 years experience in mental health administration, starting as Program Director for the Plymouth Center for Human Development to Bureau Director of Community Residential Services in the former Department of Mental Health. Prior to that, she had six years experience as a speech pathologist. Ms. Harmon has a Master's degree in Speech Pathology and a Bachelor's degree in Speech Pathology/Audiology and Psychology.

/2003/ 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, the Division of Family and Community Health and the Division of Mental Health Services to Children and Families. Mr. Paterson has 29 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. Mr. Paterson has a Master's Degree in Public Administration.

Jane L. Finn is Director of the Children's Special Health Care Services Plan Division, Medical Services Administration. Previously, Ms. Finn was Chief of the Primary Care Section, responsible for overseeing the development, regulation and technical support of the delivery of primary health care services throughout the state, including Indian and migrant health centers, federally qualified health centers, rural health clinic program and the Michigan Essential Health Provider Program. In addition to these duties, she also served as team co-leader for the CSHCS Managed Care Initiative. For six years, Ms. Finn was a program specialist with the CSHCS Division, responsible for planning and directing statewide insurance objectives, including casualty and liability recovery, alternative health care products, health insurance continuation and cost avoidance; the statewide appeals process and administrative hearings; and prior authorization of services and reimbursement for dental, pharmacy, O.T/P.T., durable medical equipment, medical supplies, orthotics and prosthetics. Prior to that, Ms. Finn was a disability examiner for the Disability Determination Services in the Michigan Department of Education. She specialized in the adjudication of disabled child cases and SSI cases as defined by

the Social Security Administration. Ms. Finn also has five years experience with volunteer services programs with the Department of Social Services, participating in training of local office staff, organizing statewide conferences and presenting annual reports to the legislature. Ms. Finn has a Bachelor's degree in social work from Michigan State University.

/2004/ Kathleen Stiffler began as the Director of the Children's Special Health Care Services Plan Division, Bureau of Children and Family Programs effective February 3, 2003. Ms. Stiffler has 16 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.//2004//

E. STATE AGENCY COORDINATION

Executive Order 1996-1, issued in January 1996, created the Department of Community Health (DCH) by combining the former departments of Mental Health and Public Health and the Office of Services to the Aging and transferring the Medicaid administration to the new department. In addition, the responsibility for provision of mental health services in the state's corrections system was transferred to the Department. The Department of Community Health includes: the Health Legislation and Policy Development Administration; Community Living, Children and Families Administration; Mental Health and Substance Abuse Services Administration; Community Public Health Administration; Budget and Finance Administration; Medical Services Administration; WIC Administration; and the Office of Services to the Aging. Responsibility for the MCH component of Title V is in the Community Living, Children and Families (CLCF) Administration, and the CSHCS component is in the Medical Services Administration.

/2003/ Effective 2/01/02, the Department of Community Health includes: Health Legislation and Policy Development Administration, Health Services Administration, Operations Administration, Health Administration, Budget and Finance Administration, Quality Assurance and Customer Services Administration, and the Office of Services to the Aging.

/2004/ See description of Department of Community Health reorganization in Section III.C above.//2004//

/2005/See description of Department of Community Health in Section III C above.//2005//

The protection of the public's health under the Public Health Code is a partnership between the state and local health departments (LHDs). This partnership continues to evolve with the implementation of Medicaid managed care. 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.

The human services departments (Community Health, Education, Family Independence Agency), along with representatives from the Governor's Office and Department of Management and Budget,

meet on a regular basis to coordinate policy and discuss cross-cutting issues affecting their common target populations. The agencies cooperatively implement and monitor activities under the Systems Reform for Children and Their Families initiative which seeks to support local collaborative efforts to improve the well-being of children and their families. Staff from the human services agencies provide training and technical assistance and some funding support to local collaborative bodies. In addition, the human services agencies collaborate on several specific program initiatives.

/2004/ 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. See also Section III.A.//2004//

/2005/The departments of Community Health, Family Independence Agency and Education 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.//2005//

DCH and the Family Independence Agency (formerly the Department of Social Services) continue to work together on outreach activities to low-income families eligible for public programs. Although the Medicaid administration was transferred to DCH, the Family Independence Agency (FIA) continues to provide information and collect applications for Medicaid. DCH and FIA 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. The Child Well-Being Program was initiated to provide home visits to families whose FIP cases have been closed due to noncompliance with work requirements to inform them of their potential eligibility for Medicaid, food stamps and other community resources. DCH and FIA also collaborate on family preservation efforts, such as Strong Families/Safe Children and MIFPI (Michigan Interagency Family Preservation Initiative), and the Child Death Review Program. Both departments maintain representation on the State Child Death Review Team. In addition, WIC and FIA coordinate annual outreach campaigns for the WIC nutrition and TANF programs. WIC and FIA are also co-locating services in the Detroit and Wayne County area to increase enrollment of the eligible population in those areas.

/2004/ For the past three years, DCH and FIA have had an interagency agreement to implement the Teen Pregnancy Prevention Project (TP3). TP3 targets communities that have high numbers of teen births and is funded by TANF bonus funds for reducing out-of-wedlock births. DCH administers the projects, including monitoring, technical assistance and consultation. At the local level, the local health department, local Family Independence Agency and intermediate school district or school system must be involved in the development and implementation of the community plan. Bonus funds will no longer be available as of FY 2004. Communities have been encouraged since the beginning to seek other sources of funding to sustain the projects.//2004//

/2005/A third year of bonus funding was provided to four communities to continue the Teen Pregnancy Prevention Program.//2005//

DCH and the Department of Education collaborate on school health programs and work together on the Early On initiative (Part H 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.

/2004/ Through the Children's Action Network, DCH is working with the Department of Education to develop plans for assisting schools not meeting performance expectations under No Child Left Behind. DCH also works with Education to administer the Adolescent Health Program. Funding for the

teen health centers was shifted to the Department of Education in 2003. See also Section III.E.//2004//

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., Opening Doors in Michigan, expansion of child death review teams statewide); 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.

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.

/2005/ The Building Bridges Project meets quarterly to discuss access to care issues between Medicaid Managed Care, health departments and Maternal Support Services.//2005//

CLCF and CSHCS collaborate on issues regarding follow-up on newborn screening, birth defects registry, newborn hearing screening, hearing screening for school-age children, maternal and infant HIV/AIDS, and children's mental health. Both programs participate on the Department's Developmental Disabilities Council and coordinate policy and program efforts for SSI-eligible children and children and families requiring hourly in-home care.

WIC 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. See also Section IV.E.

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. In FY 2000, the Family Planning program and the Breast and Cervical Cancer Control Program (BCCCP) developed a demonstration project to provide follow-up diagnosis and testing for women who had an abnormal Pap test from Family Planning services. The purpose of the project is to detect cervical cancer in women who are too young for the services of the traditional BCCC program and whether Michigan's BCCC program could provide needed diagnostic evaluations to family planning clients. Nine (of 21) local BCCCP coordinating agencies participated in the project. In the first year of the project, 463 family planning clients from around the state were referred for evaluation. Of those referred, 45 (9.7%) were diagnosed with cancer. Forty-four diagnoses were of CIN III and one was invasive cervical cancer. Because of the success of the project, it was expanded in FY 2001 to include 19 of the 21 BCCCP local agencies with the support of the Centers for Disease Control and Prevention and to date continues to be a service offered to Family Planning consumers.

/2003/This program has continued to be offered.

/2004/ In 2002, 918 women were served in the FP/BCCCP Project. Of the women referred, there were final diagnoses of 104 CINII, 79 CINIII/CIS, 2 invasive cervical cancer and 1 adenocarcinoma.//2004//

/2005/In 2003, 1108 women were served in the FP/BCCCP Project. The Caseload to date for FY 04 is 1513.//2005//

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.

/2003/ The department also supports an extensive program evaluation project in Detroit.

/2005/Michigan continues to collaborate with five Healthy Start projects. The liaison role at DCH has been reduced due to staff shortages, but the projects continue to provide input and are included in planning related to infant mortality. Because the projects are now required to provide services on perinatal depression and interconceptional care, the department is interested in obtaining a progress report in 2005 to aid in statewide planning around these issues. The local projects have focused risk reduction activities on safe infant sleep, no smoking or alcohol use during pregnancy, and planning the next pregnancy. Cultural competency has been a common theme for provider training as well as information on perinatal depression. "Baby Showers" are a format used by the projects for outreach and public education. Each project collaborates with an infant mortality coalition to outreach to the broader health care community.//2005//

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. Additional funding was made available by MDCH to local health departments to enroll families, pregnant women and children in Medicaid and MIChild. Local health departments are encouraged to partner with community agencies to extend the scope of this effort. Several community agencies have historically provided outreach and enrollment services and have indicated that they will continue to do so as long as they can find resources.

/2004/ Due to the state revenue picture, funding for local outreach programs was eliminated in FY 2003. Some of the funding from the elimination of the MIHAS program was retained and will be directed to outreach activities in areas of the state at high risk for infant mortality, low birth weight,

teen pregnancy and other MCH indicators.//2004//

/2005/ State funding retained from the elimination of the MIHAS program has been used to pilot the Nurse Family Partnership (NFP) in four local communities. NFP, a collaborative effort between MDCH, the Michigan Department of Education and Family Independence Agency (FIA), to target the unacceptable disparities in the health, education and social development statistics for many Michigan children and their families. NFP is a scientifically based, nurse home visiting program for low-income first time mothers and their children through age two.//2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

The percent of Medicaid enrolled infants who received at least one periodic screen (Indicator #02) has improved since 1998. The Bureau of Children and Family Programs continues to work with Medicaid managed care to improve the numbers screened in the plans through establishing standards and quality assurance. Programs funded by MDCH which serve Medicaid eligible populations include requirements that providers assist women in using health care services for which they are eligible.

Encounter data for SCHIP enrollees is being collected in 2003 for the first time. Data for 2002 (Indicator #03) is not available.***/2005/ Unexpected problems in linking private provider service data and the MI Child enrollment data occurred and MI Child encounter data has not yet become available.//2005//***

Indicator #05, comparing the Medicaid to non-Medicaid population, show the disparity between the two groups. The Medicaid population fared worse than the non-Medicaid population for indicators of low birth weight, infant mortality, infants born to women beginning prenatal care in the first trimester and pregnant women with adequate prenatal care. In spite of state efforts to remove barriers to accessing early prenatal care, the numbers beginning care in the first trimester continued to decline until 2001. In 2001 a policy change allowed the choice to stay with a Fee for Service provider and provided a guarantee of payment letter. Data on the percent of infants born to women who began care in the first trimester show some improvement in 2001 and 2002. Efforts to address this issue are described in Section IV. C, NPM #18 and Section IV. D, SPM #01. See also discussion on low birth weight under Section IV. C, NPM #15 and Section IV. D, SPM #03.

During 2002, MDCH contracted with 18 health plans to provide managed care services to more than 831,000 Michigan Medicaid enrollees. The HEDIS performance measurements were used to evaluate 15 components, including Access to Care. In 2003, the Access to Care results showed poor performance with all six rates falling below the national 2002 50th percentile. Recommendations were made that all health plans provide an analysis of barriers to care. Patient barriers include lack of knowledge, skepticism about the effectiveness of prevention, lack of a usual source of primary care, and lack of money to pay for preventive care. Provider barriers include limited time, lack of training in prevention, lack of perceived effectiveness of selected preventive services and practice environments that fail to facilitate prevention. System barriers can include lack of resources or attention devoted to prevention, lack of coverage or inadequate reimbursement for services, and lack of systems to track the quality of care.

During the past two years an interactive forum called Building Bridges: Assuring Continuity of Care for Medicaid Beneficiaries through Collaboration, has been convened on several occasions to promote awareness and understanding of maternal and child health care outreach activities and to find creative solutions to barriers. The primary targets of this activity were local health departments and managed care providers. A report of the forum goals, objectives and outcome was published in September 2002, noting that 12 of the 19 Medicaid Health Plans participated as well as 32 of the 45 local health departments. Linkages between Medicaid Maternal Support Services, Infant Support Services, EPSDT and WIC were the most obvious collaborative outcomes as reported on evaluation surveys.

Infant mortality data also reflects the disparity between white infants and African American and Native

American infants for SIDS. Safe Sleep messages have been devised to address sleep position, bed sharing, soft bedding, adult beds and couches. See Section IV. D, SPM #01 for further discussion.

As shown on Form 18, the Medicaid income eligibility levels for pregnant women and infants is up to 185% of poverty and up to 150% poverty for children 1-19 years of age. The Michigan SCHIP program, MIChild, serves pregnant women, infants and children 1-19 years of age whose family income is up to 200% of poverty.

In the recent two years, the department has been involved in the development of a linked data warehouse. The data warehouse, entitled the Executive Information System, Decision Support System(EIS/DSS), includes data from many of the MCH programs as well as the Vital Records data, Medicaid data and WIC databases. In the past, one of the problems Michigan faced in collecting data for the Block Grant performance measures and health status indicators was the need for utilizing data across different divisions and even departments to obtain the numerators and denominators for the measures. Consequently the sources of the data and assumptions employed varied from year to year. With the addition of the data warehouse, our MCH epidemiologist, Dr. Jianli Kan, has been developing standardized computer codes for the block grant measures so that they may be collected in the same manner regardless of changes in staff or reorganization within the department. The ability to save the computer codes will allow more consistent reporting of measures in the future. To this end, Dr. Kan serves as a member of the User Group for the EIS/DSS which functions as a workgroup to share information about techniques using the software, to assess the validity of certain variables, and to increase users' knowledge of the validity and reliability of program data. The data warehouse also provides a rich resource for linkage and analysis of program data which are being used to evaluate the effect of MCH programs on MCH outcomes. See attachment for a description of the MCH data sources included in the warehouse. ***//2005/In FY '04, responsibility for access, training and maintenance of data uploads was transferred from a contractor to the Department of Information Technology. During the past year, a major effort of the Data Warehouse has been to revise the models from various data sources to comply with HIPAA provisions and provide training to users on the the revisions. Dr. Ahmed Jamal has been hired to replace Dr. Kan who took another position in another state.//2005//***

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The state's ten 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 2003 (or the latest year for which data is available), Michigan met or exceeded targets for the following performance measures:

NPM #1 Newborn Screening

NPM #2 CSHCS Families partner in decision making

NPM #3 Medical Home

NPM #04 Adequate public or private insurance for CSHCS families

NPM #5 Community-based service systems

NPM #6 Transition Services

NPM #11 Breastfeeding

NPM #16 Suicide Deaths among youth 15-19

SPM #07 CSHCS Beneficiaries enrolled in SHP

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 #13 Children without health insurance

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

SPM #2 Maternal Mortality Ratio

SPM #04 Preterm Births

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

SPM #08 CSHCS beneficiaries receiving dental care paid by CSHCS

SPM #09 Lead testing among Medicaid eligible children 0-6

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

NPM #7 Childhood Immunizations

NPM #8 Birth Rate for Teenagers 15-17

NPM #10 Deaths to children caused by motor vehicle crashes

NPM #12 Newborn Hearing Screening

NPM #14 Medicaid-eligible children received a service

NPM #15 VLBW Births

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

SPM #01 Infant Mortality

SPM #03 LWB among live births

SPM #05 Unintended Pregnancy

National Performance Measures 2-6 are new measures related to Children's Special Health Care Services. Data from the SLAITS survey indicate that Michigan's data for NPM #2-5 were above the national average for 2001. The SLAITS survey indicated that Michigan was 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). As indicated in Section IV. C, a plan is being developed with the Medicaid program to assist persons aging out of CSHCS and who are Medicaid eligible. Our technical assistance request addresses this issue. ***2005/ CSHCS implemented a plan to assist clients indicated above. CSHCS recently hired a full time Transition Analyst to further address transition needs for clients and families.//2005//***

The strategies and activities described in Section IV. C and D are planned in the context of the new state initiatives proposed by the Governor and the Department of Community Health. The Title V program will be 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. Over the next year, the Department of Community Health will be developing a state health status report and strategic plan for addressing priority issues. The health status report will highlight the leading health indicators and update the current "Critical Health Indicators" Report. The strategic planning process is building on Healthy People 2010. As an initial step, an internal workgroup will identify focus areas, priorities and performance measures that will be the basis of a strategic plan for the next five years. The draft plan will be shared with outside stakeholders for their input before a final plan is adopted. The Title V program is participating on these workgroups. In addition, presentations are being developed for Surgeon General Dr. Kimberly Dawn Wisdom to use as she speaks to various business and community groups throughout the state. The presentations include Childhood Lead Poisoning, Infant Mortality, Maternal Mortality, Unintended Pregnancy, Teen Pregnancy and Child Deaths.

