

2011 Title V Maternal and Child Health Block Grant
Michigan Department of Community Health

Five-Year Needs Assessment

Title V of the Social Security Act of 1935, as amended, provides funding to states to "improve the health of all mothers and children, including children with special health care needs." Known as the Maternal and Child Health Block Grant, Title V allocates funding to states in proportion to their percentage of children in poverty. For fiscal year 2010, Michigan receives \$18.8 million for our MCH Block Grant allocation.

Title V Regulations require a statewide needs assessment every 5 years that identifies the need for:

1. Preventive and primary care services for pregnant women, mothers and infants
2. Preventive and primary care services for children (1-21), and
3. Services for children with special health care needs (CSHCN).

In accordance with these regulations, the Michigan Department of Community Health Title V program conducted a statewide needs assessment for the maternal and child population with the following results.

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II. Needs Assessment

A. Needs Assessment Process

The MCH needs assessment was led by the state's Title V Director and the Bureau of Family, Maternal and Child Health. This includes the WIC and Children with Special Health Care Needs programs. The Bureau of Epidemiology, Division of Genomics, Perinatal Health and Chronic Disease Epidemiology led the analysis of survey and other relevant data from a variety of sources. An internal work group consisting of representatives from CSHCN, WIC, Epidemiology and state maternal and child health programs was convened to guide the needs assessment process.

Once the analysis of maternal and child health indicators was completed, a broader group of stakeholders was convened to make recommendations for the top ten MCH priorities for 2011-2016. The Title V Needs Assessment Workgroup consisted of more than 70 invited representatives from local public health, local Great Start Collaboratives (Early Childhood Comprehensive Systems), professional organizations (MI Chapter – AAP, MI State Medical Society), Healthy Start projects, other state departments (Human Services and Education), MDCH Executive Office, MI Primary Care Association, Michigan State University, University of Michigan School of Public Health, advocacy organizations, private health care providers, consumers, and other Department of Community Health programs including Injury Control, Chronic Disease, Mental Health and Substance Abuse, and Medicaid. All geographic areas of the state were represented. Consumer representation was invited from the CSHCS Family Center, Health Start Projects and local Great Start Collaboratives. (See **Attachment 14**)

The needs assessment had three phases: 1) Survey of Stakeholders; 2) Decision-Tree like analysis and 3) Title V Needs Assessment Work Group meeting.

The needs assessment process began with an online survey of approximately 400 stakeholders from state and local government, private and public health care providers, academia and consumer groups. Potential respondents were notified of the survey by email. The survey consisted of five open-ended questions about the respondents' perceptions of the top four most important needs of the maternal and child health population in Michigan. A response rate of approximately 35% was achieved. Analysis of the survey results were reported in a technical report, *Michigan Title V Needs Assessment Pre-Survey Findings* (see **Attachment 1**), which indicated that the top four maternal and child health needs were: access to care, family planning, infant mortality and maternal depression.

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These were very broad areas, so, the next step was to break them down to more specific performance measures that could be used in the Title V planning process for the following five years. In order to do that we used the decision tree analysis (or tree diagram), a decision support tool that uses a tree-like graph or model of decisions and their possible consequences, including chance event outcomes, resource costs, and utility. Decision trees are commonly used in operations research, specifically in decision analysis, to help identify a strategy most likely to reach a goal. Another use of decision trees is as a descriptive means for calculating conditional probabilities. Generally speaking, a "decision tree" is used in decision analysis as a visual and analytical decision support tool, where the expected values (or expected utility) of competing alternatives are calculated. In our case, the expected values were the indicators/performance measures.

A decision-tree like analysis was conducted for each of the four areas identified by stakeholders and then discussed with the program staff to make sure that all program specific targets were addressed (see **Attachments 2-5**). Through these conversations with programs that perform work related to each of the four areas, we were able to also identify duplicative performance measures and also rank the end products for a more meaningful presentation for the Title V Needs Assessment Work group. Data sources for each performance measures were also highlighted to thus allow a better understanding of the available sources and ability to perform timely and valid measures.

The Title V Needs Assessment Workgroup, consisting of a broad spectrum of MCH stakeholders (see page 1), met on March 31, 2010, in-person and via webinar, to review the survey results and analysis and to make preliminary recommendations for MCH priorities. The Workgroup agreed to the following set of criteria for determining priorities:

- ◆ Prevalence of the problem/issue
- ◆ Disparity in health indicators for racial/ethnic groups
- ◆ Issue susceptible to intervention
- ◆ Potential cost savings
- ◆ Is this an emerging issue
- ◆ Data available to measure status
- ◆ Ability to demonstrate progress/accomplishments
- ◆ Collaborative opportunities

Each of the four priority areas identified by the online survey were reviewed and discussed by the Workgroup. In Family Planning, the most

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significant issues recognized were intended pregnancies, male involvement in family planning, adolescent pregnancy, sexually transmitted diseases especially among youth, parent education on how to talk with their children regarding responsible sexual behavior, and family planning information incorporated in transition planning for children with special health care needs. The discussion included identification of additional data sources and cross-cutting issues.

In Access to Care, the top issues identified as potential priorities were access to a medical home for CSHCN, access to dental care for pregnant women and children, and access to early intervention services and developmental screening. Access to care issues cut across all three target populations. The potential impact of federal health care reform was also discussed.

For Infant Mortality, the top issues identified were early and adequate prenatal care, pre-pregnancy counseling and health status assessment, preterm delivery and low birth weight, African American and American Indian infant mortality, SIDS, domestic violence, obesity, environmental issues and breastfeeding. Discussion focused on viewing maternal and child health in the context of a life-course perspective, maternal behaviors, and concentrating on the root causes of maternal and child health problems.

Maternal Depression was recognized as an emerging issue involving different aspects: homelessness, poverty, racism/discrimination, and domestic violence. Domestic violence and depression are also cited as emerging issues among military wives and female veterans.

Based on the discussion, a preliminary list of priorities was identified. Each of the priorities was then compared to the criteria and additional data was gathered (see **Attachment 6**). Workgroup members were then asked to vote on their top ten priorities. The following programs/issues received the highest number of votes:

- Reduce obesity
- Address environmental issues (asthma, lead, second-hand smoke, radon)
- Reduce African American and Native American infant mortality
- Reduce low birth weight and preterm birth
- Decrease the rate of sexually transmitted diseases among adolescents
- Reduce intimate partner and sexual violence
- Increase the rate of intended pregnancies

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- Increase access to dental care for pregnant women and children, including children with special health care needs
- Increase access to early intervention services and developmental screening
- Increase the rate of early and adequate prenatal care

Staff of the Bureau of Family, Maternal and Child Health and Bureau of Epidemiology met to review the results of the voting and the relevant data. Based on this review, the final set of priorities includes the above-mentioned priorities, with the following changes: low birth weight, preterm birth and early prenatal care were incorporated into the reduction of infant mortality for African Americans and American Indians; a priority addressing medical home for children with special health care needs was added; and a priority addressing discrimination in health care services in publicly-funded programs was added. A priority for CSHCN medical home was added since it is in line with current efforts and emphasis on establishing a medical home and follows the grant guidance to include priorities for all three Title V target populations.

Discrimination in health care services was added as a cross-cutting issue in light of the disparities that were evident in the data for many of the proposed priorities and its importance in reaching Healthy People and State goals. The final list of priorities was shared with the Title V Needs Assessment Workgroup via e-mail and was posted on the Department's website. The 2011-2016 priorities are detailed below.

The impact of racism and discrimination was especially noted in a series of Community Conversations held by the Health Disparities and Minority Health Section of the Public Health Administration. The *Community Conversations*¹ were held during the summer and fall of 2009 in key areas around the state to obtain feedback on their significant health concerns and conditions impacting the health of their communities. The key areas were Dearborn, Madison Heights/Canton, Detroit, Wayne County-SW Detroit, Genesee County-Flint, Chippewa County, Washtenaw County, Oakland County, Kent County-Grand Rapids, Muskegon County-Muskegon, Saginaw, Ypsilanti, and Lansing. The focus for the community forums was on five racial/ethnic populations: African American, Hispanic/Latino, Native American, Asian/Pacific Islander and Arab/Chaldean. Information gained from those conversations was used to inform the further development of priorities for the maternal and child population across racial and ethnic groups. As with the online survey, access to care was a top priority and a common concern across all five

¹ "Community Conversations Provider Feedback Report," Health Disparities Reduction and Minority Health, Michigan Department of Community Health, January 2010.

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groups. Other concerns expressed were cultural sensitivity and language barriers, uneven distribution of resources and knowledge of available resources, improved data collection practices, and distrust of health care professionals.

Needs assessments and reports from other organizations or programs were also reviewed for factors relevant to the maternal and child population. The findings from these reports are highlighted below.

The 2008 Children's Special Health Care Services Strategic Planning² focused on the six specific outcomes identified in MCHB's *2010 Action Plan for Children with Special Health Care Needs (CSHCN)*. Michigan's Strategic Plan for 2008-2013 identified five strategic goals:

- ❖ Provide families and providers with consistent and complete information on all available services.
- ❖ Assure that children, youth and families have access to the benefits and services they need.
- ❖ Support families and providers in using a variety of delivery methods to meet the health care needs of Children and Youth with Special Health Care Needs (CYSHCN).
- ❖ Assure that efficient and high-quality services for CYSHCN are available across delivery systems.
- ❖ Promote collaborations and coalitions among families, providers and organizations to improve CSHCS services and information about those services.

In 2008, the Department of Community Health and the Michigan Center for Rural Health released a strategic plan for 2008-2012³ based on an assessment of health status in Michigan's rural areas. The plan for improving rural health in Michigan is based on three priority areas: 1) availability and accessibility to health care services; 2) recruitment and retention of health care providers with a focus on provider shortages, maldistribution of providers, and provider education and training; and 3) healthy lifestyles with a focus on nutrition, obesity and physical activity.

*The Michigan Head Start State Collaboration Office Needs Assessment, 2008-2009*⁴ was conducted in the areas of coordination and collaboration

² http://www.michigan.gov/mdch/0,1607,7-132-2942_4911_35698-191397--,00.html

³ "Michigan Strategic Opportunities for Rural Health Improvement: A State Rural Health Plan, 2008-2012," Michigan Center for Rural Health, April 2008.

⁴ "Michigan Head Start State Collaboration Office Needs Assessment: 2008-2009 Survey Results," Michigan Head Start State Collaboration Office, June 2009.

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in accordance with federal requirements. One of the key priority areas identified was Health Care. The goal is to improve access to health care for low-income families, particularly health and dental screenings, and prevention of diabetes and obesity.

The *Michigan 2-1-1 Year-End Report for 2009* reflected the worsening economy in the state. The volume of calls increased 22% over 2008 and the most frequently requested types of services were housing and utilities, health care, and food and meals.

The six Healthy Start projects in the state – Detroit, Genesee County, Kent County, Kalamazoo County, Saginaw County and Inter-tribal Council – shared their needs assessments for their target areas. While each project's needs assessments reflected the unique needs of their target areas, some of the common issues were adequate prenatal care, prematurity and low birth weight, domestic violence, sexually transmitted diseases and maternal depression.

In addition to the online survey and analysis of the four initial priority areas noted above, key data, including the racial and ethnic breakout of data where available, were reviewed for each of the population groups. The 2008 CSHCS Strategic Plan included an analysis of the population served. A consumer survey was also commissioned by the CSHCS program in 2008 to measure how well the program was meeting their needs.⁵

The Division of Family and Community Health, which has programmatic responsibility for MCH programs other than CSHCS, conducted their strategic planning activities based on the life-course perspective approach. Programs were reviewed in the context of this approach and in the context of the state's economic situation.

The 2008 CSHCS Strategic Plan included analysis of each of the six outcome measures contained in the *MCHB 2010 Action Plan for Children with Special Health Care Needs*:

- ◆ Families of Children with special health care needs will participate in decision making at all levels and are satisfied with the services they receive.
- ◆ All children with special health care needs will receive coordinated, ongoing, comprehensive care within a medical home.

⁵ "Michigan Department of Community Health Children's Special Health Care Services – 2008 Child with Chronic Condition Custom Survey Final Report," The Myers Group, Snellville, Georgia.

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- ◆ All families of children with special health care needs will have adequate private and/or public insurance to pay for all the services they need.
- ◆ All children will be screened early and continuously for special health care needs.
- ◆ Community-based services systems will be organized so families can use them easily.
- ◆ Youth with special health care needs will receive the services necessary to make the transitions to adult life, including adult health care, work, and independence.

An issue brief was prepared for each of the outcome measures including identification of gaps in policies, quantity and quality of services, and prioritized recommendations.

Other research/evaluation reports, such as the State Rural Health Plan, were reviewed as mentioned in this document.

The Department drew on a number of state and national sources to determine the needs of the maternal and child population. In addition to the state's Vital Records, data from the following sources were used: Medicaid information system (CHAMPS), MDCH Data Warehouse, Part C State Performance Plan, program reports (e.g., Family Planning Annual Report, WIC, lead poisoning, Substance Abuse), 2008 Child with Chronic Condition Custom Survey, Michigan Labor Market Information (MI Department of Energy, Labor and Economic Growth), Michigan YRBS, Michigan BRFSS, Michigan PRAMS, and State Demographer. National sources included YRBS, BRFSS, National Survey of Children's Health, National Immunization Survey and the Census Bureau.

One of the selection criteria for the state's priorities was the opportunity for collaboration across programs and with other state and non-state agencies. Acknowledging the constraints on state resources, it is more important than ever for agencies to collaborate on program and policy development. Federal health care reform will offer more opportunities to work across organizations and programs.

The 2011 Title V Needs Assessment was shared with the Title V Needs Assessment Work Group members and posted on the Department's website. Notice of the documents availability online was also posted on the Maternal & Infant Health Program's Twitter page.

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A strength of the needs assessment process is the partnerships that are involved both in the current needs assessment process and on an ongoing basis to develop effective programs and policies that best address the needs of the Title V population. These partnerships put the Title V program in a better position to maximize efficient use of resources and to compete for relevant funding opportunities from federal and foundation sources, including implementation of federal health care reform legislation. Another strength was that the process allowed promotion of the life course approach with MCH stakeholders.

A weakness of the process is the lack of or limited availability of health status data for smaller population groups (e.g., Native American).

B. Partnership Building and Collaboration Efforts

As with ongoing analysis and program evaluation, the Bureau worked closely with the Bureau of Epidemiology, Division of Genomics, Perinatal Health and Chronic Disease Epidemiology to develop the framework for the needs assessment process, starting with the Michigan Title V Needs Assessment Pre-Survey. The Bureau of Epidemiology completed the analysis of the four top priorities identified by the Pre-Survey in cooperation with MCH program staff.

A meeting was arranged with other Department divisions and outside organizations to determine what information sources would be available for the needs assessment. This included: from within the Department, Substance Abuse, Children's Mental Health, Medicaid, Chronic Disease, Health Disparities, and Access to Care Division and Health Professions; and from outside the Department, the Early Childhood Investment Corporation representing the local Great Start Collaboratives (early childhood comprehensive system).

Two meetings were held with staff members from the Michigan Department of Human Services to discuss how we might better coordinate our programmatic efforts related to MCH services directed to the Native American, migrant and refugee populations in the state.

