

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

Michigan

FY 2018 Application/FY 2016 Annual Report

DRAFT

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I. General Requirements

I.A. Application/Annual Report Executive Summary

Michigan's Title V Maternal and Child Health (MCH) program 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 housed within the Bureau of Family Health Services (BFHS) and works collaboratively with the Children's Special Health Care Services (CSHCS) Division which is housed within the Bureau of Medicaid Care Management and Quality Assurance. Title V funding is used to support both state and local MCH activities. At the state level, funding supports a wide range of MCH and CSHCS priorities and needs, as highlighted in this application. At the local level, funding is distributed to local health departments to meet locally-identified needs, particularly those that align with Michigan's national and state performance measures.

For 2016-2020 planning and as part of the federal Title V transformation, MDHHS leadership and a broad group of partners completed a statewide five-year needs assessment to identify preventive/primary care service needs for the MCH population in Michigan. The findings of the needs assessment were used to identify strategic issues—that is, the most critical challenges that must be addressed in order to improve the health of Michigan's MCH population. MCH leadership selected priorities from the strategic issues based on data, knowledge of Title V program capacity, and the potential to leverage Title V funding to impact MCH outcomes. For 2016-2020, Michigan's seven priority needs are:

- Reduce barriers, improve access, and increase the availability of health services for all populations
- Support coordination and linkage across the perinatal to pediatric continuum of care
- Invest in prevention and early intervention strategies, such as screening
- Increase family and provider support and education for Children with Special Health Care Needs
- Increase access to and utilization of evidence-based oral health practices and services
- Foster safer homes, schools, and environments with a focus on prevention
- Promote social and emotional well-being through the provision of behavioral health services

Across the six Title V population domains, state action plans were developed to address National Performance Measures (NPMs) and State Performance Measures (SPMs) that align with each priority need. A summary is included below, and detailed action plans can be found in Section II.F.1.

Women/Maternal Health: To address identified gaps in women’s and maternal health, the need to “Reduce barriers, improve access, and increase the availability of health services” was prioritized. The NPM “Percent of women with a past year preventive medical visit” was selected as a measure of progress toward addressing this need. Michigan has seen an increase in the use of long-acting reversible contraceptives and an increase in the percent of pregnancies that are intended. However, there have been changes in funding for family planning, gaps in provider capacity to offer long-acting reversible contraceptives, and slow uptake in the provider community around discussing reproductive life planning with clients. Therefore, the five-year

plan focuses on ensuring women have the reproductive and health care services they need to plan for pregnancy. Objectives and strategies include outreach to improve awareness of family planning clinics; increasing the use of highly effective contraceptive methods among family planning clinics; providing tools for providers to support reproductive life planning; intensifying local efforts to support health insurance enrollment; and linking women who receive family planning to primary care providers.

Perinatal/Infant Health: Two needs were prioritized to improve health outcomes in the perinatal and infant stage of the life course: “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 will be measured by two NPMs that focus on perinatal care systems and breastfeeding: “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 infant’s breastfed exclusively through 6 months.” Progress toward fostering safer environments will be measured by a SPM: “A) Percent of infants put to sleep alone in their crib, bassinet or pack and play and B) Percent of infants put to sleep without objects in their crib, bassinet or pack and play.”

Michigan has seen improvement in some key areas of perinatal and infant health (e.g., the percent of infants who are put to sleep on their backs has steadily improved). Yet progress is still needed in other areas, including the percent of VLBW infants delivered at appropriate facilities, breastfeeding rates, and the percent of infants who sleep in safe environments.

Supporting coordination and linkage across the perinatal to pediatric continuum of care is addressed via two state action plans. The first plan focuses on using quality improvement

methods to support the improvement of Regional Perinatal Care Systems; promoting the use of evidence-based programs that support positive birth outcomes such as home visiting and CenteringPregnancy; and expanding quality improvement efforts to prevent and respond to perinatal substance abuse disorder. The second plan focuses on implementing the state breastfeeding plan; increasing the number of baby-friendly hospitals; improving surveillance systems related to breastfeeding initiation, duration and exclusivity; using data and best practices to reduce the gap in breastfeeding by race; and supporting health care workers in discussing breastfeeding with pregnant and postpartum women.

To foster safer environments, Michigan is focusing on infant safe sleep. Strategies include building capacity among health departments as well as non-traditional partners to implement safe sleep education and outreach activities; developing new public messaging strategies for promoting safe sleep that are reflective of the real-life context for families; and supporting providers who work with families to have effective conversations about safe sleep.

Child Health: Two priority needs align with improving child health: “Invest in prevention and early intervention strategies, such as screening” and “Foster safer homes, schools, and environments with a focus on prevention.” Progress toward the first priority need will be measured by the NPM “Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.” Based on parent self-report, the percentage of children who have received a developmental screening has been steadily increasing. However, Michigan does not have a system for consistently measuring developmental screening at the population level aside from the National Survey of Children’s Health, which has not been available with sufficient frequency or at the local level. This gap in

the state's public health infrastructure makes surveillance of developmental concerns challenging. Michigan will focus on creation of a statewide developmental screening system, including screening and referral procedures, processes for responding to referrals, and strategies to report results to families.

Progress toward fostering safer environments will be measured by the SPM "Percent of children less than 72 months of age who receive a venous lead confirmation testing within 30 days of an initial positive capillary test." While Michigan has made progress in reducing the overall level of lead poisoning in the state, as well as the inequity between black and white children under six years of age with elevated blood lead levels, specific communities have high rates of lead poisoning. To address this priority, the state will focus on increasing the percentage of young children (with particular focus on those enrolled in Medicaid Health Plans) who receive a venous lead confirmation test; enhancing analysis of the state's surveillance data; and developing educational materials related to lead testing.

Adolescent Health: Based on needs assessment results, "Reducing barriers, improving access, and increasing the availability of health services" is a priority for the adolescent population. The NPM chosen to address this need is "Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year." Data suggest that within the adolescent population, areas of concern include healthy lifestyles, suicide, and access to care. High-quality preventive care can help address each of these challenges and build on Michigan's successes in other areas of adolescent health, such as the declining teen pregnancy rate.

The adolescent health action plan includes improving adolescent preventive visits, focusing on Medicaid eligible youth; increasing the number of providers trained on culturally-competent,

adolescent-friendly care; increasing the proportion of adolescents with a documented well child exam in Michigan's Child and Adolescent Health Centers (CAHCs); and developing a social media campaign to promote adolescent well-care and targeted health messages.

Children with Special Health Care Needs (CSHCN): To address the needs of CSHCN, MCH leadership prioritized "Increasing family and provider support and education for CSHCN" and "Reducing barriers, improving access, and increasing the availability of health services." To measure progress toward increasing family and provider support and education, 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." Progress toward reducing barriers, improving access, and increasing services, will be measured by a SPM: "Percent of CYSHCN enrolled in CSHCS that receive timely medical care and treatment without difficulty."

Although Michigan's CYSHCN system has many strengths, especially around family engagement and support, the needs assessment also identified opportunities for improvement. Too few CYSHCN have access to a medical home or transition services, and CYSHCN face barriers to accessing the services they need. Three state action plans address these issues. To increase family and provider support and education and to increase access to a medical home, Michigan will provide training and technical assistance to practices to improve their policies and practices; partner to improve systems of care; and increase families' understanding of the benefits of a medical home. To improve transitions to adult care, Michigan's plan includes expanding the use of transition planning; increasing youth and family awareness of the transition process; and increasing provider awareness of the transition process. To improve

medical services and treatment for CSHCN, the plan includes covering specialty care and treatment costs when insurance is inadequate; supporting healthcare delivery models that focus on care coordination and family partnership; expanding the use of telemedicine; and strengthening care coordination, case management, and support services provided to CYSHCN and their families through local health departments.

Cross-cutting/Life Course: Based on the strategic issues identified in the needs assessment, three cross-cutting or life course priorities were selected. Progress toward the first 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.” Both pregnant women and children lack access to dental care in Michigan. To improve access to and utilization of oral health services, Michigan’s five-year plan will expand the SEAL! Michigan program to promote dental sealants through schools; establish 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 establish a communication plan. This priority will include increasing access to oral health services for CSHCN.

Progress toward the second priority, “Promote social and emotional well-being through the provision of a continuum of behavioral health services,” will be measured by a two-part SPM: “A) Percent of high school students who report feeling sad or hopeless almost every day for two or more weeks in a row, to the extent they stopped doing usual activities during the prior 12 months and B) Percent of women who enrolled in the Maternal Infant Health Program who are

screened for depression.” Depression is a serious public health concern across the adolescent and postpartum populations. Strategies in Michigan’s plan for improving adolescent mental health include training school district personnel on issues related to social and emotional health and promoting telepsychiatry among CAHCs. To address depression in the postnatal period, Michigan’s plan focuses on expanding participation in the Maternal Infant Health Program, which provides home visits to prenatal and postpartum women, and improving the program’s approach to depression screening and referral.

Finally, progress toward the priority, “Invest in prevention and early intervention strategies, such as screening” will be measured by the SPM “Percent of children 19-36 months of age who have received a completed series of recommended vaccines and B) Percent of adolescents age 13-18 who have received a completed HPV vaccine series.” Immunization rates among some of the state’s populations have not met Healthy People 2020 objectives. In particular, the immunization rate among children 19-35 months is a concern, as is the HPV vaccination rate among adolescents. To address these priorities and boost immunization rates, MDHHS is generating letters to parents who have children or adolescents with overdue immunizations; working with local providers and health departments to access immunization data to implement quality improvement efforts; and partnering with the MDHHS Cancer Program.

II. Components of the Application/Annual Report

II.A. Overview of the State

Principal Characteristics of the State

Michigan's Title V Maternal and Child Health (MCH) program operates within the larger context of public health services as articulated by the mission of the Michigan Department of Health and Human Services (MDHHS) to provide opportunities, services, and programs that promote a healthy, safe, and stable environment for residents to be self-sufficient. Following the 2015 merger of the Department of Community Health and the Department of Human Services, additional changes were made within the Population Health Administration (PHA) in 2016. Within the PHA, administration of Title V now resides in the newly formed Bureau of Family Health Services (BFHS) which houses the Division of Maternal and Infant Health, the Division of Child and Adolescent Health, the Division of Immunization, and the Women, Infants and Children (WIC) Division. The Children's Special Health Care Services (CSHCS) Division, which is housed in the Bureau of Medicaid Care Management and Quality Assurance within the Medical Services Administration, serves as the Title V CYSHCN program and is active in Michigan's Title V leadership.

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, public health preparedness 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 9,928,300 (July 2016 Current Population Survey). Michigan has seen a steady decrease in birth rates over the past 20 years, including a decline in teen births. 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 22% are age 0-17 and 78% are age 18 and over. According to 2015 U.S. Census Bureau data, Michigan's population is 79.7% White (with 75.6% identifying as White alone, not Hispanic or Latino), 14.2% Black or African American, 3.0% Asian, 2.3% two or more races, and 0.7% American Indian and Alaska Native. Out of the total population, 4.9% identify as Hispanic or Latino.

Michigan's economy has seen significant improvements over the past eight years, with the seasonally adjusted unemployment rate decreasing from 14.9% in June 2009 to 5.3% in February 2017. The median household income in Michigan in 2014 was \$49,576 (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 January 2017, Detroit's unemployment rate was 12.3%. Additionally, according to the updated 2017

ALICE (Asset Limited, Income Constrained, Employed) report, the majority (62%) of jobs in Michigan are low wage jobs, paying less than \$20 per hour; out of those jobs, two-thirds pay less than \$15 per hour.

Poverty has also remained a significant problem, especially for Michigan's children. According to Kids Count in Michigan (2017), there has been a 15% increase in children living in poverty since 2008. Overall, 22.2% of children (ages 0-17) live in poverty. Of additional concern are findings from the original 2014 ALICE report which found that even in households with earnings *above* the federal poverty level (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.

Given this environment, family support programs continue to be an important source of assistance. In FY 2015, an estimated 1,571,344 persons participated in Michigan's Food Stamp Program (USDA). In 2016, 32% of pregnant mothers enrolled in WIC during their first trimester; in 2015, 52.9% of babies born in Michigan were enrolled in WIC. Out of WIC families, 88.6% live at or below 150% of the FPL.

Agency Priorities and Title V Program Roles

The Title V program is administered by the Bureau of Family Health Services (BFHS) in coordination with the CSHCS Division. BFHS supports the MDHHS vision to develop and encourage measurable health, safety and self-sufficiency outcomes that reduce and prevent risks, promote equity, foster healthy habits, and transform the health and human services

system to improve the lives of Michigan families. Activities include funding local health departments for maternal and child health needs; supporting state MCH programs and projects; development and promotion of best practices; and program evaluation to provide quality, accessible, culturally-competent services.

Within Michigan's MCH work, the life course framework recognizes that health outcomes are the product of the complex interplay over time between an individual and his/her environment; the framework emphasizes that early life experiences and exposures can have a lasting impact on health and development. While MDHHS divisions concentrate on their respective phase of the life course, they also coordinate, complement and build on adjacent life stages. One component of the life course perspective is redefining key health outcomes and performance measures to align across the lifespan. BFHS is finalizing an integrated set of key health outcomes that align with the life course perspective. BFHS also collaborates with CSHCS as infant, child and adolescent health issues also impact Children and Youth with Special Health Care Needs (CYSHCN).

MDHHS is committed to achieving health equity 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 and preventable. 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 the former Bureau of Family, Maternal and Child Health, as well as local public health, to support shared goals and collective impact.

A key MDHHS initiative is to eliminate 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 recommended a set of strategies to address the multiple, complex causes of IM, including social determinants of health. The plan emphasized collaboration between government, health care providers, LHDs, universities, professional organizations, businesses and community leaders. In 2015, MDHHS updated the [infant mortality reduction plan](#) for 2016-2019 with an increased focus on achieving health equity and eliminating racial and ethnic disparities. Additionally, in 2015 MDHHS released the *Practices to Reduce Infant Mortality through Equity (PRIME): Guide for Public Health Professionals*. The guide was shared with state and national stakeholders and is a resource for transforming public health through equity education and action.

Early childhood system building has also been central to BFHS. Governor Snyder 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. BFHS collaborates 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 has been Michigan's federal Early

Childhood Comprehensive Systems grant. Through the grant, Michigan worked across systems to build a trauma-informed approach into programs and services for young children, with a focus on the mitigation of toxic stress. 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 services that align with the needs of families.

Health Care Reform

Since becoming law in 2013, the Affordable Care Act (ACA) has significantly impacted how health care is accessed and delivered. MDHHS is monitoring current activities related to the possible repeal and replacement of ACA or other changes to health care access and delivery. To date, health care reform efforts via ACA have changed health care delivery and the scope and breadth of services provided, which has 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 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, exceeding initial enrollment expectations.

As of March 2017, nearly 664,000 beneficiaries had HMP coverage alone. HMP benefits include preventive/wellness services, chronic disease management, prenatal care, oral health and family planning services. Most HMP beneficiaries are required to pay some level of cost-sharing

in the form of monthly contributions and co-pays based on income. Some populations are excluded from cost sharing, such as individuals enrolled in CSHCS, under 21 years of age, pregnant women, and those with no income. Enrollees who complete a health risk assessment and agree to maintain or address healthy behaviors, as attested by their primary care provider, are eligible for cost-sharing reductions or other incentives.

For 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 approximately 700 individuals who are dually enrolled in 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 often 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 helps to limit 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.

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. In FY 2016, Michigan's Home Visiting Initiative served 1,963 families, with 740 pregnant women and 1,494 children among its clients.

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 three years, the number of Federally Qualified Health Centers (FQHCs) grew as additional centers were funded and look-alike sites were approved. Michigan now has over 250 delivery sites providing care to more than 615,000 patients annually. Of those served, approximately 34% are children less than 18 years old.

In addition to ACA, 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-centered medical homes and integration among health care and community resources. During the SIM

test design process, stakeholders committed to the goals of better health, better care, and lower costs. While the model is being tested and continues to evolve, these goals and associated metrics will also evolve to better reflect what is occurring on the ground and other external factors. Current milestones include evaluating and selecting the five SIM regions, identifying backbone organizations for the regions, designing an evaluation plan, hosting statewide webinars for participants and stakeholders, and executing Collaborative Learning Network design and planning.

Factors that Impact Health Services Delivery

While many strengths and opportunities are being leveraged to support and expand Michigan's MCH infrastructure and delivery system, significant competing factors will also receive attention through 2020. A significant competing factor facing MCH is the complexity of fully embracing an upstream approach to health and wellness to impact the systemic conditions that contribute to poor health, versus paying later when health deteriorates. The reality that health begins during preconception—and that optimal health and development must occur during the earliest stages of life to improve adult health—is still not widely known by the general population and some stakeholders. 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 requiring costly and often long-term care. Among key stakeholders who work with Michigan's most at-risk families, there is a growing understanding of 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 education, adequate and sustainable income, transportation, 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 communities receive from federal, state, local and private sources can be difficult to align. A lack of stable, ongoing funding coupled with inconsistent funding priorities contributes to an inability to make long-term, sustainable changes that are based on data-driven, community-based needs.

Health care costs also impact health services delivery. Both nationally and in Michigan, health care costs are driven by 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 in rural areas. U.S. Census Bureau data indicate that there are many geographic regions in Michigan 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 Health Provider Shortage Areas, with many located in Wayne County and Detroit.

Transportation also continues to be a challenge, particularly in rural areas and 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 travel long distances with overnight stays. This requires extended time away from work/income, additional child care and other expenses.

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 in Michigan, nearly one in four Michigan children live in poverty, up from 18% in 2006. Half of these children meet the definition of living in 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. With a 30% increase over a nine-year span, 46.7% of students are eligible for free or reduced price lunches.

Michigan's current unemployment rate is 5.3% (Bureau of Labor Statistics, 2016). However, many jobs are low-wage and many Michigan residents were unemployed for long periods of time during the recession. Notably, 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.

Additionally, many workers have to take jobs that pay below the cost of living, or piece together part-time and temporary work. Thus, the long-term impact of Michigan's recession is still being felt throughout 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. Half of the state's African American children and one-third of Hispanic children live in poverty. 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 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 infants is roughly twice that of White infants. As poverty increases, IM rates also increase. At every level of poverty, the African American IM rate is higher than that of White infants. As the level of maternal education increases, IM decreases; but again, there are notable 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 monitored 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. The ratio of population to primary care providers in Michigan overall is 1240:1. However, in some rural counties the ratio was greater than 6500:1. According to Kids

Count, the proportion of children aged 0-17 without health insurance in Michigan is 3.0%. While 3.0% are uninsured, 35% are publicly insured only and another 5% are covered by both public and private payers. 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 FY 2017, state funding for MCH and CSHCS programs was appropriated through Public Act 268 of 2016 (House Bill 5294). 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. 117 of Public Act 268 of 2016, whereas CSHCS is addressed in Sec. 119. Additional MCH details are provided in Sec. 1300 – 1313. These sections identify how funding shall be used; 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 FY 2017 omnibus budget for CSHCS included criteria in Sec. 1360 for MDHHS to provide services; and in Sec. 1361, the authorization that some of the appropriated funding be used to develop and expand telemedicine capabilities.

Current and Emerging Issues

As the MCH landscape continues to shift and change, MDHHS has adapted to meet emerging needs and new challenges. Over the past several years, the health care environment has been transformed by ACA. With potentially new health care reform on the horizon, MDHHS remains committed to assuring that access to health care continues to improve even as payment systems and providers may change.

Since the fall of 2015, the Flint water crisis has been a driving issue for MCH activities in Michigan. MDHHS is extensively involved in addressing the crisis and its impacts. For example, MDHHS staff are leading efforts to increase accessibility and flexibility for case management services; expanding home visiting programs and educating home visiting stakeholders on lead testing and collaboration with case management providers; expanding school nursing and school-based health centers among K-12 public and charter schools; working with WIC clinics to support enhanced nutrition and offer blood lead testing in the WIC clinics; and providing lead and nutrition information and materials in Flint.

Other emerging issues include active surveillance and monitoring of Zika; an increase in the number of conditions included on the Newborn Screening panel and related new treatments; an increase in opioid use during pregnancy and an increase in the number of infants born with Neonatal Abstinence Syndrome; and the transition of the Maternal Infant Health Program into Medicaid Health Plans. These topics are discussed in Section II.F.5. Additionally, MDHHS recognizes that the continuum of services across the life span must align with the needs of individuals and families, and that this continuum is strengthened when it is informed by the voices of consumers (see Section II.F.3. Family Consumer Partnership). Addressing fragmentation of programs and services and breaking down silos can also improve services.

There is a particular need to build connections between behavioral health and health care systems for all populations. 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 assessment of health outcomes.

II.B.1. Five-Year Needs Assessment Summary

This section (as indicated in gray highlighter) is the original five-year needs assessment summary submitted with the FY 2016 Title V application. Per federal guidelines, this section cannot be edited in the five-year needs assessment cycle.

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 (i.e., the fundamental or critical challenges that must be addressed in order to improve maternal and child health outcomes), 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

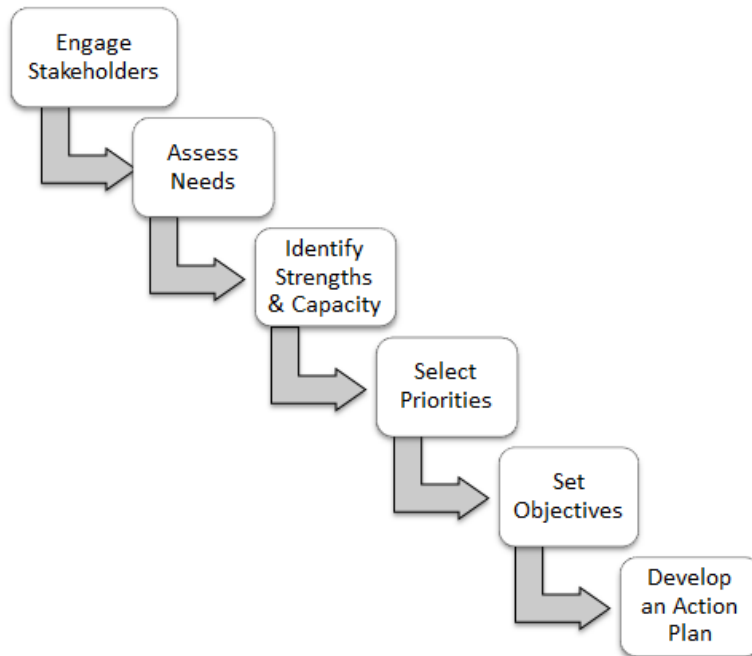
The needs assessment was led by Michigan's Title V Director and the Bureau of Family, Maternal and Child Health (BFMCH). As noted, the BFMCH organizational structure aligns with a life course approach. Leadership with expertise in each of the six population health domains identified in the Title V MCH 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 cross-cutting/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 BFMCH. 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
Family Center for Children and Youth with Special Health Care Needs
Women and Maternal Health Section

Table 1. Core MDHHS Representation on NAPC

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 identify 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 several factors). These indicators were reviewed by program staff, who suggested additional indicators to include.

Additionally, an online survey was developed to gather existing evaluation and consumer feedback information. 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.

Next, 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 strategic issues. Core indicators were presented to the stakeholders and additional metrics and analysis were provided as data sheets. The presentations and data sheets formed the basis of a rich discussion of emerging issues, unmet needs, data gaps and disparities. Stakeholders were engaged throughout the process and provided information from their own perspective and experience. Throughout the presentations, participants were asked to note the unmet needs suggested by the data as well as their own experiences. After discussing 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. Out of these strategic issues, the NAPC selected Michigan’s state priorities.

Examine Strengths and Capacity

To inform the process of identifying strategic issues, each stakeholder group also 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 2015, 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 or 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 domain 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 FY 2017.

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, staff within the Child, Adolescent, and School Health Section 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 strategic issues identified by the workgroups were considered important overarching principles and were woven throughout the action plan for each population domain.

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. Support coordination and linkage across the perinatal to pediatric continuum of care ii. Integrate CHWs to improve systems navigation iii. Improve access to and education about reproductive life planning

Table 2. Strategic Issues Identified by MCH Stakeholders

	<ul style="list-style-type: none"> iv. Assure quality accountable MIHP services v. Support 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. Support coordination and linkage across the perinatal to pediatric continuum of care ii. Community level support for breastfeeding iii. Take a family-centered approach iv. Engage and support fathers v. Increased parenting support and strategies to facilitate bonding vi. Assure quality accountable MIHP services
Child Health	<ul style="list-style-type: none"> i. Invest in prevention and early intervention strategies (e.g., screening) ii. Foster safer homes, schools and environments with a focus on prevention iii. Invest in high quality early childhood programs and services (e.g., quality child care) iv. Implement a coordinated approach to health promotion that contributes to development and academic success
Adolescent Health	<ul style="list-style-type: none"> i. Support evidence-based bullying prevention programs ii. Foster positive adolescent sexual health education and development iii. Implement a coordinated approach to health promotion that contributes to development and academic success iv. Ensure social and emotional well-being through the provision of a continuum of behavioral health services v. Reduce barriers, improve access, and increase 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 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

Table 2. Strategic Issues Identified by MCH Stakeholders

<p>Cross-cutting/Life Course</p>	<ul style="list-style-type: none"> i. Provide culturally and linguistically competent services to address disparities and achieve health equity ii. Promote equity in funding, services, and health outcomes iii. Foster safer homes, schools and environments with a focus on prevention (e.g., opportunities for physical activity, lead poisoning prevention, preventing toxic stress & ACEs) iv. Improve quality of life, healthy development, and healthy behaviors across the life course v. Collaborate to improve access to basic needs vi. Early initiation and promotion of health education across the lifespan (e.g., obesity, smoking, parent education) vii. Support families to navigate the system viii. Ensure social and emotional well-being through the provision of a continuum of behavioral health services ix. Increase access to and utilization of evidence-based oral health practices x. Support the emotional health of the frontline workforce xi. Reduce barriers, improve access, and increase availability of health services
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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% Black, 6.4% White, 6.1% Hispanic, and 5.9% 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 rate 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 deaths 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 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 aged 0-4 and 31% were aged 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 also highlighted.

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 2009, 11.5% of sexually active adolescents in Michigan reported not using any form of contraception at last sexual encounter, compared to 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 CYSHCN 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 ACS, about 7.1% of children nationally were uninsured in 2013.

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 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. Collaboration between CSHCS and DFCH is meant to assure that attention to services for CYSHCN are integrated into all Title V programs, as CYSHCN have similar child and adolescent health issues as their peers.

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. Historically, this unit has also been 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. 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 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. MDHHS recognizes the need to coordinate with all home visiting models, including Healthy Start. The MDHHS annual home visiting conference brings together all of the models currently in Michigan for “Model Day” creating an opportunity for continued collaboration. Additionally, the unit plans for a Model Consultant position that will be charged with supporting the Healthy Start model among other models in Michigan as part of the Home Visiting Initiative.

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 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 much of their day—at school.

CSHCS Division: CSHCS 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 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, MPA, Director, WIC Division** has over 37 years of 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 and recently served as its Treasurer.

- ***Sarah Davis, MPA, Departmental Specialist, Bureau of Family, Maternal & Child Health*** has 15 years of work experience in the public and private sectors, including eight years of state-level experience in the child abuse and neglect prevention field.
- ***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 policymakers about the health of MCH populations.

The following individuals (including parents, CSHCN and their families) also serve critical roles in supporting Title V work:

- **Karen Wisinski, Early Hearing Detection Intervention Parent Consultant, Infant Health Unit, Early Childhood Section**, is the parent of a child who is hard of hearing and is dedicated to guiding families through diagnosis, acceptance, intervention and advocacy related to their children's deafness or hearing loss.
- **Candida Bush, Certified Family Life Educator, Director, Family Center for CYSHCN**, is a parent of two children with special health care needs and has over 25 years of experience working to support, empower and increase access to services for CYSHCN.
- **Bambi VanWoert, Parent Consultant, Family Center for CYSHCN**, has over 25 years in the dental and health care fields and has extensive training in Autism strategies. She is a caregiver to a child with Autism.
- **Kristy Medes, Parent Consultant, Family Center for CYSHCN**, is a parent of two children with special health care needs and has over 10 years of experience working with families and children to connect them with community-based resources and supports.
- **Lisa Huckleberry, Parent Consultant, Family Center for CYSHCN**, is a parent of a child with special health care needs and has over 10 years of experience advocating, educating and supporting individuals with special health care needs.
- **Amanda Larraga, Secretary/Administrative Assistant, Family Center for CYSHCN**, is a parent of a child with special health care needs and has over three years of experience working to raise awareness and increase services to children with special health care needs.

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 American Indian community. The plan is currently being piloted.

The PRIME Local Learning Collaborative (LLC) was established in 2011 and includes members from Healthy Start projects, local health departments and community based organizations. The LLC was formed to share local lessons learned from addressing racism and health equity to improve maternal and infant health. The LLC has disseminated information on their experiences with other stakeholders throughout Michigan. LLC members have also provided input in shaping the practices and policies developed in PRIME for application at the state level.

PRIME also conducted Michigan's first PRAMS survey for mothers of American Indian 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 BRFSS for Arab/Chaldean Americans, Hispanic/Latinos and Asian Americans. HDRMHS was 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 MDHHS 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

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. Currently, the ability to meet MCH population needs with a coordinated approach is facilitated by the organizational structure of BFMCH, which allows for collaborative work and sharing of best practices across divisions and programs. In addition to CSHCS, the DFCH manages programs within the scope of reproductive health; perinatal and infant health; and child, adolescent and school health. 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 has strong collaborative partnerships with the Michigan Family to Family Health Information Center and Parent to Parent of Southwest Michigan.