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 for the purpose of gathering comprehensive data regarding our overlapping populations. The collaboration between the various programs is expected to result in even more meaningful collaboration regarding 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, and other areas for the purpose of gathering data to determine where Michigan is most and least successful in assisting families regarding multiple health care circumstances and needs, which in turn will drive the decision making process of where the greatest need exists, and how best to address it.

CSHCS is also in close collaboration with the Michigan Department of Education Early-On program which assists families with very young children (age 0-3) with developmental delays or other difficulties. A parent of a child with special needs has been hired as the liaison between the Early On program and CSHCS to increase the knowledge base of both programs, of parents whose children may be eligible for either or both of the programs, and to increase the efficiencies with which both departments communicate with and outreach to families.

The number of CSHCS enrollees for 2002 is inflated and will decrease in next year's report. The number of 2002 enrollees included people on CSHCS who were no longer eligible for coverage due to CSHCS automatically renewing people into the program while developing a new renewal process. We instituted the automatic renewal process on a temporary basis to ensure no one who was still eligible would accidentally lose program coverage. We have completed the review of all existing beneficiaries for eligibility and have instituted the new renewal process. CSHCS beneficiary numbers from March 2003 will only include persons currently eligible for program coverage.

B. STATE PRIORITIES

Reduce the racial disparity between black and white infant mortality: The racial disparity for infant mortality between the black and white populations continues to be a high priority both in Michigan and nationally. The 2010 objective is to reduce the infant mortality rate to no more than 5 per thousand live births. In the US, the mortality rate for both black and white infants declined by slightly more than 20 percent during the past decade. However, the rate for black infants is more than twice as high as that for white infants. The IMR among white infants in Michigan is almost indistinguishable from white infants across the US. However, the IMR among black infants has been persistently higher in Michigan than in the US. Black infants are 3.2 times as likely to die as white infants in Michigan. Black infants were 4 to 5 times as likely to die of low birth weight and prematurity than white infants, and 3.8 times as likely to die of SIDS as white infants in 2000. The black IMR in 2000 was 18.2 while the white IMR was 6.0. ***/2005/The black IMR in 2002 climbed slightly to 18.4 while the white IMR remained at 6.0. Efforts to understand the disparity have led to recognition of barriers to access and poor quality health care, inadequate health insurance, lower education, poor nutrition, limited***

economic resources, and the life patterns associated with living in poverty. The concept of racism is being studied as well as the lack of cultural competency in providers that limits their acceptability to many at-risk families.//2005//

Reduce the numbers of maternal deaths in the black population: Michigan experiences one of the largest disparities in the nation between maternal deaths among its black and white populations. We have recently put much effort into revamping our maternal mortality review process so we can better understand the nature and causes of each death that occurs and analyze possible prevention strategies. An example of this effort was the difficulty in gathering data on some deaths occurring in past years. Additional resources have been added to the program and this data has now been collected. We will also look at deaths of pregnant and postpartum women who die from other causes. The maternal mortality review team has been expanded to include individuals from different specialties to accommodate the broader perspective.

Reduce the percent of pre-term births and births with low birth weight with emphasis on the black population: Michigan still experiences rates of births with low birth weight (LBW) well above the national average (7.9% as compared to 7.3%). In addition, the rate has increased slightly between 1995 and 1998 from 7.7% to 7.9%. At the same time, the LBW percentage for blacks is double that for whites (13.9% compared to 6.5%). Renewed efforts are needed to determine effective interventions both pre-conceptionally and prenatally that can improve these statistics. Over the next five years, MDCH anticipates putting significant effort into linking various data bases and evaluating the impacts of specific interventions in an attempt to determine the most effective strategies to reduce infant mortality generally and low birth weight specifically. /2003/The percentage of pre-term births to all races has decreased somewhat from a high of 11.6% in 1998, to 10.9% in 2000. The percentage of births with low birth weight is down slightly to 7.9% for all races. 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.//2003//

/2005/In 2002, the percentage of low birthweight births for white mothers was 6.7, for black mothers was 14.1. Associated risk factors also reflect the difference between black and white: White women with no prenatal care was 6.9, black women was 27.2. White women with inadequate prenatal care was 5.5, and black women was 14.0. White women less than 20 years of age was 8.0, black women was 18.0. The percent of preterm births remained at 11.3.//2005/

Reduce the percentage of unintended and teen pregnancies with emphasis on repeat live births to unwed teen mothers: The objective for 2010 is to decrease this rate to no more than 30%. Among women who experienced an unintended pregnancy, our PRAMS data shows that 68.7% were Medicaid recipients at some time during their pregnancy. This calls for renewed effort to address access and barriers to care issues for women in this population. The teen pregnancy rate for Michigan is 71.6 per thousand in 1998 compared to 120 nationally. While we have seen progress in this area, it is still a high priority for the public in our state and for this administration. A significant amount of the bonus funds (total of \$20 million) that Michigan received for reducing out of wedlock births between 1995 and 1997 will be targeted toward reducing teen pregnancy rates in targeted jurisdictions within Michigan that reflect historically high teen pregnancy rates. In Michigan during 1998, 21.3% of teens who had previously given birth had a repeat birth. /2003/In Michigan during 2000, 16.7% of the unmarried teens less than 20 years of age who had previously given birth had a repeat birth. This is a reduction from a high of 26.7% in 1992. While this progress is significant, the racial disparity is alarming. In 2000, 12.8% of white teen mothers under 20 years of age experienced a repeat pregnancy, as compared to 24.9% of African-American unwed mothers under 20 years of age. /2005/In 2002, 12.9% of white teen mothers under 20 years of age experienced a repeat pregnancy, as compared to 24.2% of African-American unwed mothers under 20 years of age.//2005//

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 oftentimes a lack of communication between providers and no focal location for accumulation of comprehensive medical care and treatment records for these children. This is of great concern as medically fragile CSHCN are already at significant health risk because their medical conditions may fail to improve, or even deteriorate. Special Health Plans (SHPs) designed to deliver managed care to the Michigan CSHCS population can provide a medical home where all care and services are coordinated through the development of an Individualized Health Care Plan (IHCP) for each beneficiary. A local care coordinator and principal coordinating physician offer a coordinated approach for all medical services for CSHCN. With statewide expansion of SHP coverage in Michigan, a true medical home will be available to all persons who enroll in a CSHCS Special Health Plan, with the goal of improving quality of care. /2004/Statewide expansion of the SHPs has not occurred and the original expectation that statewide coverage is possible is under discussion. Further discussions are 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 with the SHP experience serving as a model. Additionally, efforts have begun to implement and study a model for private practices to determine how to expand the medical home concept outside of the SHPs, but utilizing the lessons learned through the SHP experience. Michigan is receiving training and technical assistance through the Federal Medical Home Learning Collaborative supported by MCHB.//2004// ***/2005/The SHP contracts are being terminated as of October 1, 2004. 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 the 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.//2005//***

Improve and assure appropriate access to health services, including oral health services, that are focused on children with special health care needs: CSHCN frequently have primary medical conditions, such as cleft lip and palate, that are eligible for CSHCS coverage of extensive and complex dental services, or have diagnoses that require use of general anesthesia during routine dental care and treatment of dental problems. Identification of qualified dentists who have the necessary equipment and access to facilities to perform these services are limited. Dental providers have also complained about low reimbursement rates, convoluted billing processes and prior authorization requirements for some services. In Michigan, we are actively making changes to appropriately increase dental reimbursement, remove some prior authorization and recruit dentists willing to serve the CSHCN population. These recent efforts are expected to increase access to dental care for the CSHCN population.

/2004/ Although the percentage of CSHCS enrollees who received dental services decreased slightly in 2002, the total number of persons who received these services increased by approximately 500 individuals. In 2002, Michigan's CSHCS program reached its highest enrollment level in 2002 due to the fact we were automatically renewing CSHCS coverage without re-assessing eligibility (since 2000). Automatic renewal occurred while we redesigned the renewal process for enrollees to avoid inappropriate loss of enrollment because we were unable to process the renewing information. We decided to err on the side of covering too many people as opposed to risking those still in need accidentally losing coverage. In addition, it was assumed that if the enrollee no longer needed specialty services then the previous providers would not be working with the enrollee any longer and therefore not billing the system. In early 2002, Michigan implemented the new eligibility renewal process. Over the period of a year (into early 2003), Michigan processed renewal information for all enrollees, removing the coverage for those who were no longer eligible for CSHCS. Those reduced numbers will appear on next year's report. Therefore, the percentage used for the dental usage (and others within this document) is based upon an inflated number that includes persons no longer in need of specialty services. The increase in the number of enrollees who actually accessed the dental services indicates Michigan has been successful in increasing dental services by those persons

eligible for dental care through CSHCS.//2004//

Improve the capacity for newborn hearing screening and assure communications with appropriate systems of follow up when indicated: There has been significant progress made in the technology that allows for effective screening of newborns for hearing loss. In Michigan, we have been working diligently to engage hospitals to voluntarily screen newborns for hearing loss. However, as of May 2000, only 61% of the total newborn population is receiving an objective hearing screen in 54 of the 120 birthing hospitals. Additionally, only 50% of the infants who failed the initial screen during the current year received further evaluation and follow-up. This new technology offers public health a new tool in our arsenal to detect and prevent significant hearing loss and development problems in our pediatric population, and we have a public obligation to take advantage of this opportunity.

/2005/Michigan has been able to increase hospital participation in universal hearing screening from 5 (5%) hospitals to 100 (100%). Screening rates have increased from less than 5% to greater than 90%. As of March 1, 2004, all Michigan hospitals are participating in universal newborn hearing screening.

Increase the screening 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 1999, it was estimated that approximately 183,000 ages 0-4 resided in households with incomes below 125% of poverty. In that same year, lead screening was reported on 77,434 children below age 6. This means that less than 42 percent of children at risk of lead exposure were screened for lead poisoning. Of the 77,434 children tested, 5,467 (7%) had levels greater than 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.

Increase the rates of breast-feeding: In 1998, the rate of breast-feeding in early postpartum was 44% among Michigan WIC clients as compared to 59% in Michigan and 64% nationally. There is a large difference in breast-feeding rates between black (32%) and white (48%) WIC mothers in Michigan. This difference also exists nationally with a breast-feeding initiation rate of 45% among black mothers as compared to 68% among white mothers. The prevalence of breast-feeding at 6 months of age was 16% for the WIC mothers compared to 25% in Michigan and 29% nationally. There has been a steady increase in both initiation and duration of breast-feeding since 1990 at all levels with the largest increase among mothers who receive WIC benefits. From 1990 to 1998 there has been a 33% increase in the initiation rate and a 50% increase in the percentage of mothers who breast-feed their infant at 6 months of age among the Michigan WIC clients. The Healthy People 2010 target is to increase the rate of mothers who initiate breast-feeding to 75% and the rate at 6 months to 50%. 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. /2003/In 2000, the rate of breastfeeding in early postpartum was 50% among Michigan WIC clients as compared to 63% in Michigan and 68% nationally. Differences remain in breastfeeding rates between black (31%) and white (49%) WIC mothers in Michigan. The prevalence of breastfeeding at 6 months of age was 17% for the WIC mothers compared to 27% in Michigan and 31% nationally. Thirty (30) percent of Michigan's WIC mothers initiated breastfeeding in 1990 compared to 50% in the year 2000. In terms of duration, only 7.8% of Michigan WIC mothers were breastfeeding at 6 months postpartum in 1990. By the year 2000, that figure had climbed to 17.4%.

Reduce the rates of childhood injury: Injuries stand out as the leading cause of death for

children and youth in Michigan, as well as the nation. Every year, approximately 240 Michigan children aged 1-14 years die as a result of injuries due to preventable motor vehicle crashes, falls, fires, drowning, bicycle crashes and poisoning. An additional 55 deaths in this age group were due to intentional injury (40 homicide and 15 suicide). Thousands of children are hospitalized or seen in emergency rooms each year as a result of injuries. Each year, more children over 1 year old die from injuries than from all childhood diseases, birth defects and chronic conditions comb

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

During 2003, 128,970 newborns were screened, and 196 infants were diagnosed with one of eight disorders. Three contractual agreements were maintained for medical management of metabolic disorders, endocrine disorders and hemoglobinopathies. The screening panel was expanded to include MCAD deficiency in April, 2003, and in August, 2003, changes were made in the screening algorithm for congenital hypothyroidism after extensive analysis of screening and follow-up data. A Newborn Screening Advisory Committee met four times, and a Birth Defects Advisory Committee met three times. The department also maintained agreements for the provision of genetic services at five center-based genetic clinics and 10 outreach sites where patients and their families received genetic evaluation and counseling services.

b. Current Activities

Implementation of the 5-year state genetics plan continues. The plan addresses all stages of the lifecycle, including reproductive issues such as birth defects prevention, birth defects follow-up and linkage with the medical home, expansion and enhancement of newborn screening, pediatric genetics, and adult genetics including integration of genomics with chronic disease programs. Preparation for additional expansion of Newborn Screening(NBS) to include Homocystinuria, Citrullinemia, Arginosuccinic aciduria, and Tyrosinemia is underway. Improvements in NBS infrastructure continue to be made as part of a HRSA Genetics Implementation grant. An algorithm to link NBS specimens with birth records has been developed in order to identify unscreened infants. An online newborn screening training course has been developed, and quarterly update newsletters are sent to hospitals and midwives. Program staff continue to collaborate with Children's Special Health Care Services to identify opportunities for facilitating the medical home concept, and participate in a work group on child health data integration that would allow provider access to NBS results through the Internet-based childhood immunization registry. A Genetics Training Curriculum was developed and delivered at 10 geographic sites to early intervention providers statewide, and continues to be offered at additional sites. To facilitate and increase communication with consumers and the public, a genetics resource center continues to be enhanced. A toll-free telephone line has been acquired and a website, www.migeneticsconnection.org has been launched that will serve as a portal to genetics-related information for the state of Michigan. A targeted folic acid educational campaign is being planned based on data from the Birth Defects Registry as well as prenatal diagnostic data submitted by selected genetic centers.

c. Plan for the Coming Year

A new center of excellence for biochemical genetics is being established at Wayne State University/Detroit Medical Center. MDCH plans to contract with this center for the provision of follow-up and medical management of children with metabolic disorders, including those identified by expanded screening. The center will feature expanded services not currently

available through the clinic hosted by the University of Michigan, such as genetic counseling and collaborations with gynecologic specialists and internal medicine/neuro-geneticists to better address issues related to maternal metabolic disease and transition to adulthood. The emphasis on family participation will increase, with plans to hire parent consultants representing each NBS disorder who can foster networking and participate in policy decisions. Follow-up with families of children with neural tube defects will begin soon, and follow-up for children with oral clefts is being explored in conjunction with CSHCS and MCH epidemiology program staff. Contractual agreements for regional genetic centers and outreach clinics will be continued. State program staff plan to participate in a HRSA-funded regional collaborative for genetics and newborn screening, should a successful proposal be submitted from the Midwest.