As noted in Section A, other organizations shared their needs assessment reports with the Bureau for this needs assessment. This included individual reports from the six Healthy Start projects in the state, *Michigan Strategic Opportunities for Rural Health Improvement: A State Rural Health Plan* from the Michigan Center for Rural Health, *Community Conversations Provider Feedback Report* from the Health Disparities Reduction and Minority Health Section of MDCH, *Michigan Head Start State Collaboration Office Needs Assessment: 2008-2009 Survey Results*,

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Michigan 2-1-1 Year-End Report, and 2008 Children's Special Health Care Services Strategic Planning.

In determining the state's final set of priorities, participation was invited from local public health, Healthy Start projects, consumers from Children's Special Health Care Services and Healthy Start projects, other State departments (Education, Human Services and Michigan Women's Commission), advocacy organizations (Michigan Council for Maternal and Child Health, March of Dimes, Michigan League for Human Services), Great Start Collaboratives, other Department programs (Mental Health and Substance Abuse, Chronic Disease, Injury Control, Health Disparities, Epidemiology, Medicaid, Health Policy and Access, and Executive Office), professional associations (Michigan Chapter of AAP, Michigan State Medical Society), Michigan Association of Health Plans, Michigan Primary Care Association, University of Michigan School of Public Health, Michigan State University, Greater Detroit Area Health Coalition, Michigan Oral Health Coalition, Michigan 2-1-1 and private providers from DeVos Children's Hospital and St. Joseph Mercy Hospital, along with staff from all three divisions in the Bureau. Public comments were also invited via the Maternal and Infant Health Program's Twitter page.

C. Strengths and Needs of the MCH Population Groups and Desired Outcomes

In analyzing the four initial priority areas, access to care was a recurring theme across all four areas. Insurance coverage is one barrier to obtaining timely, appropriate care. Although Michigan had one of the lowest uninsured rates for children, a 2009 report by the Center for Healthcare Research and Transformation⁶ indicated that the percent of uninsured children (0-18 years of age) increased from 4.7% in 2006 to 6.2% in 2007, and the percent of uninsured young children (0-5 years) increased from 4.6% to 7.8% during the same period. Overall, the uninsured population in Michigan increased from 1.04 million in 2006 to 1.15 million in 2007. African Americans and Hispanics were disproportionately represented in the uninsured population.

Recent cuts in state services have also created barriers to care. Reductions in fees to physicians and other Medicaid cuts, such as elimination of transportation coverage for families of children with special health care needs, present barriers to receiving timely health care.

Distribution of health care resources is another factor in accessing health care. According to *Michigan Strategic Opportunities for Rural Health*

⁶ Udow-Phillips, Marianne, *Cover Michigan: The State of Health Care Coverage in Michigan*. Ann Arbor, MI; Center for Healthcare Research & Transformation, 2009.

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Improvement: A State Rural Health Plan, 57 of the 83 counties in Michigan are defined as rural, containing 19% of the state's population.⁷ Rural Michigan has 165 physicians per 100,000 population, compared to 272.9 physicians per 100,000 population for the state as a whole. Two-thirds of the hospitals in Michigan are in metropolitan counties, and 40% are located in southeastern Michigan. Most of the specialty care for children is located in the southern portion of the lower peninsula of the state.

Another issue reaching across all three population groups is cultural sensitivity. In the *Community Conversations Provider Feedback Report*, all participant groups – African American, Asian/Pacific Islander, Hispanic/Latino, Native American, and Arab/Chaldean – noted that cultural and language barriers inhibited their ability and willingness to obtain health care.⁸ African American and Native American participants expressed a lack of trust for health care professionals and cited racism as a factor in their relationship with the health care system. Hispanic/Latino and Arab/Chaldean participants noted concerns regarding documented legal status.

The leading causes of death for infants under age 1 in 2008 were certain conditions originating in the perinatal period, congenital malformations, accidents, SIDS and homicide. The leading causes remained the same compared to 2003 except that homicide replaced diseases of the heart as the fifth leading cause. Black infants died at 2.7 times the rate of white infants; Hispanic infants at 1.6 times the rate for whites; and American Indian infants at 1.5 times the white rate (see **Attachment 7**). The five-year (2004-2008) average low birth weight rate (8.4) increased over the preceding five-year period (8.0). Black infants were more than twice as likely to have low birth weight as white infants. The pre-term birth rate was relatively unchanged from 2003 to 2008.

The overall infant mortality rate in Michigan in 2008 was 7.4. Of the 83 counties in Michigan, eleven counties had a higher infant mortality rate than the overall rate – Berrien (7.8), Calhoun (7.9), Genesee (8.1), Grand Traverse (8.2), Kent (7.5), Lenawee (9.6), Mecosta (20.5), Saginaw (10.2), Saint Joseph (11.0), VanBuren (10.2), and Wayne (10.7) (see **Attachment 7**). For the period 2004-2008, the average infant mortality rate for Grand Traverse, Lenawee and VanBuren is below the state average rate.

⁷ Op. cit., Michigan Center for Rural Health, p. 6.

⁸ Op. cit., Health Disparities Reduction and Minority Health, MDCH, pp. 2-3.

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

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

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

Of the live births in 2008, 15.9% of mothers were exposed to second-hand smoke at home, 27.5% of mothers with singleton births had a body mass index above 29.0, 0.8% had pre-pregnancy diabetes, 3.8% had gestational diabetes, 1.2% had pre-pregnancy hypertension, and 4.4% had gestational hypertension (see **Attachment 8**). American Indian mothers had the highest rate of exposure to second-hand smoke. Asian/Pacific Islander mothers had the lowest rate of BMI greater than 29.0, but had the highest rate of gestational diabetes.

According to the County Health Rankings for Michigan⁹, the following counties had the best rankings in both Health Outcomes and Health Factors: Livingston (central Lower Peninsula), Ottawa (southwestern Lower Peninsula), Leelenau (northern Lower Peninsula), Clinton (central Lower Peninsula), Washtenaw (southeastern Lower Peninsula), Grand Traverse (northern Lower Peninsula) and Marquette (Upper Peninsula). The only major city (population > 40,000) in this area is Ann Arbor (Washtenaw County).

The counties with the worst rankings in both categories were: Saginaw (central Lower Peninsula), Calhoun (southern Lower Peninsula), Gladwin (central Lower Peninsula), Genesee (central Lower Peninsula), Lake (northern Lower Peninsula), Wayne (southeastern Lower Peninsula) and Clare (northern Lower Peninsula). See maps at www.countyhealthrankings.org/michigan. The major cities in these areas

⁹ *County Health Rankings: Mobilizing Action Toward Community Health, 2010 Michigan*, University of Wisconsin, Population Health Institute.

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are: Saginaw (Saginaw County), Battle Creek (Calhoun), Flint (Genesee), and Detroit (Wayne). From the 2006-2008 American Community Survey 3-Year Estimates, we can see the disparities in the educational and economic indicators between the state overall and these cities.

<i>Indicators</i>	<i>Battle Creek</i>	<i>Detroit</i>	<i>Flint</i>	<i>Saginaw</i>	<i>Michigan</i>
<i>Population</i>	52,000	808,000	105,000	51,000	10,000,000
<i>Education</i>					
<i>High School Grad.</i>	85%	76%	82%	78%	88%
<i>Bachelor's Degree or Higher</i>	18%	11%	12%	10%	25%
<i>Dropout Rate</i>	15%	24%	18%	22%	12%
<i>Median Income</i>	\$39,052	\$29,423	\$28,584	\$27,066	\$49,694
<i>Poverty</i>					
<i>Overall Rate</i>	21%	34%	35%	36%	14%
<i>Related Children <18</i>	31%	46%	49%	47%	19%
<i>Unemployment</i>	5.2%	11.7%	8.2%	8.3%	6.1%
<i>Infant Mortality Rate</i>	8.0	14.9	11.8	12.7	7.4

The leading causes of death among children ages 1-19 in 2008 were accidents, assault (homicide), cancer, suicide and congenital malformations. The leading causes of hospitalizations for children were females with deliveries, injury and poisoning, asthma, pneumonia and appendicitis. Births to teens aged 15 to 17 years declined from 2004 (18.7%) to 2007 (14.0%), but then increased significantly in 2008 (18.2%). (see **Attachment 9**)

Sexually transmitted diseases are an increasing problem among adolescents since 2000. Chlamydia rates among 15 to 19 year-olds increased from 1253.0 in 2000 to 2640 in 2008. The rates for gonorrhea increased from 592 in 2000 to 820 in 2008. The rates for Black teens were more than twice the white rate for Chlamydia and more than three times the white rate for gonorrhea. The rate of new diagnoses of HIV among 13-19 year-olds more than doubled between 2003 and 2007 (from 3.2 to 7.3). Of those new diagnoses, 85% are African American and 62% are African American males having sex with males.

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According to the Youth Risk Behavior Survey (YRBS), incidents of intimate partner and sexual violence among high school students is increasing, especially among American Indian students.

There has been significant success in identifying and treating children with elevated blood lead levels over the past decade. The percent of children under six years of age with elevated blood lead levels dropped from 7.2% in 1999 to 0.9% in 2009. However, the percentage of black children with elevated blood lead levels was five times the rate for white children (1.0% vs. 0.2%).

Overweight and obesity among children is also an increasing problem in Michigan. According to the 2007 YRBS, 12.4% of high school students had a body mass index at or above 95%, compared to 10.9% in 1999. In 2007, 16.5% of high school students had a body mass index between 85% and 95%. According to WIC program statistics for 2008, 30.1% of children receiving WIC services had a body mass index at or above the 85th percentile.

Due largely to passage of legislation requiring child passenger restraint and booster seat use during the last decade and implementation of training programs regarding their proper use and installation, the death rate among children 14 years of age and under due to motor vehicle crashes has declined from 4.7 in 2000 to 2.3 in 2008. The death rate among youth aged 15 through 24 years from motor vehicle crashes also declined from 24.7 in 2000 to 19.5 in 2008. However, accidents from all causes remains a leading cause of death for children and youth ages 1-24.

From the 2008 CSHCS Strategic Planning effort, the following high priority needs were identified for the six outcome areas:

- ❖ Families of children with special health care needs will participate in decision-making at all levels and are satisfied with the services they receive
 - Collaborate with partners and build coalitions to assure that all families have full access to consistent and complete information on program benefits, information on the benefits of family partnership; conduct outreach to fathers, grandparents, youth and diverse populations; improve shared awareness of benefits of partnering organizations; develop, translate, and communicate information in multiple formats, languages and literacy levels.

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- New regional structures are required to have family advisories that will develop guidance to prepare, recruit and engage families to become advisors.
- ❖ All children with special health care needs will receive coordinated, ongoing, comprehensive care within a medical home
 - Develop consensus definition for CYSCHN family-centered medical home and all subsets of medical home such as care coordination in Michigan and method to operationalize that fully involves family representation in each group and process from start to finish.
 - Address the funding and reimbursement issues allowing for multiple strategies.
- ❖ All families of children with special health care needs will have adequate private and/or public insurance to pay for all the services they need.
 - Send letters to families reported to the Birth Defects Registry educating them on CSHCS.
 - Pursue the Medicaid buy-in option available for children with special health care needs through the federal Family Opportunity Act.
 - Improve communication, collaboration and education (regarding healthcare) to all stakeholders between public/private agencies, professional organizations (AMA, MDA, MAPD, etc.).
- ❖ All children will be screened early and continuously for special health care needs.
 - Support MCIR (Michigan Care Improvement Registry) as a single electronic record for the multiple data systems.
 - State-wide education of all providers to spread knowledge of screening and importance of follow-up (through MI-CHIP mechanism).
 - Develop performance standards for screening and follow-up.
- ❖ Community-based service systems will be organized so families can use them easily.
 - Increase system efficiency by 1) Resolve transportation problem (singular definition/provider; 2) Streamline documentation among and between agencies; 3) Provide webpage directions for who to go to in the agency ("Guide for Dummies," for services); 4) Develop a Who's Who list of important contacts within the county; 5) Develop a statewide plan with incentives/reward for collaboration; 6) Change the hours of operation of community agencies to allow for "non-work hour" availability to parents.

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- Health communications technology: 1) Implement telemedicine statewide; 2) Increase the use of Infomatics.
- ❖ Youth with special health care needs will receive the services necessary to make the transitions to adult life, including adult health care, work and independence
 - Create additional services to cover adults; health care, insurance coverage, CSHCS buy-in, pharmacy coverage, mental health.
 - All young adults with special health care needs will initiate a transition plan by 14. Create standard requirements and training for all youth with special health care needs at age 14. Review at least annually and expand who would be eligible to bill for care coordination for transition planning.

D. MCH Program Capacity by Pyramid Levels

1. Direct Health Care Services

Local Health Services – Under Michigan's Public Health Code, each county has a local health department, either as a single-county agency or as part of a multi-county health department. There are 30 single-county health departments, 14 multi-county health departments and one city health department (Detroit). The services offered vary with each local department but all offer a minimum level of primary care services.

In addition to local health departments, other safety net providers include free clinics at 53 different sites, 30 Federally Qualified Health Centers (FQHC) and FQHC-Look Alikes, and 156 Rural Health Clinics.

Of the 83 counties in Michigan, 66 counties have either full or partial Primary Medical Care Health Professional Shortage Area (HPSA) (**Attachment 10**), 61 have some type of Dental HPSA designation (**Attachment 11**), and 47 Mental Health HPSA's (**Attachment 12**).

Medical Care & Treatment for CSHCS – CSHCS reimburses providers for all specialty and subspecialty services to beneficiaries enrolled in the CSHCS program, including hospitalization, pharmaceuticals, special therapies and respite. Providers must meet established criteria in order to qualify as an approved provider of CSHCS services. The criteria focus on the demonstration of expertise and willingness to provide pediatric specialty services.

A person eligible for the CSHCS program is someone under the age of 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-

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support," according to the Michigan Public Health Code. Persons over age 21 with cystic fibrosis and hereditary coagulation defects are also eligible for the program. The program evaluates severity, chronicity and the need to be seen at least once annually by an appropriate pediatric subspecialist in making a medical eligibility determination. 36,473 children were served by the program in 2009.

CSHCS is a statewide program although certain program components may not be located in every county. Local health departments work directly with families to determine eligibility and connect them with services. Children's multidisciplinary clinics are associated with tertiary care centers, most of which are located in the southern portion of the Lower Peninsula.

The **Michigan Children with Special Needs Fund** was created with a bequest of Dow Chemical Company stock from James and Elsa Pardee. The Fund helps families obtain equipment necessary for the care of their child, such as ceiling track lift systems.

Family Planning – The Department of Community Health assures that family planning services are provided in all 83 counties, either through local health departments or other contracted providers. These agencies deliver family planning services either directly onsite or through subcontract arrangement with a community-based agency. Services include general health assessment, screenings, contraception, pregnancy detection, primary infertility services, client and community education, and follow-up and referral as necessary. Services are available to all upon request. Clients below 100% of poverty are not charged for services; clients between 100% and 250% of poverty are assessed fees based on income and family size. Those above 250% poverty are assessed full fees. No one is denied services based on inability to pay. In calendar year 2009, 120,756 women and 4,286 men received services from the program.

Plan First! (Family Planning Waiver) - In July 2006, the Department received a Section 1115 waiver to expand family planning services to women 19-44 years of age who are not currently Medicaid-eligible, with family incomes up to 185% of poverty. Should a beneficiary need primary care services beyond what is covered under *Plan First!*, the provider may either provide the services and work with a beneficiary to arrange payment options or they may refer or inform them how to access primary care services at the nearest FQHC. Under terms of the waiver, up to 200,000 women may be served.