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, Michigan Family Voices, Michigan Alliance for Families and Michigan Primary Care Association provide a voice for policy and funding considerations. 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.B.2. Needs Assessment Summary Update

Michigan's Title V program engages in ongoing needs assessment activities in order to identify emerging needs, changing conditions, and system strengths. In FY 2016, Michigan's Title V program selected three priorities for ongoing needs assessment to be carried out in FY 2017:

1. Develop a process for tracking performance data on an annual basis;
2. Facilitate needs assessments with local health departments; and
3. Assess family and consumer engagement across MCH programs, as a step toward increasing stakeholder input.

Priority 1: Performance Monitoring

In March 2017, the Title V Steering Committee—which includes managers who oversee MCH priority areas and Title V funded programs—convened to review Michigan's Title V performance measures. This process was designed to inform ongoing decision making and to help monitor the implementation and progress of state action plans.

MCH Epidemiology staff presented available data on each NPM¹, SPM, and ESM. The presentation compared Michigan and national data over time, to the extent possible, as well as progress toward annual objectives. Additionally, the presentation highlighted the Federally Available Data (FAD) as a resource for exploring stratifier information for each NPM and NOM.

After viewing the data, the group discussed takeaways and ideas for enhancing the performance monitoring process in future years. The following main points emerged:

¹ Data and charts from [TVIS web reports](#) were utilized. Additional charts were created by MCH Epidemiology staff.

1. The State appears to be making progress toward annual goals for several of the NPMs and SPMs (e.g., breastfeeding, vaccination, dental visits in pregnancy).
2. The State's progress toward a few annual goals appears to be slower than anticipated (e.g., well woman visits and developmental screening).
3. For some measures, it is difficult to assess progress because data are collected infrequently (e.g., measures using the National Survey of Children's Health).
4. For many measures, the lag time between when data are collected and when data are available makes it difficult to contextualize current performance.
5. In addition to a broad review of performance data, it may be helpful to implement a more comprehensive review of data specific to each performance measure or program area.

Priority 2: Local MCH Needs Assessments

Michigan's 45 local health departments (LHDs) each receive Title V block grant funds to address locally identified MCH needs. These Local Maternal and Child Health (LMCH) grants play an important role in building LHD infrastructure and supporting the delivery of programs and services. After the five-year needs assessment was completed in 2015, the Title V Steering Committee determined that an important next step was to support LHDs in realigning with the state's new priorities and performance measures while also supporting continuity of local infrastructure, programs, and services.

An internal LMCH workgroup was convened to design an LMCH needs assessment process in partnership with the Michigan Public Health Institute (MPHI) to help LHDs identify:

- MCH strengths and areas for improvement in their community;
- Disparities in MCH outcomes;
- The perspective of community partners and families regarding MCH needs;
- Strengths and gaps in the community's MCH infrastructure;
- Priority MCH needs;
- Clear goals and SMART objectives that respond to priority MCH needs; and
- Strategies for improving MCH infrastructure and outcomes.

The design of the needs assessment was informed by NACCHO's Mobilizing Action through Planning and Partnerships (MAPP) framework, the Public Health Accreditation Board's (PHAB) Standards and Measures, the National Public Health Performance Standards Program (NPHPSP), the MCH Essential Services, and a variety of other community health improvement tools and resources. Additionally, the LMCH needs assessment incorporates the life course framework, which understands health as the product of exposures and experiences from preconception through each stage of life.

The LMCH needs assessment process began in January 2017 and will conclude in September 2017. Although this activity was not required, all 45 LHDs chose to participate. The LMCH needs assessment was designed to be flexible and based on local capacity. LHDs were provided with \$15,000 in one-time funding to support this activity. The LMCH workgroup recognized that the budget may not fully fund all assessment activities, and that LHDs vary in their assessment and

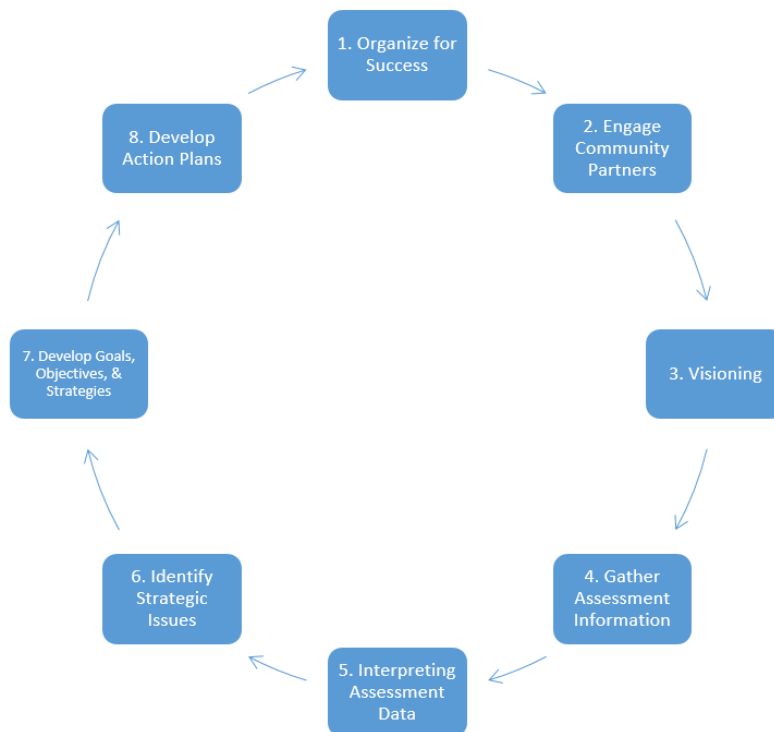
planning needs. As such, at each stage of the assessment, a range of approaches were offered.

However, LHDs were asked to include four critical components in their needs assessments:

1. Engage partners in the process, especially those most impacted by health inequities;
2. Use multiple types of data to identify both strengths and needs;
3. Engage in the process without pre-determined outcomes, such that evidence is used to select priorities and set objective targets; and
4. Ground strategies for improvement in evidence-based public health practice.

The LMCH needs assessment includes eight steps that align with the MAPP framework, which was selected because it is comprehensive and widely used. The steps are depicted in Figure 2.

Figure 2: Steps in the Needs Assessment Process



LHDs were guided through each stage by Michigan's LMCH Needs Assessment Tool and through a series of webinars and targeted technical assistance. To make the process more manageable and to support capacity building, the process was introduced one step at a time. After each step, LHDs received feedback on strengths and opportunities to expand their assessment approach.

Currently, LHDs are in the process of completing a series of three assessments. The first assessment involved gathering input from community members. LHDs were provided with an orientation to several methods of direct data collection, including community input walls, focus groups, intercept interviews, and photovoice. The second assessment involved reviewing MCH measures across the life course. The LMCH workgroup, MPHI, and MCH Epidemiology staff selected measures that included Michigan's NPMs and SPMs as well as other important measures including health outcomes, health behaviors, the service system, and social determinants of health. These measures were pulled at the state level and at either the county, LHD, or regional level. Measures were provided to LHDs in an Excel file and through supplemental documents. The third assessment, which was optional, asked LHDs to examine their MCH service system. LHDs were provided with a tool that asks LHDs and their partners to discuss their local MCH system's capacity to deliver the 10 essential MCH services. The tool was set up as a discussion guide that would lead to a description of current status, strengths, and opportunities for improvement.

Through the LMCH needs assessment process, Michigan's Title V program expects LHDs will:

1. Align local MCH priorities with Michigan's MCH priorities and NPMs and SPMs submitted to HRSA for the 2016-2020 block grant cycle;

2. Develop local MCH plans with measureable objectives and evidence-based strategies to address local MCH needs as well as Michigan’s Title V priorities and performance measures; and
3. Determine the most effective use of Title V dollars, particularly in relation to core public health functions and infrastructure.

Priority 3: Family and Consumer Engagement

Michigan’s Title V program is committed to increasing stakeholder input in programs and services, especially from consumers and families. MDHHS recognizes that understanding issues and challenges from the service recipients’ perspective helps programs strengthen services and achieve better outcomes. Many MCH programs currently involve families and consumers (on advisory committees, through program improvement efforts, etc.). However, systematic information about the levels and methods of family and consumer engagement used by MCH programs has not historically been gathered. Additionally, limited information was gathered directly from families and consumers in Michigan’s last five-year needs assessment.

To address this gap and strengthen future engagement processes, in 2016 the Title V Steering Committee decided to conduct an assessment of current family and consumer engagement across Michigan’s MCH programs. To obtain this “baseline” information, a Family and Consumer Engagement Survey² was disseminated in March 2017 to MCH program managers. The survey solicited feedback on current practices, challenges, and benefits of engagement. Preliminary results are presented in the Family/Consumer Partnership section of this

² The survey was adapted with permission from a survey developed by the Association of Maternal and Child Health Programs.

application. The full survey results will be used to assess strengths in engaging families and consumers, as well as barriers and opportunities for improvement.

FY 2018 Needs Assessment Plans

In FY 2018, Michigan's Title V program will build on the progress and initiatives that have been implemented to date. Anticipated activities include:

1. Track performance data and work with program staff to identify program-specific data that would support evaluation or improvement efforts.
2. Summarize LHD needs assessment results to better understand needs and gaps in maternal and child health across the state.
3. Use the results from the 2017 Family and Consumer Engagement Survey to inform next steps and strategies for increased stakeholder input within MCH programs.

Performance Monitoring

In FY 2018, the Steering Committee will again convene to review Michigan's performance measures—including NPMs, SPMs, ESMs, and other relevant data. This review and subsequent discussions will provide information about successes, challenges, and emerging issues that could inform Michigan's MCH priorities and state action plans. Additionally, Title V leadership and MCH epidemiology staff will work with program areas to identify data sets (e.g., FAD or life course metrics) that would be useful for further program assessment.

LMCH Needs Assessment

Michigan's Title V program will receive comprehensive LMCH needs assessment results by December 2017. Results will describe assessment findings related to needs and strengths and will identify priority MCH health issues for each local health department in the state. The Title V Steering Committee plans to use this information at the state level to better support LHDs and to enhance Michigan's next Title V five-year statewide needs assessment.

Family and Consumer Engagement

The Family and Consumer Engagement Survey closed in April 2017. In total, 37 MCH program areas completed the survey. Results of the survey will be used to identify strengths, gaps and opportunities for improvement in FY 2018. Methods for increasing family and consumer engagement will be identified or developed, depending on resource availability. For example, activities may include training or technical assistance for program staff; targeted support and resources for MCH programs that wish to strengthen family or consumer engagement; and sharing of best practices. A long-term goal is to increase family and consumer input in Michigan's MCH programming and ongoing needs assessment process. It is anticipated that information from the survey, as well as activities implemented in 2018, will inform and strengthen Michigan's next statewide needs assessment.

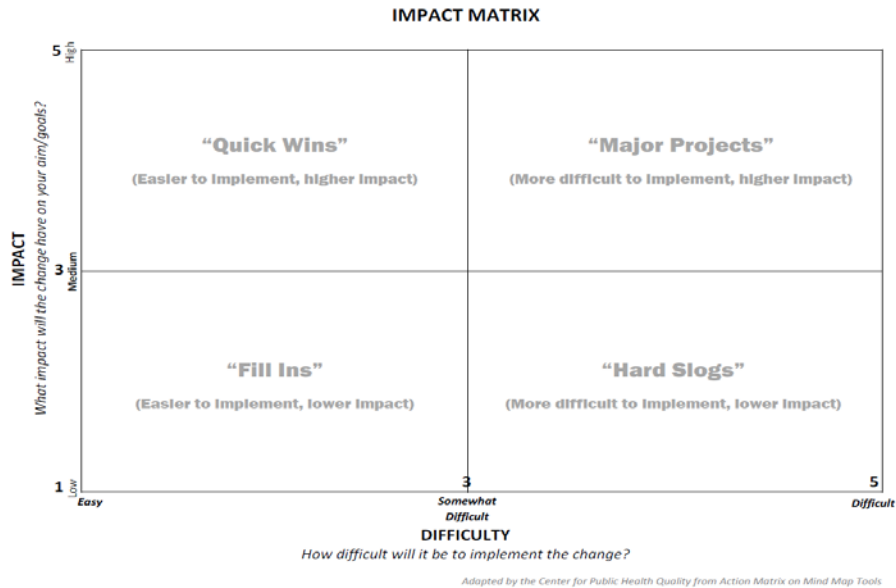
II.C. State Selected Priorities

In the process of selecting state priorities, the Title V Needs Assessment Planning Committee (NAPC) honored the input of MCH stakeholders by selecting priorities from the strategic issues identified through the 2015 needs assessment and also maintaining the language stakeholders used to describe the strategic issues. As a first step in the overall prioritization process, the NAPC recognized that some of the strategic issues were better aligned with efforts outside of the Title V block grant. Therefore, the NAPC 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. These strategic issues were removed from consideration during the prioritization process.

The NAPC then 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 NAPC 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 3). This exercise is used to help groups identify and prioritize strategic issues that are more difficult to implement but will have a high level of impact (“major projects”) or that can be implemented with less difficulty and have a high level of impact (“quick wins”). The exercise also helps groups identify and place less priority on strategic issues that are easy to implement but have little impact (“fill ins”) or that are difficult to implement but will have little impact (“hard slogs”). In order to identify where each strategic issue fell on the matrix, members of the NAPC rated each

strategic issue, on a scale of 1 to 5, on how difficult it would be to address and how much of an impact addressing the issue would have on MCH health outcomes in the next five years.

Figure 3. Prioritization Matrix



After completing the exercise, the NAPC considered strategic issues that were placed in the “quick wins” quadrant first, followed by strategic issues that were placed in the “major projects” quadrant. The NAPC did not consider strategic issues that were placed in the other two quadrants. Most of the priorities selected by the NAPC were considered more difficult to implement but highly impactful (i.e., “major projects”). The final list of priorities reflected the needs of the population, stakeholder input, and the knowledge and expertise of MCH leadership. The NAPC 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

Table 3: Michigan’s FY 2016-2020 Title V Block Grant Priorities	
Invest in prevention and early intervention strategies, such as screening	Child Health Cross-cutting/Life Course
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. NAPC 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 the 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

Table 4: Alignment between FY 2011-2015 Priorities and 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 publicly-funded programs	
	Promote social and emotional well-being through the provision of behavioral health services

Eight of the previous priorities were essentially retained or enveloped into the new priorities by combining and/or rewording them into broader priority issues. If a new priority in some way aligned with a previous priority, but the wording or scope changed, it was considered a “replaced” priority on Form 9. 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, providing culturally and linguistically competent services to address disparities and achieve health equity was identified as a priority to continue integrating across Michigan's MCH work and state action plans. Finally, reducing obesity continues to be a high priority in Michigan and within MCH-related programs; however, it is addressed through a variety of other funding streams and initiatives.

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

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

See Table 5.

Table 5: Alignment between State Priorities and National Priority Areas and Performance Measures			
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

To calculate annual objectives for each NPM, MCH epidemiology staff modeled the effect of time (year) on the corresponding proportional outcome. The Healthy People 2020 target was included in the model where available, or a target based on the same methodology as a related Healthy People 2020 target when an exact target was not available. In cases where the current Michigan-level objective surpassed the Healthy People 2020 target, an extrapolation of the current trend was used to set annual objectives. The statistical models were used to calculate annual projections approaching the five-year goal. We recognize that progression rarely occurs at a consistent interval toward a goal—and that future events, policy changes or interventions may influence the outcomes. Therefore, as information about the population attributable risk and/or other measures of impact (e.g., changes in policy or interventions) becomes available, we will reevaluate the targets to ensure we are setting challenging yet achievable goals.

In 2016, per federal Title V requirements, Michigan also created Evidence-based Strategy Measures (ESMs) for each NPM. ESMs are meant to quantify and measure states' strategies and policies to demonstrate the impact on NPMs. To assist Michigan's MCH program staff in identifying ESMs, an ESM training was provided in March 2016. The training covered the Title V transformation, the new Title V performance measurement framework, the role of ESMs, the process for choosing and creating ESMs, and example ESMs. Tools to support the process, including the Johns Hopkins "Strengthen the Evidence" resource, were provided. Program staff then created ESM detail sheets and five-year annual objectives for each NPM.

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, MDHHS 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. The ESM for this NPM will be to increase the percentage of women aged 18-44 who have ever discussed reproductive life planning during a visit with a doctor, nurse, or other health professional.

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 their regional perinatal care systems, which MDHHS is supporting via regional system quality improvement projects in three major geographic areas. 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. The ESM for NPM 3 will track the number of CenteringPregnancy sites in Michigan that are approved by the Centering Healthcare Institute. This evidence-based group model of prenatal care has been proven effective in decreasing the rate of preterm and low birthweight babies and “has been shown to nearly eliminate racial disparities in preterm birth. African American women, who are at higher risk for preterm birth in the US, experience lower risk of preterm birth when enrolled in CenteringPregnancy than in traditional care” (accessed from [CenteringPregnancy](#) on September 7, 2016). The CenteringPregnancy model of care is an important element in the reduction of preterm birth, as well as providing the linkage and information to mothers regarding the risk appropriate birthing hospital in the event preterm labor is eminent.

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. The ESM for the breastfeeding NPM will be to increase the percentage of Baby-Friendly designated birthing hospitals in Michigan.

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 MDHHS and its partners can make meaningful strides toward improving. The initial ESM will focus on creation of a strategic plan for a statewide developmental screening system.

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, MDHHS 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. The ESM for NPM 10 will measure the percent of health care providers who complete both the Motivational Interviewing web course and the Motivational Interviewing professional development training who report an increase in skills in effectively counseling youth on changing risky behaviors.

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 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. This NPM has an associated ESM that will measure the percent of families that indicate care coordination and family partnership are working well within their primary or specialty care provider setting.

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. The initial ESM for this NPM will measure the percent of local health departments with a transition policy in place. A new ESM is also planned, to track the transfer of care from pediatric to adult providers.

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. The oral health ESM will track the number of students who have received a preventive dental screening through the SEAL! Michigan program.

II.E. Linkage of State Selected Priorities with State Performance 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 five-year needs assessment. Per federal requirements, these SPMs were finalized in FY 2016 and were implemented in FY 2017. Michigan identified five SPMs related to lead poisoning prevention, safe sleep, depression across the life course, provision of medical services and treatment for children with special health care needs, and immunizations.

Lead Poisoning Prevention

To address the priority of **“Foster safer homes, schools and environments with a focus on prevention,”** Michigan’s first SPM relates to lead poisoning prevention. The SPM is the percent of children less than 72 months of age who receive a venous lead confirmation testing within 30 days of an initial positive capillary test. Between 1998 and 2014, the percentage of birth to six-year-old children in Michigan with blood lead levels ≥ 5 ug/dL decreased from 44.1% to 3.5%. However, the 3.5% still represents over 5,000 children. Many areas of the state remain at high risk, and many local health departments are re-examining local efforts because of the Flint water crisis.

Blood lead testing rates in Michigan have been decreasing since 2010. One strategy being used to increase testing is adoption of point-of-care capillary testing machines in many primary care provider offices and WIC clinics. These desktop analyzers provide parents with immediate results, and in many instances are easier on the child and the parent than a trip to a laboratory for a venous draw. However, elevated capillary results still need to be confirmed with a venous

test. Capillary blood lead tests are considered to be screening tests, and are prone to false positives. It is important to obtain a confirmatory venous test before interventions are initiated. In 2014, approximately 2,300 children aged birth to six had elevated capillary tests and never received the appropriate follow-up venous testing. This negatively impacts their access to appropriate clinical follow-up, as well as in-home supports and follow-up such as case management and environmental investigations, both of which are typically triggered by an elevated venous result.

Therefore, Michigan has identified the need to reduce the number of young children in Michigan with an unconfirmed elevated blood lead level as a means of fostering safer homes, schools and environments. Objectives for this SPM will include increasing the percentage of young children (with particular focus on those enrolled in Medicaid Health Plans) who receive a venous lead confirmation test; enhancing analysis of the state's surveillance data; and developing educational materials related to lead testing.

Safe Sleep

The second SPM to address the priority area of **“Foster safer homes, schools and environments with a focus on prevention”** was developed to promote infant safe sleep environments: A) the percent of infants put to sleep alone in their crib, bassinet or pack and play and B) the percent of infants put to sleep without objects in their crib, bassinet or pack and play. According to the Centers for Disease Control (CDC), approximately 3,500 infants die suddenly and unexpectedly in the U.S. each year. In 2014, MDHHS Vital Records reported that 125 infants died from Sudden Unexpected Infant Deaths (SUIDs) 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

overall in Michigan, and the leading cause of death for infants 28 days to one year old. Of the leading causes of death, sleep-related infant deaths are considered the most preventable.

Historically, the number of infant deaths classified as SUID is an underreporting of the actual number of infant deaths that occur from sleep-related causes. Michigan participates in the Centers for Disease Control and Prevention (CDC) SUID Case Registry Project which is a population-based, multistate surveillance system designed to identify SUID trends and risk factors. Through the SUID Case Registry Project, infant deaths are closely examined to determine if sleep-related causes were involved. Frequently, this review results in additional deaths being attributed to sleep-related causes. Thus, in 2014, Michigan's SUID Case Registry Project reported 152 sleep-related infant deaths. Although the *rate* of sleep-related deaths remained constant from 2013 to 2014, the *number* of deaths increased (from 142 deaths in 2013).

Among sleep-related infant deaths, significant and unacceptable racial disparities exist. According to MDHHS Vital Records for the birth cohort 2009-2013, Black infants were disproportionately represented with 4.6 times more SUIDs among Black infants than White infants, even after accounting for the fact that more White infants were born. The SUID Case Registry Project confirms the racial disparity, showing that Black infants in Michigan die at a rate more than three times greater than White infants, and American Indian infants die at more than twice the rate of White infants.

Data from the Pregnancy Risk Assessment Monitoring Survey (PRAMS) confirm that unsafe sleep behaviors continue to put infants at risk. PRAMS results from 2012 show that 20% of all infants usually sleep on their side, stomach or a combination; 22% of babies 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. These behaviors have been shown to increase the risk for a sleep-related infant death. According to the SUID Case Registry Project, three out of four sleep-related infant deaths in Michigan occurred in an unsafe sleep location. In addition, approximately 60% of sleep-related infant deaths occurred among infants who shared a sleep surface such as with an adult or sibling. Michigan has elevated safe sleep to a priority due to the persistently high number of sleep-related infant deaths that occur each year. Parental and caregiver behavior is a modifiable 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.

Depression across the Life Course

To address the priority area of **“Promoting social and emotional well-being through the provision of behavioral health services,”** MDHHS developed a two-part SPM related to reducing depression across the life course, focusing on adolescents and pregnant and postpartum women. The SPM includes: A) Percent of high school students who report feeling 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; and B) Percent of women enrolled in Michigan’s Maternal Infant Health Program (MIHP) who are screened for maternal depression. Depression is increasingly common in adolescence. According to the 2015 Michigan Youth Risk Behavior Survey (YRBS), 31.7% 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 12 months prior to the survey. This represents nearly a 5% increase from 2013 data (27%). Symptoms of depression among this age group are often related to the stresses and challenges of transitioning from childhood to adulthood. Depression can impact every aspect of life, from academic success to physical health, and is sometimes associated with increased risk for suicide. Early identification of depression is crucial in reducing prevalence of depression and for implementing timely and effective interventions to manage symptoms and reduce negative outcomes.

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% to 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%. The Maternal Infant Health Program (MIHP) is Michigan's largest home visiting program, serving pregnant and postpartum women with Medicaid. MIHP data are collected based on the beneficiary's response to the stress/depression risk questions asked on the maternal risk-identifier screen. FY 2014 data (utilizing the Edinburgh Postnatal Depression Scale) showed that 19,529 (100%) of enrolled women were screened for maternal depression. Of those screened, 7,736 (40%) scored moderate or high risk for depression.

Through this two-part measure on reducing depression across the life course, Michigan will focus on strategies to educate school personnel on the symptoms of depression, how social

emotional health impacts learning, and when to refer for intervention; promote integrated physical and mental health care; and reduce barriers and increase access to treatment options for those diagnosed with depression.

Provision of Medical Services and Treatment for Children with Special Health Care Needs

To address the priority area of **“Reducing barriers, improving access, and increasing the availability of health services for all populations,”** MDHHS developed a SPM for Children and Youth with Special Health Care Needs (CYSHCN): Percent of CYSHCN enrolled in CSHCS that receive timely medical care and treatment without difficulty. While access to public and private health insurance coverage has improved as a result of the ACA, 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 this SPM on the provision of medical services and treatment for CYSHCN, Michigan will 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, and culturally competent 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.

Immunizations

To address the priority area of **“Invest in prevention and early intervention strategies, such as screening,”** MDHHS developed a SPM related to Immunizations. This SPM is a priority within the Cross-Cutting/Life Course population domain, with two measures: A) Percent of children 19 to 36 months of age who have received a completed series of recommended vaccines (4:3:1:3:3:1:4 series) and B) Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus (HPV) vaccine. Within some populations, Michigan has experienced declining immunizations rates and has not met the Healthy People 2020 goal for child immunizations. For example, the percent of 19 to 35 month olds who received a full schedule of age appropriate immunizations (Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B) fell from 82% to 74.8% between 2008 and 2014.

The Division of Immunization within MDHHS operates the Michigan Care Improvement Registry (MCIR). The MCIR is a regionally based, statewide immunization registry that contains over 115 million shot records administered to 8.6 million individuals residing in Michigan. For the

4:3:1:3:3:1:4 series, MCIR rates have not increased for the past three years; in fact, gradual decreases have occurred in the compliance rates for children enrolled in Medicaid and WIC. The most recent National Immunization Surveys (NIS) data from 2014 also show that the point estimate for Michigan is 65% for the 4:3:1:3:3:1:4 series, indicating a 5% decline from the prior year and ranking Michigan 47th in the country.

Additionally, Michigan has the fourth highest percentage of kindergarten exemptions for one or more vaccines required for school entry, with some counties experiencing rates as high as 20%. Sixty-seven percent of Michigan's 13-18 year olds are complete with immunizations, but that percentage drops to 20% when HPV series completion is considered. The HPV vaccine has the potential to save thousands of lives every year, yet our adolescent completion rates are far below national goals. Over the past two years, though, Michigan has increased the completion rate for adolescents 13 through 18 years of age from 18% to 27%. We want to continue to build upon this success over the next five years. Finally, establishing an immunization SPM aligns with work at the local, state and federal level. For example, several local health departments use MCH funding for both direct services and enabling services, particularly to support childhood immunization efforts. Additionally, several of the federal National Outcome Measures (NOMs) focus on immunizations.

II.F. Five-Year State Action Plan

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

This section presents Michigan’s five-year state action plan tables as well as FY 2018 application plans and FY 2016 annual reports, as required by federal guidelines.

Women/Maternal Health Domain

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, maintain 84% of females aged 15-44 who use a most effective or moderately effective contraceptive method	<p>A1) Facilitate a Contraceptive Access Learning Collaborative with at least three family planning providers to remove contraceptive barriers</p> <p>A2) Explore the feasibility of a Contraceptive Access Workgroup comprised of state and local level stakeholders</p> <p>A3) Promote and disseminate Michigan’s new Contraceptive Counseling module series with family planning, Medicaid, and</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 fetal deaths - Neonatal mortality per 1,000 live births 	Percent of women with a past year preventive medical visit

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
		<p>clinical home visiting providers, offering continuing education credits, as resources allow</p> <p>A4) Host at least one clinical practicum on the insertion and removal of a long-acting reversible contraceptive for at least five family planning and other health care providers</p> <p>A5) Collaborate with the Maternal Infant Health Program to update its Family Planning module to align with quality family planning best practices and national standards of care</p>	<ul style="list-style-type: none"> - Postneonatal mortality rate per 1,000 live births - Preterm-related mortality per 1,000 live births 	
	<p>B) By 2020, increase by 5% the proportion of Michigan women who report ever having discussed reproductive life planning during a visit with a doctor, nurse, or other health professional</p>	<p>B1) Promote the Before, Between, and Beyond Pregnancy educational modules with family planning providers and other health care professionals</p> <p>B2) Disseminate the National Preconception-</p>		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
		<p>Interconception Care Clinical Toolkit with family planning providers and other health care professionals</p> <p>B3) Explore the feasibility of integrating interconception care education and a reproductive intentions assessment into existing state programs (e.g., WIC, Healthy Start, Home Visiting) and local programs (e.g., Breastfeeding Coalitions, Expectant Parent Organizations) serving expectant and new mothers</p>		
	<p>D) By 2020, increase by 5% the proportion of Michigan women who report having a routine check-up within the past year</p>	<p>D1) Promote enrollment in Medicaid expansion and other insurance products</p> <p>D2) Promote referrals to primary care providers within family planning clinics</p> <p>D3) Assist family planning providers</p>		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
		in fostering relationships with Medicaid Health Plans		

Well-woman Visit FY 2018 Application

Michigan’s National Performance Measure for the Women and Maternal Health Domain is “Percent of women with a past year preventive medical visit.” According to the Michigan Behavioral Risk Factor Surveillance System (BRFSS), in 2015 69% of women aged 18 to 44 years had a preventive visit in the past year. This statistic indicates that barriers to obtaining health insurance, accessible health care services, and finding a trusted provider still exist. While Michigan continues to work toward increasing access to health insurance and accessible health care for women of reproductive age, Michigan has selected an Evidence-Based or -Informed Strategy Measure (ESM) that is focused on developing quality health care services. Specifically, the ESM is to “Increase the percentage of women aged 18-44 who have ever discussed reproductive life planning during a visit with a doctor, nurse, or other health professional.”

