

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

Michigan

FY 2016 Application/FY 2014 Annual Report
Draft

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I. General Requirements

I.A. Application/Annual Report Executive Summary

The Title V Maternal and Child Health (MCH) program in Michigan operates under the vision of the Michigan Department of Health and Human Services (MDHHS) to promote better health outcomes, reduce health risks, and support stable and safe families while encouraging self-sufficiency. The Title V program is operated by the Bureau of Family, Maternal and Child Health (BFMCH) through the Division of Family and Community Health (DFCH) and Children's Special Health Care Services (CSHCS) Division. The mission of BFMCH is to promote and improve the health and well-being of women, children and families in Michigan by providing leadership in accessing services and supporting health equity. The Title V Block Grant plays a key role in supporting BFMCH programs and services. This application provides state plans for fiscal year (FY) 2016 and reports on FY 2014.

Application Summary

For 2016-2020 planning, MDHHS completed a statewide five-year needs assessment to identify preventive/primary care service needs for the MCH population. The findings of the needs assessment drove the identification of strategic issues, priority needs and a five-year action plan. The needs assessment process used population data and stakeholder expertise to identify the most critical unmet needs and issues facing the MCH population. Based on these findings, priorities were selected based on knowledge of Title V program capacity, the potential to leverage Title V funding and the potential to impact MCH outcomes. Per federal requirements, states were required to identify 7-10 state priority needs and eight corresponding National

Performance Measures (NPMs). Needs assessment findings and five-year plans are discussed in detail in Sections II.B. and II.F. Summaries are included below, by population domain.

Women/Maternal Health: Areas of unmet need were related to smoking/alcohol use and access to/ coordination of care and services. Six strategic issues were identified. After reviewing these issues, MCH leadership prioritized the need to “Reduce barriers, improve access, and increase the availability of health services.” In order to measure progress, Michigan selected the NPM “Percent of women with a past year preventive medical visit.”

Michigan’s five-year plan will integrate the following objectives and strategies: increase family planning and reproductive health preventive visits; increase use of highly effective contraception methods; develop an outreach plan for family planning services; develop and implement a statewide plan to promote reproductive life planning; reduce barriers to receiving and improve the quality of post-partum visits; promote enrollment in Medicaid expansion and other health care; and link women receiving family planning to primary care providers.

Perinatal/Infant health: Areas of unmet need included access to and coordination of care and services; health risks during pregnancy; disparities in infant mortality and safe sleep; and breastfeeding. Six strategic issues were identified, two of which were selected. Over the next five years, Michigan’s Title V program will “Support coordination and linkage across the perinatal to pediatric continuum of care” and “Foster safer homes, schools, and environments with a focus on prevention.” Progress toward supporting coordination and linkage will be measured by two NPMs: “Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU),” and “A) Percent of infants who are ever

breastfed and B) Percent of infants breastfed exclusively through 6 months.” Progress toward fostering safer environments will be measured by a State Performance Measure (SPM) related to safe sleep, which will be determined in FY16 per federal requirements.

Over the next five years, Michigan will utilize the following objectives and strategies: pilot the community perinatal care system; expand the use of the March of Dimes Preterm Labor Assessment Toolkit by birth hospitals; promote case management for at-risk pregnant women through home visiting; develop surveillance processes to monitor risk appropriate deliveries; and provide medical providers with training in screening/referral for substance abuse. Michigan will improve breastfeeding rates by developing a state breastfeeding plan; increasing the number of baby-friendly hospitals; improving surveillance systems related to breastfeeding initiation, duration and exclusivity; and increasing the percentage of VLBW babies who receive breast milk.

Child Health: Areas of unmet need were related to early development and school performance, developmental screening and child maltreatment. Four strategic issues were identified. Over the next five years, Michigan will address two priority needs: “Invest in prevention and early intervention strategies, such as screening” and “Foster safer homes, schools, and environments with a focus on prevention.” Progress toward investing in prevention and early intervention will be measured by the NPM “Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.” Progress toward fostering safer environments will be measured by a SPM related to lead poisoning prevention, which will be determined in FY16.

Michigan's Title V program will invest in prevention and early intervention, and particularly improve rates of developmental screening by exploring whether tracking developmental screening can be a component of Michigan's Medicaid State Innovation model; adopting consistent screening and referral procedures across the Great Start Early Childhood System; adopting consistent procedures for responding to referrals; and adopting procedures for reporting screening results to parents.

Adolescent Health: Areas of unmet need included bullying, suicide mortality rates, healthy lifestyles and access to care. Five strategic issues were identified. MCH leadership prioritized "Reduce barriers, improve access, and increase the availability of health services." Progress will be measured by the NPM "Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year."

To address this strategic issue, Michigan will develop a state plan for improving adolescent preventive visits, focusing on Medicaid eligible youth; increase the number of providers trained on culturally-competent, adolescent-friendly care; increase the proportion of adolescents with a documented well child exam in Michigan's Child and Adolescent Health Centers (CAHCs); and develop a social media campaign to promote adolescent well-care and targeted health messages.

Children with Special Health Care Needs (CSHCN): Areas of unmet need included access to a medical home, transition services, developmental screening and adequate insurance coverage. Stakeholders identified 11 strategic issues, and MCH leadership prioritized "Increase family and provider support and education for CSHCN." In order to measure progress, two NPMs were

selected: “Percent of children with and without special health care needs having a medical home” and “Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult care.” MCH leadership also prioritized “Reduce barriers, improve access, and increase the availability of health services.” Progress will be measured using a SPM created in FY16.

In order to increase family and provider support and education and increase access to a medical home, Michigan will provide training to medical home providers; work with partners to improve systems of care; develop reimbursement mechanisms that support the functions of a medical home; increase families’ understanding of the benefits of a medical home; connect parents with medical homes; and collect data to identify ways to improve delivery of care within a medical home. To improve transitions to adult care, Michigan will work to increase the number of youth who have a plan of care that includes transition planning; increase youth and family awareness and understanding of the transition process; and increase provider awareness and understanding of the transition process.

Cross-cutting/Life Course: All stakeholder groups reviewed data that impacts health across the MCH population. Eleven cross-cutting/life course strategic issues were identified. Two of these strategic issues were selected as priorities. Progress toward the priority “Increase access to and utilization of evidence-based oral health practices and services” will be measured by the NPM “A) Percent of women who had a dental visit during pregnancy and B) Percent of children who had a preventive dental visit in the past year.” Progress toward the priority “Promote social and

emotional well-being through the provision of a continuum of behavioral health services” will be measured by a SPM created in FY16.

In order to improve access to and utilization of oral health services, Michigan’s Title V program will expand the SEAL! Michigan program to promote dental sealants; increase the number of students who have received a dental screening through SEAL! Michigan; develop and implement a state plan for improving oral care for the MCH population; increase training for medical and dental providers who treat pregnant women and infants; distribute perinatal oral health guidelines and educational materials; and develop a communication plan.

Annual Report Summary

Michigan’s Title V program has experienced significant accomplishments as well as challenges, which are described below by population domain. Performance on most measures has remained stable, and Michigan has identified promising trends in a few key areas. Details are provided in Section II.F.

Women/Maternal Health: Accomplishments included an increase in the use of long-acting reversible contraceptives; incorporating healthy eating and exercise education into programs that serve pregnant/postpartum clients; and establishing a state position to support breastfeeding initiatives. Challenges included decreased funding for family planning; lack of a coordinated public health approach to addressing obesity; and lack of data regarding domestic violence. Over the past five years, Michigan’s performance has been stable on the percent of infants born to women receiving care in the first trimester, the percent of births to mothers with a BMI at start of pregnancy greater than 29 and percent of women physically abused

during the 12 months prior to pregnancy. Data suggest Michigan is moving the needle on intended pregnancy.

Perinatal/Infant Health: Accomplishments included the expansion of breastfeeding training for Women, Infants, and Children (WIC) providers; expansion of home visiting programs; the use of quality improvement methods to improve early hearing detection and intervention; planning for a perinatal system of care; the addition of Special Care Nursery services; the implementation of Certificate of Need Standard for Neonatal Intensive Care Services, participation in a CoIN for Risk Appropriate Care; promotion of policies to eliminate medically unnecessary deliveries before 39 weeks; and coordination among initiatives promoting developmental screening. Challenges included identifying strategies to address the social determinants of health and the lack of a data system to capture developmental screening information across programs. Michigan's performance has been stable on rates of breastfeeding, the percent of VLBW infants delivered at facilities for high-risk deliveries and percent of low birth weight births. The percent of preterm births has increased. However, Michigan has seen improvement on the percent of children receiving standardized developmental screening.

Child Health: Michigan's accomplishments included regular reporting of county level immunization rates to local health departments (LHDs); training car seat safety technicians; implementing a variety of healthy weight strategies through WIC; and providing education/technical assistance for lead poisoning. Challenges included assuring children received all vaccines and the lack of a coordinated public health approach to addressing

childhood obesity. Michigan's performance has been stable on the rate of deaths to children age 14 and younger caused by motor vehicle crashes and the percent of children receiving WIC with a BMI at or above the 85th percentile. The disparity between Black and White children under 6 years of age with elevated blood lead levels has narrowed.

Adolescent Health: Accomplishments included solid evaluation of teen pregnancy prevention efforts; leveraging funds to expand programs for pregnant/parenting teens; leveraging partnerships to provide training on preventing teen suicide; broader STI screening; expansion of Child and Adolescent Health Centers (CAHCs) and school nursing; and the delivery of curriculum promoting healthy/violence-free relationships. Challenges included the lack of funding to expand teen pregnancy prevention programs; opposition to pregnancy prevention programs in schools; and difficulties recruiting teachers/schools to deliver the Michigan Model for Health curriculum. Although provisional 2014 data suggest the trend may have reversed, Michigan's teen suicide death rate increased over the past several years. However, the teen pregnancy rate, the chlamydia rate, and the rate of dating violence have all decreased.

CSHCN: Successes included the development of a statewide database used to link families with services; the creation of new parent support positions; completion of strategic planning; strengthened partnerships with providers; procedures for helping families enroll for health insurance; completion of one accreditation cycle for LHDs; overhauling transition planning services; and involvement of families at all levels of decision making. Challenges included resource constraints; staffing transitions; poorly integrated systems of care for CSHCN; and the complexity of the health insurance system. Data are not available to report progress because all

measures are collected using the National Survey of Children and Youth with Special Health Care Needs, which has not released 2015 data.

Cross-Cutting or Life Course: In the area of dental care, the dental sealant program has continued to expand and has met its performance target each year. In the area of health insurance, the percent of children without health insurance has decreased, and MCH programs have conducted outreach/enrollment activities throughout the state. Smoking during pregnancy has gradually declined, and program successes included the release of an online training course for providers on assessment/ counseling of prenatal smokers. To continue addressing the disparity in eligibility for publicly funded health programs, MDHHS is working toward improving staff understanding of health equity and the social determinants of health as a first step toward addressing the root causes of disparities.

II.A. Overview of the State

Principal Characteristics of the State

The Title V Maternal and Child Health (MCH) program in Michigan operates within the larger context of public health services as articulated by the vision of the Michigan Department of Health and Human Services (MDHHS) to promote better health outcomes, reduce health risks and support stable and safe families while encouraging self-sufficiency. A significant change from the previous Title V reporting period is the merger of the Department of Community Health (which historically housed Title V) and the Department of Human Services to form the MDHHS. This merger to reshape and improve services became effective in April 2015.

MDHHS leverages a variety of resources including federal, state and local funding to provide or enable access to a broad range of health and social services. In accordance with the Public Health Code, Michigan's 45 local health departments (LHDs) are key partners in achieving our vision. The public health functions of assessment and assurance are shared between MDHHS and LHDs. Cooperative efforts to achieve specific initiatives are also coordinated with the private sector, such as managed care plans, universities and nonprofit partners. Within MDHHS, the Title V program coordinates program and policy activities with Medicaid, MICHild, mental health and substance abuse, chronic disease, communicable disease, injury prevention and others. The Title V program also works across state departments on initiatives of mutual importance and responsibility, which are described throughout this application.

According to the U.S. Census Bureau, Michigan's population is 9,848,100 (March 2014 Current Population Survey). This represents a decrease in the population of approximately 121,627

since July 2009. In 2013, there was a net migration loss of 3.5% for people ages 22 to 34 with a bachelor's degree or higher. Michigan has also seen a steady decrease in birth rates over the past 20 years, including a decline in teen births. In terms of population distribution, 86% of residents live in metropolitan areas. The majority of Michigan's population resides in the southern half of the Lower Peninsula, with approximately half of the population residing in Southeast Michigan. Out of the current total population, approximately 24% are children 0-8, 62% are adults 19-64, and 15% are adults 65 or older. According to 2013 U.S. Census Bureau data, Michigan's population is 80.1% White (with 76.1% identifying as White alone, not Hispanic or Latino), 14.3% Black or African American, 2.7% Asian, 2.2% two or more races, and 0.7% American Indian and Alaska Native. Out of the total population, 4.7% identify as Hispanic or Latino.

Michigan's economy has seen significant improvements, with the seasonally adjusted unemployment rate decreasing from 14.9% in June 2009 to 5.4% in March 2015. The median household income in Michigan in 2012 was \$46,793 (U.S. Census Bureau). However, the state still faces significant challenges that impact the MCH population. For instance, certain areas of the state continue to experience high unemployment. In March 2015, Detroit's unemployment rate was 11.7% and 10 rural counties had unemployment rates of 10.0% or higher. According to Kids Count in Michigan (2015), from 2006 to 2013 Michigan improved on eight key indicators of child well-being but regressed on five.

Despite the state's economic recovery, the child poverty rate has worsened. According to the U.S. Census Bureau (2013), Michigan ranked 35th in child poverty with 24% of children living

below the federal poverty level (FPL) which is an increase from 19.3% in 2008. Overall, 17% of Michigan's population lives in poverty. Of additional concern are findings from the 2014 ALICE (Asset Limited, Income Constrained, Employed) report by the Michigan Association of United Ways. The report found that even in households with earnings *above* the FPL, 40% of households struggle with basic necessities of housing, child care, food, health care and transportation. In addition to households *below* the FPL in Michigan, this equates to more than 1.54 million households struggling to meet basic needs. Certain areas of the state are particularly impacted. For instance, in addition to the 38% of households with income below the FPL in Detroit, an additional 29% are ALICE households.

Family support programs continue to be an important source of assistance. As of July 2014, 1,656,802 persons participated in Michigan's Food Stamp Program (USDA). Thirty-eight percent of pregnant mothers enroll in WIC during their first trimester and 54% of babies born in Michigan are enrolled in WIC. Out of WIC families, 90.5% live below 150% of the FPL. According to MDDHS, 1,588,572 unduplicated recipients currently receive assistance from the following services: Family Independence Program, Food Assistance Program, State Disability Assistance, Child Development and Care, and State Emergency Relief. Additionally, Michigan has 1,761,761 Medicaid-eligible recipients. Between October 2012 and April 2015, the state has seen declines across each of these programs, yet significant need still exists.

Agency Priorities and Title V Program Roles

The Title V program is operated by the Bureau of Family, Maternal and Child Health (BFMCH) within the Population Health and Community Services Administration. The BFMCH mission is to

promote and improve the health and well-being of women, children and families in Michigan by providing leadership in accessing services and supporting health equity. The Bureau includes the Division of Family and Community Health (DFCH), Children's Special Health Care Services Division (CSHCS) and the WIC Division. DFCH is responsible for over 60 initiatives/programs designed to achieve core MCH outcomes. Activities include needs assessment; policy recommendation; development/promotion of best practices; and evaluation to provide quality, accessible, culturally-competent services within the context of health care reform.

The life course framework is the model for DFCH's organizational structure and its strategic plan, and is central to the MDHHS mission to "protect, preserve and promote health with special attention to the needs of the vulnerable and underserved." The life course perspective acknowledges that health outcomes are the product of the complex interplay over time between an individual and his/her environment, and emphasizes that both early experiences and exposures during sensitive periods can have a lasting impact on health and development. DFCH's units are based on the life stages: reproductive/interconception; maternal/perinatal; infant; child; and adolescent and family. Oral health spans all stages. Priority is placed on increasing health promotion and prevention activities to improve socio-environmental, medical and dental health by integrating mental health; chronic disease; substance abuse; child development; and early, middle and adolescent education. Although DFCH units concentrate on their respective phase of the life course, they coordinate, complement and build on adjacent life stages. An important component of this life course perspective is redefining key health outcomes and performance measures to align across the lifespan. The DFCH is working toward developing an integrated set of key health outcomes that align with the life course perspective.

Additionally, BFMCH is committed to achieving health equity in MCH throughout Michigan. In August 2013, the Practices to Reduce Infant Mortality through Equity (PRIME) initiative released the state's first Health Equity Status Report. The report presented data for 14 indicators related to social determinants of health and health disparities (including psychosocial, socioeconomic, basic needs and health care access). The report demonstrated what has been long recognized: persistent racial and ethnic disparities exist across health, education and income that are systemic, avoidable and unjust. The report also made recommendations for reducing health inequities in MCH. A key strategy focusing on social justice recommended broad-based training for staff within BFMCH, as well as in local public health, to support shared goals and collective impact on this issue.

One of BFMCH's key initiatives has focused on eliminating disparities in infant mortality (IM). Governor Snyder identified the reduction of IM as a top priority, providing gubernatorial leadership on this issue. IM is considered a critical indicator of the health status of the state, the availability and quality of health care services, and exposure to socioeconomic stress. The disparities in Michigan's IM rates suggest not all population groups have the same opportunity to access health services and to reach their health potential. In 2012, Michigan published its IM Reduction Plan which recommends a set of strategies that are designed to address the multiple, complex causes of IM, including social determinants. The plan emphasizes and promotes collaboration between government, health care providers, LHDs, universities, professional organizations, business and community leaders. BFMCH is currently updating the plan and is committed to building systems that not only assure infants survive but also support healthy

development and thriving families. The updated plan will be released in the summer of 2015 and will guide efforts over the next three years.

The Department is also focusing attention on breastfeeding. Breastfeeding is central to promoting health across the life course, and breastfeeding rates reflect the degree to which systems for supporting the health of children and mothers are connected. Michigan has the opportunity to improve breastfeeding initiation and, especially, breastfeeding continuation. Several MCH initiatives in Michigan are focused on improving breastfeeding rates and are discussed in this application.

Early childhood system building has been central to BFMCH's current initiatives related to infancy and childhood. The Governor has defined a set of prenatal to age 8 outcomes and created an Office of Great Start (OGS) within the Michigan Department of Education to lead the integration of the state's health, development and early learning investments. BFMCH collaborates closely with OGS and other partners across state government to support the development of early childhood systems that are integrated and designed around the needs of children and families. One example is the implementation of Michigan's Early Childhood Comprehensive Systems grant through HRSA. Michigan is focusing on working across systems to build a trauma-informed approach into programs and services for young children.

Additionally, Michigan's implementation of the Maternal Infant and Early Childhood Home Visiting (MIECHV) Program involves collaboration across early childhood systems to assure that, as home visiting expands, it is integrated with other early childhood services and offers a continuum of home visiting services that align with what families want and need.

Health Care Reform

Since becoming law in 2013, the Affordable Care Act (ACA) has significantly impacted how health care is accessed and delivered. Health care reform efforts have made broad and profound changes to health care delivery, access and the scope and breadth of services provided—all of which have significantly impacted Michigan’s MCH populations. ACA coverage expansions provided Michigan consumers with two new options: the Healthy Michigan Plan (HMP) and the Health Insurance Marketplace (Marketplace). In January 2014, eligible individuals above 133% of the Federal Poverty Level (FPL) could enroll in private health insurance coverage through the Marketplace. In April 2014, Michigan expanded its Medicaid program to cover residents aged 19 to 64 who were at or below 133% of the FPL, and who were not previously eligible for traditional Medicaid. Between the HMP and the Marketplace, Michigan insured over 700,000 people in less than a year, far exceeding initial enrollment expectations.

HMP benefits include preventive/wellness services, chronic disease management, prenatal care, oral health and family planning services. HMP beneficiaries are required to pay some level of cost-sharing in the form of monthly contributions and co-pays based on income. Enrollees can complete a health risk assessment with their primary care provider and, in return, be eligible for incentives such as reductions in cost-sharing.

For Children and Youth with Special Health Care Needs (CYSHCN), ACA consumer protections have greatly improved access to private insurance by eliminating preexisting condition exclusions and discrimination based on health status, the two most frequently encountered

enrollment barriers for families. The ACA also expanded access to parent employer coverage for adults 19-26. The HMP covers 700 individuals who are dually enrolled in it and CSHCS. LHDs, Family Resource Centers and designated state staff work with families and community partners to help families understand and access all available private and publicly-funded resources to meet individual needs.

CYSHCN require and use more health care services than other children. Specialty care and extensive, on-going or long-term treatments and services may be required to maintain or improve health status. Financing these costs can pose significant challenges and burdens for families even with access to private insurance. Family health care costs can include deductibles, cost sharing and premium payments. In addition, private insurance may not include any covered benefit for a specific, medically necessary service. In other cases, only a limited benefit may be available through insurance. Although ACA eliminated annual and lifetime dollar limits, other annual limits exist and benefits may be exhausted for the current contract year even though needs continue. As such, CSHCS continues to be a significant resource for achieving adequate, appropriate health and specialist care and contains substantial costs to families. Steady CSHCS enrollment following ACA's implementation reflects the value of CSHCS to families even when private insurance is available.

ACA also provided significant resources targeted to MCH services including home visiting programs. Michigan received funding to increase home visiting services through MIECHV which allowed a greater number of families and children to be served in additional communities. In Fiscal Year 2014, Michigan's MIECHV program had 1,196 volunteer enrollees, with 447 pregnant

women and 834 children among its clients. Additionally, through community partner collaboration, increased funding was allocated by the state legislature for evidenced-based home visiting programs, furthering access to home-based services.

Michigan has entered into a cooperative agreement with the Center for Medicare and Medicaid Innovations to test its State Innovation Model (SIM) for health care payment and delivery system transformation. The final product of the SIM grant planning process, the Blueprint for Health Innovation, will guide the state as it strives for better care coordination, lower costs and improved health outcomes. The Blueprint will focus on transforming service delivery and payment models by concentrating on patient-center medical homes and integration among health care and community resources.

Finally, ACA provided significant funds through HRSA to expand access to primary care by increasing the number of Community Health Centers in Michigan. In the last two years, the number of Federally Qualified Health Centers (FQHCs) grew as additional centers were funded and look-alike sites were approved. Michigan now has 240 centers providing care to more than 600,000 patients annually. Funds were also made available for capital improvements to ten of the state's school-based health centers (known as CAHCs in Michigan), facilitating access to expanded health care services for additional school-aged children. Both models have been part of an overall strategy for successfully addressing, maintaining and improving health outcomes for Michigan's MCH populations, including CYSHCN.

Factors that Impact Health Services Delivery

While many strengths and opportunities in Michigan are being leveraged to strengthen and expand the MCH infrastructure and delivery system, significant competing factors will also receive attention over the next five years. As Michigan emerges from a decade of economic decline, health care spending and costs continue to pull attention away from a public health and primary prevention focus that is needed to truly improve the health and wellness of all Michigan citizens. Core state infrastructure components such as roads and bridges, public safety services and environmental threats compete for state resources and public support. Rebuilding Michigan's economic climate is critical to resourcing health and wellness, as well as other key areas that can drive people to or from living and working in Michigan.

One of the most significant competing factors facing MCH in Michigan is the complexity of fully embracing an upstream approach to health and wellness which changes the systemic conditions that contribute to poor health, versus paying later when health deteriorates. The realities that health begins during preconception—and that the earliest stages of the life course are where optimal health and development must occur if adult health is to be improved—are still not well understood by many stakeholders or the general population. Where understanding does exist, the path to redirecting resources to early life stages is difficult to achieve because of the acute needs of those already needing costly and often long-term care. Among key stakeholders involved with Michigan's most at-risk families, there is a growing understanding and commitment to reducing early life adverse experiences, addressing trauma and toxic stress and strengthening protective factors. However, the challenge is to translate these concepts into actionable strategies that compel resource and policy support.

Addressing social determinants of health holds the same challenge. Stakeholders increasingly understand that access to transportation, education, adequate and sustainable income, and social and cultural supports are critical to achieving and maintaining health. However, knowing where and how to improve these factors in high-risk communities is not easy. Furthermore, the layered funding that comes to communities from federal, state, local and private sources can be difficult to align. A lack of stable, ongoing funding and inconsistent funding priorities contributes to an inability to make long-term, sustainable changes that are based on data-driven, community-based needs.

Racism, whether at institutional or community levels, is a lived experience for many, and the long-standing disparities in Michigan's health outcomes reflect how difficult it is to affect change in a way that reduces those disparities. Competing factors such as payment systems, malpractice regulations, chronic disease incidence, nursing care costs, emergency room "super utilizers," population demographics, prevalence of adverse health behaviors and the absence of access to hospitals and physicians within a reasonable geographic distance in rural areas, are all cost-drivers both nationally and in Michigan. U.S. Census Bureau data indicate that there are many geographic regions within Michigan that are facing provider shortages, with the greatest provider shortage occurring among nurse practitioners. Using the U.S. Department of Health and Human Services designation for primary care professional shortage areas, 18.2% of Michigan's population has insufficient access to primary care. The state has 270 geographic primary medical care HPSAs, with the vast majority located within Wayne County and in Detroit.

Transportation also continues to be a challenge, particularly in rural areas and in the Upper Peninsula. This includes not only the method of transportation, but also the time and distance that needs to be covered to get to services. Securing transportation providers and appropriate levels of reimbursement is also challenging for the CSHCS population. Families who need to take a child to specialized care often have to travel long distances with trips that involve overnight stays. This requires extended time away from work/income, additional child care and other expenses.

Across state government as a whole, as well as within MCH specifically, Michigan is focusing on improving capacity to make data-driven decisions. Establishing more defined return on investment profiles assists in this process, as does expanding the ways in which conceptual frameworks identify important resource and outcomes. Michigan's SIM model seeks to create both health care and community resources into a more aligned, IT-connected and cohesive whole. Building in quality improvement processes helps guide where and how to redirect resources to improve outcomes. Michigan uses a variety of risk assessment strategies connected to impact and outcome analyses to help determine what is most likely to impact cost, quality and outcomes. The very process contained within the MCH Block Grant application is driving continued work on defining our MCH priorities.

Challenges for Delivery of Title V Services

After a decade-long recession, Michigan's economy has seen recent improvements, but women and children still face many economic disadvantages. According to Kids Count Michigan, nearly one in four Michigan children live in poverty, up from 18% in 2006. Half of these children living

in poverty meet the definition of extreme poverty, with their families struggling to get by on incomes that are less than half the poverty level. Statewide, the percentage of students eligible for free or reduced price lunches has steadily increased in recent years. In 2013, nearly 70% of Michigan's students were eligible for free or reduced price lunches.

Michigan's unemployment rate is currently at 5.4%, its lowest rate since 2009; however, 24% of jobs in our state are considered low-wage. While the unemployment rate has improved, many Michigan residents were unemployed for long periods of time during the recession. Long-term unemployment impacts health and well-being. A 2013 study by the Urban Institute found that persons who have been out of work for more than 27 weeks see their incomes decline by as much as 40%. These individuals are likely to have poorer health and their children do worse in school and earn less income over time. Therefore, the long-term impact of Michigan's recession is still being felt through the state.

Economic disadvantage is dispersed inequitably among racial and ethnic groups in our state, particularly for African-American children, who are roughly five times more likely to live in poverty than an Asian child and three times more likely than a White child. Poverty is linked with conditions such as substandard housing, homelessness, inadequate nutrition and food insecurity, inadequate child care, lack of access to health care, unsafe neighborhoods and under-resourced schools. Poorer children and teens are also at greater risk for poor academic achievement, school dropout, abuse and neglect, behavioral and social-emotional problems and physical health problems (such as higher rates of asthma, higher exposure to environmental contaminants such as lead, exposure to violence and developmental delays).

These effects are compounded by the barriers children and their families encounter when trying to access all forms of health care.

Socioeconomic determinants of health such as education, unemployment and poverty as they specifically relate to IM were also examined by the Health Equity Status Report. For every 1,000 babies born in Michigan, almost seven die by age one. The IM rate for African-American and American Indian babies is more than twice that of Whites. As poverty increases, IM rates also increase. At every level of poverty, the Black IM rate is higher than that of White infants. As the level of maternal education increases, IM decreases; but again, there are disparities between Black and White rates across all education levels. Because IM is an important indicator of the overall health of the population, it is one measure selected by Governor Snyder for monitoring on Michigan's Health and Wellness Dashboard.

Access to all forms of health care is a problem for many Michigan residents, particularly those living in rural areas. In 2011, the ratio of population to primary care providers in Michigan overall was 1268:1. However, in some rural counties the ratio was greater than 6500:1.

According to the American Community Survey, the proportion of children 0-17 without health insurance in Michigan is 4.0%. However, older children and adolescents 6-17 were more than twice as likely to be uninsured compared to children under 6 years of age (6.0% and 2.4% respectively). The greatest *number* of uninsured children resides in large urban counties, while the greatest *proportion* of uninsured children resides in low-income rural counties with relatively high unemployment rates. Lack of providers, health care facilities and lack of

transportation all underscore the need for safety net services such as those provided to the MCH population by LHDs and through programs supported by MDHHS.

State Statutes Relevant to Title V

In FY15, state funding for MCH and CSHCS programs was appropriated through Public Act 252 of 2014 (House Bill 5313). CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, in cooperation with the federal government under Title V of the Social Security Act and the annual MDHHS Appropriations Act. State general fund dollars for MCH programs are itemized in Sec. 112 of Public Act 252 of 2014, whereas CSHCS is addressed in Sec. 114. Prenatal care is addressed in Sec. 1136 – 1138 and 1140. These sections essentially prescribe what funding shall be used for; MDHHS and contractor requirements; and requirements that some appropriated funding be used to implement evidence-based programs to reduce infant mortality. Statutory requirements in the FY14 omnibus budget for CSHCS included criteria in Sec. 1202 for the MDHHS to provide services; and in Sec. 1205, a requirement that some of the appropriated funding be used to develop and expand telemedicine capabilities.

Current and Emerging Issues

Although Michigan has many long-term, stable MCH programs and services, as the MCH landscape has shifted and changed, MDHHS has adapted to meet emerging needs. As ACA transforms the health care system, MDHHS is committed to assuring access to health care continues to improve as payment systems and providers change. The state has made progress such as assuring women and children receive preventive care visits, and wants to assure that as the role of public health changes, this trend continues.

Additionally, MDHHS has recognized the need to assure access to a continuum of services across the life course that aligns with the needs of families. Addressing fragmentation of programs and services and breaking down silos are key components of several major initiatives. There is a particular need to build connections between behavioral health and health care systems for all populations, and especially for the many mothers, adolescents, and CYSCHN struggling with depression. Data systems have the ability to support such connections, and MDHHS is working toward developing the capacity to connect records across data systems through a master person index. Such linkages would create the ability to follow individuals across systems and over time, creating a person-centered view of individual experiences and outcomes. While these emergent needs have shaped priority initiatives over the past several years, BFMCH entered the Title V Needs Assessment process ready to learn from data, consumers and partners about progress as well as unmet needs across Michigan.

II.B. Five-Year Needs Assessment Summary

MDHHS completed a statewide five-year needs assessment between December 2014 and April 2015 in order to identify needs for preventive and primary care services for women, mothers, infants, and children as well as services for children with special health care needs (CSHCN). The findings of the needs assessment drove the identification of strategic issues, priority needs, and a five-year action plan. The needs assessment process and key findings are described below, as are Michigan's priorities, selected National Performance Measures (NPMs), the linkage between Michigan's priorities and NPMs and Michigan's action plan.