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Childhood Lead Poisoning Prevention Program – The Childhood Lead Poisoning Prevention Program (CLPPP) supports the coordination of lead poisoning prevention and surveillance services for children in Michigan and the funding of pilot sites for primary prevention of lead poisoning through the identification of lead hazards in housing. Infants, children under six years, and pregnant women are priorities for screening and testing. Program service components are education and outreach, blood screening and testing, tracking, reporting, primary prevention activities, policy development and program management, quality assurance, and evaluation. Of the 154,570 children tested in 2009, 1,405, or 0.9%, had blood lead levels at or above 10 ug/dL.

Child and Adolescent Health Centers – The Department of Community Health supports 62 clinical child and adolescent health centers and 12 non-clinical centers. The clinical center model provides on-site primary health care, psycho-social services, health promotion/disease prevention education, and referral services to children ages 5-10 or youth 10-21 years of age. The non-clinical adolescent health center model focuses on limited clinical services, case finding, screening, health education and referral for primary and other needed health services. The target population for both models is uninsured, under-insured and publicly insured children and youth. The centers are operated by local health departments, hospitals, federally qualified health centers, school districts, and community-based organizations. The centers served 36,163 children and youth in 2009.

2. Enabling Services

Fetal Alcohol Spectrum Disorders - 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, Maternal & Infant Health Program, 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.

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WIC Program - The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federally-funded program that serves low and moderate income pregnant, breastfeeding, and postpartum women, infants, and children up to age 5 who have a nutrition-related health problem. The program provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals to health care. Michigan's WIC program is the eighth largest program in the country serving more than 255,000 clients monthly. Michigan's WIC Program provides services to over 50% of all infants born in the state. MI-WIC has several components that support linkage with public health services accessed by WIC families, like immunizations, maternal support home visiting services, and verification of enrollment in our Medicaid program. The system also supports client participation in the Farmers Market Nutrition Program, a program that makes Michigan locally grown fruits and vegetables available to WIC participants. Services are provided to clients by local health departments and other community-based agencies. Over 900 WIC clinic staff in 83 counties provide WIC services. Approximately 2,000 WIC vendors participate in the program using Electronic Benefits Transfer (EBT) technology instead of the old paper WIC coupons (over 10 million a year).

Prenatal Smoking Cessation - 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. A Smoke Free for Baby and Me online course has been established and active since November 2007. In Calendar Year 2009, 728 women were served.

Maternal and Infant Health Program – MIHP is a program for all Michigan women with Medicaid health insurance who are pregnant and all infants with Medicaid. MIHP provides support to promote healthy pregnancies, good birth outcomes, and healthy infants. Throughout the state, MIHPs are administered in rural and urban communities through federally qualified health centers, hospital based clinics and private providers as well as through local and regional public health departments. Services include: Maternal and infant health and psychosocial assessment completed by nurse or social worker; Registered Nurse, Licensed Social Worker and Registered Dietician team development of beneficiary care plans; coordination of MIHP services with the beneficiary's medical care provider and Medicaid Health Plan; Registered Nurse, Licensed Social Worker, Registered Dietitian and Infant Mental Health Specialist home or office visits provided with interventions based on the beneficiary's plan of

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care; transportation services arranged if needed; referrals to local community services (e.g., mental health, substance abuse, domestic violence, basic needs assistance) as needed; and referral to local childbirth education or parenting classes. In 2009, 24,131 individuals were served by the program.

In FY2009, budget cuts approved by the Legislature eliminated funding for transportation and durable medical equipment for CSHCN. This is especially problematic for families that live in northern and rural areas of the state where tertiary care is either not available or not easily accessible. Transportation support is vital to families needing to travel long distances to obtain necessary, timely care for their child.

Teen Pregnancy Prevention Initiative (TPPI) - TPPI is a comprehensive pregnancy prevention program through implementation of comprehensive, evidence-based interventions that target the sexual and non-sexual factors that lead to delayed initiation of sex and increased condom or other contraception use. TPPI programs target youth and young adults between the ages of 10 and 18 (up to age 21 for special education populations).

3. Population-based Services

Newborn Screening Program – The Newborn Screening Program currently screens for 50 disorders. Blood samples are submitted by hospitals to the state laboratory which analyzes the samples and reports the results to the Newborn Screening Program. Program staff follow up on all positive or unsatisfactory test results with hospitals, family or family physician. MDCH contracts with three medical centers to assure and/or provide comprehensive diagnostic and treatment services.

The **Hereditary Disorders Program (HDP)** coordinates statewide services for genetic diagnosis and counseling, and provides information about birth defects and inherited diseases. Six regional coordinating centers are funded to provide a network of clinics for diagnosis, counseling and medical management, and to provide outreach education to community groups, including families, health professionals and teachers.

Newborn Hearing Screening – 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

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local team for infants requiring follow-up, and maintains a statewide database for tracking screening and follow-up activities. All Michigan birthing hospitals are participating in the screening program.

Safe Sleep – The Safe Sleep program provides a statewide, consistent, comprehensive message and strategy to inform families and caregivers about unsafe sleep. Recognizing that sleep-related infant deaths represent a large, preventable component of all post-neonatal deaths in Michigan, an Infant Safe Sleep State Advisory Team was formed. The Team is a public/private partnership that coordinates statewide efforts to implement Infant Safe Sleep and reduce infant deaths related to unsafe sleep environments. The Team includes representatives from the Department of Community Health, Department of Education, Department of Human Services, Michigan Public Health Institute and Tomorrow's Child.

Safe Delivery - The Safe Delivery program targets parents and encourages the placement of their newborns in a safe environment, allowing for the anonymous surrender of an infant (within 72 hours of birth) to an Emergency Service Provider without the expressed intent to return for the newborn, per the Michigan Safe Delivery of Newborns Act. A toll-free hotline exists to provide information to the public regarding the law, resources for counseling and medical services, and information on adoption services.

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

Oral Health Program – 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

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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). The department provides dental services to the developmentally disabled populations who are not eligible for Medicaid, cannot access a Medicaid provider, do not have other dental coverage, and cannot afford dental care. Services provided are limited to the treatment of those conditions that would lead to generalized disease due to infection or improper nutrition. The SMILE! Michigan state-wide school-based/school-linked dental sealant program targets second grade children. Over 13,000 children received dental sealants in 2009.

Hearing Screening for Pre-School and School-Age Children – 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 ten years. LHD staff are trained as either an EPSDT technician or a comprehensively trained school screening technician. Quality assurance is provided for approximately 200 LHD threshold technicians by the MDCH audiology consultant, through field visits and required biennial skills update workshops. Over 680,000 children are screened per year in preschool and school programs, and between 40,000 and 50,000 referred for evaluation each year. Increasingly, agencies are utilizing otoacoustic emissions (OAE) technology, for screening young children and children who are difficult to test. Follow-up for all referred children is required to assure that needed care has been received, or assistance given to be seen at an Otology clinic provided through CSHCS. Most screenings are conducted in schools and day care centers.

Vision Screening of Pre-School and School-Age Children - 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 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.

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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.

Michigan Model – The Michigan Model for Comprehensive School Health Education Program is a planned, age appropriate, sequential K-12 health curriculum, which has been in many Michigan schools since 1984. The major goal of this program is to create a partnership between homes, schools community groups and government to educate young people about current health risks. The Model gives children the information and skills that they need to make healthy choices now and in the future. At this point in time over 90% of the public school districts provide Michigan Model to their students. Health education was provided to more than 1,000,000 students this past school year, out of total K-12 enrollment of 1.8 million (per 2006-2008 American Community Survey). Twenty-five local coordinators train teachers to make this program available to all of the public and private schools in the state.

Teen Pregnancy Prevention Initiative (TPPI) - TPPI is a comprehensive pregnancy prevention program, whose goal is to reduce teen pregnancy in MI through the implementation of the evidence-based program, Safer Choices, in eleven high need communities – Lake County, Newaygo County, Wexford County, Oceana County, Berrien County, Ingham County, Jackson County, Washtenaw County, Wayne County, Kent County and Muskegon County.

Immunizations – This program promotes vaccines through a public/private provider network; facilitates development, use and maintenance of immunization information systems; supports disease surveillance and outbreak control activities; and provides educational services and technical consultation for public and private health care providers. This is done through a variety of complementary program elements, including AFIX (Assessment, Feedback, Incentives, and Exchange). AFIX is a quality improvement strategy used to raise immunization coverage levels and provider-level practice standards. The Vaccine-Preventable Disease Surveillance Component provides information for evaluating success toward the goal of immunization, which is the prevention or reduction of vaccine-preventable diseases.

4. Infrastructure-building Services

PRAMS - The Pregnancy Risk Assessment Monitoring System is a study of risk factors among women related to birth outcomes. Data is gathered through interviews with new mothers by registered nurses trained in interview techniques. The information collected includes use of birth

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control and prenatal care, plans for breastfeeding, use of tobacco and alcohol during pregnancy, exposure to smoke, and access to and use of information on infant care such as the importance of sleep position. Most of the data obtained through the PRAMS study are not available from any other source.

Fetal Infant Mortality Review (FIMR) – MDCH provides support for case abstraction and consultation to local teams. Multidisciplinary teams review cases of fetal and infant death to identify factors and implement improvements in systems of maternal care.

Maternal Mortality Surveillance – The Michigan Maternal Mortality Study (MMMS) is a voluntary collaborative effort between the Michigan Department of Community Health (MDCH), the Committee on Maternal and Perinatal Health of the Michigan State Medical Society (MSMS) and the Chairs of the Departments of Obstetrics and Gynecology of the medical schools in Michigan. The Committee members are obstetricians/gynecologists, maternal/fetal medicine specialists, midwives, pathologists, anesthesiologists, nurses, and an obstetrician/gynecology intensivist with extensive experience working with women with high-risk pregnancies. Case reviews and the expert judgment of the Medical and Injury Committees are essential for the development of public health recommendations. Review of non-pregnancy related cases as well as the Interdisciplinary Committee role in identifying these recommendations and moving from recommendation to action is of great importance to the entire maternal mortality surveillance process.

Early On – Public Health collaborates with the MI Department of Education to manage and implement a statewide comprehensive, coordinated interagency system of early intervention services for infants and toddlers birth to age three years with disabilities and their families.

Family Center for Youth and Children with Special Health Care Needs – This program is a core component of the CSHCS organization and is headed by a parent of a child with special health needs. The program is responsible for maintenance of a statewide, community-based network of parent-to-parent support; provision of parental input to CSHCS administration regarding programs and policies; and facilitation of timely responses to families in need. The program includes all families of children with special health needs whether or not they are enrolled in the program. The program also operates the Family Phone Line.

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Early Childhood Comprehensive Systems Grant (ECCS) – The Michigan Department of Community Health (MDCH) has a grant agreement with the Early Childhood Investment Corporation (ECIC) to manage the day-to-day activities of the ECCS grant. As a public non-profit agency, ECIC has garnered over \$10.0 million in private dollars and secured \$6.75 million in state school aid funds. As of April 1, 2009, every county in the state has a Great Start Collaborative (GSC) and a local Great Start Parent Coalition. The GSC's oversee the planning, implementation and ongoing improvement of the local early childhood comprehensive system, and are composed of community leaders from health, mental health, education, child welfare, philanthropy and business, as well as parents. The Parent Coalitions train and support parents in State Implementation Grant advocacy, education and public will-building. There are about 15,000 parents connected to these coalitions.

Children's Special Health Care Services State Implementation Grant - CSHCS is the recipient of a State Implementation Grant for Building Systems of Services for Children and Youth with Special Health Care Needs (June 2008 – May 2011). By working with primary care practices, the goal is to implement the six core components of a system of services for CYSHCN with the establishment of a regionalized model of family-centered medical homes. Eleven diverse practices across the state (ten pediatric practices and one family medicine practice) have implemented quality improvement activities based on the Medical Home Index. Practice-based experiences are informing the development and spread of community-based medical homes for children and youth with special health care needs. Partnerships with local health departments to develop plans of care with the medical homes have been implemented. Work with the Michigan AAP ABCD project is helping realize standardized development screening and appropriate referrals to early intervention programs at pilot sites and statewide. Parent involvement in the Medical Home is supported by The Family Center through focus groups, educational sessions, and encouraging parent partners as active members of practice-based quality improvement teams. Regional training for parents, providers, and youth on insurance issues and transition planning have been held across the state. Issues related to medical home certification are being examined. Defined expectations for family-centered care coordination with the Medical Homes and associated costs are under study to inform future plans for additional per member per month payments (PMPM) for care coordination activities based on the complexity of a child's condition. Electronic systems for Medical Home enrollments and payments are being tested with the pilot sites. A Medical Home Learning Collaborative is supported to spread the adoption and

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implementation of the medical home model of comprehensive, coordinated, family-centered care.

Project LAUNCH - The purpose of Project LAUNCH Michigan (MI) is to improve the comprehensive wellness of all young children 0-8 and their families by using the public health approach to expand and enhance our early childhood system of care. MI LAUNCH will increase the use of evidence-based practices that promote comprehensive wellness as well as the integration of behavioral health into primary care. A sustainable model will be built that can be replicated throughout the state to drive a culture change in MI regarding the importance of investing in comprehensive wellness to improve child and family outcomes. MI LAUNCH will partner with Saginaw County, population 205,000, a once thriving industrial and agricultural area, that is now, like much of Michigan, suffering the impacts of a seven year recession and the demise of the automobile industry. Seventy percent of the population to be served by MI LAUNCH in Saginaw will be drawn from its largest city and 30% from its rural, isolated hamlets. The target population is diverse (61.5% White/Non-Hispanic, 26.4% African-American, 10.7% Hispanic, .3% Native American and 1.1% Other/Non-Hispanic) and poor, with nearly 24% of the families living below the poverty line. MI LAUNCH will impact 1,000-1,500 children per year during its five year project period, resulting in up to 7,000 children receiving the direct benefit of the project. Emphasis will be given to coordinating and improving data collection systems to document the promotional and preventive comprehensive health services

Regional Perinatal System – In 2009, The Department convened a panel of experts to develop level of care guidelines as a foundation for a coordinated perinatal system. Three workgroups were formed – Neonatal, Obstetric, and Pediatric – to develop recommendations in each of their areas of expertise, based on AAP/ACOG Level of Care Guidelines modified to Michigan's standards. The Guidelines provide a framework to define and evaluate the level of perinatal care delivered by hospitals. The Department has been working with the Michigan Chapter of March of Dimes and the State Legislature to develop a coordinated trauma and perinatal system.

Maternal and Infant Health Re-Design - The MIHP Re-Design was a strategic planning initiative to re-engineer the Medicaid Maternal Support Services (MSS) and Infant Support Services (ISS) programs, using a population management model. The goal was to improve the health and well being of Medicaid-eligible pregnant women and infants through a standardized, system-wide process to:

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- Screen all Medicaid-eligible pregnant women for key risk factors
- Assign risk stratification
- Engage all Medicaid-eligible pregnant women to participate
- Deliver targeted interventions
- Measure specified outcomes.

Assuring Better Child Development (ABCD) Project – Michigan's ABCD grant activities focus on increasing the use of standardized developmental screening tools in primary care providers' offices. The pilot project has been completed and efforts are now directed to taking the model statewide.