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)*

a. Last Year's Accomplishments

SLAITS reported 61.3% success resulting from the combination of results to two questions for Michigan as of 2001. This result is above the national average. Positive response to "Doctors usually or always made family feel like a partner." was 89.1%. Positive response to "Family was very satisfied with services received." was 63.9%. Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed.

The parent-directed staff of the Parent Participation Program (PPP) (including 9 parents of children with special needs) remains in contact with families statewide, using the information that is obtained to provide consultation to the Michigan Title V programs regarding program and policy development. The PPP is an integral part of CSHCS Plan 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 this group for recommendation and revision as needed. Family participation has been and continues to be a main feature in the development and implementation of the contractual requirements for the Special Health Plans (SHPs). Therefore, significant contractual requirements included are a direct result of the family participation in the administration of the SHP contract and in the care decisions and management of the enrolled child under these contracts. Children enrolled in the SHPs benefit from the additional family participation involved in the development of the family centered requirements, which include participation on various SHP boards. Family participation is also a constant regarding other CSHCS program policy 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 and comment of the federal MCH Block Grant application was also provided by PPP. Due in part to PPP, there are also 131 volunteer Family Support coordinators within various communities in Michigan who provided over 1,238 volunteer hours in 2002. PPP continued 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. PPP provided scholarship for parents to attend conferences when the subject matter was germane to their child's specific diagnosis, medical care and treatment. PPP also provided In-service training from a family centered perspective for families, Pediatric Regional Centers, local health departments, and various agencies.

/2005/ Michigan CSHCS has continued with the activities and accomplishments as described in prior years. CSHCS has not initiated anything new since Michigan's results from SLAITS placed Michigan above the national average and there were more urgent needs at the time.

b. Current Activities

Michigan's Parent Participation Program (PPP) is an excellent resource for obtaining family input and determining problem areas in need of being addressed. As a pro-active process, PPP provides Parent Empowerment sessions to assist families in learning how to be most effective in communicating with their children's physicians and other caregivers. Based on the large number of calls that PPP receives per year from families, we are able to keep abreast of current and rising issues in the families of children with special needs "community". In addition, Michigan has consistently had a very high rating for the old NPM #14 regarding family participation in program and policy activities. NPM #02 does not appear to be a large problem in Michigan based upon the types of calls received by PPP. ***/2005/ CSHCS is working on the satisfaction survey for CSHCS clients and their families that will include families feeling like partners at all levels of decision making. CSHCS continues to monitor client and family satisfaction through the types of calls received at PPP through the Family Phone Line.//2005//***

c. Plan for the Coming Year

The Michigan CSHCS program will work collaboratively with the PPP to develop, use and analyze the results of a satisfaction survey intended to address the concern stated in NPM #02. In addition, Michigan will include features related to physicians partnering with families of children with special needs while developing the medical home model, and incorporate aspects of family centered care and family inclusion as partners in the decision making process as related to individual practices and the medical home model (see NPM #03).

PPP will continue to provide consultation to the Michigan Title V programs, as well as the existing services to families that include:

?The Family Phone Line; a statewide Family Support Network that offers information, family "matches" between families dealing with similar circumstances regarding the child with special needs, emotional support to parents, grandparents, siblings and other care givers of children with special needs;

?A biennial conference for siblings of children with special needs;

?Scholarships to enable Parents to attend conferences related to the diagnosis, care, or medical treatment of their children with special needs.

?In-service training for families, Pediatric Regional Centers, local health departments, and various agencies.

/2005/CSHCS plans to complete and administer a satisfaction survey of CSHCS clients and their families in FY 2005. The survey will include families as partners in decision making.//2005//

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)*

a. Last Year's Accomplishments

Last year Michigan was still defining a medical home as enrolled with a commercial HMO or a CSHCS Special Health Plan. The result of that measurement was 33.2% had a medical home. Michigan is now taking a new approach regarding the definition a medical home (see below) in conjunction with this new performance measure for 2004.

SLAITS reported 55.8% success resulting from the combination of results to five questions, with ten sub-questions, for Michigan as of 2001. This result is above the national average. Positive response to "The child has a usual source of care." was 88.2%. Positive response to "The child had a personal doctor or nurse." was 89.7%. Positive response to "The child had no

problems obtaining referrals when needed." was 82.7%. Positive response to "Effective Care coordination was received when needed." was 48.9%. Positive response to "The child received family-centered care." was 70.3%. Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed. ***/2005/Michigan was still working closely with the SHPs in developing and testing a medical home model. Other partners were brought into the process such as the Michigan AAP Chapter, and the Federal Medical Home Learning Collaborative. Michigan did not pursue a manner to measure for this in 2003 and assumed that since significant changes had not yet occurred related to medical home the SLAITS results would remain constant for 2003. The results to SLAITS placed Michigan above the national average thereby allowing Michigan time to put it's energies on the further development of a medical home model as opposed to developing a method for measuring this factor so soon after the SLAITS process had occurred.//2005//***

b. Current Activities

The Michigan CSHCS Program has acknowledged that the definition of Medical Home used in recent reports is inconsistent with the model promoted by MCHB and the American Academy of Pediatrics, i.e., the medical home for children with special needs. A process to develop a new definition was initiated by applying to join the Medical Home Learning Collaborative (MHLC), supported by the Maternal and Child Health Bureau (MCHB). The MHLC provides educational support to three practices, while they modify their style of practice to be consistent with the medical home for CSHCN. The Title V program is encouraged to use the practices as laboratories to gain experience upon which to base future policy in support of the medical home for CSHCN.

To develop consensus and support for the definition, an interest group of the Michigan Chapter of the AAP has joined with the CSHCS program to carry out the work of the MHLC. The Michigan consensus definition will be critical to the process of developing future support for policy and reimbursement mechanisms, steps needed to expand the medical home concept across practices in the State.

/2005/ Activities are currently focused on the sudden termination of the CSHCS SHP contracts, and the subsequent transition of CSHCS clients back to the traditional CSHCS model. Medical Home activities continue but now must incorporate what was learned in the SHPs without the actual use of the SHP model through which to advance the initiative.//2005//

c. Plan for the Coming Year

In addition, we are working toward the further development and expansion of the medical home concept. The SHPs will be central to that effort. While they haven't promoted the precise model of the medical home for CSHCN, much of their work has been consistent with its precepts. Michigan has a rich experience with care coordination and family-centered care, two of the major components of the Medical Home. The SHPs have integrated these values in their structure. They use Principal Coordinating Physicians (either sub-specialists or primary care physicians) and non-physician Local Care Coordinators to develop, using family centered decision-making, an Individualized Health Care Plan that authorizes coverage of medically necessary services. While the traditional CSHCS Basic Health Plan with 80% of the CSHCS enrollees is still constrained by the financial and programmatic exclusion of primary care, the SHPs provide an innovative organizational structure that can readily accommodate a shift in philosophy to include the Medical Home initiative. The coming year is expected to show increased enrollment into the SHPs due to both SHPs currently accepting new enrollees. We also anticipate activating six more counties for SHP operations this year. Each of the SHPs will work directly with one of the practices to integrate the medical home for CSHCN into the SHP structure. Another effort is envisioned, targeting the Federally Qualified Health Centers (FQHC). The third MHLC participating practice has recently been incorporated into the Cherry

Street Community Health Center, a long established and respected FQHC in Grand Rapids. We are expecting to partner with the Cherry Street leadership in approaching the Michigan Primary Care Association to expand and spread the Medical Home Initiative throughout that network to take advantage of their coverage of underserved areas of the State.

To maximize efficiency the CSHCS Program is joining a coordinated effort with the Metabolic Screening and the Early Hearing Detection and Intervention (EHDI) Programs to develop the Medical Home concept. Each program has requested the Office of Medical Affairs (OMA) to lead in the effort to see that all children with special health care needs will receive coordinated ongoing comprehensive care within a medical home.

//2005/ CSHCS will continue to work with the Michigan AAP Chapter and the Federal Medical Home Learning Collaboration as well as the Michigan physicians who have become involved in using their practice sites as the initial testing sites. A consensus definition of medical home for MI CSHCN will be finalized.//2005//

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)*

a. Last Year's Accomplishments

SLAITS reported 66.5% success resulting from the combination of results to five questions for Michigan as of 2001. This result is above the national average, however significantly different from the data Michigan routinely monitors as related to the CSHCS specific population. Positive response to "The child has public or private insurance at time of interview." was 96.0%. Positive response to "The child has no gaps in coverage during the year prior to the interview." was 91.5%. Positive response to "Insurance usually or always meets the child's needs," was 88.5%. Positive response to "Costs not covered by insurance are usually or always reasonable." was 75.3%. Positive response to "Insurance usually or always permits child to see needed providers." was 92.0%. Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed.

Michigan has been monitoring the status of private and public insurance for persons enrolled in the CSHCS program. We have no way of identifying other persons with special needs who are eligible but not on CSHCS, or those having special needs other than those which would be covered by Michigan CSHCS if enrollment occurred.

Of those with CSHCS coverage in 2002, the following is the historical trend regarding the percentage of CSHCS enrollees with insurance coverages, i.e., Medicaid, MICHild (SCHIP), and/or private insurance as identified on the Medicaid Management Information System (MMIS):

1997	1998	1999	2000	2001	2002	Target	2003
88.5%	89.2%	90.5%	91.7%	92.2%	93.3%	95.0%	96.3%

//2005/ In an attempt to increase the number of children with special needs who have insurance, Michigan sent a specific mailing to families with CSHCS coverage when it appeared they might be eligible for the MICHild/Health Kids programs to invite them to apply.//2005//

b. Current Activities

We continue to monitor the CSHCS population regarding their access to other insurance, either private or public. See Form #7 for a more detailed breakout of coverage.***//2005/The mailing continues to occur for new applicants who appear to be eligible at the time of CSHCS***

application.//2005//

c. Plan for the Coming Year

We will continue to monitor the CSHCS population in the same manner as we have been monitoring for other insurance coverage. The target of 95% appears to remain reasonable.***./2005/ Given the current rate of success, Michigan CSHCS plans to continue with the current practice. //2005//***

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)*

a. Last Year's Accomplishments

New performance measure for 2004. SLAITS reported 75.7% success resulting based on a single question for Michigan as of 2001. This result is above the national average. Positive response to "Services are usually or always organized for easy use." was 75.7%. Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed.***./2005/SLAITS resulted in Michigan having a higher than average score for this factor. Michigan relies heavily upon the local health departments(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 to this end.//2005//***

b. Current Activities

New performance measure for 2004 Since February of 2003, the CSHCS Plan Division has worked to develop collaborative mechanisms with local health departments.***./2005/CSHCS has established workgroups with various LHD representatives to reconsider many of the requirements or restrictions on the LHDs that have been in place for some time. This appears to be increasing communication and the generation of creative ideas. CSHCS has also very recently hired a Transition Analyst whose role it is to work with the LHDs in identifying what types of information and assistance they need regarding the transition services and resources that are available to clients as well as appropriate timing for approaching a family with recommendations of preparing for certain transitions which will include community resources. //2005//***

c. Plan for the Coming Year

Michigan acknowledges that organization of services within specific communities is the responsibility of the communities. We rely upon the local health departments to assist families in locating and accessing services within the local or nearby community. We will continue to work to establish a collaborative relationship with the local health departments in Michigan including revision of the methodology by which the local health departments are reimbursed for their valuable services. Improvement in local CSHCS infrastructure is needed and local/state collaboration will be necessary to successfully accomplish this improvement. A work group will be developed to study the funding structures with the goal of having a new methodology delineated in the spring of 2004 to become effective on October 1, 2004 with the start of the new fiscal year for Michigan.

Steps taken to ensure a statewide system of services that reflect the principles of comprehensive, community-base, coordinated, family-centered care include the reconsideration of the role of the Local Health Departments within the communities. Previous efforts have focused on centralizing activities, operations and communication with families and

the medical community. Michigan is re-assessing that direction in such a way as to utilize the best of both approaches by considering what can and should be available centrally, locally or both. Under new leadership, the Michigan CSHCS program is reconvening various advisory groups, and ad hoc committees to determine current needs of families regarding special health care needs. It is believed that Michigan's greatest resource and strength for supporting communities including the coordination of health and other services within the communities is found in the Local Health Departments. ***//2005/ The CSHCS Transition Analyst will provide certain information, assistance and supports to the LHDs. The LHDs will assist families in when and how to access the needed services at the appropriate time so families will have some advance assistance regarding community resources. //2005//***

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

New Performance Measure for 2004. SLAITS reported 5.3% success resulting from the combination of results to two questions and three sub-questions for Michigan as of 2001. This result is .5% below the national average, yet the study itself indicates these results do not meet the standard for reliability or precision. The relative standard error is greater than 30%. Positive response to "The child receives guidance and support in the transition to adulthood." was 18.5%. Positive response to "The child has received vocational or career training." was 24.9%. Persons beyond those with Michigan CSHCS coverage or eligibility were interviewed. ***//2005/The Michigan CSHCS program focused on this factor as a higher priority than many of the others due to the low rating Michigan received from SLAITS. CSHCS worked more closely with the local health departments (LHD) who are the community arm of CSHCS in order to discuss and empower them in assisting families in locating and accessing services that will assist clients in transitioning to adult life.//2005//***

b. Current Activities

CSHCS staff has been in discussion with Medicaid staff to develop a plan to assist people with both CSHCS and Medicaid, who are close to "aging out" of CSHCS (age 21) to prepare in advance for the Medicaid Health Plan selection process. This process requires persons with Medicaid to choose a Medicaid Health Plan (MHP), or secure an exception to the process, or be automatically enrolled in a MHP. CSHCS will be working with the local health departments to prior-identify individuals who are about to "age out" of CSHCS eligibility and develop a plan by which to work with the individuals or families early enough to educate them as to what to expect in the process. This includes identifying which MHP the person's providers participate with to be prepared to make the choice as soon as the enrollment information arrives to avoid being automatically enrolled with a different MHP, or to have started the exception to MHP enrollment process if applicable. The intent is to inform and assist with the transition into an MHP as an adult and to provide whatever assistance will be of use to the family and the MHP (when the family signs a release of information). As aged out members choose an MHP, the department will identify the individual as a previous CSHCS enrollee so the MHP has advance notice that a person with exceptional and possibly immediate needs is enrolling in the MHP. Families will be forewarned about any change in coverage. ***//2005/CSHCS implemented a plan, through the LHDs to identify and assist clients who are aging out of CSHCS (age 21) who also have Medicaid in order to prepare and assist them as they transition into the Medicaid Managed Care environment. This additional requirement for the LHDs should increase the number of aging-out clients who have done the research and deliberately chosen the best MHP for their needs thereby decreasing the level of disruption to care and confusion during a transition time. CSHCS also very recently hired a Transition Analyst***

with the express focus of providing additional support to the LHDs regarding the various types and timing of transition needs for the special needs population and sub-populations. The focus will start with transition needs related to medical circumstances and need, and eventually expand to include broader transition needs and focus such as social and work related transition needs.//2005//

c. Plan for the Coming Year

We plan to work out the details of the process described above, and implement in the coming year. We also plan to identify other areas of transition need, and determine which would result in the most useful (to families and the department) to assist with transition into adulthood for future activities. Plans include the state CSHCS staff developing systems to prior-identify those with CSHCN about to "age out" and then have the family work with the local health department and possibly the selected MHP to ease the transition.***//2005/Develop a survey of the LHDs to identify the types of transition information they feel they are lacking or would like addition support and information. Research what other states have done to learn from their experiences. Develop and maintain a resource document for what is available elsewhere if it is not available in the community for the LHDs to include LHDs that might be a resource for other LHDs. Develop a plan for addressing transition needs in an orderly and sequenced manner. Increase the tracking of clients who are aging-out of CSHCS who also have Medicaid regarding the results of their move into the Medicaid Health Plan environment.//2005//***