Process

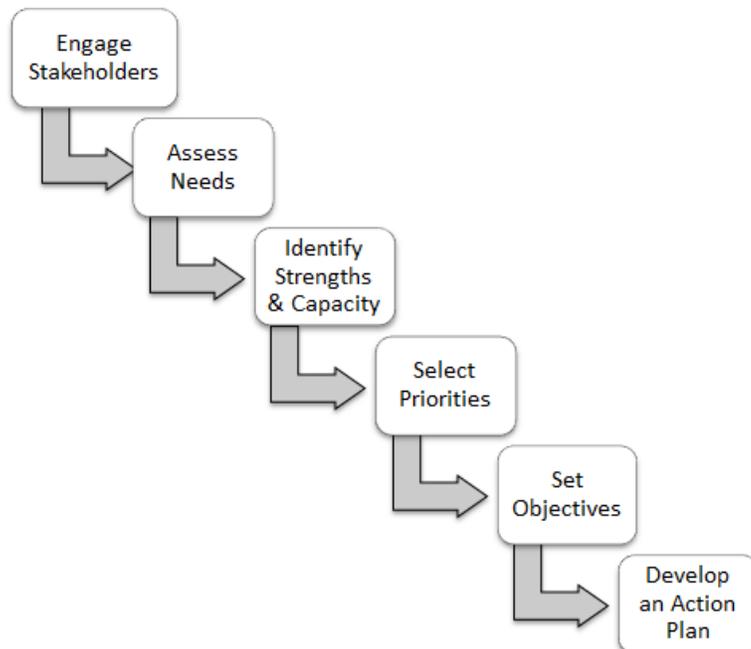
The needs assessment was led by Michigan's Title V Director and the Bureau of Family, Maternal and Child Health. As noted, the Bureau's organizational structure aligns with a life course approach. Leadership with expertise in each of the six population health domains identified in the Title V MCH Block Grant Guidance were engaged in needs assessment planning and implementation. The six population health domains that guided the structure of the Needs Assessment Planning Committee (NAPC) and the needs assessment process included women/maternal health, perinatal/infant health, child health, CSHCN, adolescent health, and crosscutting health/health across the life course. The goals of the needs assessment process were to:

- Engage a diverse group of stakeholders to assess both needs and system strengths and capacity;

- Utilize existing data and stakeholder experience and expertise to identify strategic issues or unmet needs, that, if addressed, would improve health in each of the six population health domains; and
- Identify priority unmet needs in each of the population health domains and strategies for addressing those needs.

The needs assessment process was modeled after the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau’s conceptual framework for the Title V needs assessment. HRSA’s framework is designed to improve outcomes for MCH populations and strengthen partnerships. The HRSA framework maintains that stakeholder engagement is necessary, and that needs assessment should be an ongoing activity. While HRSA’s framework includes 10 steps, Michigan’s needs assessment was abbreviated to align with time and resource constraints. Michigan’s process is illustrated in Figure 1 and described below.

Figure 1. Michigan’s Needs Assessment Process



Engage Stakeholders

The NAPC included a team of individuals representing key leadership across the Bureau of Family, Maternal and Child Health. The NAPC was responsible for determining the goals of the needs assessment, identifying major steps of the needs assessment process, providing feedback on planning documents, assuring the completion of each stage of the process, and selecting strategic priorities. Core MDHHS representation on the NAPC is listed in Table 1.

Table 1. Core MDHHS Representation on NAPC
Bureau of Family, Maternal, and Child Health
Division of Family and Community Health
Children’s Special Health Care Services Division
Women and Maternal Health Section
Early Childhood Health Section
Child, Adolescent, and School Health Section
Division of Life Course Epidemiology and Genomics
Maternal and Child Health Epidemiology Section

In order to assure broad stakeholder representation, the NAPC convened three stakeholder workgroups that reflected the six population health domains. The first group included maternal/women’s health and perinatal /infant health stakeholders. The second group included child and adolescent health stakeholders. The third group included children and youth with special health care needs (CYSHCN) stakeholders. Stakeholders were identified by members of the NAPC who worked most closely with each population group. Each stakeholder group included state and local MCH staff; state and local MCH system partners; consumers and/or parent representatives; and partners with expertise in health equity. Stakeholders were invited

to participate in the process to help identify unmet needs or strategic issues facing each population group based on data and their experience and expertise in the MCH system.

Assess Needs

The primary types of information used to identify unmet needs included population health data, program evaluation data and consumer input data. Due to time and resource constraints, other features of the MCH system—namely program and workforce capacity, organizational relationships, and family and consumer partnerships—were discussed and assessed, but not formally evaluated. In future needs assessment processes, Michigan plans to incorporate additional types of data.

In order to identify population health data to include in the needs assessment, a comprehensive list of health status measures was compiled by population group. The list included the NPMs and National Outcome Measures (NOMs) in the Title V MCH Block Grant Guidance, as well as Michigan's Life Course Metrics. The list was prioritized by the NAPC through a survey process.

Using these measures, the Maternal and Child Health Epidemiology Section within the Bureau of Epidemiology and the Children's Special Health Care Services (CSHCS) Policy and Program Development Section led the compilation and presentation of data. From the prioritized list, epidemiology staff reviewed health status data by race/ethnicity, trends and geography. A variety of different sources were used, such as the Michigan Behavioral Risk Factor Surveillance System (MI BRFSS), the Youth Risk Behavior Surveillance System (YRBSS), Vital Records, the National Immunization Survey (NIS), the American Community Survey (ACS), the National

Survey of Children's Health (NSCH), the National Survey of Children with Special Healthcare Needs (NSCSHN) and the Pregnancy Risk Assessment Monitoring System (PRAMS).

Epidemiology staff then selected indicators that suggested an unmet need based on geography, trends or disparities. The indicators selected by epidemiology staff were reviewed by program staff, who suggested additional indicators to include based on their knowledge of state systems and current priorities.

Additionally, an online survey was developed to gather program evaluation and consumer feedback data. Members of the NAPC reached out to program staff to complete the survey. Participants were asked to report on any program evaluation findings or consumer feedback data collected in the past five years that suggested unmet needs related to maternal and child health.

The three stakeholder groups, which included a total of 84 participants, were convened to review these data and participate in a consensus workshop designed to identify unmet needs or "strategic issues." The workgroups were presented with the core set of indicators, as well as evaluation and consumer input data. Throughout the presentations, participants were asked to note the unmet needs suggested by the data and their experience in the field. After presenting the data, participants were asked to write down the 7-10 unmet needs they felt were most critical to improving health for the population group over the next five years. Participants then worked in small groups to build consensus around 6-8 unmet needs. After the small groups reached consensus, the entire workgroup built consensus around a set of strategic issues that reflected the unmet needs. Each of the three workgroups developed between 10 and 15

strategic issues, for a total of 37 strategic issues across the six MCH population domains. These strategic issues provided the pool of options that the NAPC drew from to select Michigan's 7-10 state priorities.

Examine Strengths and Capacity

Each stakeholder group participated in a focused conversation designed to gather information about system strengths and capacity. Each of the three workgroups was asked to reflect on the ways the MCH system supports each population group by identifying the following:

- Accomplishments of MCH programs in improving health status in the past five years
- Strengths of the MCH system for promoting health
- Programs and services that are working well
- Programs and services that have greatest capacity to address MCH health needs

Feedback from each group was captured and summarized.

Select Priorities

The NAPC was responsible for reviewing the strategic issues identified by stakeholder workgroups and selecting strategic priorities. In April, the NAPC selected the strategic priorities that will guide the implementation of the Title V Block Grant. The list of strategic issues was first narrowed by the leadership group by considering the following factors:

- The strategic issue could be addressed through means other than Title V Block Grant funding,
- The strategic issue was not within the control of influence of the state MCH program, or

- The strategic issue was not aligned with programmatic, state and federal priorities.

After narrowing the list, the remaining strategic issues were prioritized using a matrix methodology. Each issue was rated against two scales. The first scale was related to the difficulty of achieving change through a focused programmatic effort and the second was related to the potential to achieve an improved outcome or impact. Members of the leadership group were asked to focus on the population they were most familiar with and rate the issue on each scale. They were asked to consider system strengths and capacity, their organizational structure and relationships, and existing priorities. Based on the matrix rating and their own expertise, the NAPC selected seven strategic priorities.

Select Performance Objectives

The NAPC selected NPMs based on the final priorities and the strategies that might be used to address those priorities. The selection of NPMs was also informed by current performance on the measure. Additionally, the NAPC identified priorities that will require state performance measures (SPMs) starting in FY17.

Develop an Action Plan

NAPC members were responsible for overseeing development of action plans for the strategic priorities that were related to their population domain. For example, Child, Adolescent, and School Health Section staff developed an action plan for priorities and NPMs related to adolescent health. In order to facilitate this process, a guidance document and an example action plan were provided. Several of the strategic issues were considered important principles

that were woven throughout the action plans for each selected priority across all population domains.

Findings

Michigan's priorities were selected based on identifying MCH population needs, the capacity of Michigan's MCH and CSHCN programs, and partnerships that expand the reach of these programs. A summary of the findings that supported the selection of priorities is presented here.

MCH Population Needs

MCH population needs were identified based on reviewing key measures in each of the six MCH population domains; gathering evaluation and consumer feedback findings; and accessing the expertise and experience of key stakeholders using the process described above. A summary of system strengths and unmet needs for each population health domain is presented. This is not a comprehensive description of all the data that were reviewed as part of the needs assessment.

Women/Maternal Health: The MDHHS Maternal and Child Health Epidemiology Section and the Women and Maternal Health Section reviewed 27 measures of women's and maternal health. Measures that suggested an unmet need were identified and presented to key stakeholders. Additionally, stakeholders identified areas of strength and system capacity. Areas of unmet need suggested by the data and based on the experience of stakeholders were related to smoking and alcohol use, as well as access to and coordination of care and services.

In Michigan, the overall percent of women aged 18-44 who smoked cigarettes every day or some days decreased from 23.9% in 2011 to 22.1% in 2013 (MI BRFSS). This trend was not significant and smoking rates remained above the U.S. rate of 18.7%. Additionally, disparities continued to be high with more than 30% of women who have a high school education or less reporting current smoking. About 20% of women 18-44 reported binge drinking in the last 30 days in 2013, a slight but insignificant increase from 2011 (MI BRFSS). The rate of binge drinking among women in Michigan exceeded the U.S. rate of 17.2%.

Data from the needs assessment revealed strengths as well. The percent of women 18-44 who reported having a preventive medical visit in the past year increased significantly from 62.2% in 2011 to 67.0% in 2013 (MI BRFSS). This exceeded the U.S. rate of 66.1%. However, disparities persisted in this indicator, with 47.3% of women who were uninsured receiving a preventive medical visit.

Additionally, stakeholders identified system strengths that could provide the foundation for improving access to care and service coordination. Stakeholders noted an increase in collaboration and integration of services in and between health departments, hospitals and state and local community-based organizations. Stakeholders also felt that programs for women have an increased awareness and capacity for addressing social determinants of health, adverse childhood experiences and health inequities.

Using the consensus process described above, stakeholders used the data presented and their experience and expertise to identify strategic issues that, if addressed, would improve

women/maternal health in Michigan over the next five years. Strategic issues are presented in

Table 2.

Table 2. Strategic Issues Identified by MCH Stakeholders	
Population Domain	Strategic Issues
Women/Maternal Health	<ul style="list-style-type: none"> i. Supporting coordination and linkage across the perinatal to pediatric continuum of care ii. Integrating CHWs to improve systems navigation iii. Improving access to and education about reproductive life planning iv. Assuring quality accountable MIHP services v. Supporting access to appropriate obstetrical care vi. Access to and integration of improved health services including substance use, IPV, and mental health
Perinatal/Infant Health	<ul style="list-style-type: none"> i. Supporting coordination and linkage across the perinatal to pediatric continuum of care ii. Community level support for breastfeeding iii. Taking a family-centered approach iv. Engaging and supporting fathers v. Increased parenting support and strategies to facilitate bonding vi. Assuring quality accountable MIHP services
Child Health	<ul style="list-style-type: none"> i. Investing in prevention and early intervention strategies (e.g., screening) ii. Fostering safer homes, schools and environments with a focus on prevention iii. Investing in high quality early childhood programs and services (e.g., quality child care) iv. Implementing a coordinated approach to health promotion that contributes to development and academic success
Adolescent Health	<ul style="list-style-type: none"> i. Supporting evidence-based bullying prevention programs ii. Fostering positive adolescent sexual health education and development iii. Implementing a coordinated approach to health promotion that contributes to development and academic success iv. Ensuring social and emotional well-being through the provision of a continuum of behavioral health services v. Reducing barriers, improving access, and increasing availability of health services
Children and Youth with Special Health Care Needs	<ul style="list-style-type: none"> i. Better utilization of data measuring performance and outcomes ii. Assure that all components of a medical home are put into practice iii. Increase coordination and collaboration in Systems of Care

	<ul style="list-style-type: none"> iv. Assure residents in all areas of the state have access to appropriate primary and specialty providers v. Care based on need not funding or program criteria vi. Remove barriers to access to improve health equity vii. Bridge mental, behavioral, developmental, and physical health viii. Lack of early and continuous screening ix. Lack of transition planning over the life course x. Increase family/provider support and education xi. Improve quality of life, healthy development and healthy behaviors across the life course
<p>Cross-cutting/Life Course</p>	<ul style="list-style-type: none"> i. Providing culturally and linguistically competent services to address disparities and achieve health equity ii. Promoting equity in funding, services, and health outcomes iii. Fostering safe homes, schools and environments with a focus on prevention (e.g., opportunities for physical activity, lead poisoning prevention, preventing toxic stress & ACEs) iv. Improving quality of life, healthy development, and healthy behaviors across the life course v. Collaborating to improve access to basic needs vi. Early initiation and promotion of health education across the lifespan (e.g., obesity, smoking, parent education) vii. Supporting families to navigate the system viii. Ensuring social and emotional well-being through the provision of a continuum of behavioral health services ix. Increasing access to and utilization of evidence-based oral health practices x. Supporting the emotional health of the frontline workforce xi. Reducing barriers, improving access, and increasing availability of health services

Perinatal/Infant Health: A total of 61 perinatal and infant health measures were reviewed.

Measures that suggested an unmet need were prioritized and presented to stakeholders. Based on the data and the experience of key stakeholders, areas of unmet need included access to and coordination of care and services; health risks during pregnancy; disparities in infant mortality and safe sleep; and breastfeeding.

Disparities were identified across several measures of health during pregnancy. In 2012, about 77% of women reported receiving prenatal care in the first trimester, exceeding the U.S. rate of 73.1% reported in 2010 (CDC NCHS) and approaching the Healthy People 2020 target of 77.9%. However, while about 80% of White women reported receiving care in the first trimester, only 67% of Black women and 69% of Hispanic women reported receiving first trimester prenatal care in 2012 (MI Resident Live Birth File). (Note: Rates reported as White and Black include only non-Hispanic White and non-Hispanic Black populations.)

Among women who had a live birth and were enrolled in Medicaid, Black women reported a diagnosis of hypertension during pregnancy at higher rates than all other racial/ethnic groups (9.6% of Black, 6.4% White, 6.1% Hispanic, and 5.9% of Native American women; Michigan Medicaid 2013). Native American (7.1%) and Black (8.4%) women receiving Medicaid were twice as likely to experience obesity during pregnancy as White (4.8%) and Hispanic (4.3%) women (Michigan Medicaid, 2013).

More White women reported smoking during the last three months of pregnancy than any other racial/ethnic group. In 2011, 16.8% of White women smoked during the last three months of pregnancy compared to 12.6% of Black women (PRAMS). However, the percent of women reporting that smoking was allowed in the home after delivery was much higher for Black women than White women (16.8% vs. 6.3% respectively, PRAMS). Overall, 14.7% reported smoking during the last three months of pregnancy and 8.4% reported that smoking was allowed in the home after delivery. Michigan's rates of smoking during pregnancy and in the home exceed U.S. rates, as reported by 25 states. In 2011, about 10.2% of women in the U.S.

reported that they smoked during the last three months of pregnancy and 4.8% of women reported that smoking was allowed in the home after delivery (PRAMS).

Michigan has the 8th highest pregnancy-related mortality rate in the country. The Michigan pregnancy related mortality rate was 22.2 per 100,000 live births compared to the U.S. rate which was 15.6 per 100,000 live births (NVSS 1999-2010). The Healthy People 2020 target for reducing the rate of maternal mortality is 11.4 per 100,000 live births.

While the infant mortality rate steadily decreased in Michigan from 8.2 per 1,000 live births in 2000 to its lowest of 6.6 per 1,000 live births in 2011, the 2013 rate of 7.0 per 1,000 live births exceeded both the Healthy People 2020 target (6.0 per 1,000) and the U.S. rate (6.0 per 1,000). Additionally, racial disparities in infant mortality persisted. In 2013, the Black infant mortality rate was 13.1 per 1,000 live births compared to the White infant mortality rate which was 5.7 per 1,000 live births (MI Resident Birth and Death Files).

In 2013, the sleep-related infant death rate for Black infants (20.6 per 10,000 live births) was twice the rate of all sleep-related infant deaths in Michigan (10.3 per 10,000 live births) and nearly three times the rate of sleep-related infant death rate for White infants (7.6 per 10,000) (MI Resident Infant Mortality File). Although in 2011 78.7% of Michigan infants slept on their back, which exceeded the Healthy People target of 75.9%, the percent of infants who slept in safe sleep environments was only 37.8% (MI PRAMS). Only 29.4% of Black mothers reported their infants sleep in safe sleep environments compared to 39.9% reported by White mothers (MI PRAMS). Furthermore, Black mothers had the lowest reported percent of infants who are

put to sleep on their backs (59.5%) compared to Hispanic mothers (79.5%) and White mothers (83.4%) (MI PRAMS).

In 2011, the total percent of infants ever breastfed in Michigan was 79.8% compared to 83.9% of infants in all PRAMS states (PRAMS). Michigan's rate of breastfeeding did not meet the Healthy People target for breastfeeding initiation, which is 81.9% of infants. Black mothers and mothers with the lowest level of education had the lowest rates of breastfeeding. About 65.1% of Black mothers reported ever breastfeeding their infant compared to 84.0% of White mothers and 88.2% of Hispanic mothers (MI PRAMS). About 60.9% percent of mothers with less than a high school education and 75.6% of mothers with a high school diploma reported ever breastfeeding their infants compared to 92.4% of mothers with college degrees (MI PRAMS). In 2011, the percent of infants breastfed exclusively through six months in Michigan was 16.2% compared to 18.8% in the U.S. (CDC NIS). Michigan's rate of exclusive breastfeeding through six months falls below the Healthy People target of 25.5%.

Stakeholders discussed strengths of the system for improving perinatal outcomes including increased access to health insurance, expanding home visiting services, and increased engagement of community health workers to connect families with resources. They also noted increased collaboration and integration of services for mothers and babies, movement toward more holistic care, greater utilization of quality improvement methods, and an increased focus on social determinants of health.

Based on the data presented and the experience and knowledge of the stakeholders, strategic issues were identified for improving perinatal and infant health, which appear in Table 2.

Child Health: The MDHHS Maternal and Child Health Epidemiology Section and the Child Health Section reviewed 39 measures of child health; those that suggested an unmet need were identified and presented to key stakeholders. Areas of improvement suggested by the data relate to early development and school performance, as well as child maltreatment. System strengths suggested by measures related to immunization and lead poisoning prevention were also highlighted.

In Michigan, in 2011, 25.3% of parents of children aged 10-71 months who had a health care visit in the past 12 months reported completing a standardized developmental screening tool (NSCH). The U.S. rate in the same year was 37.2%. Additionally, 58.6% of children aged 0-17 received care within a medical home, while only 33.7% of Black children received care within a medical home (NSCH). The U.S. rate in 2011 was 54.4%, while the Healthy People 2020 target is 63.3%.

In order to understand school performance, the NSCH promoting school success summary measure was reviewed. To meet all criteria in the measure, children had to have positive responses on the following: 1) Usually/always engaged in school; 2) Participate in extracurricular activities; 3) Usually/always feel safe at school. In 2011, 64.3% of parents reported their children are experiencing school success; however, school success was less frequently reported by Black parents (40.9%). The percent of children experiencing school success in the U.S., in 2011, was 61.0%. State data on school performance were reviewed as well. Third grade reading proficiency as measured by a state-based standardized test (the

Michigan Education Assessment Program) is one measure on Michigan's Governor's State of the State Dashboard. In 2013-14, 61.3% of children were proficient in reading by the end of third grade. However, in the same year only about 37.3% of Black or African American children were reading proficiently.

According to data reported by Kids Count (datacenter.kidscount.org), in 2008 there were 11 substantiated cases of child maltreatment per 1,000 children aged 0-17, compared to 15 cases per 1,000 children in 2012. The U.S. rate in 2012 was nine substantiated cases per 1,000 children, while the Healthy People 2020 target is 8.5 maltreatment victims per 1,000 children. In Michigan, in 2012, 42% of victims of child maltreatment were age 0-4 and 31% were age 5-10. In 2012, 84% of victims were victims of neglect, 40% were victims of emotional abuse and 25% were victims of physical abuse.

The needs assessment revealed areas of strength as well. Since 2010, the percentage of 19-36 month old children who have received the full schedule of age appropriate immunizations rose steadily from 60% in 2010 to 74% in 2014 (MCIR). Additionally, rates of lead testing increased and the percent of tested children with blood lead levels greater than 5 ug/dl decreased from 9.8% in 2008 to 4.6% in 2012 among tested children less than six years of age (Childhood Lead Poisoning Prevention Program). However, testing rates in certain areas of the state were low and lead poisoning rates remained high such as the city of Detroit, which had over half the state's lead poisoning cases in 2012.

Child health stakeholders reported that evaluation, quality improvement, interdepartmental collaboration, and a commitment to evidence-based practice were system strengths for

promoting child health. Furthermore, stakeholders identified developmental screenings, evidence-based home visiting programs, school-based services, and maternal child health nutrition programs as services that have the greatest capacity to improve child health.

Using a consensus process, stakeholders used the data as well as their experience and expertise to identify strategic issues that, if addressed, would improve child health in Michigan over the next five years. Strategic issues are listed in Table 2.

Adolescent Health: The MDHHS Maternal and Child Health Epidemiology Section and the Adolescent Health Section reviewed 42 measures. Measures that suggested an unmet need were presented to stakeholders. Opportunities for improvement as suggested by the data included bullying, suicide mortality rates, healthy lifestyles and access to care. System strengths related to motor vehicle accident mortality, adolescent condom use and teen birth rate were highlighted as well.

The Youth Risk Behavior Survey (YRBS) provides data on bullying on school property among adolescents. Michigan saw an increase on this measure from 22.7% in 2011 to 25.3% in 2013 (YRBS). This exceeded the 2013 U.S. rate of 19.6% and the Healthy People 2020 target of 17.9%. Additionally, the percent of adolescents who felt sad or hopeless has remained stable from 27.4% in 2009 to 27.0% in 2013 (YRBS). The U.S. percent in the same year was 29.9%. According to data reported by the MI Resident Death File, the suicide mortality rate for adolescents aged 15-19 increased from 6.8 per 100,000 in 2007 to 10.5 per 100,000 in 2013. The national rate of adolescent suicide mortality was 8.3 per 100,000.

The percent of adolescents aged 12 through 17 with a preventive medical visit in the past year was 85.6% in 2012 (NSCH). This exceeded the national rate of 81.7%. Additionally, 58.6% of children aged 0-17 received care within a medical home, which also exceeded the U.S. rate in 2011 of 54.4%. However, only 39.1% of Hispanic children and 33.7% of Non-Hispanic Black children received care within a medical home compared to 68.0% of Non-Hispanic White children (NSCH). The Healthy People 2020 target for this measure is 63.3%.

The needs assessment revealed areas of strength as well. In Michigan, in 2009, 11.5% of sexually active adolescents reported not using any form of contraception at last sexual encounter, compared with 8.9% of adolescents in 2013 (YRBS). The U.S. rate in 2013 was 13.7%. Additionally, since 2009 the live birth rate per 1,000 females aged 15-19 decreased from 31.9 to 23.6 in 2013 (MI Resident Live Birth File). According to the National Center for Health Statistics, the U.S. rate was 26.5 per 1,000 adolescents in 2013. Furthermore, the percent of live births among females aged 15-19 that were repeat births decreased slightly from 17.7% in 2009 to 16.4% in 2013 (MI Resident Live Birth File). According to the National Center for Health Statistics, 17% of births to 15-19 year-olds in the U.S. were to females who already had one or more babies.

Additionally, both motor vehicle and homicide mortality rates have decreased among adolescents aged 15-19. The motor vehicle accident mortality rate decreased from 14.4 per 100,000 individuals aged 15-19 in 2009 to 8.5 per 100,000 in 2013 (MI Resident Death File).

According to the MI Resident Death File, in 2009 there were 13.3 homicides per 100,000 individuals aged 15-19, compared with 8.3 homicides per 100,000 in 2013.

Adolescent health stakeholders reported that evaluation and interdepartmental collaboration were system strengths for promoting adolescent health. Stakeholders identified school-based health programs, reproductive health education, and behavioral and mental health programs as services that have the greatest capacity to improve adolescent health.

Using a consensus process, stakeholders used the data as well as their experience and expertise to identify strategic issues that, if addressed, would improve child health in Michigan over the next five years. Strategic issues are listed in Table 2.

Children and Youth with Special Health Care Needs: The Policy and Program Development Section within MDHHS CSHCS Division reviewed 45 measures, and identified measures to present to stakeholders. Areas of improvement suggested by the data related to medical home, transition services, developmental screening and adequate insurance coverage. System strengths suggested by measures related to early and continuous screenings and shared decision-making were also highlighted.

According to the NSCH 2011/2012, 47.8% of MI CSHCN had a medical home compared to 46.8% in the U.S. However, only 35.1% of CSHCN with more complex needs had a medical home compared to 61.4% of non-CSHCN and 68.2% of CSHCN with less complex health needs (NSCH). The Healthy People target for the percent of CSHCN having a medical home is 54.8%.

In addition, in 2011, 33.9% of CSHCN with more complex needs had difficulty getting needed referrals compared to 19.8% of non-CSHCN (NSCH). In the U.S. during the same period, 26.4% of CSHCN with more complex needs had difficulty getting needed referrals compared to 18.5% of non-CSHCN (NSCH). In 2011, 52.6% of CSHCN with more complex needs received effective care coordination, and 77.2% of CSHCN with less complex needs received effective care coordination (NSCH). Non-CSHCN reported effective care coordination at 72.9% during the same time period (NSCH). While 45.2% of non-CSHCN met the quality of care summary measure (which includes children having adequate insurance, receiving ongoing and coordinated care within a medical home, and at least one preventative health care visit in the past 12 months) only 24.2% of CSHCN with more complex medical needs met all quality of care criteria (NSCH). In comparison, 27.7% of U.S. CSHCN with more complex medical needs met all quality of care criteria.

In 2009, 47.5% of parents of CSHCN aged 12 months to 5 years in Michigan who had a health care visit in the past 12 months reported completing a standardized developmental screening tool (NSCHCN). In comparison, only 37.4% of all U.S. parents of CSHCN reported completing the standardized developmental screening tool in the same year. Additionally, in Michigan, 79.3% of CSHCN were screened early and continuously, which was higher than the U.S. rate of 78.6% (NSCSHN). However, only 61.1% of Hispanic children were screened early and continuously compared to 76.8% of Non-Hispanic Black children and 80.5% of Non-Hispanic White children.

In 2010, 41.2% of children in Michigan with special health care needs aged 12-17 received the services needed for transition to adult health care, work and independence compared to 40.0%

of CSHCN aged 12-17 receiving services needed for transition in the U.S. (NSCHCN). The Michigan rate, however, does not meet the Healthy People 2020 target which is 45.3%. Furthermore, only 15.1% of Hispanics and 27.7% of Blacks reported receiving necessary services needed for transition (NSCHCN).

CSHCN stakeholders reported family-professional partnerships and local health departments (LHDs) as system strengths for promoting the health of children and youth with special health care needs. Furthermore, stakeholders identified comprehensive medical homes, telemedicine and transition services as having the greatest capacity to improve the health of CSHCN.

Stakeholders used the data as well as their experience and expertise to identify the strategic issues that, if addressed, would improve health for CYSCN in Michigan over the next five years, which appear in Table 2.

Cross-Cutting/Life Course: The MDHHS Maternal and Child Health Epidemiology Section reviewed 35 cross-cutting measures. Selected measures were presented to all three stakeholder groups. Data related to the identified priorities across populations are reported.

In Michigan, the overall percent of individuals with annual household incomes below the Federal Poverty Level (FPL) increased from 14.4% in 2008 to 17.0% in 2013 (ACS). In 2013, 34.6% of Black individuals and 26.7% of Hispanic individuals reported annual incomes below the FPL compared with 13.0% of White individuals (ACS). In 2013, about 15.8% of individuals in the U.S. were living below the FPL (ACS).

The overall percent of children with no health insurance in Michigan significantly decreased from 5.2% in 2008 to 4.0% in 2013 (ACS). However, 10.5% of Native American children were uninsured and 5.6% of Hispanic children were uninsured. According to the 2013 ACS, 7.1% of children under the age of 18 were insured.

Overall, 13.3% of women reported that their household sometimes or often doesn't have enough food to eat; however, this value varied by race and insurance status. About 22.9% of Black women reported not having enough food to eat compared to 11.1% of White women (MI BRFSS). More than 25% of uninsured women reported not having enough food to eat in 2013 compared to about 11% of insured women (MI BRFSS).

In 2011-12, 77% of all students in Michigan graduated within four years compared to 81% of all high school students in the U.S. (datacenter.kidscount.org). Michigan's four-year graduation rate is also lower than the Healthy People target of 82.4%. White (82.1%) and Asian (87.9%) students graduated at higher rates in four years than Hispanic (67.3%), Native American (64.1%) and Black (60.5%) students (Michigan Department of Education).

In Michigan, in 2011, 86.9% of households with children aged 0-17 reported that they felt their child was safe in their community as compared with 86.6% of U.S. households (NSCH). Feelings of safety were less frequently reported by Black households (64.8%) and Hispanic households (73.9%).

Oral health measures were also reviewed. In 2011, although 57.7% of women reported having their teeth cleaned in the 12 months prior to pregnancy compared to 56.6% of all total reporting states, there were disparities on this measure (PRAMS). Hispanic women least

frequently reported having their teeth cleaned (43.2%), followed by Black women (46.9%). 61.9% of White women reported having their teeth cleaned (MI PRAMS). Additionally, in 2008, 44.5% of women in Michigan reported having their teeth cleaned during their most recent pregnancy (MI PRAMS). However, only 24.5% of Black women reported having their teeth cleaned during pregnancy, compared to 50.7% of White women.

The number of children aged 1 to 17 with at least one oral health problem in the past 12 months decreased from 25.4% in 2007 to 15.7% in 2012 despite the fact that the percent of children who had preventive dental visits in the past year decreased from 83.0% to 77.4% during the same period (NCHS). However, 28.1% of Black children had one or more oral health problem compared to 12.9% of White children (NSCH). Only 71.3% of Black children had a preventive dental visit compared to 81.2% of White children. In comparison, in the U.S., the percent of children with at least one oral health problem was 18.7% and the percent of children with a preventive dental visit was 77.2% (NSCH).

Cross-cutting strategic issues that, if addressed, would impact health outcomes across the life course were identified by the three stakeholder groups. These appear in Table 2.

Title V Program Capacity

While the needs assessment process did not include a formal assessment of program capacity, assessment and discussions occurred internally within BFMCH. Key components of Michigan's Title V program capacity are described below. In the future, BFMCH will also consider options for completing a formal assessment of its MCH program capacity and workforce.

Organizational Structure: The Title V program is operated by the Bureau of Family Maternal and Child Health (BFMCH) within MDHHS. The Bureau Director is also the Title V Director. The Bureau includes the Division of Family and Community Health (DFCH), Children's Special Health Care Services (CSHCS) Division, and the WIC Division. Structurally, the Title V Director reports to the Senior Deputy Director for Population Health and Community Services who reports to the Director of MDHHS (see attached organization chart). The MDHHS Director reports directly to the Governor. The BFMCH is responsible for the administration of programs carried out with allotments under Title V. The mechanisms by which the BFMCH administers Title V in Michigan are described throughout this grant.

Agency Capacity: BFMCH has a longstanding history and proven capacity to promote and protect the health of all mothers and children, including CYSHCN. The majority of Title V services and programs are delivered through DFCH, while services focused on children and youth with special needs are administered by CSHCS.

The DFCH is responsible for assessing need; recommending policy; developing and promoting best practices and service models; and advocating for the development of capacity within communities to provide high quality, accessible, culturally competent services. DFCH focuses on improving the health, well-being, functioning and quality of life for infants, children, adolescents, women of childbearing age and their families. The maternal and child health programs in this division focus on health status assessment, priority health issue identification, and development and support of programs and systems that address these health issues in the context of health care reform, systems integration and life course theory.

The life course approach is the model for the DFCH organizational structure and strategic plan and is central to the MDHHS goal “to protect, preserve and promote health with special attention to the needs of the vulnerable and underserved.” Priority is placed on increasing health promotion and prevention activities to improve socio-environmental, medical and behavioral health by integrating public health, mental health, substance abuse and Medicaid services for all ages. Although each section concentrates on their respective stage of the life course, they coordinate, complement and build on adjacent life stages.

DFCH provides ongoing public health focus, capacity building, technical assistance, epidemiologic support and infrastructure-building activities across five of the six population health domains. Specifically, Title V services are prioritized and maintained through the following sections:

Women and Maternal Health Section: Provides leadership, expertise, program management and public health focus for the Women/Maternal Health and Perinatal/Infant Health population domains. The focuses are preconception, interconception, maternal and perinatal health for women, newborns and infants.