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

CSHCN – four constructs of a service system

- ◆ State program collaboration with other State agencies and private organizations:

CSHCS functions from the broader perspective on behalf of the CSHCN population and collaborates with other State agencies such as the Department of Education, Mental Health Administration and their affiliated Medicaid Waiver programs of the Children's Waiver, Children With Serious Emotional Disturbance Waiver (SEDW) and the Habilitative Supports Waiver. CSHCS also collaborates with the Medical Services Administration for Medicaid, MIChild (CHIP), and their affiliated health plans, the Public Health Administration for Early On, Vital Records, Epidemiology and the Health Disparities program in gathering and assessing data for a more complete picture of various special needs groups as well as to increase outreach efforts to mutual populations. Other agencies and private organizations includes the Hemophilia Foundation, United Cerebral Palsy of MI, Children's Hospital of the Detroit Medical Center, University of Michigan Mott Children's Hospital, DeVos/Spectrum Children's Hospital, Michigan State University Clinics,

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Henry Ford Hospital, MI Cleft Network, individual medical practices for development of the Medical Home process and others.

◆ State support for communities

The Michigan Public Health Administration has formal agreements with the Local Health Departments (LHD), covering all counties to provide services within the context of their community and in conjunction/collaboration with local resources. CSHCS also has specific agreements with the LHDs to be the local face for the program and to provide services and referral for services within the context of the community. The State supports these efforts through funding, training, and technical support.

◆ Coordination of health components of community-based systems, The community-based CSHCS staff in the Local Health Departments work closely with families and community health care providers to coordinate all of the CSHCS clients' health needs including the various components of the community-based systems with the CSHCS clients, in context of the family needs and the health care providers. CSHCS is also increasing the use of telehealth systems to better coordinate the community-based systems activities with the specialty systems that may be outside of the community. This keeps the family within the community for medical services whenever possible and increases the communication between community providers and the specialist(s) serving the child.

◆ Coordination of health services with other services at the community level

In addition to the description in the previous paragraph, the providers with whom the local CSHCS/LHD staff coordinate services include early intervention services which may lead to assisting the family regarding the coordination of medical needs with a special education program. CSHCS/LHD staff also work with social services when this becomes a need and are always informing and linking the family to various family support services.

◆ Groups and individuals involved in the assessment process.

The assessment process is a voluntary activity for the family. In the event the family agrees to under-go an assessment the primary participants are the family and client. Beyond that it would depend upon the other circumstances are present in their lives. If early intervention (Early On) services are involved, then that programs services and/or remaining needs would be included. The same is true for any other services the family is currently involved with or that the assessment results in the identification of a need.

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E. Selection of State Priority Needs

1. List of Potential Priorities

Increase proportion of intended pregnancies	Included in Final List of Priorities	Key factor in improving women's health and birth outcomes
Increase male involvement in family planning	Not included	Incorporated as a strategy under intended pregnancies
Decrease adolescent pregnancy	Not included	Incorporated as a strategy under intended pregnancies
Decrease sexually transmitted diseases	Included	Data indicates alarming trends particularly among youth
Promote parent education regarding responsible sexual behavior	Not included	Can be incorporated as a strategy under previous priority
Include family planning information in transition planning for CSHCN	Not included	Too narrow
Increase proportion of CSHCN population that has access to medical home and integrated care planning	Included	
Increase access to dental care for pregnant women and children	Included	
Increase access to early intervention services and developmental screening	Included	
Increase the rate of early and adequate prenatal care	Not included	Incorporated as a strategy under infant mortality reduction
Promote pre-pregnancy counseling and health status assessment	Not included	Incorporated as a strategy under several priorities
Reduce pre-term delivery and low birth weight	Not included	Incorporated under infant mortality reduction
Reduce Black and American Indian infant mortality rates	Included	Continuing state focus on infant mortality
Reduce infant suffocation	Not included	Too narrow
Increase breastfeeding rates	Not included	Incorporated as a strategy under obesity reduction
Reduce intimate partner and sexual violence	Included	Data indicate increasing rate
Address environmental issues	Included	High rates of preventable hospitalization and disparity

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		between rates for white and black residents
Reduce obesity	Included	Increasing rates for all age groups; implications for other priorities
Reduce discrimination in health care services	Included	Issue cutting across all priorities
Provide adequate housing	Not included	Outside area of responsibility
Address chronic poverty	Not included	Outside area of responsibility
Reduce maternal mortality	Not included	Still a priority but not in top ten

2. Methodologies for Ranking/Selecting Priorities

The Needs Assessment Workgroup met on March 31, 2010 (in-person and webinar) to review the survey results and analysis and to make preliminary recommendations for MCH priorities. The Workgroup agreed to the following set of criteria for determining priorities:

- ◆ Prevalence of the problem/issue
- ◆ Disparity in health indicators for racial/ethnic groups
- ◆ Issue susceptible to intervention
- ◆ Potential cost savings
- ◆ Is this an emerging issue
- ◆ Data available to measure status
- ◆ Ability to demonstrate progress/accomplishments
- ◆ Collaborative opportunities

Based on the discussion of the four priority areas, a preliminary list of priorities was identified. Each of the priorities was then compared to the criteria and additional data was gathered. Workgroup members were then asked to vote on their top ten priorities.

Staff of the Bureau of Family, Maternal and Child Health and Bureau of Epidemiology met to review the results of the voting and the relevant data. Based on this review, the final set of priorities includes the above-mentioned priorities, with the following changes: low birth weight, preterm birth and early prenatal care were incorporated into the reduction of infant mortality for African Americans and American Indians; a priority addressing medical home for children with special health care needs was added; and a priority addressing discrimination in health care services in publicly-funded programs was added.

3. Priorities Compared with Prior Needs Assessment

2006-2011 Priorities	2011-2016
Establish a system to better identify, screen	

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and refer for maternal depression.	
Increase the rate and duration of breastfeeding.	
Reduce the percentage of unintended and teen pregnancies.	Increase the proportion of intended pregnancies
Reduce the percentage of preterm births and births with low birth weight.	
Establish a medical home and increase care coordination for children with special health care needs.	Increase the proportion of CSHCN population that has access to a medical home and integrated care planning
Increase the number of CSHCS-enrolled youth who have appropriate adult health care providers.	
Reduce the proportion of children and adolescents who are obese.	Reduce obesity in children, including children with special health care needs, and women of child-bearing age.
Reduce the incidence of teen suicide.	
Increase the testing rate of low-income children for lead poisoning.	Address environmental issues (asthma, lead and second-hand smoke) affecting children, youth and pregnant women.
Reduce the racial disparity between black and white infant mortality and between Native American and white infant mortality.	Reduce African American and American Indian infant mortality rates.
	Decrease the rate of sexually transmitted diseases among youth 15-24 years of age
Reduce	intimate partner and sexual violence
	Increase access to early intervention services and developmental screening within the context of a medical home for children.
	Increase access to dental care for pregnant women and children, including children with special health care needs.
Re	duce discrimination in health care services in publicly-funded programs.

Five of the previous priorities were retained with some wording changes. In looking at the analysis for maternal depression, it was decided to focus on narrower factors contributing to the problem – domestic violence and discrimination. In the new set of priorities, breastfeeding is considered a strategy for reducing obesity, and preterm and low birth weight birth are incorporated under reducing African American and American Indian infant mortality. While CSHCN transition to adulthood and teen suicide remain priorities in Michigan, it was determined that the alarming rates of sexually transmitted diseases and the desire to focus on early intervention strategies for addressing developmental and behavioral problems

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(consistent with a life course development approach) should be included in the ten priorities submitted with the Block Grant application.

4. Priority Needs and Capacity

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

Priority Need	Pyramid Level	MCH Program Capacity
Increase the proportion of intended pregnancies	Direct Care Services Population-based Services	Title X Family Planning Plan First! Waiver TPPI
Increase the proportion of CSHCN population that has access to a medical home and integrated care planning	Infrastructure	Dept of Pediatrics Henry Ford Health System Coop Project MCAAP Residents Training Local MCH Great Start Initiative CSHCS State Implementation Grant
Reduce obesity in children and women of child-bearing age, including children with special health care needs.	Direct Care Services Enabling Services Infrastructure	Child & Adolescent Health Centers WIC WIC Breastfeeding Promotion Michigan Nutrition Network <i>Coordination with other state programs (e.g., Chronic Disease, Surgeon General's MI Steps Up)</i>
Address environmental issues (asthma, lead and second-hand smoke) affecting children, youth and pregnant women.	Direct Care Services Enabling Services Population-based Services	Childhood Lead Poisoning Prevention Program Child & Adolescent Health Centers Prenatal Smoking Cessation Michigan Model
Reduce African American and American Indian infant mortality rates.	Direct Care Services Enabling Services	Medicaid covered services Local MCH Medicaid Outreach

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	Population-Based Services Infrastructure Services	Maternal & Infant Health Program Safe Delivery Safe Sleep Infant Death Prevention & Bereavement FIMR Maternal Mortality Surveillance
Decrease the rate of sexually transmitted diseases among youth 15-24 years of age	Direct Care Population-based Services	Family Planning Child & Adolescent Health Centers Local MCH TPPI
Reduce intimate partner and sexual violence	Direct Care Enabling Services	Child & Adolescent Health Centers MIHP
Increase access to early intervention services and developmental screening within the context of a medical home for children	Direct Care Services Infrastructure	CSHCS Multidisciplinary Clinics Regional Perinatal System <i>Early On</i> ECCS ABCD Project
Increase access to dental care for pregnant women and children, including children with special health care needs	Population-Based Services	Healthy Kids Michigan Oral Health Program – MI Door Project, Educations & Access Promotion, Points of Light Oral Health Program, Community Water Fluoridation Promotion,, School Fluoride Mouthrinse Program, Cavity Free Kids© Head Start Curriculum, Dental Workforce Development, Dental Hygiene PA 161 Program, Volunteer Dental program, Dental Treatment for Developmentally Disabled, School-Based/School Linked Oral Health, Dental Sealant Program, VARNISH! Michigan, Oral Health Surveillance & Evaluation
Reduce discrimination in health care services in publicly-funded programs	Infrastructure W	KKF Grant Project

5. MCH Population Groups

2011-2016 Priorities	Title V Population Group
Increase the proportion of intended	Pregnant Women & Infants

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pregnancies	Children and Adolescents
Increase the proportion of CSHCN population that has access to a medical home and integrated care planning	CSHCN
Reduce obesity in children and women of child-bearing age, including children with special health care needs.	Pregnant Women & Infants Children and Adolescents CSHCN
Address environmental issues (asthma, lead and second-hand smoke) affecting children, youth and pregnant women.	Pregnant Women & Infants Children and Adolescents CSHCN
Reduce African American and American Indian infant mortality rates.	Pregnant Women and Infants
Decrease the rate of sexually transmitted diseases among youth 15-24 years of age	Children and Adolescents
Reduce intimate partner and sexual violence	Pregnant Women and Infants Children and Adolescents
Increase access to early intervention services and developmental screening within the context of a medical home for children	Children and Adolescents CSHCN
Increase access to dental care for pregnant women and children, including children with special health care needs	Pregnant Women & Infants Children and Adolescents CSHCN
Reduce discrimination in health care services in publicly-funded programs	Pregnant Women & Infants Children and Adolescents CSHCN

6. Priority Needs and State Performance Measures

2011-2016 Priorities	State Performance Measure
Increase the proportion of intended pregnancies	SPM #01 - Percent of pregnancies that are intended
Increase the proportion of CSHCN population that has access to a medical home and integrated care planning	See NPM #03
Reduce obesity in children and women of child-bearing age, including children with special health care needs.	SPM #04 - Percent of singleton births by mother's BMI at start of pregnancy > 29.0
Address environmental issues (asthma, lead and second-hand smoke) affecting children, youth and pregnant women.	SPM #05 - Ratio between black and white children under 6 years of age with elevated blood lead levels
Reduce African American and American Indian infant mortality rates.	SPM #02 Percent of low birth weight births (<2500 grams) among live births SPM #03 - Percent of preterm births (<37 weeks gestation) among live births
Decrease the rate of sexually transmitted diseases among youth 15-24 years of age	SPM #06 - Rate, per 100,000, of Chlamydia cases among 15-19 year-olds
Reduce intimate partner and sexual violence	SPM #07 - Percent of women physically abused during the 12 months prior to pregnancy SPM #08 - Percent of high school students who experienced dating violence

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Increase access to early intervention services and developmental screening within the context of a medical home for children	SPM #09 - Percent of children receiving standardized screening for developmental or behavioral problems
Increase access to dental care for pregnant women and children, including children with special health care needs	See NPM #09
Reduce discrimination in health care services in publicly-funded programs.	SPM #10 - Proportion of the minority population served in relation to the general minority population

F. Outcomes Measures – Federal and State (**Attachment 13**)

From 2004-2008, very little progress had been made in the outcome measures related to infant mortality. The ratio of black to white infant mortality (2.7) remains high and the ratio of Native American to white infant mortality (1.5) has only improved slightly. Previous success in decreasing adolescent (15-17 years of age) pregnancy has been reversed in 2008. The rate of low birth weight and preterm birth has been relatively unchanged in the past five years, and the percent of women accessing prenatal care in the first trimester has actually declined over the past five years. There remains significant racial/ethnic disparity in infant mortality and the risk factors associated with it.

The focus for current and future strategies to address this problem has shifted to earlier interventions designed to improve the pre-conceptual health of women and to address the social determinants of health.

As the economy in Michigan has declined, so has the availability of health care coverage and access to appropriate, timely services. Medicaid and WIC caseloads are at an all-time high. In spite of significant state revenue shortfalls and budget cuts, the Medicaid benefit package for children and pregnant women has remained intact. However, physician's fees have been cut by 8%. This is expected to impact the availability of prenatal care and other health care services for our target populations.

The child death rate decreased from 19.4 per 100,000 in 2004 to 16.8 in 2008, largely due to the enactment of seatbelt and car seat safety legislation along with training on proper installation of car seats.

G. Needs Assessment Summary

The assessment of needs for the MCH population for 2011-2016 highlights the continuing need to focus on reducing infant mortality and the associated risk factors. Michigan's infant mortality rate remains above the national rate and significant disparities exist between indicators for the white population and for minority populations. To accomplish reductions in these indicators, a change in

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approach is necessary. Priorities for the 2011-2016 period will not only focus on the traditional indicator of infant mortality, including low birth weight, preterm birth and unintended pregnancy, but also on the social determinants of health and the patterns of health established during the life course. Strategies will focus on improving the pre-conceptional and inter-conceptional health status of women of child-bearing age, including addressing chronic disease, obesity and domestic violence factors. Increasing the proportion of intended pregnancies, including reducing adolescent pregnancy, will also continue to be an important effort. With a grant from the Kellogg Foundation, the Department will develop and implement a training curriculum for state staff on multi-culturalism and the effects of racism in areas such as developing a common language, analysis and definition of racism, and understanding the connection of their work to institutional racism.

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

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

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

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

Access to dental care has become a priority concern in terms of its availability to adults and children including children with special health care needs, and in

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terms of the impact of oral health upon the general health of children and pregnant women.