Increasing the proportion of Michigan women of reproductive age who regularly participate in routine preventive appointments, addressing health issues as they arise, and focusing on long-term health outcomes starts with receiving quality health care services. Given that the majority of women of reproductive age either want to prevent or achieve pregnancy, focusing on strategies aimed at increasing preconception health (such as reproductive life planning) is a smart investment. According to the 2015 Michigan BRFSS, 60% of Michigan women aged 18 to

44 reported ever having discussed reproductive life planning during a visit with a doctor, nurse or other health professional, indicating that family planning providers and other health care professionals are experiencing barriers to addressing prevention across the life span, preconception health, and contraceptive care with women of reproductive age.

Objective A: By 2020, maintain 84% of females aged 15-44 who use a most effective or moderately effective contraceptive method.

Contraception is a highly effective clinical preventive service that assists women in achieving their reproductive health goals, such as preventing teen and unintended pregnancy, and achieving healthy spacing of births. While there is no single method of contraception that is right for everyone, the type of contraceptive method used by women is strongly associated with her risk of unintended pregnancy. Having access to a full range of contraceptive methods allows each woman the opportunity to choose the method that is right for her to successfully delay or prevent pregnancy. During 2016, 84% of female family planning users aged 15-44 used a most effective (i.e., sterilization or long-acting reversible contraception) or moderately effective (i.e., injectable, patch, pills, ring or diaphragm) contraceptive method. In FY 2018, the MDHHS Family Planning Program will focus its efforts on maintaining this level of most or moderately effective contraceptive utilization given the declines in client volume and the opportunity for expanded visit types within family planning settings. The five strategies associated with this objective will focus on increasing contraceptive access for Michigan women by removing barriers to contraceptive access, developing a coordinated statewide strategy for contraceptive access, increasing providers' knowledge about patient-centered care and

contraceptive counseling, enhancing family planning providers' long-acting reversible contraceptive (LARC) insertion skills, and collaborating with the Maternal Infant Health Program (MIHP) to better support the family planning needs of pregnant women on Medicaid.

The first strategy, facilitate a Contraceptive Access Learning Collaborative (CALC) with at least three family planning providers, will focus on assisting family planning providers in removing individual and organizational barriers that impede contraceptive access. The Michigan CALC will be a replication of the national CALC in which MDHHS and two sub-recipient agencies are currently participating through the Family Planning National Training Center. MDHHS will use local Family Planning agencies' performance measure data on the two contraceptive care measures (i.e., most or moderately effective method use and long-acting reversible contraceptive use) to determine which agencies would benefit the most from participation. The Michigan CALC will be administered during a six-month period and will use the Institute for Healthcare Improvement's Breakthrough Series Learning Collaborative Model, where participating Family Planning agencies engage in the quality improvement (QI) process through alternating learning sessions and action periods. Learning sessions will be discussion-based and focused on the implementation of best practices and removal of barriers to improve contraceptive access, whereas action periods will be focused on conducting small tests using Plan-Do-Study-Act (PDSA) cycles and scaling up changes within their respective agencies. Participating agencies will complete a baseline assessment on the extent to which they are implementing best practices for contraceptive access. Once completed, baseline assessment results will be used to assist the agencies in identifying one or two best practices for quality improvement. Best practices for contraceptive access include: 1) stocking a broad range of

contraceptive methods, including all provider-dependent, FDA-approved methods; 2) discussing pregnancy intention and supporting patients through evidence-informed, patient-centered counseling; 3) developing systems for same-visit provision of all contraceptive methods, at all visit types; and 4) utilizing diverse payment options to reduce cost as a barrier for the facility and patient.

The second strategy, explore the feasibility of a Contraceptive Access Workgroup, will focus on bringing together state and local stakeholders to develop a coordinated, integrated, and systematic approach to increasing contraceptive access within Michigan. During FY 2018, MDHHS will focus on laying the groundwork for the workgroup, such as receiving administrative approval, identifying stakeholders, securing additional grant funding to support the workgroup efforts, and contracting with an individual or organization to facilitate a strategic planning process.

The third strategy, promote and disseminate Michigan's new Contraceptive Counseling Module Series, will focus on enhancing provider knowledge on patient-centered care, contraceptive counseling skills, and maximizing contraceptive reimbursement. The series will be hosted on the Michigan Public Health Institute's Event Planning website, and will be disseminated among local Family Planning agencies using Constant Contact. Continuing education credits will be offered as resources allow. MDHHS Family Planning Program staff will also promote and disseminate the series among key contacts within Medicaid and clinical Home Visiting Programs. Statewide programs will be encouraged to disseminate the series to local programs, as appropriate, as well as to interested community partners and stakeholders.

The fourth strategy, host at least one clinical practicum on the insertion and removal of LARC, will focus on expanding client access to highly effective reversible contraceptive methods from Family Planning providers within Michigan. Local Family Planning providers have indicated continuous training on LARCs as an area of need. In FY 2018, the MDHHS Family Planning Program will offer a clinical practicum at its Annual Family Planning Conference; however, it will also assess provider training needs on a quarterly basis to enhance timeliness of LARC training opportunities. Training opportunities scheduled outside of the Annual Family Planning Conference will be offered to statewide clinical programs and health care organizations.

The fifth strategy, collaborate with MIHP to align its Family Planning module with quality family planning best practices and national standards of care, will focus on enhancing MIHP provider knowledge and service delivery of post-partum and interconception care, reproductive life planning, contraceptive counseling and care, and sexually transmitted infection prevention. In FY 2018, the MDHHS Family Planning Program will collaborate with MIHP to ensure the Family Planning module reflects current best practices and national standards of care for sexual and reproductive health services. In addition, the MDHHS Family Planning Program will work with MIHP to assess additional sexual and reproductive health program needs within its sphere of influence.

Objective B: By 2020, increase by 5%, the proportion of Michigan women who reported ever having discussed reproductive life planning during a visit with a doctor, nurse, or other health professional.

Family planning providers and other health care professionals recommend women and men of reproductive age who want to achieve or prevent a pregnancy consider making a reproductive life plan. Reproductive life plans assist individuals in thinking about when and under what conditions they would like to become pregnant or, conversely, thinking about how pregnancy will be prevented, with the primary focus on increasing the overall health and well-being of the individual regardless of reproductive intentions. According to the 2015 Michigan BRFSS, 60% of Michigan women aged 18 to 44 reported ever having discussed reproductive life planning during a visit with a doctor, nurse or other health professional, indicating that family planning providers and other health care professionals are experiencing barriers addressing prevention across the life span, preconception health, and contraceptive care with women of reproductive age.

The first strategy, promotion of the Before, Between, and Beyond Pregnancy educational modules, will focus on increasing provider knowledge on preconception, interconception, and post-partum care. In FY 2018, the MDHHS Family Planning Program will promote and disseminate the Before, Between, and Beyond Pregnancy educational modules through the Family Planning Medical Advisory Committee to local agencies. In addition, key contacts within Medicaid, clinical Home Visiting Programs, and health care organizations will be asked to share these modules as a professional development opportunity for providers within their networks, highlighting the availability of free continuing education credits.

The second strategy, dissemination of the National Preconception-Interconception Care Clinical Toolkit, will focus on increasing provider skills to incorporate and implement efficient,

evidence-based preconception and interconception care messages and services into routine preventive care. In FY 2018, the Family Planning Medical Advisory Committee will develop a promotion and dissemination plan for local agencies that will ensure integration of key toolkit components and enhance service delivery. In addition, the National Preconception-Interconception Care Clinical Toolkit will be disseminated by the MDHHS Family Planning Program to key contacts within Medicaid, clinical Home Visiting Programs, and health care organizations.

The third strategy, explore the feasibility of integrating interconception care education and a reproductive intentions assessment into existing state programs (e.g., WIC, Home Visiting) and local programs (e.g., Breastfeeding Coalitions, Expectant Parent Organizations) serving expectant and new mothers, will focus on increasing expectant and new mothers' knowledge about the maternal and infant health benefits of interconception care, in addition to facilitating the appropriate contraceptive care referrals for pregnancy prevention. In FY 2018, efforts will focus on reaching out to interested state and local level programs, intervention development, and program planning. Ideally, this intervention will be integrated into existing service delivery components with minimal disruption to the fidelity of existing evidence-based and evidence-informed models. State and local level programs situated within high infant mortality communities will be ideal pilot sites.

Objective D: By 2020, increase by 5%, the proportion of Michigan women who reported having a routine checkup within the past year.

Access to comprehensive quality health care services assists individuals in participating in routine preventive appointments, improving ability to address health issues as they arise, and fosters positive long-term health outcomes. According to the 2015 Michigan BRFSS, 69% of Michigan women aged 18 to 44 reported having a preventive visit during the past year, indicating that barriers to obtaining health insurance, accessing health care services, and finding a trusted provider still exist.

The first strategy, promote enrollment in Medicaid expansion and other insurance products, will focus on increasing the number of Michigan women who have primary care coverage. In FY 2018, the MDHHS Family Planning Program will continue to promote Medicaid Outreach opportunities among local Family Planning agencies, and promote Medicaid Outreach training and technical assistance by involving the MDHHS Medicaid Outreach Consultant in appropriate agency training opportunities and the Annual Family Planning Conference. Local Family Planning agencies will also continue to assist and enroll clients in Medicaid or Medicaid Health Plans, the Marketplace, and other health insurance plans. For agencies that do not offer on-site enrollment, clients will be referred to community partners that have the on-site capacity.

The second strategy, promote referrals to primary care providers within family planning clinics, will focus on strengthening and enhancing family planning client referrals to primary care providers. In FY 2018, local Family Planning agencies will continue to assess client need for primary care referrals, update referral agreements with primary care providers as necessary, and strengthen linkages. The MDHHS Family Planning Program will continue to strengthen state and local level relationships with primary care organizations, particularly Federally Qualified

Health Centers, by using appropriate training opportunities offered by the Michigan Primary Care Association and the Annual Family Planning Conference.

The third strategy, assist family planning providers in fostering relationships with Medicaid Health Plans, will focus on expanding the number of family planning providers that have established business agreements to improve coordination of care and linkages to services. The MDHHS Family Planning Program will work to enhance local Family Planning agency relationships by involving Medicaid Health Plans in appropriate agency training opportunities and the Annual Family Planning Conference, as well as funding relationship-building efforts between local Family Planning agencies and Medicaid Health Plans, as resources allow. Local Family Planning agencies that have been successful in establishing additional business agreements for reproductive health services will be asked to share promising practices, lessons learned, and appropriate resources with the network during applicable trainings and conference sessions.

Well-Woman Visit FY 2016 Annual Report

During FY 2016, the Michigan Department of Health and Human Services achieved several notable accomplishments. Based on Michigan's Family Planning Program needs assessment results, low-income women ($\leq 100\%$ poverty), adolescents and young adults, and the uninsured remained most at-risk of an unintended pregnancy and are in highest need of publicly subsidized Family Planning services, despite post-Affordable Care Act implementation. To address this need, Michigan's Family Planning Program awarded four Community Outreach Mini-Grants of \$30,000 during FY 2016 to three local health departments and one Planned

Parenthood Affiliate. Agencies implemented both traditional and social media campaigns to increase community awareness and knowledge about reproductive and sexual health services, as well as preconception health within predominantly high infant mortality communities. Media campaigns were implemented across 33 Michigan counties with a combined estimated reach of just under a half million Michiganders of reproductive age, with targeted audiences of low-income women ($\leq 100\%$ poverty), adolescents and young adults, and resettled refugees.

During FY 2016, the MDHHS Family Planning Program began monitoring performance for the program and local agencies on two of the contraceptive care measures endorsed by the National Quality Forum to develop data-driven strategies for increasing contraceptive access across Michigan in subsequent grant years; and began identifying opportunities for quality improvement among local agencies. Family planning provider barriers to long-acting reversible contraceptives (LARCs) were assessed, and provider professional development opportunities were offered to enhance LARC knowledge and skills. In addition, the MDHHS Family Planning Program established a contract to pursue the development of a three-part Contraceptive Counseling Module Series that focuses on enhancing provider knowledge of patient-centered care and contraceptive counseling skills, as well as emphasizing billing and coding strategies that maximize reimbursement. The Before, Between, and Beyond Pregnancy educational modules and the National Preconception-Interconception Care Clinical Toolkit were identified to promote preconception health, post-partum care, and interconception care among Family Planning providers and other health care professionals in Michigan. Efforts to promote enrollment in Medicaid and other health insurance products, as well as referrals to primary care providers, continued among local Family Planning agencies.

Objective A: By 2020, increase by 5% the proportion of Michigan pregnancies that are intended.

The Family Planning Program uses the Guttmacher Institute's *Contraceptive Needs and Services Update* to annually assess unmet needs within the state for contraceptive services and supplies. During FY 2016, this annual needs assessment was used to guide program planning at both state and local levels. Based on the *Contraceptive Needs and Services, 2014 Update*, 38.3 million U.S. women between the ages of 13 to 44 were in need of contraceptive services and supplies. Of the women in need, 4.7 million U.S. women were in need of publicly supported contraceptive services and supplies, defined as adult women living below 250% of the federal poverty level, plus all women younger than age 20 in need. For Michigan, 2,017,700 women were in need of contraceptive services and supplies, and of those in need, 635,660 women were in need of publicly supported contraceptive services and supplies. Of the Michigan women in need of publicly supported contraceptive services, 32% (201,460) were living at or below 100% poverty, 27% (171,780) were under the age of 20, and 15% (97,490) were uninsured. From 2010 to 2014, there were 12,600 more Michigan women in need of publicly supported contraceptive supplies and services.

At the state level, these data were used to assess priority populations, as well as determine program priorities and initiatives as they related to populations in highest need. This needs assessment indicated low-income women, teens, and the uninsured were most at-risk of an unintended pregnancy and were in highest need of publicly subsidized family planning services within Michigan. Even though contraceptive needs persisted, Michigan's Family Planning

Program experienced an 18% decrease in client volume in 2016 compared to 2014, including a 26% decline in uninsured clients, a 23% reduction in low-income individuals, and a 13% reduction in teens served. The client decline mirrored a national trend in which nearly all states experienced a client decline. Michigan's Family Planning Program prioritized strengthening local Family Planning agency outreach and engagement efforts and released Community Outreach Mini-Grants to identify effective and promising outreach methods for increasing priority population awareness of the benefits of family planning and access to services and supplies.

At the local level, these data were used to assess priority populations within service areas and guide community participation, education, and project promotion. Similarly, low-income women, teens, and the uninsured were highest in need during FY 2016 in the majority of service areas across the state. Each year, local Family Planning agencies submit a work plan outlining community participation, education, and project promotion. These work plans are reviewed and monitored throughout the year during comprehensive site reviews and monitoring visits. Local Family Planning agency community participation, education, and project promotion strategies were primarily focused on traditional and social media campaigns, health fair events, sexual health presentations, and providing clinic materials to referral agencies and community partners within service areas of highest need. Local Family Planning agencies engaged consumers and priority populations by gathering satisfaction feedback for program improvements, evaluating clinic educational materials for audience appropriateness, and participating as members of local Family Planning Advisory Councils.

Michigan's Family Planning Program unveiled Title X mappist to its network as a resource for assessing priority population need and coordinating local level outreach efforts within communities of highest need. Title X mappist is an online mapping tool that estimates the number of low-income ($\leq 250\%$ poverty) women of reproductive age (15 to 49) at both state and county levels. This tool was first introduced to the Michigan family planning network during the 2016 Annual Family Planning Conference where session participants were given an overview of the mapping tool's capacity, functionality, and limitations. Session participants learned that Michigan's state level need for Title X services is 20%, which is comparable to other states of similar population density and geography. Participants also learned that more than half of Michigan's 83 counties have communities with a local level need that exceeds the state, with community need ranging from 30% to 50%, on average. During the session, a live demonstration was given where both urban and rural family planning service areas were explored, communities of highest need were identified, and discussion focused on outreach strategies that would provide the greatest impact. Following the conference, the Title X mappist tool was disseminated to the Family Planning network via email, where local agencies were encouraged to integrate this tool into their annual needs assessment to guide program planning to ensure local level outreach efforts were data-driven, targeted, and maximized limited resources.

In an effort to strengthen community outreach efforts, Michigan's Family Planning Program released a one-time mini-grant of up to \$30,000 to fund a maximum of six Title X-funded agencies to implement evidence-based community outreach strategies or promising practices that were focused on, but not limited to: 1) increasing a priority population's access to family

planning services, 2) expanding the preconception and reproductive life planning knowledge and behavior of a priority population, 3) developing community linkages with referral agencies, and 4) increasing community awareness and messaging for family planning services. In an effort to build upon and leverage existing community-based efforts to reduce infant mortality, applicants were encouraged to select communities with an infant mortality rate above the state rate. MDHHS funded three health departments and one Planned Parenthood Affiliate. Each project utilized a combination of traditional and social media campaigns to increase community awareness and knowledge about reproductive and sexual health services, as well as preconception health within predominantly high infant mortality communities. These outreach campaigns were implemented across 33 Michigan counties, with a combined estimated reach of just under a half million Michiganders of reproductive age, with targeted audiences of low-income women, adolescents and young adults, and resettled refugees.

Increasing contraceptive access is a proven strategy for reducing unintended pregnancy and achieving healthy birth spacing. During FY 2016, the MDHHS Family Planning Program began monitoring program performance on two of the National Quality Forum endorsed contraceptive care measures, most or moderately effective method utilization and access to LARCs. Baseline performance was established for each measure at both state and local program levels using Michigan's 2013 and 2014 Family Planning Annual Report (FPAR) data. During the 2016 Coordinator's meeting, these data were presented to the network and highlighted national, regional, state, and local level comparisons. The baseline results were encouraging given that Michigan's most or moderately effective method utilization among female users aged 15 to 44 (81% FPAR 2013 and 83% FPAR 2014) exceeded national network performance

(72% FPAR 2013 and 73% FPAR 2014) by approximately 10 percentage points each year; whereas Michigan's network performance for access to LARCs was approximately one half to one third (6% FPAR 2013 and 8% FPAR 2014) of national network performance (11% FPAR 2013 and 12% FPAR 2014) for female users aged 15 to 44. These data provided the opportunity to discuss the benefits of using a data-driven approach to develop program priorities and strategies, make improvements, and demonstrate a program's value and worth. Following the Coordinator's meeting, local agencies were provided with their performance measure data. Statewide performance measure data from 2013 to 2016 FPAR will be used to develop data-driven strategies focused on increasing contraceptive access across the network and the state during FY 2018, and will also be used to identify opportunities for quality improvement among local agencies.

Objective B: By 2020, increase by 5% the proportion of Michigan women who report ever having discussed reproductive life planning during a visit with a doctor, nurse, or other health professional.

During FY 2016, the Family Planning Program completed an environmental scan of existing evidence-based preconception health and reproductive life planning toolkits and educational materials. The environmental scan identified the Before, Between, and Beyond Pregnancy educational modules and the National Preconception-Interconception Care Clinical Toolkit. State and local level stakeholder feedback is being solicited during FY 2017 to develop a streamlined approach for translating current recommendations and preconception health

strategies into clinical practice among family planning providers and other health care professionals.

MDHHS determined it would not be feasible to replicate and expand Kent County's Interconception Care Project within three to five high infant mortality communities across Michigan. This decision was based on the evaluation findings from Kent County's Interconception Care Project, which indicated the model was not suitable (nor sustainable) for scaling up within local public health settings. MDHHS remains committed to interconception care as a means of reducing rapid repeat pregnancies, and as such will focus future interconception care efforts within direct service settings where expectant and first-time mothers are served.

Objective C: By 2020, increase the capacity of 50 Michigan reproductive health providers to offer highly effective contraceptive services.

In FY 2016, MDHHS established a Contraceptive Counseling Module Series contract and accompanying scope of work with the Michigan Public Health Institute. The three-part Contraceptive Counseling Module Series focuses on enhancing providers' knowledge of patient-centered care and contraceptive counseling skills, as well as emphasizing billing and coding strategies that maximize reimbursement. Module content development and production is occurring in FY 2017, and FY 2018 will focus on the promotion and dissemination of the series to family planning providers, Medicaid, and clinical home visiting providers.

Also in FY 2016, MDHHS assessed individual and organizational level barriers for long-acting reversible contraceptives (LARC) within local Family Planning agencies. These findings were

presented at the 2016 Family Planning Coordinator's meeting and the survey was shared with Medicaid for replication with health plans for their Contraceptive Performance Measure grant.

From mid-May to mid-June 2016, the electronic survey was administered anonymously to Family Planning coordinators via email, with two reminder emails sent to encourage participation. Coordinators were asked to forward the survey link to their providers as the MDHHS does not maintain provider contact information for local agencies. Approximately 85% of local Family Planning agencies participated in this survey.

When respondents were asked about provider training for LARCs, almost 62% indicated their providers were trained, although 45% were interested in additional training. Barriers to training included time, lack of administration support, pharmaceutical company responsiveness, and infrequent requests from clients to maintain proficiency. Just over half (52%) of survey respondents indicated LARCs were provided on-site, with Paragard, Mirena, and Nexplanon as the most commonly provided methods. About half (47%) of respondents reported their protocols allow for same day LARC insertion. Respondents indicated ordering and stocking LARCs was primarily constrained by the cost of the device and inadequate program funding amounts. Even though 52% of respondents indicated LARCs were provided on-site, a substantial number of agencies indicated providing LARCs by paid referral, which on average, delayed insertion visits up to two to four weeks and required that clients travel 10 to 20 miles for the insertion visit. When asked about health plan coverage for LARCs, 72% of respondents reported Medicaid Health Plans covered the actual cost of the device and service, whereas 67% of respondents indicated this was true with private insurers. Noted barriers to LARC

reimbursement were LARC method coverage, out-of-network denials, prior authorization requirements, and dually enrolled clients. Given the 2016 Medicaid Health Plan common formulary changes, it is anticipated that many of the aforementioned LARC reimbursement barriers currently reside with private insurance plans.

Respondents were also asked to comment on client awareness and interest in LARC methods, as well as provider approaches to contraceptive counseling. Ninety-seven percent of respondents reported clients were made aware of LARC availability with 61% of respondents having indicated an increased awareness and interest in LARCs from clients. As for provider approaches to contraceptive counseling, 71% of respondents indicated providers started with the most effective methods for new or undecided clients. Several respondents noted that if a client had indicated their method of choice at the outset of the visit, the provider would educate on that method and only discuss additional methods, starting with the most effective, if contraindications were present or if the client changed their mind after receiving additional information on their method of choice. Lastly, respondents were asked to comment on how MDHHS could better support the provision of LARCS among the network. Financial support was of highest priority, along with training opportunities for providers and staff, educational materials for clients, and working with private insurance plans to remove existing LARC barriers. This survey will be replicated during FY 2017 to reassess LARC barriers, inform contraceptive access initiatives for FY 2018, and provide targeted technical assistance to agencies most interested in removing barriers and increasing access to LARCs.

To increase provider professional development surrounding LARCs, a clinical practicum was offered at the Annual Family Planning Conference during FY 2016, where at least five Family Planning providers were trained on implant insertion and removal. Two educational sessions (on LARCs and contraceptive care) were offered at the Annual Family Planning Conference in FY 2016 by Dr. Elisabeth Quint. Her keynote, *Adolescents, LARCs, and Clinical Practice*, covered adolescent specific issues with the use of contraceptive methods, including barriers to contraception and strategies to improve adherence; LARCs as the preferred choice for adolescents; and indications, contraindications, and complication management of LARC. This keynote was attended by 150 Family Planning providers and staff. Dr. Quint's breakout session, *Contraceptive Challenges – Case-Based Learning*, used client scenarios to interpret the 2016 Contraceptive Guidelines, assess risks and benefits of prescribing contraceptives for women with chronic medical conditions, and discussed changes to the CDC's 2016 Contraceptive Recommendations. This breakout session was attended by 30 Family Planning providers and staff.

Objective D: By 2020, increase by 5% the proportion of Michigan women who report having a routine check-up within the past year.

In FY 2016, Medicaid outreach opportunities were promoted among local Family Planning agencies with 15 agencies (just under half) having received training or technical assistance from the MDHHS Medicaid Outreach consultant. Local Family Planning agency efforts to educate clients about health insurance focused on providing brochures and educational materials, provider referrals to other organizations, and working with other organizations for on-site

enrollment or enrollment events. Across Michigan's Family Planning network, approximately 8,314 individuals received Medicaid or Medicaid Health Plan assistance, whereas 1,018 individuals received Marketplace plan assistance, and 3,715 individuals received assistance with other health plans. Local Family Planning agencies enrolled 4,322 individuals in Medicaid or a Medicaid Health Plan, 284 individuals were enrolled in a Marketplace health insurance plan, and 2,233 individuals were enrolled in another type of health plan.

Local Family Planning agencies were reviewed and monitored on their development of medical and social service referral agreements and collaboration at the local level, as well as their assessment of client needs for primary care or other services. Primary care providers are included as a program minimum requirement for countable client encounters and established medical referral agreements. Of the agencies reviewed during FY 2016, 100% had incorporated asking clients whether they were in need of primary care services into their Electronic Health Record systems, and had current referral agreements with primary care providers within their community. Referrals to primary care providers were promoted on an as-needed basis. In FY 2017, local Family Planning agencies will continue to promote referrals with primary care providers and the MDHHS will work to strengthen state and local level relationships with primary care organizations, particularly Federally Qualified Health Centers.

Perinatal/Infant Health Domain

NPM 3 – Perinatal Regionalization

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 care	A) By 2020, support the implementation and evaluation of Regional Perinatal Care System Quality Improvement Initiatives in five pilot communities or regions	<p>A1) Disseminate guidance documents for the development and improvement of Regional Perinatal Care Systems (RPCS)</p> <p>A2) Provide staff and financial support to assist Regional Perinatal Care System Quality Improvement Initiatives</p> <p>A3) Assess for expansion of RPCS quality improvement efforts in other regions of Michigan</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 	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
	B) By 2020, increase Risk Appropriate Care for mothers and infants from baseline data indicators by 20%: Percent Very Low Birth Weight (VLBW); Percent Low Birth Weight (LBW); Percent live births 32-33 weeks gestation (preterm); Reduction of VLBW, LBW,	<p>B1) Promote case management/care coordination for at-risk pregnant women in Michigan through evidence-based programs such as CenteringPregnancy®, CenteringParenting® and maternal, infant and early childhood home visiting (MIECHV)</p> <p>B2) Participate in the Maternal and Child Health Bureau’s Alliance for Innovation on</p>		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
	preterm disparity	Maternal Health (AIM)		
	C) By 2020, expand quality improvement efforts related to the prevention and response of Perinatal Substance Use.	<p>C1) Prevention and Wellness: promote opioid use disorder prevention and increase screening and identification of women for opioid use disorder</p> <p>C2) Capacity: enhance capacity among cross-sector partnerships through increased capacity to monitor health and risk indicators and optimized resource allocation</p> <p>C3) Quality improvement: improve workforce development and training programs to improve education and training</p>		

Perinatal Regionalization FY 2018 Application

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, as a result of the five-year needs assessment process. 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 of VLBW or low birth weight (LBW) are at greater risk of longer hospital lengths of stay, compromised health statuses, developmental delays and even death in comparison to their full term, healthy weight counterparts. Black, Native American, Middle Eastern and Hispanic babies are seriously impacted by health inequities specifically related to gestation and birth weight. In Michigan, the percentage of preterm births steadily decreased from 10.5% in 2008 to 9.8% in 2015. However, Black infants experience twice the percentage of prematurity, very low and low birth weight in comparison to White infants. In 2015, the percentage of Black VLBW infants (3.2%) was nearly triple that of White VLBW infants (1.1%). Low birth weight percentages have remained fairly stagnant at 8.0% in 2008 to 8.5% in 2015. The singleton low birth weight percentages also remained quite consistent, from 6.3% in 2000 to 6.7% in 2015. However, in 2015, the percentage of low birth weight for White, non-Hispanic, infants was 6.9% compared to 14.6% for Black, non-Hispanic infants. These flat line percentages and persistent disparity indicate the need for innovation and collective efforts to move the percentages in a downward trend.

Addressing the existing 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 risk appropriate care hospital has reduced the risk of neonatal death.

Objective A: By 2020, support the implementation and evaluation of Regional Perinatal Care System Quality Improvement Initiatives in five pilot communities or regions.

Due to the diverse geographical make-up of Michigan, MDHHS is improving the Statewide Perinatal Care System through Regional Perinatal Care System (RPCS) Quality Improvement Initiatives. The regional approach responds to the variation of the regions.

Regional Perinatal Care System quality improvement efforts have been launched in four regional areas of Michigan with varied demographic compositions that is inclusive of rural and urban communities. Key community stakeholders include, but are not limited to: families, birthing hospitals, insurance payers, local health departments (LHDs), professional organizations, medical providers, health systems, Federally Qualified Health Centers, home visitation programs, and other community agencies. In FY 2018, two additional Regional Perinatal Care Systems will be launched in southwest Michigan and the Upper Peninsula.