The *Reproductive and Preconception Health Unit* focuses on preconception and interconception health planning and promotion through the delivery of equitable, quality contraceptive and reproductive health services. This program makes available general reproductive health assessment, comprehensive contraceptive services, health education and counseling, and referrals to other needed services. Services provided by a network of local providers are available to the general population; however, the primary target population is low-income men

and women. The unit has recently become the epicenter of statewide breastfeeding promotion and planning and is a major promoter of prenatal smoking cessation.

The *Health Equity and Perinatal Systems Unit* has two focuses: promote and guide the division-wide effort on achieving health equity and promote a healthy perinatal period with positive pregnancy outcomes. The target populations are pregnant and postpartum women and their newborns through their first year of life. Current efforts work to reduce infant mortality and morbidity; eliminate infant mortality disparity; and implement risk-appropriate community perinatal care systems. This unit is also responsible for conducting MCH Block Grant subrecipient consulting and monitoring to Michigan's local public health system on the appropriate use of these funds.

The *Maternal Health Unit* monitors and assures fidelity to Michigan's statewide home visiting program for Medicaid beneficiaries, the Maternal & Infant Health Program (MIHP). The program's certified local provider network provides assessment, case management and support services to pregnant women and infants to improve birth outcomes. Additionally, this unit provides oversight and supports state efforts to reduce maternal mortality, morbidity and eliminate disparity; and to prevent and identify Fetal Alcohol Syndrome Disorders. This unit also links with perinatal oral health planning and promotion.

Early Childhood Health Section: Provides leadership, expertise, program management, and public health focus for the Infant Health and Child Health population domains.

The *Infant Health Unit* is responsible for infant health promotion and initiatives to reduce fetal and infant deaths; increase the percentage of infants sleeping in safe environments; promote

screening and evidence-based treatment for known chronic conditions in newborns; and increase the proportion of newborns that receive hearing screens, evaluations and services. This unit oversees the Early Hearing Detection and Intervention Program which includes screening, diagnosis and intervention for newborns with congenital hearing loss; the Safe Delivery Program which by state law allows for the anonymous surrender of an infant within 72 hours of birth to an Emergency Service Provider; and the Infant Death Prevention and Bereavement Program, which works with high-risk families to develop bereavement counseling, education, advocacy and support services for families who have experienced the loss of a young child. The Michigan Fetal Infant Mortality Review (FIMR) Program aims to reduce infant mortality by informing target communities about risk factors and issues contributing to poor pregnancy outcome and infant health and safety issues. FIMR brings together multidisciplinary community teams to review confidential, de-identified cases of infant and fetal death for the purpose of making recommendations to improve care, services and resources for women and families.

The *Early Childhood Systems Unit* administers programs and initiatives that improve early child wellness across all domains of development; increase family ability to understand and promote child wellness; support the development of an integrated and comprehensive early childhood system that spans public/private organizations and includes promotion, prevention and intervention activities; and collects and analyzes data to improve systems and service outcomes. Initiatives within the unit include: Childhood Lead Poisoning Prevention, Parent Leadership in State Government initiative, and the Trauma-Informed System ECCS grant. This unit serves as a liaison between Public Health and Part C/Early On and Race to the Top, which

are administered by the Michigan Department of Education (MDE). The unit collaborates with internal and external partners on initiatives to improve early childhood systems coordination and seeks to include and empower parents at all levels of local and state initiatives as partners in decision making, community collaboration and communication.

The *Home Visiting Unit* administers the MIECHV grant and state dollars with the goal of strengthening home visiting infrastructure to achieve positive outcomes for children and families. The unit engages stakeholders in a collaborative process to build a more effective and efficient system as well as improve and expand home visitation services within high-need communities.

Child, Adolescent and School Health (CASH) Section: Improves the health and well-being of Michigan's school-aged children, adolescents and young adults by addressing a range of adolescent and school health issues and providing leadership, expertise, program management and public health focus for the Child Health and Adolescent Health population domains.

The *Child & Adolescent Health Systems Unit* oversees three federal teen pregnancy prevention programs including the Personal Responsibility & Education Program (PREP), the Title V State Abstinence Education Program (which funds the Michigan Abstinence Program) and Pregnancy Assistance Funds used to implement the Michigan Adolescent Pregnancy and Parenting Program. All three programs work collaboratively with state and local partners including MDE, the former Department of Human Services, faith-based organizations, schools, LHDs and other critical stakeholders. This unit will also house a DFCH position dedicated to the MCH Block Grant and an MCH liaison position with the State Innovation Grant.

The *Child & Adolescent Health Center (CAHC) Unit* oversees Michigan's school-based/school-linked health center program, funding 100 health centers and related programs in medically underserved, high-need communities. CAHCs provide comprehensive primary care and behavioral health services, health education, Medicaid outreach and enrollment, and screening/case finding to K-12 students and young adults up to age 21. This unit also oversees the state's school nurse program, mental health in schools initiative, adolescent health demonstration grants and a new telehealth pilot. MDHHS and MDE co-manage the CAHC program and have two shared staff members, the State School Nurse Consultant and the State School Mental Health Consultant.

The *School Health Unit* provides a range of public health and education programs aimed at school-aged children. This unit works extensively with MDE, collaboratively overseeing initiatives such as Coordinated School Health and Michigan's comprehensive school health education program, the Michigan Model for Health. This area also houses the preschool and school-aged Hearing & Vision Screening Program, which provides early screening and follow up to eligible children throughout the state. This unit coordinates extensively with local schools, intermediate school districts, early childhood partners, and health organizations to bring services to where kids spend the majority of their day—at school.

CSHCS Division: focuses on identifying and addressing the health needs of CYSHCN. CSHCS achieves this aim by partnering with families, community providers and other state agencies to ensure that quality services are accessible to children with special needs and their families. CSHCS creates and administers policies, provides oversight and support to local partners,

promotes evidence-based care models, and facilitates positive change through the extensive involvement of family advocates. CSHCS's goal is to help children with special needs achieve optimal health and an improved quality of life.

MCH Workforce Development and Capacity: Michigan has many long-standing leaders in the MCH field who provide strategic leadership and oversight to the various programs and initiatives that reside in the Department. Currently, 1.5 State civil servant positions are supported by Title V funding. These positions are located in the BFMCH and support Title V administratively. Senior-level leadership and program staff includes:

- **Rashmi Travis, MPH, CHES, Director, Bureau of Family, Maternal and Child Health** has 12 years of local public health experience and currently serves as Bureau Director at the state level. She possesses a dual bachelor's degree in Microbiology and Communications and a Master's of Public Health Degree with a concentration in Behavioral and Community Health Sciences. She is a Certified Health Education Specialist.
- **Brenda Fink, A.C.S.W., Director, DFCH** has over 35 years of clinical and administrative public sector experience at both local and state levels, directed toward improving the lives of at-risk children, families and adults. Ms. Fink is administratively responsible for managing the majority of Michigan's MCH services and initiatives using a life course approach that seeks to address equity and the social determinants of health.
- **Lonnie Barnett, MPH, Director, CSHCS Division** has over 20 years of state and local public health experience in a variety of areas including community health assessment, planning, policy and primary care systems development. Mr. Barnett has served as the Title V CYSHCN Director since 2011.

- **Stan Bien, M.P.A, Director, WIC Division** has over 37 years of diverse state-level experience in public health, administration and nutrition programs. Mr. Bien was appointed by USDA and U.S. Secretary of Agriculture to the National WIC Advisory Council and elected by his peers to chair the council. He was elected to the Executive Committee of the National WIC Association (NWA) and recently served as the NWA Treasurer. He was also selected by USDA-FNS to serve on the advisory council for WIC Vendor high risk in EBT.
- **Sarah Davis, MPA, Departmental Specialist, Bureau of Family, Maternal & Child Health** has 15 years of experience in the public and private sectors, including eight years of state-level experience working in child abuse prevention. She serves on state-level committees and advisory boards focused on maternal, child and family health and well-being.
- **Paulette Dunbar-Dobynes, Women and Maternal Health Section Manager** has over 30 years of state-level experience working in maternal and child health, overseeing a range of programs such as Title X Family Planning, the Maternal & Infant Health Program, Infant Mortality Prevention and Maternal-Infant Death Review.
- **Nancy Peeler, Early Childhood Section Manager** has over 30 years of experience working in research impacting early childhood development, and in local and state-level service and early childhood system design and implementation.
- **Carrie Tarry, MPH, Child, Adolescent & School Health Section Manager** has over 15 years of state-level experience working in child health, adolescent and school health, and teen pregnancy prevention programs and initiatives.

- ***Patti McKane, MCH Epidemiology Section Manager*** has over five years of state-level experience with epidemiologic analysis and interpretation to inform and guide MCH program leaders and policy makers about the health of MCH populations.

The following individuals (including parents, CSHCN and their families) also serve critical roles as Title V program staff:

- DFCH: Karen Wisinski, Early Hearing Detection Intervention Parent Consultant, Infant Health Unit, Early Childhood Section
- CSHCS Family Center for CYSHCN: Candida Bush, Director; Bambi VanWoert, Kristy Medes, Lisa Huckleberry, Parent Consultants; Amanda Larraga, Secretary

Several projected shifts are expected to occur over the next five years related to the MCH workforce, including the need to build additional state infrastructure across key areas of maternal and child health such as administration and program coordination, epidemiologic support, and data analysis. Key positions that were historically established as full-time contractual staff may also be moved into civil servant positions. More details on the MCH workforce are included in Section II.F.2.

MDHHS promotes and provides culturally competent services through several mechanisms, many of which are coordinated through the Practices to Reduce Infant Mortality through Equity (PRIME) initiative. PRIME supports MCH staff training to understand equity concepts and to focus programming and policy to consider historic, social, economic and environmental factors that impact MCH outcomes. Additionally, PRIME developed and piloted Health Equity Learning Labs with WIC staff with a goal of incorporating equity thinking, perspectives and action into

daily work responsibilities. After participating in a Lab, WIC staff developed a plan to increase outreach to the Native American community. The plan is currently being piloted.

PRIME also conducted Michigan's first PRAMS survey for mothers of Native American infants. The process included development of MOUs for each tribe and data agreements with the Inter-Tribal Council of Michigan (ITCM) and the Great Lakes Inter-Tribal Epidemiology Center. Cultural sensitivity training was developed in collaboration with ITCM and provided to staff that made calls to mothers, which resulted in a 50% response rate. PRIME also disseminated Michigan's first Health Equity Status Report highlighting 14 indicators related to the social context in which women and children live.

The Health Disparities Reduction and Minority Health (HDRMHS) Section also promotes the provision of culturally competent services. HDRMHS sponsored a BRFS for Arab/Chaldean Americans, Hispanic/Latinos and Asian Americans. HDRMHS was also awarded an Office of Minority Health grant that led to a 'Developing Culturally and Linguistically Appropriate Services through the Lens of Health Equity' workshop available to MDDHS staff and partners. To strengthen broad community partnership and address some aspect of racial and ethnic health disparities, HDRMHS funds agencies through its Capacity Building Grant Program. It also developed a Health Equity Toolkit to increase awareness around health and racial equity.

MDHHS is supporting the provision of culturally competent services through initiatives such as a data inventory and quality improvement project to standardize collection and use of race, ethnicity, sex, language and disability status data. The project has expanded to include six additional measures including a postpartum care measure. Additionally, MDHHS Human

Resources includes a question on health equity in hiring, and developed managerial annual performance evaluations that include a measure related to inclusion of equity work or addressing disparities.

MCH programs also implement specific strategies to provide culturally competent services. For example, the Home Visiting Program developed contractual requirements to use specific data analysis (Kitagawa) to develop outreach plans to enroll the most at-risk moms. This method uses data analysis of infant mortality disparities to identify minority populations with the greatest need and aids in setting recruitment goals.

Partnerships, Collaboration & Coordination

Partnerships, collaboration and coordination that are critical to Michigan's MCH services and activities are described here. While the needs assessment did not include a formal assessment of partnerships, BFMCH has continuous internal discussions and will consider options for completing a formal assessment of its MCH partnerships in the future.

The ability to meet MCH population needs with a coordinated approach is facilitated by the organizational placement of BFMCH, which allows for collaborative work and sharing of best practices across divisions and programs. In addition to CSHCS, the DFCH manages all programs within the scope of reproductive health; perinatal and infant health; and child, adolescent and school health. Many programs, some of which are described in the Agency Capacity section, are aimed at improving the health of persons within all MCH populations. The BFMCH is located in the Population Health and Community Services administration, as are the Bureau of Local Health and Administration Services (Vital Records and Health Statistics, Chronic Disease and Injury Control which is where the oral health office resides) and the Bureau of Disease Control,

Prevention and Epidemiology (Immunizations, Lifecourse Epidemiology and Genomics, Communicable Disease). Other administrations within MDHHS include Health Services and Family Support where the state Medicaid program is housed and the Behavioral Health Services Administration. The Children's Services Agency was also recently created as part of the merger between the Departments of Community Health and Human Services to house child welfare and children's mental health services.

MDHHS has long-standing relationships with numerous public and private organizations and service providers to carry out the scope of work within the MCH Block Grant. MDHHS contracts with LHDs, making Title V MCH Block Grant funds available to address identified MCH needs within their jurisdictions through local program implementation and direct service delivery. MDE is a close partner in numerous programs supporting early childhood, school health and child and adolescent health at the state, intermediate and local school district levels. MDE and MDHHS have a long history of integrating funding around early childhood, Child and Adolescent Health Centers, and Hearing and Vision school-based screenings. They have created shared state-level positions to address school nursing and social-emotional health support needs in local districts.

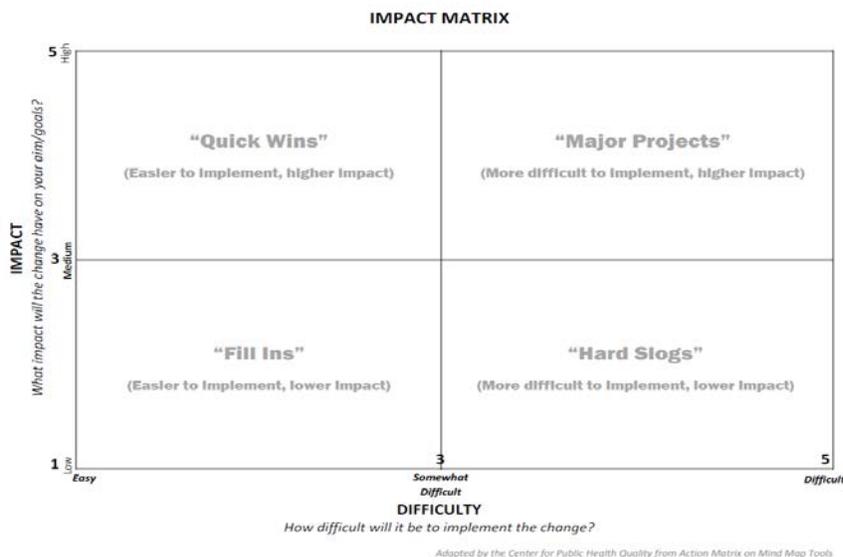
MDHHS also partners with many non-governmental organizations. Advocacy organizations such as the Michigan Association for Local Public Health, Maternal and Child Health Council, Early Childhood Investment Corporation, School-Community Health Alliance of Michigan, Michigan Association of Health Plans, Michigan Health and Hospital Association, and Michigan Primary Care Association provide a voice for policy and funding considerations to the state

administration and legislature. Provider organizations such as the Michigan chapters of the American College of Obstetrics and Gynecology, American Academy of Pediatrics and Society of Adolescent Medicine enhance advocacy efforts and offer services (e.g., education and training). Several Michigan universities partner in program evaluation and in pilot projects to expand services, including projects in telemedicine and telepsychiatry. Tribal, youth-serving, faith-based, community-based and other non-profit organizations are often recipients of grant funds for service delivery and create linkages to service recipients, allowing MDHHS to engage the consumer voice through consumer representation on various permanent and ad-hoc advisory boards, councils and task forces.

II.C. State-Selected Priorities

In preparation for selecting priorities, the Title V Planning Committee reviewed the strategic issues developed by stakeholder groups and identified strategic issues that a) could be addressed without using Title V Block Grant funding, b) were not within the control or influence of the state MCH program, or c) were not aligned with programmatic, state and federal priorities. The Planning Committee selected priorities from among the remaining strategic issues based on the results of a prioritization exercise, their knowledge of Title V program capacity, and the potential to leverage Title V funding through partnerships and coordination. Additionally, the Planning Committee considered the need to sustain activities currently funded by Title V. The prioritization exercise involved placing each strategic issue on an impact matrix (see Figure 2). Members of the Planning Committee rated each strategic issue, on a scale of 1 to 5, on how difficult it would be to implement strategies to address the issue and how much of an impact addressing the issue would have on MCH health outcomes in the next five years.

Figure 2. Prioritization Matrix



The Planning Committee considered strategic issues that were placed in the “Quick Wins” quadrant first, followed by strategic issues that were placed in the “Major Projects” quadrant. They did not consider strategic issues that were placed in the other two quadrants. The final list of priorities reflects the needs of the population, stakeholder input, and the knowledge and expertise of MCH leadership. The Planning Committee selected the priorities that appear in Table 3.

Table 3: Michigan’s FY 2016-2020 Title V Block Grant Priorities	
FY 2016-2020 Priorities	Title V Population Domain
Reduce barriers, improve access, and increase the availability of health services for all populations	Women/Maternal Health Adolescent Health CSHCN
Support coordination and linkage across the perinatal to pediatric continuum of care	Perinatal/Infant Health
Invest in prevention and early intervention strategies, such as screening	Child Health
Increase family and provider support and education for Children with Special Health Care Needs	CSHCN
Increase access to and utilization of evidence-based oral health practices and services	Cross-cutting/Life course
Foster safer homes, schools, and environments with a focus on prevention	Child Health Perinatal/Infant Health
Promote social and emotional well-being through the provision of behavioral health services	Cross-cutting/Life course

Through the prioritization process, several strategic issues were identified as factors that would be incorporated as common core values woven throughout all of the action plans under each selected priority and population domain. Planning Committee members agreed that these strategic issues were important because they affect all populations, programs and implementation. These priorities are as follows:

- Improve quality of life, healthy development, and healthy behaviors across the life course;
- Provide equity in funding, services, and health outcomes;
- Provide culturally and linguistically competent services to address disparities and achieve health equity; and
- Better utilize data measuring performance and outcomes.

Selected Priorities Compared with Prior Needs Assessment

Michigan’s FY 2011-2015 priorities align with the FY 2016-2020 priorities as displayed in Table 4.

Table 4: Alignment between FY 2011-2015 Priorities and FY 2016-2020 Priorities	
FY 2011-2015 Priorities	FY 2016-2020 Priorities
Increase the proportion of intended pregnancies	Reduce barriers, improve access, and increase the availability of health services for all populations
Decrease the rate of sexually transmitted diseases among youth 15-24 years of age	
Increase access to early intervention services and developmental screening within the context of medical home for children	Invest in prevention and early intervention strategies, such as screening
Address environmental issues (asthma, lead and second-hand smoke) affecting children, youth and pregnant women	Foster safer homes, schools, and environments with a focus on prevention
Reduce intimate partner violence and sexual violence	
Increase the proportion of CHSCN population that has access to a medical home and integrated care planning	Increase family and provider support and education for Children with Special Health Care Needs
Reduce African American and American Indian infant mortality rates	Support coordination and linkage across the perinatal to pediatric continuum of care
	Foster safer homes, schools, and environments with a focus on prevention
Increase access to dental care for pregnant women and children, including children with special health care needs	Increase access to and utilization of evidence-based oral health practices and services
Reduce obesity in children and women of	

child-bearing age, including children special health care needs	
Reduce discrimination in health care services in publically-funded programs	
	Promote social and emotional well-being through the provision of behavioral health services

Eight of the previous priorities were essentially retained and incorporated into the new priorities by combining and/or rewording them into broader priority issues. By increasing access to health services, many specific issues can be addressed, including unintended pregnancies and sexually transmitted diseases. Infant mortality has been a continued focus across the state and improving coordination of the system was chosen as a priority to address multiple factors related to infant mortality and the pressing disparity. While reducing discrimination in health care services remains a priority in Michigan, it was decided that providing culturally and linguistically competent services to address disparities and achieve health equity would be a priority incorporated into all action plans.

**II.D. Linkage of State Selected Priorities with National Performance Measures
and Outcome Measures**

The Needs Assessment Planning Committee selected eight National Performance Measures (NPMs) by identifying which measure aligned most closely with each priority. See Table 5.

Table 5: Alignment between State Priorities and National Priority Areas and Performance Measures			
MCH Population Domain	State Priorities	National Priority Areas	National Performance Measures
Women/ Maternal Health	Reduce barriers, improve access, and increase the availability of health services for all populations	Well-woman visit	1. Percent of women with a past year preventive medical visit
Perinatal/ Infant Health	Support coordination and linkage across the perinatal to pediatric continuum of care	Perinatal Regionalization	3. Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU
Perinatal/ Infant Health	Support coordination and linkage across the perinatal to pediatric continuum of care	Breastfeeding	4. A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
Child Health	Invest in prevention and early intervention strategies, such as screening	Developmental Screening	6. Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool
Adolescent Health	Reduce barriers, improve access, and increase the availability of health services for all populations	Adolescent well-visit	10. Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year
CSHCN	Increase family and provider support and education for Children with Special Health Care Needs	Medical Home	11. Percent of children with and without a special health care needs having a medical home
CSHCN	Increase family and provider support and education for Children with Special Health Care Needs	Transition	12. Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
Cross-cutting/ Life course	Increase access to and utilization of evidence-based oral health practices and services	Oral Health	13. A) Percent of women who had a dental visit during pregnancy and B) percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Women/Maternal Health

In order to measure progress toward “Reducing barriers, improving access, and increasing the availability of health services,” Michigan will report progress on the “Percent of women with a past year preventive medical visit” (NPM 1). Although 67.0% of women in 2013 received a preventive medical visit in Michigan (MI BRFSS), there were significant disparities on this measure, with only 47.3% of women who were uninsured receiving a preventive medical visit. As insurance options for women expand, MDDHS wants to maintain and build on the state’s success in connecting women with preventive care by helping women access insurance and connecting them with primary care providers.

Perinatal/Infant Health

Michigan’s Title V program will measure progress toward “Supporting coordination and linkage across the perinatal to pediatric continuum of care” through two NPMs. Michigan will report progress on the “Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ NICU” (NPM 3). The needs assessment revealed several challenges related to the perinatal to pediatric continuum of care, such as the disparity in first trimester prenatal care, the disparity in hypertension and obesity in pregnancy, smoking during pregnancy and in the home after delivery, and the disparity in infant mortality. One avenue for assuring the most vulnerable infants and their families receive the support they need is through perinatal systems of care, which are being developed and piloted by MDHHS. While the selected NPM measures only one component of the perinatal systems of care concept, it will provide an indicator of the success of this effort.

Additionally, Michigan will measure progress toward “Supporting coordination and linkage across the perinatal to pediatric continuum of care” by reporting progress on the “A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months” (NPM 4). The needs assessment found that Michigan does not meet the Healthy People 2020 target for breastfeeding initiation or breastfeeding at six months. Breastfeeding is an indicator of successful coordination and linkage, and it was identified by stakeholders as an opportunity to improve over the next five years.

Child Health

Progress toward “Investing in prevention and early intervention strategies, such as screening” will be measured by the “Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool” (NPM 6). Although rates of developmental screening have increased in Michigan, the 2011 rate of 25.3% in Michigan was well under the U.S. rate (NSCH). However, interdepartmental collaboration and a quality improvement focus were identified as system strengths, and developmental screening is a cross-system function that MDDHS and its partners can make meaningful strides toward improving.

Adolescent Health

In the area of adolescent health, the priority “Reduce barriers, improve access, and increase the availability of health services for all populations” will be measured by the “Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year” (NPM 10). Although according to the NSCH, 85.6% of adolescents had a preventive medical visit in the past year in Michigan, in-state data suggest there are wide disparities in this measure. As the

insurance landscape continues to change the health care system, MDDHS wants to maintain and build on the state's success in connecting adolescents with preventive care in appropriate settings and using practices that are sensitive to the needs of this age group.

Children with Special Health Care Needs

Progress toward the priority "Increase family and provider support and education for Children with Special Health Care Needs" will be measured using two NPMs. Michigan will measure progress on the "Percent of children with and without a special health care needs having a medical home" (NPM 11). Only 47.5% of CSHCN in Michigan had a medical home in 2011, and even fewer CSHCN with more complex needs had a medical home (NSCH). Stakeholders identified the need to support and educate providers and families on the components of a medical home and how they relate to the unique needs of the CSHCN population.

Additionally, Michigan will measure progress toward the "Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care" (NPM 12). The needs assessment found that in 2010, only 41.2% of CSHCN received the services needed for transition to adult health care, which falls below the Healthy People 2020 target (NSCHCN). Furthermore, there are wide disparities in Michigan's performance on this measure. Michigan will work toward improving performance and reducing the disparity in this measure by supporting and educating providers and families on transition planning.

Cross-cutting/Life Course

Michigan will measure progress toward "Increasing access to and utilization of evidence-based oral health practices and services" by reporting progress on the "A) Percent of women who had

a dental visit during pregnancy and B) percent of children, ages 1 through 17, who had a preventive dental visit in the past year” (NPM 13). The needs assessment found that only 44.5% of women had their teeth cleaned during their most recent pregnancy, and that there were disparities in this measure (MI PRAMS). There were also disparities in the percent of children who had a preventive dental visit in the past year, and fewer children had preventive dental visits in 2012 as compared with 2007 (NSCH). Stakeholders recognized the need to build on Michigan’s efforts to improve access to oral health care across population groups.

II.E. Linkage of State Selected Priorities with State Performance and Outcome Measures

The Title V federal guidance requires states to develop three to five State Performance Measures (SPMs) to further address state priorities based on the results of the needs assessment. Per federal requirements, these SPMs will be developed in FY16 and formally implemented in FY17. To address the priority area of **“Foster safer homes, schools and environments with a focus on prevention,”** MDHHS anticipates developing two SPMs. The first of these SPMs is related to **promoting safe sleep environments.** According to the Centers for Disease Control (CDC), approximately 3,500 infants die suddenly and unexpectedly in the U.S. each year. Sudden Unexpected Infant Deaths (SUIDs) are typically reported as one of three types: Sudden Infant Death Syndrome (SIDS), Unknown Cause or Accidental Suffocation and Strangulation in Bed (ASSB). In 2013, 117 infants died from SUID in Michigan, accounting for almost 15% of all infant deaths. For the last several years, SUID has been the third leading cause of death for infants in Michigan, behind complications due to preterm birth (22%) and congenital anomalies (20%). Of the three leading causes of death, sleep-related infant deaths are considered the most preventable. Among sleep-related infant deaths, significant racial disparities exist. Statewide, Black infants are disproportionately represented among SUIDs with 4.6 times more SUIDs among Black infants than White infants, even after accounting for the fact that more White infants are born.

Historically, the number of infant deaths classified as SUID is an under-reporting of the actual number that occurs from sleep-related causes. Michigan is fortunate to be one of nine states participating in the CDC’s SUID Case Registry Project which is a population-based surveillance

system designed to identify SUID trends and risk factors. Through the project, infant deaths are examined in order to determine if sleep-related causes were involved. Additional sources are reviewed including death scene investigations, autopsies and medical records. This review frequently results in additional deaths being attributed to sleep-related causes. Thus, in 2013, Michigan's SUID Case Registry Project reported 142 sleep-related infant deaths. This number has remained relatively consistent over the past four years.

According to responses to the Pregnancy Risk Assessment Monitoring Survey (PRAMS), parents and caregivers too frequently place infants in unsafe sleep environments. Almost 25% of all infants usually sleep on their side, stomach or a combination; 14% usually bed-share with another person; and 12% do not usually sleep in a crib or portable crib. Furthermore, almost half of all babies regularly sleep in an environment with at least one item such as a pillow, blanket or stuffed toy. All of the aforementioned behaviors have been shown to increase the risk for a sleep-related infant death.

The annual 2012 Child Death Review (CDR) report (most current year available) indicates that risky behaviors can lead to sleep-related infant deaths. Of the 119 SUIDs reviewed in 2012, over three-quarters of the deaths occurred in locations unsafe for infant sleep such as on a chair, couch, floor or adult bed. In almost half of the deaths reviewed, the infant died after being placed to sleep on an adult bed. The CDR report found that of the 20% of sleep-related infant deaths that occurred in a crib or bassinet, the majority of those deaths involved a suffocation hazard (most often a blanket) present in the sleep environment. Among cases reviewed, well over half of infants were sleeping with an adult and/or a child at the time of death.

Michigan has elevated safe sleep to a priority due to the persistently high number of sleep-related infant deaths that occur each year. Significant racial disparities exist among the deaths with Black infants and Native infants dying at much higher rates than White infants. Parental and caregiver behavior is a modifiable risk factor which can be addressed through culturally appropriate, relevant education and counseling. Although difficult to accomplish, changing parental and caregiver behavior is key to reducing and ultimately eliminating these preventable infant deaths.

To address sleep-related infant deaths, the Michigan Department of Health and Human Services (MDHHS) Infant Safe Sleep Program will implement the following:

- Mini-grants (ranging from \$22,500-\$45,000) will be given to the Inter-Tribal Council and to 14 local health departments (LHDs) in counties with the highest numbers of SUIDs. Under the guidance of local community advisory boards, mini-grant funds will support community-based safe sleep education, outreach and awareness activities.
- Public awareness campaigns will be undertaken including mass media as well as mobile and internet-based advertising approaches. Funds will be targeted to areas with racial disparities.
- The Michigan Infant Safe Sleep State Advisory Committee will complete a strategic planning process and priority activities will be supported.
- Infant safe sleep educational materials, including new and revised materials, will be available, free of charge statewide.

- Professional education will be accomplished through the availability of two online trainings and through presentations at conferences and professional meetings.
- Active participation in the Infant Mortality CoIIN Safe Sleep Learning Network.
- Continued collaboration with other state departments, LHDs, hospitals, community organizations and others.

The second SPM to address the priority of **“Foster safer homes, schools and environments with a focus on prevention,”** is related to **lead prevention**. Michigan has made great strides in the past few years in reducing the number of children with elevated blood lead levels, but this is still a high priority area. In 2013, over 5,000 children were identified with lead poisoning. The rate of lead poisoning was about 4%, less than one-tenth of the rate 15 years ago. But many small areas of the state remain at high risk. For example, 14 ZIP code areas had rates of lead poisoning over 10%.

Traditionally, efforts to reduce childhood lead poisoning have included testing, providing case management for children found to be lead-poisoned, and (if possible) removing lead hazards from those children’s homes. In recent years, the Childhood Lead Poisoning Prevention Program (CLPPP) has worked to eliminate lead poisoning before it occurs through education and outreach grants across the entire state, and through prevention grants in areas with the highest levels of lead poisoning. Education and outreach has been directed to various professionals who work with young families. These efforts will continue with the goal that all of these families will know about the dangers of lead. Prevention efforts will shift in FY16, with a range of low-cost, in-home activities designed to reach pregnant women living in high-risk

homes and young children showing early indications of lead exposure. A specific SPM will be finalized in 2016.

To address the priority need to **“Promote social and emotional well-being through the provision of behavioral health services,”** MDHHS anticipates developing a State Performance Measure (SPM) in FY16 related to **reducing depression across the life course.** Clinical depression is a leading cause of disability. Depression affects twice as many women as men, regardless of racial and ethnic background and income; and one in four women will experience severe depression at some point in life.

According to the National Survey of Children with special Health Care Needs (CSHCN), 32% of all CSHCN experienced internalizing mental health symptoms defined as anxiety and depression (16% of 3-5 year olds and almost 39% of 12-17 year olds). The conditions most strongly associated with internalizing symptoms were autism spectrum disorders (70.7% of children with ASD experienced symptoms of anxiety and/or depression), behavior problems (69%) and developmental delays (61%). These results highlight the prevalence of symptoms among CSHCN, particularly adolescents; and suggest that health care providers should routinely screen for depression and facilitate connections to appropriate services for this population. According to the 2013 Michigan Youth Risk Behavior Survey, 27% of the state’s high school students felt sad or hopeless almost every day for two or more weeks in a row to the extent they stopped doing some usual activities during the prior 12 months.

Untreated depression among pregnant and postpartum women is of concern due to its adverse effects on the health of the mother, infant and the mother-infant relationship. Between 10%

and 20% of all women experience depression during the perinatal period, with prevalence in low-income and Black women estimated at almost double that of White women. Analysis of depression rates across six home visiting programs found that the percentage of women exceeding clinical cutoff for depression at enrollment ranged from 28.5% to 61%. FY14 data from the Maternal & Infant Health Program Screener for Maternal Depression showed that more than 43% scored moderate or high risk, but just over 12% received treatment.

Among its potential consequences (and one that MDHHS intends to impact), chronic depression is sometimes a factor in suicide causality. In 2013, the adolescent suicide rate in Michigan was at a six-year high of 10.5 per 100,000 population. Provisional 2014 data shows a significant drop in the teen suicide rate, to the second lowest rate (6.9) in the past seven years. Suicide rates among adolescent males remain much higher than that of adolescent females, with the rate among males four times higher than that of females.