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.*

a. Last Year's Accomplishments

In 2003, the Michigan Childhood Immunization Registry (MCIR) transitioned completely to the web based application. The MCIR continues to lead the way nationally, and has been recognized as such, in implementing a fully functional immunization registry which is available to both public and private providers across the state. The MCIR also added more functionality in 2003. A batch query functionality was added which allows providers to create lists of children they need immunization records for and submit them as a group to obtain printed reports on all children. A new recall/reminder system was created. In 2003, the system was rolled out to local health departments for use. This recall system was made available to private providers in 2004. The MCIR system has been integrated with the Medicaid system (MMIS) and the Women Infant and Children (WIC) systems. This allows us to create profile reports by WIC clinic in another effort to identify children who are behind in their immunizations.

b. Current Activities

Michigan is working on integrating the MCIR with the SIRS software which is used to report school and child care data. This integration will streamline the reporting process as well as save time for physician offices, schools and child care centers, local health departments, and at the state health department. Michigan is increasing the number of outreach activities to provider offices. Michigan plans to do 300 Assessment, Feedback, Incentive, and Exchange (AFIX) sessions in provider offices as compared to 128 last year. These AFIX visits provide physician offices with valuable information to help them improve their immunization levels. The Immunization Division is in the process of developing a flu module to be used by the Immunization Nurse Educators and Peer Educators to promote the new flu recommendations for children. Michigan has experienced significant difficulties promoting the pneumococcal conjugate vaccine due to vaccine shortages.

c. Plan for the Coming Year

FY05 Plans include promoting and making available the Michigan Childhood Immunization Registry (MCIR) to every immunization provider in the state free of charge. Currently, 2039 provider offices are submitting data to the MCIR and over 34 million shot records have been entered into the system for 28 million children. A web-based version of the MCIR has been developed which has made the MCIR much more accessible for all providers. Also, MCIR will be made available to all childcare centers and schools within the state to monitor and tract immunization coverage rates. Additionally the promotion of AFIX for vaccination rates obtained at provider sites (private and public) has been implemented to increase immunization coverage rates. Promoting immunization education for current immunization recommendations and standards of practice continues to be another strategy toward increasing immunization rates. Numerous educational presentations (pediatric, family practice, adult, varicella, OB/GYN, influenza, etc.) are available to providers and clinic staff free of charge as another mode for increasing the immunization rates.

For 2005, monitoring will occur for the number of provider users enrolled in the MCIR. Immunization completion rates for children in MCIR will also be assessed and tracked. In addition, the number of AFIX assessments to private and public providers will be monitored. For providers who have repeat AFIX assessments, a change in immunization rates will be monitored for improvement. Evaluation strategies for FY 05 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 among childcare centers and schools statewide.
4. Monitor the number of educational presentations to providers and their staff. Evaluate the change in immunization knowledge, attitude and behavior following educational presentations to providers.

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

a. Last Year's Accomplishments

During FY 03 Michigan had several programs in place striving to impact the rate of birth to teenagers in the 15-17 year old age bracket.

Easy to access, comprehensive Family Planning services remain a priority intervention for NPM 8 as well as SPM 5 and SPM 6. Targets for NPM 8 were reduced in FY04 to reflect trends. In 2003, 172,007 women and 4,187 men were served in Family Planning Clinics. This represents a reduction of 4.3% in women served and 23.2% in men served, a result of state budget and funding constraints. The Family Planning Program has an objective that the percentage of teens served in the program compared to total users is at least 30% of the caseload and this was met for FY 03.

The family planning program also provides support to the Michigan Abstinence Program (MAP), so that preteens, teens and parents/guardians receive education regarding the benefits of abstinence and how to communicate with their youth about sexuality. MAP aims to positively impact adolescent health problems by promoting abstinence from sexual activity and related risky behaviors such as alcohol, tobacco and other drugs. During FY 03 there were 12 funded community agencies. The target population of MAP is 9-17 year old youth (up to 21 years of

age for special education populations) and their parents/guardians. During FY03, 17,252 youth participated in MAP programs across Michigan. In addition, 558 parents/guardians participated in education sessions about communicating with their children about sexuality and the benefits of abstinence. Local coalitions provide direction and oversight and develop community awareness activities. A media campaign targets youth and their parents/guardians through television, radio and posters. MAP meets the definition of abstinence education outlined in Section 510 of Title V of the Social Security Act and the MDCH appropriation boilerplate.

The Michigan Teen Outreach Program (MTOP) strives to increase the number of adolescents in Michigan who are making positive choices to abstain from risky behaviors, including sexual activity and the use of alcohol, tobacco and other drugs through participation in service learning and abstinence education intervention. During FY 03, five community organizations were funded for MTOP through a SPRANS Community-Based Abstinence Education grant. During calendar year 2003 MTOP provided service learning programming to 2,832 youth and 776 parents/guardians.

The Teen Pregnancy Prevention Project (TP3) completed a two-year funding cycle in FY 02 with four communities receiving bonus funding based on performance reviews and actual reduction of teen births. A wide range of research-based services for youth were provided to 500 youth participants aged 13-19.

The Adolescent Health Program administers 22 clinical teen health centers and nine non-clinical teen health centers throughout Michigan. Greater than 20,000 youth ages 10-21 received services through these centers, a 20% increase from 2002.

b. Current Activities

Michigan Public Act 360 became effective April 1, 2003. The act requires the department to give priority of funding to family planning providers who do not engage in one or more of the following activities: (a) perform elective abortions, or allow the performance of elective abortions within a facility owned or operated by the provider, (b) refer a pregnant woman to an abortion provider for an elective abortion, (c) adopt or maintain a policy in writing that elective abortion is considered part of a continuum of family planning or reproductive health services, or both. As a result of implementation of this act, provider arrangements were not interrupted.

MDCH is preparing to submit a Section 1115 Family Planning Waiver to the Centers for Medicare and Medicaid Services (CMS) by July 2004. Approval of this waiver will provide Family Planning Services coverage to women of childbearing age who are not on Medicaid and whose family income falls at or below 185% of federal poverty guidelines.

MAP continues in the current year with the original 12 communities funded. Funding allocations have been reduced 15% for each community for FY 04 due to the decrease in federal funds allocated to Michigan for the State Abstinence Education Program as a result of re-calculating the funding formula using Census 2000 data.

MTOP is currently in the third and final year of funding, with four communities funded, rather than the original five. An application was submitted to HRSA for continued funding of this project for an additional three-year funding cycle of 2005-2008.

Michigan continues to fund 31 School Based/Linked Health Centers to provide primary health care, psycho-social services, health promotion/disease prevention education, and referral services to youth 10-21 years of age. The Michigan Department of Community Health and Michigan Department of Education are currently pursuing federal matching Medicaid dollars for FY05. MDCH received approval from the Center for Medicare and Medicaid Services (CMS) in March 2004 to match the 3.74 million in Teen Health Center funding. The state is now working

out implementation details for this outreach match.

The Teen Pregnancy Prevention Project (TP3) completed programming at the end of the third and final year of funding, the bonus year, on September 30, 2003.

c. Plan for the Coming Year

Strategies described above will be maintained including the availability of Family Planning services to Michigan residents in need, assuring Family Planning services for the target low-income population, assuring the percentage of teens served is a minimum of 30% of the total caseload, continued implementation of PA 360 in such a way as to assure continuous and accessible Family Planning Program services meeting program guidelines, and increasing the number of individuals served in Family Planning Programs through an approved adult benefit waiver.

Continue current MAP projects through FY 07.

If awarded funding for MTOP, utilize a competitive Request for Proposals (RFP) process to select seven Michigan communities to implement local projects for the 2005-2008 funding cycle. Local projects will provide service-learning and abstinence education activities utilizing the Teen Outreach Program's Changing Scenes curriculum with abstinence-based portions of the curriculum replaced with community selected (and MDCH approved) abstinence-until-marriage curriculum, to meet the requirements of the SPRANS Community-Based Abstinence Education Grant.

Through increased funding obtained through federal Medicaid matching dollars, additional centers will be funded through the SBLHC program. Priority will be given to failing schools and medically underserved communities. Elementary models will also be incorporated into the program. Billing and reimbursement will continue to be a major activity over the upcoming year as the State continues to bring centers and Medicaid HMOs together to begin developing contracts and establishing working relationships. All state-funded centers will continue to provide primary medical services to at-risk children and youth in Michigan with a goal of increasing utilization numbers by 5% over the previous year.

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

a. Last Year's Accomplishments

Improvement seen in this measure has been due to an increase in Medicaid reimbursement to providers for services and an increase in the number of insured children in the MI Child program that covers sealants for the age group.

The Oral Health Program provides consultation, technical assistance, and statewide coordination for oral health programs to local health departments and other community agencies. Forty-six local agencies, including local health departments, primary care centers, migrant health clinics, and Indian Health Services (HIS) conduct public health dental programs. The local health department program receiving funding from the MCH block grant has been continued to provide dental care to dentally underserved children in a five county area. Other programs continue to be funded through several sources. Volunteer dentists continue to provide 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 population 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. Michigan has continued its program to increase capacity for oral health services in the low income, dentally uninsured through the Healthy Kids Dental program.

b. Current Activities

In FY 04, Michigan established an oral health coalition to expand the focus on oral health. An MCH epidemiologist was hired to develop a statewide surveillance system to collect data and monitor progress on HP 2010 goals for Oral Health.

c. Plan for the Coming Year

For FY 05, Michigan will coordinate with the local Oral Health Coalition to develop a five year oral health plan and a report on the oral health disease burden in the state. Increasing sealant application will be addressed in the oral health plan.

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

a. Last Year's Accomplishments

MDCH continues to lead a number of programs statewide for public education on child passenger safety and safety belt laws, the benefits of proper restraint use for children, and the dangers that air bags pose to unrestrained occupants and infants in rear-facing car seats. Programs have been continued that specifically focus on the needs of at-risk populations including minority, non-English-speaking, and low-income groups. The National Highway Traffic Safety Administration's Standardized Child Passenger Safety Technical Certification Course is the curriculum that is used to qualify people to conduct child safety seat checks to educate the public on child safety seat correct use and installation. Graduates of the course become certified as a child passenger safety technician for one year. MDCH conducted 13 courses last year and plans to conduct additional courses in FY 05. There are currently greater than 1,000 child passenger safety technicians and 35 child passenger safety instructors in Michigan. In addition, the program begun last year with 400 child safety seats distributed to 19 agencies who had agreed to become fitting stations has continued. These fitting stations provide a specific place and time period each month where parents can come in and have their child safety seat inspected for recalls and proper use. Fitting stations enable parents who cannot attend a public child safety seat inspection clinic a chance to have their seat checked by a certified child passenger safety technician.

To increase public awareness of the need for booster seat use, two booster seat radio public service announcements were developed by MDCH and began airing in July 2002. The MCH Clearinghouse has a toll-free number that people can contact to request booster seat brochures. Phone calls continue to be received as a result of the campaign and brochures mailed as a result.

To determine the future focus of child passenger safety efforts in Michigan, MDCH initiated a child passenger safety strategic planning process. A 37 member team of child passenger safety professionals and advocates was put together to assess the current status of CPS programs and scope of resources in Michigan and to identify strengths, weaknesses and gaps in programming. As a result of the process, MDCH prepared a three-year strategic plan with recommendations for improving child passenger safety in Michigan.

In FY 03, MDCH received a 4-year grant from the Centers for Disease Control and Prevention for Community Based Interventions to Prevent Motor Vehicle Related Injuries. MDCH will develop and implement a plan to increase the possession and correct use of appropriate child restraint systems, with a specific emphasis on booster seats among low use groups in Michigan.

b. Current Activities

Child safety seat inspections are conducted at the end of each 4-day certification course and, in addition, coalitions and chapters of MDCH's Michigan SAFE KIDS Program conduct many additional clinics throughout the state. A public seat inspection clinic invites community members to have a child safety seat inspected for correct use, recalls, and structural integrity. At most events, child safety seats are given to those families that do not have a seat or to those found to be using an unsafe seat during the inspection. Information is provided about proper seating positions for children in air bag-equipped motor vehicles, the importance of restraint use, and instruction on child safety seat correct use and installation. Over 10,000 car seats are checked and 3750 distributed annually through SAFE KIDS groups statewide.

c. Plan for the Coming Year

The Child Passenger Safety Strategic Plan identified significant gaps in education for health care providers including hospital personnel, family physicians, and pediatricians. Recommendation areas include legislation, law enforcement, education and awareness, health care and family service providers, and funding. Continued efforts in these areas will provide child passenger safety training for all groups.

In addition, MDCH will continue:

1. A public awareness campaign regarding booster seat use.
2. Assure education to health care providers including hospital personnel, family physicians, and pediatricians,
3. Conduct additional National Highway Traffic Safety Administration Child Passenger Safety Technical Certification Courses
4. Continue to provide the 4-day certification course to hospital personnel that work with infants and children
5. Utilize the physician's program to increase safety belt use among 9-15 year old patients.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

Accomplishments in promoting breastfeeding at hospital discharge through the WIC Program included the Mother-to-Mother Program ?Breastfeeding Initiative. This program has its 10th anniversary in August 2003 and is a joint project of the MDCH WIC Program and Michigan State University Extension (MSUE). The program involves hiring and training paraprofessional peer counselors to work with WIC eligible mothers before and after delivery, in the WIC clinic, the hospital and in homes. Contacts include home visits, support groups for breastfeeding moms and telephone consultation. Peer counselors were employed in 17 counties and the City of Detroit. Supervision is provided by MSU Extension; training and monitoring is provided by lactation consultants. In the past fiscal year ninety-five (95) percent of Mothers enrolled in the Mother-to-Mother Program initiated breastfeeding.

The WIC Division received one of nine competitive USDA Loving Support Grants. Implementation of the "Building a Breastfeeding Friendly Community" was initiated with

national trainers from Best Start, Incorporated in January 2003. This Social Marketing kick-off campaign included Bay County stakeholders, state program leaders from MDCH, WIC, MSUE and national leaders from the Centers for Disease Control. A two-day follow-up training was held in August with an emphasis on direct care providers with over 50 people in attendance. Consequent to the training, the Bay Area Breastfeeding Coalition (BABFC) membership expanded significantly. With the assistance of a grant project manager, the Coalition trained over fifty staff from local physician offices, one HMO direct service provider and the Family Independence Agency Workfirst staff. They also coordinated an outreach campaign that included radio and print advertising, two Loving Support Rock and Rest tents for families attending the Tall Ships Festival, and the sale of "Got Breastmilk" T-shirts. BABFC leaders initiated worksite manager breastfeeding education with the Physician who directs employee health care services at the General Motors Powertrain Division.

Another accomplishment was the Breastfeeding Basics Training Program. The WIC Division sponsors a two-day training four times each year for local agency WIC clerical and professional staff, local agency Maternal and Infant Support staff, breastfeeding peer counselors, Head Start, MSUE and hospital/physician office staff. The training provides an introduction to breastfeeding and emphasize support for breastfeeding women. To date over 1100 Michigan local agency staff have been trained.

Michigan WIC also provides an annual one-day training for New Breastfeeding Coordinators. Twenty-one local agency WIC staff and the MSUE Mother-to-Mother Program Leader attended this training in Spring 2003.