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

MICHIGAN TITLE V NEEDS ASSESSMENT PRE-SURVEY FINDINGS

TECHNICAL REPORT 2009

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MICHIGAN TITLE V NEEDS ASSESSMENT PRE-SURVEY FINDINGS

Introduction:

This report details results of the Michigan Title V Needs Assessment Pre-Survey, conducted to learn about stakeholders' perceptions of primary MCH needs in Michigan, the terminologies they use, and their interest in participating in the Title V Needs Assessment process. Specifically, this effort was aimed to allow stakeholders to provide open ended responses about perceived MCH needs in hopes of ascertaining an 'off the cuff' impression of perceptions that would likely surface during initial Title V Needs Assessment meetings. Knowledge of stakeholder perceptions prior to initial needs assessment meetings will likely allow more focused preparation towards consensus building, facilitation of collaboration and avoidance of alienation.

The research questions intended to be answered by the pre-survey are as follows:

- R1:** What are the most important Maternal & Child Health needs in the State of Michigan as perceived by internal & external stakeholders?
- R2:** How many distinct MCH topics will be perceived as primary needs by Michigan stakeholders?
- R3:** Can perceived needs be categorized in a manner that will facilitate inter-stakeholder collaboration?
- R4:** Do stakeholders use different terminologies to describe similar needs and/or problems.
- R5:** Which Maternal & Child Health stakeholders are interested in actively participating in the Title V Needs Assessment?

Methods:

To answer the above research questions, a brief internet survey asking respondents to rank their top four perceived MCH needs in Michigan was sent to stakeholders, both internal and external to MDCH, identified by MDCH staff (convenience sample). Analysis of collected survey data included a) counting unique organizations and 'needs' identified, b) categorizing organizations and 'needs' into associated groupings, c) tabulation of categorized data, and d) calculation of the proportion of respondents interested in participating in the needs assessment process.

Results:

With assistance from Carol Ogan and others, approximately 400 stakeholders' email addresses were obtained and used to disseminate a solicitation for participation in the Title V Needs Assessment Pre-Survey. Nearly 35% (N=136) of those solicited responded to the survey.

Table 1 reports the types of organizations represented among survey respondents. In total, survey participants

Table 1: Organizations Represented Among Michigan Title V Pre-Survey Respondents

Organization	N	%
Agency/Group	26	19.12
County/District Health Department	44	32.35
Department of Community Health	27	19.85
Hospital/Healthcare	27	19.85
State Govt. (non-DCH)	8	5.89
University	2	1.47
Other	2	1.47

represented 119 unique organizations or programs. Approximately half of the respondents worked in either DCH (20%) or a county/district health department (32%); agencies/groups (19%) and hospital/healthcare (20%) related organizations accounted for the majority of the remaining participants.

‘Needs’ reported were either specified via narrative or were topics of perceived importance. When asked to rank the most important MCH need in Michigan, respondents reported 128 unique responses. Topics reported by multiple respondents using identical terminology included infant mortality, health disparities, and access to care. Respondents’ greatest perceived MCH needs were categorized as reported in Table 2 in descending order of frequency.

Access to healthcare (27%), infant mortality (15%), and family planning (10%) were the most commonly reported MCH topics perceived to be in greatest need of being addressed in Michigan.

Health disparities, mental illness, and oral health were each ranked as the most important MCH need by nearly 5% of the respondents.

Table 3 reports the second greatest perceived MCH need in Michigan as reported by survey respondents. Again, healthcare access (21%) and family planning (10%) were ranked as being significantly important topics requiring attention.

Care coordination, infant mortality, mental illness, each were reported as being the second most important MCH need in Michigan by approximately 5% of the respondents.

Table 2: Greatest Perceived Michigan MCH Needs (Categorized for reporting purposes)

Michigan MCH Need	N	%
Healthcare Access	37	27.2%
Infant mortality	21	15.4%
Family planning	13	9.6%
Disparities 6		4.4%
Mental Illness/Maternal Depression	6	4.4%
Oral Health	6	4.4%
Care Coordination	5	3.7%
Prenatal Care	5	3.7%
N/A 4		2.9%
Services 4		2.9%
Obesity 3		2.2%
Prematurity/LBW 3		2.2%
Social Determinants	3	2.2%
Breast Feeding	2	1.5%
Funding 2		1.5%
Immunizations 2		1.5%
Lead poisoning	2	1.5%
Other 12		8.8%
Total 136		100.0%

Table 3: Second Greatest Perceived Michigan MCH Needs (Categorized for reporting purposes)

Michigan MCH Need	N	%
Healthcare Access	27	20.5%
Family Planning	13	9.8%
Care Coordination	7	5.3%
Infant Mortality	7	5.3%
Mental Illness/Maternal Depression	7	5.3%
Oral Health	5	3.8%
Pre/Inter-conception care	4	3.0%
Premature Birth/LBW	4	3.0%
Prenatal Care	4	3.0%
Substance Abuse	4	3.0%
Funding 3		2.3%
Lead poisoning	3	2.3%
Obesity 3		2.3%
Screening 3		2.3%
Increased Services	3	2.3%

Table 4 reports the third greatest perceived MCH needs reported by survey respondents. Again, healthcare access (15%) and family planning (7%) were the most frequently reported perceived needs. Need for more services was reported by 6% of the respondents.

Infant mortality and prenatal care, mental illness, oral health and nutrition were each reported as the third greatest MCH need in Michigan by approximately 5% of the respondents.

Table 5 reports the fourth greatest perceived MCH need in Michigan reported by survey respondents; family planning (9%), access to healthcare (9%) and nutrition (7%) were most commonly reported by survey respondents.

Care coordination, mental illness, education, oral health, and parenting support services were each reported as the fourth greatest MCH need by 5-6% of survey respondents.

As indicated in Figure 1, 33% of the survey respondents were very interested in participating in the Michigan Title V Needs Assessment process, 51% were somewhat interested, and only 15% were not interested in participating.

DCH employees (41%) and hospital/healthcare (41%) affiliates were most likely to report being very interested in participating in the needs assessment process. County/District Public Health workers (30%) were most likely to report *no interest* in participation.

Limitations:

The results of this survey are limited by several factors. First, approximately 65% of those solicited to participate refused. Thus, results of this survey may not be generalizable to the greater population of Michigan MCH stakeholders. However, given that participation in the Title V Needs Assessment process will be voluntary for many, these results are likely representative of those willing to participate. Results were categorized by a single person (SK); others may have categorized findings differently which could potentially lead to different results. However, the impact of categorization is deemed minimal given the similarity of intra-category responses. Thus, the overall findings of this survey appear reasonably valid and reliable. Finally, important

Table 4: Third Greatest Perceived Michigan MCH Needs (Categorized for reporting purposes)

Michigan MCH Need	N	%
Healthcare Access	19	14.7%
Family Planning	9	7.0%
Increased Services	8	6.2%
Infant mortality	7	5.4%
Prenatal Care	7	5.4%
Mental Illness/Maternal Depression	6	4.7%
Oral Health	6	4.7%
nutrition 6		4.7%
Obesity 5		3.9%
Substance Abuse	5	3.9%
Abuse/neglect 4		3.1%
Education 4		3.1%
Other 43		33.3%
Total 129		100.0%

Table 5: Fourth Greatest Perceived Michigan MCH Needs (Categorized for reporting purposes)

Michigan MCH Need	N	%
Family Planning	10	8.6%
Healthcare Access	10	8.6%
Nutrition 8		6.9%
Care continuation	7	6.0%
Mental Illness/Maternal Depression	7	6.0%
Education 6		5.2%
Oral Health	6	5.2%
Parenting 6		5.2%
Social Determinants	5	4.3%
Breastfeeding 4		3.4%

stakeholders may not have been solicited for participation in this survey given that a convenience sample was employed.

Discussion:

Overall, access to healthcare, family planning, and infant mortality were the most important MCH topics that need be addressed in the State of Michigan as perceived by surveyed internal & external stakeholders.

While over 100 unique responses were provided regarding each perceived MCH need, they were amendable to categorization meaning that similar themes ran through most of the participants responses. Themes included access to and coordination of care, increased services (particularly prenatal care, mental health and oral health), promotion of healthy lifestyles (particularly family planning, nutrition/health weight management, breast feeding and substance abuse services), and specific topics, primarily infant mortality, health disparities and lead poisoning were deemed important across the majority of observations (perceived needs 1-4).

Many of the topics could be addressed by collapsing needs under main topics during the needs assessment process. For instance, prenatal care, breast feeding support, and nutrition services, among others, could be addressed under an umbrella of focus on infant mortality. However, the CDC Title V Needs Assessment Training warns against the impetus to please all stakeholders by broadening the number of topics addressed under global categories such as infant mortality stating that the ability to effect change is reduced as the scope of focus is expanded.

It is recommended that consensus building be a major focus of Title V Needs Assessment pre-planning. Specifically, a rational portrayal of the significance of highly cited MCH needs, in terms of prevalence, magnitude of risk (i.e., what are the outcomes associated with factors of interest and how severe are they on an individual and population basis), and estimated ability of DCH to effect change, with specific attention to the relation between highly and less frequently cited needs, would likely facilitate inter-stakeholder agreement and collaboration. A report could be generated detailing the aforementioned issues and opened to the floor for discussion and further input. Stakeholders should also perhaps be notified that DCH may assert priorities beyond those specified during the Title V Needs Assessment process to avoid alienation of stakeholders with disparate views on the most significant state MCH needs. Thus reference to future DCH needs assessments that may address other issues, or consideration of smaller work groups led by impassioned stakeholders outside of the Title V Needs Assessment process, could potentially diffuse stakeholder alienation.

Conclusion:

It is relatively clear that access to healthcare, family planning, and infant mortality are the most frequently cited MCH needs in Michigan. While a range of needs/topics were cited, there appeared to be several themes evident in stakeholders' responses as detailed above. Most (84%) of the survey respondents were interested in participating in the Title V Needs Assessment process; DCH and hospital/healthcare affiliates are most interested in participation, county/district health department workers were least interested. Attention to consensus building, focusing on objective comparison of cited needs (when possible) and clarification of the departments ability to attribute needs beyond those focused upon during the Title V specific process, is highly recommend.

Family Planning															
Indicator	Healthy People 2010 Goal	Specific Indicator	US Status	MI Status	Indicator by Race	Disparity proportion	US Status	MI Status	Indicator by Type of Insurance	US Status	MI Status	Data Source(s)	Title V Performance		
													(are we meeting goals?)		
Contraceptive coverage-revised based on FP input see notes below*		Increase the proportion of women of reproductive age 15-44 yrs who have contraceptive care covered by insurance			Black, non-Hispanic				Uninsured			Alan Guttmacher Institute (2002) estimates 86% of health plans offer contraception	Other data source: Society for Human Resources Management survey Overall 66% of all US employers offer employees contraception coverage		
					Hispanic				Medicaid						
					White, non-Hispanic				Private/HMO						
9.1 Unintended pregnancy	70%	The proportion (%) of intended pregnancies out of all pregnancies	51.0%	59.3%	Black, non-Hispanic	Blacks are 0.5 times as likely to have an intended pregnancy	31.0%	38.3%	Uninsured	non-Mcd: 72.8%	59.10%	Pregnancy Risk Assessment Monitoring System (PRAMS), National Survey of Family Growth (NSFG),			
					Hispanic				Medicaid						
					White, non-Hispanic				Private/HMO						
Sub categories															
Unwanted pregnancy		The proportion (%) of unwanted pregnancies out of all pregnancies among women 20 years or older		11.2%	Black, non-Hispanic	Blacks are 2.4 times more likely to have an unwanted pregnancy (MI)	31.1%*	21.8%	Uninsured	33.6%*	16.0%	Prams 2006 except* Prams 2000 Note: % of unwanted = number of unintended/ number of unintended Additional data is available through PRAMS			
					White, non-Hispanic				Insurance						non-mcd: 7.4%
Unintended pregnancy		The proportion (%) of unintended pregnancies out of all pregnancies among women younger than 20 years	13-17 yrs =79.6%	18-19 years = 69.2%	<29 yrs 72.8%	Black, non-Hispanic				Uninsured					
						Hispanic				Medicaid					
						White, non-Hispanic				Private/HMO					
9.10 Pregnancy prevention and sexually transmitted disease protection-ages 15 to 17 years	49%	e. Females: proportion of sexually active, unmarried 15-17 yrs old used condoms(partner) at last intercourse from all sexually active, unmarried 15-17 yrs old females	56.0%	58.1%	Black, non-Hispanic	DSU			Uninsured						
					Hispanic				Medicaid						
					White, non-Hispanic				Private/HMO						
	79%	f. Males:the proportion of sexually active, unmarried 15-17 yrs old who used condoms at last intercourse from all sexually active, unmarried 15-7yr old males.	84.0%	72.8%	Black, non-Hispanic	DSU			Uninsured						
					Hispanic				Medicaid						
					White, non-Hispanic				Private/HMO						
Prevalence of STIs among adolescents		Prevalence of STIs among adolescents			Black, non-Hispanic				Uninsured			MDCH - Communicable Disease * Katie Macomber			
					Hispanic				Medicaid						
					White, non-Hispanic				Private/HMO						

*Note: contraceptive coverage indicator will need to be modified based on data availability . Other sources: Medicaid and private insurance claims data, Society for Human Resources Management survey Overall 66% of all US employers offer employees contraception coverage this differs from the Guttmacher number. Guttmacher reports 86% of plans cover contraceptive supplies,