While adolescent rates are concerning, in a broader context, adolescents traditionally have the lowest suicide rates per population as suicide rates increase by age group. According to the CDC, suicide rates among the state's middle-aged population (35-64 years) increased more than 41% between 1999 and 2010, which is significantly higher than the 28% rise for the U.S. middle-aged population over the same time period.

Through an SPM on reducing depression across the life course, Michigan will identify and develop effective strategies to educate the public on recognizing the symptoms of depression; reduce stigma surrounding depression as a means to reduce barriers for those reluctant to seek help; educate and encourage primary care providers to recognize depression and appropriate

treatment and referrals for patients with depression; promote integrated physical and mental health care; and reduce barriers and increase access to effective and affordable treatment options for those diagnosed with depression.

To address the priority area of **“Reducing barriers, improving access, and increasing the availability of health services for all populations,”** MDHHS anticipates developing a State Performance Measure (SPM) in FY16 related to **provision of medical services and treatment for children with special health care needs.** Even though access to public and private health insurance coverage has improved as a result of the ACA, families with a child with special health care needs continue to experience financial challenges due to the cost of medical care and treatment.

Children and Youth with Special Health Care Needs (CYSHCN) require and use more health care services than other children. Specialty care and extensive, on-going, or long-term treatments and services may be required to maintain or improve health status. Financing these costs can pose significant challenges and burdens for families even if a family has access to private insurance. Family health care costs can include deductibles, cost sharing and premium payments. In addition, private insurance may not include any covered benefit for a specific, medically necessary service. In other cases, only a limited benefit may be available through insurance. Transportation costs may also pose challenges to families who may need to travel long distances to appropriate specialty medical care. Although the ACA eliminated annual and lifetime dollar limits, other annual limits exist, and benefits may be exhausted for the current contract year even though the need continues. For each of these financing and resource

challenges, CSHCS continues to be a significant resource for achieving adequate, appropriate health and specialist care and also provides a way to contain substantial costs to families.

Through an SPM on the provision of medical services and treatment for CYSHCN, Michigan will identify and refine strategies to assist individuals with special health care needs in accessing the broadest range of appropriate medical care, health education and supports; assure delivery of these services and supports in an accessible, family-centered, culturally competent, community-based and coordinated manner; promote and incorporate parent/professional collaboration in all aspects of the CSHCS program; and remove barriers that prevent individuals with special health care needs from achieving optimal health.

II.F. Five-Year State Action Plan

II.F.1. State Action Plans and Reports by MCH Population Domain

This section presents Michigan’s five-year state action plan tables and FY16 narrative plans as well as FY14 reports, by population domain. National Performance Measures (NPMs) from the previous reporting cycle are organized by population domain, as required by federal guidelines.

Women/Maternal Health Domain

Five-Year Plan (NPM 1 – Well-woman Visit)

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
Reduce barriers, improve access, and increase the availability of health services for all populations	A) By 2020, decrease Michigan’s unintended pregnancy rates by 5%	<p>A1) Increase the number of publicly-funded family planning and reproductive health related preventive visits</p> <p>A2) Increase the number of women using highly effective contraceptive methods</p> <p>A3) Develop an outreach plan to increase access to family planning services and clinics</p>	<ul style="list-style-type: none"> - Severe maternal morbidity per 10,000 delivery hospitalizations - Maternal mortality rate per 100,000 live births - Low birth weight rate (%) - Very low birth weight rate (%) - Moderately low birth weight rate (%) - Preterm birth rate (%) - Early preterm birth rate (%) - Late preterm birth rate (%) - Early term birth rate (%) - Infant mortality per 1,000 live births - Perinatal mortality per 1,000 live births plus 	Percent of women with a past year preventive medical visit
	B) Develop a statewide plan to promote	B1) Convene a workgroup to develop a state		

	<p>reproductive life planning in health care settings</p> <p>C) By 2020, increase the number of women who receive a post-partum visit</p>	<p>plan for reproductive life planning</p> <p>B2) Develop a model reproductive life plan tool for use in publicly-funded family planning clinics</p> <p>B3) Promote use of the reproductive life plan tool with other relevant health care provider networks</p> <p>B4) Determine feasibility of replicating the Kent County inter-conception care project in 3-5 communities with high infant mortality disparity</p> <p>C1) Strengthen the role of health plan care coordinators and home visiting to address barriers to women receiving a post-partum visit</p> <p>C2) Review and update MQIC prenatal and postnatal care guidelines (for low-risk women)</p> <p>C3) Develop prenatal and postnatal care guidelines for high-risk women</p>	<p>fetal deaths</p> <ul style="list-style-type: none"> - Neonatal mortality per 1,000 live births - Postneonatal mortality rate per 1,000 live births - Preterm-related mortality per 1,000 live births 	
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	D) By 2020, increase by 10% the number of women reporting routine check-ups within the last year	D1) Promote enrollment in Medicaid expansion and other insurance products to increase number of women with primary care coverage D2) Promote referrals to primary care providers with family planning clinic network		
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Women/Maternal Health Action Plan Narrative

Through the five-year needs assessment process, the state priority issue of “Reduce barriers, improve access and increase the availability of health services for all populations” was selected for the Women/Maternal Health domain. The percent of adult women with a preventive medical visit in the past year (NPM 1) was selected to address this priority need. According to the Michigan Behavioral Risk Factor Surveillance System (MI BRFSS) report for 2013, 74.4% of women over 18 years of age received a preventive medical visit in the year preceding the survey. While these rates may appear relatively high, the combined rates for men and women vary by age, with adults aged 18-44 reporting lower preventive care visit rates than older adults, ranging from 57.2% to 62.2%. It is also important to note there is disparity in access to care. Michigan Medicaid HEDIS results for 2014 report breast cancer screening at 62.56%, cervical cancer screening at 71.34% and Chlamydia screening for women aged 16-24 at 63.4%. While breast cancer screening rates rose in 2014, rates for cervical cancer and Chlamydia

screening fell from 2012. This decline is concerning because more Michigan adults gained coverage in 2014. MDHHS will work to address disparity in access to well woman preventive care for publicly-insured women, as well as improve access for all women in Michigan.

Objective A: By 2020, decrease Michigan’s unintended pregnancy rate by 5%. According to the Office of Vital Statistics, Michigan’s unintended pregnancy rate has hovered around 51% since 2007. Several factors have recently come together to give us the tools needed to move the mark, including increased access to family planning services through insurance expansion programs such as Michigan’s Medicaid expansion program (Healthy Michigan Plan) and an increased use of highly effective, long-acting reversible contraceptives (LARCs).

The first strategy toward meeting this objective is to monitor and increase the number of publicly-funded family planning and reproductive health/preventive health visits. During these visits, the reproductive life plan of clients should be addressed and developed based on their needs. The visits should also include a discussion on either having a healthy, planned pregnancy or how to prevent pregnancy through effective, affordable methods of contraception. Women should have access to these visits at unprecedented levels as more women are enrolled in insurance programs. Visits can be monitored through state Medicaid data and data from Title X family planning clinics.

The second strategy to reduce the unintended pregnancy rate is to increase the number of women using highly effective methods of contraception. These methods are categorized as having a high effectiveness rate and include implants, intrauterine devices (IUDs), sterilizations and injectables. These methods are highly effective once correctly administered and rely less on

correct and consistent use. The high up-front cost for many of the most effective methods (e.g., IUDs and implants) poses a barrier despite proven cost-effectiveness over time. The Affordable Care Act (ACA) is drastically expanding the availability of effective contraceptive methods as both public and commercial insurance plans are required to cover them without cost share. FDA approval of a low-cost IUD will help publicly-funded providers stock a previously high-cost option. Michigan will monitor state Medicaid data and data from Title X family planning clinics to measure if use of highly effective methods of contraception is increasing.

The final strategy for this objective is to create and implement a statewide outreach plan to promote the availability of family planning services in Michigan. Michigan's Title X Family Planning client numbers have been decreasing over recent years with a dramatic 12% decrease between calendar year 2013 and 2014. The causes need exploration but are believed to be related to decreased funding for services; increased insurance coverage for clients who then choose to see other providers of care; a decrease in the need for frequent family planning visits with pap smear protocol changes; and increased use of long-acting reversible contraceptives such as IUDs. State Title X providers report that clients with new insurance plans think they can no longer visit their trusted, publicly-funded family planning providers. In fact, Title X providers can bill most insurance plans. The outreach plan would target Michiganders in need of family planning services statewide. The plan is expected to include media spots, social media and use of local resources to help area providers conduct outreach in their communities.

Objective B: Develop a statewide plan to promote reproductive life planning in health care settings. While initiatives are under way to improve access to family planning services and

encourage preventive health care for women and girls prior to pregnancy, the 2010 Michigan PRAMS reports that only 32.1% of new mothers had received advice about healthy pregnancy from a health care provider in the year prior to conception. To address this gap in preconception care, MDHHS will promote reproductive life planning as a routine part of health care for women of reproductive age. Recent expansion of health care coverage provides an opportunity to expand the number of women who receive care. Challenges to integrating reproductive life planning into routine care include a lack of awareness among many providers, lack of comfort in raising reproductive issues and a lack tools to facilitate these discussions. MDHHS will develop a statewide plan to overcome these challenges in order to promote reproductive life planning in a broad range of health care settings.

The first strategy is to convene a state-level workgroup comprised of provider groups such as the family planning provider network, Health Plans and Federally Qualified Health Centers (FQHCs), the Michigan Quality Improvement Consortium (MQIC), local health departments (LHDs) and key maternal and child health stakeholders to develop a state plan for promoting and integrating reproductive life planning into health care settings.

A second strategy is to develop a model reproductive life plan tool for use in publicly-funded family planning clinics. MDHHS will convene a workgroup of providers in the family planning network to review existing tools and develop a model reproductive life plan tool for statewide use in family planning clinics. The family planning network is an ideal group to develop and refine a tool since they have used reproductive planning and preconception health concepts for many years. In addition, the 2014 Office of Population Affairs (OPA) and Centers for Disease

Control (CDC) recommendations on Providing Quality Family Planning Services re-emphasized these concepts. OPA and CDC are supporting efforts to train staff on reproductive life planning and providing guidance that can be used to develop a model tool.

As a third strategy, MDHHS and workgroup partners will explore ways to promote the use of the reproductive life plan tool with other health care provider networks. MDHHS and family planning providers have strong collaborative relationships with publicly-funded provider groups such as FQHCs, Medicaid Health Plans, community Medicaid providers and home visiting programs serving at-risk women and families. MDHHS will work with the state Medicaid office to determine the feasibility of convening a group of Medicaid Health Plans to share and promote the use of the reproductive life plan tool.

As a final strategy, MDHHS will work with our statewide partners to determine the feasibility of replicating a model inter-conception care project, operated by the Kent County Health Department, in three to five communities with high infant mortality disparity. This project identifies women who have experienced an adverse pregnancy outcome and offers comprehensive interconception care to reduce the risk of another poor birth outcome. The program provides supportive services to help at risk women achieve optimal health before becoming pregnant again, and promotes planned pregnancies and optimal birth spacing. MDHHS is currently working with Kent County to develop an evaluation process for this innovative practice model based on evidence-based inter-conception programs in other states.

C) By 2020, Increase the number of women who received a post-partum visit. Michigan Medicaid Statewide HEDIS results for 2014 report that 70.84% of Medicaid patients received a

postpartum care visit, a slight increase over 2013. While this statewide rate is above the national Medicaid 75th percentile, there is wide disparity with Health Plans serving predominantly high risk populations.

As one strategy, Michigan Medicaid and MDHHS maternal and child health staff is participating with a Centers for Medicare and Medicaid Services sponsored Maternal Infant Care Quality Improvement Project to improve the rate and quality of postpartum care visits. The Michigan Project is working with four Health Plans serving the southeast Michigan Medicaid population with the goal of developing and testing practice models to improve the post-partum visit rates. The project aims to improve visit rates by improving access to the Medicaid transportation benefit; strengthening the role of health plan care coordinators; and improving coordination between health plans and the Maternal & Infant Health Program. MDHHS expects the project will result in the development of practice models that can be shared with health plans statewide to reduce the disparity in other areas of the state.

A second strategy is to work with the MQIC for an ongoing review and update of current prenatal and postnatal care guidelines for low risk women to focus on improving the quality of the post-partum visit. Guidelines were updated in 2014, including a number of updates focusing on prenatal care. MDHHS will explore strategies for enhancing awareness and distribution of the guidelines among providers.

A third strategy is to work with the MQIC to explore the feasibility of developing prenatal and postpartum guidelines focusing on socially at-risk women from a life course perspective, including addressing social determinants of health. MDHHS and its workgroup partners will

work to identify ways to enhance connections with local mental health providers and other social supports to address psychosocial issues identified within medical visits.

D) By 2020, increase by 10% the number of women reporting routine checkup within the last

year. In 2013, the MI BRFSS indicated that 74.4% of adult women reported having a routine medical visit within the past year, while 15.9% reported not seeing a doctor within the past year due to cost and 11.4% reported not having a personal health care provider. In 2013, 13.8 % of women aged 18-64 reported having no health care coverage. MDHHS expects these numbers to improve due to new access to health care coverage under the ACA. MDHHS will work with its workgroup partners to continue to encourage enrollment and health coverage continuation in order to increase the number of women who receive regular health care.

The first strategy to increase coverage is to increase efforts to encourage enrollment into the Healthy Michigan Plan and other insurance products in partnership with the family planning provide network, LHDs and other community partners. The family planning network has developed expertise in enrollment activities since 2006, when Michigan began its Medicaid Family Planning Expansion Program, Plan First. Michigan is phasing out Plan First as Healthy Michigan Plan has expanded coverage, but the family planning network has continued to provide outreach and enrollment activities.

A second strategy to increase routine primary care visits among women is the promotion of referrals to primary care providers within the family planning clinic network. State guidelines and standard practice among family planning clinics include asking each client about access to primary care services and to make referrals to care where needed.

Women/Maternal Health Annual Report

The following performance measures and the related data trends, program summaries, successes, and challenges address the **Women/Maternal Health** population domain for FY14 reporting.

NPM 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester

Data Trends: The trend in percent of infants born to pregnant women receiving prenatal care beginning in the first trimester has remained relatively unchanged over the past five years, from 73.5% in 2009 to 73.1% in 2013. The 2013 indicator remains below the Healthy People 2020 target of 77.9%.

FY14 Program Summary: Women report a variety of barriers to accessing prenatal care in PRAMS. Local health departments (LHDs) continue to provide Medicaid Outreach activities to assist women in enrolling in Medicaid and thereby improving access to care. The Healthy Michigan Plan was implemented in April 2014 which also facilitates access to health care. Once women are in care, there are a number of home visitation programs in place to provide services that complement prenatal care (i.e., Maternal & Infant Health Program and Nurse-Family Partnership). Additionally, MDHHS worked with the Michigan Primary Care Association to bring Centering Pregnancy/Parenting (a multi-component group care model that integrates health assessment, education and support into a unified program) to four Federally Qualified Health Centers.

Program Successes: One of the Governor's priorities in his campaign to 'Reinvent Michigan' is to reinvent our health care system. Michigan was granted the CMS State Innovation Model (SIM) Award to test and evaluate multi-payer health system transformation models. The state's initiative proposes Community Health Innovation Region (CHIR) pilots (cross-sector partnerships addressing population health and connecting patients with community services) to test new models of care and payment to achieve the 'Triple Aim.' The state will test whether Accountable Systems of Care (networks of providers utilizing patient-centered medical homes) working with CHIRs can achieve better health outcomes (e.g., prenatal care) at lower cost for targeted populations of patients including those with adverse birth outcomes. The statewide perinatal care system is under development.

SPM 1: Percent of pregnancies that are intended

Data Trends: Provisional data indicates that the percent of pregnancies that are intended gradually increased from 55.4% in 2008 to 58.2% in 2014.

FY14 Program Summary: The Michigan Title X Family Planning Program served 80,490 clients in 2014 through a network of 34 local providers operating 97 clinics. Twenty percent of clients were teens.

Program Successes: The percent of clients using highly effective long-acting reversible contraceptives is increasing; from 5% in 2013 to almost 7% in 2015. According to a cost savings methodology by The Guttmacher Institute, Michigan's Family Planning Program helped avert an estimated 19,340 unintended pregnancies in 2014.

Program Challenges: The program has faced challenges through funding reductions, cost increases and revenue decreases with the end of Plan First, Michigan's Family Planning Section 1115 Waiver. However, family planning agencies have been instrumental in enrolling clients in Michigan's Medicaid expansion and have been aggressive in billing private third party payers as clients gain insurance coverage through Marketplace products. Family Planning programs remain a primary source of health care for many clients and providers are leveraging that role by encouraging clients to apply for newly available insurance coverage and to access comprehensive care beyond family planning. Moving forward, the Family Planning Program plans to emphasize reproductive life planning and utilizing highly effective contraceptives with clients, as well as emphasizing program solvency with providers.

SPM 4: Percent of singleton births by mother's BMI at start of pregnancy greater than 29.0

Data Trends: Provisional data show 27.7% percent of mothers with a pre-pregnancy BMI >29.0, which remains below both national and overall state adult obesity rates, but does not meet the performance objective of 22%. This percentage has increased minimally over the past five years (25.2% in 2010) but has increased at a slower pace than that of the national rate and parallel to the overall state rate. From 2012-2013, the Michigan obesity rate (i.e., BMI of ≥ 30) increased 0.4% while the pre-pregnancy BMI of >29 increased 0.6%.

FY14 Program Summary and Successes: Title X Family Planning clinics assessed BMI and provided education for all clients; the Maternal & Infant Health Program (MIHP) and Nurse-Family Partnership Program assessed BMIs of all mothers served and provided healthy eating and exercise education; WIC clinics provided nutrition education for pregnant and postpartum

clients, promoting healthy prenatal and postpartum weight with an emphasis on breastfeeding. A State Breastfeeding Consultant position was created to further increase breastfeeding rates. Pre/interconception efforts were intensified in an attempt to increase the rate of planned pregnancies. Michigan continues to provide education on the importance of planned pregnancies to achieve optimal health prior to conception, which includes a healthy BMI.

Program Challenges: The underlying challenge for all programs in meeting this performance measure is that complex physical and behavioral changes are necessary to reduce obesity rates and, therefore, require consistent public health efforts.

SPM 7: Percent of women physically abused during the 12 months prior to pregnancy

Data Trends: Provisional data estimates (from the 2014 Michigan PRAMS and MDHHS Data Warehouse) of the percent of women physically abused during the 12 months prior to pregnancy has remained stable for the last two years at 4.4%. In FY14, 21,628 pregnant Medicaid beneficiaries completed a risk screener. Of those, 8,085 (37%) scored moderate or high risk for domestic violence. Almost 6% (1,285 women) answered yes to the question, “Within the last year, have you been hit, kicked, slapped or otherwise physically hurt by someone?”

FY14 Program Summary: MIHP is a population-based model. Every Medicaid-insured pregnant woman is eligible for comprehensive risk screening, care coordination and services based on risk. Data is collected on domestic violence risk through the validated, maternal risk-identifier screen and stored in the MDHHS Data Warehouse. MIHP provides universal screening and education for domestic violence at entry into the program and again at time of delivery. An

evidence-based plan of care is developed for women who screen at-risk for domestic violence, including a required intervention to develop a safety plan. Charts are reviewed during the MIHP provider’s certification review to assure safety plans are in place and that women at high risk have had this issue addressed by the home visiting professional within the first three visits. Staff training on domestic violence is provided using an adaptation of the “Futures without Violence” curriculum. Continuing education credits are available for MIHP nurses and social workers providers upon completion.

Program Successes and Challenges: Data availability has both impeded and contributed to the success for this indicator. The MIHP risk screeners are electronic, allowing for accurate data extraction; but other forms with pertinent data are either newly electronic or not electronic at this time. Discharge summaries are now electronic and will make discharge data more readily available to monitor outcomes and current status of domestic violence in the MIHP population. Future plans include making all MIHP documents electronic. Data for the domestic violence questions included in this report will be available for FY15, along with data from additional domestic violence questions asked on the Maternal Discharge Summary, Infant Risk Identifier, and the Infant Discharge Summary.

Perinatal/Infant Health Domain

Five-Year Plan (NPM 3 – Perinatal Regionalization)

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
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<p>Support coordination and linkage across the perinatal to pediatric continuum of care</p>	<p>A) By 2020, support the implementation and evaluation of Community Perinatal Care Systems in three pilot communities</p> <p>B) By 2020, increase Risk Appropriate Care for mothers and infants from baseline data indicators by 20%:</p> <ul style="list-style-type: none"> • Percent Very Low Birth Weight (VLBW) • Percent Low Birth Weight (LBW) • Percent live births 32-33 weeks gestation (preterm) 	<p>A1) Create guidance documents for the development of a Community Perinatal Care System</p> <p>A2) Provide support in the initiation of three Community Perinatal Care Systems in one rural and two urban areas</p> <p>B1) Participate in the MCHB Infant Mortality CollN and Risk Appropriate Care Network</p> <p>B2) Evaluate delivery data at Level I and Level II birth hospitals regarding Risk Appropriate Care including, but not limited to, the following: Very Low Birth Weight, Low Birth Weight and preterm deliveries of 32-33 weeks gestation</p> <p>B3) Promote the March of Dimes Preterm Labor Assessment Toolkit to Michigan birth hospitals</p> <p>B4) Promote case management/care coordination for at-risk pregnant women through the Michigan Home Visitation Initiative</p>	<ul style="list-style-type: none"> - Infant mortality per 1,000 live births - Perinatal mortality per 1,000 live births plus fetal deaths - Neonatal mortality per 1,000 live births - Preterm-related mortality per 100,000 live births 	<p>Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)</p>
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	<p>C) By January of 2020, develop and implement a surveillance process to monitor risk appropriate deliveries at Level II Special Care Nurseries and Level III & IV Neonatal Intensive Care Units via Certificate of Need Annual Survey and a utilization review process</p> <p>D) By 2020, initiate collaboration with medical provider organizations in the creation of training for medical providers of women of childbearing age to screen for substance use and referral options if substance use is identified</p>	<p>C1) Utilize Certificate of Need Annual Survey data and/or Michigan Vital Records and Pregnancy Risk Assessment Monitoring Systems (PRAMS) as surveillance methods of risk appropriate care, perinatal outcomes and critical infant mortality data indicators</p> <p>C2) Develop and implement evaluation mechanisms for the validation of Certificate of Need Annual Survey data</p> <p>D1) Promote screening for substance use as part of pre and inter-conception care, and during pregnancy, according to nationally established standards</p> <p>D2) Implement training for women’s health providers regarding the screening for all forms of substance use and providing treatment referrals when necessary</p> <p>D3) Create and disseminate public health information on substances that have been deemed unsafe to utilize prior to and during pregnancy</p> <p>D4)Continue quality and surveillance efforts regarding Neonatal</p>		
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	Abstinence Syndrome through the Michigan Quality Collaborative Initiative		
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Perinatal/Infant Health Action Plan Narrative

From the five-year needs assessment process, the state priority need to “Support coordination and linkage across the perinatal to pediatric continuum of care” was selected for the Perinatal/Infant Health domain. The percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU) (NPM 3) was selected as the **first of two measures to address this priority need.**

Infants born prematurely and at VLBW or low birth weight (LBW) are at greater risk of hospitalization, long-term health and developmental problems and death in comparison to their full-term, healthy weight counterparts. Families in poverty have higher rates of low birth weight babies and subsequent health and developmental problems. There are serious inequities which disproportionately affect racial/ethnic minorities as well. The rate of premature and LBW births to Black infants is nearly double that of White infants. The percent of Black VLBW infants (3.2%) was nearly triple that of White VLBW infants (1.2%) in 2013. Preterm births have been rising in Michigan, moving away from the Healthy People 2020 preterm birth target of 11.4%. In Michigan, the percentage of preterm births increased from 9.8% in 2009 to 12.0% in 2013. In addition, the percent of LBW and VLBW infants in the state has remained stagnant and above the Healthy People 2020 target of 7.8% for LBW and 1.4% for VLBW (LBW was 8.4% in 2009 and 8.3% in 2013; VLBW was 1.7% in 2009 and 1.6% in 2013).

Addressing health inequities and disparities that exist in Michigan will result in the reduction of the overall Michigan LBW, VLBW and preterm birth rates. At the same time, increasing the number of very preterm and VLBW infants born in a hospital with a Level III+ NICU will reduce the subsequent likelihood of neonatal death.

Objective A: By 2020, support the implementation and evaluation of Community Perinatal Care Systems in three pilot communities. The development of a statewide Perinatal Care System in Michigan was re-initiated in 2009. Each local community plays a vital role in the successful implementation of a statewide Perinatal Care System.

As a first strategy, the Michigan Department of Health and Human Services (MDHHS) will develop guidance documents for the implementation of a Community Perinatal Care System (CPCS) utilizing the life course perspective. CPCSs will be piloted in three areas of Michigan with varied demographic compositions, including rural and urban communities. Key stakeholders at the community level include birth hospitals, local health departments (LHDs), professional organizations, medical providers, health systems, Federally Qualified Health Centers (FQHCs), home visitation programs and other community agencies. Community-identified key stakeholders will make up the leadership team for each identified pilot community charged with the development of a CPCS.

It is expected that a preliminary guide will be developed within the first eighteen months of the five-year block grant cycle. In years two through five, three pilot CPCSs will be implemented. It is expected that level of participation and progress will vary among communities depending on community variations, local funding and local capacity.

Objective B: By 2020, increase Risk Appropriate Care for mothers and infants from baseline data indicators by 20% for the following measures: Percent VLWB, Percent LBW, Percent live births 32-33 weeks gestation (preterm). MDHHS has been a participant in the federal Maternal & Child Health Bureau effort to reduce infant mortality by using a team workgroup model called Collaborative Improvement and Innovations Networking (CoIIN). Michigan has been working through efforts with Region V and nationally to identify and achieve improvements in six “Learning Networks” that impact infant mortality. Michigan’s continued participation in the Infant Mortality CoIIN and in the Risk Appropriate Care Network will be the first strategy for this objective. The identification of primary drivers and root causes that contribute to risk appropriate care are critical to increase the delivery of higher-risk infants and mothers at appropriate care facilities.

The second strategy for this objective is to explore data on delivery patterns of VLBW, LBW and preterm births at Level I and Level II hospitals to better understand gaps in the delivery of ‘Risk Appropriate Care’ and social determinants of health that may impact birth outcomes. MDHHS is developing a pilot project which includes use of a chart audit tool. The tool will be a part of rapid Plan-Do-Study-Act (PDSA) quality improvement cycles and will help identify gaps and barriers to the transport of mothers to a higher level of care for delivery. Additionally, the tool looks at social determinants of health in an attempt to identify the root causes potentially impacting maternal and infant health outcomes.

The third strategy to be utilized will be the promotion of the March of Dimes Preterm Labor Assessment Toolkit to birth hospitals in Michigan. This toolkit supports hospital clinicians in

understanding the importance of standardizing preterm labor assessment and the steps to take to drive change in assessing patients presenting with signs and symptoms of preterm labor.

The final strategy for this objective is to promote case management for at-risk pregnant women through home visitation programs. Evidence-based home visitation programs promote health care utilization and reduced risk for adverse birth outcomes such as VLBW, LBW and premature birth.

Objective C: By January of 2020, develop and implement a surveillance process to monitor risk appropriate deliveries at Level II Special Care Nurseries and Level III & IV Neonatal Intensive Care Units via Certificate of Need Annual Survey data and a utilization review process.

Michigan has endorsed the Perinatal Levels of Care Guidelines from the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists. The guidelines, however, are not part of the Public Health Code, Administrative Rules or hospital licensure process. Michigan is a Certificate of Need (CON) state and has regulated NICU bed services for decades. In 2014, Special Newborn Nursery Services were added to CON. The addition of these services for the first time ever marks a new era of quality and safety for newborn care in the state.

As a first strategy to meet this objective, MDDHS will utilize questions on the CON Annual Survey and/or epidemiologic data (e.g., Michigan Vital Records, Pregnancy Risk Assessment Monitoring System/PRAMS) to monitor outcomes which impact infant mortality by Level of Care. The Division of Family and Community Health will work closely with CON to make the

survey tool more robust, and to collect data to measure whether at-risk mothers and infants receive services at a facility appropriate for their care.

As a second strategy, MDHHS will develop and implement a utilization review process as another means of external validation of self-reported CON Annual Survey data.

Objective D: By 2020, initiate collaboration with medical provider organizations in the creation of training for medical providers of women of childbearing age to screen for substance use and referral options if substance use is identified. Substance use during pregnancy (including smoking, alcohol and illicit drug use) is a risk factor for adverse birth outcomes such as preterm birth and LBW. Opiate use/abuse has become an epidemic in Michigan. The number of infants affected by Neonatal Abstinence Syndrome (NAS) and treated pharmacologically has increased at an alarming rate from 84.8 per 100,000 births in 2003 to a staggering 658.6 per 100,000 live births in 2013. According to PRAMS 2011 data, 6.2% of mothers reported having alcoholic drinks during the last 3 months of pregnancy and 14.9% of mothers reported smoking cigarettes. In Michigan in 2013, 21.9% of women of childbearing age (18-44 years) reported smoking compared to 20.5% of women nationally. Many of the rural areas of the state have higher substance use rates.

The first strategy for this objective will be to determine best practice standards for identifying and subsequently caring for mothers and infants that have been impacted by substance use. Screening for substance use is part of pre/interconception care and prenatal care. Screening childbearing women, and early and continued screening of pregnant women, is a secondary prevention measure that helps to detect and treat those impacted by substance use.

The second strategy is to increase efforts to provide education to providers statewide who come into contact with women of childbearing age, as a mechanism for increasing overall provider knowledge of the need to assess and provide resource referrals when substance use is identified. Provider networks (including, but not limited to, the Michigan State Medical Society, Michigan State Osteopathic Association, and Michigan Hospital Association) will be engaged to promote delivery of this education.

A third strategy will be to create and disseminate public health information on substances deemed unsafe to use prior to and during pregnancy.

As a final strategy, MDHHS will continue quality and surveillance efforts regarding NAS through the Michigan Collaborative Quality Initiative (MICQI) which includes the Vermont Oxford Network participation. This is a tertiary prevention strategy that works with infants and families affected by NAS to help infants have a safe withdrawal from opiate or other drugs; and to support on-target growth and development.

Perinatal/Infant Health Domain

Five-Year Plan (NPM 4 – Breastfeeding)

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
Support coordination and linkage across the perinatal to pediatric continuum of	A) By 2017, develop a state plan to improve and support breastfeeding with a focus on duration,	A1) Collaborate with key stakeholders to convene a state breastfeeding summit and create the state	<ul style="list-style-type: none"> - Infant mortality per 1,000 live births - Postneonatal mortality rate per 1,000 live births - Sleep-related SUID per 100,000 live 	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively

care	<p>initiation and reducing disparities</p> <p>B) By 2020, increase Baby-Friendly hospitals to 20% across Michigan</p> <p>C) Study and determine method(s) to accurately measure breastfeeding initiation, duration, and exclusivity rates and measure racial and ethnic differences</p>	<p>breastfeeding plan</p> <p>A2) Promote the state breastfeeding plan statewide</p> <p>A3) Develop a website to support state breastfeeding efforts, including promotion of state breastfeeding plan</p> <p>B1) Complete a statewide assessment of hospital maternity care practices supporting breastfeeding</p> <p>B2) Promote Baby-Friendly Hospital Initiative and the availability of funding opportunities and additional supports</p> <p>C1) Develop a workgroup to obtain input on determining a baseline for breastfeeding data collection</p> <p>C2) Determine the feasibility of collecting standardized breastfeeding data from community partners including hospitals and pediatricians</p>	births	through 6 months
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	<p>D) By December 2016, increase breast milk at discharge by \geq 10% (over baseline) for VLBW (under 1500 grams at birth) infants</p>	<p>D1) Support the Michigan Quality Collaborative Initiative and staff</p> <p>D2) Support the use of RedCap for breastmilk use in NICUs</p> <p>D3) Analyze data in RedCap for strengths; areas to improve receipt of human milk in the NICU; increased breast milk at discharge; and factors that affect mothers' ability to sustain milk production</p>		
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Perinatal/Infant Health Action Plan Narrative

The percent of infants who are ever breastfed and percent of infants breastfed exclusively through six months (NPM 4) was selected as the **second of two measures to address the priority need** of “Support coordination and linkage across the perinatal to pediatric continuum of care” in the Perinatal/Infant Health domain.

The State of Michigan encourages breastfeeding with support from the Healthy People 2020 objectives. The Healthy People 2020 objective targets are 81.9% of infants ever breastfed and 25.5% of infants exclusively breastfed through six months. The National Immunization Survey 2011 reported that 75.3% of Michigan’s infants ever breastfed with a decline to 16.2% exclusively breastfed through six months. According to Michigan Women Infant and Children

(WIC) data from 2014, 62.9% of women breastfeed initially but just 9.2% exclusively breastfeed through six months.