The 2003 Michigan WIC Conference had three breastfeeding sessions for local agency staff.

The MDCH WIC Program also provided Pharmacist consultation concerning medication and breastmilk.

b. Current Activities

In fiscal year '04, the WIC Division has continued to offer Breastfeeding Basics and Breastfeeding Coordinator training. Along with these, WIC Conference 2004 offered three new breastfeeding training sessions attended by 291 local agency staff.

The Mother-to-Mother Program ?Breastfeeding Initiative has grown to provide services in 6 more counties bringing the total to 24 counties with peer counseling. Plans are in process to further strengthen the partnership through joint conferences of local agency staff from MSUE and WIC. State and local WIC and MSUE staff are attending a USDA Midwest Region meeting and training to learn more about a new effort to institute and/or enhance peer counseling programs at the local agency level.

Michigan Breastfeeding Awareness Month (August) will again be celebrated with a proclamation from the Governor, development and distribution of breastfeeding promotion materials (by state WIC) for use by the local WIC and MSUE agencies and activities such as breastfeeding walks, billboards, and rock and rest tents at local festivals. This information and sponsoring organizations will be included in the Monthly Health Awareness Campaign Calendar of the Chronic Disease and Prevention Section of the MDCH.

The WIC Division is participating in a six-state Nutrition Education on the Internet Project. Michigan WIC and the local Agency Breastfeeding Workgroup are taking the lead in developing the Breastfeeding Module for use by WIC moms.

The USDA/Loving Support Grant to Build a Breastfeeding Friendly Community is in its second

year. The focus is on local worksite and daycare provider breastfeeding education, peer counseling services to breastfeeding moms and creating community awareness using a multi-media campaign.

c. Plan for the Coming Year

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 breastpump or time and space for expressing milk, and both Medicaid and its contracted providers breastpump policies are often inconsistent in terms of providing pumps to mothers whose infants are either in the NICU or whose infants 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.

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

a. Last Year's Accomplishments

? Hearing screening by one month: Michigan had a reporting rate of 92% and a screening rate of 91%. Of the infants screened, 97% passed and 3% referred. In March '04, EHDI distribute screening tips and quality assurance guidelines to hospitals. Literature distribution for 2003 included: parent information brochure (English 57,800, Spanish 2,350 and Arabic 850) and parent contact card (1,287 English and 172 Spanish).

? Collaboration with other state programs to improve public awareness (exhibited at the Maternal/Infant Support regional meetings)(Oct 03':145 Nurses/Providers), MI Perinatal Nurses conference (Nov.'03:65 Nurses), Childbirth Educators conference (Jan. 03': 50 Nurses) and MI Pediatric Nurse Practitioners (May 03': 75 Nurses).

? In June 2003, the EHDI web page was completed with sections on screening, diagnosis and early intervention, with links to literature and reporting forms for parents and professionals.

? Provided funds and technical assistance to 23 counties to develop county brochures related to EHDI services.

? A training consortium for birth centers was held in November 2003 (60 Attendees).

? Outcome by three months:

? Since 2000, 701 infants with hearing loss have been identified and referred to Part C or Part B services. The percent of children identified by 3 months has increased from 36% (2000) to 82% (2003).

? Guidelines were reviewed by key MI pediatric audiologists'.

? An audiology survey was completed and the information was used to complete a Pediatric Audiology Services directory of 19 audiology diagnostic sites.

? A proposed Medicaid draft policy was sent for out for public review. The proposal addressed EHDI equipment requirements for providing pediatric audiology services.

? The 2003 Pediatric Audiology Training was held in October 2003 (65 audiologists attended).

? EHDI staff presented at 4 Part C Regional meetings (317 attendees).

? 107 physicians were surveyed and sent information on the EHDI system.

? Distributed 1,090 EHDI informational packets to MI pediatricians in May 2003. Exhibitions provided for two MI Otolaryngology Society meetings (April and July 2003), MI State Med Society conference (March 03': 50 attendees) and MI AAP conference (80 participants).

? Intervention by six months:

? Of the 701 infants with hearing loss, the number of children enrolled by 6 months has

increased from 42% (2000) to 87% (2003). Part C and B service coordinators are provided with EHDI literature for parents.

? The Michigan Hands and Voices Chapter parent support group started monthly meetings in June 2003 with 78 families participating.

? Presentations have been completed for the: State Interagency Coordinating Council (Oct 03'), Project Find coordinators (Oct 03' 25 attended), Supervisors of Hearing Impaired meetings (throughout 2003), Part C update regional trainings, Early Child Conference (Jan 04).

First annual Early Intervention/parent conference took place with 100+ attendees.

b. Current Activities

~Hearing screening by 1 month: A new database to better support the program is being developed.

~A physician education CD Rom presentation for use at grand rounds and residency trainings is complete.

~Outcome by 3 months: Collaborating with the Women Infant and Children's (WIC) program to increase follow-up rates; approximately 50% of Michigan mothers receive WIC services.

Intervention by 6 months: Collaborating with the Wisconsin EHDI guide by your side program to develop a MI program.

~The last non-participating birthing hospital joined the screening program in April, 2004.

c. Plan for the Coming Year

? Screen by 1 month:

? Ensure linkage to other MDCH database to increase follow-up capabilities.

? Develop a technical assistance bulletin for PART C and local health departments.

? Develop 20 more county level EHDI brochures.

? Continue to distribute the Guidelines for Newborn Hearing Services.

? Conduct physician education trainings

? Outcome by 3 months:

? Use the new database to monitor the number of infants who complete diagnosis by 3 months of age and provide automatic faxing of referrals to increase follow-up.

? Refer all children identified with hearing loss to either Part C (0-3 years) or Part B (over 3 years) services.

? In October 2004, the 2004 Michigan Pediatric Audiology Conference will be held.

? Distribute the updated hospital and diagnostic list to Michigan audiologists.

? Conduct biannual statewide consortiums.

? Work with genetic/EHDI workgroup teleconferences to increase awareness of genetic services.

? Establish the "Guide by your Side" program, designed to connect parents after diagnosis.

? Provide the 2005 Early Intervention/Parent Conference.

? Create a Medical Home brochure and ENT guidelines for physicians.

? Create a physician fax to document medical services for an infant identified with hearing loss.

? Monitor the number of families enrolled in Michigan Hands and Voices.

? Develop a new parent resource guide by Fall 2004.

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

a. Last Year's Accomplishments

The dual enrollment procedure utilized to bring children into the Medicaid and MIChild programs continues. Although funding for outreach to local health departments has been cut

due to budget shortfalls, between 10,000-14,000 children are enrolled per month with between 3,000-4,000 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 steady during 2003, with MIChild enrollments between 33,000 and 35,000 in any given month during the fiscal year.

The rate of uninsured in Michigan increased in 2001 (non-elderly, 11.7%) compared with the previous year (11.%). The rate of uninsured children for 2001 was 8.1%, which is a decrease from 1999 (9.7%), but up from 2000 (6.7%). The three-year average from 1999 to 2001 was 8.2% while the national rate was 12.5%. The rate of uninsured children in 2002 was 7%. Children represent 21.1% of the uninsured. Nearly nine of ten of uninsured individuals reside in an urban area.

b. Current Activities

While outreach funds to local health departments were cut in early 2003, collaborative efforts including with the Governor's Children's Action Network have maintained enrollments in publicly-funded programs stable and outreach to uninsured families ongoing. 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. Newly funded Nurse Family Partnership programs in Detroit, Pontiac and Grand Rapids and an additional team in Berrien County will also identify families who will need coverage for their children, and these programs assist with enrollments in publicly-funded programs.

c. Plan for the Coming Year

Since the elimination of outreach funding to local health departments, the department has sought other 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 Head Start, the Children's Action Network, schools and employers.

Dual program enrollment will continue, and additional partners will be identified that are able to assist with outreach and/or direct enrollment on site. Presumptive eligibility allows children to enroll immediately for a temporary period while the family completes the application process, in case income verification is needed by a particular program. Collaboration will be sought 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 (Medicaid) programs.

Assistance for on-site enrollment will also be encouraged whenever possible. Teen 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

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

The percentage of children enrolled in Medicaid who received a service attained a small growth between 1999 and 2000, but a drop in the percentage receiving a service was experienced in 2001, primarily due to the increase in the number of children enrolled in Medicaid during that year. Enrollments in Medicaid increased by nearly 70,000 during 2001. In 2002 the percentage receiving services increased while the overall number of children enrolled decreased. In 2003, both the number enrolled and the number receiving a service increased. The resulting percent receiving a service decreased by < 1 %.

The Michigan MICHild Program (CHIP) continues to enroll children, and the dual enrollment procedure for MICHild and Medicaid program for children (Healthy Kids) continues. MICHild continues to serve as a significant source of outreach for the Medicaid program. During the period between January and March of 2004, nearly 10,000 applications were forwarded to the Medicaid program by the MICHild program. In March 2004, nearly 3,500 applications were received for MICHild for over 6,200 children. As of April 1, 2004, more than 35,000 children were enrolled in MICHild. The cumulative totals for MICHild and Medicaid applications are 233,808 covering nearly 417,000 children. Twenty-nine and one-half percent of the total enrollments are MICHild with the remainder enrolled in Medicaid.

Outreach activity has been strong with a range of between 14,00 and 18,000 calls to the MICHild program each month between January and March 2004. The sources of information about MICHild and Medicaid Healthy Kids are varied, but the majority of referrals come from friends and family (31%), human services agencies (24.9%), physicians (12.1%) and the Internet (10.2%).

b. Current Activities

The dual application process for Medicaid and MICHild continues, with the majority of children eligible for the Healthy Kids program and nearly 30% eligible for MICHild. With the elimination of outreach funding to local health departments in 2003 due to a significant state of Michigan budget deficit, it was anticipated that this measure would be affected, but requests for applications have remained high, with referrals from a wide variety of sources. Several new initiatives have begun during the past year focused on young children and assisting them in accessing services. Several sites have been funded for Nurse Family Partnership programs, the HRSA system of care grant which includes medical home and sources of health care is in continuing development, and the "Failing Schools" project initiated by the Children's Action Network, based in the Office of Governor Jennifer M. Granholm, are all focused on increasing access to care for young children

c. Plan for the Coming Year

Work will continue on the HRSA system of care grant, with seven workgroups that will conduct analysis of data trends, identify current program efforts, gaps and needs and identify implementation strategies. The dual application process for MICHild and Medicaid will continue. Collaboration with other human services agencies will continue to assure the integration of outreach and enrollment activities. The Building Bridges project will continue to work with agencies to maximize access to outreach activities and the maximization of public and private insurances. Enrollment and service levels for eligible clients will also be monitored. In addition, the Children's Action Network is expected to add at least 20 more schools that will implement in-school activities to increase access to services for children.

a. Last Year's Accomplishments

The trend in the elevated number of very low birth weight infants continues despite widespread knowledge of the problem of prematurity and very low birth weight in the state. There is some evidence that the rate of multiple births has increased, especially among white women, a possible factor in the failure to improve. In 2002, all infants born with very low birth weight experienced an infant death rate of 288.6 per 1,000 live births compared with a rate of 2.7 for those infants weighing 2,500 grams or more.

The PPOR data analysis for 2002 Maternal Health/Prematurity indicates there were 486 VLBW fetal and infant deaths for a rate of 3.7. This represents only a decrease of 0.1 from the 3.8 rate in 1993.

Healthy Start projects continue to actively work in five areas to reduce very low birth weight infants. The project in Detroit and the Native American project target women after the sentinel pregnancy to reduce risks and plan for the next pregnancy, factors that are linked to prematurity and low birth weight

The city of Pontiac completed their transportation demonstration project this year. The total transports in 2003 were 1,730. Projects are ongoing in Kent and Genesee Counties to encourage universal assessment of prenatal risk behaviors. Local infant mortality coalitions continue to meet to plan and implement strategies to improve health systems in their jurisdiction.

Ten local projects provided data to the state FIMR program database in FY2003, and a state report was completed for information from 1997 through 2001. The first statewide report was written and produced as part of the Child Death Review Report. The report showed that the cause of death for 49% of the reviewed cases was prematurity/low birth weight. In those cases nearly two-thirds of the women had either a previous voluntary interruption of pregnancy or a spontaneous miscarriage. Infections, including sexually transmitted infections were present in 60% of the women who lost infants to prematurity and 15% of the women had a previous loss of either a live born or stillborn infant. Women with a premature birth smoked during pregnancy (35%), drank alcohol (14%) and 17% used drugs. Other factors related to prematurity are multiple stressors (43% of cases), Medicaid or self-insured (66%), poor nutrition (13%), no social support (28%) and violence (21%).

b. Current Activities

WIC clinics have been screening and referring women to Maternal Support Services as a means to assure early psychosocial support for at-risk pregnant women. The Building Bridges project meet quarterly to discuss access to care issues between Medicaid Managed Care, health departments, and MSS.

The FIMR management team at the department is developing a strategic plan for the program including strategies to obtain fetal death reports locally for review. Access to fetal death reports began in June 2003 with a change to the state Public Health Code. Data collection tools are being revised for FIMR to allow consistent reporting to the state database.

A pilot preconception project is underway in Kent County to assess and manage interconception risks after the loss of an infant.

MDCH has developed priority initiatives aligned to the governor's policy priorities that include reducing infant mortality. One of the focuses of that initiative is improving maternal preconception health. Strategic planning is underway to determine the best practice strategies in this area and how programmatically this objective can be accomplished, namely to consider

how to redesign women's health services to include pregnancy planning and prepregnancy risk reduction.

c. Plan for the Coming Year

The plan for activities to reduce VLBW babies involves exploring new interventions recognizing that current programs are not resolving this issue. The identification of maternal health as the key focus for intervention leads to a need to find effective points of contact for women prior to pregnancy. Measures to expand health care coverage for preconception health assessment and risk reduction intervention need to be found. More information about the pertinent risk factors that predict a fetal death or a VLBW birth needs to be discovered. These efforts will be addressed through the following strategies:

- 1) Evaluate statewide fetal death data to provide more information on risks for early death and very low birth weight.
- 2) Begin reviewing fetal deaths through local FIMR teams.
- 3) Identify mechanisms to improve intendedness of pregnancy.
- 4) Continue to implement the preconception project in Kent County.

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

a. Last Year's Accomplishments

School-linked Services for identified priority schools have been developed in 20 priority schools. School-linked services include linking mental health, public health and child welfare services to targeted schools, located in the metropolitan areas of Michigan. DCH provided information to communities on models of school-linked mental health services. Information on Asset Development was provided at regional and statewide Technical Assistance Meetings for local collaborative body coordinators. Several communities have shared information on their asset development activities and the results of their asset surveys

Mental health services for children/youth who have a serious emotional disturbance and their families are provided by Community Mental Health Services Programs (CMHSPs) across the state of Michigan. Mental health services are provided for those children/youth who are Medicaid eligible, in need of specialty mental health services and who do not qualify for Community Mental Health Services through the Medicaid Health Plans (up to 20 outpatient visits). Children without Medicaid and who have the most severe disorders are served on a fee for service basis by CMHSPs.

Communities have developed Crisis Response Teams to respond to suicides, deaths and various traumas impacting the lives of young people. These teams are comprised of representatives of the schools, mental health, faith-based organizations, and emergency services. The teams have developed protocols and provide support and intervention to young people in schools and in the community. The teams also provide support to parents of young people. The Teams can act to contain people's reaction to suicide and prevent cluster suicides.