Regional Perinatal Care System quality improvement efforts in northern Lower Michigan, an entirely rural area, have resulted in two quality areas of focus: perinatal substance use and a sustainable system of family support visits in the home for pregnant/postpartum women and their infants, with the intent of connecting families to evidence-based home visiting programs.

Secondly, Regional Perinatal Care System efforts have been initiated in southeast Michigan, an area that is inclusive of the cities of Pontiac and Detroit. Stakeholders are slated to focus on two quality improvement areas by June 2017 to help steer their work in FY 2018. The southeast Michigan project partnered with the Centers for Disease Control and Prevention (CDC) and all birthing hospitals in southeast Michigan to complete the Levels of Care Assessment Tool

electronic (LOCATe). As a result of the aggregate survey responses, an educational conference is being planned for September 2017 regarding the national guidelines for Perinatal and Maternal Levels of Care, which will help to inform FY 2018 activities.

Regional Perinatal Care System quality improvement efforts on the west side of the state have resulted in the selection of home visiting and perinatal substance use prevention and response as focus areas for quality improvement project initiation. All Regional Perinatal Care System initiatives are inclusive of active family engagement and based on a framework of health equity. Input from families is received through multiple mechanisms, including in person through participation at regional meetings, through focus group participation, and via community health workers who work with families and share their concerns and feedback. Moving forward, each regional project has committed to increasing family involvement/engagement. Prosperity Region 4 has been offering gift cards to help cover the costs of families that attend quarterly meetings, and plans to increase outreach through Great Start Collaboratives to invite more families. Regions 2 and 3 are conducting a pilot project regarding Perinatal Substance Use at two OB offices; the pilot includes a patient evaluation component to hear from patients regarding the process.

In FY 2018, each launched regional project will continue quality improvement efforts aimed at the improvement of maternal, infant, and family outcomes, as a means of decreasing the percentage of infants born prematurely and/or with very low or low birth weights. Assessment for potential additional regional perinatal care system quality improvement sites will be

conducted in FY 2018 in an effort to continue expansion to be inclusive of the entire state of Michigan.

Objective B: By 2020, increase Risk Appropriate Care for mothers and infants from baseline data indicators by 20%.

Strategy B1 is to promote case management and care coordination for pregnant women in Michigan through evidence-based programming. The department has partnered with the Michigan Primary Care Association to support and expand CenteringPregnancy® and CenteringParenting® in Michigan. CenteringPregnancy® is an evidence-based group prenatal care model that has been proven effective in decreasing the rate of preterm and low birth weight babies and “has been shown to nearly eliminate racial disparities in preterm birth. African American women, who are at higher risk for preterm birth in the US, experience lower risk of preterm birth when enrolled in CenteringPregnancy than in traditional care” (accessed from <https://www.centeringhealthcare.org/why-centering> on April 25, 2017). Given the model’s potential to impact premature birth rates and racial disparities, the number of CenteringPregnancy sites in Michigan is the ESM for this National Performance Measure. To date, there are 14 CenteringPregnancy group prenatal care sites in Michigan. In addition, MDHHS promotes case management and coordination for women through evidence-based 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 births. The MDHHS remains committed to ongoing promotion of the aforementioned evidence-

based case management and care coordination strategies aimed at decreasing poor outcomes for infants in FY 2018 and thereafter.

Strategy B2 remains the participation in the Maternal and Child Health Bureau's Alliance for Innovation of Maternal Health (AIM). In partnership with stakeholders and professional organizations, Michigan is collaboratively working toward improved maternal morbidity and mortality outcomes. It is imperative that the health status of mothers be addressed in prevention efforts aimed at reducing the number of premature, very low and/or low birth weight babies. The work of MI-AIM will continue lead the effort of improving maternal health of Michigan mothers in FY 2018 and beyond.

Objective C: By 2020, expand quality improvement efforts related to the prevention and response of Perinatal Substance Use.

Perinatal substance use is a risk factor for preterm births and infants born very low or low birth weight. Michigan has been impacted by opioid use in epidemic proportions. See the Emerging Issues section for detailed Michigan rates of impact of opioid use and abuse for the maternal/infant health populations.

In FY 2017, the MDHHS was one of ten states to participate in the Substance Abuse and Mental Health Services Administration (SAMHSA) and National Centers on Substance Abuse and Child Welfare (NCSACW) Policy Academy to improve outcomes for pregnant and postpartum women with opioid use disorders and their infants, families and caregivers. The charge for FY 2017 is the creation of a state-specific policy agenda and action plan that strengthen collaboration across systems to improve outcomes for infant and their families. This action plan will be

implemented in FY 2018 and will be inclusive of strategies C1 through C3 as outlined in the State Action Plan Table. Through this comprehensive effort, all strategies for NPM 3 include addressing perinatal substance use prevention and response through the Regional Perinatal Care System Quality Improvement Initiatives and evidence-based case management and care coordination efforts. Regional Perinatal Care System Quality Improvement projects in two areas of Michigan have begun piloting screening tools and protocols to identify and connect pregnant women to perinatal substance use resources. In FY 2018, it is anticipated that the pilots will result in a regional effort to prevent, screen and address perinatal substance use for all women of reproductive age in 21 counties in northern Michigan. Michigan will be taking strides to improve the knowledge and tools home visitors are equipped with regarding substance use when serving families, as a fragmented approach will not be successful in decreasing the number of mothers, infants and families impacted by substance use. Michigan is steadfast to the systems integration approach aimed at decreasing the percentage of infants born too early and too small.

Perinatal Regionalization FY 2016 Annual Report

Building on Michigan's existing perinatal care system, FY 2016 resulted in the expansion to Regional Perinatal Care System Quality Improvement efforts in west and southeast Michigan. Regional quality improvement efforts have served as the backbone of addressing risk appropriate care for mothers and infants and perinatal substance use. Focus was also placed on expanding and linking families to the evidence-based CenteringPregnancy and CenteringParenting prenatal and postnatal care models and evidence-based home visiting. The

importance of comprehensive system linkages and quality improvement remain the driving force behind the Michigan efforts to improve maternal, infant and family health.

Objective A: By 2020, support the implementation and evaluation of Regional Perinatal Care System in five pilot communities or regions.

In FY 2016, Regional Perinatal Care System Quality Improvement projects expanded from two collective areas in northern Lower Michigan to both southeast and west Michigan. Both regions encompass the largest number of births in the state. Southeast Michigan, inclusive of Wayne, Oakland and Macomb counties, is home to 24 of Michigan's 83 birthing hospitals. Of these 24 birthing hospitals in southeast Michigan, ten are neonatal intensive care units (NICUs) and represent just under half of the NICUs in all of Michigan. In calendar year 2015, 46,537 (41%) of the births in Michigan occurred in southeast Michigan. The southeast Michigan project chose birthing hospitals as the area for quality improvement and specifically assessing the neonatal levels of care per the CDC LOCATe survey. West Michigan contains 13 rural and urban counties, nine local health departments, 13 birthing hospitals and a reported 19,612 births in calendar year 2015. This project launched two months before the close of FY 2016 and was successful in engaging a multi-sector membership, which included many families residing in the region.

Objective B: By 2020, increase Risk Appropriate Care for mothers and infants from baseline data indicators by 20%.

In FY 2016, through the partnership of MDHHS and Michigan Primary Care Association, two additional CenteringPregnancy sites were opened. The Michigan Primary Care Association contracted with the Centering Health Institute to offer training and technical assistance for new

and existing CenteringPregnancy sites, as well as two sites expanding the Centering prenatal model to include the CenteringParenting model.

The Birthing Hospital Project was initiated in FY 2014, as a means of funding birthing hospitals to conduct quality improvement projects aimed at increasing the linkage of families in birthing units to evidence-based home visiting. Birthing hospital quality improvement included the implementation of referral mechanisms such as, but not limited to: hospital-produced videos regarding home visiting programs, enhancing electronic medical systems to trigger home visiting program referrals, training hospital staff regarding the importance and availability of home visiting programs, and the provision of training by birthing hospitals to prenatal care providers about the importance of referring pregnant women to home visiting programs. In FY 2016, 12 additional birthing hospitals were awarded funding as part of the Birthing Hospital Project. The 12 funded hospitals were in addition to the 32 birthing hospitals awarded funding in FY 2015.

In addition to the aforementioned successes, Michigan also participated in the Health Resources and Services Administration (HRSA) Infant Mortality Collaborative Improvement and Innovation Networks (CoIIN) regarding Risk Appropriate Care. As a part of the Risk Appropriate Care CoIIN, a quality improvement project was launched in northern Lower Michigan with nine birthing hospitals serving 21 rural counties, to delve further into the number of low birth weight infants delivered at birthing hospitals with well newborn nurseries as the highest level of birthing care. Based on the National Guidelines for Perinatal Care, the well newborn nurseries of Michigan most correlate as Level I nurseries. This quality improvement project resulted in

ongoing regional and individual institution quality improvement efforts to assure that babies are born at the hospitals that best medically meet their needs whenever possible.

Objective C: By 2020, expand quality improvement efforts related to the prevention and response of Perinatal Substance Use.

The MDHHS-supported Michigan Collaborative Quality Initiative is a voluntary quality collaborative of 25 Michigan birthing hospitals. In FY 2016, the Michigan Collaborative Quality Initiative conducted five learning opportunities regarding addressing Neonatal Abstinence Syndrome (NAS) throughout the state, held monthly webinars to share best practices and discuss collaborative efforts, and collected data to monitor improvements regarding NAS, breast milk use for very low birth weight babies, and infection rates of infants care for in Neonatal Intensive Care Units.

The Regional Perinatal Care System Quality Improvement Initiative of northern Lower Michigan convened maternal and child health partners from across their respective regions to learn about and devise a strategic plan to prevent and address perinatal substance use. The regions were experiencing epidemic rates of families impacted by substance use and infants being born with Neonatal Abstinence Syndrome (NAS). Those in attendance (i.e., laws enforcement, court system, local health departments, birthing hospitals, medical providers, child protective services, early childhood providers, substance abuse treatment agencies, community mental health authorities and many others) committed instituting a regional system of preventing, identifying, and addressing perinatal substance use.

Perinatal/Infant Health Domain

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 care	A) By 2018, develop a system for state breastfeeding plan implementation, along with a method to measure progress	<p>A1) Publish and promote the state breastfeeding plan statewide</p> <p>A2) Form a workgroup that will develop a plan to implement strategies</p> <p>A3) Identify shared measurement goals that will be utilized to measure progress on state breastfeeding plan</p> <p>A4) Develop a process to gather information on the strategies external partners are accomplishing on state breastfeeding plan</p>	<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 births 	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
	B) By 2020, increase Baby-Friendly hospitals to 20% across Michigan	<p>B1) Using Michigan’s mPINC scores, target educational and outreach efforts towards Prosperity Regions that have the greatest opportunity for improvement</p> <p>B2) Utilize a collaborative approach to move multiple hospitals towards Baby-Friendly status</p>		
	C) By 2020, determine all available resources to	C1) Collaborate with epidemiology workgroup to determine the most accurate resources for		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
	accurately measure breastfeeding initiation, duration, and exclusivity rates and measure racial and ethnic differences	<p>breastfeeding data collection in Michigan</p> <p>C2) Compile and disseminate breastfeeding data source document to internal and external breastfeeding stakeholders</p> <p>C3) Create annual data sheet highlighting Michigan’s breastfeeding statistics</p>		
	D) Reduce the gap between non-Hispanic white and non-Hispanic black women in breastfeeding initiation from 9% in 2014 to 8% in 2020 and in 3-month duration from 20.5% in 2014 to 19.5% in 2020	<p>D1) Analyze Michigan PRAMS race, education, age and stress data to ascertain causes of disparity in breastfeeding rates</p> <p>D2) Increase the racial, disability and cultural diversity of the IBCLC, CLC and CLS workforce in order to reflect the communities in which they work</p> <p>D3) Encourage the development of peer support groups that are culturally-representative of their communities</p>		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
	E) By 2020, increase the percentage of mothers who discussed feeding only breastmilk to their babies with their health care worker from almost 44% in 2013 to 48% as measured by PRAMS	E1) Utilize WIC Statewide Initiative 2016 hospital survey data to focus community outreach education efforts E2) Facilitate collaboration between home visiting, WIC and hospitals to ensure consistent messaging using evidence-based maternity care materials		

Breastfeeding Narrative FY 2018 Application

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 2016 Breastfeeding Report Card reported that 80.8% of Michigan’s infants are ever breastfed with a decline to 26.6% exclusively breastfed through six months. According to Michigan’s Women, Infants, and Children (WIC) breastfeeding rate report from September 2016, 65.1% of

women breastfed initially. The 2015 WIC pediatric nutrition surveillance reveals just 7.3% are exclusively breastfed through six months.

The American Academy of Pediatrics (AAP) reaffirms its recommendation of exclusive breastfeeding for the first six months of a baby's life. This recommendation is supported by positive health outcomes, as well as social and economic advantages for mothers and children, making it a public health issue and not just a lifestyle choice. Families require 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 2018, develop a system for state breastfeeding plan implementation, along with a method to measure progress.

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 1) the breastfeeding efforts occurring throughout the state and 2) ways to collaborate with partners to reach breastfeeding goals. In 2016, MDHHS and the workgroup planned two state breastfeeding forums to obtain key stakeholder input on how to remove barriers to breastfeeding, build on successful interventions, and build a culture in Michigan that supports breastfeeding families. Key stakeholders included employers, educational institutions, health

care professionals, health care systems, public health professionals, community organizations and community members.

From the results of the forums, Michigan created a State Breastfeeding Plan. The plan describes the approach and milestones to be achieved for the next three years with an added focus on reducing breastfeeding disparity. It will be a living document identifying strategies that programs and partners across sectors can use. The plan has been reviewed by internal and external breastfeeding stakeholders and is currently in final review by MDHHS Communications. Once published, MDHHS will promote the plan throughout the state with community partners and the public. In FY 2018, the plan will be promoted on the infant mortality website and the Michigan Breastfeeding Network (MIBN) website. A process to identify shared measurement goals among MDHHS programs and external breastfeeding partners will be identified and implemented.

Objective B: By 2020, increase Baby-Friendly hospitals to 20% across Michigan.

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 evidence-based practices that 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. Thus, increasing the percentage of Baby-Friendly designated birthing hospitals in Michigan is the ESM for the Breastfeeding National Performance Measure.

As of April 2017, 12 out of 83 Michigan hospitals (14%) have independently achieved the prestige of Baby-Friendly status to help initiate breastfeeding at birth. Multiple birthing hospitals throughout Michigan are on the path towards Baby-Friendly status. 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.

As a first strategy for this objective, in FY 2018 MDHHS will use Michigan's mPINC (Maternity Practices in Infant Nutrition and Care) scores to target education and outreach efforts towards Prosperity Regions that have the greatest opportunity for improvement. Staff training and discharge planning will be the focus of hospital and community trainings. A second strategy will use a collaborative approach to move multiple hospitals forward simultaneously, including monthly webinars, technical assistance, resource creation and sharing, and in-person trainings. MDHHS will continue to offer guidance and technical assistance to hospitals that plan to complete the Baby-Friendly process, as well as to hospitals that don't plan to complete the process but are interested in improving their breastfeeding supportive practices. 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: By 2020, determine all available resources 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.

In FY 2018, the first strategy will involve collaboration between MDHHS and epidemiology to determine the most accurate resources for breastfeeding data collection in Michigan. Current information from available local, state and national sources will be reviewed and utilized.

Identification of breastfeeding data that are not available within an organization or geographic area will be noted. The workgroup will determine additional data needs and how to collect data; identify potential links to existing activities and interventions; analyze data for patterns of needs and potential areas/groups to target; and develop best practices that support higher breastfeeding rates. In the second strategy, MDHHS will compile and disseminate a breastfeeding data source document to internal and external breastfeeding stakeholders. In FY 2018, MDHHS will work with eight to ten hospitals participating in collaborative work and quality improvement to obtain breastfeeding initiation, breastfeeding exclusivity and skin to skin data. This initial attempt at collecting data across multiple hospitals will determine feasibility of expanding this effort. In the final strategy, an annual data sheet highlighting Michigan's breastfeeding statistics will be developed and posted on the infant mortality website for use by breastfeeding partners in their statewide and local efforts.

Objective D: Reduce the gap between non-Hispanic white and non-Hispanic black women in breastfeeding initiation from 9% in 2014 to 8% in 2020 and in 3-month duration from 20.5% in 2014 to 19.5% in 2020.

Clear disparities exist in Michigan's rates of breastfeeding initiation and duration. Black women report the lowest rates for initiation and duration and mothers who are under 20 years old initiate breastfeeding at similar rates to older mothers, but fall far behind in duration by two months postpartum. Every woman and her family should have the opportunity to make the choice to breastfeed for as long as desired.

The first strategy to address disparities in breastfeeding rates must focus on ascertaining the causes of disparities. In FY 2018, Michigan's PRAMS data will be analyzed by race, education, age and stress. The data will help to focus future collaborative efforts. An analysis of Michigan's current breastfeeding workforce will preclude work on the second strategy, with efforts to increase workforce diversity. Intentional efforts to promote scholarships and trainings for minority counselors will increase the number of Black and teen breastfeeding support professionals. The third strategy to reduce disparities involves the development, support and promotion of diversity within breastfeeding support groups in order to reflect the communities they represent.

Objective E: By 2020, increase the percentage of mothers who discussed feeding only breastmilk to their babies with their health care worker from almost 44% to 50% as measured by PRAMS.

Research has shown that healthcare providers have a strong influence on a mother's decision to breastfeed. Therefore, it's important that the information provided is evidence-based and consistent. MDHHS's breastfeeding coordinator will provide education and tools to providers who work with pregnant women and their families. The first strategy will use results from WIC's

2016 hospital survey to help focus educational efforts. This survey of hospital leaders and staff identified a strong need for tools to improve referrals and for staff education of community resources. The most requested topics that staff wished mothers were more aware of included limiting visitors, basic breastfeeding knowledge and having an engaged champion. In FY 2018, there will be an increased focus on consistent messaging through printed materials, websites, webinars, and seminars. A monthly breastfeeding webinar, in collaboration between the Indiana Perinatal Network and MDHHS, will provide clinical and community breastfeeding education to Michigan's breastfeeding educators. The webinars are available at no-cost to participants and provide continuing education credits for lactation educators, nurses, dietitians and social workers. The second strategy will focus on collaboration between MIHP, home visiting, WIC and hospitals to ensure that consistent messaging is being used based on evidence-based maternity care materials. Collaboration will be encouraged through attendance at coalitions, provision of webinars, regular meetings with the state breastfeeding coordinator and continuing education seminars.

Breastfeeding FY 2016 Annual Report

During FY 2016, breastfeeding initiation and duration rates were maintained through training, education, promotion and support. The National Immunization Survey (NIS) 2016 Breastfeeding Report Card reported that breastfeeding initiation rates in Michigan have consistently increased over the past several years to an overall rate of 80.8% among 2013 births. However, Michigan rates remain slightly below both the U.S. National average of 81.1% and below the Healthy People 2020 objective target of 81.9% for infants ever breastfed. Michigan's rate of exclusive

breastfeeding at six months is 26.6%, above both the U.S. National average of 22.3% and above the Healthy People 2020 objective of 25.5%. According to Michigan's Women, Infants, and Children (WIC) breastfeeding rate report from March 2017, 64.8% of women initiated breastfeeding. The 2016 WIC pediatric nutrition surveillance reveals just 8.1% of infants were exclusively breastfed through six months.

Significant changes were made to the Breastfeeding state action plan in 2017 for the FY 2018 application. For clarity of reporting, the objectives used in this reporting section are from the original state action plan.

Objective A: By 2018, develop and promote a state plan to improve and support breastfeeding with a focus on duration, initiation and reducing disparities.

In recognition of the impact of breastfeeding on infant mortality and improving health and wellness, in the spring of 2016, MDHHS hosted two regional summits titled *Working to Bridge the Gap: Removing Breastfeeding Barriers*. To meet the first strategy of creating a state breastfeeding plan utilizing key stakeholder input, nearly 200 stakeholders participated in the forum in Lansing and nearly 50 participated in Marquette (in Michigan's Upper Peninsula). Efforts were made to include employers; educational institutions; state, local and tribal government; health care professionals and organizations; community organizations and members; and public health professionals. Specific efforts were made to involve families and consumers in the forums and numerous breastfeeding mothers attended. Forum participants learned about breastfeeding rates in Michigan, current efforts to promote breastfeeding in the state, and racial and ethnic disparities. Participants were then invited to help Michigan identify priority strategies for supporting breastfeeding families. Attendees brainstormed strengths,

areas for improvement, and specific strategies of focus for Michigan with the expressed goal of increasing breastfeeding initiation, duration, exclusivity and eliminating disparities. The ideas and suggestions from these summits formed the basis of the State of Michigan Breastfeeding Plan which has been written and reviewed. The plan is currently undergoing final review with publication expected in 2017.

Objective B: By 2020, increase Baby-Friendly hospitals to 20% across Michigan.

The number of Baby-Friendly designated birthing hospitals and centers in Michigan remains at 12 with a reduction in the number of birthing hospitals from 84 to 83 due to one closure.

Therefore, no change in the percentage of Baby-Friendly hospitals in Michigan was seen in FY 2016. However, 17 birthing hospitals are currently on the path to Baby-Friendly designation due to the collaborative efforts of Michigan's breastfeeding stakeholders. To accomplish the first strategy of beginning a statewide assessment of hospital maternity care practices supporting breastfeeding, MDHHS completed a statewide assessment of maternity care practices in Michigan using mPINC data and a WIC Statewide Hospital Survey. Michigan's mPINC data were organized/gathered by Prosperity Region which helped us identify areas of high need. The WIC Statewide Hospital Survey is being utilized to help focus educational efforts.

In order to assist hospitals in their breastfeeding promotion efforts, a competitive request for proposals was created. The second strategy of awarding a minimum of four mini-grants to assist hospitals in Baby-Friendly Hospital Initiative implementation was accomplished when ten birthing hospitals completed an application and eight grants of \$10,000 each were awarded. Money was awarded January 1, 2017 and a collaboration has been formed with these hospitals.

Objective C: By 2020, study and determine method(s) to accurately measure breastfeeding initiation, duration, and exclusivity rates and measure racial and ethnic differences.

In FY 2016, the MDHHS Breastfeeding Coordinator formed a workgroup with data partners in the Maternal and Infant Health Division and the Maternal Child Health Epidemiology Section to obtain input on determining a baseline for breastfeeding data collection in Michigan. The workgroup determined that the majority of Michigan's breastfeeding stakeholders were unaware of data parameters or how to access data. A breastfeeding data source document is being drafted. Future plans include creating a formal workgroup between epidemiology and maternal and child health, and finalizing the breastfeeding data source document for distribution.

The variance in electronic health record collection systems throughout Michigan has made collection of standardized breastfeeding data from hospitals and pediatricians an unobtainable goal at this time. MDHHS has requested and received Michigan mPINC data which can be shared by region for informational, program planning and reporting purposes. Data collection from specific birthing hospitals participating in collaborative work will be available in 2017.

Strategy D: By 2020, increase breast milk at discharge by $\geq 10\%$ (over baseline) for VLBW (under 1500 grams at birth) infants.

Supporting the Michigan Quality Collaborative Initiative and staff was accomplished through collaborative work in the education of NICU nurses in 2016. Support of the Michigan Collaborative Quality Initiative through education on the importance of early pumping and Kangaroo care occurred through trainings, webinars and resource sharing. Use of RedCap data

on breastmilk usage was found to be unobtainable and therefore, the second and third strategies related to use of RedCap data have been discontinued. Updated objectives and strategies are reflected in the current state action plan.

Perinatal/Infant Health Domain

SPM 2 – Safe Sleep Environments

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
Foster safer homes, schools, and environments with a focus on prevention	<p>A) By 2020, increase the percent of infants put to sleep alone in their crib, bassinet or pack and play by 4%</p> <p>B) By 2020, increase the percent of infants put to sleep without objects in their crib, bassinet or pack and play by 4%</p>	<p>A1, B1) Provide funding to a subset of local health departments and the Inter-Tribal Council of Michigan to support the implementation of community-based infant safe sleep activities</p> <p>A2, B2) Facilitate new collaborations with non-traditional partners to carry out programming that promotes infants being placed to sleep alone in their crib, bassinet or pack and play</p> <p>A3, B3) Develop and implement more effective messages and methodologies that are best-practice driven, reflect the needs and choices of families, align safe sleep implementation within a real-life context and provide messaging that is appropriate and relevant to diverse target population groups</p> <p>A4, B4) Provide education and tools for providers who work with pregnant and parenting families (in programs such as home visiting, WIC, child care, prenatal care, etc.) to have effective conversations about infant safe sleep</p> <p>A5, B5) Produce a safe sleep report</p> <p>A6, B6) Reduce the racial disparity related to unsafe sleep practices</p>	<p>A) Percent of infants put to sleep alone in their crib, bassinet or pack and play and B) Percent of infants put to sleep without objects in their crib, bassinet or pack and play</p>

Safe Sleep Environments FY 2018 Application

Through the needs assessment process, the state priority issue of “Foster safer homes, schools, and environments with a focus on prevention” was selected for the Perinatal/Infant Health

domain. The SPM created to address this priority need is: 1) the percent of infants put to sleep alone in their crib, bassinet or pack and play and 2) the percent of infants put to sleep without objects in their crib, bassinet or pack and play. These two behaviors are critical in the prevention of sleep-related infant deaths which are the third leading cause of death for infants overall in Michigan and the leading cause of death for infants 28 days to 1 year old. Of the leading causes of infant death, sleep-related infant deaths are considered the most preventable.

In 2015, MDHHS Vital Records reported 125 infants died in Michigan from Sudden Unexpected Infant Death (SUID). Historically, the number of infant deaths classified as SUID is an under reporting of the actual number of infant deaths that occur from sleep-related causes. Michigan is fortunate to be one of 18 jurisdictions/states that participate in the Centers for Disease Control and Prevention (CDC) SUID Case Registry Project which is a population-based, multistate surveillance system designed to identify SUID trends and risk factors. Through the SUID Case Registry, infant deaths are examined in detail to determine if sleep-related causes were involved. Additional sources are reviewed including death scene investigations, autopsies, and medical records. Frequently, this thorough review results in additional deaths being attributed to sleep-related causes. Thus, Michigan's SUID Case Registry reported 159 sleep-related infant deaths in 2015 (CDC SUID Case Registry, Michigan Public Health Institute, 2017). The rate of sleep-related deaths (deaths per 1,000 live births) for infants in Michigan (reported by the CDC SUID Case Registry Project) increased from 2014 to 2015 (1.2 to 1.3) as well as the number of deaths (from 152 to 159).

In addition to persistently high numbers, significant racial disparities exist among sleep-related infant deaths. Statewide, according to MDHHS Vital Records for the birth cohort 2009-2015, Black infants were disproportionately represented with three times more SUIDs than White infants, even after accounting for the fact that more White infants were born. The SUID Case Registry confirms the racial disparity, showing that Black infants in Michigan die at a rate more than three times greater than White infants (2.8 per 1,000 live births for Black infants compared to .8 per 1,000 live births for White infants), and American Indian infants die at more than twice the rate of White infants (2.0 per 1,000 live births for American Indian infants compared to .8 per 1,000 live births for White infants). These rates are likely an underreporting of the actual racial disparity as they do not include infants whose parents are of different races.

In addition to looking at data on sleep-related infant deaths, it is important to look at parental behavior related to infant sleep. Data reveal that although there has been modest improvement in some areas, parents are continuing to practice infant sleep behaviors that put infants at risk, which is confirmed by data from the Michigan Pregnancy Risk Assessment Monitoring Survey (PRAMS). Michigan PRAMS is a population-based survey that assesses the experiences and behaviors of mothers before, during, and after pregnancy, as well as experience of their babies. Michigan PRAMS employs a stratified random sample of live birth certificates and surveys approximately 1% of resident mothers in Michigan who have recently given birth during the calendar year. PRAMS results from 2014 show that 18% of all infants usually sleep on their side, stomach or a combination (an improvement from 21% in 2012); 19% of babies usually bed share with another person (an improvement from 21% in 2012); and 11% do not usually sleep in a crib or portable crib (remained the same from 2014). All of these

behaviors increase the risk for a sleep-related infant death. Overall, in 2014, only 38.5% of infants slept with no hazards in their sleep environment (hazards include sleeping in a position other than on their back, sleeping anywhere other than a crib, sleeping with people and sleeping with objects). PRAMS also provides data by race/ethnicity. For PRAMS results from 2012-2014, 37.6% of non-Hispanic Black mothers reported that their baby usually slept on their side, stomach or a combination compared to 16.4% of non-Hispanic White mothers. Similar differences are found in the other behaviors with 31.6% of non-Hispanic Black mothers reporting that their baby usually slept with the mother or another person (compared to 17.7% of non-Hispanic White mothers) and 17.5% of non-Hispanic Black mothers reporting that their baby does not usually sleep in a crib or portable crib (compared to 9.2% of non-Hispanic White mothers).

One behavior that continues to improve is back sleeping. In 2014, 81.7% of Michigan infants were usually sleeping on their back (improved from 79% in 2012), exceeding the Healthy People 2020 goal of 75.9%. This behavior varies by race, according to 2014 Michigan PRAMS, with 86% of White infants, 77% of Hispanic infants, 72% of Asian/Pacific Islander infants and 68% of Black infants being put to sleep on their backs.