The AAP reaffirms its recommendation of exclusive breastfeeding for the first six months of a baby's life. This recommendation is supported by many health outcomes, including social and economic advantages for mothers and children, making it a longstanding public health initiative. Each woman who gives birth requires an enabling environment to achieve optimal breastfeeding. By addressing this need, MDHHS will move closer to achieving breastfeeding initiation, duration and exclusivity goals while reducing any disparities in breastfeeding.

Objective A: By 2017, develop a state plan to improve and support breastfeeding with a focus on initiation, duration and reducing disparities. While hospitals, coalitions and other support systems have long tried to increase breastfeeding initiation, duration and exclusivity, the importance of comprehensive breastfeeding support is still under-recognized. As a result, breastfeeding promotion and support efforts have been fragmented. As a part of the first strategy, MDHHS has reinstated an internal breastfeeding workgroup. This workgroup has been charged with providing an assessment of the breastfeeding efforts occurring throughout the state and providing ways to collaborate with partners to reach breastfeeding goals. To improve breastfeeding rates, Michigan plans to collaborate with key stakeholders to convene a state breastfeeding summit to cohesively assess and address breastfeeding gaps within the state. From the results of the summit, Michigan will create a State Breastfeeding Plan. The plan will describe the approach and milestones to be achieved for the next three to five years with a focus on reducing breastfeeding disparity. It will be a living document that identifies strategies that can be used by programs and partners across sectors. It is expected that a preliminary plan

will be developed within a year of this five-year block grant cycle. The statewide plan will provide a systematic approach to support breastfeeding families in Michigan in an effort to reduce the disparity and improve breastfeeding initiation and duration rates.

The second strategy centers on promoting the State Breastfeeding Plan and its priority recommendations. Dissemination of the plan to community partners will advance the key strategies identified. The promotion plan will include media advisories, press releases and community events.

As a final strategy for this objective, MDHHS will develop a website to support state breastfeeding efforts. The website will be maintained as a source of reputable breastfeeding resources helpful to organizations and breastfeeding families. The website will increase collaboration efforts among state programs and community partners and will assist in promoting the State Breastfeeding Plan and monitoring progress toward plan recommendations.

Objective B: By 2020, increase Baby-Friendly hospitals to 20% across Michigan. *The Surgeon General's Call to Action* stated that studies have identified major deficits relevant to breastfeeding in hospital policies and clinical practices, including a low priority given to breastfeeding support and education; inappropriate routines and provision of care; fragmented care; and inadequate hospital facilities for women who are breastfeeding. Recognizing the important role that hospitals and birthing facilities play in supporting and encouraging mothers' efforts to breastfeed, the Baby-Friendly Hospital Initiative (BFHI) was launched by WHO and UNICEF in 1991. The "Ten Steps to Successful Breastfeeding" are a central part of the BFHI and are practices that have been reported to support breastfeeding behaviors and influence

outcomes. Having the BFHI helps hospitals give mothers the information, confidence and skills they need to successfully initiate and continue breastfeeding. Nine out of 83 Michigan hospitals have independently achieved the prestige of Baby-Friendly status to help initiate breastfeeding at birth. The AAP states that several studies have demonstrated that implementation of Baby-Friendly maternity care practices is associated with increased rates of exclusive breastfeeding. All health care facilities should aim to adhere to BFHI practices which are known to increase initiation, duration and exclusivity of breastfeeding.

A first strategy for this objective is to provide a statewide assessment of the Baby-Friendly process. During state-conducted site visits, MDHHS will observe hospital maternity care policies and advise on ways to improve and support breastfeeding practices. MDHHS will also offer guidance and technical assistance to hospitals that plan on completing the Baby-Friendly process. Having this continual assessment will help recognize hospitals that are particularly supportive of breastfeeding by achieving Baby-Friendly status.

The second strategy will promote the BFHI and the availability of funding opportunities and additional supports. Identifying available funding and other resources will assist hospitals that want to begin the process of becoming Baby-Friendly. MDHHS will offer support through training and technical assistance, enabling hospitals to sustain continuation of these activities beyond the term of any funding support. It is anticipated that long-term impacts of this project will increase breastfeeding rates by encouraging successful breastfeeding-friendly practices in health facilities.

Objective C: Study and determine method(s) to accurately measure breastfeeding initiation, duration and exclusivity rates and measure racial and ethnic differences. Tracking

breastfeeding rates in Michigan is crucial to evaluating and improving infant health programs. While WIC is a critical source of breastfeeding duration and exclusivity data, it is important to identify other sustainable resources to support data collection. Other sources (mostly national) provide initiation, duration and exclusivity rates, but definitions and findings often vary.

The first strategy for this objective would require MDHHS to form an internal workgroup with representation from epidemiology staff to obtain input on determining a baseline for breastfeeding data collection. Current information from available local, state and national sources will be reviewed and utilized. Identification of breastfeeding data that is not available within an organization or geographic area will be noted. The workgroup will determine additional data needs and determine how to collect it; identify potential links to existing activities and interventions; analyze data for patterns of needs and potential areas/ groups in which to target activities to increase rates; and develop best practices that produce high breastfeeding rates. MDHHS will disseminate this information for learning opportunities and future planning.

Tracking breastfeeding data is often difficult. There is no consistent, standardized terminology being used and data is not uniformly collected. At times data is not collected at all, particularly related to items such as exclusive breastfeeding rates. The last strategy includes determining the feasibility of collecting standardized breastfeeding data from community partners including hospitals and pediatricians. MDHHS will work with existing partners to determine what data is needed and how it could be efficiently obtained throughout the state. Having additional data can help Michigan focus on needs and develop plans to move together to reach state breastfeeding goals.

Objective D: By December 2016, increase breast milk at discharge by $\geq 10\%$ (over baseline) for VLBW (under 1500 grams at birth) infants. There is substantial research supporting the benefits of breastmilk being provided to very low birth weight (VLBW) infants within Neonatal Intensive Care Units (NICU). The first strategy for this objective is to support the Michigan Quality Collaborative Initiative (MICQI) and its staff. The MICQI is a voluntary collaboration of NICUs that has been working to increase human milk use within the NICU, and to decrease nosocomial infections in VLBW infants. Currently, all 20 NICU hospitals throughout Michigan participate in some way with this collaborative.

The second strategy is to support the use of Research Electronic Data Capture (RedCap) for breast milk use in NICUs. MICQI uses the RedCap system to collect all of its data with the support of the MICQI nurse.

The final strategy is to analyze data collected through RedCap for strengths; areas to improve receipt of human milk in NICU; increased breast milk at discharge; and factors that affect mothers' ability to sustain milk production. Analyzing this data will provide further insight on how to best provide support of using breast milk for the nutrition of preterm infants.

Perinatal/Infant Health Annual Report

The following performance measures and the related data trends, program summaries, successes, and challenges address the **Perinatal/Infant Health** population domain for FY14 reporting.

NPM 11: Percent of mothers who breastfeed their infants at 6 months of age

Data Trends: The Michigan WIC breastfeeding duration rate has remained relatively stable since FY08. The 6-month breastfeeding duration rate for FY14 (18%) meets the annual performance objective. The 2020 Healthy People Performance Objective is 60.6%, but the percent achieved nationally (18.8%) in 2014, was similar to the state rate.

FY14 Program Summary and Successes: Staff education is critical to supporting WIC moms. In FY14, WIC hosted 40 local agency staff at the Certified Lactation Specialist Course. Two hundred staff attended WIC Conference sessions focused on supporting breastfeeding moms to meet their personal goals. A block session for 800 attendees focused on the role of breastfeeding in obesity prevention. Approximately 200 staff attended a one-day Baby Behavior Course where they learned to differentiate between hunger cues versus other behavior cues. For the fourth consecutive year, WIC offered Building Bridges to Breastfeeding Duration in partnership with local WIC agencies and birthing hospitals.

Additionally, strong support for initiation prior to birth, at birth and for overcoming challenges is also necessary to achieve six-month breastfeeding duration. Eight Michigan hospitals have achieved a Baby-Friendly status as they provide strong support to breastfeeding initiation at birth. Home visiting programs provide new mothers with extra support for breastfeeding duration. The Nurse Family Partnership (NFP) has a high breastfeeding initiation rate of 80%, with 24% still breastfeeding at six months. Two NFP teams are participating in the Home Visiting Collaborative Improvement and Innovation Network (HV CoIIN) which provides interventions to improve breastfeeding duration. The Maternal & Infant Health Program (MIHP) provides prenatal and postpartum breastfeeding interventions.

Program Challenges: In FY15, WIC is piloting a mentoring project with local agency WIC staff. It is recognized that breastfeeding duration depends on multiple factors. Staff need help to identify challenges of mother and baby and how to successfully resolve identified issues in order to increase duration. Staff is learning by watching a Lactation Consultant (LC) counsel moms; counseling moms while working under the direction of the LC; and then counseling solo under LC observation. It is expected that staff success will be mirrored by improved duration rates.

NPM 12: Percentage of newborns who have been screened for hearing before hospital discharge

Data Trends: The Early Hearing Detection and Intervention (EHDI) Program continues to have 100% birthing hospitals participating in infant hearing screening. Last year, over 97% of infants completed the hearing screening by one month of age. Of infants diagnosed with permanent hearing loss, 57.6% (n=87 of 151) were diagnosed by three months of age. Enrollment in early intervention services was 54.3% (n=82 of 151).

FY14 Program Summary and Successes: EHDI uses the quality improvement framework, Plan-Do-Study-Act (PDSA) with collaborative strategies via a statewide network. These strategies to reduce loss to follow up include implementation of 1) two regional audiology consultants who provide site visits to designated hearing screening hospitals to facilitate best practices; 2) Wayne Children's Health Access Program partnership to assist families with follow up appointments; 3) Michigan Midwives partnership to provide hearing screenings, now at 66% of home births; 4) Henry Ford Hospital collaborative to utilize new hearing screening equipment to

decrease screening referral rates. Program quality improvements focus on provider and parent education of the EHDI process. The EHDI Guide by Your Side (GBYS) program continues to offer resources to families with infants who are deaf or hard of hearing. The program increased family services by 300% in one year.

In the coming year, EHDI will complete revisions to the Family Resource notebook given to parents in the GBYS program. EHDI will continue to conduct statewide advisory and learning collaborative meetings with input from providers and parents for program improvement. EHDI will maintain efforts to improve data collection methodology via system upgrades, with a proposed electronic HL7 data messaging system to be piloted this year. The program will continue to provide quarterly reports to hospitals to improve screening efforts.

NPM 17: Percent of VLBW infants delivered at facilities for high-risk deliveries and neonates

Data Trends: The trend in the percent of low birthweight infants delivered at facilities for high-risk deliveries has remained relatively stable over the past five years, ranging from 85.2% to 86.6%. Provisional data for 2014 indicate 87.3% of low birthweight infants were delivered at these facilities, which exceeds the Healthy People 2020 target of 83.7%.

FY14 Program Summary: Key strategies to assure VLBW infants are delivered at facilities equipped to care for them are to implement a perinatal care system and to have a surveillance system in place to monitor this trend. Implementation of a regional perinatal system of care is one of the state's infant mortality reduction strategies. Implementation of Certificate of Need Standards for Neonatal Intensive Care Services/Beds and Special Newborn Nursing Services beds standards, effective in March 2014, will facilitate the process. The addition of Special Care

Nursery services for the first time marks a new era of quality and safety for newborn care in the state. In FY15, the state is participating in CoIIN for Risk Appropriate Care in FY15 and, as part of this effort, Plan-Do-Study-Act cycles will be implemented in pilot areas of the state.

SPM 2: Percent of LBW births (<2500 grams) among live births

Data Trends: The trend in percent of low birthweight (LBW) births among live births has remained relatively unchanged over the last five years (8.4% in 2009 to 8.3% in 2013), which does not yet meet the Healthy People 2020 target of 7.8%.

FY14 Program Summary and Successes: A key strategy to address LBW infants is to assure they are delivered at facilities equipped to care for them within a perinatal care system. Again, implementation of Certificate of Needs Standards for Neonatal Intensive Care Services/Beds and Special Newborn Nursing Services beds standards, effective in March 2014, will facilitate the process. In FY15, Michigan is participating in CoIIN for Risk Appropriate Care, with a pilot project that includes development of a chart audit tool for LBW infants to determine gaps in delivery of risk appropriate care.

Program Challenges: Families in poverty have higher rates of LBW and subsequently higher rates of infants with health and developmental problems. Serious inequities in poverty which disproportionately affect racial/ethnic minorities pose a challenge to moving the needle on this indicator. Data regarding social determinants of health in addition to income level need to be consistently and systematically collected so that data can be used to develop more specific and targeted interventions.

SPM 3: Percent of preterm births (<37 weeks gestation) among live births

Data Trends: The trend in percent of preterm births among live births does not meet the Healthy People 2020 target of 11.4%, having increased from 9.8% in 2009 to 12.0% in 2013. Babies born before 37 completed weeks of gestation are at increased risk of immediate life-threatening health problems as well as long-term complications and developmental delays. Prematurity and low birth weights remain the leading causes of infant death in Michigan. There continues to be a racial disparity among premature infant deaths with Black infants experiencing significantly higher death rates compared to Hispanic and White infants.

FY14 Program Summary: Population strategies to improve birth outcomes continue such as the avoidance of alcohol, tobacco cessation and avoidance of other substances among pregnant women. Home visitation programs (i.e., MIHP and NFP) are encouraged for pregnant women. Targeted strategies to reduce disparities remain a priority. Other strategies to reduce prematurity include promotion of adoption of policies to eliminate medically unnecessary deliveries before 39 weeks gestation, and promotion adoption of progesterone protocol for high-risk women.

SPM 9: Percent of children receiving standardized screening for developmental or behavioral problems

Data Trends: Between 2010 and 2012, the National Survey of Children's Health (NSCH) showed a 7.1% increase in the percentage of Michigan children receiving standardized developmental screening. This upward trend is supported by other data sources. From 2013 to 2014, Medicaid claims for billing codes 96110 and 96111 (developmental screenings) increased from 14,400 to

47,771 for 0-3 year olds. Similarly, during 2014, evidence-based home visiting programs reported that 96% of enrolled children received developmental screens. New NSCH data should be available in June 2015; at that time MDHHS will be able review trends from that data source and confirm new targets.

FY14 Program Summary and Successes: In 2014, a number of special activities contributed to increases in developmental screening. All evidence-based home visiting programs are conducting screening, and two MIECHV funded sites are focusing on developmental screening and surveillance in the HV CoIIN project. Michigan began to refine its plan for its Race to the Top-Early Learning Challenge grant, which will educate both families and child care providers about the importance of developmental screening. In its final year of funding in 2014, Project LAUNCH trained primary care providers in Federally Qualified Health Centers to improve screening in primary care offices; and the facilitator recorded a training video to further support these efforts.

Program Challenges: A significant challenge is that Michigan does not currently have a data system to capture screening activities and results from across agencies and funding streams. This has been recommended for policy discussion within the cross-agency Great Start Steering Team (state-level early childhood administrative team).

Child Health Domain

Five-Year Plan (NPM 6 – Developmental Screening)

State Priority Need	Objectives	Strategies	National Outcome Measures	National Performance Measure (NPM)
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			(NOM) (prepopulated by HRSA)	(prepopulated by HRSA)
Invest in prevention and early intervention strategies, such as screening	<p>A) By 2017, explore whether tracking Developmental Screening results can be a component of Michigan’s Medicaid State Innovation Model</p> <p>B) By 2020, adopt consistent screening and referral procedures across the system</p> <p>C) By 2020, adopt consistent procedures for responding to referrals, receipt and disposition</p> <p>D) By 2020, adopt procedures/strategies for reporting results to parents</p>	<p>A1) Develop an issue paper describing the issue and send to public health administration</p> <p>A2) Convene conversations with SIM grant staff</p> <p>A3) Convene stakeholder workgroup to outline a plan for implementation</p> <p>B, C, D1) Ask Great Start Steering Team to adopt this objective as a focus item for the Great Start early childhood system</p> <p>B, C, D2) Conduct analysis and compile current policy/funding streams</p> <p>B, C, D3) Develop a state plan for developmental screening for 0-5 year olds</p>	<ul style="list-style-type: none"> - Percent of children in excellent or very good health - Percent of children meeting the criteria developed for school readiness 	Percent of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool

Child Health Action Plan Narrative

Through the five-year needs assessment process, the state priority issue of “Invest in prevention and early intervention strategies” was selected for the child population domain. The percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool (NPM 6) was selected to address this priority need.

According to the 2011-2012 National Survey of Children’s Health, 25.3% of Michigan children aged 10 months to 5 years received a standardized screening for developmental or behavioral problems. It is important to note that according to U.S. Census estimates, in Michigan in 2013, approximately 51% of children (351,326 children) aged 0-5 years were enrolled in Medicaid or MIChild and should have received standardized developmental screening as part of EPSDT.

According to the Michigan Medicaid 2014 HEDIS Results, 73% of children aged 15 months were up to date on their well-child visits, while 77% of children aged 3-6 had an annual visit. This would seem to indicate that a fairly high percentage of children 0-5 years enrolled in Medicaid are up to date on well-child visits, but a much smaller number of children (56,763 or approximately 16%) have a billing code that indicates a developmental screening was conducted. This could mean one was not conducted or billing practices are inconsistent.

Developmental Screening has been a priority in Michigan for several years, yet a coordinated, unduplicated system of screening—with a reliable way to track screening and referrals—has not been developed. Standardized developmental screening is a key part of ensuring children at risk of developmental disability or delay are identified and referred for further evaluation as soon as possible; thereby enrolling in services at an earlier age and improving developmental

outcomes for each child and their family. The Michigan Department of Health and Human Services (MDHHS) will address the need to improve developmental screening policies and coordination across the state. Our proposed approach will primarily focus on addressing state level coordination, policy and procedures.

Objective A: By 2017, explore whether tracking Developmental Screening results can be a component of Michigan’s Medicaid State Innovation Model (SIM). As a first strategy to improve the developmental screening rates in Michigan, an issue paper describing the issue of consistent tracking of completed screens will be developed and forwarded within our public health administration for consideration. MDHHS will gather input from a range of state-level early childhood stakeholders to review what is currently happening and challenges created by the current lack of coordination in policy and service provision. As with any change to a system, it is essential to ensure that there is sufficient buy-in at administrative levels to be able to make the work progress. Certainly in Michigan, there is a high level of gubernatorial leadership on early childhood issues. The Governor has defined a set of prenatal to 8 outcomes for Michigan’s children in the areas of health, development and early learning. Developmental screening can play a role in helping to ensure the outcomes are met.

A second strategy is to convene conversations with SIM grant staff. SIM grant staff are housed within MDHHS and historically have been eager to work together to improve efficiencies within the health care delivery system. Conversations will help to identify the feasibility of tying a developmental screening tracking data element and/or system to Accountable Care Organizations, or to cross-sector partnerships called Community Health Innovation Regions

(CHIR), which are developing across the state to address gaps in access at the local level, including by conducting a community health needs assessment. Discussing ways to include developmental screening as a key part of child well-being, improve health outcomes and reduce health risks as well as duplicative efforts, is in alignment with SIM goals.

Based on the outcomes of the initial activities, MDHHS will convene a stakeholder workgroup to outline a plan for implementation. The plan would address how policy and implementation strategies regarding developmental screening could be incorporated with efforts at the community level, thereby addressing the needs of all children and families, not just those enrolled in Medicaid. Due to the high number of entities within the early childhood system which are currently conducting developmental screening (e.g., physicians, home visitors, Head Start) and which are talking about incorporating screening into their care efforts (i.e., child care), there is the possibility that children could be screened so often that parents will become desensitized to the importance of quality standardized screening. Therefore, there is a need to convene a number of statewide stakeholders and partners to develop a plan that could help to increase screening rates but reduce duplicative screening.

Objective B: By 2020, adopt consistent screening and referral procedures across the system

Objective C: By 2020, adopt consistent procedures for responding to referrals, receipt and disposition

Objective D: By 2020, adopt procedures/strategies for reporting results to parents

This plan identifies three separate objectives which build upon each other toward improving the system of developmental screening. Each objective addresses policy and procedures at the state level, across agencies. Because the approach will be similar for each objective, the strategies are described together in the text that follows.

The state is using an interdepartmental structure and team process to address early childhood systems, services integration and coordination. Primary partners include MDHHS, the Michigan Department of Education and the Early Childhood Investment Corporation. These agencies/organizations partner in forming the Great Start Steering Team (GSST) and the Great Start Operations Team, which function as the means through which early childhood systems, resources, strategic direction and system building is occurring for Michigan's young children and their families. This approach ensures that efforts are efficient and not duplicated, and that meaningful connections are made within the agencies as well as within the local communities they serve. Because of this structure and its connectivity to all early childhood system activities, the strategies to achieve the three objectives listed above (B, C, and D) are the same.

The initial strategy to address each of the objectives is for MDHHS staff, who serve on the Great Start Steering Team, to bring this issue of developmental screening to the GSST and ask for it to be adopted as an item of state-level focus in the upcoming year. If the GSST adopts this item, there will be a broader framework of cooperation and system development upon which to build, as well as the understanding by statewide agencies and departments that this is considered an area of importance by the Great Start System.

As a second strategy to address each of the objectives, the state-level partners will conduct an analysis and compile current policy around developmental screening. Formal developmental screening policy exists within several statewide entities such as Michigan Medicaid, the American Academy of Pediatrics (e.g., Bright Futures Periodicity Schedule), the home visiting system and the child care system. However, there are also many smaller, community-based developmental screening initiatives that have been established in recent years that do not align with any formal policy or connect to other statewide systems such as health or education. An additional issue is that not all children who most need to be identified through developmental screening (those living in poverty or other at-risk situations) are the children who are being screened through community initiatives. MDHHS will include in its analysis what disparities exist around developmental screening, and how communities and agencies are guaranteeing that screening services are culturally and linguistically competent. A final piece of the analysis will be to consider the number of different funding streams for these screening initiatives that run from foundation or community agency funding to federal sources of funding. The analysis of current policy and funding streams will provide MDHHS and its state-level partners the opportunity to identify ways to change or align these policies/procedures in order to produce a more efficient and non-duplicative system; one that provides equity in funding and services.

The final strategy for these three objectives is for Michigan to develop a state plan for developmental screening for children 0-5 years of age. The state plan will be the culmination of the previous strategies listed above. The steps toward creating a state plan are as follows.

Based on previous participation, MDHHS will identify an appropriate group of stakeholders to make recommendations for the plan, based on the information from the policy and funding

analysis, the partnership with the SIM grant and recommendations from the GSST. This group will also recommend metrics that could measure successful implementation of the recommendations, and also serve as a platform for a continuous quality improvement process (such as Plan-Do-Study-Act) to ensure that any implementation could be comprehensive and achieve quality. As part of the planning phase, consistent statewide screening procedures will be identified (e.g., quality tools to use, when to refer, community resources, screening junctions). Short cycles of public comment and testing will be identified to determine if the procedures can be implemented at a statewide level, are clear and consistent, and do not cause undue burden on the early childhood system. The plan will be modified based on the results from the short testing cycles. Identification of possible funding streams to support developmental screening will flow through each stage of the planning process.

An important part of the process to create a developmental screening state plan will be to make sure that procedures to assure sharing of screening results with parents are included and highlighted. What has become known to MDHHS from reports from several of the screening initiatives is that screening results are not always shared with a parent. It is not clear why this step is missed, but what is clear is that parents are not always clear on the importance of providers sharing all information, be it positive or negative, so that parents can make informed choices about next steps. A communication strategy will be developed to ensure that parents are receiving the appropriate messaging about the importance of developmental screening, what it is, what to expect, and what should happen based on screening results. Lessons learned through the Assuring Better Child Development project (National Academy for State Health Policy) support the role of parents in enhancing a developmental screening system within a

state. The more parents know about and understand developmental screening, the more responsive providers are to their requests, leading to a high-quality system of screening for all children.

Child Health Annual Report

The following performance measures and the related data trends, program summaries, successes, and challenges address the **Child Health** population domain for FY14 reporting.

NPM 7: Percent of 19-35 month-olds who have received a full schedule of age-appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B

Data Trends: Coverage level trends for vaccination of 19-35 month olds against measles, mumps, rubella, polio, diphtheria, and tetanus have decreased from 91% in 2008 to 78% in 2014. Starting in 2013-2014, Michigan Care Improvement Registry (MCIR) data was used to assess coverage levels; therefore, coverage prior to this time (2012 and earlier) is not a meaningful comparison as National Immunization Survey estimates were used previously. Health care provider reporting to MCIR is mandatory for individuals less than 20 years of age, and doses documented in the registry are provider-verified (correct intervals and timing), so MCIR estimates are the gold standard for vaccination assessment in Michigan. NIS estimates use a small sample size of less than 400 individuals with large confidence intervals, while MCIR rates are population-based and are an underestimate of true vaccination coverage levels. Coverage levels for other routinely recommended vaccines not listed here—including flu and hepatitis A—are also low among children 19-35 months of age.

FY14 Program Summary and Successes: County level report cards are distributed quarterly and posted at www.michigan.gov/immunize. These report cards rank counties according to coverage levels for children, adolescents, and adults, as well as waiver rates for childcare and school entry. County coverage levels are compared to state and national coverage estimates, as well as Healthy People 2020 targets. MCIR quarterly workbooks include 19-35 month old coverage level by race. These are updated semi-annually and posted on the HAN under resources for local health departments. The Vaccines for Children (VFC) program has over 1,300 enrolled providers for administration of nearly \$90 million worth of vaccines in Michigan.

Program Challenges: The Immunization Program in Michigan has identified fourth dose DTaP coverage as an area where improvements need to be made, as many children are not receiving the recommended fourth dose at 15 through 18 months of age. Research shows that children who delay or forgo needed vaccines as infants are not as likely to ever catch up and become up-to-date as children and adults; therefore timely infant immunization is a top priority. Hepatitis A coverage is also low and has become a priority for our program. Challenges in coverage levels are being addressed through provider education and training during in-office and grand rounds settings and during the fall regional immunization conferences that are hosted each year in eight different regions of the state. AFIX feedback sessions (quality improvement meetings at provider offices) focus on strategies, behaviors, and office systems/policies that help or inhibit timely vaccination. During FY14, administrative rules were written and introduced which will require education of parents (at the local health department) who waive vaccines in a school or child care setting.

NPM 10: Rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children

Data Trends: Deaths to children aged 0-14 caused by motor vehicle crashes remain low. The motor vehicle death rate per 100,000 children in this age range fell from 3.0 in 2008 to 1.9 in 2014 (provisional data), and has remained relatively stable over the past four years. For children under age 5, occupant injuries are more prevalent while, for older children, pedestrian-related injuries are more prevalent.

FY14 Program Summary: MDHHS does not have specifically-funded motor vehicle safety programs (e.g., Child Passenger Safety, pedestrian safety, bicycle safety) but supports local Safe Kids Coalition initiatives to reduce motor vehicle crash related deaths of children. In FY14, the MDHHS Injury & Violence Prevention Section assisted local Child Passenger Safety (CPS) programs and 14 community-based Safe Kids Coalition child safety seat program efforts. Marketing and outreach efforts for CPS-certified technician classes were provided through local partners.

Program Successes and Challenges: More than 5,500 car seats were delivered to CPS technicians in 61 counties. Instructors certified 110 new CPS technicians through the delivery of seven classes; another 167 technicians worked toward recertification through participation in three continuing education classes; and 11 former technicians were recertified. While the goal to retain 63% of certified technicians was not met, steps were taken with instructors to keep current technicians engaged and involved. Spanish-language materials were obtained for use by instructors and technicians, and plans are underway to train five bilingual technicians.

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

Data Trends: The percentage of children, aged 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile has remained relatively stable since 2008. In 2014, the rate of 30.9% was unchanged from the previous year, and remained higher than the performance objective of 28%.

FY14 Program Summary and Successes: Individual counseling, group education, and internet education opportunities on healthy eating (including breastfeeding) and physical activity continued to be offered to all WIC families as obesity prevention measures. WIC clients were supported in nutrition and lifestyle change through access to 22 online, interactive education modules in English and Spanish. More than 67% of WIC clients utilized this service. WIC continued to assess and monitor the weight of all WIC children; and those aged 2 to 5 years with a BMI $\geq 95^{\text{th}}$ percentile were referred to registered dietitians for high-risk nutrition counseling. Childhood obesity was addressed at the 2014 Michigan WIC Conference, attended by approximately 800 individuals including local agency WIC staff. WIC local agencies developed annual Nutrition Services Plans based on predominant client risks, with 11 of 47 agencies specifically targeting childhood obesity.

Program Challenges: Childhood overweight and obesity prevention and intervention are complex, multifactorial issues. The changes necessary to reduce obesity rates require consistent, ongoing, and collaborative public health efforts. Michigan WIC will continue to support breastfeeding initiation and breastfeeding exclusively to prevent obesity; offer client

learning opportunities; and expand quality training opportunities for staff around the topics of breastfeeding, obesity prevention and intervention, and client-centered nutrition counseling. Revised training on WIC service delivery and care coordination for WIC high-risk clients is targeted for FY15.

SPM 5: Ratio between black and white children under 6 years of age with elevated blood lead levels

Data Trends: Despite a slight increase in elevated blood lead levels (EBLL) in 2014, the trend in recent years is downward. EBLLs among black children have decreased faster than among white children, narrowing the ratio between black and white children and meeting the 2014 performance objective of 2.6: 1.

FY14 Program Summary and Successes: Title V funds were provided to local health departments to deliver lead education to professionals who work with children. In FY14, over 100 educational sessions were provided, with at least one in every county. Knowledge about the dangers of lead poisoning is an effective means of prevention, and educating those who work with families is a cost-effective means of spreading that knowledge. Funds were also used for technical assistance (fielding 1,900 calls from medical professionals, parents, and public health professionals) assuring accurate information regarding the care of children with EBLL. In FY14, 155,919 BLL results were processed. Results were made available to providers and local health departments through the Michigan Care Improvement Registry via weekly download.

Adolescent Health Domain

Five-Year Plan (NPM 10 – Adolescent Well-Visit)

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
Reduce barriers, improve access, and increase the availability of health services for all populations	<p>A) Develop a state plan for improving adolescent well-care, focusing on Medicaid eligible youth</p> <p>B) By 2020, increase by 750 the number of providers trained on culturally-competent, adolescent-friendly preventive care</p>	<p>A1) Convene a state-level workgroup to promote comprehensive adolescent well-care</p> <p>A2) Review and update relevant MQIC adolescent clinical practice guidelines</p> <p>A3) Determine feasibility of implementing the Young Adult Healthcare Survey</p> <p>A4) Work with Health Plans to expand strategies to incentivize well-child exams</p> <p>B1) Promote Michigan’s adolescent web courses (e.g. Motivational Interviewing, Positive Youth Development) among health plans and providers groups</p> <p>B2) Provide training and professional development in partnership with health plans and provider networks</p>	<ul style="list-style-type: none"> - Percent of children in excellent or very good health. - Percent of children ages 6 months through 17 years who are vaccinated annually against seasonal influenza - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine - Adolescent mortality ages 10 through 19 per 100,000 - Adolescent motor vehicle mortality ages 15 through 19 per 100,000 - Adolescent suicide ages 15 through 19 per 100,000 - Percent of children with mental/behavioral health condition who receive treatment or counseling - Percent of adolescents who are overweight or obese (BMI at or above the 85th percentile) - Severe maternal 	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year

	<p>C)By 2020, increase by 10% the proportion of adolescents with a documented well-child exam among 25 Child & Adolescent Health Centers</p> <p>D) Develop a social media campaign to promote adolescent well-care and targeted health messages</p>	<p>C1) Implement annual CQI initiative among CAHCs</p> <p>C2) Assist 3-5 CAHCs annually in achieving NCQA PCCC (PCMH) status</p> <p>D1) Work with MDHHS Communications to develop a coordinated social media campaign</p> <p>D2) Identify and disseminate best practice guidelines for the use of social media to promote services and appointment reminders</p>	<p>morbidity per 10,000 delivery hospitalizations</p> <ul style="list-style-type: none"> - Maternal mortality rate per 100,000 live births - Low birth weight rate (%) - Very low birth weight rate (%) - Moderately low birth weight rate (%) - Preterm birth rate (%) - Early preterm birth rate (%) - Late preterm birth rate (%) - Early term birth rate (%) - Infant mortality per 1,000 live births - Perinatal mortality per 1,000 live births plus fetal deaths - Neonatal mortality per 1,000 live births - Postneonatal mortality rate per 1,000 live births - Preterm-related mortality per 100,000 live births 	
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Adolescent Health Action Plan Narrative

Through the five-year needs assessment process, the state priority need to “Reduce barriers, improve access and increase the availability of health services for all populations” was selected for the adolescent health population domain. The percent of adolescents, aged 12-17, with a preventive medical visit in the past year (NPM 10) was selected to address this priority need.