School-linked Services for identified priority schools have been developed in 20 priority schools. School-linked services include linking mental health, public health and child welfare services to targeted schools, located in the metropolitan areas of Michigan. In FY05 an additional 20 schools are being targeted for the development of school-linked services. Currently over 25 communities report that a focus of community planning and implementation activities in Positive Youth Development (Assets Approach). The Asset Approach develops protective factors in young people.

b. Current Activities

A grassroots movement in Michigan, the Yellow Ribbon Campaign, continues to work in the schools and communities. The Campaign works with young people 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." In the upper peninsula of Michigan, a regional conference was held on Suicide Prevention (fall, 2003). The conference was well attended and focused on prevention of suicide among youth. Range Suicide Prevention Coalition and local collaborative bodies sponsored the conference. The Michigan Model for Comprehensive School Health Education? is currently being implemented 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. The elementary section of the curriculum is to be revised after a series of focus groups (spring/summer, 2004).

c. Plan for the Coming Year

Share information on models for school-linked mental health services for newly identified priority schools. Provide consultation for communities using Assets Approach in community planning. Assist with the implementation of Mental Health Commission's recommendations regarding Children's Mental Health Services. Support the re-design of the Michigan Model for Comprehensive School Health Education in Michigan and provide review/comment on newly developed lessons.

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

a. Last Year's Accomplishments

Final data for 2003 on this parameter shows no change over 2002. This is greater than the annual performance objective of 85.2% and suggests that the system of referral of high-risk pregnancies and neonates is generally working.

The Wayne State University study of fetal deaths has been collecting data during the past year and presented their research in OBGyn News. There is growing research that suggests a link between pre-existing health problems in mothers and high-risk pregnancy with a specific indication for admission to high-risk facilities.

Local FIMR projects have produced reports on issues surrounding barriers to appropriate delivery and provided community forums for local discussion. Detroit, for instance, determined that the black feto-infant mortality rate for the Maternal Health Period of Risk, 2000-2002, was 12.0 per 1000 live births and represented 6.6 excess deaths per 1000 live births using birth cohort data.

b. Current Activities

There is growing interest in whether the Regional Perinatal System should be reinstated, however there is no solid evidence currently that the rate of mothers delivering at inappropriate facilities is growing.

c. Plan for the Coming Year

The emphasis for this performance measure will be on collecting data on the systems of care involved in access to neonatal intensive care across the state. The strategies are:

- 1) Receive a provisional report on the Wayne State University study of fetal death.
- 2) Implement the review of the statewide perinatal system
- 3) Analyze current data from across the FIMR projects on place of delivery and relationship to infant death.

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

a. Last Year's Accomplishments

The final data on this indicator for 2003 is 84.2% of mothers received early prenatal care. This is a modest improvement over 2002, but still does not meet the performance objective of 85.9%.

The development of a data collection system for assessment of client needs and services provided by the Maternal Support Services program and the Infant Support Services program is underway with an intra-departmental work group setting the agenda for systems change.

A Building Bridges forum held in 2003 was designed to address collaborative outreach at a broad systems level and to present successful real world models for improving access to care. There were a total of 84 attendees with 16 health plans and 19 health departments represented. The fiscal challenge includes increasing Medicaid caseload and revenue while the state's revenue is significantly declining. For instance, in fiscal year 2000 the state spent 19% of its general fund on Medicaid, whereas in fiscal year 2003 it spent 24%. Several counties have documented a significantly increased referral rate from WIC to MSS/ISS with the process.

b. Current Activities

The collaborative approaches of the Building Bridges initiative are being continued through a meeting of partners in health departments, health plans, and state-level Medicaid policy makers in June 2004. The focus is still on identification of new pregnancies through WIC referral.

The MSS program policy makers are continuing the collaborative planning for program change that will assure earlier client identification. Cultural competence is an important consideration for readiness of women to seek early prenatal care determined from Healthy Start data.

Four new Nurse Family Partnership projects were begun in 2003 located in urban communities with the highest infant mortality rates. These projects hope to duplicate the lessons learned in Berrien County where early prenatal care was an expectation of admission to the program. Part of the competitive application for selection of the projects was an extensive needs assessment, which shed some light on access to care issues and cultural competency issues that will be addressed by these projects with first time mothers.

c. Plan for the Coming Year

The plan for improvement in this measure involves attention to data collection on new projects and continued learning from redesigning current programs to meet current needs. The strategies include:

- 1) Evaluate the first year of the new NFP projects for time of entry into care.

- 2) Pilot the MSS/ISS program redesign.
- 3) Assure continuity of care for Medicaid beneficiaries through specific policy change.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Purchase and distribution of formula for individuals without cost	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Maintain 3 contracts held with medical mgmt centers for metabolic, endocrine and hemoglobinopathies	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Complete the data system linking newborn screening records with birth certificates	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Assure transportation through medical mgmt centers, as needed, to access follow up services.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Identify unscreened infants through linkage of Newborn Screening specimens and birth records	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Develop child health data integration allowing provider access to Newborn Screening results via Internet Imm. Registry	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) 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)				
1. Review CAHPS results to assess issues, needs, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Develop, distribute, and analyze results of family satisfaction survey targeted to this issue.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Incorporate requirement to address families as partners in decision making into Medical Home Model.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Administer another CAHPS.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Identify a CSHCS Division staff member to lead or monitor the progress of achieving this measure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) 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)				
1. Develop new & comprehensive Medical Home Model in collaboration with Public Health entities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work closely with some practices to incorporate new or revised model.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Finalize consensus definition in collaboration with the MI Chapter of the AAP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Identify a CSHCS Division staff member to lead or monitor the progress of achieving the measure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) 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)				
1. Continue to monitor.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Identify ways to increase outreach to families who may need assistance paying insurance premiums.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Enlist local health depts. to be more proactive assisting families with application process who might be eligible	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Identify a CSHCS Division staff member to take the lead on or monitor the progress of achieving this measure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) 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)				
1. Continue to establish closer relations with the Local Health Departments than has occurred in the past.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Establish workgroup to study funding structures to recommend improvement from current structure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Enlist the CSHCS Advisory Committee to monitor & recommend program revisions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Identify a CSHCS staff member to lead or monitor the progress of achieving this measure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. ID aging-out of CSHCS with outdated hemophilia codes to determine if recode for adult coverage.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Local Health Departments work with aging-out pop. with MA to assist with MA managed care rules.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. New Transition Analyst to begin assessing current circumstances and needs of LHDs to help families.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Identify a CSHCS Division staff member to lead or monitor the progress of achieving this measure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) 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.				
1. Promote and make available MCIR to every immunization provider in Michigan free of charge	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Make MCIR available to all childcare centers and schools within the state	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Promote AFIX for vaccination rates obtained at provider sites	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Promote immunization education for current immunization recommendations and standards of practice	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Monitor the number of provider users enrolled in the MCIR	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Assess and track completion rates for children in MCIR	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Monitor the number of AFIX assessments to private and public providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Monitor change in immunization rates for providers who have repeat AFIX assessments	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Integrate MCIR and SIRS software to streamline to reporting process.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Assure Family Planning Program services as needed to Michigan residents	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assure Family Planning Program services for the target low income population	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assure that at least 30% of users in Family Planning program are teens	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assure Family Planning Program clinics are held at times convenient for teens	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Maintain compliance with Michigan PA 360 without reducing access to service or compliance with FP Guidelines	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Increase number served in Family Planning Services through the Medicaid Adult Benefit Waiver	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue to provide Michigan Teen Outreach Program Services in 4 Michigan communities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Continue to provide comprehensive health services to adolescents through School Based/Linked Health Centers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Final year of bonus funding for four Teen Pregnancy Prevention Projects in four Michigan communities.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Continue to provide abstinence education activities through MAP.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Assure funding of services through public dental Health clinics for the uninsured population	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Assure Medicaid Healthy Dental coverage through Delta Dental	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assure dental coverage for MI Child recipients	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Coordinate school-based Weekly Flouride Mouth Rinse Program in non-flouridated communities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Continue campaign to increase public awareness of need for booster seat use	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Implement actions recommended through the passenger safety strategic planning process	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Assure education to health care providers including hospitals, family physicians & pediatricians	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Conduct 3 additional NHTSA child Passenger Safety Technical Certification Course in FY 03	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Develop plan to increase use of child restraint systems with an emphasis on booster seats among low use groups.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Provide the Mother-to-Mother Breastfeeding Initiative	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide Breastfeeding Basics Training Program	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Assure Pharmacist consultation for drug/medicine/breastfeeding questions	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Provide WIC Breastpump Program	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Assure Breastfeeding Coordinator training	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Provide consultation for Loving Support Grant in Bay County	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Promote Breastfeeding Awareness month in August 2004	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

8. Continue development of Breastfeeding Module for use by WIC moms as part of Nutrition Education on the Internet project.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Implement new database allowing greater flexibility for reports	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Continue to provide consultations to hospitals on progress and protocols	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Survey hospitals for feedback on protocols and parents to assess barriers to the system of screening	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Provide and monitor for use linguistically appropriate and culturally sensitive brochures/materials	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Assure infants not born in birthing hospitals will receive a hearing screening	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Develop a system to reduce/eliminate financial barriers to rescreening and follow-up	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7. Assure results of hearing screening are provided to all parents and infants' primary care providers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Reprint resource guide with updated referral information	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Reprint guidelines and distribute to all Michigan hospitals	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Collaborate with WIC program to increase follow-up rates	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Continue mechanisms to streamline enrollment into MIChild and Healthy Kids (Medicaid)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Encourage local integration of outreach and enrollment activities via work with other state agencies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Utilize Building Bridges Project to maximize enrollment and use of insurance programs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to monitor enrollment levels in insurance programs	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5. Support development of clinics in failing schools identified by Gov. Granholm and FIA as enrollment sites.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Continue mechanisms to streamline enrollment into MIChild and Healthy Kids (Medicaid)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Encourage local integration of outreach and enrollment activities via work with other state agencies	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Utilize Building Bridges Project to maximize enrollment and use of insurance programs	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Encourage local health departments assistance to clients in use of health insurance with all service	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Monitor evidence regarding use of Medicaid service by eligible clients	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
6. Support development of clinics in failing schools identified by Gov. Granholm and FIA as enrollment sites.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Evaluate statewide fetal death data to provide more information on risks for early death and very low birth weight.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Begin reviewing fetal deaths through local FIMR teams.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Identify mechanisms to improve intendedness of pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Continue to implement the preconception project in Kent County.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. Share information on models for school-linked mental health services for newly identified priority schools.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Provide consultation for communities using Assets Approach in community planning.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Assist with the implementation of Mental Health Commission's recommendations regarding Children's Mental Health Services.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

4. Support the redign of the Michigan Model for Comprehensive School Health Education in Michigan and provide review/comment on newly developed lessons.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Receive a provisional report on the Wayne State University study of fetal deaths.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Implement the review of the statewide perinatal system.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Analyze current data from across the FIMR projects on place of delivery and relationship to infant death.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Evaluate the first year of the new NFP projects for time of entry into care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Pilot the MSS/ISS program redesign.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assure continuity of care for Medicaid beneficiaries through specific policy change.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Infant mortality rate of live births*

a. Last Year's Accomplishments

The preliminary data for 2003 shows an overall IMR of 8.5 with 6.6 for white infants and 17.5 for black infants. The gap is narrowed by the decrease in IMR for black infants and increase for white infants.

The greatest predictor of infant death is the birth of a baby that weighs 1499 grams or less (295 per 1000 live births). Being black is the second greatest predictor of infant death of all the variables studied at this time.

Phase 1 analysis of Perinatal Periods of Risk for 2002 data found the following:

-Maternal Health/Prematurity 486 (3.7 IMR)

-Maternal Care 177 (1.4 IMR)

-Newborn Care 173 (1.3 IMR)

-Infant Health 253 (2.0 IMR)

Overall IMR = 8.4

Comparison with a state-defined reference group revealed an overall excess number of infant deaths of 388 (3.0 IMR)

Of particular concern was 2002 data showing white women with no prenatal care stood at 6.9% and black women at 27.2%. White women with inadequate prenatal care was 5.5% and black women was 14.0%.

In looking at HEDIS performance measures to evaluate 15 components, including Access to Care, for the 18 health plans providing managed care services to Michigan Medicaid enrollees, results showed poor performance with rates falling below the national 2002 50th percentile. Recommendations were made that all health plans provide an analysis of barriers to care.

Thirteen FIMR teams reviewed cases in their local communities. Technical assistance and training is provided. These local teams have identified local support and funding for their work.

A goal of a statewide Infant Mortality Summit held in 2001 was to inform and encourage local strategic planning. Distribution of updated MCH profiles for each county in Michigan and training in maternal child health assessment and program evaluation was provided for local MCH leadership staff.

SIDS is the leading cause of death for infants in the post-neonatal period. SIDS rates have declined by almost 60% since the recommendation regarding placing infants to sleep on their backs was made. There was no significant decline in black SIDS rates until 1999. Black rates continue to be more than twice the white rate. Bereavement support is offered in one-on-one counseling visits through local health departments.

A commitment was made in FY 2003 to initiate the Nurse Family Partnership program in communities with high black infant mortality. This model of service delivery is not directly aimed at reducing infant mortality but includes several risk reduction measures that will improve birth outcomes for families.

b. Current Activities

Five projects were selected to implement the Nurse Family Partnership program in their local

health department. Providers were hired and several trainings have been done through the Colorado program headquarters. Each project is designed to impact the local black community through the cultural competence of the service providers, the case identification and the strategies to influence improvement in the life expectations of the young mothers involved.

The first program report of FIMR findings was written and included in the Child Death Review annual report. This venue helps to inform the systems that review child death as well as FIMR team members. Currently the data collection forms are being revised to assure the breadth of information needed to inform communities about risk factors is included. An expanded database is being developed to facilitate a more complex and meaningful report of findings from FIMR review. FIMR teams are being encouraged to analyze their findings and then initiate community projects designed to eliminate risk factors for low birth weight and prematurity.

The SIDS/OID program has recognized the decline in SIDS deaths but has not seen a significant reduction in postneonatal deaths, suggesting that a shift in diagnosis for sudden infant deaths has occurred. Tomorrow's Child (Michigan SIDS) is implementing a systems approach to defining the knowledge about safe sleep considerations for infants in Detroit through a foundation grant. The approach involves training of hospital educators and postpartum staff. An interagency committee has been formed at MDCH to compile a joint position statement on safe sleep.

The SIDS/OID program is also implementing a new strategy to offer grief counseling in group sessions in several urban areas. The sessions are facilitated by social workers or psychologists employed by local funeral service providers and evaluated by patient satisfaction surveys.

Collaboration with the 5 Healthy Start projects (Intertribal Council, Detroit, Kalamazoo, Genesee County, and Saginaw County) has continued. Evaluation data is gathered on infant mortality, neonatal mortality, post-neonatal mortality, perinatal mortality, and LBW, as well as core services. These local projects have focused risk reduction activities on safe infant sleep, no smoking or alcohol use during pregnancy, and planning the next pregnancy. Project strategies and coalition activity have found successes in core service areas but also describe barriers, especially due to community resource funding constraints. Projects provide input at the state level and are included in infant mortality planning.

c. Plan for the Coming Year

The plan for reducing overall infant mortality includes attention to current programs, particularly to understanding where current programs are failing to influence the rate of infant mortality. Specific strategies include:

1. Work in concert with the Michigan Surgeon General as part of Healthy Michigan 2010 Planning on infant mortality reduction.
2. Receive preliminary data from Nurse Family Partnership.
3. Begin using the new data collection tools for FIMR and compile statewide data for a FY2005 FIMR Report.
4. Analyze the FIMR data by site to identify specific risk factors or problems that have to be addressed.
5. Continue to use Perinatal Periods of Risk approach to further explore the risks associated with IMR, especially for those with birthweight less than 1500 grams.
6. Complete a position statement and educational message on Safe Sleep for Infants and distribute statewide.
7. Evaluate the response to group grief counseling sessions.
8. Continue to work with Healthy Start sites and offer assistance in data evaluation.