ACCESS TO CARE											
Indicator	Healthy People 2010 Goal	Specific Indicator	US Status	MI Status	Indicator by Race	MI Status	Black / White Ratio	Indicator by Type of Insurance	MI Status	Medicaid / Non Medicaid Ratio	Data Source(s)
Usual Primary Care Provider	85%	% of women (18 years and older) who have a usual primary care provider	78%	91%	% of African American women with a usual PCP (compared to white women)	African American - 88%, white - 92%	1.0	% of women with Medicaid with a PCP (compared to women with private insurance)	Medicaid - 94%, non-Medicaid - 93%	1.0	BRFSS
		% of children (age 0-23) who have been to a child and adolescent health center (CAHC)			% of those children (age 0-23) receiving care from a CAHC who are African American (compared to white children)	African American-43%, white - 38%		1.1			
Medical Home ¹		% of children (0-17 years of age) who have a medical home	58%	63%	% of African American Children with a medical home (compared to white children)	African American - 49%, white - 67%	0.7	% of children with Medicaid with a medical home (compared to children with private insurance)	Public Insurance - 50%, private - 70%	0.7	NCHS
Prenatal Care											
Early and Adequate Care	90%	% of pregnant women receiving early and adequate care	74%	75%	% of African American women with early and adequate care (compared to white women)			% of women with Medicaid with early and adequate care (compared to women with private insurance)			PRAMS, Live Birth Records, Medicaid, Maternal Infant Health Program (MIHP)
Healthy Behaviors											
Smoking ²	99%	% of babies who are not exposed to cigarette smoke during pregnancy		93%	% of African American babies who are not exposed to cigarette smoke (compared to white women)	African American - 93%, white - 92%	1.0	% of babies with Medicaid who are not exposed to cigarette smoke (compared to women with private insurance)	Medicaid - 90%, non-Medicaid - 94%	1.0	PRAMS, MIHP
Alcohol consumption ³	94%	% of women who abstain from alcohol consumption during pregnancy	~90%	93%	% of African American women abstaining from alcohol (compared to white women)	African American - 95%, white - 93%	1.0	% of women with Medicaid abstaining from alcohol (compared to women with private insurance)	Medicaid - 96%, non-Medicaid - 91%	1.1	PRAMS, MIHP
Multivitamin Consumption ⁴	80%	% of women who consume multivitamins before becoming pregnant		27%	% of African American women with multivitamin consumption before pregnancy (compared to white women)	African American - 21%, white - 29%	0.7	% of women with Medicaid with multivitamin consumption before pregnancy (compared to women with private insurance)	Medicaid - 16%, non-Medicaid - 36%	0.4	PRAMS, (WIC)
Obstetrical Care	90%	% of very low birth weight (VLBW) infants born at level III hospitals or subspecialty perinatal centers	73%		% of African American infants in specialty hospitals (compared to white infants)			% of infants with Medicaid in specialty hospitals (compared to infants with private insurance)			Live Birth Records
Services for children with special health care needs	100% of states to have service systems for children with special health care needs. In development	% of children (0-2 years of age) with special needs who are receiving early intervention services	23%	25%	% of African American children with services (compared to white children)	African American - 22%, white - 23%	1.0	% of children with public insurance with services (compared to children with private insurance)	Public Insurance - 37%, private - 6%	6.2	Children's Special Health Care Services (CSHCS) and NCHS, Early On
		% of children (3-17 years of age) with special needs who are receiving Special Education services	29%	28%	% of African American children with services (compared to white children)	African American - 39%, white - 27%	1.4	% of children with public insurance with services (compared to children with private insurance)	Public Insurance - 42%, private - 21%	2.0	CSHCS, NCHS, Early On
		% of children (0-17 years of age) with special needs who have a medical home	50%	56%	% of African American children with a medical home (compared to white children)	African American - 42%, white - 60%	0.7	% of children with public insurance with a medical home (compared to children with private insurance)	Public Insurance - 45%, private - 62%	0.7	CSHCS, NCHS, State and Local Area Integrated Telephone Survey (SLAITS)
Immunizations	80%	% of children age 19-35 months who receive all recommended 4:3:1:3:3 vaccines	80%	83%	% of African American children with immunizations (compared to white children)			% of children with Medicaid with immunizations (compared to children with private insurance)			Michigan Care Improvement Registry (MCIR), National Immunization Survey (NIS)
		% of children (age 5-17) who receive influenza vaccine				% of African American children who receive all influenza vaccines (compared to white children)		% of children with Medicaid who receive influenza vaccines (compared to children with private insurance)		MCIR	
		% of women of reproductive age (18-44 years old) who receive influenza vaccine				% of African American women of reproductive age who receive influenza vaccine (compared to white women)		% of women of reproductive age with Medicaid who receive influenza vaccine (compared to women with private insurance)		MCIR	
Racism in the health care setting ⁷		% of women who thought they were treated worse than other races		6%	% of African American women who thought they were treated worse than other races (compared to white women)	African American - 19%, white - 4%	4.8	% of women with no insurance who thought they were treated worse than other races (compared to those with insurance)	No Insurance - 14%, Have insurance - 5%	2.8	BRFSS

Screenings												
Hearing Screens		% of infants with diagnosed with permanent hearing loss by 3 months of age		35%	% of African American infants diagnosed with permanent hearing loss by 3 months of age (compared to white infants)	African American - 29%, white - 33%	0.9	% of infants with Medicaid with diagnosed with permanent hearing loss by 3 months of age (compared to infants with private insurance)				Early Hearing Detection and Intervention (EHDI) Database
		% of preschool and school age children who refer from hearing screenings		11%	% of African American preschool and school age children who refer from hearing screenings (compared to whites)			% of preschool and school age children with Medicaid who refer from hearing screenings (compared to those with private insurance)				Vision and Hearing Screens Data: MDCH

INFANT MORTALITY								
Indicator	Healthy People 2010 Goal	Specific Indicator	US Status	MI Status	Indicator by Race	MI Status	Black to White Ratio*	Data Source(s)
Maternal Health/Prematurity (deaths among those 500-1499 g)								
% of births that are preterm	7.6%	% of births that are preterm	12.8%	12.5%	% African American women with preterm infants (compared to white women)	African American - 18.8%, White - 11.1%	1.7	Pregnancy Risk Assessment Monitoring System (PRAMS), Live Births records, National Center for Health Statistics, final natality data
% of births that are low birth weight	5.0%	% of births that are low birth weight	8.3%	8.4%	% African American women with low birth weight infants (compared to white women)	African American - 14.4%, White - 7.0%	2.1	PRAMS, Live Births records, National Center for Health Statistics, final natality data
Prenatal Care - Kotelchuck Index								
% of pregnant women receiving early and adequate care	90%	% of pregnant women receiving early and adequate care	74%	75%	% of African American women with early and adequate care (compared to white women)			PRAMS, Live Births Records
Maternal Behaviors								
% of women who smoke during pregnancy	1%	% of women who smoke during pregnancy	12%	18%	% of African American women who smoke during pregnancy (compared to white women)	African American - 16%, White - 19%	0.8	PRAMS, Behavioral Risk Factor Surveillance System (BRFSS)**
% of women who consume alcohol during pregnancy	6%	% of women who consume alcohol during pregnancy	-10%	7%	% of African American women who consume alcohol during pregnancy (compared to white women)	African American - 5%, White - 7%	0.7	PRAMS, BRFSS**
% of women who binge drink during pregnancy	0%	% of women who binge drink during pregnancy	1%		% of African American women who binge drink during pregnancy (compared to white women)	African American - 1%, White - 1% (US)	1.0	PRAMS, BRFSS**
% of women who use illicit drugs during pregnancy	0%	% of women who use illicit drugs during pregnancy	2%		% of African American women who use illicit drugs during pregnancy (compared to white women)	African American - 5%, White - 2% (US)	2.5	National Household Survey on Drug Abuse
Maternal Care (fetal deaths 1500 g+ and >=24 weeks gestation)								
Fetal death rate (fetal deaths at 20 or more weeks of gestation per 1,000 live births plus fetal deaths)	4.1	Fetal death rate (fetal deaths at 20 or more weeks of gestation per 1,000 live births plus fetal deaths)	6.8	5.9	Fetal death rate among African American women (compared to white women)	African American - 10.4, White - 4.5	2.3	National Vital Statistics System (NVSS), CDC, NCHS, Michigan Fetal Death Registry
% of pregnant women who are insured	100%	% of pregnant women who are insured		-80%	% African American women who are insured (compared to white women)	African American - 81%, White - 77%	1.1	PRAMS, BRFSS**
% of children (0-17 years of age) who are insured	100%	% of children (0-17 years of age) who are insured	91%	94%	% of African American children who are insured (compared to white children)	African American - 97%, White - 95%	1.0	National Survey of Children's Health (NSCH)
Maternal Behaviors								
% of women with non-obese pre-pregnancy BMI		% of women with non-obese pre-pregnancy BMI		74%	% of African American women with non-obese pre-pregnancy BMI (compared to white women)	African American - 60.7%, White - 76.7%	0.8	PRAMS, BRFSS**
		% of women with an appropriate weight gain during pregnancy			% of African American women with appropriate gain (compared to white women)			PRAMS

INFANT MORTALITY								
Indicator	Healthy People 2010 Goal	Specific Indicator	US Status	MI Status	Indicator by Race	MI Status	Black to White Ratio*	Data Source(s)
Pre-existing Conditions								
Diabetes		% of pregnant women with diabetes with a usual care provider			% of African American pregnant women with diabetes with a usual care provider (compared to white women)			PRAMS, BRFSS**
Hypertension		% of pregnant women with hypertension with a usual care provider			% of African American pregnant women with hypertension with a usual care provider (compared to white women)			PRAMS
Newborn Care (deaths 1500 g+ between 0 and 28 days of life)								
High-risk referral	90%	% of very low birth weight (VLBW) infants born at level III hospitals or subspecialty perinatal centers	73%	78%	% of African American infants in specialty hospital (compared to white infants)			Title V Reporting System
Infant Health (deaths 1500 g+ between 28 and 365 days of life)								
Back sleeping	70%	% of infants placed on back for sleep	35% (1996)	74% (2006)	% of African American infants placed on back (compared to white infants)	African American - 57.6%, White - 77.1%	0.7	PRAMS
Co-sleeping		% of women who never co-sleep with their infant		81%	% of African American women who never co-sleep with their infant (compared to white women)	African American - 60%, White - 86%	0.7	PRAMS
Breastfeeding	75%	% of children 0-5 ever breastfed	76%	72%	% of African American children 0-5 ever breastfed (compared to white children)	African American - 61.1%, White - 76.3%	0.8	NSCH, WIC
Birth Defects	1.1	Infant mortality rate due to birth defects (per 1,000 live births)	1.6	1.5	Infant mortality rate due to birth defects for African Americans (compared to white)	African American - 2.1, White - 1.4	1.5	FIMR, Death certificates linked to live births records, CDC Wonder, Michigan Birth Defects Registry (MBDR)
SIDS	2.5	Infant mortality rate due to SIDS (per 10,000 live births)	7.2	3.8	Infant mortality rate due to SIDS for African Americans (compared to white)	African American - 7.6, White - 3.0	2.5	Fetal Infant Mortality Review (FIMR), Death certificates linked to live births records, CDC Wonder
Accidents		Infant mortality rate due to accidents (per 10,000 live births)	2.9	5.7	Infant mortality rate due to accidents for African Americans (compared to white)	African American - 8.0, White - 5.1	1.6	FIMR, Death certificates linked to live births records, CDC Wonder
Homicide		Infant mortality rate due to homicides (per 10,000 live births)	0.7	0.8	Infant mortality rate due to homicides for African Americans (compared to white)	African American - 1.8, White - 1.2	1.5	FIMR, Death certificates linked to live births records, CDC Wonder

*Calculated by dividing the rate or percentage among African Americans by the rate or percentage among whites

**BRFSS data can be used to obtain information on women of reproductive age.

Maternal Depression

Maternal Depression													
	Indicator	Healthy People 2010 Goal	Specific Indicator	US Status	MI States	Indicator by Race	MI Status	Indicator by Type of Insurance	MI Status	Data Sources	Title V Performance (are we meeting goals?)		
Prior & During Pregnancy	Lifestyle Behaviors	Alcohol consumption	94%	% of women who abstain from alcohol consumption during pregnancy	-90%	93%	% of African American women abstaining from alcohol (compared to white women)	African American- 95%, white - 93%	% of women with Medicaid abstaining from alcohol(compared to women with private insurance)	Medicaid-67%, non-Medicaid-94%	Pregnancy Risk Assessment Monitoring System		
		Smoking	99%	% of women who abstain from smoking during pregnancy	88%	82%	% of African American women abstaining from smoking (compared to white women)	African American - 84%, white - 93%	% of women with Medicaid abstaining from smoking(compared to women with private insurance)	Medicaid-96%, non-Medicaid-91%	PRAMS		
	Chronic Disease	Prevalence of Diabetes		% of women who had diabetes during pregnancy		-9.4%	% of African American women who had diabetes during pregnancy	African American - 13.8%, white - 8.6%	% of women with Medicaid who had diabetes during pregnancy(compared to women with private insurance)		PRAMS		
	Stressful Life Events	Unwanted Pregnancy		% of pregnant women who had an unwanted pregnancy		41%	% of African American women who had an unintended pregnancy (compared to white women)	African American - 63.3%, white - 35.7%	% of women with Medicaid who had an unwanted pregnancy(compared to women with private insurance)		PRAMS		
		Physical Abuse		% of women involved in physical abuse 12 months prior to pregnancy		-4.4%	% of African American women involved in physical abuse 12 months prior to pregnancy(compared to white women)		% of women with Medicaid involved in physical abuse(compared to women with private insurance)		PRAMS		
	Socioeconomic Status	Health Insurance	100%	% of pregnant women who are insured		-80%	% African American women who are insured (compared to white women)	African American - 81%, white - 77%	% of women with Medicaid (compared to women with private insurance)	Medicaid-56%, non-Medicaid-94%	PRAMS		
		Early and Adequate Care	90%	% of pregnant women receiving early and adequate care	74%	75%	% of African American women with early and adequate care (compared to white women)		% of women with Medicaid with early and adequate care(compared to women with private insurance)		PRAMS, Live Birth Records, Medicaid		
		Care in 1st Trimester	90%	% of pregnant women receiving care in their 1st trimester of pregnancy	83%	83%	% of African American women with care in 1st trimester (compared to white women)		% of women with Medicaid with care in 1st trimester (compared to women with private insurance)		PRAMS, Medicaid, Live Birth Records		
		Lifestyle Behaviors	Alcohol Consumption		% of women who abstain from alcohol consumption after pregnancy			% of African American mothers who currently smoke (compared to white women)		% of women with Medicaid who abstain from alcohol after pregnancy (compared to women with private insurance)		PRAMS	
			Smoking		% of mothers who currently smoke		-22.42 %	% of African American mothers who currently smoke (compared to white women)		% of women with Medicaid who abstain from smoking after pregnancy (compared to women with private insurance)		PRAMS	
Chronic Disease		Source of Ongoing Care	96%	% of women of reproductive age (15-49 years old) who have a source ongoing care	87%		% of African American women of reproductive age (15-49 years old) who have a source ongoing care(compared to white women)		% of women with Medicaid with a source of ongoing care (compared to women with private insurance)		PRAMS		

Maternal Depression

After Pregnancy	Stressful Life Events	Unintended Birth	% of women who had an unwanted birth			% of African American women who had an unintended birth (compared to white women)	African American - 20.4%, white - 7.6%	% of women with Medicaid who had an unintended birth (compared to women with private insurance)		Behavioral Risk Factor Surveillance System(BRFFS)	
		Physical Abuse	% of pregnant women involved in physical abuse			% of African American women involved in physical abuse (compared to white women)		% of women with Medicaid involved in physical abuse (compared to women with private insurance)		PRAMS	
		Homicide	Infant mortality rate due to homicides	0.7 per 10,000 live births	1.3 per 10,000 live births	Infant mortality rate due to homicides for African Americans (compared to white)	African American - 1.8/10,000 live births, White - 1.2/10,000 live births	Infant mortality rate due to homicide for Medicaid recipients (compared to women with private insurance)		FIMR, Death certificates linked to live births records	
	Socioeconomic Status	Health Insurance	% of women of reproductive age (15-49) who are insured		-90%	% of African American women of reproductive age (15-49) who are insured (compared to white women)		% of women with Medicaid (compared to women with private insurance)		BRFFS	
		Inter-Pregnancy Care	% of women with inadequate well baby visits		8.60%	% of African American women who had sufficient well-baby care (compared to white)	African American - 11.4%, white - 8.1%	% of women with sufficient well-baby care who had medicaid(compared to women with private insurance)		PRAMS	
		Postpartum Depression	% of women who said to have postpartum depression		-50.5%	% African American women who said to have postpartum depression (compared to white women)		% of women with Medicaid who said to have postpartum depression(compared to women with private insurance)	Medicaid-57%, non-Medicaid-46%	PRAMS	