According to the 2011-2012 National Survey of Children's Health (NSCH), 86.2% of Michigan children aged 0-17 received a preventive medical care visit in the year preceding the survey. While this may seem high, a disparity among adolescent well-care rates exists that needs attention. According to the Michigan Medicaid 2014 HEDIS results, an average of only 58% of Michigan's Medicaid-covered adolescents aged 12-21 were current with at least one comprehensive well-care visit. This represents a significant decline of 3.66% from 2013; it is also nearly 30% lower than what is reported for adolescents overall in the NSCH. The decline is concerning because well-child exams decreased at a time when more adolescents gained coverage for preventive visits. The disparity also points out a difference in access to well-care for Medicaid-covered beneficiaries and older adolescents versus younger adolescents with any type of health care coverage. By addressing this disparity, MDDHS will move closer to achieving health equity for publicly-insured adolescents in this critical health outcome.

Objective A: Develop a state plan for improving adolescent preventive visits, focusing on Medicaid eligible youth. While initiatives are underway to improve adolescent well-care in Michigan, these efforts are largely uncoordinated among key stakeholders. As a first strategy to improve these rates, MDHHS will convene a state-level workgroup comprised of health plans, provider groups (e.g., Michigan Chapter of the American Academy of Pediatrics (AAP) and the Society for Adolescent Medicine), Michigan Quality Improvement Consortium (MQIC), local health departments (LHDs), health systems and Federally Qualified Health Centers (FQHCs) to examine gaps in existing efforts and to identify opportunities for coordinating efforts to promote comprehensive adolescent well-care.

As part of an initial gap analysis, the workgroup will be charged with reviewing all relevant MQIC adolescent clinical practice guidelines and making recommendations for either improvement of existing guidelines and/or creating supplementary guidelines to meet national practice recommendations for well-child exams. Through this second strategy, this workgroup will also assess the extent of utilization of the AAP/Bright Futures (AAP/BF) guidelines and make recommendations to increase their use among Michigan providers. Michigan adopted the AAP/BF-recommended periodicity schedule and distributed notice to all Medicaid providers via a Medicaid Provider Manual update in October 2014. While this is a step in the right direction, the extent of its use is currently unknown.

As a third strategy, MDHHS and workgroup partners will explore the feasibility of implementing the Child and Adolescent Health Measurement Initiative's Young Adult Health Care Survey (YAHCS). This teen survey assesses whether young adults aged 14-18 are receiving nationally-recommended preventive services during a well-care visit. Nine quality measures of care are gathered and scored which measure the presence, helpfulness and experience of preventive screening in a private and confidential setting. The YAHCS was designed specifically to measure the communication-dependent aspects of care during the well-care visit through patient-reported measures. Adolescents have been shown to be reliable reporters of what happens during these health care visits and their reports are more appropriate than relying on medical chart reviews, claims and billing data as they do not capture the *relational* portion of the well-care visit. Other states have implemented YAHCS as part of an overall Medicaid quality improvement effort. Child, Adolescent and School Health (CASH) staff will work with its internal Medicaid partners to determine the interest of utilizing YAHCS in a similar fashion. If all

partners agree on its implementation, YAHCS surveys will be administered in year two of this grant cycle.

As a final strategy for this objective, MDHHS will work with the state Medicaid office to determine feasibility of convening a sub-group of Medicaid Health Plans to share and expand strategies to incentivize well-child exams among their provider networks. Ideally, this would include initiatives already underway in some health plan regions, such as linking payments to achievement of well-child exam goals and adolescent-friendly performance requirements including care satisfaction, privacy and confidentiality. Additionally, MDHHS' Child and Adolescent Health Center (CAHC) program will share its "Proactive Reminders" publication to foster successful proactive approaches to well-child exam appointment-making and reduction of no-show rates. These approaches were successful when used by Michigan's CAHCs, which report annually on proactive steps taken to increase well-child exams as part of their contract requirements.

It is expected that a preliminary plan will be developed within the first 18 months of this five-year block grant cycle. This plan will include specific strategies involving LHDs in leading local efforts to promote and improve adolescent well-child exams in their jurisdictions. In years two through five, LHDs will be expected to report on progress in contributing to an improvement in adolescent well-care rates in their areas. It is expected that level of participation and progress will vary among LHDs based not only on varying need, but also on varying levels of local funding and staff capacity.

MDHHS will capitalize on current relationships and successes with established stakeholders to facilitate achievement of the proposed strategies. For example, health plan Quality Managers and several other state-level stakeholders are engaged in an evolving HPV Immunization Improvement Initiative facilitated by MDDHS' Immunizations Section. This initiative brings stakeholders together to share best practices, data collection/reporting and evaluation strategies to improve HPV immunization rates among adolescents. Participants have voiced the importance of increasing annual well-child exams in improving immunization rates, providing an opportunity on which MDHHS can build to achieve this mutual objective.

Objective B: By 2020, increase by 750 the number of providers trained on culturally-competent adolescent-friendly preventive care. A key component of quality adolescent care is the extent to which services are delivered in a developmentally-appropriate, adolescent-friendly and confidential manner. Positively impacting adolescent care requires significant system changes aimed at addressing known barriers to quality care: health professional lack of training; lack of effective communication skills; and low self-efficacy in providing adolescent preventive services. In real-world practice, the quality and delivery of preventive health care for adolescents varies widely and is highly dependent on the experience of the individual healthcare provider or professional; his or her knowledge of clinical guidelines; communication skills and training; subconscious biases; and personal comfort level.

For the past two years, CASH staff have partnered with Michigan Public Health Institute to design two web-based Adolescent Health Courses, grounded in research and best practice, to improve provider competencies in Motivational Interviewing (MI) and Positive Youth

Development/Resiliency. A third course on Adolescent Growth Development and Brain Development is slated for a 2016 release. These courses will be promoted and offered at no charge to public and private providers throughout the state. As incentive for participation, continuing medical education credits will be offered for course completion. The objective is to reach 250 providers over five years with these foundational adolescent health courses. To supplement the MI course, in-person training will be offered each year to interested providers who have completed the web-based course. CASH will offer additional professional development and training opportunities focused on culturally-competent, adolescent-friendly preventive care with a goal of reaching 500 providers over the five-year period.

Objective C: By 2020, increase by 10% the proportion of adolescents with a documented well-child exam among 25 Child and Adolescent Health Centers (CAHCs). With 81 state-funded clinical school-based/school-linked health centers, Michigan has one of the nation's largest programs of its kind. To demonstrate quality across its program, each CAHC is required to participate in a multi-faceted approach to quality improvement which has led to dramatic improvements in core performance measures, including a 14% increase over two years in the percentage of adolescents up-to-date with a documented comprehensive physical exam. (In FY14, more than half of the state's CAHCs report 53% or more of their clients were up-to-date with annual well-care exams.) To continue this momentum, MDDHS will engage five CAHCs each year for the next five years in Continuous Quality Improvement (CQI) initiatives to increase well-child exam rates.

The CAHC Quality & Evaluation Support Team (QuEST) will coordinate the months-long, tailored initiatives using the Plan-Do-Study-Act cycle of change, partnered with regular coaching calls, meetings and/or site visits with all participating CAHC staff. To initiate each project, QuEST will conduct conference calls/meetings with each CAHC to review the following: current available data; data that is needed to set goals; current processes for consent and well-child exam administration; challenges and facilitating factors for implementing the initiative; and next steps. A second conference call/meeting and a series of email, telephone and/or in-person communications will follow to review data, develop goals and action steps, and determine resources and support needed for success. QuEST will provide ongoing support tailored to each health center which will include guidance and support for policy/procedure and process review, revision and development. Access to current and relevant journal articles, tip sheets, training and educational materials will also be provided as relevant.

QuEST used this same approach in an HPV immunization improvement initiative with four CAHCs, resulting in dramatic increases in HPV immunization series completion rates (three-dose series) among adolescent males aged 11-21 years over the course of nine months. Results showed statistically significant improvement in HPV immunization series completion rates among the CAHC clients when compared to the control group. The increase in completion rates in CAHC's ranged from 9.7% to more than 30%. Increases in completion rates in sponsoring agencies, by comparison, were between zero and two percent over the same time period. Using the same model, MDHHS intends to achieve its established objective for adolescent well-care exams.

In a second strategy to increase the proportion of adolescents with documented well-care exams in CAHCs, MDHHS will annually assist at least three to five health centers in achieving National Committee for Quality Assurance (NCQA) Patient-Centered Connected Care (PCCC) Recognition, the equivalent of Patient-Centered Medical Home (PCMH) status for school-based health centers. MDDHS has already contacted NCQA and is encouraged that, because of existing quality/performance measure requirements for state-funded CAHCs in Michigan, its health centers are well-positioned to successfully pursue PCCC status. Common PCCC/PCMH standards around areas such as service delivery, policy and procedures, data collection, needs assessment, identification of disparities and proactively reminding clients of preventive services appointments are just a few of the criteria that CAHCs meet per state contract requirements.

Again, QuEST will lead this initiative and will be responsible for identifying participating CAHCs; acting as a liaison to NCQA to foster understanding and interpretation of requirements; and advising CAHCs in making necessary changes to meet standards for recognition. Due to limited CAHC staff time and capacity, just two CAHCs in the state have achieved any type of PCMH status on their own; therefore, this support is critical to foster the attainment of PCCC recognition among state-funded health centers. As PCCC status will open a door for enhanced payment incentives, CAHC sponsoring medical agencies (LHDs, FQHCs, health systems and standalone centers) are expected to support these efforts.

Objective D: Develop a social media campaign to promote adolescent well-care and targeted health messages. Finally, CASH will work with MDHHS' Communications staff to develop a coordinated social media campaign that brings attention to the importance of annual

preventive service visits for maintaining lifelong health. Part of this approach will include targeted health messages to adolescents and their families. Lessons learned from other successful campaigns will be researched and evaluated for use in Michigan. A second strategy under this objective is to identify and disseminate best practice guidelines using social media to promote preventive services and for appointment reminders.

Adolescent Health Annual Report

The following performance measures and the related data trends, program summaries, successes, and challenges address the **Adolescent Health** population domain for FY14 reporting.

NPM 8: Rate of birth per 1000 females aged 15 through 17 years

Data Trends: Since 1990, the teen birth rate in Michigan among females aged 15-17 years has decreased by 76% to a historic low. The rate among both Black and White females has declined over this time period. Michigan continues to exceed its performance objective for this measure (target for 2014: 10.3; actual: 8.8).

FY14 Program Summary: The MDHHS provides funding to organizations to implement teen pregnancy prevention and parenting programs through schools, after-school programs, community-based organizations, faith-based organizations and local health departments. In FY14, Michigan's three teen pregnancy prevention and parenting programs provided programs and services to both youth and parents. The Michigan Abstinence Program (MAP) promotes sexual risk avoidance among youth aged 10-15 and served over 3,000 youth and 300 parents.

The Taking Pride in Prevention Program (TPIP) utilizes evidence-based curricula to educate adolescents on both abstinence and contraception along with three adulthood preparation topics: healthy relationships, adolescent development and parent-child communication; and served 5,027 youth aged 12-19 and 1,610 parents in high-need geographical areas (high numbers of teen births). The Michigan Adolescent Pregnancy and Parenting Program (MI-APPP) works to create an integrated system of care and linkages to support services for pregnant and parenting adolescents aged 15-19, young fathers and their families. This system of care includes strength-based case management and linkages to support services. MI-APPP aims to serve 300 pregnant and parenting teens and their families each year. MAP has 9 grantees, TPIP has 12, and MI-APPP has 6, for a total of 27 teen pregnancy prevention and parenting contracts.

Program successes: Successes include a solid evaluation plan and participant data tracking system at the state level; using creative, non-traditional methods to increase youth and parent participation; and leveraging funds to expand programming especially for MI-APPP, which allows an additional 100 teens and families to be served. Each MI-APPP grantee conducts a comprehensive needs assessment that identifies population strengths. Each grantee specifically addresses needs and barriers through supplemental services and individual case management, which leverages the strengths of resources in each community.

Program challenges: Challenges include a lack of funding to expand teen pregnancy prevention and parent programs into additional high-need communities or to serve more youth; access to in-school programming in some locations despite evidence that participant retention increases when programming is delivered during the school day; and no legislative mandate for

evaluation of sexual risk avoidance at the federal level to substantiate effectiveness. For MI-APPP specifically, the multi-faceted and complex needs of families served (particularly fatherhood engagement and navigating the many available services) pose additional challenges.

NPM 16: Rate of suicide deaths among youth aged 15 through 19 per 100,000 population

Data Trends: The suicide death rate per 100,000 population for youth aged 15-19 increased between 2008 and 2013 from 7.3 to 10.5, which was a six-year high. Provisional 2014 data indicate the rate fell to 6.9 in 2014, which is below the annual performance indicator of 10.0. MDHHS will monitor data to determine if last year's rate was an anomaly and if the upward trend is, in fact continuing.

FY14 Program Summary: MDHHS was awarded a federal State/Tribal Youth Suicide Prevention and Early Intervention grant in fall of 2014. Technical assistance continues to be provided to Community Mental Health agencies, local human services collaborative bodies and suicide prevention coalitions. The Michigan Model for Comprehensive School Health Education (Michigan Model) continues to be used in Michigan's public, charter and private schools. The curriculum promotes life skills for children and youth in grades K-12 in areas such as problem solving, decision making, resolving conflict, anger management and listening skills.

During FY14, work continued around addressing the need for suicide prevention among youth. MDHHS has relationships with several entities that provide training and resources around suicide prevention. LivingWorks, Michigan Public Health Institute and University of Michigan's Depression Center house certified trainers who are available to schools and service agencies to conduct trainings and/or presentations to address this issue. Through these partnerships,

SafeTALK and ASIST trainings as well as other suicide prevention workshops have been provided to local community agency representatives and residents. Michigan Association for Suicide Prevention members meet regularly to discuss needs in the state around suicide prevention for youth and adults. Staff from MDHHS attends these meetings regularly.

Program Challenges: With suicide prevention, stigma can keep progress at bay. Public awareness and education are needed to address the challenge of de-stigmatization. Funding limitations, access to qualified trainers and availability of time for training can impede progress. However, because Michigan has qualified trainers and supports this effort, headway is being made to improve education and awareness of this issue. With additional grant funds received by MDHHS, SafeTALK train-the-trainer models will be provided around the state to increase the number and location of qualified trainers. Once trained, these representatives will provide SafeTALK training in their local communities, allowing for school trainings where youth spend the majority of their time. Additionally, ASIST trainings are being provided around the state through this grant.

Program Successes: The Michigan Department of Education, in partnership with MDHHS, received the Project Aware grant and funding from the Governor's office which will allow three intermediate school districts to provide Youth Mental Health First Aid (YMHFA) trainings to school representatives over the next two years. YMHFA gives attendees the knowledge, skills and tools to talk with young people who are contemplating suicide in an effort to keep them safe until additional support is available. To date, over 18,000 people statewide have been trained in YMHFA.

SPM 6: Rate per 100,000 of chlamydia cases among 15 to 19 year-olds

Data Trends: Michigan saw consistent increases in chlamydia rates among teens through 2009, followed by a plateau until 2011. There have been considerable annual declines over the last three years. This trend is seen in major metropolitan areas as well as the state overall. In the 2009 annual report, we predicted with consistent and broad screening of young women and their partners, the state will reach a "tipping point" where cases diagnosed and treated will outpace new infections; and case rates would begin a consistent downward trend. This appears to be coming to fruition.

FY14 Program Summary: In FY14, a total of 15,921 youth aged 15-19 were screened in publically funded sites, identifying 2,064 chlamydia infections (13% positivity). Of these, the Child and Adolescent Health Center (CAHCs) specifically supported a total of 6,930 chlamydia tests, identifying 1,063 positive youth (15.3% positivity). Almost every CAHC (school-based/school-linked health center) treated 100% of these cases onsite.

The decrease in the rate of chlamydia among Michigan teens can be attributed to the combined efforts of providers in public and private sectors. While Michigan continues to support testing for those with no other payer and those requesting confidential services, screening has also increased in the private sector as chlamydia screening of females aged 16-24 is a national quality standard of care. Emphasis on screening, diagnosis and treatment of asymptomatic infection decreases prevalence in the population over time.

Program Successes: Michigan is building upon its success in numerous ways. First, CAHCs are working to increase medical access to at-risk teens throughout the state. They have

implemented a number of new service models and sites with a consistent message to providers to screen teens for chlamydia regardless of symptoms. Staff from the STD Section annually partner with medical personnel to take testing to the highest risk populations via school-wide screening events. These events decrease the stigma of testing and cull disease out of communities, decreasing future transmissions.

SPM 8: Percent of high school students who experienced dating violence

Data Trends: According to the YRBS, the percentage of high school youth who experienced dating violence dropped dramatically from 11.9% in 2013 to 8.8% in 2014.

FY14 Program Summary: Efforts to prevent dating violence among high school students has focused on coalition building, training, changing policy and norms, distributing informational materials and public service announcements. In 2014, Michigan Sexual Violence Prevention (MSVP) grantees collectively trained over 6,458 people and provided high school focused educational seminars to 14,834 participants. Also, 100,921 units of informational materials were distributed and 381,470 public service announcements were aired throughout Michigan. Twelve grantees targeted individual level change through youth primary prevention programming. On pre/post-test assessments, nearly all youth respondents in MSVP programs disagreed with the statement ‘Dating violence is personal and family, friends and others should not get involved,’ with demonstrated improvements after program participation.

Dating violence prevention efforts are not exclusive to MSVP alone. Early prevention lessons are delivered in K-12 classrooms using the evidence-based Michigan Model’s Social and Emotional Health curriculum. Additionally, the “Safe and Sound for Life: Social and Emotional

Health and Safety” module (released in 2014) targets middle school students in an effort to establish social skills and healthy relationship dynamics before students reach high school and young adulthood.

Program Challenges: Recruitment of teachers for Michigan Model training has at times been challenging in some regional implementation sites. In order to encourage participation from schools, grant funding may be utilized by training sites for substitute teacher costs or in providing curriculum manuals and support materials for free or low cost to districts. Also, to accommodate scheduling and increase turn-out, some grantees have begun providing curriculum training after school or on weekends.

CSHCN Domain

Five-Year Plan (NPM 11 – Medical Home)

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
Increase family and provider support and education for Children with Special Health Care Needs	A) Increase the number of CSHCN served in a medical home by 4.7% within 5 years (by 2020)	<p>A1) Increase the capacity and efficacy of established medical homes, including FQHCs, by providing training on care coordination, transition planning, and family partnership</p> <p>A2) Work with partners across the state to improve the system of care coordination by providing education, leadership, and</p>	<ul style="list-style-type: none"> - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system - Percent of children in excellent or very good health - Percent of children ages 19 through 35 months, who have received the 	Percent of children with and without special health care needs having a medical home

		support	4:3:1:3(4):3:1:4 series of routine vaccinations	
	B) Increase families' understanding of the benefits of the medical home model, and help connect families to medical homes in their region	A3) Encourage primary care practices to adopt medical home practices by developing reimbursement mechanisms that support the additional functions of a medical home	- Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza	
		B1) Develop and disseminate educational materials to CYSHCN enrolled in CSHCS about additional services provided by Medical Homes	- Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	
		B2) Connect parents who request additional information with a Medical Home in their region to learn more	- Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	
	C) Identify ways to improve the delivery of care within a medical home	C1) Survey families on the strengths and weaknesses of care coordination and family partnership in the provider setting	- Percent of adolescents, ages 13 through 17, dose of the meningococcal conjugate vaccine	
		C2) Support practices to build partnerships with families (e.g., family advisory groups, focus groups, family-centered processes)		

CSHCN Action Plan Narrative

Through the five-year needs assessment process, the state priority issue of “Increase family and provider support and education for Children with Special Health Care Needs” was selected for

the CSHCN population domain. Percent of children with and without special health care needs having a medical home (NPM 11) was selected to address this priority need.

Objective A: Increase the number of CSHCN served in a medical home by 4.7% within 5 years (by 2020). The Healthy People 2020 objective for the percent of all children having a medical home (63.3%) is 4.7% higher than the state measurement as indicated on the 2011/2012 National Survey of Child Health (NSCH). The current trend in Michigan shows an average annual decrease of 0.8% in the percent of all children having a medical home. In order to meet the HP 2020 objective, this indicator would need to increase by an average of 0.6% annually. In order to achieve this goal, CSHCS will assist medical homes in providing more effective and efficient care to children with special needs, and assist primary care practices in becoming medical homes.

One of the challenges preventing children with special needs from receiving care in a medical home is the capacity and efficiency of pediatric medical homes. Children with special needs often require more complex care, which involves many providers beyond a primary care physician. Coordination among all of the necessary partners involved in a child's care is time intensive, and limits the medical homes' capacity to serve more children. Additionally, children with special needs may require additional support and resources to make a successful transition into adulthood. CSHCS will assist medical homes in administering more effective and efficient care to CSHCN by providing training to six select medical homes in FY 2016. These trainings will be evaluated and refined to better meet the needs of medical homes and families, and will be used as a model to be implemented statewide.

CSHCS will continue its involvement with the Michigan Primary Care Transformation (MiPCT) project. MiPCT includes approximately 50 pediatric practices across the state with about 115,000 pediatric patients—approximately 4,000 of whom are enrolled in CSHCS. The major intervention of the MiPCT model is to provide care management at the practice level, which is supported by a reimbursement model that does not burden the practice with the cost of care managers. CSHCS will continue to work with the care managers in pediatric practices to support their efforts to coordinate care across medical, mental health, educational and developmental domains, and to understand the needs of CYSHCN.

CSHCS will also continue its partnership with the Michigan Chapter of the American Academy of Pediatrics (MiAAP), Children's Healthcare Access Program (CHAP), local health departments, and others to provide training and support to practices to improve their medical home capacities.

Objective B: Increase families' understanding of the benefits of the medical home model, and help connect families to medical homes in their region. CSHCS recognizes the value in empowering families to be their own advocates and to seek the necessary services that provide optimal care for their child. CSHCS and the Family Center will develop and disseminate educational materials to CYSHCN that are enrolled in CSHCS, which will inform families about the additional services offered by medical homes.

In addition, CSHCS and the Family Center will work with key partners on developing a solution to connecting parents to a medical home within their available provider network. Families that

receive information on the value of the medical home model will then be able to more readily identify and access services within a medical home.

Objective C: Identify ways to improve the delivery of care within a medical home. Effective care coordination first requires involving the families as partners for developing a plan of care that meets families’ needs and is achievable within each family’s unique circumstances. In order to better understand families’ needs, CSHCS and the Family Center will survey families on the strengths and weaknesses of care coordination and family partnership in the provider setting. The information gathered through this process will be used to support our efforts in identifying best practices, and developing strategies and tools to help address gaps.

CSHCS and the Family Center will also support practices in forging their own partnerships with families by encouraging and providing technical assistance regarding the formation of family advisory groups, focus groups, and family-centered processes. Through the years, CSHCS and the Family Center have gained valuable expertise in effective ways to engage families. CSHCS and the Family Center will work with practices to identify the types of support that practices need to implement family partnership strategies, and provide resources to address those needs.

CSHCN Domain

Five-Year Plan (NPM 12 – Transition)

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
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<p>Increase family and provider support and education for Children with Special Health Care Needs</p>	<p>A) Increase the number of youth who have a plan of care that includes transition planning beginning at age 14 by 4.1% within 5 years (by 2020)</p> <p>B) Increase youth and family awareness and understanding of the transition to adulthood process</p> <p>C) Increase provider awareness and understanding of the transition to adulthood process</p>	<p>A1) Hire staff to address transition needs of clients</p> <p>A2) Increase the number of local health departments that develop and implement a transition policy</p> <p>A3) Develop electronic solutions that help us identify clients with greater need for transition services</p> <p>B1) Facilitate discussions with youth and their families on how to better address needs relating to transitioning to adulthood</p> <p>B2) Identify new, effective ways to provide transition services and resources that are more accessible to today's youth</p> <p>C) Develop informational and educational materials, including a webinar, to support the awareness and implementation of transition planning</p>	<ul style="list-style-type: none"> - Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system - Percent of children in excellent or very good health 	<p>Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care</p>
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CSHCN Action Plan Narrative

Through the five-year needs assessment process, the state priority issue to “Increase family and provider support and education for Children with Special Health Care Needs” was also linked to

NPM 12, the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

Objective A: Increase the number of youth who have a plan of care that includes transition planning beginning at age 14 by 4.1% within 5 years (by 2020). The revised transition analyst position, once filled, will be responsible for leveraging technology to better reach and assist youth with special needs who are entering adulthood. Through the use of online tools, including the CSHCS website and social media, the transition analyst will develop and implement strategies that enable CSHCS to better engage youth with special needs.

Local health departments (LHDs) are in a unique position to provide comprehensive transition planning for youth with special needs and their families. LHDs have a greater knowledge of the services and resources available in the local community, and are better suited to assist families in connecting to those resources. Many LHDs have been limited in their ability to provide transition planning to youth with special needs due, in part, to the need for additional training and assistance. CSHCS is currently developing an online webinar that will serve as a training tool for LHDs. This webinar is the first step in building the LHDs' capacity to provide transition planning. CSHCS will also work with the LHDs to develop electronic tools that will assist the LHDs in tracking and assisting clients in their communities in need of transition planning.

Youth with special needs require varying levels of assistance to successfully transition into adulthood. The transition analyst, in collaboration with families and key stakeholders, will assist in the development of database tools and data analysis that will help us strategize how to identify youth with the greatest need of transition services. This effort will be the first step

toward exploring additional strategies on how CSHCS can develop a statewide approach to transition planning in a way that best meets the needs of each individual.

Objective B: Increase youth and family awareness and understanding of the transition to adulthood process

Youth with special needs and their families often have additional considerations when transitioning to adulthood. Many youth and their families are unfamiliar with the process of transitioning to adult providers, seeking assistance with continued educational or vocational training, or finding new insurance coverage if necessary. Additionally, many youth and their families are unaware that CSHCS and our partners in local health are able to assist families in making this transition.

Beginning in FY15, CSHCS, the Family Center and LHDs will partner in facilitating discussions with youth and their families to understand what they identify as their greatest transition needs. CSHCS will revise its transition materials based on the input received and will follow-up with families to ensure that the new materials meet their needs.

One of the resources CSHCS will make available to youth with special needs and their families is an online webinar that will provide training and resources regarding power of attorney, guardianship, educational needs and workforce development. This webinar will also continue to develop as CSHCS learns more about what will benefit families the most. Additional materials, such as mail correspondence, will also be updated.

Once transition materials have been developed with youth and family input, these materials will be made available online on the CSHCS website, as well as publicized using social media and correspondence mailed to families. Each marketing strategy will be monitored and evaluated to

optimize the reach and value, and will be continually revised to have maximum impact. LHDs will also develop ways to increase awareness of transition services that are specific to their local communities.

Objective C: Increase provider awareness and understanding of the transition to adulthood process

A key aspect to successful transition planning is a competent public health workforce that has the knowledge and training to provide comprehensive transition services. CSHCS has been developing a webinar that will be delivered to LHDs and provider practices on the transition process. These webinars will be evaluated and refined based on the identified needs. CSHCS anticipates providing a series of webinars that will include content related to consent, power of attorney, guardianship, educational needs and workforce development. In addition to these webinars, CSHCS and the Family Center will create additional supporting documents and educational materials that providers indicate would be helpful.

CSHCN Annual Report

NPM 2: The percent of children with special health care needs age 0 to 18 years whose families' partner in decision making at all levels and are satisfied with the services they receive

Data Trends: Data for this performance measure are collected from the National Survey of Children and Youth with Special Health Care Needs. The data for 2015 is not yet available; therefore, no trends can be identified.

FY14 Program Summary: The Family Center for Children and Youth with Special Health Care Needs (Family Center) is the parent-directed section of the Children's Special Health Care Services (CSHCS) division. The Family Center is an integral part of the division. The Family Center provides services to families statewide and serves as the collective voice for families. The information the Family Center receives from families is used to provide consultation to Michigan Title V programs regarding policy and program development. All written materials intended for families created by CSHCS, as well as CSHCS policy and procedure, are reviewed by the Family Center for recommendations or revisions. The Family Center also provides review of the federal MCH Block Grant application.

An important service the Family Center continues to provide is the toll-free Family Phone Line. The Family Phone Line is available to families who have children with special needs throughout Michigan, whether they are enrolled in CSHCS or not, meeting the broader definition of special health care needs as outlined by the MCH Block Grant. The Family Phone Line is used to assist families in accessing providers and obtaining information on the CSHCS program, as well as general information and referral to resources for families of children with special needs. In 2014, the phone line handled 11,022 calls. In an effort to be culturally competent and accessible to all families, the Family Phone Line uses a Language Line to increase access for individuals who do not speak English. In 2014, 13 calls used the language line, primarily for Spanish and Arabic translation.

The Family Center developed a statewide database that is used to help make parent matches, outreach to parents with children with special needs, and provide information on parent and

professional resources. This database also serves as a case management system for Family Center staff, which ensures that quality, timely services are delivered to families that request them.

The Family Center also continues to provide parent support through its statewide Family Support Network of Michigan. This network matches parent volunteers with other parents in similar situations in need of support. In 2014, the Family Support Network made 10 parent matches and held three Parent Support trainings, which provided education and resources to parents across the state. The Family Center also provided conference scholarships for youth and family to attend conferences around the United States that pertain to their diagnosis.

The Family Center underwent significant changes in 2014 with the hiring of a new Family Center Director. Under the direction of the new director, and with guidance from key stakeholders, the Family Center revised the parent consultant and secretary position descriptions. These changes were a part of a broader strategic planning initiative aimed at broadening the breadth and depth of quality services provided by the Family Center. Another primary goal identified by the new director is to increase the awareness of, and access to, services that the Family Center provides.

Program successes: The Family Center had many successes throughout FY14, most notably are the development of a statewide database, the creation of new parent consultant and secretary positions, and a robust strategic planning initiative that resulted in the development of new policies and procedures.

Program challenges: The Family Center experienced a transitional period in 2014, with the hiring of a new director. Throughout the year, the director and existing Family Center staff worked to continue the services that families have come to expect from the Family Center, while simultaneously forging new relationships and planning for the future. The Family Center's employees were also split between two offices, making efficient workflow and effective communication difficult at times. Limited funding and resources exacerbated the challenges encountered by the Family Center, and at times delayed the progress that the new director had planned to accomplish.

NPM 3: The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home

Data Trends: Data for this performance measure is collected from the National Survey of Children and Youth with Special Health Care Needs. The data for 2015 is not yet available; therefore, no trends can be identified.

FY14 Program Summary: In late FY14, CSHCS was awarded a HRSA grant to improve services for young children with autism spectrum disorders and other developmental disabilities (ASD/DD). As part of the ASD/DD grant, CSHCS will train 12 medical homes on effectively managing populations with ASD/DD, and providing better care coordination services for all children with special needs. The ASD/DD grant will also strengthen our collaboration with the Behavioral Health and Developmental Disabilities Administration (BHDDA) at both the state and local levels.

During FY14, CSHCS was also in its second year of administering a HRSA grant focused on the Awareness and Access to Care for Children and Youth with epilepsy. Part of this grant involves working with *Federally Qualified Health Centers (FQHCs)* in rural areas to strengthen their capacity to provide services to CYSHCN through the use of telemedicine. These FQHCs received training on topics including care coordination, transition planning, and incorporating telemedicine capabilities within their practice. Increasing the use of telemedicine provides the opportunity for families in rural settings to get comprehensive, specialty care provided by a multi-disciplinary team that would otherwise be unavailable in their region.

Both HRSA grant projects partnered with the Family Center to plan and coordinate family advisory activities within the medical homes. In addition to their partnerships with the Family Center, both projects worked with local health departments, local Early On programs, the local Community Mental Health program, and local school districts to enhance access to community-based resources and to further the coordination of care.

CSHCS also continues to participate with the Michigan Primary Care Transformation (MiPCT) demonstration project, which focuses on the advanced primary care practice (patient-centered medical home) model. The project has a steering committee for implementation, which includes Jane Turner, MD, the CSHCS Medical Home Physician Consultant. The primary goals of MiPCT are to support care coordination within medical homes, and encourage further medical home site development in pediatric and family practices across the state.

Children's Multi-Disciplinary Specialty (CMDS) Clinics are specialty pediatric health care providers throughout Michigan that provide comprehensive specialty care to children with

particular diagnoses. This model of care is largely derived from the medical home model, but pertains to specific conditions that are often at the center of the child's health needs. In the beginning of 2014, CSHCS embarked in efforts to significantly strengthen its partnership with CMDS clinics, which included establishing a workgroup consisting of CMDS clinic staff at each of the approved CMDS clinic organizations throughout the state. This workgroup set out on the task of learning from each other to identify best practices and to devise solutions to shared problems in administering care to CYSHCN. This workgroup, in addition to CSHCS staff and stakeholders, created a new report that must be submitted annually to help CSHCS monitor the performance of each CMDS clinic. These annual reports will also be used to identify issues that can be explored more thoroughly during the revitalized site visits that will be performed on a triennial basis.