State Performance Measure 2: *Maternal mortality ratio in black women*

a. Last Year's Accomplishments

Six maternal deaths to blacks were reported by vital statistics based on ICD 10 "O" Codes from death certificates.

A new case ascertainment method was created through a collaborative effort between MCH epidemiology within the Bureau of Epidemiology and the Vital Records and Health Data Development Section. Death certificates of women of reproductive age (10 to 45 years) were linked to live births certificates. The cases in which pregnancy ended in fetal deaths were identified from hospital reports to MDCH and added to the linked file. The pregnancy-related deaths not previously identified, such as deaths due to ectopic or molar pregnancies, were identified using ICD10 "O" codes from death certificates and added also.

Thus, the maternal mortality file created comprises all maternal deaths that occurred from 1999 to 2002, irrespective of time from delivery, pregnancy outcomes or cause of deaths. Further, the methodology by which the file was created offers the opportunity for more timely identification of deaths and subsequent tracking of those deaths.

Surveillance and analysis of pregnancy-related maternal deaths continued as planned. The Medical Committee conducted case reviews, thus making information from findings available to schools of medicine and other places where medical information sharing occurs. Membership in the Medical Review Committee includes obstetricians/gynecologists, fetal medicine specialists, nurse midwives, anesthesiologists, and a nurse educator.

Although Michigan's reported MMR mirrors that of the United States (US), Michigan's Black/White MMR ratio is the largest in the nation. As a consequence, additional effort is being directed toward comprehensive case reviews of pregnancy-associated deaths. An Injury Committee whose membership includes representatives from law enforcement, highway safety, courts, community based agencies, local health departments, nurse midwifery, medical trauma care, social work education and injury prevention has been reactivated and retrieval of case information resumed.

If maternal mortality is to be reduced, maternal morbidity must be evaluated. To estimate the burden of maternal co-morbid conditions and the racial distribution of these conditions among Michigan mothers, a morbidity file by linking the Michigan in-patient database (MIDB) and the resident birth file was created. This file named Maternal Morbidity Data Base (MMDB) is a claim-based file, which includes more than one million records (from 1995 to 2001), the majority of Michigan's hospital inpatient discharges, and identifies reporting hospitals. This longitudinal file presents a unique opportunity to evaluate a single woman before, during, and after her pregnancy. This pregnancy file will be updated on a regular basis. A preliminary analysis showed the largest black/white gap in diagnosis of fibroids, hypertension, obesity, asthma, and diabetes mellitus.

b. Current Activities

Identification of maternal deaths through reporting continues and the review of pregnancy-related and non-pregnancy-related deaths is occurring. Maternal Mortality Review is interested to expand reviews and use new case ascertainment methods. Refinement of review processes including the forms and data collection system, particularly for pregnancy-associated, non-medical deaths and the initial identification of recommendations also comprise current activity.

Meanwhile, analyses on the prevalence of different health conditions (pregnancy and nonpregnancy related) that Michigan's mothers experienced as well as their association with pregnancy outcomes are being conducted as part of the maternal morbidity study.

c. Plan for the Coming Year

Continue to conduct the pregnancy-related as well as the non pregnancy-related reviews. The Injury Committee will be looking particularly for civic and health care system failures that contribute to deaths. The Medical Committee will expand the reviews to pre-existing health conditions as the leading causes of death that have an influence on pregnancy outcomes.

These two Committees are expected to work together and thus generate final prevention recommendations. Michigan has an urgent need to share analyses of how maternal deaths are occurring with schools of medicine, nursing, and social work, with the courts and law enforcement agencies, and with community agencies.

By working closely with them and identifying changes for improvements in resources or procedures used, there are promises of reducing maternal deaths

State Performance Measure 3: *Percent of low birth weight births among live births*

a. Last Year's Accomplishments

Preliminary data from 2003 shows a total LBW rate of 8.2% with a white rate of 6.9% and black rate of 14.2%.

The awareness of the damage caused by prenatal alcohol exposure, including growth retardation, is being raised through encouragement to include this education as part of Maternal Support Services. The FAS Outreach and Education projects at 12 sites across the state have provided over 1000 presentations and generally take responsibility for raising awareness for constituents of their area.

Preconception counseling is also recommended for MSS/ISS clients. Screening to identify risks and providing education to address maternal disease, use of medication, immunizations status, genetic factors, chemical exposure, nutritional status, tobacco, alcohol and illicit drugs, and exposure to violence and sexually transmitted diseases, including HIV are components of preconception health promotion. Low birth weight is often related to risks that need to be reduced before pregnancy begins to be effective.

Although gradually declining overall, smoking rates for pregnant women in Michigan have remained continuously higher than rates nationally. Data from prenatal care programs where staff have been trained in the "Smoke Free for Baby and Me" program show about 7000 smoking women received these program interventions in the most recent years for which full reporting data is available (2000-2001). Training and production of reports continue.

b. Current Activities

MDCH identified 8 local communities with high infant mortality rates and low birth weight statistics and invited each to present a proposal for implementation of a Nurse Family Partnership project during 2003. Seven communities responded and five were chosen to receive funding. Each community hired staff, attended training and is participating in planned implementation. This activity represents a response to the lack of success of current programs to improve pregnancy outcomes, and a change in direction to utilize a tested and effective program.

MDCH received CDC funding for Fetal Alcohol Syndrome prevention in Detroit in Fall 2003. One part of the grant is the testing of a strategy for determining the incidence of FAS in the city and Wayne County. More accurate information will inform the department of the part prenatal alcohol exposure plays in the prevalence of low birth weight. A new FAS diagnostic clinic has been developed at Children's Hospital of Michigan in Detroit. Information from that site will help to understand the dynamics of children born with prenatal alcohol exposure. The grant also offers two strategies for helping women to reduce or eliminate alcohol use during pregnancy. At this time, some staff has been hired, protocols have been approved, training is underway and the clinic has seen its first clients.

A pilot Preconception Project was begun this year to identify women at high risk for low birth weight and other indicators for infant death. The project has had many barriers to implementation, but has promise for a unique opportunity to influence women to attain optimal health before beginning another pregnancy.

c. Plan for the Coming Year

Though the incidence of low birth weight shows no sign of declining the department is optimistic that new programs started this year will make some progress. The strategies for next year involve evaluation of these efforts with the objective of informing program and policy developers about what works. The strategies include:

- 1) Evaluate the process of implementation of the NFP projects in 5 communities and begin accumulating data for determining the impact on such indicators as low birth weight births.
- 2) Collect information from NFP local staff about lifestyle indicators that may be precursors or predictors of low birth weight births.
- 3) Monitor the progress of the FAS Prevention Project in Detroit and make any needed modifications to reach the most at-risk families in the city.
- 4) Modify the implementation strategy for the Preconception Project to improve the likelihood of beginning the enrollment of clients in 2005.

State Performance Measure 4: *Percent of preterm births (<37 weeks gestation) among live births*

a. Last Year's Accomplishments

2003 preliminary data shows the percent of preterm births was 11.2%. Racial breakout data for preterm births is not yet available.

Efforts to prolong pregnancies past 37 weeks have been largely unsuccessful, as is evident by a parallel increase in both LBW and preterm births over the last decade. Factors that contribute to increasing rates of preterm births are: increasing rates of multiple births, increasing rates of births to women >35 years of age, induced deliveries, management of maternal and fetal health conditions, scheduled deliveries, and patient preference, intensive prenatal care utilization, substance abuse, and symptomatic bacterial and viral infection.

FIMR projects continued to analyze issues related to premature births, and found that 46% of mothers with a premature infant that died had a previous termination of pregnancy or spontaneous abortion; 16% had a previous infant or fetal loss; and 57% had an infection. The information on substance use and prematurity was also significant, 35% smoked during pregnancy, 14% drank alcohol and 17% used drugs. This subset of women also experienced significant stressors during their pregnancies: 43% indicated multiple stressors, 66% were using Medicaid for health care, 13% had poor nutrition, 28% had no social support and 21%

experienced violence in the home.

Healthy Start projects continued to emphasize prevention strategies to reduce preterm delivery. Each project aimed to identify pregnancy early to improve the mother's information about signs of premature labor, to increase the treatment of infections, to reduce the use of substances, improve nutrition and intervene to improve the social support network of at-risk families.

A small database was kept of death scene investigations of infant deaths to babies born prematurely in 2003. This information revealed that most of the home situations in this sample had substance abuse involved. Many of the infants died due to birth defects such as heart disease or gastroschisis, but it appeared that poor education or poor home situations were important to the infant's demise. Often the cause of death, or the history revealed a respiratory infection or pneumonia that was untreated, poorly managed, or questionable follow-up was given.

b. Current Activities

The SIDS/OID program helped sponsor a professional training this year entitled A Broader View: Maternal Health, Lessons for Prevention, Revisiting Grief Services that focused on preconception health as a means to prevent prematurity. The audience was nurses, social workers, and other health professionals who work with families who have lost an infant.

A preconception health project was begun this year, as outlined above, but has not had great success in implementation. However, there is considerable interest in incorporating preconception risk assessment and intervention in redesigning MSS/ISS services. There is a greater likelihood of dealing with this as a secondary prevention strategy for women who have been identified during pregnancy, but will be followed during an interconception period to address risks and prolong the pregnancy interval.

The Birth Defects Registry steering committee meets quarterly to continue the implementation of a state plan for birth defects prevention. It now works closely with the Michigan chapter of March of Dimes to facilitate their prematurity prevention campaign, collaborates with genetic counselors across the state and presents prevention information on a program website, in articles and publications, and at conferences.

c. Plan for the Coming Year

Current efforts will continue related to preconception, and birth defects prevention. The strategies to be addressed are:

1. Overcome the barriers to implementation of the pilot preconception project.
2. Analyze statewide FIMR data to inform programs about maternal and family characteristics associated with premature births.
3. Determine the role of multiple births in the overall trend of prematurity.
4. Assess the success of the Healthy Start projects in reducing premature births.

State Performance Measure 5: *Percent of live births resulting from unintended pregnancies*

a. Last Year's Accomplishments

Most recent available PRAMS data (2001) indicates 40.5% of pregnancies in Michigan are unintended.

The Teen Pregnancy Prevention Project (TP3), funded with Temporary Assistance for Needy Families (TANF) bonus award funding, provided a third year of bonus funding to four communities selected through performance reviews and reductions in births within the targeted population. The four communities were: Flint (Genesee County), Benton Harbor (Berrien County), Muskegon (Muskegon County, and Jackson (Jackson County).

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 are beginning to highlight the responsibility of the male. Sterilization service has been expanded to focus on male clients as well. Michigan currently has one agency providing sterilization service statewide. This agency provided 1,482 sterilizations during CY 2003.

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 30% of the caseload; this objective was met last year. In 2003, 53,279 male and female teens were served in Family Planning Clinics.

The Family Planning Program also provided support to the Michigan Abstinence Program (MAP), so that preteens, teens and parents can be educated about abstinence. The MAP program aims to positively impact adolescent health problems by promoting abstinence from sexual activity and related risky behaviors such as alcohol, tobacco, and other drugs. During FY 03, there were 12 funded community agencies. The target population of MAP is 9-17 year-old youth (up to 21 years of age for special education populations) and their parents. During FY 03, MAP programs across Michigan served 17,252 youth through 156,514 encounters. Of these youth, 8775 received intense intervention (14 hours of more). In addition, 558 parents received information and education regarding how to talk with their children about sexuality and the benefits of abstinence.

School-based/linked health centers continue to be included in strategies to reduce unintended pregnancies. Michigan currently funds 31 school based/linked teen health centers to provide primary health care, psycho-social service, health promotion/disease prevention education, and referral services to youth 10-21 years of age. The Michigan Department of Community Health (MDCH) and the Michigan Department of Education are currently pursuing federal matching Medicaid dollars for FY05. MDCH received approval from the Center for Medicare and Medicaid Services (CMS) in March 2004 to match the 3.74 million in Teen Health Center funding. Implementation details for this outreach match are now being developed.

b. Current Activities

In 2003, 172,007 women and 4,187 men were served in Family Planning Clinics. Although this represents a reduction of 4.3% in women served and 23.2% in men served, a result of state budget and funding constraints, a process of dialogue led by MDCH with providers to look at the allocation process and opportunities to maximize revenue is occurring.

Michigan Department of Community Health(MDCH)is preparing to submit a Section 1115 Family Planning Waiver to the Centers for Medicare and Medicaid Services (CMS)by July 2004. Approval of this waiver will provide Family Planning services coverage to women of childbearing age who are not on Medicaid and whose family income falls at or below 185% of federal poverty guidelines.

The Michigan Abstinence Partnership (MAP) projects and school-based/linked health centers continue in the current year as described in the Past Accomplishments section earlier .

Michigan also received in FY 2001 a SPRANS Abstinence Education Grant to implement the four research based Teen Outreach Program (TOP) without the comprehensive sex education component. Four communities are currently receiving the final grant year of these funds: Arab-American and Chaldean Council (Detroit), Kent County, Muskegon County and Shiawassee. MDCH has applied for additional SPRANS funding to continue the Michigan Teen Outreach Program.

c. Plan for the Coming Year

Maximize use of Family Planning Program funds to serve as many individuals as possible in these programs, especially for low-income population. Continue to monitor for 30% teen users of services. Assure that Family Planning clinics are held at times are convenient for teens. Assure implementation of Michigan PA 360 in such as way as to assure continuous and accessible Family Planning Program services meeting program guidelines. Increase the number of individuals served through the adult benefit waiver.

Continue current MAP projects through FY 07.

If awarded funding for MTOP, utilize a competitive Request for Proposal (RFP) process to select seven Michigan communities to implement local projects for the 2005-2008 funding cycle.

Through increased funding obtained through federal Medicaid matching dollars, use additional centers as funded through the School Based/Linked Health Center program with a goal of providing primary medical services to an increased number of at-risk children.

Maintain the statewide Maternal Support Services program and four funded sites for the new initiative, the Nurse Family Partnership including components to provide reproductive health information and assist women served to make choices about birth control methods.

State Performance Measure 6: *Percent of repeat live births to unwed mothers 15-19 years of age*

a. Last Year's Accomplishments

Progress in the reduction in the percent of repeat live births to unwed mothers 15-19 years of age has been uneven.

Program efforts described in NPM 8 and SPM 5 to reduce the rate of births(per 1000)for teenagers aged 15 through 17 years and to reduce unintended pregnancies are also viewed as directed to this performance measure.

The Teen Pregnancy Prevention Project (TP3), funded with Temporary Assistance for Needy Families (TANF) bonus award funding, provided a third year of bonus funding to four communities selected through performance reviews and reductions in births within the targeted population. The four communities were: Flint (Genesee County), Benton Harbor (Berrien County), Muskegon (Muskegon County), and Jackson (Jackson County).

All prenatal programs funded by MDCH have a service component that connects women postnatally to family planning services, either the Title X program or the medical provider. Prevention of unintended pregnancy is the responsibility of both partners. Many programs are beginning to highlight the responsibility of both partners. Sterilization service has been expanded to focus on male clients as well. One agency providing service statewide is funded and provided 1,482 sterilizations during DY 2003.

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 30% of the caseload; this objective was met last year. In 2003, 53,279 male and female teens were served in the Family Planning Clinics.

A very important strategy to aid this effort is the submission of a Section 1115 Family Planning Waiver to the Centers for Medicare and Medicaid Services (CMS)currently being prepared by MDCH. Approval of this waiver will provide Family Planning services coverage to women of childbearing age who are not on Medicaid and whose family income falls at or below 185% of federal poverty guidelines.