Infant deaths in the sleep environment continue to occur due in large part to the risky behaviors discussed above. According to the SUID Case Registry, three in four sleep-related infant deaths in Michigan occurred in an unsafe sleep location—with nearly 50% of infants who died being placed in an adult bed for sleep; 15% placed on a couch or chair; and 12% placed in other unsafe sleep locations. Only 22% of infants who died of sleep-related causes were placed

to sleep in a crib, bassinet or portable crib. A crib, bassinet or portable crib was not present in the home in 15% of the deaths. Additionally, approximately 60% of sleep-related infant deaths occurred among infants who shared a sleep surface such as with an adult or sibling. One in two infants found unresponsive are not on their backs with approximately 44% found on their stomach and 11% on their side. Although these data look at the position when the infant was found unresponsive, it is unclear whether infants were placed to sleep in the found position or if they moved to that position during sleep.

While two distinct objectives for infant safe sleep have been identified, the strategies to address them are combined since the safe sleep behaviors are so closely related. Additionally, although infants being placed to sleep on the back was not chosen as a performance measure (as that behavior has seen improvement and is higher than the national average), all strategies and activities will promote the three key messages to parents and caregivers: infant sleeps alone, on the back, in a crib, bassinet or pack and play.

Objective A: By 2020, increase the percent of infants put to sleep alone in their crib, bassinet or pack and play by 4%.

Objective B: By 2020, increase the percent of infants put to sleep without objects in their crib, bassinet or pack and play by 4%.

The first strategy is to increase the capacity of communities to implement infant safe sleep education, awareness and outreach activities to promote infants being placed to sleep alone in their cribs, bassinets or pack and plays with no objects. This strategy will be accomplished through the provision of mini-grants to communities identified as having high numbers of

SUIDs. In addition to high numbers of deaths, many communities experience significant racial disparities among the deaths. In FY 2018, 15 LHDs and the Inter-Tribal Council of Michigan will be offered such grants. Each community currently uses a local advisory council to guide activities; coordination with any existing regional Perinatal Care Systems activities will be encouraged in FY 2018. All efforts must adhere to the current American Academy of Pediatrics recommendations for a safe infant sleeping environment issued in October 2016. Additionally, in FY 2017, training was provided to the mini-grantees in three key areas that complement existing strategies and have the potential to significantly reduce the number of sleep-related infant deaths. These key areas are: 1) promotion of breastfeeding, 2) promotion of smoking cessation, and 3) use of a trauma-informed approach. In FY 2018, mini-grantees will be encouraged to incorporate these areas into their overall plan for reduction of sleep-related infant deaths in their communities. Technical assistance and support will be provided, not only from MDHHS Infant Safe Sleep, but also from MDHHS Breastfeeding, MDHHS Trauma-Informed Systems and MDHHS Tobacco.

The second strategy to increase the percent of infants put to sleep safely is to facilitate new collaborations with non-traditional partners so the message spreads in communities that may not have been reached previously. Non-traditional partners often have greater acceptance in high-risk communities due to increased levels of trust and their ability to reach community members who are not being served in traditional settings. This approach has the potential to impact racial disparity as many of the populations that are disproportionately affected by sleep-related infant deaths may have strong connections with non-traditional community partners. In FY 2018, efforts to collaborate with faith-based organizations will be expanded, building on a

successful pilot that was conducted in FY 2016 and FY 2017 in Detroit. Initial plans are to increase the faith-based initiative in four counties that are eager to be a part of this expansion. Technical assistance and resources will be provided from MDHHS Infant Safe Sleep and the MDHHS Office of Inter-Agency Collaboration.

After further identification of non-traditional partners through a series of parent/caregiver focus groups, activities will be implemented in FY 2018 to develop effective messaging for these non-traditional partners as well as effective means of reaching them. This may be best accomplished through a number of methods such as social media, print material, PSAs, in-person events, etc.

The third strategy has been refined for FY 2018 to align with one of the major activities in a grant awarded to the MDHHS Infant Safe Sleep Program from the Michigan Health Endowment Fund (MHEF) in December 2016. The strategy has been expanded to include not only public awareness mediums, but to include the development and implementation of effective core messages that are best-practice driven, reflect the needs and choices of families, align safe sleep implementation within a real-life context and provide messaging that is appropriate and relevant to diverse population groups. The goal is that improved messaging and methodologies will translate to increased use of safe sleep practice among high-risk populations and ultimately reduce the number of deaths, in addition to the racial disparity. Much of the work in this area will hinge on the results of focus groups that will be conducted to identify what safe sleep messages resonate with families and trusted sources of information—and how to best deliver the message. Focus group results will be available at the beginning of FY 2018 in order to

inform and impact the development of new messages and methodologies during the course of the year. After initial development of messages and methodologies, market testing will be done so that refinements can be made prior to large scale dissemination. As in previous years, a media plan will be developed that will coordinate all education and awareness activities.

As a fourth strategy, the MDHHS Infant Safe Sleep Program will continue to provide safe sleep education and tools to providers who work with pregnant and parenting families in programs that reach those populations including home visiting, WIC, child care, and prenatal care. Staff at state and local levels will continue to provide training to these provider groups at state and local events. An online safe sleep training for health care providers will continue to be available, offering continuing education credits for social workers, nurses and certified health educators. A second online safe sleep training will also continue to be available and be included as a required training for child care providers by Licensing and Regulatory Affairs.

A focus for FY 2018 will be on providing training and tools for providers to have more effective conversations with parents/caregivers about infant safe sleep. Thus, the education will go beyond teaching them how parents should practice infant safe sleep, and will explore how to have conversations with parents about barriers to practicing safe sleep and how to help parents meet and overcome those challenges, using motivational interviewing and risk reduction theory. The MHEF grant will assist in advancing these efforts. A major objective of the grant focuses on increasing the number of trained partners who provide safe sleep education with one of the key activities being the development of a training for home visitors that uses the “conversations” approach described above. Additional support for professionals will be

provided through the development of a Community of Practice for safe sleep which will include quarterly webinars, establishment of an online professional resource and information forum and the option to participate in an infant safe sleep email subscription management system. Throughout the approaches for professionals described above, education and discussion about the impact of culture and trauma on parenting behavior will be addressed, along with teaching on how to work effectively with families by respecting their cultural traditions and experiences while also providing information and support to keep their infant safe. The Inter-Tribal Council of Michigan has done much work on this approach, and we hope to share their strategies with mini-grantees and other partners to learn from their success.

The next strategy is to produce an infant safe sleep report. A detailed report that compiles and analyzes data from all available sources, including providing recommendations based on the data, would be valuable in guiding programming and targeting resources. Racial disparities will be highlighted throughout the report which would be disseminated widely so that providers, partners and the general public could gain a better understanding of the problem and what can be done. The final report is scheduled for completion in December 2017. A dissemination plan will be established with input from MDHHS Communications.

The final strategy focuses on the need to reduce the unacceptable racial disparity that exists in sleep-related infant deaths in Michigan. As noted in the narrative above, each strategy integrates the need to address racial disparity. Approaches will vary according to the activity, but may involve allocating more resources to areas that experience greater racial disparity and

also gaining a better understanding of messages and methodologies that may be more effective with different racial or ethnic groups.

Family input is another component of program activities. Two parents regularly attend quarterly meetings of the Michigan Infant Safe Sleep State Advisory Committee and are active promoters of infant safe sleep in their communities. Several other parents are on the distribution list for the meetings and/or are in contact with MDHHS Infant Safe Sleep Program staff about their interest in becoming involved. It is hoped that in FY 2018, family/parent involvement will be expanded and staff will be able to provide the necessary supports to increase this important part of the program.

Safe Sleep Environments FY 2016 Annual Report

Objective A: By 2020, increase the percent of infants put to sleep alone in their crib, bassinet or pack and play by 4%.

Objective B: By 2020, increase the percent of infants put to sleep without objects in their crib, bassinet or pack and play by 4%.

Overall, in FY 2016 significant activity occurred in five of the six strategies. The sixth strategy, to reduce racial disparity, is tied to activities in the other five strategies so is not singled out in the narrative below. The Infant Safe Sleep Program is staffed by a part-time Program Coordinator and a Unit Manager who oversees additional programs. Limitations of staff time impact program activities. In December 2015, additional challenges arose as a subcontracted partner that provided a significant amount of safe sleep education around the state, including the

production and distribution of educational materials, closed unexpectedly. MDHHS Infant Safe Sleep Program staff and an additional part-time Consultant transitioned the partner's activities to MDHHS so there would be no disruption in services.

Six major strategies were implemented to impact parents' infant sleep practices. First, to continue and further expand a program initiated in 2013, funding in the form of mini-grants was provided to 14 LHDs and the Inter-Tribal Council of Michigan. The LHDs represented Michigan communities with the highest numbers of Sudden Unexpected Infant Deaths (SUIDs) and the Inter-Tribal Council of Michigan (due to the historically high numbers of SUIDs among American Indian infants). Grants were in the amount of \$22,500, with two mini-grantees receiving \$45,000 due to the highest numbers of deaths (City of Detroit and Wayne County). The mini-grants allowed communities to develop local programming to provide culturally relevant, community-based infant safe sleep education, awareness and outreach activities. Activities ranged from provision of 1:1 safe sleep education sessions at home or in a community setting to group classes to large community awareness events. In some communities, mini-grant funds were used to purchase billboards and develop and/or translate materials specific to the populations served. A portion of the mini-grant could be used to purchase pack and plays and/or sleep sacks. Through mini-grants 3,800 individuals (parents, caregivers, professionals and community members) received infant safe sleep education in a class or workshop and over 15,000 people were provided infant safe sleep information at community events such as health fairs. Pre/post test scores of attendees in the classes/workshops show that infant safe sleep knowledge and intention to practice safe sleep behaviors increased after attendance.

Another strategy was to facilitate new collaborations with non-traditional partners to carry out programming that promotes infants being placed to sleep alone in their crib, bassinet or pack and play. The main focus of this strategy was to engage faith-based organizations, and a pilot project was initiated with the Detroit Health Department. Expertise in working within the faith-based community was provided by the MDHHS Office of Inter-agency Collaboration with infant safe sleep content expertise provided by MDHHS Infant Safe Sleep Program. The project began in February 2016, with sessions designed to inform and engage pastors and congregants.

Participants included men, women, grandparents and others, reaching many for the first time with infant safe sleep education. After several months of educational and engagement activities, the initiative culminated in September 2016 with an Infant Safe Sleep Awareness Luncheon with representatives from the five faith-based organizations that participated in the pilot and Detroit Health Department and MDHHS staff. These organizations continue to be engaged at this time, conducting education and awareness activities in their communities with support from the Detroit Health Department. In FY 2018, MDHSS will expand the pilot statewide to add four faith-based organizations in each of four high-risk SUIDs counties.

The third strategy was to develop new public awareness mediums that focus on scenarios that support infant safe sleep. A radio PSA was developed in August 2016 that targeted young African-American women with a message about the danger of bed-sharing and the need to sleep an infant on a separate sleep surface. Radio was deemed a good modality as 61% of the target audience listen to traditional radio. The PSA has been received favorably and ran four weeks in August/September with over three million impressions in high-risk areas of the state. Due to the importance of the message and how it is communicated, in the fall of 2016 MDHHS

applied for a grant from the Michigan Health Endowment Fund (MHEF) with a main activity being to evaluate the message and methodologies. Since the number of sleep-related infant deaths in Michigan is not decreasing, and significant racial disparities exist among these deaths, evaluation was needed to ensure that the messaging and the methods used (e.g., radio, digital, etc.) resonate with parents and caregivers and is supportive of families in practicing safe sleep. The grant was received and funding will be provided through 2018.

The fourth strategy, to provide education and tools for providers who work with pregnant and parenting families to have effective conversations about infant safe sleep, is part of ongoing program efforts. Program staff provide training at conferences, professional trainings and webinar presentations to reach many who work in the field. The staff supported by the infant safe sleep mini-grantees are another critical component of this work, as they provide education for local groups such as hospitals, home visiting collaboratives, child care centers, community agency staff, etc. Online training opportunities are available as well, with provision of a training for child care providers and a broader one for others providing care for pregnant women and parenting families. In FY 2016, 6,390 individuals completed infant safe sleep training online. Providers are also supported with access to free educational materials to use in their work with families; 339,000 educational items were distributed by MDHHS in FY 2016.

The fifth strategy is the production of an annual safe sleep report. This activity was not completed due to other program priorities, but work began on the report in FY 2017 with completion scheduled for December 2017. Due to staffing and other resource limitations, the report will not be produced annually.

Child Health Domain

NPM 6 – Developmental Screening

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
Invest in prevention and early intervention strategies, such as screening	A) By 2018, identify initial implementation steps of a statewide developmental screening system	A1) Create a strategic plan for a statewide developmental screening system A2) Ask Great Start Steering Team to adopt this objective as a focus item for the Great Start early childhood system	<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
	B) By 2020, adopt consistent screening and referral procedures across the system C) By 2020, adopt consistent procedures for responding to referrals, receipt and disposition D) By 2020, adopt procedures/strategies for reporting results to parents	B1, C1, D1) Conduct analysis and compile current policy/funding streams		

Developmental Screening FY 2018 Application

Through the five-year needs assessment process, the state priority issue of “Invest in prevention and early intervention strategies, such as screening” 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. Notably, according to U.S. Census estimates, in Michigan in 2015 approximately 45% of children (308,043 children) aged 0 to 5 years were enrolled in Medicaid or MICHild and should have received standardized developmental screening as part of EPSDT. According to the Michigan Medicaid 2016 HEDIS Results, 66% of children aged 15 months were up-to-date on their well-child visits, while 75% of children aged 3-6 had an annual visit. This would seem to indicate that a fairly high percentage of Medicaid-enrolled children aged 0 to 5 are up-to-date on well-child visits, but this does represent a slight decrease overall from 2015. 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. MDHHS will address the need to improve developmental screening policies and coordination across the state. Our approach will primarily focus on addressing state level coordination, policy and procedures.

Objective A: By 2018, identify initial implementation steps of a statewide developmental screening system.

Although it is important for Michigan to build off other state initiatives such as Michigan’s Medicaid State Innovation Model (SIM), in FY 2018, MDHHS will focus on our Evidence-based Strategy Measure (ESM): Create a strategic plan for a statewide developmental screening system to begin to focus on addressing state level coordination, policy and procedures. Michigan currently lacks a coordinated, comprehensive developmental screening state system—one that identifies and tracks children who are receiving screens, increases efficiency by reducing duplication, and identifies potential groups of children who are not being screened. In FY 2017, Michigan has convened a range of early childhood and other stakeholders, including parents of young children, to begin discussion and the process of writing a strategic plan to develop a statewide developmental screening system. By FY 2018 the plan will:

- Identify key criteria and components of a state system and its most appropriate uses
- Identify the elements needed to put a state system place
- Identify the outcomes to be achieved with a statewide plan
- Ascertain any potential barriers as well as potential opportunities that can be leveraged
- Identify groups that would be the prime users of the system (i.e., Health Plans, Medicaid, Education, Home Visiting, and other community stakeholders)
- Identify potential funding sources
- Develop an estimated timeline for implementation

The Early Childhood Health Section has a long history of including parents as partners in state level work, and has established procedures to identify and support parents. To ensure

appropriate parent representation, established procedures to recruit and support parent involvement in the stakeholder workgroup and activities at all levels have been used.

The strategic plan to develop a statewide developmental screening system will 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. Given the high number of entities within the early childhood system currently conducting developmental screening (e.g., physicians, home visitors, Head Start, county-wide initiatives) and also discussing incorporating screening into their care efforts (i.e., child care), there is a 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.

MDHHS is part of Michigan's Early Childhood System, using an interdepartmental team through the Great Start Steering Team (GSST) and the Great Start Operations Team (GSOT) approach to address early childhood services integration and coordination. MDHHS, the Department of Education (MDE), and the Early Childhood Investment Corporation convene via the GSOT to provide strategic direction and system-building expertise for programs focused on Michigan's young children and their families. This approach ensures that efforts are efficient and not duplicated, and that meaningful connections are made within our agencies as well as with the local communities they serve. The strategic plan will lay out the steps with concrete and deadline-driven activities to achieve longer-term goals of the MDHHS Title V MCH Block Grant and the MDE Child Care Development Fund grant to align developmental screening policies and

procedures across state and local systems to ensure that by 2020, Michigan is successful in meeting our additional objectives (see below).

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

The Early Childhood Health Section has a long history of providing successful implementation of a variety of initiatives (e.g., Project Launch, MIECHV, and ECCS grants). Currently, while the desire to move this project forward is strong, capacity of staff to facilitate the workgroup that will develop the strategic plan has created a challenge. A solution to our capacity challenge has been to identify a staff person (hired in the fall of 2016) whose primary duties are to focus on early childhood projects within MDHHS to lead this group. Our commitment to work within the early childhood system, not in silos, has led us to partner with MDE to combine efforts to align each other's work related to developmental screening. In FY 2017, the workgroup has begun an analysis of 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. Additionally, many smaller, community-based developmental screening initiatives have been established in recent years and are building capacity in their local communities but do not align with a formal policy or connect to other statewide systems such as health or education. An additional challenge is that not all children who most need to be

identified through developmental screening (e.g., those living in poverty or other at-risk situations) are the children who are being screened through community initiatives. In its analysis, which continues in FY 2018, MDHHS will assess which disparities exist around developmental screening and how communities and agencies ensure 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 range from foundation or community agency funding to federal 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 strategic plan will be the culmination of the activities listed above and will be developed in FY 2018. Future steps for this stakeholder group include recommending 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 future implementation of the strategic plan, consistent statewide screening procedures will be identified (e.g., quality tools to use, when to refer, community resources, screening junctions). As time and funding allow, short cycles of public comment and testing will be utilized 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. Plan modifications will be made based on these results.

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. 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—thereby aligning efforts with the Department’s scope of work for the Race to the Top Early Learning Challenge Grant, conducted in partnership with the Department of Education.

Developmental Screening FY 2016 Annual Report

The opportunities for families to participate in standardized developmental screening in Michigan have increased over the last several years with increases in the numbers of families screened through local and state level screening projects (e.g., universal screening in Kent County, Michigan; increased awareness of the developmental screening Healthcare Effectiveness Data and Information Sets (HEDIS) measure for Medicaid Health Plans). However, there is still a lack of coordination which leads to inefficiency and duplication.

Objective A: By 2018, identify initial implementation steps of a statewide developmental screening system.

As part of our process to move toward a statewide strategic plan, in FY 2016 MDHHS began moving forward with the Michigan Department of Education (MDE) to align activities of each department. MDHHS and MDE both participate in the Great Start Operations Team (GSOT)—an interagency body designed to coordinate and align early childhood efforts within Michigan. In FY 2016, MDE notified the GSOT that they, as part of their Child Care Development Fund

grant, were required to complete work specifically related to standardized developmental screening, particularly as it related to children in early care and learning settings. MDHHS also notified the GSOT that developmental screening was a component of our Title V grant. A subcommittee of the GSOT crafted a developmental screening workgroup charge with corresponding action steps, and in FY 2017 the workgroup was formally implemented. The goals of the workgroup include 1) Coordinate efforts to enable early learning and care providers to access and share developmental and behavioral health screening with families. As needed, recommend changes to current policies, rules and procedures that could strengthen coordination; and 2) Develop a strategic plan for a statewide developmental and behavioral health screening system to meet the activities defined in the Title V Maternal and Child Health Block Grant.

To achieve these ends, MDE and MDHHS began discussing options for identifying staff to facilitate the work outlined by the charge to ensure that the work could continue to be a priority and continue to move forward. MDHHS, with MDE's agreement, identified a staff person who was already slated to function as the Early Childhood liaison was the ideal facilitator. That person was hired in early FY 2017.

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.

Activities for Objectives B, C and D were not completed in FY 2016. These objectives will be addressed after the strategic plan is created in FY 2018.

SPM 1 – Lead Poisoning Prevention

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
Foster safer homes, schools, and environments with a focus on prevention	A) By 2020, increase by 20% from baseline data the percent of Medicaid-enrolled children under age 6 with an elevated blood lead level (EBLL) from a capillary test who receive a venous lead confirmation test	<p>A1) Identify and implement strategies to ‘flag’ the capillary results that need venous lead confirmation testing for Medicaid-enrolled children</p> <p>A2) Develop and disseminate educational materials and trainings focused on Medicaid Health Plans and Medicaid providers that support understanding of the need for venous lead confirmation testing and overcoming barriers to retesting</p>	Percent of children less than 72 months of age who receive a venous lead confirmation testing within 30 days of an initial positive capillary test
	B) By 2020, increase by 10% from baseline the percent of all children under age 6 with an EBLL from a capillary test who receive a venous lead confirmation test	<p>B1) Develop and implement a set of data analyses which will provide health care providers, other agencies and the public with information on where to target outreach to improve confirmatory testing</p> <p>B2) Provide Local Health Departments and health care providers with lists of EBLL children who need confirmatory venous testing so they can contact families of EBLL children</p> <p>B3) Develop and implement educational materials and strategies targeted to non-Medicaid</p>	

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
		providers and the public that support understanding of the need for venous lead confirmation testing	

Lead Poisoning Prevention FY 2018 Application

Blood lead testing of children at risk of exposure to lead in homes or from other sources is critical for targeting interventions to prevent adverse health effects of lead. Children who are poor, live in homes built before 1978, are enrolled in Medicaid, and/or receive other social services (e.g. WIC) are especially at risk of lead exposure and are targeted for blood lead testing. Children with elevated blood lead levels (EBLLs), defined as a blood lead level (BLL) equal to or greater than 5 micrograms per deciliter of blood ($\mu\text{g}/\text{dL}$), should have interventions to identify and mitigate the sources of lead in their environments.

One strategy being used to increase blood lead testing is adoption of point-of-care capillary testing machines in many primary care provider offices and WIC clinics. These desktop analyzers provide parents with immediate results, and are often easier on the child and the parent than a trip to a laboratory for a venous draw. However, elevated capillary results still need to be confirmed with a venous test because they are prone to false positives. It is important to obtain a confirmatory venous test before interventions are initiated. Failure to obtain a confirmatory venous test negatively impacts children’s access to appropriate clinical follow-up, as well as in-home support and follow-up such as case management and environmental investigations; both of which are typically triggered by an elevated venous result. In 2015, only 21% of children with a capillary EBLL received the appropriate follow-up

confirmatory venous testing, resulting in inadequate or no interventions for over 2,000 children with potential EBLL. The State Performance Measure “Percent of children less than 72 months of age who receive a venous lead confirmation testing within 30 days of an initial positive capillary test” was selected to address this problem. The impact of events in the city of Flint brought extraordinary attention to lead exposure, blood lead testing, and the health effects of lead not only in Flint, but throughout the state. These events have impacted future activities to address the state’s priority need.

In October 2015, the State of Michigan confirmed observed increases in EBLLs in young children in Flint. These changes were associated with a change in the source of water from Lake Huron to the Flint River, which occurred in April 2014. The failure to add corrosion inhibitors to the water resulted in leaching of lead from pipes into the water supply, which in turn resulted in increased blood lead levels in children.^{3,4} This public health emergency response brought local, state and federal resources together to coordinate a response that is expected to continue well into the future, with the common goal of protecting Michigan residents from lead exposure.

The impact of the [Flint Water Crisis](#) on subsequent blood lead testing was notable. Multiple agencies were involved in implementing recommendations that all Flint residents have at least one blood lead test: Blood lead testing was offered at health fairs and other public venues in Flint; community groups and local governmental agencies reached out to families with whom they were engaged for other reasons (e.g. housing, WIC clinics); and messages to families were

³ Hanna-Attisha M, LaChance J, Sadler RC, Schnepf AC. Elevated blood lead levels in children associated with the Flint drinking water crisis: A spatial analysis of risk and public health response. *American Journal of Public Health*. 2016; 106(2): 283-290

⁴ Kennedy C, Yard E, Dignam T, et al. Blood Lead Levels Among Children Aged <6 Years — Flint, Michigan, 2013–2016. *MMWR Morb Mortal Wkly Rep* 2016;65. DOI: <http://dx.doi.org/10.15585/mmwr.mm6525e1>

disseminated using the press and social media. Because of extensive coverage of the Flint crisis in the media, providers and the public across the state were more cognizant of the need for testing. Thus, the number of children tested, which had been declining from a peak of 155,847 in 2010 to 140,857 in 2015, rose to 157,633 in 2016. The number of registered Leadcare II users, which are the source for capillary test results, jumped from 31 in 2015 to 55 in 2016. Highlighted concerns about lead poisoning and lead exposure also led to the creation of the Governor's Child Lead Poisoning Elimination Board to address the need for coordinated efforts to design a long-term strategy for eliminating child lead poisoning in Michigan. The Board's recommendations focused on the importance of eliminating sources of lead in the environment before children become lead poisoned. Further, it recommended that Michigan "...require that 100% of children are tested for lead poisoning at 9 to 12 months and at 24 to 36 months of age. Confirmation of a capillary EBLL should occur within 1 month by a venous blood sample."⁵ In March 2017, a permanent Child Lead Exposure Elimination Commission was created to implement the recommendations of the Child Lead Poisoning Elimination Board, one of which is to change Michigan from a state that targets lead testing for high-risk children to one that promotes universal testing of young children. These recommendations, if implemented, will have ramifications on increased testing and the imperative to procure venous confirmatory testing of EBLL capillary tests.

Finally, in the aftermath of the Flint Water Crisis, MDHHS made an organizational change in 2016 to ensure that childhood lead poisoning prevention was fully integrated with related

⁵ http://www.michigan.gov/documents/snyder/CLPEB_Report--Final_542618_7.pdf

services and expertise. This involved moving the Childhood Lead Poisoning Prevention Program (CLPPP) from the Division of Family and Community Health to the Division of Environmental Health, (within the Bureau of Epidemiology and Population Health), which has overall responsibilities for addressing environmental hazards and for administering the state's Lead Safe Home Program. This move strengthened integration of the blood lead surveillance and epidemiology functions with MDHHS's area of epidemiologic expertise. In addition, three additional staff were hired in 2016, and two in 2017, who will be involved in carrying out the activities described in this plan.

Objective A: By 2020, increase by 20% from baseline the percent of Medicaid-enrolled children under age 6 with an elevated blood lead level (EBLL) from a capillary test who receive a venous lead confirmation test.

The first strategy is to identify and implement ways to 'flag' capillary results for Medicaid-enrolled children who need a venous lead confirmation test. Medicaid-enrolled children are targeted because they are a high-risk group and because Medicaid requires BL testing of all Medicaid children by age 3, or by age 6 if not tested previously. Calling specific attention to any unconfirmed EBLL capillary results will support Medicaid Health Plan case managers and primary care providers to take specific steps to follow-up with families to order tests, help arrange transportation as needed, and address any other barriers to obtaining the venous test. Medicaid currently sends a weekly data extract to Medicaid Health Plans of their children's blood lead test results, and CLPPP will be working with Medicaid staff to modify that weekly data extract so that all children with unconfirmed elevated capillary results are flagged as needing the follow-up venous test. In addition, Medicaid uses a case management data system

called CareConnect 360 which has recently been expanded to include a lead module. CLPPP will work with Medicaid to assure that CareConnect 360 can be programmed to include a 'flag' for unconfirmed elevated capillary tests for children that need a venous lead confirmation test. Medicaid also mails a hard copy list of enrolled children and their BL test status to each Local Health Department (LHD) quarterly, but historically no follow-up has been conducted to determine if any LHD uses these lists to follow up with families of EBLL children. CLPPP will work with Medicaid to provide these lists to the LHDs electronically and to assure that the LHDs are accessing and using these lists to promote confirmatory testing, as well as overall testing. One critical intervention to prevent adverse health effects of lead is to conduct in-home nursing case management for EBLL children. Until 2017, very few LHDs had the resources to provide this service for all EBLL children, especially those with lower EBLLs. In January 2017, in partnership with Medicaid, a new program was made available to LHDs whereby they can be reimbursed at a rate that covers expenses for nursing case management for Medicaid-enrolled children with blood lead levels of 5 µg/dL and greater. One of the requirements for reimbursement is that the child's EBLL be confirmed with a venous test, thus LHDs are expected to work with the families of capillary EBLL children to obtain the venous before initiating case management. This program will continue in FY 2018, and CLPPP will be managing and auditing the contracts with LHDs to ensure that they are making efforts to obtain confirmatory venous tests where needed, and providing training to support these activities.

The second strategy is to develop and disseminate educational materials and trainings focused on Medicaid Health Plans and Medicaid providers that support understanding of the need for venous lead confirmation retesting and overcoming barriers to retesting. MDHHS will work with

Medicaid Health Plans and Medicaid health care providers, including LHDs, to identify priority actions to overcome barriers to testing and confirmatory retesting, in partnership with the Governor's Child Lead Exposure Elimination Commission. Since one barrier is lack of awareness by providers and the public on this issue, CLPPP and LHDs will be conducting trainings and disseminating educational materials to create awareness. Contracts with LHDs also will require that LHDs work with local infrastructure to mitigate transportation barriers and educate families and providers about transportation resources (e.g. Medicaid reimbursement for public transportation to doctors' offices). CLPPP will be encouraging LHDs to disseminate its updated "[Blood Lead Level Quick Reference for Primary Care Providers](#)" factsheet, which highlights testing frequency, confirmatory retesting and interpretation of test results. One Medicaid Health Plan has started sending phlebotomists to the homes of capillary EBLL children in order to obtain the venous sample. The success of this program will be monitored and brought to the attention of other Medicaid Health Plans, if appropriate.