SUGGESTED PRIORITIES FOR MATERNAL AND CHILD HEALTH

Criteria Priority	What is prevalence of the problem/issue?		Is there disparity between race/ethnic groups?	Is issue susceptible to intervention?	Are there potential cost savings?	Is this an emerging issue?	Are data available to measure?	Can we demonstrate progress/accomplishments?	Are there collaborative opportunities?
	US M	I							
1. Increase proportion of intended pregnancies	51.0%	59.3%	Black – 31.0% Hispanic – 46.0% White – 60.0%	Yes Yes	s	No	Pregnancy Risk Assessment Monitoring System (PRAMS) (2006)	1996 – 56.9% 2006 – 59.3%	- LHD - DHS - MDE - GSC - Healthy Start - MSMS - MI-ACOG - MOA
2. Increase male involvement in family planning	68.5%	72.8% of male students who had sexual intercourse during past 3 months and used a condom 4,286 male Family Planning users	Black - 1,272 Hispanic – 313 White – 2,720 AI/AN – 29 AS/PI – 42	Yes Yes	s	No	Youth Risk Behavior Survey (YRBS) (2007) Family Planning Annual Report (FPAR) (2008)	Improvement from 58.2% in 1997 to 65% in 2007.	- MDE - LHD
3. Decrease adolescent (15-17 yrs of age) pregnancy	44.0 per 1,000	28.3 per 1,000	Black – 88.0 Hispanic – 85.0 White – 25.0	Yes Yes	s	No	Vital Records (2007)	From 1996 to 2007 the MI teen pregnancy rate declined by 29.6%	- DHS - MDE - LHD - Teen Health Centers - MSMS - MI-ACOG - MOA - MI-AAP
4. Decrease sexually transmitted diseases (rate per 100,000)	<u>Chlamydia:</u> 15-19 yrs – 1956.4 <u>Gonorrhea:</u> 15-19 yrs – 453.1	<u>Chlamydia:</u> 15-19 yrs – 2640 <u>Gonorrhea:</u> 15-19 yrs – 820	Chlamydia: 15-19 yrs: Black – 2898 White – 1360 Gonorrhea: 15-19 yrs: Black – 966 White – 311	Yes Yes	s	No	Sexually Transmitted Disease (STD) Database	The rate of infection among 15-19 yr-olds increased by 119.8% from 1997 to 2008 for Chlamydia and by 36.7% for gonorrhea	- DHS - MDE - LHD - Teen Health Centers - MSMS - MOA - MI-AAP - MI-ACOG

Criteria Priority	What is prevalence of the problem/issue?		Is there disparity between race/ethnic groups?	Is issue susceptible to intervention?	Are there potential cost savings?	Is this an emerging issue?	Are data available to measure?	Can we demonstrate progress/ accomplishments?	Are there collaborative opportunities?
	US M	I							
5. Promote parent education re: responsible sexual behavior		72.1% of students whose parents or other adults in their family have ever talked with them about what they expected them to do or not do when it comes to sex	Black – 81.8% White – 70.6 AI – 61.6% Hispanic – 70.1%	Yes/Yes	s	No	YRBS	Some improvement from 1999 (69.1%) to 2007 (72.1%).	- MDE - LHD
6. Include family planning information in transition planning for CSHCN*									
7. Increase proportion of CSHCN population that has access to medical home and integrated care planning	To	be determined	Yes	s	Yes	Yes	CHAMPS?	-	LHD - MSMS - MOA - Mi-AAP
8. Increase access to dental care for pregnant women and children, including children with special health care needs	78.4%	49.2% of Medicaid-eligible children 6 through 9 years who received any dental service during the year (2008) 83.0% of children with a preventive dental visit in past year	Yes	s	Yes	Yes	CHAMPS National Survey of Children's Health	2001 – 40.5% 2008 – 49.2%	- LHD - MDA

Criteria Priority	What is prevalence of the problem/issue?		Is there disparity between race/ethnic groups?	Is issue susceptible to intervention?	Are there potential cost savings?	Is this an emerging issue?	Are data available to measure?	Can we demonstrate progress/ accomplishments?	Are there collaborative opportunities?
	US M	I							
9. Increase access to early intervention services & developmental screening	19.5% 26.4% 1.04% 2.66%	18.2% of children receiving standardized screening for developmental or behavioral problems 23.7% of children determined to be at moderate or high risk of developmental or behavioral problems based on parents' specific concerns 1.15% infants birth to one with IFSPs 2.67% of infants and toddlers birth to 3 with IFSPs	Yes	s	Yes	No	National Survey of Children's Health Part C State Performance Plan 2010	2003 – 35.8% 2007 – 23.7% 2002 – 0.9% 2009 – 1.15% 2002 – 1.9% 2009 – 2.67%	- Head Start - Early Head Start - Early On - DHS - GSC - LHD - MI-AAP - MSMS - MOA
10. Increase the rate of early and adequate prenatal care	74%	75% (2007)	Black – 64.5% White – 76.7% AI – 72.3% Asian – 75.5% Hispanic – 67.3%	Yes	Yes	No	Vital Records	From 1997 (75.9%) to 2007, the percent receiving early & adequate prenatal care the rate was relatively unchanged	- DHS - LHD - MSMS - MI-ACOG - MOA
11. Promote pre-pregnancy counseling and health status assessment*				Yes	Yes	No	Medicaid Waiver?		- MI Primary Care Consortium - MSMS - MOA - LHD

Criteria Priority	What is prevalence of the problem/issue?		Is there disparity between race/ethnic groups?	Is issue susceptible to intervention?	Are there potential cost savings?	Is this an emerging issue?	Are data available to measure?	Can we demonstrate progress/ accomplishments?	Are there collaborative opportunities?
	US M	I							
12. Reduce preterm delivery and low birth weight (LBW)	Preterm – 12.8% LBW – 8.3%	Preterm – 12.5% LBW – 8.4%	Preterm Black – 18.8% White – 11.1% AI – 10.1% ASPI – 8.3% Hispanic – 10.1% LBW Black – 14.4% White – 7.0% AI – 8.2% ASPI – 8.6% Hispanic – 6.7%	Yes – Preconception Ed (Chronic Disease); Risk Factor Ed. (smoking, alcohol, drugs, infection, etc.); Early ID & mgmt of high risk pregnancies	Yes	No	Vital Records	Preterm Births: 1998 – 11.0% 2008 – 12.5% LBW: 1998 – 7.8% 2008 – 8.4%	- March of Dimes - MI Primary Care Asso. - MSMS - MI-ACOG - MOA - LHD
13. Reduce Black and American Indian infant mortality rates	6.7 (2006)	7.4 (2008)	Black – 14.6 White – 5.4 AI – 7.9	Yes	Yes	No	Vital Records	Black mortality rate: 1998 – 16.8 2008 – 14.6 American Indian mortality rate: 1998 – 8.3 2008 – 7.9	- LHD - March of Dimes - Healthy Start - MSMS - MOA - MI-ACOG - MI-AAP
14. Reduce Infant Suffocation	5.4 per 10,000	3.8 per 10,000 74% place baby to sleep on back	Black – 7.6 White – 3.0 Black – 57.2% White – 7.8% AS/PI – 85.1% Hispanic – 69.1%	Yes – suffocation cases No - true SIDS	No No		Vital Records PRAMS	1998 – 11.1 2007 – 3.8 2001 – 71.4% 2006 – 74.0%	- MSMS - MOA - MI-AAP
15. Increase breastfeeding rates: Initiation At 6 months	64% 43.4%	69% 31.2%	Black – 55.9% White – 70.2%	Yes Yes	s	No	PRAMS (2006) National Immunization Survey (2006)	Initiation: 1997 – 61.7% 2006 – 69%	- LHD - MSMS - MOA - MI-AAP - MI-ACOG

Criteria	What is prevalence of the problem/issue?		Is there disparity between race/ethnic groups?	Is issue susceptible to intervention?	Are there potential cost savings?	Is this an emerging issue?	Are data available to measure?	Can we demonstrate progress/ accomplishments?	Are there collaborative opportunities?
	US M	I							
Priority									
17. Address environmental issues:				Yes	Yes	No			
Asthma	10.9%	11.4% of high school students who have current asthma	Black – 14.7% White – 10.5% Hispanic – 9.5%				YRBS	(Only reported in 2007)	- LHD - Bureau of Epidemiology - Chronic Disease - MSMS - MOA - MI-AAP MI-ACOG
	20.3%	23.5 % of high school students who have ever been told by doctor or nurse that they have asthma	Black – 24.0% White – 19.6% Hispanic – 18.5%				YRBS	2003 – 21.1% 2007 – 23.5%	
Lead	1.21% (2006)	0.9% EBLL (2009)	Black – 1.0% White – 0.2% AI/AN – 0.2% Asian – 0.2% Hispanic – 0.5%				MDCH Data Warehouse Center for Disease Control & Prevention (CDC) National Survey of Children's Health	1999 – 7.2% 2009 – 0.9%	
Second-hand smoke	26.2%	29.7% children who live in households where someone smokes	Black – 15.1% White – 16.7% AI – 31.2% AS/PI – 5.0% Hispanic – 10.2%				Vital Statistics	2003 – 38.4% 2007 – 29.7%	
Radon		15.9% of live births/mothers exposed to smokers at home							

Criteria Priority	What is prevalence of the problem/issue?		Is there disparity between race/ethnic groups?	Is issue susceptible to intervention?	Are there potential cost savings?	Is this an emerging issue?	Are data available to measure?	Can we demonstrate progress/ accomplishments?	Are there collaborative opportunities?
	US M	I							
18. Reduce obesity	Adults – 26.7% Students – 13.0%	Adults – 30.1% 27.5% singleton births by mother's BMI at start of pregnancy > 29.0 Students – 12.4%	Adults: Black – 39.8% White – 28.8% Hispanic – 23.7% Black – 35.7% White – 26.4% AI – 33.1% Asian – 8.0% Hispanic – 29.0% Students: Black – 18.5% White – 11.2% AI – 13.6% Hispanic – 14.5%	Yes Ye	s	Yes	Behavioral Risk Factor Survey (BRFS) Vital Statistics YRBS	1999 – 22.8% 2008 – 30.1% 1999 – 10.9% 2007 – 12.4%	- Chronic Disease - MDE - LHD - MSMS - MOA -MI-ACOG - MI-AAP
19. Reduce discrimination in health care services	?			Yes	Yes	No	?		-MSMS -MOA -MI-ACOG - MI-AAP
20. Provide adequate housing				Yes – not MCH		No			
21. Address chronic poverty									

Criteria Priority	What is prevalence of the problem/issue?		Is there disparity between race/ethnic groups?	Is issue susceptible to intervention?	Are there potential cost savings?	Is this an emerging issue?	Are data available to measure?	Can we demonstrate progress/ accomplishments?	Are there collaborative opportunities?
	US M	I							
22. Reduce Maternal Morbidity and Mortality	13.3 (2006)	<p>26.4 (per 100,000 live births)</p> <p>0.8% live births – mothers with pre-pregnancy diabetes</p> <p>3.8% live births – mothers with gestational diabetes</p> <p>1.2% live births – mothers with pre-pregnancy hypertension</p> <p>4.4% live births – mothers with gestational hypertension</p>	<p>White – 22.9 Black – 44.1 ASPI – 23.9</p> <p>Black - 1.1% White – 0.7% AI – 1.2% AS/PI – 1.1% Hispanic – 0.9% Arab – 0.6%</p> <p>Black – 2.6% White - 3.9% AI – 4.5% As/PI – 7.9% Hispanic – 4.5% Arab – 4.6%</p> <p>Black – 2.0% White – 1.0% AI – 1.2% AS/PI – 0.4% Hispanic – 0.6% Arab – 0.3%</p> <p>Black – 3.8% White – 4.6% AI – 4.5% AS/PI – 2.8% Hispanic – 3.2% Arab – 2.6%</p>	Yes Yes	s	No	Vital Records CDC	1999 – 55.5 2008 – 26.4	- LHD - MSMS - MI-ACOG - MOA

* Is this an activity/task rather than a priority objective?

Abbreviations:

- AI – American Indian
- AI/AN – American Indian/Alaskan Native
- ASPI – Asian/Pacific Islander
- BMI – Body Mass Index
- CSHCN – Children with Special Health Care Needs
- DHS – Department of Human Services

GSC – Great Start Collaborative
IFSP – Individualized Family Service Plan
LHD – Local Health Department
MDE – Michigan Department of Education
MI-AAP – Michigan Chapter of the American Association of Pediatricians
MI-ACOG – Michigan Chapter of the American College of Obstetricians & Gynecologists
MDA – Michigan Dental Association
MOA – Michigan Osteopathic Association
MSMS – Michigan State Medical Society

**Number of Infant Deaths, Live Births and Infant Death Rates by
Michigan and Michigan County of Residence,
2008 and 2004-2008 Average**

County of Residence	2008				2004-2008			
	Infant Deaths	Live Births	Infant Death Rate	Low Weight Live Birth Ratios	Average Infant Deaths	Average Live Births	Average Infant Death Rate	Average LBW Ratio
Michigan	894	121,231	7.4	8.5	965.6	126,233.6	7.6	8.4
Alcona	1	70	*	15.7	0.6	68.6	*	*
Alger	2	85	*	9.4	0.4	78.8	*	*
Allegan	6	1,452	4.1	5.9	10.2	1,509.2	6.8	6.8
Alpena	1	286	*	9.4	1.4	295.4	4.7	9.9
Antrim	2	211	*	7.1	1.8	239.0	7.5	6.5
Arenac	-	151	-	9.3	0.4	167.4	*	7.3
Baraga	1	81	*	-	0.6	92.0	*	*
Barry	5	707	*	5.2	4.4	701.0	6.3	6.7
Bay	8	1197	6.7	8.7	8.0	1,241.6	6.4	7.3
Benzie	-	159	-	7.6	1.4	189.8	7.4	7.4
Berrien	16	2,044	7.8	9.3	16.4	2,079.4	7.9	8.3
Branch	2	557	*	6.5	4.0	602.2	6.6	6.5
Calhoun	14	1,776	7.9	9.0	19.0	1,843.2	10.3	8.5
Cass	4	500	*	7.6	4.2	515.6	8.1	8.6
Charlevoix	1	244	*	8.2	1.0	276.2	*	6.3
Cheboygan	-	243	-	6.2	0.8	260.8	*	6.1
Chippewa	1	356	*	6.5	2.2	382.6	5.8	5.8
Clare	1	328	*	9.2	2.4	346.0	6.9	8.5
Clinton	3	769	*	6.6	2.6	812.8	3.2	7.2
Crawford	1	133	*	9.8	1.6	132.2	12.1	8.4
Delta	-	353	-	7.4	2.0	392.8	5.1	7.9
Dickinson	2	266	*	5.6	1.8	268.4	6.7	6.0
Eaton	6	1,136	5.3	7.9	5.6	1,149.4	4.9	6.7
Emmet	2	332	*	7.2	1.4	352.8	4.0	6.8
Genesee	46	5,690	8.1	10.6	58.8	5,998.8	9.8	10.3
Gladwin	1	237	*	8.4	1.8	255.8	7.0	7.7
Gogebic	-	156	-	10.3	0.8	146.8	*	7.6
Gr. Traverse	8	975	8.2	6.1	6.6	983.2	6.7	7.0
Gratiot	3	468	*	6.0	3.6	482.6	7.5	7.1
Hillsdale	4	561	*	6.8	3.2	577.8	5.5	6.5
Houghton	4	407	*	4.9	2.6	402.8	6.5	4.4
Huron	-	304	-	6.6	1.2	320.4	3.7	7.1
Ingham	26	3,538	7.3	7.9	26.8	3,602.6	7.4	8.3
Ionia	1	840	*	6.2	3.2	845.8	3.8	6.6
Iosco	1	196	*	6.6	1.0	214.8	*	6.2
Iron	-	102	-	-	0.4	94.4	*	*