Program successes: One of the major successes of 2014 was strengthening the partnerships between CSHCS and provider practices, as well as the Behavioral Health and Developmental Disabilities Administration (BHDDA). Major steps were taken toward a more integrated approach to caring for children and youth with special needs. This strengthened partnership provided opportunities to work with the largest health care providers throughout the state on identifying and promoting evidence-based best practices. Another critical success was the continued involvement of families at all levels of decision making.

Program challenges: One of the greatest challenges, despite the progress that has been made, remains the poorly integrated systems of care for CYSHCN. Forming new partnerships and strengthening existing ones requires time and resources that are often limited. Another major

challenge faced by CSHCS is limited funding. With additional funding, CSHCS would be able to pilot and implement new programs that could benefit CSHCN, develop additional electronic solutions to help identify and manage CSHCN, and increase the awareness and engagement of families and providers.

NPM 4: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need

Data Trends: Data for this performance measure is collected from the National Survey of Children and Youth with Special Health Care Needs. The data for 2015 is not yet available; therefore, no trends can be identified.

FY14 Program Summary: CSHCS provides coverage for medical care and treatment regarding over 2,700 different diagnoses. In 2014, the program provided services to 41,552 children and some adults. CSHCS also has the Insurance Premium Payment Benefit, whereby the state pays the private health insurance premium for the eligible client. This benefit allows for the CSHCS client to maintain their private health insurance coverage that they may otherwise not be able to afford. This enables the state to prevent the cost of medical services from shifting from the private health insurance company to CSHCS state funding. The majority of the premiums paid for the benefit are when COBRA coverage is offered to a family when the policyholder loses a job or a young adult is no longer covered. Cost effectiveness must be proven in order for CSHCS to pay premiums. In 2014, the Insurance Premium Payment Benefit assisted 224 families with insurance premiums, saving the program over \$2.73 million.

CSHCS policy became effective requiring applicants who—based on financial information provided—may be eligible for MICHild (Michigan's SCHIP program) or Medicaid to apply for the programs. As CSHCS only provides payment for medical care and treatment of approved diagnoses, this change also increased access to primary care and other services for many of our clients. Beginning in the fall of 2013, BCBS began phasing out as Michigan's MICHild provider, and MICHild enrollees were transitioned to the Medicaid Health Plans to provide the MICHild benefits.

CSHCS has continued its policy whereby Medicaid enrollees who are determined eligible for CSHCS no longer need to complete the CSHCS application process, and are automatically enrolled in CSHCS. The majority of CSHCS clients that are dually enrolled in Medicaid received services through Medicaid Health Plans (MHP). There are some populations within CSHCS that are excluded, or have the option but are not required to enroll in an MHP. CSHCS and the Family Center continued to work with the MHPs, state partners, and providers to monitor the care provided by MHPs. A significant benefit of CYSHCN receiving care through Medicaid managed care plans has been the ability to provide increased access to primary care, and more effective care coordination.

The Michigan Health Insurance Program (HIP) was a temporary initiative that provided additional health insurance coverage until the full benefits of the Affordable Care Act (ACA) were implemented. CSHCS assisted clients who were enrolled in HIP convert to the Federal ACA Plan until January 2014, when the full ACA requirements became effective. To further ensure that CSHCS clients had adequate private and/or public insurance, CSHCS developed tools and partnered with external organizations to help eligible CSHCS clients enroll in the Healthy

Michigan Plan (Medicaid Expansion) or any of the available plans through the Health Insurance Exchange (HIE). CSHCS also developed an electronic work queue that allowed our local health department (LHD) affiliates to more readily identify CSHCS clients who may be eligible for an insurance plan provided through the HIE. This tool was used by our LHD partners to provide outreach and education about the HIE, as well as direct CSHCS clients to a Certified Application Counselor or Navigator.

Program successes: CSHCS developed and implemented an “under-insured” work queue that our LHD affiliates used to contact families that were potentially eligible for plans through the ACA. The LHDs used this tool to inform families about the ACA and to direct them to Certified Application Counselors or HIE Navigators. CSHCS also participated in discussions regarding the implementation of the statewide Healthy Michigan Plan (Medicaid Expansion) that will benefit some of our adult clients.

Program challenges: Health insurance related to special health care needs remains a complex process for families to navigate, and makes it difficult to direct families to seek the appropriate insurance coverage. Additionally, uncertainty regarding how the ACA and Healthy Michigan Plan would impact the health care environment made it difficult to plan for the future.

NPM 5: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily

Data Trends: Data for this performance measure is collected from the National Survey of Children and Youth with Special Health Care Needs. The data for 2015 is not yet available; therefore, no trends can be identified.

FY14 Program Summary: Michigan relies heavily on our LHD partners to be the community-based arm of the CSHCS program. CSHCS works with the LHDs to assist families in locating additional resources within their community. Because CSHCS relies so heavily on the LHDs, it is crucial that the division provide them with the most current information and a streamlined process to handle clients' needs. The CSHCS database, implemented in 2011, continued to undergo enhancements that allowed for improved client management. This same database is also used by all CSHCS central office staff, which removes many barriers to a more effective partnership. CSHCS's internal staff and LHDs use this database to handle issues relating to the enrollment and renewal process for all CSHCS clients and their families.

CSHCS continued the process of the Michigan Local Public Health Accreditation Program for local CSHCS offices. In 2014, the third and final year in a three-year accreditation cycle was completed, which denotes that all LHDs participated in the CSHCS portion of the LHD accreditation. The first accreditation cycle involving CSHCS (2012-2014) required the LHDs to meet the following six minimum program requirements:

- Minimum Program Requirement 1: The local health department (LHD) Children's Special Health Care Services (CSHCS) program shall assure that adequate, trained personnel are available to provide outreach, enrollment and support services for children and youth with special health care needs (CYSHCN) and their families.
- Minimum Program Requirement 2: In accordance with the security and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), the local health department

CSHCS program shall manage CSHCS client protected health information (PHI) in a secure and private manner that results in coordinated care.

- Minimum Program Requirement 3: The local health department CSHCS program shall have family-centered policies, procedures and reporting in place.
- Minimum Program Requirement 4: The local health department CSHCS program shall provide outreach, case-finding, program representation and referral services to CYSHCN/families in a family-centered manner and to community providers.
- Minimum Program Requirement 5: The local health department CSHCS program shall assist families in the CSHCS application and renewal process as well as the application processes for other relevant programs.
- Minimum Program Requirement 6: The local health department CSHCS program shall provide information and support services to CSHCS enrollees and their families. The division also worked closely with the Family Center for CYSHCN to provide outreach and information to 13 organizations regarding the CSHCS program, its benefits, and how to access services including the pediatric medical home model.

The accreditation process is one mechanism CSHCS used to evaluate the delivery of a high standard of services to our clients and their families. CSHCS staff also worked closely with local health departments and identified many areas of need for additional technical assistance. These efforts continued to strengthen the partnership between the CSHCS central office and the community based local health department staff.

Program successes: In 2014, CSHCS completed its first cycle of accrediting LHDs. This process provided a better understanding of the strengths and needs of each LHD, and revealed ways that CSHCS could provide better assistance to our local partners. The accreditation process also strengthened the relationship between LHDs and CSHCS, and improved the communication among and between LHDs and CSHCS.

Program challenges: Perhaps the biggest challenge in providing easily accessible community-based services remains the limited funding available to LHDs and other community providers. The ability for LHDs to address the health issues of their population is restricted by the limited resources they have at their disposal. Another challenge is the segregation of accessing and receiving services for physical health needs and behavioral, developmental, and emotional health.

NPM 6: The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence

Data Trends: Data for this performance measure is collected from the National Survey of Children and Youth with Special Health Care Needs. The data for 2015 is not yet available; therefore, no trends can be identified.

FY14 Program Summary: The CSHCS division continued to distribute transition anticipatory guidance letters. Each month in 2014, the Medicaid payment system (CHAMPS) identified clients based on their birthdates to create five client/family specific letters for ages 16, 17, 18, and 21. Additionally, all CSHCS authorized providers with a client turning 16, 18, and 21

received a letter each month reminding them of the importance to discuss transition planning with their client at their next visit.

CSHCS began the process of revising its transition analyst position in order to provide more effective transition planning across the state. This effort began, in part, because our LHD partners identified the need for additional training and resources to help youth with special needs transition into adulthood. The transition analyst, in collaboration with CSHCS staff and the LHDs, will develop and revise online training tools that provide LHDs and families with the information they need to help youth transition into adulthood.

Additionally, the transition analyst position was revised to have a stronger focus on effective outreach and communication with youth. The revised transition analyst position will be responsible for leveraging technology to better reach and assist youth with special needs who are entering adulthood. Through the use of online tools, including the CSHCS website and social media, the transition analyst will develop and implement strategies that enable CSHCS to better engage youth with special needs.

CSHCS also administered a HRSA grant throughout FY14 that focused on building telemedicine capacity for children with epilepsy. The grant work included a significant emphasis on the development of the transition process for children and youth with epilepsy. In the beginning of FY14, nine epilepsy telemedicine sites were surveyed to assess the transition policies within the organizations. These nine sites included five rural FQHCs and four private pediatric practices. The results of these surveys showed varying levels of transition policies in place among the providers, but all sites indicated that their policies would benefit from a review and comparison

to current national guidelines. Families within these practices were also surveyed, which revealed that children and youth with epilepsy (CYE) and their families were unaware of a transition policy at their local primary care provider. These findings led to significant efforts to engage providers and patients in developing transition plans. By the end of FY14, every telemedicine site had a transition to adulthood policy in place that was developed using guidance from GotTransition.org. One staff person at each site was trained in current transition guidelines and began to incorporate transition planning in at least one yearly visit beginning at age 14 for each child with epilepsy.

Additionally, CSHCS improved the transition process for young adults receiving private duty nursing who are approaching 21 years old. Once a young adult turns 21, Medicaid will no longer cover private duty nursing in Michigan. These young adults must transition to a Medicaid Waiver option in order to continue receiving private duty nursing in their communities through a state plan. In 2014, CSHCS successfully transitioned 25 young adults onto a waiver program.

Program successes: Throughout FY14, CSHCS began a major overhaul of its transition planning strategies, including: assessing transition planning in pediatric practices, revising the transition analyst position description, and developing a training model that can be used within various provider entities across the state. Another major success remains the involvement of parents, youth, and multiple state agencies in the planning and development process.

Program challenges: Transition needs vary greatly among the CYSHCN population, making it difficult to ensure the right person gets the right services. Additionally, transitioning to adulthood requires a cross-sector approach that includes educational and vocational training,

continuing medical care, and at times legal matters such as power of attorney or guardianship.

Providing comprehensive transition services requires specific knowledge and training that many public health workers cannot provide, or may have difficulty assisting families in accessing the needed services.

Cross Cutting/Life Course Domain

Five-Year Plan (NPM 13 – Oral health)

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
Increase access to and utilization of evidence-based oral health practices and services	<p>A) By 2020, the SEAL! Michigan program will increase from 10 to 14 grantees to provide dental sealants on first and second molars of students in public schools with more than 50% of students participating in the Free and Reduced Priced Lunch Program</p> <p>B) Increase the number of students who have received a preventive dental screening within a school-based dental sealant program</p>	<p>A1) Seek additional partners to expand the existing sealant program</p> <p>A2) Maintain full-time sealant coordinator position</p> <p>A3) Release an RFP to award funding to grantees prioritizing high risk schools across the state</p> <p>B1) Utilize the SEAL! Michigan database to track the number of students annually receiving a preventive dental screening</p> <p>B2) Promote dental sealant programs</p>	<ul style="list-style-type: none"> - Percent of children in excellent or very good health - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months 	<p>A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year</p>

		through school health professionals		
		B3) Monitor evaluations to determine best practices in school sealant programs in schools with high participation		
	C) By 2020, develop and implement a state plan for improving oral health care focusing on pregnant women, infants, children and youth	C1) Develop and disseminate a survey to stakeholders to prioritize proposed goals		
		C2) Convene regional stakeholder focus groups to prioritize and expand strategies for specific populations of pregnant women and children		
		C3) Publish and disseminate a plan for specific populations of pregnant women and children		
	D) By 2020, increase by 10 percent the number of medical and dental providers trained to treat, screen and refer pregnant women and infants to oral health care services	D1) Plan and develop standardized training modules and courses for medical and dental professionals		
		D2) Utilize pre and post-tests to evaluate trainings for effectiveness		
	E) By 2020,	E1) Develop and market		

	increase by 10 percent the number of pregnant women and infants receiving oral health care services	statewide Perinatal Oral Health Guidelines to medical and dental practitioners E2) Develop and distribute promotional and education materials to health entities across Michigan E3) Develop and implement a multifaceted communication plan		
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Cross-Cutting/Life Course Action Plan Narrative

Through the five-year needs assessment process, the state priority need “Increase access to and utilization of evidence-based oral health practices and services” was selected for the cross cutting/life course domain. The National Performance Measure (NPM #13) was selected to address this priority need: A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1-17, who had a preventive dental visit in the past year. In Michigan, 68 counties have a full, partial or facility Health Provider Shortage Area (HPSA) designation, with 12 out of 83 counties having less than five dentists. Only 10% of the state’s dentists are accepting new Medicaid patients. Just 42% of pregnant women reported seeing a dentist during their pregnancy, with 27% reporting a need for immediate care. Children in Michigan face a similar struggle with only 32% of Medicaid-eligible children receiving dental services. Children under age 5 are the least likely to have visited a dentist. The Healthy People 2020 goal is to have 28.1% of children ages 6-9 with one or more dental sealant in place. According to the 2006

Count Your Smile Survey (last year data available), 26.4% of Michigan's third graders have had sealants placed on first molars. By addressing this need, Michigan will move closer to improving health outcomes for women and children.

Objective A: By 2020, the SEAL! Michigan program will increase from 10 to 14 grantees to provide dental sealants on first and second molars of students in public schools with more than 50% of students participating in the Free and Reduced Priced Lunch Program. Dental decay is the leading chronic childhood disease and nationally leads to more than 51 million missed school hours per year. Dental sealants are an evidence-based strategy to prevent dental decay. SEAL! Michigan is a school-based dental sealant program that focuses on providing dental screening and placing dental sealants on students at no charge to families. In addition to dental sealants, students receive a dental screening, oral health education and fluoride varnish. Dental sealants ultimately decrease dental disease in youth as they are 100% effective in preventing dental decay when they are retained by the tooth.

SEAL! Michigan began in 2007 with a single pilot program serving a handful of schools. Through increased awareness and advocacy, the program has seen consistent growth, adding more programs and each individual program expanding into more schools annually. Currently the program has 10 grantees around the state and two previously-funded, now self-sustaining programs. Although the program has experienced significant growth into over 200 schools, the majority of schools in Michigan are not offering a dental sealant program to their students.

As a first strategy, with funding from oral health partners, the program will increase from 10 to 14 grantees while aiming for a geographically equal distribution of programs around the state.

The program will target public schools that have 50% or more students participating in the Free and Reduced Priced Lunch Program. With progression of SEAL! Michigan, more schools and ultimately more children will be served.

The second strategy is to maintain the 1.0 FTE sealant coordinator position in the Michigan Department of Health and Human Services (MDHHS) which is currently funded under a CDC Cooperative Agreement. The primary roles of the sealant coordinator are to provide technical assistance to all grantees and to strategically manage the SEAL! Michigan program both internally and externally to reach as many students possible with preventive dental care. The sealant coordinator will continue to conduct SWOT analysis (strengths, weaknesses, opportunities and threats) of the SEAL! MI program and forecast program growth accordingly.

The third strategy will be to release a Request for Proposal (RFP) to award funding to grantees, prioritizing high risk schools across the state, by February 2016. The RFP will detail the SEAL! Michigan program guidelines and will be widely distributed by MDHHS and the Michigan Oral Health Coalition to all local health departments (LHDs), Federally Qualified Health Centers (FQHCs) and other non-profit organizations. Proposals will go through a competitive scoring process to ensure the most highly qualified programs are prioritized for funding. Proposal reviewers will be organized into teams that represent a diverse group fully educated in public health programs. The grants will be issued for three years, as funding allows, as longevity assists in program growth and sustainability.

Objective B: Increase the number of students who have received a preventive dental screening within a school-based dental sealant program. Program management and growth

significantly rely on data collection. SEAL! Michigan has made ongoing improvement modifications in its data collection efforts. Data is collected annually and entered into an ACCESS database where it is cleaned and analyzed by the Oral Health Epidemiologist. Annual reports are written and released for each local program and aggregated into a statewide report. Data can show program success by ongoing, annual increases in number of schools and students served and in number of sealants placed. Ultimately, this data will be captured by the Michigan Basic Screening Survey of third grade students, Count Your Smiles Report, and will demonstrate increases in dental sealant placement and decreases in dental decay in youth across the state.

The first strategy under this objective is to utilize the SEAL! Michigan database to track the number of students receiving annual preventive dental screening. Continual updating of the database will allow for tracking the number of unique students who receive one or more dental sealants through the program.

The second strategy is to promote dental sealant programs through school health professionals. The growth of the program relies on continual expansion into new schools. The MDHHS sealant coordinator will continue to a) promote dental sealant programs through school nurses and other school health professionals and b) encourage participation with the SEAL! Michigan or other school-based dental sealant programs. This will be accomplished through collaboration with internal MDHHS partners, as well as embracing external partnership opportunities via professional organizations, conferences and educational venues.

The third strategy is to monitor evaluations to determine best practices in school sealant programs in schools with high participation. Ongoing evaluation of sealant programs is imperative to overall growth. Learning from all partners involved (school administrators, teachers, school nurses, health professionals, social workers, students and parents) through evaluation will assist in directing the SEAL! Michigan program towards continued success.

Objective C: By 2020, develop a state plan for improving oral health with a focus on pregnant women, infants, children and youth. Michigan published the first State Oral Health Plan (SOHP) in 2006. It discussed a plan of action to improve the oral health status of the state's population around four broad topic areas and ten goals. In 2010, the SOHP was re-evaluated and updated based on the progress review and consideration of more recent data about prevalence of oral disease in Michigan. In addition, other documents list oral health priorities such as the Perinatal Oral Health Action Plan, the Michigan Oral Health Coalition Policy Priorities and the Director Dental Report. Plans are underway to update the SOHP and combine it with these other reports into one cohesive document.

The first strategy is to survey stakeholders in order to prioritize goals and objectives based on feasibility and need. The goals and objectives that stakeholders will prioritize are encompassed within the SOHP, the Perinatal Oral Health Action Plan, and priorities identified by the Michigan Oral Health Coalition that include preventive strategies for infants and children along with increasing school-based dental sealant programs.

After survey completion, the second strategy will be to convene regional stakeholder focus groups to further prioritize and develop strategies around the established five-year goals. It is

expected that the convening of focus groups and development of a subsequent report will be completed within the first nine months of the five-year grant cycle.

The third strategy is to publish and disseminate the updated SOHP to stakeholders such as the Michigan Oral Health Coalition, LHDs, FQHCs, WIC programs, dental programs and non-profit organizations and advocacy groups. In years two through five, the oral health program will report progress in contributing to increased access and utilization of evidence-based oral health practices and services.

Objective D: By 2020, increase by 10 percent the number of medical and dental providers trained to treat, screen and refer pregnant women and infants to oral health care services.

The call for improving perinatal oral health falls under a broad strategy to support better health status for women and girls, with a goal of integrating oral health promotion and treatment into the medical home model. The Perinatal Oral Health Action Plan—a broad and multifaceted statewide initiative intended to inspire stakeholders to engage in the dynamic process of changing the oral health care delivery system—was created to address this call.

Data collected from a statewide provider survey indicates that the majority of medical providers (82%) acknowledged that perinatal oral health was an important consideration for optimal obstetric management; however, only one-fifth (22%) of providers stated that they routinely examined the patient's oral cavity during pregnancy. Routine oral health assessments by a dentist were also infrequently recommended (28%). These data indicate a need to promote the practices of oral health screening and referral for preventive and restorative

dental services among perinatal care providers. In addition, there is a need to provide resources that assist in facilitation of referrals.

As a first strategy, the MDHHS oral health program plans to model an evidence-based educational program utilizing the current Smiles for Life curriculum along with peer-reviewed materials selected by medical and dental partners. This comprehensive training course will be taken statewide to educational institutions, community clinics, FQHCs and hospitals.

For the second strategy and as part of the curriculum and educational model, standardized pre and post-tests will be utilized to evaluate effectiveness.

Objective E: By 2020, increase by 10 percent the number of pregnant women and infants receiving oral health care services. In 2013, MDHHS analyzed data from the 2004-2008 Pregnancy Risk Assessment Monitoring System (PRAMS) surrounding the oral health needs of pregnant women. Participants were asked whether they “needed to see a dentist for a problem” during their most recent pregnancy. Over one quarter of women reported that they needed dental care during their pregnancy. Of the women who needed care, 58.4% sought dental care during their pregnancy while 41.6% did not seek dental care. Unfortunately, in 2012, only 3.6 % of Michigan’s Medicaid-eligible children under the age of two received an oral health evaluation.

Together with a variety of medical and dental professionals and other stakeholders, MDHHS will develop and market the Perinatal Oral Health Guidelines as the first strategy to increase the number of pregnant women and infants receiving oral health care. These guidelines will create a unifying voice that emphasizes the importance of perinatal oral health to perinatal care and

dental providers. The guidelines will provide state-specific resources and tools; provide a summary of the issues surrounding perinatal oral health; and promote the consistent delivery of medical and dental services.

In the second strategy, MDHHS will develop and distribute promotional and education materials that promote dental visits both during pregnancy and infant oral health to health entities across the state. These materials will be developed in partnership with stakeholders and distributed to LHDs, FQHCs, WIC clinics, dental offices, medical offices (including obstetric providers) and other important entities.

For the final strategy, MDHHS has already developed and begun implementing a multifaceted communications plan, using a core message document to standardize communication efforts across the state. Communications began in the fall of 2014, when MDHHS began broad-scale messaging of a trial perinatal oral health public service announcement that informs mothers about caries transmission and encourages them to see a dentist. MDHHS will continue to expand communication efforts to reach pregnant women across Michigan through the use of large-scale messaging as well as educational materials created in partnership with maternal and child health entities.

Cross-Cutting/Life Course Annual Report

The following performance measures and the related data trends, program summaries, successes, and challenges address the **Cross-cutting/Life Course** population domain for FY14 reporting.

NPM 9: Percent of third grade children who have received protective sealants on at least one permanent molar tooth

Data Trends: Last year, just over 30% of third grade children (33,681 of 111,321 children) received protective sealants on at least one permanent molar tooth according to provisional data. For the fourth consecutive year, the annual performance objective (30% for FY14) for this NPM was met.

FY14 Program Summary: The SEAL! Michigan program continues to see a steady increase in the number of local programs as well as the number of children seen for a preventive dental visit. The program began in 2007, under a pilot with one funded program. The program continues to expand and now has ten funded programs and two self-sustaining programs that deliver services in 21 (one of every four) Michigan counties. In FY14, SEAL! Michigan was delivered in 121 schools and screened 5,145 unduplicated students. The program requires a positive parental consent for students to receive oral health education, dental screening, dental sealants and fluoride varnish, which is a preventive service to decrease dental decay.

Program Successes: Several local programs have been in continuous operation for a number of years. The longer a program is in operation, the more cost-effective the program becomes and the more the program grows internally (in terms of both the number of schools and the number of students seen within those schools). As program costs decline, additional programs are launched around the state. The CDC continues to support a 1.0 FTE dental sealant coordinator position; funding from HRSA and Delta Dental have allowed for program expansion as well.

Program Challenges: In FY14, Michigan experienced an unusually harsh winter which resulted in service delivery barriers throughout the state due to school delays, cancellations, and subsequent rescheduling challenges at mutually convenient times for both the program and the schools. Since programs book their schedules a year out, rescheduling under these extreme circumstances posed a challenge. To address the issue, many programs were able to work into the summer months to deliver services in unique settings such as summer childcare programs and health fairs.

NPM 13: Percent of children without health insurance

Data Trends: The proportion of children aged 0-17 without health insurance in Michigan is 4.0% and remains unchanged from the prior year; but represents a significant decrease of 1.2% from 2008. Older children and adolescents aged 6-17 were more than twice as likely to be uninsured compared to children under 6 years of age (6.0% and 2.4% respectively). According to the 2013 American Community Survey (ACS) 5-year estimates, the greatest *number* of uninsured children reside in the large urban counties of Wayne, Oakland, Macomb, and Kent. However, the greatest *proportion* of uninsured children reside in low-income rural counties with relatively high unemployment rates including Oscoda, Gladwin, Mackinac, and Hillsdale (19.9%, 16.4%, 13.1%, 11.9% uninsured, respectively).

Among Michigan children with health insurance, 53.2% rely exclusively on employer-based coverage. Medicaid and other means-tested coverage represented the next largest single source of insurance for children (35.7%), followed by direct-purchase insurance (3.9%), TRICARE/military health coverage (0.4%), Medicare (0.1%), and VA health care (<0.1%). An

additional 6.7% of insured children reported more than one type of health care coverage. There has been a slight increase in the proportion of children covered by employer-based insurance, reversing a downward trend since 2009.

Additionally, African-Americans and Hispanics are more likely to be uninsured than Whites.

Families with children are more likely to be uninsured than those without children. Still, children under age 18 make up only 8% of Michigan's uninsured population.

FY14 Program Summary and Successes: In a larger context, enrollment in the Healthy Michigan Plan (HMP), Michigan's Medicaid expansion plan for adults, and the Health Insurance Marketplace (Marketplace) greatly influences the proportion of uninsured, making the percentage of uninsured a moving target. The HMP is available to those at or below 133% of federal poverty level, and the Marketplace to those above 133%. Initial projections indicated that within five years of Affordable Care Act implementation, the percent of uninsured would drop by more than half. With enrollment exceeding expectations in both the HMP and the Marketplace, those projections will likely be modified. Michigan began accepting applications for the HMP on April 1, 2014, and reached its initial enrollment goals eight months early. Across Michigan, roughly 75% of those eligible are estimated to be enrolled in the HMP. Between the HMP and the Marketplace, Michigan insured over 700,000 people in less than a year. Children under 18 may qualify for MI-Child (the Michigan Children's Health Insurance Program for children whose parents lack insurance) or for Healthy Kids (which provides health care coverage for qualifying pregnant women, babies and children under age 19).

Local health departments (LHDs) and other entities (e.g., FQHCs, school-based/school-linked health centers, “free” clinics and Health Plans) continue to conduct outreach and enrollment activities across the state. Several public and private initiatives exist to expand the number of Navigators and Certified Application Counselors (CAC) available to assist in identification of and enrollment in an appropriate health insurance plan. MDHHS issued an RFP to LHDs, FQHCs, free clinics and others to facilitate Navigator and CAC training. CAHCs (school-based/school-linked health center programs) also incentivized these same trainings with grantees in an effort to strengthen existing, required outreach and enrollment activities.

NPM 15: Women who smoked in the last three months of pregnancy

Data Trends: The percentage of women who smoked in the last three months of pregnancy has been slowly declining over the past six years. Preliminary 2014 data suggest 14.8% of pregnant women smoked during the last trimester, representing a 2% decrease since 2009 and which meets the annual performance objective for the first time.

FY14 Program Summary: Michigan addresses prenatal smoking cessation as part of perinatal health and overall population smoking cessation efforts. The Smoke Free for Baby and Me (SFBM) online course is a provider training program on assessment and counseling of prenatal smokers, and is required for all Maternal & Infant Health Program providers statewide. SFBM addresses the risk of smoking tobacco in pregnant women and mothers of infants in order to decrease the percentage of women who smoke during and after pregnancy, and exposure of tobacco smoke to their infants and other children in their homes. In FY14, 620 individuals viewed the program, and 427 were awarded a certificate of completion.

Previous smoking cessation efforts will continue in the coming year. Funds are allocated for course updates and to include social work and nurse certification for the first time.

SPM 10: Ratio of the percent of minority population eligible for publicly-funded health programs to the percent of White, non-Hispanic population eligible for publicly-funded health programs

Data Trends: The ratio of the percent of the minority population eligible for publicly-funded health programs to the percent of White, non-Hispanic population eligible for publicly-funded health programs increased from 2.1 in 2013 to 2.5 in 2014. The percentage of eligible minorities slightly increased (by 1.1%, from 38.8% to 39.9%) whereas the percentage of eligible White, non-Hispanics decreased (by 2.8 %, from 18.6% to 15.8%). This movement in an undesirable direction represents a disparity between the proportion of minorities and Whites needing Medicaid. It is likely an indicator of greater economic improvements for Whites versus minority populations. The increase in the percentage of Medicaid-eligible minorities may indicate an increase in unemployment among minorities. In 2013, the overall unemployment rate for Michigan was 8.6%. However, the rate was 7.4% for Whites as compared to 16.5% for African Americans and 13.0% for Hispanics. In prior years, African-Americans consistently experienced more than double the unemployment rate than Whites.

FY14 Program Summary: In April 2014, Michigan began accepting applications for the HMP which provides low-income residents access to affordable health care coverage. It is plausible that there were increased efforts to enroll minorities because, as noted earlier, African-Americans and Hispanics are more likely to be uninsured than Whites; in part due to higher

unemployment rates in these populations. MDHHS will also want to examine if eligible Whites in Michigan are aware of the HMP and, if eligible, are enrolling in the plan in anticipated numbers.

MDHHS works with LHDs to provide Medicaid outreach in local communities. Additionally, the Michigan Medicaid office has implemented strategies to improve post-partum visits for Medicaid patients in southeast Michigan, which has the highest minority population in the state. This effort may have also increased the number of minorities who were enrolled in Medicaid.

Program Successes: MDHHS has engaged in the Practices to Reduce Infant Mortality through Equity (PRIME) initiative where staff's knowledge and understanding of social determinants of health (e.g. employment) and equity has increased, based on evaluation results. Several maternal and child health state staff and local partners have already developed health equity plans while others will develop plans within the next year. These plans will guide the Department to develop programming and policy to better serve all populations in Michigan.

II.F.2. MCH Workforce Development and Capacity

As part of planning for the next five-year cycle of the Title V MCH Block Grant, Michigan will focus workforce development efforts on strengthening state-level staffing infrastructure across key areas of Maternal and Child Health (MCH) relative to this grant. Historically, Michigan has used very little Title V funding for state-level infrastructure and support, dispersing the majority of funding to local health departments (LHDs) and providers to support local infrastructure and service delivery. This has left MDHHS struggling to find appropriate funding to maintain and grow its staff infrastructure across key positions such as administrative/program support, epidemiology and data analysis. With this next five-year funding cycle, Michigan will plan carefully to fulfill two major goals: maintain the MCH local delivery system and infrastructure and utilize Title V funding to maintain and expand state MCH staffing infrastructure. This shift will happen gradually to ensure that no disruption of service or loss of capacity occurs.

Over the next six months, 2.0 full-time positions will be established within the Division of Family & Community Health to provide strategic guidance and technical support for the MCH Block Grant across the women, perinatal/infant, child, adolescent and cross-cutting/life course population domains. The first position will be housed within the Child and Adolescent Health Systems Unit located in the Child, Adolescent and School Health Section. This public health consultant position will be administratively responsible for the oversight and coordination of MCH services funded by and/or in alignment with objectives within the MCH Block Grant. This position will provide leadership and strategic guidance in meeting programmatic and fiduciary responsibilities of this grant; and will be responsible for implementing a continuous quality

improvement framework, monitoring key outcomes and impacts on state MCH priorities and objectives.

A second departmental specialist position will be established to work with the Division's administrative team to coordinate special projects associated with maternal and child health activities and initiatives supported by Title V. This position will also help streamline reporting, assist in data collection efforts, assure that staff orientation and ongoing training is inclusive of knowledge and skills needed to support MCH goals and outcomes and support the Division Director in community capacity and infrastructure development as needed to support Title V requirements and outcomes. It will assist in assuring that the fiduciary and contract obligations are met across the DFCH relative to Title V. Another anticipated shift is the move of one Title V-funded, full-time contractual position (working on the lead program) to a designated civil servant position. MDHHS also plans to support part of an epidemiologist position to assist with data collection/analysis and creation and analysis of additional performance measures.

MDHHS has made substantial growth in the areas of integrating life course theory into its structure and MCH related work; engaging in meaningful trainings and practical application of health disparities and health equity and how they manifest in populations served through MCH; continuous quality improvement efforts in home visitation programs and Child and Adolescent Health Centers; and foundational professional development in Motivational Interviewing. However, there is still a need for further advanced professional development and training in all of these key areas as well as cultural competence, social justice, application of an upstream approach to all aspects of work, and outcome/impact-based work.