Objective B: By 2020, increase by 10% from baseline the percent of all children under age 6 with an EBLL from a capillary test who receive a venous lead confirmation test.

Because of Medicaid's BL testing requirements and the infrastructure and data available from Medicaid to reach this population, Medicaid-covered children and their families remain primary targets of this objective. In addition, the strategies and activities developed and implemented with Medicaid-covered children will be expanded to impact children served by private insurance carriers and children with no insurance coverage, as CLPPP learns from experiences with the Medicaid population.

The first strategy is to develop and implement a set of data analyses which will provide health care providers, other agencies and the public with information on where to target outreach to improve confirmatory testing. MDHHS will use BL surveillance data to identify non-Medicaid children and their risk factors and to disseminate these data so that LHDs, providers, private insurers and other agencies can promote testing and confirmatory retesting. Data analysis activities in FY 2018 will include:

- Adding a section to the CLPPP [annual surveillance summary reports](#) on analysis of the rates of confirmatory testing of capillary EBLLs.
- Preparing a special report on testing and confirmatory testing that provides data on risk factors including gender, race/ethnicity, geographic location, population characteristics (e.g. percent older housing) and other contributing factors (e.g. rural versus urban residence); and that provides recommendations for targeted education and other interventions.
- Generating quarterly reports of the number of EBLL tests; number of capillary EBLL tests with confirmatory venous tests conducted within 30 days and 90 days of the screening test; and the numbers of EBLL screening tests that are confirmed as elevated by confirmatory tests. These data will be provided to LHDs as a “report card” on their efforts to increase testing and confirmatory EBLL testing, and used by CLPPP to evaluate the positive predictive values of screening test results by testing method and laboratory or provider.
- Responding to special data analysis requests from LHDs and other agencies that do not have access to the surveillance data or epidemiologic expertise in-house.

The second strategy is to provide LHDs and health care providers with lists of EBLL children who need confirmatory venous testing so they can contact families of EBLL children. CLPPP will flag

children needing confirmatory venous tests for LHDs and health care providers. CLPPP will provide LHDs with confidential lists of non-Medicaid children in their jurisdictions who are in need of confirmatory venous testing. Although the new in-home nursing case management project described above is for Medicaid-covered children because funding comes from Medicaid, many LHDs have committed to doing follow-up with non-Medicaid children with EBLLs, including pursuing venous confirmatory tests where indicated. Contracts with three LHDs with the largest caseloads of EBLL children will help support follow-up with non-Medicaid EBLL children. In addition, CLPPP will explore the feasibility of adding a “flag” for unconfirmed elevated capillary tests that are now displayed in every child’s record in the state immunization registry, the Michigan Care Improvement Registry (MCIR).

The third strategy is to develop and implement educational materials and strategies targeted to non-Medicaid providers, families, and the general public that support understanding of the need for venous lead confirmation testing. Grants will continue to be provided by MDHHS to nine LHDs to provide regional lead education and outreach. MDHHS will continue to provide technical assistance to the grantees in development of work plans that increase testing.

Grantees are also required to provide education, outreach and training to professionals who serve as distribution channels to families with a high risk of lead exposure. These professionals include WIC staff, Great Start Collaborative partners and participants, child care providers and others involved with the care of children under six years of age.

Lead Poisoning Prevention FY 2016 Annual Report

The Childhood Lead Poisoning Prevention Program (CLPPP) has carried out mandated blood lead surveillance and lead poisoning prevention activities since 1998. Childhood lead poisoning

has declined steadily in Michigan, but elimination has not yet been attained. In 1998 (the first complete year of required reporting) among children under the age of six tested for lead, the percentage of children with elevated ($\geq 5 \mu\text{g/dL}$) blood lead levels (EBLL) was 42.7% (31,395 children). In 2015, the percentage decreased to 3.4% (4,791 children) but increased in 2016 to 3.6% (5,715 children). This increase is at least partly due to dramatically increased testing in Flint and, to a lesser extent throughout Michigan, as a result of the Flint Water Crisis. The number of Flint children under age 6 tested rose from 3,387 in 2015 to 6,640 in 2016; and, for all of Michigan, from 140,961 in 2015 to 157,633 in 2016. The highest rates of EBLL were in the city of Detroit, which accounted for more than half of all children with confirmed EBLL in the state, followed by the City of Grand Rapids. The rate of confirmatory venous testing of EBLL capillary tests in 2015 was 21.1% which rose to 23.6% in 2016.

This report describes activities undertaken in FY 2016 to improve testing in general and confirmatory testing specifically. The attention brought to lead poisoning prevention as a result of the Flint Water Crisis drove the allocation of additional resources and staff to the CLPPP at MDHHS; and increased collaboration with other agencies and organizations involved in lead poisoning prevention including Michigan's Medicaid program, LHDs, non-profit organizations, universities, researchers and advocacy groups. The Flint Water Crisis response began in October 2015. The three CLPPP staff at that time were located in the Division of Family and Community Health. The blood lead data management system and staff were transferred to the Division of Environmental Health in November 2015, and the intervention staff were transferred in August 2016. This ensured co-location of CLPPP staff with environmental, epidemiologic and lead

abatement subject matter experts. In addition, new funds from state general fund appropriations and other grant funding allowed the CLPPP to expand to seven staff.

In 2016, Medicaid-enrolled children were the focus of programs and activities because of Medicaid BL testing requirements, increased programmatic collaboration between CLPPP and Medicaid, and the focus on Flint, where over 80% of the children are enrolled in Medicaid.

Objective A: By 2020, increase by 20% from baseline data the percent of Medicaid-enrolled children under age 6 with an elevated blood lead level (EBLL) from a capillary test who receive a venous lead confirmation test.

Programs and activities undertaken in FY 2016 to improve testing and confirmatory retesting of Medicaid-enrolled children included:

- Weekly reports to Medicaid Health Plans (over 80% of Medicaid enrolled children are in managed care Health Plans) with lists of enrolled children under age three that included their blood lead test results, flagging children who had not had a blood lead test.
- Monthly data summary reports of the testing status of Medicaid-enrolled children that included data by Medicaid Health Plan, posted on the MDHHS website, in an effort to bring all Medicaid Health Plans in line with the Medicaid goal of 80% of continuously-enrolled children tested by age three.
- New Medicaid contract language requiring Medicaid Health Plans to ensure care coordination and case management services were provided to children with venous-confirmed EBLLs.
- Planning for the FY 2017 roll-out of a new reimbursement rate (with Medicaid funding) for in-home nursing case management for children with EBLLs, including engagement with their

families, to be provided by LHDs; the program has a requirement that the capillary EBLLs must have a confirmatory venous before case management services can be provided.

- Establishment of a monthly Medicaid - CLPPP workgroup to ensure coordination between Medicaid programs and services and CLPPP.
- Facilitating requests for BL data and Medicaid data by researchers, in particular, those interested in the impacts of the lead-contaminated water on the health of children in Flint.
- Oversight over a contract to provide in-home nursing case management to EBLL children in Genesee County, including the city of Flint. The contract included a requirement that the case managers engage families and health care providers of the children with capillary EBLLs to encourage them to obtain the confirmatory venous test.

Objective B: By 2020, increase by 10% from baseline the percent of all children under age 6 with an EBLL from a capillary test who receive a venous lead confirmation test.

At the beginning of FY 2016, the CLPPP program included only three staff; two of whom provided data management of the surveillance system, and a nurse consultant who oversaw contracts with LHDs to provide outreach, education and interventions with children with high EBLLs. Epidemiologic support was provided by a .10 FTE epidemiologist in another Bureau.

Because of the Flint Water Crisis, MDHHS reorganized and identified additional staff for CLPPP, with a focus on improving BL surveillance data quality and data analysis, recognizing that program activities needed to be driven by quality data. Thus, the first step to meeting this objective was to improve the surveillance data system and expand on data analyses. The following data-related activities took place in FY 2016:

- CLPPP, in partnership with the Michigan Public Health Institute, worked on development of MiCLPS (Michigan Childhood Lead Prevention Surveillance), a web-based surveillance data application with significantly enhanced functionality which is replacing the current data management system that has been used since 1998. MiCLPS is designed to streamline the processing of laboratory blood lead reports and ensure that data linkages (e.g. with Medicaid claims files and MCIR) are accurate and complete.
- All BL test results were uploaded to a data application called Mi-HHLPSS which has been used by LHDs to view BL results of children in their jurisdiction (including test results and test type) and input information about follow-up activities with EBLL children. Mi-HHLPSS was installed on a Michigan server in 2014, based on an application that was developed by the CDC CLPPP and made available to states.
- CLPPP generated weekly lists of children's test results by LHD jurisdiction, including BLL and test type, and made these lists available to LHDs on a secure FTP site.
- The annual surveillance data summary with calendar year 2014 lead data was released and posted on the MDHHS website in March 2016. The summary included data on venous and capillary blood lead tests by county. Data analysis for the 2015 annual report was started.
- Numerous Flint-specific data reports were prepared for the public (), MDHHS senior management and the Governor's Office.
- Responses to over 100 data requests from the LHDs, the press, public, researchers and other agencies were prepared.
- All data analyses and data request responses included guidelines for analysis and interpretation of BL values generated by capillary tests without a confirmatory venous.

Education and outreach to overcome barriers to testing and confirmatory testing were also highlighted in FY 2016. Contracts were provided to eight LHDs to provide lead education regionally to the public and providers, supported by written educational materials (e.g., public FAQs, guidance documents for providers). LHDs conducted 218 trainings and presentations in FY 2016 targeting public health professionals, health care providers, and others on the importance of testing and appropriate follow-up, among other subjects. Recommendations from a health care provider workgroup that met quarterly in FY 2015 were incorporated into the work plans of the LHD grantees. A SharePoint site was set up for LHDs to access MDHHS's protocols, educational materials, and other materials to support their lead activities and also so that they could share materials they developed with each other.

Another set of contracts was provided to seven LHDs to target high-risk geographic areas (e.g. Detroit and Grand Rapids) for prevention activities in the communities and engagement with families of EBLL children and pregnant women, including obtaining the venous confirmatory test for capillary EBLLs.

Contracts were provided to three health departments with the greatest numbers of EBLL children (City of Detroit, Wayne County and Kent County) to conduct case management activities in coordination with Medicaid Health Plans. This included obtaining the confirmatory venous tests for capillary EBLLs.

Finally, special funding was provided for case management of EBLL children in Flint, first with a contract with the Genesee County Health Department and then, starting May 2016, with the Greater Flint Health Coalition. All children in Genesee County with an EBLL since April 2014 (the date the water supply was switched to the Flint River, which initiated the problem of lead in the

water supply) were placed on the list for follow-up so they could receive intensive in-home nursing case management, connected with the Lead Safe Home Program at MDHHS so their homes could be tested for lead and abated as needed, and re-tested until their venous BL went below 5 µg/dL. In FY 2016, 366 children under age six were placed on the list who had an EBLL. In addition to supporting intensive case management in Flint, state and local partners made an intensive effort to promote lead testing for everyone in Flint, regardless of age or previous test status. This was accomplished in part by making lead screening available at community events, generally using the LeadCare II equipment which generated capillary results. Children with capillary EBLLs from these community events were placed on the list for case management and were targeted for confirmatory venous testing. A training video for providers was prepared by the MDHHS Chief Medical Executive and was made available on YouTube.

Critical to the success of CLPPP and LHDs in meeting the objectives of this project were numerous partnerships with community groups, advocacy organizations, health care provider groups, local governmental agencies and the families of lead exposed children. Partners included the Michigan Environmental Council, Ecology Center, Healthy Homes Coalition of Western Michigan, WIC, Michigan State Housing Development Authority, Genesee County Medical Society, Mott Children's Health Center, Michigan Association of School Nurses, Michigan Chapter of the American Academy of Pediatrics, and many others.

Adolescent Health Population Domain

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	A) Develop a state plan for improving adolescent well-care, focusing on Medicaid eligible youth	<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) Work with Health Plans to expand strategies to incentivize well-child exams</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 12 through 17, with a preventive medical visit in the past year
	B) By 2020, increase by 625 the number of providers trained on culturally-competent, adolescent-friendly preventive care	<p>B1) Promote Michigan’s adolescent web courses (e.g. Motivational Interviewing, Positive Youth Development) among health plans and provider 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 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 	

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
	C) By 2020, increase by 10% the proportion of adolescents with a documented well-child exam among 25 Child & Adolescent Health Centers	C1) Implement annual CQI initiative among CAHCs C2) Provide technical assistance as needed to CAHCs seeking NCQA PCCC (PCMH) status	meningococcal conjugate vaccine - Adolescent mortality ages 10 through 19 per 100,000 - Adolescent motor vehicle mortality ages 15 through 10 per 100,000	
	D) Develop a social media campaign to promote adolescent well-care and targeted health messages	D1) Work with MDHHS Communications to develop a coordinated social media campaign D2) Identify and disseminate best practice guidelines for the use of social media to promote services and appointment reminders	- Adolescent suicide ages 15 through 19 per 100,000 - Percent of children with mental/behavioral health condition who receive treatment or counseling	

Adolescent Well-visit FY 2018 Application

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 adolescent 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. While reported bullying on school property slightly increased between 2011 and 2013, the Michigan Department of Education coordinates efforts to address this issue and has launched

multiple initiatives to reduce bullying among all school-aged youth. MDHHS efforts are being targeted to increasing preventive medical visits as part of overall efforts to increase access to care, and based on the following data.

According to the 2011-2012 National Survey of Children's Health, 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, it is important to note the disparity among adolescent well-care rates.

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 decline of 3.66% from 2013, and is nearly 30% lower than what is reported for adolescents overall in the NSCH survey. This 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 well-care rates, MDHHS will convene a state-level workgroup comprised of health plans, provider groups (e.g., Michigan Chapter of the American Academy of Pediatrics 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, the workgroup will also assess the extent of utilization of the American Academy of Pediatrics/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 final strategy for this objective, MDHHS will work with the state Medicaid office to convene a sub-group of Medicaid Health Plans to share and expand strategies to incentivize well-child exams among their provider networks. Ideally, this will include initiatives already underway, such as linking payments to achievement of well-child exam goals and adolescent-friendly performance requirements including care satisfaction, privacy and confidentiality. Additionally, the 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 three years of this 5-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 jurisdiction. 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 HPV Immunization Improvement Initiative facilitated by the MDDHS Immunizations Section. This initiative brings stakeholders together to share best practice, data collection/reporting and evaluation strategies to improve HPV immunization rates among adolescents. Participants have voiced the importance of increasing annual well-child exams to improve immunization rates, providing an opportunity to work toward achieving this mutual objective.

Objective B: By 2020, increase by 625 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 three years, MDHHS Child, Adolescent and School Health (CASH) Section staff have partnered with the 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. Two additional courses are currently under development including Adolescent Brain Development & Decision Making which is slated for Fall 2017 and Encouraging Healthy Teen Relationships (an interpersonal violence prevention course) which will be released in 2018. These courses will be promoted and offered at no charge to public and private providers throughout the state. The objective is to reach 250 providers over five years with these foundational adolescent health courses. To supplement the MI course, in-person training (Improving Adolescent Health by Motivating Change for Primary Care Providers) will be offered each year to providers who have completed the web-based course, and continuing medical education credits will be offered for those who complete both courses. Additional professional development and training opportunities focused on culturally-competent, adolescent-friendly preventive care will be offered, with a goal of reaching 375 providers over the five-year period.

The combined impact of completion of both the Motivational Interviewing web course and professional development training will lead to higher quality care for adolescents. Increased skills in not only counseling adolescents on behavior change, but in communicating with adolescents overall, promotes a better provider-patient relationship and increases the likelihood that adolescents will access care (including preventive services) with that provider. Therefore, the ESM selected for this strategy to demonstrate communication skills is: Percent of health care providers who complete the Motivational Interviewing web course and subsequently complete the Motivational Interviewing professional development in-person training who report skills in effectively counseling youth on changing risky behaviors.

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 more than 70 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 28% increase over four years in the percentage of adolescents up-to-date with a documented comprehensive physical exam. (In FY 2016, more than half of the state's CAHCs reported 67% or more of their clients were up-to-date with annual well-care exams.) To continue this momentum, MDDHS will engage up to five CAHCs each year 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 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 CAHCs 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 provide technical assistance as needed to health centers in achieving National Committee for Quality Assurance (NCQA) Patient-Centered Connected Care Recognition, the equivalent of Patient-Centered Medical Home status for many school-based health centers. MDHHS 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. State staff will be available to provide technical assistance to CAHCs pursuing PCCC status; to act as a liaison to foster understanding and interpretation of requirements; and to advise CAHCs in making necessary changes to meet standards for recognition. A crosswalk of CAHC and PCCC standards will be created to readily identify areas of both alignment and discrepancy; and to determine how CAHCs can best meet PCCC standards that are not fully aligned with current CAHC standards. Due to limited CAHC staff time and capacity, few 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. MDHHS staff will monitor progress of PCCC recognition status in order to determine specific resources needed to facilitate PCCC recognition beyond its current capacity.

Meaningful engagement of parents and youth is a longstanding priority of the CAHC Program and is accomplished through various strategies. Per boilerplate requirements, each CAHC must operate a community advisory committee that is comprised of at least 1/3 parents of school-aged children and youth. These advisory groups are tasked with giving input and approving core health center policies, including confidentiality, abuse and neglect; and parental consent; they have a range of other responsibilities that are unique to each center. When funding for the CAHC program was eliminated in 2003, these advisory groups rallied other parents to provide a critical advocacy voice that was instrumental in reinstating funding. This example demonstrates how parents are a powerful ally in this work.

Youth input is also a requirement of the program and occurs through various strategies. Centers are required to obtain youth input through either their existing CAC or through a stand-alone youth advisory committee. As part of ongoing CQI activities, CAHCs must implement a client satisfaction survey at least annually. Results of these surveys are compiled and centers must demonstrate how this feedback was used to improve services and supports to clients.

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 Well-visit FY 2016 Annual Report

FY 2016 activities focused on implementing a motivational interviewing webcourse and in-person training to public and private providers, as well as CQI activities to improve adolescent-well visits among state-funded school-based and school-linked health centers. Investigation of various PCMH processes that may be suitable for these health centers also occurred in efforts to position centers for enhanced reimbursement and other opportunities for sustainability.

Objective A: Develop a state plan for improving adolescent well-care, focusing on Medicaid eligible youth.

This objective will be addressed as part of year three efforts.

Objective B: By 2020, increase by 625 the number of providers trained on culturally-competent, adolescent-friendly preventive care.

For the past three years, MDHHS Child, Adolescent and School Health Section (CASH) staff have partnered with the 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. Two additional courses are currently under development including Adolescent Brain Development & Decision Making which is slated for a Fall 2017 release, and Encouraging Healthy Teen Relationships (interpersonal violence prevention) which will be released in 2018. These courses will be

promoted and offered at no charge to public and private providers throughout the state. The objective is to reach 250 providers over five years with these foundational adolescent health courses.

Since April 2015, 419 health professionals (e.g., medical providers, mental health providers and health educators) have completed the MI webcourse. Of those, 349 individuals requested continuing education contact hours from their respective professions: nursing contact hours (32.6%); Michigan Social Work clock hours (17.7%); NASW Social Work contact hours (12.3%); and Certified Health Education Specialist (30%).

MDHHS offered two in-person MI trainings, reaching 35 providers including physicians, nurse practitioners, physician assistants, nurses and other providers (e.g., social workers). The trainings were promoted through provider organizations such as the Michigan Regional Chapter of the Society for Adolescent Health and Medicine, American Academy of Pediatrics, American Family Physicians, National Association of Pediatric Nurse Practitioners and the CAHC Medical Directors listserv. As a result of the MI training, 100% of evaluation respondents reported a change in practice when counseling youth on changing risky behaviors; 87.5% reported a change in skills and/or attitude; and 75% reported using MI techniques in their practice either daily or weekly. These evaluation results are based on a small sample size (eight of 35 participants, or just over 20% of total participants). An evaluation was administered immediately following the training; however, the contractor inadvertently used the wrong evaluation tool. To collect the necessary data, an online evaluation was administered to participants six months post-training, leading to a low response rate. This error has been

corrected going forward. Also, a greater focus will be placed on recruitment of physician and mid-level providers and determining how to overcome high last-minute cancellation and no-show rates that were experienced in 2016.

Objective C: By 2020, increase by 10% the proportion of adolescents with a documented well-child exam among 25 Child & Adolescent Health Centers.

As a first strategy to meet this objective, the CAHC Quality & Evaluation Support Team (QuEST) reviewed quality performance data across all state-funded health centers in order to select participants for a Continuous Quality Improvement (CQI) project aimed at increasing the proportion of clients with a documented, up-to-date well-care exam. Data reviewed included number of unduplicated clients, number of well-care exams provided and percent of clients up-to-date with a well-care exam (two-year trend) for each health center. Other factors taken into consideration were geographic location, staff longevity and commitment to a CQI process. Two centers completed CQI projects with QuEST guidance, while one center terminated the project midway due to administrative staff turnover. Prior to the CQI initiative, these centers were among the lowest-performing CAHCs for the quality measure “percentage of adolescents with a documented, up-to-date comprehensive well-care exam.”

QuEST coordinated tailored initiatives using the Plan-Do-Study-Act cycle of change, partnered with regular coaching calls and meetings with participating CAHC staff. To initiate each project, QuEST conducted conference calls to review the following: current available data; data 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 and

a series of email and telephone communications followed to review data; develop goals and action steps; and determine resources and support needed for success. QuEST provided ongoing support tailored to each health center which included 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 were also provided as relevant.

Centers reviewed practices on requesting date of last well-care exam provided upon registration/completion of medical history form; reviewed options for documenting and retrieving date of last exam from respective EHRs; implemented methods for proactively reminding and following up on those who were due/overdue which included contacting both parent and adolescent by phone, text, direct mail; coordinated with mental health providers to assure documentation of last well-care exam and warm hand-offs to schedule appointments for those who were due/overdue; increased communication via newsletters, public awareness announcements, and visible presence at school events.

CQI project results showed the following increases in the percentage of clients with a documented, up-to-date comprehensive well-care exam: Pontiac Teen Health Center improved from 41% in FY 2015 to 75% in FY 2016 (a 34% increase); and Beaumont Oakwood-Adams Health Center improved from 36% in FY 2015 to 63% in FY 2016 (a 27% increase). Ingham's Willow Health Center experienced an 11% improvement although the project was terminated at its midpoint.

While overall the CAHCs experienced just a 1% increase in the percentage of clients with a documented, up-to-date comprehensive well-care exam, there were 15 health centers

(including the centers participating in the QuEST CQI initiative) that individually saw an increase of 10% or greater in the measure in FY 2016 over FY 2015. The average increase was 17.7% among these 15 centers.

As a second strategy, QuEST met with clinical consultants to the CAHC program, the CAHC Program Coordinator and CASH Section Manager to review multiple PCMH-model requirements and the feasibility of acquiring recognition for Michigan's CAHCs among myriad models.

Through this research, two models emerged as being most aligned with the CAHC model: NCQA's PCCC (as previously identified) and Blue Cross Blue Shield of Michigan's (BCBSM) Provider Group Incentive Program (PGIP), which is gaining recognition with Medicaid payers outside of BCBSM. QuEST offered technical assistance (policy review, interpretation of requirements) to health centers as they applied for PCMH or PCCC status.

CAHCs that already achieved recognition with either or both models were interviewed as to their decision to pursue a particular model and to determine benefits, challenges and applicability to all CAHCs. A list of concerns and questions was developed and discussed with NCQA and BCBSM regarding their respective model standards and fit/applicability to the CAHC program model. After confirming NCQA's PCCC and BCBSM's PGIP recognition standards as initial fits to the CAHC program, a cross-walk document was created which compares requirements of the two models to CAHC program requirements and standards. This crosswalk may need to be updated pending changes to NCQA's certification processes in 2017.

Objective D: Develop a social media campaign to promote adolescent well-care and targeted health messages.

Development of a social media campaign promoting adolescent well-care is expected to occur in years four and five of the five-year cycle. CASH staff are researching other state and national public awareness campaigns to determine whether these messages and/or campaign could be utilized in future efforts.

Children with Special Health Care Needs (CSHCN) Population Domain

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) By 2020, increase the number of CSHCN served in a medical home by 4.7%	<p>A1) Support practices with training or technical assistance to develop or improve policies 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 support</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
	B) Increase families' understanding of the benefits of the medical home model, and help connect families to medical homes in their region	B1) Conduct training and outreach to families about availability and benefits of the medical home	<ul style="list-style-type: none"> 4:3:1:3(4):3:1:4 series of routine vaccinations - Percent of children 6 months through 17 	
	C) Improve the delivery of care within a medical home	<p>C1) Survey families on the strengths and weaknesses of care coordination and family partnership in the provider setting</p> <p>C2) Support practices to build partnerships with families (e.g.,</p>	<ul style="list-style-type: none"> years who are vaccinated annually against seasonal influenza - Percent of adolescents, ages 13 	

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
		family advisory groups, focus groups, family-centered processes)	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, dose of the meningococcal conjugate vaccine	

Medical Home FY 2018 Application

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: By 2020, increase the number of CSHCN served in a medical home by 4.7%.

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 Children's Health (NSCH). The current trend in Michigan shows an average annual *decrease* of 0.8% in all children having a medical home. In order to meet the Healthy People 2020 objective, this indicator would need to increase by an average of 0.6% annually.

To meet this objective, the Children's Special Health Care Services (CSHCS) Division aims to support practices with training or technical assistance to develop or improve policies on care coordination, transition planning, and family partnership. CSHCS has partnered with many of the larger healthcare providers throughout Michigan to assist and support their pediatric subspecialty clinics, known as Children's Multi-Disciplinary Specialty (CMDS) clinics. In FY 2018, CSHCS will continue to provide enhanced reimbursement to these clinics to better support care coordination and transition related activities. This enhanced reimbursement provides the additional funding needed for these clinics to support a multi-disciplinary clinical team that focuses on all aspects of the child's life.

In addition to the enhanced reimbursement, CSHCS also supports CMDS clinics by hosting a bi-monthly conference call in which all CMDS clinics participate. The focus of these calls is to provide a forum for clinicians, billing staff, and clinic managers to address issues, share best practices and learn from each other. It also provides a great opportunity to engage the clinics on potential changes in CSHCS and Medicaid policy, understand the needs of the CYSCHN population, and partner on initiatives and activities to improve the care provided to CYSCHN and their families.

Objective B: Increase families' understanding of the benefits of the medical home model, and help connect families to medical homes in their region.

In FY 2018, CSHCS will conduct training and outreach to families about availability and benefits of the medical home. 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 continues to support the Michigan Public Health Institute's (MPHI) *Care Coordination: Empowering Families* training by directing grant dollars to MPHI to host these trainings for parents of CYSHCN. These trainings provide families with an understanding of what the medical home model is, the benefits of having a medical home for their child with special needs, and how to find a medical home or work with their existing practice on incorporating concepts of the medical home.

Objective C: Improve the delivery of care within a medical home.

CSHCHS will identify the strengths and weaknesses of care coordination and family partnership in the provider setting. The main components of the medical home model are improving access to quality care, providing care that is centered on the patient's needs, and assisting patients and their families with coordinating health care among their various providers. Effective patient-centered care and care coordination first requires a thorough understanding of the barriers and challenges families encounter when trying to access care for their child with special needs. To better understand the needs and barriers of families, CSHCS and the Family Center created an electronic patient/parent satisfaction survey that aims to assess care coordination and family partnership within the CMDS clinic model. After a successful pilot in 2016, the electronic survey will be fully implemented across all participating CMDS clinics in FY 2018. The

data gathered from this survey will help CSHCS pinpoint areas for improvement related to care coordination and patient-centeredness throughout the state.

The information gathered from the electronic survey will strengthen the position of CSHCS and its partners to make effective, data-driven decisions on improving care coordination within a medical home. The outcomes of these efforts will be as follows: to intervene at the state agency level if barriers are identified for any particular state-led programs; create trainings for providers, families, and LHDs on effective care coordination and communication; and develop an online resource center for families to more readily find the pertinent information they need relating to their child's care.

CSHCS and the Family Center will also support practices in forging their own partnerships with families (e.g., family advisory groups, focus groups, family-centered processes) by encouraging and providing technical assistance regarding the formation of practice-based family advisory groups, focus groups, and adoption of 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 medical practices to identify the types of support that practices need to implement family partnership strategies, and provide resources to address those needs.

Medical Home FY 2016 Annual Report

Through the five-year needs assessment process, the state priority issue of "Increasing family and provider support and education for Children with Special Health Care Needs" was selected for the CSHCN population domain. To address this issue, in FY 2016 CSHCS and its partners

helped support care coordination and family partnership in the practice setting, and trained parents of children with special needs on the concepts and value of the medical home model.

Objective A: By 2020, increase the number of CSHCN served in a medical home by 4.7%.