Constraints in Family Planning funding threaten program efforts important to meet needs in this area. Collaborative work with Family Planning providers has been utilized to help assure the availability of Family Planning services to Michigan residents in need.

b. Current Activities

The Michigan Abstinence Project (MAP) and school-based/linked health centers continue in the current year.

Michigan also received in FY 2001 a SPRANS Abstinence Education Grant to implement the research based Teen Outreach Program (TOP) without the comprehensive sex education component. Four communities are currently receiving the final grant year of these funds: Arab-American and Chaldean Council (Detroit), Kent County, Muskegon County, and Shiawasee County. MDCH has applied for additional SPRANS funding to continue the Michigan Teen Outreach Program.

Connecting women served in prenatal programs to family planning services, either Title X or the medical provider.

Opportunity to increase access to family planning services is being sought through a waiver application. MDCH has included family planning as part of an adult benefit waiver which is being submitted to the Centers for Medicare and Medicaid Services (CMS) to extend eligibility for Medicaid family planning services to women of childbearing age who are not currently on Medicaid and whose family incomes fall below 185% of the poverty guidelines.

An additional opportunity to provide more accessible Family Planning services is occurring in southeast Michigan is due to Wayne County Health Department's reapplication to provide

Family Planning services for adolescents and adults. This application is currently under review. Services are currently available through the Teen Health Center.

c. Plan for the Coming Year

Strategies described under NPM 8 and SPM 5 are also directed to reduce repeat live births to unwed mothers 15-19 years of age. The statewide Maternal Support Services program and four funded sites for the new initiative, the Nurse Family Partnership include components to provide reproductive health information and assist women served to make choices about birth control methods.

Maintain the availability of Family Planning services.

If awarded funding for MTOP, utilize a competitive Request for Proposals (RFP) process to select seven Michigan communities to implement local projects for the 2005-2008 funding cycle.

Through increased funding obtained through federal Medicaid matching dollars, additional centers will be funded through the School Based/Linked Health Center program with a goal of providing primary medical services to an increased number of at-risk children.

State Performance Measure 7: *Percent of CSHCS beneficiaries enrolled in a managed care Special Health Plan*

a. Last Year's Accomplishments

This performance measure was new for FY 2001. Enrollment in a CSHCS SHP continues to be voluntary, and therefore enrollment increases incrementally as families gain experience and share those experiences with each other. Enrollment in the counties that have had the SHP option the longest demonstrate the highest percentages of enrollment, supporting the need for time, experience and dialogue among families for the idea of managed care for children with special needs to become a more comfortable option for families to try. The percentage of enrollment into SHPs in counties with active SHPs the longest range between 40% and 60%. It is expected that enrollment will continue to increase in the newer counties as time passes and more families experience and share their positive experiences.//2004/ Statewide expansion of the SHPs has not occurred and the original expectation that statewide coverage is possible is under discussion.//2004//

//2005/The number of SHP enrollees increased in FY '03. One of the SHPs changed its administration from one organization to another. New enrollment was placed on hold until that change could be completed.//2005//

b. Current Activities

In response to the comments received from the MCHB regarding last year's report and expectations being "optimistic" in this area, and because we agree there should be a more realistic target of SHP enrollment, we are changing the target to 28% of the SHP eligible population for the 2002 reporting year. Previous reporting has been based on the percentage of SHP enrollees relative to the entire CSHCS population. Reporting is more meaningful when reported relative to the number of persons who are able to enroll in a SHP (only persons living in a county with an active SHP have the opportunity to enroll in a SHP. Persons living in a non-active SHP county are not allowed to enroll in a SHP. There are also some people who are excluded from SHP enrollment [e.g., people who are incarcerated] and therefore should not be counted as "not in a SHP" since they don't have the opportunity). The department is re-

opening the SHP that was under an enrollment hold for a year to new enrollments in their current counties of operation, effective July 1, 2003. We plan to activate six additional counties for SHP operations this year based upon prior agreements, with no further geographic expansion expected until the qualitative evaluation has been completed.

Also in response to the comments received from the MCHB regarding the need for more quality information regarding the services received through a SHP, and our own need for more specific data regarding the "value added" of the SHPs, Michigan has begun to focus current activities related to the SHPs on the quality aspects more so than just increasing the number of enrollees. The Actuarial Division of MDCH has started an analysis of existing encounter data, cost data, enrollment trends by population, and other data as identified by the SHPs and others to begin to assess the impact of SHP enrollment on beneficiaries in comparison to the Fee-For-Service (FFS) population. A work group is being developed including SHP staff to design an evaluation methodology.

/2005/Recently Michigan made the decision to terminate the SHP contracts as of October 1, 2004, due to limited resources that could not provide for the administration of both the FFS system and the SHP system. Michigan is completing the contract termination and transition of SHP enrollees back to the FFS system./2005//

c. Plan for the Coming Year

/2004/Significant discussions are occurring within the department regarding lessons learned from the current SHP model, possible revisions needed which may include re-thinking original assumptions and expectations, and exploring options available under a very constrained budget time period. We will discuss more realistic expectations for the remainder of the reporting period after we have had these internal discussions. A determination has been made of no further geographic expansion for SHP operation beyond those counties already approved until it has been determined what added value the SHPs provide to beneficiaries.***/2005/ There is no plan for the coming year regarding this performance measure as the SHP contracts will have been terminated by the beginning of the new fiscal year(10-1-04)./2005//***

State Performance Measure 8: *Percent of CSHCS beneficiaries who received dental services reimbursed by CSHCS*

a. Last Year's Accomplishments

This measure was new for FY 2001.

/2004/ / In response to the comments received from the MCHB regarding last year's report and expectations being "optimistic" in this area, and because we agree there should be a more realistic target of CSHCS beneficiaries receiving dental services reimbursed by CSHCS, we are changing the target to 15%. Even though the percentage of CSHCS enrollees receiving dental services increased slightly, we were unable to meet the original target. The results for 2002 are skewed by an inflated number of enrollees that included people on CSHCS who were no longer eligible for coverage due to CSHCS automatically renewing people into the program while developing a new renewal process to ensure no one who was still eligible would accidentally lose program coverage. We consider the 2002 results a success in increasing the number of beneficiaries who received dental services in that the total number of beneficiaries who received these services increased by approximately 500 people.***/2004// /2005/ Michigan experienced a small increase in the results for '03. No new activities were implemented therefore it is believed that the activities implemented initially are still impacting this population regarding dental care./2005//***

b. Current Activities

Current Activities:

/2004/CSHCS has completed the implementation and use of the new renewal system, which has resulted in ending the coverage of persons who are no longer eligible for CSHCS coverage. Also, in response to the comments received from the MCHB regarding last year's report being "optimistic" in this area, and because we agree there should be a more realistic target regarding dental services as covered by CSHCS for this population, we are changing the target to 15% of the population for the 2002 reporting year. //2004// **/2005/ Due to significant changes in focus and energies in Michigan, there are no new activities underway to impact this performance measure. //2005//**

c. Plan for the Coming Year

Plan for the Coming Year:

/2004/The numbers of persons covered by CSHCS will be lower next reporting year than indicated for this year, and will better reflect the persons who are eligible for coverage. The target for the next reporting year (2003) should remain at 15%. //2004// **/2005/ Michigan is in discussion regarding the current state deficit and potential changes to the CSHCS program which is interfering with making plans regarding this performance measure for next year. Michigan does not expect to implement any changes that will further impact this measure due to conflicting priorities. //2005//**

State Performance Measure 9: *Percent of Medicaid enrolled children 0-6 years of age who receive lead testing*

a. Last Year's Accomplishments

The last calendar year ended with another modest (additional 7414) increase in the numbers of children tested for elevated blood lead levels. At the same time, the percentage of children determined to have lead poisoning decreased (from 4.4% to 3.2%).

A local lead contact at the county health department and a Regional Coordinator to provide oversight for the case management that takes place for children with blood lead levels =>20ug/dL was put into place, as well.

Work continued on geocoding; the priority was to map the eleven targeted communities (City of Detroit, Battle Creek, Kalamazoo, Grand Rapids, Muskegon, Jackson, Pontiac, Flint, Saginaw, Highland Park, Hamtramck) so that Regional Coordinators and the county health department can provide targeted outreach in the geographic portions of the state with the largest numbers of children with Elevated Blood Lead Level. The goal: enhanced (direct) outreach for testing and for primary prevention activities for pregnant women and children younger than age six in each of the targeted communities.

Major program enhancements accomplished:

- 1.) Medical Services Administration ("Medicaid") in Michigan changed their policy re: reimbursement for testing (collection of specimens) so that county health departments can bill Medicaid directly for specimen collection. The revised policy strengthens "no missed opportunities" for testing.
- 2.) Collaboration with MCIR (Michigan Childhood Immunization Registry), so that providers will receive a "pop-up" reminder when a child's immunization status is reviewed that an individual child is/is not at high risk for lead poisoning, and is one of the age group of children for whom testing is required and/or strongly recommended.

STATE PERFORMANCE MEASURE	DHC	ES	PBS	IB
2) Maternal mortality ratio in black women				
1. Assure presentation of data analysis and case review findings, recommendations, and an action plan at least annually.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2. Assure case reviews by both Medical and Injury Committees, refining processes used in conducting the reviews.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3. Assure reviews consider preexisting medical conditions, of accessibility and acceptability of health care, patient compliance with medical recommendations, and use of best practice interventions.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. Refine overall methodology used in Maternal Mortality to assure tracking of findings, establishing recommendations, identifying actions, and measuring activity and outcomes designed to implement recommendations.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) Percent of low birth weight births among live births				
1. Evaluate the process of implementation of the NFP projects in 5 communities and begin accumulating data to determine impact on LBW births.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Collect information from NFP local staff about lifestyle indicators that may be precursors or predictors of LBW births.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Monitor the progress of the FAS Prevention Project in Detroit and make any needed modifications to reach the most at-risk families in the city.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Modify the implementation strategy for the Preconception Project to improve the likelihood of beginning the enrollment of clients in 2005.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of preterm births (<37 weeks gestation) among live births				
1. Overcome barriers to implement pilot preconception project.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Analyze statewide FIMR data & inform programs on maternal & family				

characteristics associated with premature births.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Determine the role of multiple births in the overall trend of prematurity.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Assess the success of the Healthy Start projects in reducing premature births	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of live births resulting from unintended pregnancies				
1. Assure Family Planning Program services as needed for Michigan residents	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assure Family Planning Program services for the target low income population	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assure that at least 30% of Family Planning users are teens	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assure Family Planning Program clinics are held at times convenient for teens	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Assure implementation of Michigan PA 360 while maintaining program access & program guidelines	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Increase number served in Family Planning through use of the Medicaid Adult Benefit Waiver	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Continue to provide comprehensive health services to adolescents through Teen Health Centers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Continue the service learning & abstinence education activities provided by MTOP	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of repeat live births to unwed mothers 15-19 years of age				
1. Assure Family Planning Program services as needed to Michigan residents	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assure Family Planning Program services for the target low income population	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assure that at least 30% of Family Planning users are teens	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assure Family Planning Program clinics are held at times convenient for teens	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Assure implementation of Michigan PA 360 while maintaining program access & program guidelines	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

6. Increase individuals served in Family Planning through use of the Medicaid Adult Benefit Waiver	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Assure and monitor reproductive health service education provided as part of funded mch programs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Continue to provide comprehensive health services to adolescents through Teen Health Centers	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Continue the service learning & abstinence education activities provided by MTOP	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of CSHCS beneficiaries enrolled in a managed care Special Health Plan				
1. This performance measure is deleted for 2005.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) Percent of CSHCS beneficiaries who received dental services reimbursed by CSHCS				
1. Benefit from the State's venture to continue with expansion of program to increase dental care acces	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

9) Percent of Medicaid enrolled children 0-6 years of age who receive lead testing				
1. Work with managed care to increase the percent of Medicaid eligible children who are tested	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Work with local health departments to assure they are not missing opportunities to test children	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Assure GIS mapping is available & used for testing & primary prevention outreach in the 11 target communities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Assure case management of children with blood lead levels at or above 20 mg/dl	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E. 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.

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 1998-99, 26,685 calls were handled by the statewide and Detroit area hotline.

The Children's Special Health Care Services Family Phone line provides families with a toll free number to communicate with CSHCS staff (at state and local levels), other agencies serving children with special needs (e.g.; genetics counseling centers, newborn screening, local health departments), 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, and contact the Michigan SIDS Center for support services or information. The line is publicized at local parent group meetings and at CSHCS presentations throughout the state. In addition, this number is used to refer families to local health departments and the number is included in the CSHCS brochure, Family Support Network brochure, and the newborn hearing brochure. Family Phone Line calls are compiled and analyzed quarterly to determine areas of special concern to families and to identify needed policy or procedural changes.

/2004/ The total number of calls received on the Family Phone Line in 2002 was 46,051. The number of calls is somewhat lower than the previous year due to technical difficulties with the line which are now resolved. The line is also now used for families to ascertain the status of their application or renewal paperwork. Many families check on the status of their CSHCS application or renewal process

over the phone. The PPP phone staff provides this additional support to local health departments, and the Customer Support Section, which handles CSHCS operations. The Family Phone Line took a total of 2,777 online calls related to this specific need.//2004// ***/2005/ The Family Phone Line received 41,780 calls for FY '03. The decline in numbers is due to a change that is beneficial to families. Other programs and providers are implementing their own direct toll-free numbers. Families are benefiting from increased direct toll-free access to providers.//2005//***

F. TECHNICAL ASSISTANCE

No technical assistance requests are identified at this time.

V. BUDGET NARRATIVE

A. EXPENDITURES

On Form 5, no funds are budgeted or expended for infrastructure. Michigan has historically allocated all of its Title V dollars directly to programs. One exception was in FY 2000 when the Legislature appropriated \$450,000 to Michigan State University as one-time funding for the establishment of a state infant mortality review network. The project did not start until late in the fiscal year and the remainder of activities (and expenditures) were carried out in FY '01. Michigan spends in excess of \$13 million for infrastructure activities, funded by a combination of state, Medicaid and grant resources. A policy decision has been maintained not to re-direct Title V dollars from programs to infrastructure.

/2004/ Expenditures for 2002 reflect the elimination of funding for the Adolescent Health program. Funding for this program was subsequently restored in the Department of Education's budget. The budget for Administration showed no charges for 2002. Administration costs for rent of the regional CSHCS office, Random Moment Sample study charges for administrative staff time spent on Title V activities and CSHCS payment processing charges are included in expenditures for 2002. The CSHCS processing charges reflect time spent by Medical Services Administration staff on payment activities for Title V eligible clients.//2004//

/2005/ The variation between Budgeted and Expenditure figures for Children 1-22 on Form 4 and for Population-based Services on Form 5 reflects the elimination of outreach funding by Executive Order in 2003. Budgeted figures were submitted prior to the Executive Order cuts. The amount shown in the budgeted column for Children with Special Health Care Needs reflects the amount authorized by state appropriation for FY '03. The actual cost allocation for Administration (CSHCS processing, rent and Random Moment Sampling) was lower than budgeted for 2003.//2005//

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 (including overmatch) for FY '03 is \$46,190,300. 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.

There are no significant budget variations from 2001 to 2002.

/2004/ Budget for 2004 includes an additional \$250,000 for services to pregnant women to support outreach services. Reduced budget for Children 1-22 years old reflects the elimination of the Adolescent Health program from the Department's budget. See Section III.B, Preventive and Primary Care Services for Children for further information.//2004//

/2005/ The budgeted amount for Population-Based Services for FY '05 on Form 5 and for Infants on Form 4 includes fee increases for additional tests and new technology in the Newborn Screening Program.//2005//

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.