II.F.3. Family/Consumer Partnerships

The MCH service recipient (whether a family or individual infant, child, adolescent or adult) is at the center of all plans, policies, programs and initiatives that the Michigan Department of Health & Human Services (MDHHS) undertakes. Service recipients are central to the Department's continued commitment to patient and family-centered care. Their input is used to identify and address unique population needs. Understanding their issues and challenges helps MDHHS choose the best means of accomplishing the steps required to equitably minimize or eliminate challenges and service barriers. MDHHS respects the dignity of each individual and their respective culture, language, customs and beliefs, and considers these factors in program development and service provision.

Examples of the roles of service recipients in programs funded or impacted by Title V are plentiful. Families and consumers are represented in strategic planning initiatives for the reduction of infant mortality and fetal alcohol disorders. They are instrumental in the development of material and guidelines for Oral Health, Family Planning and other programs.

As members of advisory committees for Oral Health, Family Planning, Child and Adolescent Health Centers, maternal and child home visiting programs, they provide valuable insight into the needs and priorities of their respective population groups. Program development is enhanced with specific insight into the various populations affected when consumers and families play an expanded role in the direction and development of services and policies.

A specific example of how family and consumer partnerships are fostered is within the Early Hearing Detection and Intervention (EHDI) program through use of Michigan Hands and Voices Guide By Your Side™ (GBYS) program. GBYS gives families who recently learned of their child's

hearing loss an opportunity to meet with another parent of a child who is deaf or hard of hearing. Families are also involved in updating EHDI materials, which are available in Spanish and Arabic. In an effort to assure cultural and linguistic competence, the EHDI program formed a partnership with Wayne Children's Healthcare Access Program to establish an EHDI Program Specialist position to provide assistance to families with babies who do not pass an initial hearing screen. The EHDI Specialist, who speaks Arabic, works extensively with families in the Detroit/Wayne County area, which has a significant Arabic population. Efforts to promote health equity through the EHDI program include diverse parent representation on advisory committees and a family-focused conference for families of children who are deaf or hard of hearing.

Another example that demonstrates parent and caregiver involvement is the Michigan Infant Safe Sleep State Advisory Committee. Currently, three parents are involved. Parents and caregivers are also involved in advocacy projects including sharing their stories by speaking at public events and creating videos for use in trainings so that professionals, parents and caregivers can understand the importance of this issue from the perspective of those who have lost infants. The program currently funds 13 local health departments (LHDs) and the Inter-Tribal Council to develop and implement community-based infant safe sleep education, awareness and outreach activities. The LHDs are chosen because they are located in counties with high numbers of Sudden Unexpected Infant Deaths (SUID). Overall, these counties also experience significant racial disparity in the number of deaths among Black infants compared to the number of deaths among White infants. The Inter-Tribal Council of Michigan is funded because of the historically high SUID rate among Native American babies.

Many LHDs involve parents and caregivers in their mini-grant funded activities as parent educators, speakers and outreach workers. When revising and/or developing educational materials, parent and caregiver input is a valued component of the process, both in terms of obtaining the parent and caregiver perspective and from a cultural and linguistic competence standpoint. The results of parent and caregiver focus groups are taken into account while developing materials and programming.

The MDHHS (Division of Family and Community Health, Early Childhood Health Section) coordinates and is the fiduciary for the Parent Leadership in State Government (PLISG) initiative. PLISG is an interagency effort designed to recruit, train, and support parents so that their voices can help shape programs and policy at the local, state and federal level. Since 2007, several state agencies have collaboratively funded the PLISG which is directed by the Parent Leadership Advisory Board. The Board includes representatives from each of the public state agencies providing funding support, the Early Childhood Investment Corporation and parent representatives who have received services from the funding agencies and/or are in leadership positions within those agencies. At least 51 percent of board members must be parents of children ages 0-18 who have been or are eligible to utilize specialized public services (health, disability, social services, special education, early childhood intervention, mental health, etc.). A primary role of the PLISG is to provide the “Parents Partnership for Change” leadership training which targets any family whose child is using specialized services. The parent training is based on the following competencies: participants will have an understanding of their own leadership direction; participants will have the ability to be an effective partner and exhibit leadership when working alongside professionals; and participants will understand and have

the ability to advance cultural competence. To date, over 830 parents from across the state have participated in the training. Approximately 45% of the participants report involvement in MCH programs. Out of the training alumni, 87% report that they are better leaders as a result of the training; 60% report that subsequent to the training, they are involved in “just the right amount” of leadership activities; and 73% have encouraged other parents to attend one of the trainings.

Michigan’s Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants have also integrated parent and caregiver involvement. MIECHV patterned its approach to parent involvement on previous state-level collaboration with parents for Part C, local Great Start Parent Coalitions, and Project LAUNCH, integrating policy and procedures around parent involvement into the home visiting work. MIECHV communities receive funding to convene a home visiting Local Leadership Group (LLG), which is connected to their existing local Great Start early childhood collaborative. The LLGs are comprised of representatives from across Head Start, Substance Abuse, Child Abuse and Neglect Councils, Public Health, Mental Health, Education (including Part C), Great Start staff, and parents whose children have participated in evidence-based home visiting programs. Parents are included to assure that the consumer voice is part of local program decision-making and policy development. All of the parents on the LLGs are graduates of the Parent Leadership in State Government training.

Because some LLGs are less successful in recruiting and including parents, during 2015 the LLGs are engaged in a Learning Collaborative in which they are using CQI to enhance parent involvement. For the communities that already have active parents, those parents are highly valued members of their CQI teams and serve as a resource to other communities. In 2016, the

LLG Learning Collaborative will shift to focus on supporting home visiting programs with outreach, enrollment and retention; parents will once again be critical members of the local CQI teams.

Parents who participate on the LLGs are also invited to a quarterly parent-specific learning community, which provides an opportunity for mutual support, sharing of information and ideas and skill development. Participants from the parent learning community presented a workshop at the 2014 Michigan Home Visiting conference about working with families, which was so highly regarded that they will be presenting the opening keynote for the 2015 conference.

Finally, Children's Special Health Care Services (CSHCS) utilizes a multifaceted approach to ensure that services reflect the needs of the population served. A critical component to administering meaningful and appropriate services is the involvement of families of children with special needs in the decision-making process. To achieve this goal, CSHCS works closely with the Family Center for Children and Youth with Special Needs (Family Center) and the CSHCS Advisory Committee (CAC). Additionally, CSHCS participates in workforce development opportunities that aim to increase the cultural competency of its workforce.

The CAC is comprised of professionals and family members who are involved in the care for children with special needs. The CAC makes recommendations to the CSHCS Division on policy and promotes awareness to assure that services reflect the voices of individuals with special health care needs and their families. The primary responsibilities of the CAC are to support and maintain clarity of the mission, philosophy and service goals of CSHCS; promote public

awareness of the CSHCS program in the community; and to identify strengths and gaps in the services provided to children with special needs in the state of Michigan.

In order to assure that the diversity of the community is reflected in the CAC's membership, CSHCS has recently conducted an analysis of its membership, comparing membership to the demographics of the populations served. The findings led to collaborative efforts between the CAC and CSHCS to strategically seek new members that will strengthen the voice of families with children with special needs in marginalized communities.

In addition to the CAC, the Family Center provides families with an even greater opportunity to contribute to CSHCS's programs and policies. The Family Center's primary purposes are to help shape CSHCS policies and procedures and to help families navigate the systems of care for children with special needs. Through its Family Support Network of Michigan, the Family Center also provides emotional support and information to families of children with special health needs. One of the ways the families can access Family Center support is through the Family Phone Line, which is a service provided to any family that has a child with special needs. The Family Phone Line assists families in navigating the systems of care; finding additional resources at the national, state, and local levels; and connecting parents through the parent-to-parent support network.

By assisting families across Michigan, the Family Center remains connected and updated on challenges that families with children with special needs encounter. This allows the Family Center to advocate for families and helps inform CSHCS on emerging issues and trends. This information is invaluable in helping CSHCS remain responsive to families' needs in an ever-changing health care landscape.

The Family Center is centrally located within the same offices as CSHCS, allowing staff to remain integrally involved in the planning and implementation of CSHCS programs and initiatives. The Family Center provides input from a family perspective on all CSHCS policies, correspondence to families, and major initiatives that involve CSHCS. In addition, the Family Center staff review and contribute to the Title V Block Grant every year.

Additionally, the FY 2016 Title V application needs assessment process that drove the selection of our strategic priorities embraced consumers and families—especially those representing populations where the largest health disparities exist. The application will be posted on the MDHHS website, and our partners across the state will be informed so that consumers, communities and advocacy organizations can review and make comments or suggestions. The next five years will see more focus on inclusion of consumers and families who are the service recipients, as these engaged individuals have a vital role in improving the quality of care and services that MDHHS provides or oversees.

II.F.4. Health Reform

Supporting Health Reform Efforts: MDHHS, as the agency that oversees Michigan's Title V Maternal and Child Health Block Grant, actively supports health care reform efforts. Affordable Care Act (ACA) coverage expansions provided Michigan consumers with two new options: the Healthy Michigan Plan (HMP) and the Health Insurance Marketplace (Marketplace). In January 2014, eligible individuals who were above 133% of the Federal Poverty Level could enroll in private health insurance coverage through the Marketplace. In April 2014, Michigan expanded its Medicaid program to cover residents aged 19-64 who were at or below 133% of the Federal Poverty Level, and who were not previously eligible for traditional Medicaid. Between the HMP and the Marketplace, Michigan insured over 700,000 people in less than a year, far exceeding initial enrollment expectations. Outreach and enrollment assistance efforts were implemented by Children's Special Health Care Services (CSHCS), local health departments (LHDs) and others including Child and Adolescent Health Centers (CAHCs) and Federally Qualified Health Centers. Michigan has entered into a cooperative agreement with the Center for Medicare and Medicaid Innovations to test the State Innovation Model (SIM) for health care payment and delivery system transformation. The final product of the SIM grant planning process, the Blueprint for Health Innovation, will guide the state as it strives for better care coordination, lower costs and improved health outcomes. This Blueprint will focus on transforming service delivery and payment models by concentrating on patient-centered medical homes and integration among health care and community resources.

Service Provision to Advance ACA Implementation: Multiple maternal and child health (MCH) programs and services advance ACA implementation while filling gaps that are not specifically addressed in ACA or that require supplemental services. While not an exhaustive inventory, the following summarizes examples of such programs and services.

The Division of Family and Community Health (DFCH) addresses infant mortality in part by focusing on improving the health of mothers, during both pre- and inter-conception. This is done by increasing access, knowledge and availability of health care information and services. The Maternal & Infant Health Program is integral to meeting this goal. This program serves Medicaid pregnant women and infants with assistance to services, education and support by home visits conducted by Registered Nurses and Licensed Social Workers. DFCH has expanded evidenced-based home visiting programs throughout the state through its Maternal, Infant and Early Childhood Home Visiting Program. DFCH also works with hospitals, healthcare providers and communities to promote good birth outcomes through the development of a strong and vibrant perinatal system of care, including improved perinatal risk identification and risk-appropriate care.

While the need for family planning services has remained steady, women now have more options to receive services through their primary care provider as the result of changes in ACA. However, there still remains a need for publicly-funded family planning services, which are provided by Title X, for at-risk youth as well as for women of all ages to obtain certain services and contraceptive methods.

CAHCs provide school-aged children and youth with primary care, mental/behavioral health and other services in or very close to schools, regardless of insurance coverage or ability to pay. CAHCs are critical care access points for Michigan's most vulnerable youth. Medicaid beneficiaries may be assigned providers who are too far away to access easily. Regardless of coverage type, co-pays and deductibles can be cost-prohibitive to seeking care in other settings.

The ACA addressed private insurance access barriers for Children and Youth with Special Health Care Needs (CYSHCN) by eliminating exclusions for pre-existing conditions and annual and lifetime dollar benefit limits; prohibiting discrimination based on health status; permitting dependent coverage continuation for ages 19-26; and guaranteeing access to and renewability of policies. In this context, coverage, services and CSHCS support to CYSHCN have continued to be a significant resource in the following four areas of family-identified needs:

- 1) Family costs for deductibles, co-payments and premiums can be substantial even with premium tax credits. Deductibles vary by policy from modest dollar amounts to a very high percentage of total family income. For CYSHCN children, CSHCS enrollment increases access to specialized care and services and reduces the family's risk of financial hardship, as well as the stress associated with being unable to meet a child's needs for care. CSHCS and LHDs work closely with families to understand the ways CSHCS interfaces with private insurance and can reduce costs for deductibles and cost-sharing.
- 2) Insurance policy benefits vary widely, and not all policies are mandated to include the ACA's ten Essential Health Benefit categories. CSHCS enrollment can provide access to and

financing for relevant specialty care when either no benefit exists or when a limited benefit is exhausted.

- 3) Transitions in insurance coverage occur more frequently because more individuals are enrolled in private insurance after the ACA. These changes can have significant impact on CYSHCN care whether due to a change in employer coverage, a job change or an income change resulting in transition to or from Medicaid eligibility. Each change can result in provider and specialist changes, benefit and payment variations, the need for new prior authorization processes, and challenges to continuity of care for the family. Families identify these changes as stressful. LHD nurses serve a significant role in helping families complete the needed steps, and work with families to achieve continuity of care and address concerns related to changes in the system of care.
- 4) Some CYSHCN require in-home services and supports to meet their health care needs. LHD nurses refer and coordinate with Community Mental Health agencies in the family's county of residence and with other community partners to identify all available options for such additional services. Historically, the publicly-funded sector offers in-home supports that would not be considered medically necessary by private insurers.

Cultural and Linguistic Competence and Promoting Health Equity: The Practices to Reduce Infant Mortality through Equity (PRIME) initiative developed and piloted the first Health Equity Learning Labs with WIC staff with a goal of incorporating equity thinking, perspectives and action into daily work responsibilities. CSHCN staff and local partners participated in a second iteration of the Learning Labs. Separate labs were developed for managers across MDHHS. The Learning Labs focused on 1) fostering institutional change to develop policies and procedures

that always promote and never inhibit health equity; and 2) incorporating equity thinking, perspectives and action into daily work assignments and responsibilities. PRIME also disseminated Michigan's first Health Equity Status Report with data for 14 indicators (psychosocial, socioeconomic position, basic needs, health care access) related to the social context in which women and children live. These data are regularly updated to monitor progress toward achieving health equity.

The Health Disparities Reduction and Minority Health Section (HDRMHS) was awarded a grant by the HHS Office of Minority Health to adopt and implement culturally and linguistically appropriate standards, leading to the "Developing Culturally and Linguistically Appropriate Services through the Lens of Health Equity" workshop with MDHHS staff and local partners. HDRMHS funds agencies under the Capacity Building Grant Program, representing over 100 local organizations. Each lead agency must strengthen broad community partnership and each grantee must address some aspect of racial and ethnic health disparities. HDRMHS also developed a Health Equity Toolkit to increase community and professional awareness around health and racial equity.

Finally, MDHHS Human Resources hiring questions now include a question on health equity which is utilized in multiple MDDHS divisions including DFCH. MDDHS developed managerial annual performance evaluations that include a measure related to inclusion of equity work or addressing disparity in their respective program areas.

II.F.5. Emerging Issues

Adolescent Health

One of the key factors in increasing adolescent preventive medical visits is assuring adolescents have access to care. While insurance coverage with preventive service benefits is critical, adolescents need places they can go to receive care, preferably a routine primary care provider. Over the past several years, new HRSA funding has led to the creation of new Federally Qualified Health Centers (FQHCs) and expanded services in existing FQHCs in Michigan. (Such funding includes \$5.1 million granted in early 2015 that will allow for access to 29,000 new patients of all ages across the state.) The Child and Adolescent Health Center program (school-based/school-linked health centers), which provides a full-range of adolescent primary care services, has also recently expanded by 20% to a total of over 70 centers. These access points provide options for comprehensive care that may not otherwise be available to adolescents.

An expected benefit of increased well-care rates is increased immunization rates, as immunizations are an important part of preventive care. All medical visits, but particularly those for well-child exams, are opportunities to assess immunization status and recommend/provide needed immunizations. Only 67% of Michigan's 13-18 year olds are complete with immunizations (1 Tdap, 3 Polio, 2 MMR, 3 Hep B, 2 Varicella, 1 MCV); but that percentage drops to just 20% when HPV series completion is factored in.

While nationally, a median of 1.8% of children entering kindergarten are exempted from immunizations, in Michigan that rate is 5.9%. Michigan has the fourth highest percentage of kindergarten exemptions for one or more vaccines required for school entry, with some

individual counties experiencing rates as high as 20%. About 90% of all immunization waivers granted in the state are for non-medical reasons. Children who lag behind in childhood immunizations are also likely to lag behind as adolescents. In response, and as higher rates of unvaccinated youth lead to increased outbreak of vaccine-preventable disease, the state's Joint Committee on Administrative Rules recently approved new requirements for parents seeking immunization waivers which went into effect January 1, 2015. It is expected that this change in waiver policy would lead to a 30% increase in immunization rates in the near future. With this change in policy and with increased well-care, Michigan intends to impact immunization rates throughout the state.

Michigan (and MDDHS in particular) has increased efforts to better integrate physical and behavioral health care, especially for adolescents. While some youth may first seek medical care and then receive a referral for behavioral health services, more youth may access needed behavioral health care if services are integrated into a single setting or even a single appointment. In addition to depression and suicide, there are other emerging mental health issues of concern among the state's adolescents. The 2013 Michigan YRBS reports that Michigan high school students are more likely than their national counterparts to be 1) bullied at school (25.3% versus 19.6%, respectively); and 2) electronically bullied (18.8% vs 14.8%, respectively). When comparing the 2013 Michigan and United States YRBS Reports, these two areas are among the only four areas where Michigan risk exceeds national risk. Whether or not services are integrated, increasing comprehensive well-child exams that include age-appropriate risk assessment allows providers the opportunity to identify and determine the best treatment options for a wide range of issues affecting adolescents.

Along those lines, one adolescent risk-taking behavior on the rise that needs attention is e-cigarette use. In April 2015, the CDC reported that e-cigarette use now exceeds use of every other tobacco product. Current e-cigarette use among middle and high school students tripled in one year (2013 to 2014). While e-cigarette use was reported as the most common tobacco product used by high school students (13.4%), it was closely followed by hookah (9.4%), regular cigarettes (9.2%) and cigars (8.2%). Nearly half of students in both age groups reported using multiple tobacco products. Risk-reduction/cessation counseling by a provider trained in Motivational Interviewing, provided within the framework of a comprehensive preventive visit, complements macro-strategies designed to reduce tobacco use among youth including product and marketing regulations, enforcement strategies (e.g., smoke free laws and policies), increased pricing/taxes and media campaigns.

Finally, stakeholders are interested and engaged in pursuing ways to confidentially share pertinent electronic health record data which will provide more accurate counts on the proportion of adolescents with up-to-date well-child exams. A challenge in many health care settings is the ability to accurately determine the date of a last exam, as an adolescent may have received an exam from a different provider, but there is no way to verify the information because electronic health records cannot easily be shared across platforms, even with necessary release of information consents in place.

Children with Special Health Care Needs

Michigan currently screens newborns for more than 50 disorders. Given new testing and treatment, Michigan's newborn screening panel will expand, significantly impacting the

Children's Special Health Care Services (CSHCS) program. The recent addition of critical congenital heart disease added 12 serious heart conditions needing treatment, typically surgery, and often multiple-staged surgeries in the first year of life. Michigan recently added Glycogen Storage Disease type 2 to the panel which may identify two babies with early onset disease and seven with late onset disease each year. Treatment requires enzyme replacement therapy (ERT) every two weeks for the rest of an affected individual's life, with a number of specialists involved in their care. Mucopolysaccharidosis type I is currently under consideration. This may identify one to two newborns a year, typically treated with ERT and Hematopoietic Stem Cell Transplant (HSCT). MDHHS has been petitioned to add X-linked adrenoleukodystrophy (X-ALD), which is scheduled for advisory review later this year. Screening for X-ALD is expected to identify seven children who will need HSCT in addition to other services. These screens also identify individuals with secondary disorders in addition to many individuals in preclinical state who will need long term diagnostic monitoring. This may include, for example, aggressive monitoring for early CNS signs through frequent MRI.

With the increase in the number conditions screened in the panel, we will be able to identify and treat some rare conditions that we had not previously been able to identify or treat early. The numbers of newborns identified will be small, but the cost to treat will be potentially high, and this could further strain Michigan's CSHCS resources, given the gaps that still exist in insurance coverage.

Cross-Cutting across All Population Domains

Local health departments (LHDs) play an important part in the provision of all maternal and child health (MCH) services in Michigan, whether by directly rendering services or facilitating access to them. There are two major drivers for future MCH services within LHDs: the Affordable Care Act (ACA) and decreasing revenues from federal, state or local sources. LHDs bill for some services and are looking at expansion of these efforts as more individuals gain health care coverage.

The roles of LHDs as facilitators of access to MCH services and as navigators within this new health care environment are growing. LHDs will need to expand on their current activities of referrals for, and assisting in, obtaining coverage or services to focus on the essential public health functions for their communities—as well as on the infrastructure changes required to fulfill these roles. The state will support LHDs in their changing and broadening roles as the impact from health care reform continues, whether it is with expanded health care eligibility and access or through participation in the State Innovation Model.

II.F.6. Public Input

The Michigan Department of Health and Human Services (MDHHS) engaged an array of stakeholders, including parents and consumers, prior to and during the Title V application process. Before beginning the application, MDHHS completed a statewide five-year needs assessment to identify strategic issues and priority needs to drive creation of the five-year action plans. When determining the process to be used, the Needs Assessment Planning Committee prioritized the need to engage a diverse group of stakeholders to assess both needs and system strengths and capacity. As a result, the needs assessment workgroups (which reflected the six population health domains) included state and local MCH staff, state and local MCH system partners, parent consultants, consumers, and partners with expertise in health equity. Their input and experience directly shaped the issues and priority needs considered and included in Michigan's application.

Once the Title V application was drafted, the application was posted on the MDHHS website for public review and comment. Public input was invited through direct notification via email to advisory groups, local health departments, nonprofit partners, advocacy groups and other state programs. Stakeholders (including parents and consumers) who participated in the 2015 needs assessment workgroups received direct notification of the posting. Information was also shared through the MDHHS Facebook and Twitter pages. Public input will be shared with the Title V steering committee for review and consideration. The number and nature of the public comments received, and how they were addressed, will be included prior to grant submission.

After the application has been submitted, the Bureau of Family, Maternal and Child Health (BFMCH) will continually work with entities representing advocates, advisory bodies, providers and consumers to receive input on the programs, policies, reports and plans included in the Title V application. For example, the Children's Special Health Care Services (CSHCS) division works routinely with parent consultants through the Family Center for Children and Youth with Special Needs (Family Center) and the CSHCS Advisory Committee (CAC). The Family Center provides information and support to families and input on CSHCS program operations. A youth consultant also participates in CSHCS strategic planning and advisory meetings and offers guidance to make division materials and outreach activities more youth friendly. The CAC is comprised of professionals and family members who are involved in the care for children with special needs. The CAC makes recommendations to the CSHCS Division on policy and promotes awareness to assure that services reflect the voices of individuals with special health care needs and their families.

As another example, families and consumers are represented in strategic planning initiatives for the reduction of infant mortality and fetal alcohol disorders. They serve on advisory committees for Oral Health, Family Planning, Child and Adolescent Health Centers, Safe Sleep, Teen Pregnancy Prevention Local Coalitions, Parent Leadership in State Government, and maternal and child home visiting programs. Additionally, to implement the state's Infant Mortality Reduction Plan, BFMCH works with the Infant Mortality Advisory Council which consists of providers from hospitals and local health departments as well as partners from research institutions, professional associations, community organizations, state programs and

nonprofit organizations. These and other examples of consumer, family, and stakeholder partnership and involvement are discussed in detail in Section II.F.3. of this application.

II.F.7. Technical Assistance

Identification of potential areas of technical assistance needed from the federal Maternal and Child Health Bureau will be included in the application prior to final submission.

III. Budget Narrative

III.A. Expenditures

Please refer to budget forms in Section IV. The variance in Line Form 2 Line 1A - Preventive and Primary Care Expended Actual expenditures is a result in a change of reporting in categories within the Local Maternal and Child Health (MCH) line. The state now tracks local MCH expenditures by women and infants, Children and Children's Special Care Services. Therefore, the 2014 actual expenditures reflected that change.

The variance in Line 3, State MCH Funds, is related to the change in federal and state appropriations amounts in the Children's Special Health Care Services Line. The variance in Line 5, Other Funds is due to decreased donations to the Children's Special Health Care Services Fund.

III.B. Budget

Budget projections are completed throughout the year, based on current expenditures, to assure the 30% match requirement will be met for Preventive and Primary Care for Children and Children with Special Health Care Needs. Projections are also completed on an ongoing basis to assure we are meeting the required match and maintenance of effort. If a shortfall is projected, MCH leadership and appropriate program staff would be notified and necessary adjustments would be made.

Beginning with the 2015 fiscal year, to assure the 30% match requirement is properly accounted for, the state accounting system tracks expenditures by Preventive and Primary Care Services for all Pregnant Women, Mothers and Infants up to the age of one; Preventive and Primary Care Services for Children; and Services for Children Special Health Care Needs. In FY 2016, we plan to begin accounting for Enabling Services and Public Health Services and Systems to record expenditures related to categories in the Title V block grant.

Other funding sources that support MCH programs and services include Title X (Family Planning); Women, Infants, and Children (WIC); Medicaid; and grants from other federal sources.

IV. Forms and Supporting Documents

Form 2

**MCH Budget/Expenditure Details
State: Michigan**

	FY16 Application Budgeted	FY14 Annual Report Expended
1. FEDERAL ALLOCATION		
(Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$18,734,500	\$18,326,720
Of the Federal Allocation, the amount earmarked for:		
A. Preventive and Primary Care for Children	\$5,987,600	\$6,037,748
	(32%)	(32.9%)
B. Children with Special Health Care Needs	\$7,157,200	\$6,994,407
	(38.2%)	(38.2%)
C. Title V Administrative Costs	\$589,000	\$330,070
	(3.1%)	(1.8%)
2. UNOBLIGATED BALANCE	\$0	\$0
(Item 18b of SF-424)		
3. STATE MCH FUNDS	\$42,520,600	\$38,907,988
(Item 18c of SF-424)		
4. LOCAL MCH FUNDS	\$0	\$0
(Item 18d of SF-424)		
5. OTHER FUNDS	\$1,008,900	\$550,965
(Item 18e of SF-424)		
6. PROGRAM INCOME	\$67,996,600	\$65,101,031
(Item 18f of SF-424)		
7. TOTAL STATE MATCH	\$111,526,100	\$104,559,984
(Lines 3 through 6)		
A. Your State's FY 1989 Maintenance of Effort Amount	\$13,507,900	
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL	\$130,260,600	\$122,886,704
(Same as item 18g of SF-424)		
9. OTHER FEDERAL FUNDS		
Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS	\$309,508,839	
(Subtotal of all funds under item 9)		
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL	\$439,769,439	\$122,886,704
(Partnership Subtotal + Other Federal MCH Funds Subtotal)		

9. OTHER FEDERAL FUNDS

Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$1,530,244
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$3,074,727
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	\$200,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$175,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$120,542
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	\$327,353
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	\$98,318,100
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$6,039,658
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	\$140,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$97,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$250,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$7,275,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$190,163,631
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$430,521

Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Ryan White	\$1,057,813
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Oral Health	\$309,250

FY14 Annual Report Budgeted

1. FEDERAL ALLOCATION	\$18,086,500
A. Preventive and Primary Care for Children	\$7,028,400
B. Children with Special Health Care Needs	\$7,105,800
C. Title V Administrative Costs	\$312,700
2. UNOBLIGATED BALANCE	\$0
3. STATE MCH FUNDS	\$55,721,400
4. LOCAL MCH FUNDS	\$0
5. OTHER FUNDS	\$1,005,900
6. PROGRAM INCOME	\$66,799,700
7. TOTAL STATE MATCH	\$123,527,000

Form Notes For Form 2:

None

Field Level Notes for Form 2:

- 1 . **Field Name :** Federal Allocation, A. Preventive and Primary Care for Children:
Fiscal Year : 2014
Column Name : Annual Report Expended
Field Note :
Local MCH allocation consists of several categories related to Women and Infants, Preventive and Primary Care for Children' and Children with Special Health Care Needs. The difference between the 2014 budget and actual was related to the allocation changes between categories.
- 2 . **Field Name :** 3. STATE MCH FUNDS
Fiscal Year : 2014
Column Name : Annual Report Expended
Field Note :
Children's Special Health Care Services - Actual CSHCS expenditures for 2014 reflect changes in federal and state appropriation amounts.
- 3 . **Field Name :** 5. OTHER FUNDS
Fiscal Year : 2014
Column Name : Annual Report Expended
Field Note :
Due to decrease donations in the Children's Special Health Care Fund.

Data Alerts for Form 2:

None

Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: Michigan

I. TYPES OF INDIVIDUALS SERVED	FY16 Application Budgeted	FY14 Annual Report Expended
IA. Federal MCH Block Grant		
1. Pregnant Women	\$0	\$0
2. Infants < 1 year	\$3,453,500	\$3,369,127
3. Children 1-22 years	\$5,267,000	\$5,290,347
4. CSHCN	\$7,031,600	\$6,889,000
5. All Others	\$2,393,300	\$2,448,176
Federal Total of Individuals Served	\$18,145,400	\$17,996,650
IB. Non Federal MCH Block Grant		
1. Pregnant Women	\$2,959,600	\$3,566,591
2. Infants < 1 year	\$71,018,700	\$66,211,629
3. Children 1-22 years	\$302,500	\$336,577
4. CSHCN	\$36,893,000	\$34,140,887
5. All Others	\$352,300	\$304,300
Non Federal Total of Individuals Served	\$111,526,100	\$104,559,984
Federal State MCH Block Grant Partnership Total	\$129,671,500	\$122,556,634

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

- 1. Field Name :** IA. Federal MCH Block Grant, 3. Children 1-22 years
Fiscal Year : 2016
Column Name : Application Budgeted
Field Note :
Did not include administrative expenses on 3a
- 2. Field Name :** IA. Federal MCH Block Grant, 4. CSHCN
Fiscal Year : 2016
Column Name : Application Budgeted
Field Note :
Did not include administrative expenses on Form 3a
- 3. Field Name :** IA. Federal MCH Block Grant, 3. Children 1-22 years
Fiscal Year : 2014
Column Name : Annual Report Expended
Field Note :
Did not include administrative expenses on 3a
- 4. Field Name :** IA. Federal MCH Block Grant, 4. CSHCN
Fiscal Year : 2014
Column Name : Annual Report Expended
Field Note :
Did not include administrative expenses on 3a

Data Alert for Form 3a:

None

Form 3b
Budget and Expenditure Details by Types of Services
State: Michigan

	FY16 Application Budgeted	FY14 Annual Report Expended
I. TYPES OF SERVICES		
IIA. Federal MCH Block Grant		
1. Direct Services	\$18,090,800	\$17,782,878
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$5,135,500	\$4,898,226
B. Preventive and Primary Care Services for Children	\$5,923,700	\$5,995,652
C. Services for CSHCN	\$7,031,600	\$6,889,000
2. Enabling Services	\$374,100	\$379,799
3. Public Health Services and Systems	\$269,600	\$164,043
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$7,331,488
Physician/Office Services		\$0
Hospital Charges (Includes Inpatient and Outpatient Services)		\$0
Dental Care (Does Not Include Orthodontic Services)		\$953,481
Durable Medical Equipment and Supplies		\$0
Laboratory Services		\$92,849
Other		
Miscellaneous		\$9,405,060
Direct Services Total		\$17,782,878
Federal Total	\$18,734,500	\$18,326,720

**FY16 Application
Budgeted**

**FY14 Annual
Report Expended**

IIB. Non-Federal MCH Block Grant

1. Direct Services	\$49,796,900	\$43,875,149
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$12,870,300	\$9,621,762
B. Preventive and Primary Care Services for Children	\$33,600	\$112,500
C. Services for CSHCN	\$36,893,000	\$34,140,887
2. Enabling Services	\$61,076,100	\$60,050,822
3. Public Health Services and Systems	\$653,100	\$634,013
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$23,312,823
Physician/Office Services		\$890,417
Hospital Charges (Includes Inpatient and Outpatient Services)		\$4,193,901
Dental Care (Does Not Include Orthodontic Services)		\$140,334
Durable Medical Equipment and Supplies		\$2,050,531
Laboratory Services		\$0
Other		
Miscellaneous		\$13,287,143
Direct Services Total		\$43,875,149
Non-Federal Total	\$111,526,100	\$104,559,984

IV.D. Others Forms and Supporting Documents

All required forms and other documentation will be submitted as part of the state's final online application.