The primary strategy designed to meet this objective is to support practices with training or technical assistance to develop or improve policies on care coordination, transition planning, and family partnership. In late FY 2014, CSHCS was awarded a two-year HRSA grant to improve services for young children with autism spectrum disorders and other developmental disabilities (ASD/DD). Throughout the course of FY 2016, CSHCS and its partners carried out this grant by training 38 primary care practices on ways to better serve children with ASD/DD. These trainings focused on helping physicians and their front and back office staff 1) implement developmental screening tools; 2) more effectively manage the care of patients with ASD/DD; and 3) provide better care coordination services for all children with special needs. Two of the primary goals of these trainings were to help physicians properly screen and monitor the development of young children and know what to do when a child screened positively for ASD/DD. Following the trainings, practices were able to appropriately use evidence-based screening tools and effectively coordinate with Early On, Community Mental Health, and other local agencies involved in caring for children diagnosed with ASD/DD.

In addition to training primary care practices, CSHCS worked closely with Michigan's Behavioral Health and Developmental Disabilities Administration (BHDDA) to train local agencies within each of the target regions. The primary purpose of these trainings was to increase communication and coordination among the various systems of care for children with special

needs. This included ways to partner with medical practices in the community and help families navigate the available services and resources that families were eligible to receive.

CSHCS also continued its participation 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 Chief Medical Consultant. The primary goals of MiPCT are to support care coordination within the medical homes and encourage further medical home site development in pediatric and family practices across the state.

In September 2016, the MiPCT project held a pediatric summit that covered a wide array of topics from Adverse Childhood Experiences (ACES) to integrating behavioral health into primary care. Attendees indicated that the summit helped them discuss and understand cultural competency, and identify adverse childhood experiences and their long-term impact.

A second strategy to meet this objective was to work with partners across the state to improve the system of care coordination by providing education, leadership, and support. Children's Multi-Disciplinary Specialty (CMDS) clinics are specialty pediatric health care providers located throughout Michigan, which 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 a child's health needs. In FY 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 partnership continued through FY 2016, and the

workgroup contributed to CSHCS and Medicaid policy changes, piloting an electronic survey, and resolving technical issues regarding their facility fee reimbursement through Michigan's Community Health Automated Medicaid Process System (CHAMPS).

A third strategy was to encourage primary care practices to adopt medical home practices by developing reimbursement mechanisms that support the additional functions of a medical home. The contracts between the State of Michigan and its Medicaid Health Plan vendors includes additional requirements for Primary Care Physicians (PCPs) to serve CSHCS enrollees. PCPs that attest to meeting these requirements are eligible to receive an enhanced capitated payment of \$4 Per Member Per Month for serving children that meet the Temporary Assistance for Needy Families (TANF) criteria, and \$8 Per Member Per Month for serving children that meet the Aged, Blind, and Disabled criteria. The additional requirements are derived from Medical Home Model concepts and are as follows:

1. Contractors must assign CSHCS Enrollees to CSHCS-attested PCP practices that provide family-centered care.
2. Contractors must obtain a written attestation from PCPs willing to serve CSHCS Enrollees that specifies the PCP/practice meets the following qualifications:
 - a. Is willing to accept new CSHCS Enrollees with potentially complex health conditions.
 - b. Regularly serves children or youth with complex chronic health conditions.
 - c. Has a mechanism to identify children/youth with chronic health conditions.
 - d. Provides expanded appointments when children have complex needs and require more time.

- e. Has experience coordinating care for children who see multiple professionals (pediatric subspecialists, physical therapists, behavioral health professionals, etc.).
- f. Has a designated professional responsible for care coordination for children who see multiple professionals.
- g. Provides services appropriate for youth transitioning into adulthood.

In FY 2015, CSHCS also worked with Medicaid to allow CMDS clinics to receive enhanced reimbursement through the CHAMPS Medicaid Payment system using Title V dollars. This allowed CMDS clinics to use the billing and reimbursement mechanisms with which they were already familiar, while simultaneously providing the State of Michigan with better oversight of the payment process. CSHCS continued to provide the enhanced reimbursement to these clinics throughout FY 2016, which is used to support care coordination and transition related activities in the clinic practices. This enhanced reimbursement provides the additional funding needed for these clinics to support a comprehensive clinical team that focuses on all aspects of the child's life.

Objective B: Increase families' understanding of the benefits of the medical home model, and help connect families to medical homes in their region.

A core strategy to achieve this objective is to conduct outreach to families about availability and benefits of the medical home. In FY 2016, CSHCS provided funding to support the Michigan Public Health Institute's (MPHI) *Care Coordination: Empowering Families* training. As a result, MPHI held six trainings in various regions across the state. In total, 79 parents of children with

special needs attended these trainings. These trainings provided families with an understanding of what the medical home model is, the benefits of having a medical home for their child with special needs, and how to find a medical home or work with their existing practice on incorporating concepts of the medical home.

Objective C: Improve the delivery of care within a medical home.

The first strategy to meet this objective is to identify the strengths and weaknesses of care coordination and family partnership in the provider setting. In FY 2016, CSHCS piloted an electronic survey to assess how well care coordination and family partnership were working in the provider setting. The electronic survey utilizes a custom software application loaded onto an iPad, which submits information securely from the providers' offices to the State of Michigan. This allows CSHCS to capture the responses of individuals with special needs or their families with a greater level of anonymity and security, while also allowing MDHHS to capture protected health information. The pilot period ran for approximately three months, at three separate health care organizations around the state.

In addition to the electronic survey created by CSHCS, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey was used to capture several key metrics, which assessed how well children with special needs and their families perceived the systems of care were working for them. This survey, which will be administered on an annual basis beginning in FY 2017, has several key indicators that help inform how well some of the medical home concepts are working throughout the state. Of these indicators, three were chosen to be included in the evidence-informed strategy measure:

- 1) In the last six months, how often did you have your questions answered by your child's doctors or other health providers?
- 2) In the last six months, how often did your child's doctor or other health providers explain things about your child's health in a way that was easy to understand?
- 3) In the last six months, did anyone from your child's health plan, doctor's office, or clinic help coordinate your child's care among these different providers or services?

The combination of these indicators will be used to help determine how well Michigan's providers are incorporating patient-centered, well-coordinated care to children with special needs.

A second strategy is to provide support to practices to build partnerships with families (e.g., family advisory groups, focus groups, family-centered processes). In FY 2016, CSHCS and the Michigan chapter of the American Academy of Pediatrics trained 38 primary care practices on how to incorporate developmental screening and how to assure a friendly and safe practice environment for children with ASD/DD. Included in this training were topics on family engagement and partnership. Practices were able to share their successes and challenges in having parents and patients involved in an advisory capacity. The trainers were also able to highlight the advantages of involving patients and parents in an advisory role, as well as strategies for effective engagement.

CSHCN Domain

NPM 12 – Transition

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) By 2020, increase the number of youth who have a plan of care that includes transition planning beginning at age 14 by 4.1%	<p>A1) Collaborate with MDHHS’s Managed Care Division, Medicaid Health Plans, and other commercial payers to identify strategies and methods</p> <p>A2) Provide on-going technical assistance to LHDs following training in summer of 2017</p> <p>A3) Continue to explore and develop electronic solutions to identify and assist clients with unmet transition related needs</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 adolescents with and without special health care needs who received services necessary to make transitions to adult health care
	B) Increase youth and family awareness and understanding of the transition to adulthood process	<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>		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
	C) Increase provider awareness and understanding of the transition to adulthood process	C1) Partner with AAP, AFP, ACP, and AANP to disseminate evidence-informed transition resources to primary care practices, specialty providers, and local health departments C2) Explore and strategize ways to incorporate transition planning protocols into electronic health record systems		

Transition FY 2018 Application

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: By 2020, increase the number of youth who have a plan of care that includes transition planning beginning at age 14 by 4.1%.

Achieving this objective would bring Michigan into alignment with the Healthy People 2020 goal. CSHCS has developed key strategies to help achieve this goal, which include collaborating with public and private insurances, training health care professionals, and engaging directly with youth with special needs and their families.

The first strategy is to collaborate with MDHHS's Managed Care Division, Medicaid Health Plans, and other commercial payers to identify strategies and methods related to transition planning.

MDHHS's Managed Care Division is responsible for overseeing the contracts between the State of Michigan and its Medicaid Health Plan vendors. Part of the Managed Care Division's charge is ensuring that consistently high-quality medical services are accessible to today's Medicaid beneficiaries. CSHCS will collaborate with the Managed Care Division and Medicaid Health Plans to determine a feasible way for Medicaid Health Plans to engage in the transition planning process. Together, CSHCS and its partners in Medicaid Managed Care will ensure that transition planning is included among the consistently high-quality services provided from our Medicaid managed care program.

The second strategy is to provide on-going technical assistance to local health departments (LHDs) following training in summer of 2017. As described throughout other sections of this grant application, CSHCS has been developing tools, resources and strategies that will be provided to LHDs during a statewide training in the summer of 2017. The goal of these trainings is to provide our LHD affiliates with clear expectations, tools and strategies for transitioning youth into adulthood. Following these trainings, CSHCS will continue to provide technical assistance to LHDs on ways to engage families, utilize evidence-informed transition planning tools, and evaluate their efforts to ensure continuous quality improvement. In addition to providing technical assistance, CSHCS will also continue to engage LHDs on evaluating the transition services they are providing to families. Through this partnership and continued effort,

CSHCS and LHDs will continue to refine and improve the transition services CYSHCN and their families receive.

A third strategy is to continue to explore and develop electronic solutions to identify and assist clients with unmet transition related needs. In FY 2018, CSHCS will continue to pursue ways to leverage technology to reduce the burden on health professionals and families, while improving transition services delivery. One existing technology that CSHCS will explore is CareConnect 360. CareConnect 360 is an integrated data system which was designed to improve care coordination for Medicaid beneficiaries. The system facilitates critical cross-system information for providers to improve the coordination of services delivered across multiple entities. It also assists users with more effectively assessing and analyzing healthcare program data, which will help to improve decision-making processes, evaluate program results and reduce costs for the purpose of improving health outcomes.

Utilizing CareConnect 360 for transition planning will allow health care providers to securely store and exchange health information electronically, which allows CSHCS clients, their families, and providers to have the information they need when it is needed. Additional electronic solutions, such as incorporating transition tools into the CSHCS application, will also provide a greater opportunity to track and monitor transition activities.

In addition to exploring the use of CareConnect 360 and other electronic health record (EHR) systems to exchange transition-related information, CSHCS will also utilize the MDHHS Data Warehouse to track when CSHCS clients transfer care from a pediatric to an adult provider. With the assistance of the University of Michigan's Child Health Evaluation and Research

(CHEAR) unit, CSHCS will be able to determine its clients that are seen by pediatric and adult provider specialists. This new tracking metric will be utilized as an evidence-informed strategy measure in future Title V MCH Block Grant applications.

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

In FY 2017, CSHCS will be releasing free online transition courses for youth with special needs and their families. The topics for the courses include: What Is Transition; Working with Doctors; Role of Young Adults in Transition; Health in the Home, School, and Community; Transition in Action – Tools and Resources; and Creating a One-Page Person Summary.

Throughout FY 2018, CSHCS and the Family Center for Children and Youth with Special Needs (i.e., the Family Center) will direct youth and families to these courses to help them better understand and engage in the transition process. Website analytics will allow CSHCS to monitor how often the courses are completed, which will inform our marketing and outreach strategies to promote the widespread awareness and use of these trainings.

The first strategy is to facilitate discussions with youth and their families on how to better address needs relating to transitioning to adulthood. CSHCS has a long-standing partnership with the Family Center, which employs parents of CYSHCN to assist families as well as CSHCS initiatives. Family Center staff have been involved in the development of transition letters, tools, strategies and resources that will be used to guide young adults, their families, and providers through the transition process.

In addition to the involvement of Family Center staff, CSHCS is working with LHD Family Advisory Boards to gain input into the development and implementation of our transition services. These LHD Family Advisory Boards will help to provide a better understanding of what works for families throughout our many communities.

The second strategy is to identify and implement new, effective ways to provide transition services and resources that are more accessible to today's youth. CSHCS realizes that, while paper mail and the Michigan.gov website have their benefits, they cannot be the only solution to engage today's youth. Therefore, CSHCS will continue to explore and implement more accessible and effective ways of communicating with today's youth. Some mechanisms that aren't being fully utilized today will be explored in FY 2018 are social media outlets, smartphone applications, text messaging, and email.

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

Provider awareness and understanding of the transition process is an important step in ensuring youth with special needs receive care from age appropriate providers. The first strategy is to partner with American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians and American Academy of Nurse Practitioners to disseminate evidence-informed transition resources to primary care practices, specialty providers, and local health departments. A key aspect to successful transition planning is a competent public health workforce that has the knowledge and training to provide comprehensive transition services. Following the development or adaption of evidence-

informed transition tools and resources, CSHCS will partner with the Michigan chapters of the aforementioned groups as well as the Michigan State Medical Society to disseminate transition tools and resources to primary care providers throughout Michigan.

After initially engaging and sharing tools and resources with these partners and practitioners, CSHCS will gather feedback from the provider community to identify new methods and strategies to assist the medical community in transitioning youth to adulthood. These strategies and methods may include creating an online, interactive resource database; electronic tools; training webinars and more.

The second strategy is to explore and strategize ways to incorporate transition planning protocols into electronic health record systems. Michigan has developed an electronic data product called CareConnect 360. This product was designed to improve the coordination of physical and behavioral health care by expanding the exchange of electronic health records among providers. In FY 2018, CSHCS will explore CareConnect 360 as a platform to include transition planning protocols.

CSHCS will learn how to effectively incorporate transition planning protocols from Henry Ford Health System (HFHS), which is currently integrating transition protocols into their health system's electronic health record (EHR). HFHS and CSHCS understand that the ability to share transition specific information within or across health record systems will greatly help to streamline the transfer of care from pediatric to adult providers. As HFHS leads this effort, CSHCS will continue to learn from them in the hopes of identifying ways to replicate their transition protocols across many systems throughout the State of Michigan.

Transition FY 2016 Annual Report

Objective A: By 2020, increase the number of youth who have a plan of care that includes transition planning beginning at age 14 by 4.1%.

The first strategy related to this objective was to hire staff to address transition needs of clients. In FY 2015, CSHCS revised its Transition Specialist position to include responsibilities relating to developing online transition tools and resources to support families and LHDs in the transition process. The revised Transition Specialist position was filled at the end of FY 2016, and engagement with LHDs and the development of online tools immediately followed. By the end of FY 2016, a strategic plan, an online transition course for LHD orientation and a transition-related framework had been created.

The second strategy was to increase the number of LHDs that develop and implement a transition policy. At the end of FY 2016, CSHCS began a review of LHD policies to determine the number that had a transition policy in place. This activity was identified as an evidence-informed strategy measure (ESM) to ensure that Michigan's Local Public Health infrastructure had a foundation in place that could be further built upon. Upon completing this review, it was determined that all LHDs had a transition policy in place. As a result, this ESM will be retired, and a new ESM (tracking the transfer of care from pediatric to adult providers) will be created. While transition policies were present among all LHDs, the quality and comprehensiveness of these policies varied. This will be addressed during FY 2017 in a statewide training effort designed to increase the knowledge and skill of LHD transition efforts.

A final strategy related to this objective was to develop electronic solutions to help identify clients with greater need for transition services. Clients with the greatest need for transition planning may be those receiving private duty nursing (PDN). Michigan's Medicaid program covers PDN for eligible beneficiaries until their 21st birthday. In order to continue PDN following their 21st birthday, beneficiaries must be transitioned onto one of two waiver options: Habilitation Supports Waiver (HSW) or MIChoice. Failure to transition onto one of these waivers on or prior to the 21st birthday can result in a disruption of PDN services. In order to address this concern, CSHCS and its partners within Medicaid have created a report containing a list of upcoming PDN transition cases. The Transition Specialist contacts each beneficiary to set up a PDN transition conference call with the family, each of the waiver managers, and the local agencies involved in the case. These conference calls allow for the waiver agencies to better understand the needs of the family, and set up a plan to enroll them onto a waiver prior to the 21st birthday. This process has ensured that no beneficiaries have had a lapse in their PDN coverage.

In addition to beneficiaries receiving PDN, CSHCS has identified clients who have complex or poorly managed health needs and may benefit from increased case management and transition planning services. The report, called the "High Cost Beneficiary Report," analyzes claims and encounters data within the MDHHS Data Warehouse. The report identifies our most high-cost health care utilizers as one means of determining CSHCS clients with greater needs. This report will allow the program to identify the most at-risk clients that can be targeted for case management and health education, while also gaining a better understanding of their medical needs.

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

The first strategy for Objective B was to facilitate discussions with youth and their families on how to better address needs relating to transitioning to adulthood. In FY 2016, two transition workgroups were created to inform the strategies and tools created by CSHCS. The first workgroup is responsible for revising system-generated transition letters and tools that get sent to clients, their families and their providers. This “Transition Letter Workgroup” is comprised of four parents of children with special needs, a pediatrician, LHD public health nurse, Epilepsy grant coordinator and Hemoglobinopathy Program Coordinator.

The second workgroup is comprised of LHD staff and is focused on developing, revising and piloting transition tools, resources and training materials that will be used by LHDs as they engage clients in the transition process. The strategies, letters and tools developed by these transition workgroups will be adapted from evidence-informed tools, and will be reviewed in FY 2017 by the Got Transition team. CSHCS will update and revise its approach as needed following review of the strategic plan, tools and resources.

The second strategy is to identify new, effective ways to provide transition services and resources that are more accessible to today’s youth. The Family Center began leading an effort in FY 2016 to create online transition courses directed at youth with special needs and their families. These courses will be hosted on the CSHCS website, and will be freely accessible to anyone. The topics for the courses are as follows: What Is Transition; Working with Doctors;

Role of Young Adults in Transition; Health in the Home, School, and Community; Transition in Action – Tools and Resources; and Creating a One-Page Person Summary.

Throughout these courses, youth with special needs and their families will learn the concepts, skills, and tools to successfully transition to adult health care. The goal is to help young adults build independent living skills by making sure they're aware of the responsibilities required in managing their own health and health care. Included in these courses are topics about health insurance coverage, decision-making and self-determination, and living a healthy life in the school, home and community setting. These courses will be made available to the public in FY 2017.

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

The strategy identified for FY 2016 under this objective was to partner with medical associations and societies to disseminate evidence-informed transition resources to primary care practices and local health departments. CSHCS, the Family Center and its LHD partners began gathering and reviewing evidence-informed transition tools and resources that are being used throughout the country, including the resources provided by GotTransition.org. These materials were reviewed in the context of identifying strategies and solutions that would best fit Michigan's existing systems and structures. Upon completion of the review process, CSHCS will utilize or adapt the selected resources it deems most appropriate for our state for dissemination across the broader provider community. These tools and resources will initially

be shared with the medical community through collaboration with medical associations and societies.

In addition to reviewing and adapting evidence-informed tools, CSHCS has partnered with Henry Ford Health System (HFHS) to learn from their transition focused efforts. HFHS is leading an initiative to incorporate transition service protocols into their electronic health record (EHR) system. These protocols will help providers identify youth that are of a transition age, and establish rules for securely sending medical and transition information within their EHR system. This allows pediatric providers to readily share transition related information to adult providers prior to the transfer of care.

CSHCN Domain

SPM 4 – Provision of Medical Services and Treatment for CSHCN

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
Reduce barriers, improve access, and increase the availability of health services for all populations	A) Reduce barriers to medical care and treatment by minimizing financial barriers from the increased medical services associated with the child’s special need	A1) Cover specialty care and treatment related to a qualifying condition when insurance is not existent or is inadequate for children that require the recurring care from a pediatric sub-specialist	Percent of CYSHCN enrolled in CSHCS that receive timely medical care and treatment without difficulty
	B) Improve access to medical care and treatment by improving the systems of care for CSHCN	B1) Support models of care delivery, such as Medical Homes and Children’s Multi-disciplinary Specialty Clinics, which focus on increased care coordination and family partnership	
	C) Increase the availability of health services, particularly in underserved regions, through the utilization of telemedicine and community-based services	C1) Expand, promote, and support the use of telemedicine/telehealth in rural and underserved communities C2) Support and assist local health departments in providing care coordination, case management, and support services for CSHCN and their families	

Provision of Medical Services and Treatment for CSHCN FY 2018 Application

Michigan’s State Performance Measure (SPM) for the CSHCN population domain measures the percent of CYSHCN enrolled in Children’s Special Health Care Services (CSHCS) that receive timely medical care and treatment without difficulty. This measure is aimed at addressing Michigan’s need to reduce barriers, improve access, and increase the availability of health services for all populations.

Objective A: Reduce barriers to medical care and treatment by minimizing financial barriers from the increased medical services associated with the child's special need.

A core strategy to reducing barriers to medical care and treatment for CYSHCN is to provide payment assistance for specialty care and treatment related to a qualifying condition. CSHCS will continue to enroll children with special needs into the medical care and treatment benefit, which provides payment for medical care and treatment related to the child's qualifying condition. This benefit, while not intended to cover all of the care a child needs, helps reassure families that necessary specialty care for their child's qualifying diagnosis will not create undue financial burden. CSHCS is the payer of last resort, and requires that families follow their primary and secondary insurance rules. Additionally, if a family's income indicates they may be eligible for Medicaid, they are required to apply to Medicaid. Initially, the child will be temporarily enrolled in CSHCS for 90 days.

Children with special needs who qualify for Medicaid and CSHCS will continue to receive care through Medicaid managed care plans, barring a few exceptions. Children who are already enrolled in Medicaid, and are determined eligible for CSHCS, will be automatically enrolled in the program. Automatically enrolling families in CSHCS benefits the family by increasing their access to care coordination and case management services.

Objective B: Improve access to medical care and treatment by improving the systems of care for CSHCN.

Another objective identified by CSHCS is to improve access to medical care and treatment by improving the systems of care for CYSHCN. To achieve this objective, CSHCS will support models

of care delivery, such as Medical Homes and Children's Multi-Disciplinary Specialty (CMDS) clinics, which focus on patient-centered care and improved care coordination. CSHCS will continue to provide enhanced reimbursement for CMDS clinics: a model of care delivery that provides greater care coordination and family participation than typical specialty care models. At the heart of the CMDS clinic model is a family-centered approach that recognizes the value of creating treatment plans that work within the context of the family's strengths, needs and preferences. CMDS clinics engage the patients and their families to create a mutually beneficial partnership, which is incorporated throughout the planning, delivery, and evaluation of the individual's health care.

Objective C: Increase the availability of health services, particularly in underserved regions, through the utilization of telemedicine and community-based services.

To increase the availability of health services in underserved regions, CSHCS will expand, promote and support the use of telemedicine/telehealth in rural and underserved communities. CSHCS has been engaged in telemedicine/telehealth activities through work supported by a HRSA grant. Through this grant, CSHCS and its partners have established several new telemedicine sites throughout rural and underserved regions of the state. These sites are able to connect to specialists at University of Michigan's C.S. Mott Children's Hospital, which helps to ensure access to high-quality, well-coordinated care. In FY 2018, CSHCS will continue building upon the successes experienced with C.S. Mott's Children's Hospital, and will increase the availability of specialty care available to telemedicine sites by adding tertiary care centers to the network of telemedicine providers. While these telemedicine activities have been focused

on providing care to patients with epilepsy, CSHCS will work with the telemedicine sites and hubs to increase telemedicine use for other conditions and diagnoses throughout FY 2018.

Once telemedicine sites are established, it's vital to ensure they have the support and guidance to be successful. Many of the existing telemedicine sites have expressed uncertainty in how to appropriately bill for telemedicine services. To address this issue, CSHCS will work with the American Academy of Pediatrics and other organizations to develop practice vignettes that illustrate appropriate billing and use of ICD-10 codes for epilepsy telehealth services. CSHCS will also monitor the scheduling activities of these telemedicine sites to ensure timely service delivery, and will provide additional technical assistance to practices that have challenges incorporating telemedicine services.

A second strategy to increase the availability of health services is to support and assist local health departments (LHDs) in providing care coordination, case management and other services for CSHCN and their families. CSHCS utilizes the statewide LHD network as the local arm of the CSHCS program. Each LHD has at least one CSHCS nurse coordinator and CSHCS representative who work to assist CSHCS clients in their community. A significant part of their roles is to provide care coordination and case management. In order to ensure consistent and effective care coordination/case management throughout the state, CSHCS will develop and implement training curriculum as needed.

To further support the LHD efforts to provide care coordination and case management services, CSHCS developed an automated system for all LHDs to use. Children's Healthcare Automated Support Services (CHASS) was developed, with input from LHDs and CSHCS staff, to monitor the

delivery of care coordination and case management services for CSHCS clients. CHASS provides a greater ability to ensure financial controls and program integrity, while providing a mechanism to identify best practices through data-supported evidence. In FY 2018, CHASS will continue to be developed to increase its functionality and provide greater assistance to LHDs. In addition to care coordination and case management, CHASS will also be developed to support LHDs in providing transportation assistance to families.

Provision of Medical Services and Treatment for CSHCN FY 2016 Annual Report

The following report illustrates activities and progress made throughout FY 2016 to improve the percent of Children and Youth with Special Health Care Needs (CYSHCN) enrolled in Children's Special Health Care Services (CSHCS) who receive timely medical care and treatment without difficulty.

Objective A: Reduce barriers to medical care and treatment by minimizing financial barriers from the increased medical services associated with the child's special need.

Children with special needs who enroll into the CSHCS program benefit from Medical Care and Treatment payment assistance that helps cover the costs of specialty care relating to a client's qualifying diagnoses. This benefit helps CYSHCN access specialty medical care by greatly reducing the financial burden that is often associated with such care. Throughout FY 2016, 42,502 clients were enrolled in the CSHCS program. For these clients, CSHCS helped to cover the costs of medical services and treatment including prescription and pharmacy services, medical supplies and equipment, disease treatment and management, and more.

Objective B: Improve access to medical care and treatment by improving the systems of care for CSHCN.

The core strategy to achieve this objective was to support models of care delivery, such as Medical Homes and Children's Multi-disciplinary Specialty (CMDS) clinics, which focus on increased care coordination and family partnership. CMDS clinics provide pediatric specialty care to children that have complex medical needs. These clinics have been supported through enhanced reimbursement by the CSHCS program. This enhanced reimbursement provides additional revenue to support members of the clinical care team that provide more coordinated and integrated care.

In FY 2016, CSHCS migrated the enhanced reimbursement for CMDS clinics from a contract/grant based model, to providing additional reimbursement through the Community Health Automated Medicaid Processing System (CHAMPS). This reimbursement mechanism provides a greater level of monitoring and control of services provided, helps ensure appropriate reimbursement, and provides increased access to data through the MDHHS Data Warehouse. Additionally, this mechanism is familiar to CMDS clinics, as it is the system used to seek reimbursement for Medicaid services.

Objective C: Increase the availability of health services, particularly in underserved regions, through the utilization of telemedicine and community-based services.

The first strategy used in FY 2016 was to expand, promote, and support the use of telemedicine/telehealth in rural and underserved communities. FY 2016 marked the end of a three-year grant cycle dedicated to improving the awareness of, and access to, quality care for

children and youth with epilepsy. One of the primary goals of this grant was to help build and support telemedicine sites throughout rural locations in Michigan. A total of 12 telemedicine sites were supported in rural and underserved areas. These telemedicine sites connected to a telemedicine hub at either the University of Michigan C.S. Mott Children's Hospital or to DeVos Children's Hospital. These large pediatric and tertiary care centers are able to provide the smaller telemedicine sites with pediatric specialty and sub-specialty care that is otherwise unavailable in these rural communities.

The second strategy was to support and assist local health departments in providing care coordination, case management, and support services for CSHCN and their families. In FY 2016, CSHCS developed an electronic Children's Healthcare Automated Support Services (CHASS) system to support local health department's care coordination and case management services. CHASS was developed, with input from LHDs and CSHCS staff, to monitor the delivery of care coordination and case management services for CSHCS clients. This system provides a greater ability to ensure financial controls and program integrity, while providing a mechanism to identify best practices through data-supported evidence. The CHASS system was adopted by all LHDs, and was quickly recognized as a superior tool that increased efficiency and control of the care coordination and case management billing and monitoring process.

In addition to supporting LHDs with CHASS, CSHCS began strategizing new ways to better support LHDs in their day-to-day operations. The discussions that took place in FY 2016 identified a strategy to create an online and telephonic forum for periodic support meetings called "Technical Assistance Tuesdays." In FY 2017, CSHCS staff began hosting periodic call on

Tuesdays for LHDs to ask questions and learn about various topics. LHDs provided input into the topics that would be most helpful to learn about, and CSHCS staff gathered information and provided expertise on those topics.

Cross Cutting/Life Course Domain

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	A) Increase the number of students who have received a preventive dental screening within a school-based dental sealant program	<p>A1) Utilize the SEAL! Michigan database to track the number of students annually receiving a preventive dental screening</p> <p>A2) Promote dental sealant programs through school health professionals</p> <p>A3) Prepare and analyze the SEAL! Michigan annual all grantee reports to monitor for annual growth of students receiving a preventive dental screening</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>
	B) By 2020, develop and implement a state plan for improving oral health care focusing on pregnant women, infants, children and youth	<p>B1) Develop and disseminate a survey to stakeholders to prioritize proposed goals</p> <p>B2) Publish and disseminate a plan for specific populations of pregnant women and children</p>		
	C) By 2020, increase by 100 the number of medical and dental providers trained to treat, screen and	C1) Plan and develop standardized training modules and courses for medical and dental professionals		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
	refer pregnant women and infants to oral health care services	C2) Utilize pre- and post-tests to evaluate trainings for effectiveness		
	D) By 2020, increase by 10 percent the number of pregnant women and infants receiving oral health care services	D1) Develop and market statewide Perinatal Oral Health Guidelines to medical and dental practitioners D2) Develop and distribute promotional and education materials to health entities across Michigan D3) Develop and implement a multifaceted communication plan		

Oral Health FY 2018 Application

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. 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, 58 of the state’s 83 counties have a full, partial or facility Health Provider Shortage Area (HPSA) designation; with 11 counties having less than five dentists. In addition, 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 38% of Medicaid-eligible children receiving dental services. Children under age 5 are the least likely to have visited a dentist.