County of Residence	2008				2004-2008			
	Infant Deaths	Live Births	Infant Death Rate	Low Weight Live Birth Ratios	Average Infant Deaths	Average Live Births	Average Infant Death Rate	Average LBW Ratio
Isabella	1	762	*	7.7	5.0	741.4	6.7	7.8
Jackson	14	1,945	7.2	7.6	17.0	2,040.2	8.3	8.1
Kalamazoo	22	3,151	7.0	8.0	22.2	3,152.4	7.0	8.3
Kalkaska	-	196	-	10.2	0.8	217.4	*	8.0
Kent	68	9,028	7.5	7.4	72.0	9,346.2	7.7	7.6
Keweenaw	-	18	-	-	0.2	17.6	*	*
Lake	-	106	-	6.6	1.0	114.2	*	6.8
Lapeer	5	865	*	6.9	4.2	960.2	4.4	6.8
Leelenau	-	171	-	-	1.0	180.4	*	*
Lenawee	11	1,146	9.6	7.4	8.2	1209.2	6.8	7.3
Livingston	10	1,738	5.8	6.9	9.4	1,901.0	4.9	6.3
Luce	2	70	*	-	1.0	60.6	*	*
Mackinac	2	73	*	-	1.0	96.0	*	*
Macomb	61	9,706	6.3	9.3	59.8	9,929.8	6.0	8.3
Manistee	1	226	*	7.1	1.4	233.0	6.0	9.2
Marquette	3	641	*	8.3	2.4	640.8	3.7	6.8
Mason	2	329	*	5.8	1.6	325.2	4.9	7.3
Mecosta	9	439	20.5	9.6	4.0	447.0	8.9	7.0
Menominee	2	228	*	8.3	0.8	225.6	*	6.8
Midland	3	829	*	7.1	6.0	903.2	6.6	7.6
Missaukee	-	157	-	-	0.4	171.8	*	*
Monroe	11	1,656	6.6	6.5	12.0	1,727.2	6.9	7.2
Montcalm	3	809	*	5.4	2.8	826.4	3.4	6.5
Montmorency	-	69	-	-	0.2	7.4	*	*
Muskegon	16	2,388	6.7	9.3	16.4	2,363.2	6.9	8.6
Newaygo	3	601	*	5.8	4.8	641.0	7.5	6.6
Oakland	88	13,844	6.4	8.3	94.0	14,448.4	6.5	8.1
Oceana	3	393	*	8.1	3.4	393.4	8.6	6.8
Ogemaw	1	202	*	6.4	1.2	206.2	5.8	6.5
Ontonagon	-	32	-	-	0.6	45.8	*	*
Osceola	-	293	-	4.4	2.0	291.4	6.9	6.1
Oscoda	2	85	*	7.1	0.4	83.4	*	*
Otsego	1	285	*	6.0	2.2	281.6	7.8	6.1
Ottawa	23	3,437	6.7	6.2	19.4	3,512.0	5.5	6.5
Presque Isle	1	92	*	-	1.0	110.6	*	*
Roscommon	1	178	*	8.4	2.0	192.8	10.4	6.7
Saginaw	25	2,454	10.2	9.7	23.6	2,557.2	9.2	9.8
St Clair	8	1,812	4.4	7.7	13.4	1,967.4	6.8	8.0
St Joseph	10	913	11.0	5.3	8.4	950.0	8.8	7.0
Sanilac	1	476	*	8.2	3.2	509.4	6.3	6.8
Schoolcraft	-	7	-	-	0.8	76.2	*	*
Shiawassee	1	772	*	6.9	6.2	840.4	7.4	7.5

County of Residence	2008				2004-2008			
	Infant Deaths	Live Births	Infant Death Rate	Low Weight Live Birth Ratios	Average Infant Deaths	Average Live Births	Average Infant Death Rate	Average LBW Ratio
Tuscola	1	573	*	8.7	3.8	628.8	6.0	7.0
Van Buren	10	976	10.2	7.9	8.0	1,046.6	7.6	7.2
Washtenaw	17	3,844	4.4	7.8	23.4	4,111.6	5.7	7.6
Wayne	275	25,774	10.7	10.7	285.2	27,055.0	10.5	10.6
Wexford	3	454	*	6.2	3.2	435.8	7.3	7.0

Pregnant Women and Infants Health Index

	White	Black	American Indian	Asian/PI	Hispanic
Infant Mortality	5.4	14.6	7.9	4.1	8.5
Low Birth Weight	7.0%	14.4%	8.2%	8.6%	6.7%
Pre-term Birth	11.1%	18.8%	10.1%	8.3%	10.1%
Intended Pregnancy	60.0%	31.0%			46.0%
Early & adequate prenatal care	76.7%	64.5%	72.3%	75.5%	67.3%
Ever Breastfed	70.2%	55.9%			
Live births where mothers exposed to smokers at home	16.7%	15.1%	31.2%	5.0%	10.2%
Singleton births by mother's BMI at start of pregnancy > 29.0	26.4%	35.7%	33.1%	8.0%	29.0%
Maternal Mortality	22.9	44.1		23.9	
Sudden Infant Death Syndrome	3.0	7.6			
Infant Sleep Position - back	77.8%	57.2%		85.1%	69.1%
Live births – mothers with pre-pregnancy diabetes	0.7%	1.1%	1.2%	1.1%	0.9%
Live births – mothers with gestational diabetes	3.9%	2.6%	4.5%	7.9%	4.5%
Live births – mothers with pre-pregnancy hypertension	1.0%	2.0%	1.2%	0.4%	0.6%
Live births – mothers with gestational hypertension	4.6%	3.8%	4.5%	2.8%	3.2%

Children and Adolescents Health Index

	2005	2008
Immunization Rates (% of 19-35 month olds)	81.0%	82.0%
Death rate to children 14 and younger due to motor vehicle accidents	2.9	2.4
3 rd grade children with protective sealants	22.5%	31.3%
Rate of nonfatal injuries, children 14 & younger	209.7	279.6
% of children uninsured	5.7%	5.9%
Children <6 with elevated blood lead levels	2.39%	1.1%
Teen (15-17) Birth rate	18.1	18.2
Rate of women 15-19 with reported case of chlamydia	34.6	44.6
Death rate, 15 thru 24 years, from motor vehicle crashes	17.5	19.5

**Title V National & State Performance & Outcome Measures – Michigan
(based on 2006-2010 Needs Assessment)**

National Performance Measure	2004	2005	2006	2007	2008
1. % of screen positive newborns who received timely follow-up to definitive diagnosis and clinical mgmt for condition(s) mandated by their state Target Objective Actual	100% 100%	100% 100%	100% 100%	100% 100%	100% 96.4%
2. % of CSHCN age 0-18 whose families partner in decision-making at all levels and are satisfied with the services they receive ¹ Target Objective Actual	64.0% 61.3%	61.3% 61.3%	61.3% 61.3	61.3% 56.4%	56.4% 56.4%
3. % of CSHCN age 0-18 who receive coordinated, ongoing comprehensive care within a medical home Target Objective Actual	58.0% 55.8%	55.8% 55.8%	55.8% 55.8 %	55.8% 46.0%	46.0% 46.0%
4. % of CSHCN age 0-18 whose families have adequate private and/or public insurance to pay for the services they need Target Objective Actual	50.0% 66.5%	66.5% 66.5%	66.5% 66.5%	66.5% 60.8%	60.8% 60.8%
5. % of CSHCN age 0-18 whose families report the community-based service systems are organized so they can use them easily Target Objective Actual	79.0% 75.7%	75.7% 75.7%	75.7% 75.7%	75.7% 90.0%	90.0% 90.9%
6. % of youth with SHCN who received the services necessary to make the transition to all aspects of adult life Target Objective Actual	6.0% 5.8%	5.8% 5.8%	5.8% 5.8%	5.8% 40.8%	40.8% 40.8%
7. % of 19-35 month olds who have received full schedule of age-appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B Target Objective Actual	87.0% 81.2%	89.0% 81.0%	91.0% 82.7%	91.0% 81.8%	91.0% 82.0%
8. Rate of birth (per 1,000) for teenagers 15 through 17 years. Target Objective Actual	18.0 18.7	17.8 18.1	17.4 17.0	17.4 14.0	17.4 18.2

¹ Indicator 2- 6 data comes from the National Survey of CSHCN conducted by HRSA and CDC, 2005-2006.

National Performance Measures	2004	2005	2006	2007	2008
9. % of third grade children who have received protective sealants on at least one permanent molar tooth. Target Objective Actual	41.0% 33.4%	33.6% 22.5%	25.0% 23.4%	25.0% 23.4%	30.0% 31.3%
10. Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children Target Objective Actual	4.1 3.5	4.1 2.9	3.4 2.4	3.2 2.3	3.0 2.4
11. % of mothers who breastfeed their infants at 6 months of age Target Objective Actual		NA 14.6%	35.0 15.8	40.0% 15.8%	20.0% 15.8%
12. % of newborns who have been screened for hearing before hospital discharge Target Objective Actual	100% 90.9%	100% 93.3%	100% 96.7%	100.0% 97.1%	100.0% 96.7%
13. % of children without health insurance Target Objective Actual	6.7% 5.8%	5.6% 3.7%	3.7% 5.0%	3.7% 4.7%	4.5% 5.9%
14. % of children ages 2 to 5 years receiving WIC services with a BMI at or above the 85 th percentile Target Objective Actual		NA 16.1%	16.0% 16.2%	15.8% 29.5%	29.5% 30.1%
15. % of women who smoke in the last three months of pregnancy Target Objective Actual		NA 15.6%	14.6% 15.8%	13.6% 17.1%	12.6% 17.5%
16. Rate (per 100,000) of suicide deaths among youths aged 15-19 Target Objective Actual	8.4 8.2	8.1 8.0	7.9 7.8	7.8 7.0	7.7 7.4
17. % of VLBW infants delivered at facilities for high-risk deliveries and neonates Target Objective Actual	88.0% 86.0%	88.2% 88.0%	88.2% 88.0%	88.4% 85.0%	88.4% 78.0%
18. % of infants born to pregnant women receiving prenatal care beginning in the first trimester Target Objective Actual	85.9% 82.7%	86.6% 83.3%	87.8% 83.38%	89.0% 81.5%	90.3% 73.2%

State Performance Measures	2004	2005	2006	2007	2008
1. Number of Medicaid-enrolled women who are screened for maternal depression Target Objective Actual			25.0% NA	30.0% NA	35.0% NA
2. Percent of low birth weight (<2500 grams) among live births Target Objective Actual	7.9% 8.4%	7.8% 8.3%	8.2% 8.4%	8.1% 8.4%	8.0% 8.5%
3. Percent of preterm births (<37 weeks gestation) among live births Target Objective Actual	11.1% 10.0%	11.0% 10.1%	11.0% 9.7%	10.9% 10.0%	10.2% 10.8%
4. Percent of live births resulting from unintended pregnancy Target Objective Actual	39.2% 40.6%	38.7% 40.1%	38.7% 41.3%	38.3% 40.2%	37.8% 39.6%
5. Increase the percent of Medicaid-enrolled children 0-6 years of age who receive lead screening Target Objective Actual	25.0% 24.3%	60.0% 27.1%	70.0% 28.9%	80.0% 29.2%	30.0% 28.6%
6. Maternal mortality ratio in black women Target Objective Actual	26.4 80.1	25.7 98.6	90.0 118.6	90.0 87.0	89.0 44.1
7. The rate of breastfeeding at six months Target Objective Actual		NA 14.6	35.0 15.8	40.0 15.8	20.0 15.8
8. Percent of WIC-enrolled children who are overweight Target Objective Actual		NA 13.2%	12.3% 13.2%	12.1% 12.4%	12.0% 30.1%

National Outcome Measures	2004	2005	2006	2007	2008
The infant mortality rate per 1,000 live births					
Target	8.0	7.9	7.8	7.7	7.6
Actual	7.6	7.9	7.4	8.0	7.4
The ratio of black infant mortality rate to the white infant mortality rate					
Target	2.4	2.4	2.3	2.3	2.3
Actual	3.3	3.3	2.7	2.8	2.7
The neonatal mortality rate per 1,000 live births					
Target	5.6	5.5	5.4	5.4	5.3
Actual	5.4	5.5	5.2	5.6	5.0
The postneonatal mortality rate per 1,000 live births					
Target	2.5	2.5	2.4	2.4	2.3
Actual	2.2	2.5	2.2	2.4	2.4
The perinatal mortality rate per 1,000 live births plus fetal deaths					
Target	9.8	9.8	9.7	9.6	9.6
Actual	10.4	10.7	10.0	6.9*	10.3
The child death rate per 100,000 children aged 1 through 14					
Target	19.4	18.8	18.1	17.5	16.9
Actual	19.4	20.6	17.3	17.2	16.8
State Outcome Measure					
The ratio of Native American infant mortality to the white infant mortality rate					
Target	NA	NA	1.7	1.7	1.6
Actual	1.7	1.7	1.8	1.8	1.5

*Provisional data. Fetal deaths are under-counted due to change over to electronic birth record system.

TITLE V MCH BLOCK GRANT NEEDS ASSESSMENT, 2011

Priorities Workgroup

Representing:	Contacts	Name
Local Public Health	Nurses Forum	Karen Flowerday Julie Dingerson
	Health Officers	Renee Canady Lisa McCafferty William Ridella
	MALPH	Michael Krecek
Consumers	Family Center	Chris Buczek Lisa Huckleberry Dianna Rigato
	Healthy Start Projects	Asia Chidzikwe
Advocacy	MCMCH	Amy Zaagman
	March of Dimes	Kara Hamilton
	MI Women's Commission	Judy Karandjeff
	MI League for Human Services	Jan Hudson
State Staff	BFMCH	Alethia Carr Carol Ogan Stan Bien Diane Revitte Kobra Eghdetary Brenda Fink Orlene Christie Paulette Dunbar Rose Mary Asman Jeanette Lightning Nancy Peeler Jeff Spitzley Carrie Tarry Kathy Stiffler
	Chronic Disease	Linda Scarpetta Rochelle Hurst
	Health Disparities	Sheryl Weir
	Mental Health/Substance Abuse	Deb Hollis
	Epidemiology	Violanda Grigorescu Patricia McKane Mary Kleyr
	MSA	Sue Moran Chris Farrell
	Health Policy & Access	Bob Esdale

	DCH Executive Office	Dr. Holzman
	DHS	Stacey Tadgerson Marcelina Trevino-Savala
	Education	Kyle Guerrant Emily Brewer
ECIC/Great Start Collaboratives		GSC Reps – Don Trap, Jane Clingman, Emily Krznarich, Susan Kabat
Providers	MI Primary Care Asso	Kim Sibilsky
	Healthy Start Projects	Dawn Shanfelt -Saginaw Dawn Scharer - Genesee CO HD Intertribal Council of MI Peggy VanderMeulen - GR Detroit Dept of Hlth Wellness Promotion Carmen Sweezy- Kalamazoo
	MI Chapter AAP	Denise Sloan
	U of M SPH	Dr. Marjorie Treadwell
	DeVos Children's Hospital	Dr Wendy Burdo- Hartmann
	St. Joseph Mercy	Dr Paul Holtropp
2-1-1		Sherry Miller
Oral Health		Karlene Ketola
	U of M	Phyllis Meadows
	MSU	Mary Crawford