Over time, the Medicaid Program has been addressing access to oral health care by implementing the Healthy Kids Dental program throughout the state. The Healthy Kids Dental program began as a demonstration program through a contract with Delta Dental Plan of Michigan in 22 counties in May 2000. By October 2015, the program had expanded into all 83 counties. Healthy Kids Dental utilizes Delta Dental's network of dentists and provides a higher reimbursement rate to dentists, thereby allowing greater access to dental care for Medicaid-enrolled children. The utilization of dental care within this program has increased to over 50% of enrollees. The Healthy People 2020 goal is to have 28.1% of children aged 6-9 with one or more dental sealant in place. According to the 2010 Count Your Smile Survey (last year data available), 26.4% of Michigan's third graders had sealants placed on first molars. (The survey was updated in 2016, and new data reports are expected by October 2017.)

Objective A: Increase the number of students who have received a preventive dental screening within a school-based dental sealant program.

This objective aligns with the ESM for the Oral Health NPM, which is the number of students who have received a preventive dental screening through the SEAL! Michigan 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. Although this strategy does not include comprehensive dental services, dental screenings are an effective point of entry to connect to a dental provider. 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 by adding more programs and with each individual program expanding into more schools annually. Currently the program has 10 grantees across 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 do not offer a dental sealant program to students.

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 illustrate program success through annual increases in number of schools and students served and through number of sealants placed. Ultimately, the data will be captured by the Michigan Basic Screening Survey of third grade students, Count Your Smiles Report, to demonstrate the rates of dental sealant placement and dental decay in youth across the state.

The SEAL! Michigan program attempts to reach the target population through family and consumer outreach and engagement. The program relies on parent and guardian awareness of the program; thus, parents' consent for their children to receive the preventive oral health services made possible by the program. To reach families and consumers, staff from the funded programs attend back-to-school nights and Parent Teacher Organization (PTO) meetings whenever possible. All student consent forms are delivered home with an informational brochure on the SEAL! MI program and the benefits of dental sealants. The brochure was developed by professional health literacy specialists, and is written at a third grade reading level to accommodate varying literacy levels.

The first strategy under this objective is to utilize the SEAL! Michigan database to track the number of students receiving an annual preventive dental screening. Continual updating of the database allows 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 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. In FY 2017, a full SEAL! MI program evaluation was conducted by the Michigan Public Health Institute. Final evaluation reports will be examined to identify areas for program improvement, and improvement strategies will be implemented in FY 2018.

Objective B: Implement a state plan for improving oral health with a focus on pregnant women, infants, children and youth, including CYSHCN.

Michigan published the first State Oral Health Plan (SOHP) in 2006, which 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 oral health data. In FY 2016, the SOHP was combined with the Perinatal Oral Health Action Plan, the Michigan Oral Health Coalition Policy Priorities and the Director Dental Report into one cohesive document. Stakeholders were surveyed to prioritize goals and objectives based on feasibility and need. Priorities identified by the Michigan Oral Health Coalition included preventive strategies for infants and children as well as increasing school-based dental sealant programs.

The Oral Health Program is actively implementing this plan with the goal of contributing to increased access and utilization of evidence-based oral health practices and services. A survey

regarding this implementation has been developed and disseminated to numerous state partners and stakeholders, with results anticipated in FY 2018.

Objective C: Increase by 20 the number of medical and dental providers trained to treat, screen and refer pregnant women and infants to oral health care services.

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.

Perinatal Oral Health Program training events, which include lectures, webinars, conference calls and other training events provided to health professionals in the medical and dental fields, will continue through FY 2018. Additionally, the Perinatal Oral Health Program is collaborating with the Division of Maternal and Infant Health on the development and implementation of a curriculum evaluation project in Michigan OBGYN Residency programs as well as dental and nursing schools. This project enacts an upstream approach towards assessing and enhancing the education of Michigan health care providers surrounding the topics of perinatal oral health, substance use assessment, health literacy and health equity. Considerable time and effort are committed to the continuing education of established Michigan healthcare professionals, but

this pilot project focuses on improving the education of future health professionals while they are still in their respective educational programs. The project has established a partnership with the Wayne State University Area Health Education Center (AHEC) and other AHECs across the state. FY 2018 will focus on the first wave of evaluation with participating institutions. The Perinatal Oral Health Consultant will continue to partner with maternal and child health staff, medical and dental institutions, AHECs and other parties to develop an evaluator mechanism; to identify and evaluate gaps in curriculum; and to enact curriculum change, if indicated.

Objective D: Increase by 2% the number of pregnant women and infants receiving oral health care services. To increase the number of pregnant women and infants receiving oral health care, the Perinatal Oral Health Guidelines were developed by MDHHS and a variety of medical and dental professionals and other stakeholders. The guidelines are aimed at perinatal care and dental providers and provide state-specific resources and tools; summarize the issues surrounding perinatal oral health; and promote the consistent delivery of medical and dental services. During FY 2018, the perinatal oral health program will continue to promote the guidelines through partnerships with statewide public health, medical and dental entities.

In the second strategy, MDHHS will continue to 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 are developed in partnership with stakeholders and distributed to LHDs, FQHCs, WIC clinics, dental offices, medical offices (including obstetric providers) and other important entities. The development of a specific Perinatal Oral Health module in partnership with WIC was completed in FY 2016. In FY 2018, MDHHS will focus on

the rollout of this module, evaluation capabilities, and promotion with maternal and child health entities. The module (delivered through wichealth.org) serves as a training mechanism to mothers across Michigan as well as nationally. Women receive personalized feedback and educational materials as well as nurse follow-up on any questions raised during the lessons.

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. Communication began in 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. In FY 2018, Michigan will utilize the pregnancy and oral health video created by AMCHP and customized to the state of Michigan. This video has been shared electronically with our partners including community medical and dental clinics, professional organizations, the Michigan Primary Care Association, home visiting, WIC, oral health coalitions, and other community organizations. In addition, the video will be shared via the MDHHS website and Facebook page as well as the social media accounts of oral health partners.

Oral Health FY 2016 Annual Report

The Oral Health Program increases access to oral health through oral health education and prevention programs. The focus of the program is population-based oral health prevention and effective utilization of the dental workforce to implement and improve oral health access. With

the increased awareness of the impact of oral health to overall health, the Oral Health Program has increased its collaborations with community partners to improve oral health through prevention activities and direct access programs.

Objective A: Increase the number of students who have received a preventive dental screening within a school-based dental sealant program.

SEAL! Michigan had several improvements and successes in FY 2016. In the fall of 2015, the Oral Health Program acquired Teleform scanning software. Since then, staff have been trained on the software and have begun to change their data collection forms into scanned forms. SEAL! Michigan was the first program to adopt the scanned form, and last year 11 SEAL! Michigan programs used the form in the field. This change has led to a more cost-effective and more efficient data submission and reporting process. Data entry time has decreased significantly and staff can now enter 200 student forms in one hour. This allows reports to be generated more quickly, which in return allows for more rapid and responsive technical assistance, when needed.

The SEAL! Michigan school-based dental sealant programs continued to grow within each individual program and in the overall number of programs. SEAL! Michigan currently funds 11 programs, with an additional three unfunded programs receiving technical assistance from the sealant coordinator at MDHHS. The existing programs continue to grow in the number of consent forms returned and in the number of schools served. The growth is also indicated by the ESM associated with this NPM, which is the number of students who have received a preventive dental screening through the SEAL! Michigan program. In FY 2016, 8,039 students

received a preventive dental screening, which exceeded the annual target. The Delta Dental Foundation continues to financially support the program; the program also receives funding and support from Title V and HRSA.

While the program has experienced growth, there are also challenges to expansion. In FY 2016, SEAL! Michigan expanded into Saginaw, Michigan. However, six months into the year, school collaboration proved to be a challenge due to another active program in the area. Thus, the decision was made to focus available funding on Allegan, Calhoun and Eaton Counties (ACE), where several schools were served. Due to the change in geographical location late in the fiscal year, the ACE program experienced limited growth in FY 2016 but took hold and continues to grow.

In FY 2016, the SEAL! Michigan program continued to reach the target population through family and consumer outreach and engagement. To reach families and consumers, the funded programs attended back-to-school nights and Parent Teacher Organization (PTO) meetings. These settings provided an opportunity to share information and answer questions about oral health. Student consent forms were delivered home with an informational brochure on the SEAL! Michigan program and the benefits of dental sealants.

Objective B: Implement a state plan for improving oral health with a focus on pregnant women, infants, children and youth, including CYSHCN.

In FY 2016, the State Oral Health Plan (SOHP) was developed. Stakeholders were surveyed in order to prioritize goals and objectives based on feasibility and need. Priorities identified by the Michigan Oral Health Coalition included preventive strategies for infants and children as well as

increasing school-based dental sealant programs. The SOHP was combined with the Perinatal Oral Health Action Plan, the Michigan Oral Health Coalition Policy Priorities and the Director Dental Report to create one cohesive document. An extensive goal-identifying process with members resulted in prioritizing professional integration between providers across the lifespan, increasing knowledge and awareness of the importance of oral health to overall health, and increasing access to oral health care among the underserved and hard-to-reach populations. A press release announcing the release of the SOHP occurred in May 2016, followed by a roll out at the Michigan Oral Health Conference in September 2016. The SOHP has been disseminated to stakeholders including the Michigan Oral Health Coalition, LHDs, FQHCs, WIC programs, dental programs and non-profit organizations and advocacy groups. The Oral Health Program began to implement this plan and provide presentations on the SOHP with the goal of contributing to increased access and utilization of evidence-based oral health practices and services.

Objective C: Increase by 20 the number of medical and dental providers trained to treat, screen and refer pregnant women and infants to oral health care service.

During FY 2016, 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 implemented to support better health status for women and girls. One strategy was to train and educate Michigan health professionals. In FY 2016, the Perinatal Oral Health Program trained 390 health professionals in the medical and dental fields through lectures, webinars, conference calls and other training events. As a result of needs

identified from these trainings, the Perinatal Oral Health Program began collaborating with the Division of Maternal and Infant Health on the development and implementation of a curriculum evaluation project in eight locations, including Michigan OBGYN residency programs and in dental and nursing schools. The project enacts an upstream approach towards assessing and enhancing the education of Michigan's future health care providers surrounding the topics of perinatal oral health, substance use assessment, health literacy, and health equity. While considerable time and effort are committed to the continuing education of established Michigan healthcare professionals, this pilot project focuses on improving the education of Michigan's future health professionals while they are still in their respective educational programs. The project established a partnership with the Wayne State University Area Health Education Center (AHEC) and other AHECs across the state and is being implemented in the current fiscal year.

Objective D: Increase by 2% the number of pregnant women and infants receiving oral health care services.

Together with a variety of medical and dental professionals and other stakeholders, MDHHS developed and began to distribute and promote Perinatal Oral Health Guidelines as the first strategy to increase the number of pregnant women and infants receiving oral health care. These guidelines presented a unified voice that emphasizes the importance of perinatal oral health to perinatal care and dental providers. A year-long information gathering process resulted in a comprehensive document that also provides tear-out information sheets and a referral form for providers. The guidelines provide state-specific resources and tools;

summarize the issues surrounding perinatal oral health; and promote the consistent delivery of medical and dental services. In FY 2016, over 1,000 copies were distributed, with additional copies printed at the request of medical and dental providers. The guidelines are also accessible electronically and are available on the oral health program website.

In the second strategy, MDHHS developed and distributed promotional and education materials that promote dental visits during pregnancy and promote infant oral health to health entities across the state. The development of a specific Perinatal Oral Health module in partnership with WIC was established in FY 2016. This module (delivered through wichealth.org) served as a training mechanism to mothers across the state of Michigan as well as on a national level.

Wichealth.org provides stage-based, client-centered, WIC nutrition education and an anticipatory guidance model where WIC clients could complete educational lessons in English or Spanish in order to receive their WIC benefits. Clients received personalized feedback and educational materials, as well as nurse follow-up on any questions raised during the training.

Life Course/Cross-cutting Health Domain

SPM 3 – Depression across the Life Course

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
Promote social and emotional well-being through the provision of behavioral health services	A) Participants of Eliminating Barriers for Learning training will demonstrate a 45% increase in ability to identify symptoms of mental health disorders including depression; and a 30% increase in ability to identify ways mental health affects learning and classroom environment	A1) Provide Eliminating Barriers for Learning training to school district personnel	A) Percent of high school students who report feeling 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, and B) Percent of women enrolled in MIHP who are screened for maternal depression
	B) Increase by 920 per year the number of school personnel who are trained on the impact of social and emotional health on learning	B1) Provide Eliminating Barriers for Learning training to school district personnel B2) Provide Eliminating Barriers for Learning Training of Trainers	
	C) 60 adolescents per year will access child psychiatry case consultation services through the provision of telepsychiatry services at Child and Adolescent Health Centers (CAHCs)	C1) Provide MC3 telepsychiatry services to patients of Child and Adolescent Health Centers (CAHCs)	
	D) Increase by 5% the enrollment of Medicaid-eligible pregnant women into MIHP	D1) Incorporate transition of changes in Benefit Administration of Maternal Infant Health Program Services for Individuals Enrolled in a Medicaid Health Plan	

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
	E) Ensure appropriate coordination of care for MIHP enrolled women identified at risk for maternal depression	E1) Enhance data collection process to improve maternal depression referrals and follow up to care	

Depression across the Life Course FY 2018 Application

To address the priority area of “Promoting social and emotional well-being through the provision of behavioral health services,” MDHHS developed a two-part State Performance Measure relative to reducing depression across the life course, focusing on two high need populations: adolescents and pregnant and postpartum women. The SPM includes A) Percent of the Michigan’s high school students who report having 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, and B) Percent of women enrolled in Michigan’s Maternal Infant Health Program (MIHP) who are screened for maternal depression.

To address this SPM, Michigan has identified strategies related to reducing depression among adolescents: educate school personnel on recognizing depression, reducing stigma surrounding depression and increasing referrals for depression to appropriate resources; and increase access to child psychiatry services for adolescents with depression while promoting integrated physical and mental health care.

To address depression among pregnant and postpartum women, MDHHS will focus on MIHP for pregnant and postpartum women with Medicaid. MIHP is the largest evidence-based home visiting program in Michigan. This population-based program serves pregnant mothers and

their infants and provides professional services from a registered nurse and licensed social worker, and when applicable, registered dietician (with a physician order), and an infant mental health specialist. Strategies for this population are implemented through the program and consist of standardized depression screening through a validated risk screener, required behavioral health and stress/depression education for MIHP health professionals, increasing behavioral health referrals, and improving access through increasing the number of endorsed Infant Mental Health Specialists in MIHP.

Part A: Adolescent Health

Depression is increasingly common in adolescence. According to the 2015 Michigan Youth Risk Behavior Survey (YRBS), 31.7% 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 12 months prior to the survey. This represents nearly a 5% increase from 2013 data (27%). Symptoms of depression among this age group are often related to the stresses and challenges of transitioning from childhood to adulthood. Depression can impact every aspect of life, from academic success to physical health and is sometimes associated with increased risk for suicide. Early identification of depression is crucial in reducing prevalence of depression and for implementing timely and effective interventions to manage symptoms and reduce negative outcomes. Increased attention to integrated care, with primary care and mental health providers working closely together in the same setting, enable health care providers to achieve the best outcomes for clients in a timelier manner without fragmenting care.

Objective A: Participants of Eliminating Barriers for Learning training will demonstrate a 45% increase in ability to identify symptoms of mental health disorders including depression; and a 30% increase in ability to identify ways mental health affects learning and classroom environment

Objective B: Increase by 920 per year the number of school personnel who are trained on the impact of social and emotional health on learning

As a first strategy to address depression in adolescents, in FY 2018 Michigan's Statewide School Mental Health Consultant (a shared position with MDDHS and the Michigan Department of Education) will provide SAMSHA's Eliminating Barriers for Learning curriculum to two to three school districts, reaching approximately 40 teachers and school staff at each training (80 to 120 participants total). Eliminating Barriers for Learning (EBL) is a continuing education program for secondary school teachers and other school personnel that focuses on mental health issues in the classroom and school environment. Its goals are to inform participants about adolescent social-emotional wellness (including depression) and provide specific skill-based techniques which 1) increases knowledge of adolescent mental health, including risks and protective factors; 2) shows teachers and staff how to develop an action plan to help students who need additional support; 3) suggests ways to promote a mentally healthy learning environment through instructional techniques that account for individual styles of learning and the classroom climate; and 4) helps staff identify school/community resources and partnerships to promote youth mental health.

The curriculum consists of four modules, each designed for a continuing education or in-service workshop: 1) social-emotional development, stigma and discrimination; 2) overview of disorders, effects on learning and risk factors; 3) formulating a plan to help; and 4) creating a climate that promotes learning and mental health. Based on current education and behavioral science research, the training modules compile practices supported by research and that are associated with positive outcomes for youth. Based on prior implementation, the expected participant outcomes include: a 45% increase in identifying symptoms of mental health disorders, and a 30% increase in identifying ways mental health affects learning and classroom environment.

As a second strategy, to expand the reach of EBL, in FY 2018 the School Mental Health Consultant will provide a Training-of-Trainers (TOT) to 10 professionals. EBL is designed to be delivered by a variety of professionals (e.g., school social worker, psychiatrist, guidance counselor, school nurse or other staff member). Each participant who completes the TOT will be expected to provide a minimum of two trainings within a year of receiving the TOT. This will expand the reach of EBL to a minimum additional 800 school district personnel, bringing the total number of school district personnel trained to 920.

Objective C: 60 adolescents per year will access child psychiatry services through the provision of telepsychiatry case consultation services at Child and Adolescent Health Centers (CAHCs). As a final strategy, the MDHHS Child and Adolescent Health Center Program (CAHC) will incorporate the use of telehealth technology to increase and improve the care and treatment of adolescents with depression. Administered and coordinated by the University of

Michigan, in FY 2018 MDHHS will provide funding support for CAHC participation in the MC3 Program. MC3 provides psychiatry support to primary care providers in CAHCs who are managing patients with mild to moderate behavioral health concerns including depression, which complements social work services (individual and group therapy) provided at the centers. Psychiatrists offer case consultation on diagnoses, medications and psychotherapy interventions so that primary care providers can better manage patients in their practices. This integration of care is welcome by primary care providers who may not want to independently prescribe psychotropic medications, but who want more integrated physical and mental health care for their patients with mental health needs. Additionally, psychiatric support is provided through phone consultations with providers and by remote psychiatric evaluation to patients and families through video telepsychiatry. This access may be the only access to child psychiatrists that many providers and patients have. It is expected that a minimum of 60 patients will be reached at select CAHCs across the state.

Part B: Women/Maternal Health

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. 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 Michigan's six home

visiting programs found that the percentage of women exceeding clinical cutoff for depression at enrollment ranged from 28.5% to 61%. The largest home visiting program in Michigan, the Maternal Infant Health Program (MIHP), stores data in the MDHHS Data Warehouse, allowing for further analysis. MIHP data are collected based on the beneficiary's response to the stress/depression risk questions asked on the maternal risk-identifier screen and stored in the MDHHS Data Warehouse. FY 2016 data from the MIHP screener for maternal depression (utilizing the Edinburgh Postnatal Depression Scale) showed that 23,296 (100%) of pregnant women enrolled in MIHP were screened for maternal depression. Of those screened, 8,958 (38%) scored moderate or high risk for depression.

Every Medicaid-insured pregnant woman is eligible for MIHP which includes a comprehensive risk screening, care coordination and up to nine additional visits based on risk. A validated standardized risk screener is administered for all participants at entry to the MIHP which encompasses many domains, including a stress/depression domain utilizing an embedded Edinburgh Postnatal Depression Scale. If a participant screens "at risk" for stress/depression, an evidence-based plan of care is implemented. This plan of care includes education, coping strategies, referral offerings as needed, discussion of treatment options, preparation of a postpartum support plan, and development of a safety plan. To better integrate consumer feedback, in 2017 MIHP will implement a beneficiary satisfaction survey related to the MIHP services received. The results will be anonymous and will be used to inform program practices and program improvement in FY 2018.

To support the SPM related to maternal depression, general strategies include: a revision of the Maternal Risk Screener that includes evidenced-based depression screening based on current literature review; revision of the depression plan of care to include more robust evidenced-based interventions; continued required training for MIHP professionals (implementation of MIHP Depression Interventions; Infant Mental Health Training; Supporting Infant Parent Attachment; Reaching the Most Difficult to Reach Families: An Attachment perspective; and Motivational Interviewing and the Theory Behind MIHP Interventions); continuation of the MDHHS MIHP Mental Health Workgroup which meets monthly to assure that the most beneficial and current interventions are included in the program; and the inclusion of MDHHS MIHP staff as liaisons for various Michigan organizations and projects (Community Mental Health, Michigan Association for Infant Mental Health, and the Michigan Statewide Perinatal Mood Disorder Coalition).

Objective D: Increase by 5% the enrollment of Medicaid-eligible pregnant women into the Maternal Infant Health Program (MIHP). A core strategy toward meeting this objective is through a new MIHP enrollment partnership with the Medicaid Health Plans. An increase in MIHP enrollment is anticipated beginning January 1, 2017, as MIHP services provided to individuals enrolled in a Medicaid Health Plan (MHP) will be administered by the MHP. As a result of this change, all MIHP services provided to MHP enrollees on and after January 1, 2016, will be coordinated and reimbursed by the MHPs. Increased screening for maternal depression among Medicaid eligible pregnant women is expected as MIHP enrollment increases, since MHPs are required to assign all MIHP-eligible women and infant enrollees to an MIHP provider

for MIHP outreach, screening and care coordination within one month of the effective date of MIHP eligibility.

Objective E: Ensure appropriate coordination of care for MIHP enrolled women identified at risk for maternal depression. A strategy to meet this objective is to enhance data collection processes to improve maternal depression referrals and follow up to care. This includes standardized referral data capture processes among all MIHP agencies in order to better capture data from the referral portion of those at risk for maternal depression.

The first activity is to implement the Michigan Home Visiting Workgroup's CQI project definition of a maternal depression referral. This state-level continuous quality improvement project aims to improve the rate of referral for maternal depression services by developing and aligning common definitions for counting referrals for maternal depression—a critical precursor to accurately collecting data. This recommended referral definition will be included in the MIHP operation guide, a manual listing MIHP requirements for the providers.

The second activity to standardize data is to perform special analyses to build knowledge of effective maternal depression interventions and communicate the value of referral offerings currently in place. MIHP providers are required to use program documents to maintain fidelity to the program using evidenced-based criteria. A revision of the Maternal Risk Screener that includes evidenced-based depression screening based on current literature review is complete. The next step is the current literature review and revision of the depression plan of care to include more robust evidenced based interventions. The final step will be the revision of the discharge summary which will more accurately capture depression data. MIHP providers will be

trained on the enhanced documents (risk identifier, depression plan of care, and discharge summary) via two-day trainings in FY 2018.

Depression across the Life Course FY 2016 Annual Report

Part A: Adolescent Health

Several activities in this SPM were not slated for implementation until the current fiscal year (FY 2017). As such, FY 2016 activities for Objectives A and B centered on planning and organization for the Training of Trainers (TOT) for the Eliminating Barriers for Learning curriculum. As of the writing of this report, ten school professionals are confirmed for the FY 2017 TOT. Activities for Objective C (telepsychiatry services) were implemented in FY 2016 as an expansion of existing efforts.

Objective A: Participants of Eliminating Barriers for Learning training will demonstrate a 45% increase in ability to identify symptoms of mental health disorders including depression; and a 30% increase in ability to identify ways mental health affects learning and classroom environment.

Training manuals for a Training of Trainers (TOT) of the Eliminating Barriers for Learning (EBL) curriculum were developed and training registration processes are in place. A pre/post survey will be utilized to evaluate TOT outcomes which will be reported during the next reporting cycle. Each FY 2017 TOT participant will be expected to provide a minimum of two trainings within a year, in an effort to expand the reach of EBL to local school district personnel.

Objective B: Increase by 920 per year the number of school personnel who are trained on the impact of social and emotional health on learning.

Training of additional school personnel on the EBL curriculum is slated to begin in the fall of 2017. Most, if not all, schools host Professional Development days at the end of the summer before the new school year starts, offering ideal opportunities for the EBL training to be conducted. Training facilitators have already identified locations in which to host EBL trainings. The outcomes of this objective will be updated and reported on during the next reporting year.

Objective C: 60 adolescents per year will access child psychiatry case consultation services through the provision of telepsychiatry services at Child and Adolescent Health Centers (CAHCs).

With funding support separate from Title V, telepsychiatry services (offered through the University of Michigan and called “MC3”) are provided to 16 Child and Adolescent Health Centers. These case consultation services are available as needed to the medical and mental health providers in these school-based and school-linked health centers. Virtual consultation sessions with providers typically last 60 to 75 minutes and include consultation for up to six clients per session. Discussion usually revolves around the need for medication (primarily to address depression and/or anxiety); guidance around appropriate prescriptions; and next steps needed to fully serve the client. Efforts to engage families of clients have been successful in some situations. Providers have shared how valuable the service is as they are working with youth with multiple mental health challenges. The efficiency in which the psychiatric services are provided is of huge benefit, as case consultation services are provided within 24 to 48 hours

after a request is made and, in some instances, psychiatrists are able to respond to calls within two hours. (Additionally, regularly-scheduled case consultations also take place to assist in follow up care.) In FY 2016, 30 youth were provided cases consultation services through this mechanism. As each provider sees the benefit and adjusts their practice to more routinely include this integrated service, it is anticipated that usage will increase.

Part B: Women/Maternal Health

A core strategy for the second component of this SPM is centered on developing partnership and collaboration between the MIHP provider agencies and the Medicaid Health Plans (MHP). Since the beginning of the MIHP program in the late 1980s, MIHP services were paid on a fee-for-service basis. In FY 2016, MDHHS announced the MIHP payment structure was to be administered by the MHP. The anticipated date of the change in payment structure was October 1, 2016; however, logistics dictated the need to push back the date to January 1, 2017. This transition process is expected to occur throughout 2017 and into FY 2018.

Objective D: Increase by 5% the enrollment of Medicaid-eligible pregnant women into the MIHP.

It is anticipated that enrollment of Medicaid-eligible pregnant women into MIHP will increase due to the January 1, 2017, promulgation of the policy requiring Medicaid Health Plans (MHP) to reimburse and coordinate MIHP services. As a result of this change, all MHP beneficiaries who are pregnant are required to be referred for MIHP services by the MHP.

Objective E: Ensure appropriate coordination of care for MIHP enrolled women identified at risk for maternal depression.

The first activity for FY 2016 was to bring stakeholders together to share best practices, data collection, reporting and evaluation processes to improve monitoring and data capture for MIHP maternal depression referrals. MDHHS MIHP staff participated in the MDHHS home visiting workgroup where MHVI partners came together to coordinate efforts and improve quality across models, programs, and partners. The workgroup participated in a state-level continuous quality improvement project to improve the rate of referral for maternal depression services by developing and aligning common definitions for how to count referrals for maternal depression—a critical precursor to accurately collecting data.

The second activity was to perform special analyses to build knowledge of effective maternal depression interventions and to communicate the value of referral offerings currently in place. The analysis began in FY 2016 and continues into FY 2017. A revision of the Maternal Risk Screener that includes evidenced-based depression screening based on current literature review is complete; however, it needs to be added to the MIHP database. This update should be completed in FY 2017. Revision of the depression plan of care to include more robust evidence-based interventions is scheduled for completion by early FY 2018.

Cross-cutting/Life Course Population Domain

SPM 5 – Immunizations

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
Invest in prevention and early intervention strategies, such as screening	A) Increase the percentage of children 19-36 months of age who receive recommended vaccines	<p>A1) Use data in the Michigan Care Improvement Registry (MCIR) to identify all children 6-18 months of age who are overdue for a vaccine</p> <p>A2) Generate quarterly letters to parents of children 6-18 months of age who are overdue for a vaccine</p>	<p>A) Percent of children 19 to 36 months of age who have received a completed series of recommended vaccines (4:3:1:3:3:1:4 series) and B) Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus (HPV) vaccine</p>
	B) Make quality improvement reports (AFIX reports) available to immunization providers using the MCIR	<p>B1) Identify requirements needed to make AFIX reports available to immunization providers</p> <p>B2) Provide requirements to MCIR technical staff for programming into the MCIR</p> <p>B3) Train providers on the use of AFIX reports</p> <p>B4) Outreach to providers who see the largest number of pediatric patients and have the lowest immunization levels and offer AFIX visits in their practice</p>	
	C) Enable local health departments to better track successes or shortfalls for their health jurisdiction	C1) Using MCIR data, generate county report cards that rank all counties based on pediatric, adolescent, and adult immunization rates	

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
		<p>C2) Post county report card data on the MDHHS Immunization website</p> <p>C3) Provide county level drop-off data to local health departments on a routine basis for targeted immunization efforts</p>	
	<p>D) Increase the percentage of adolescents who have completed the HPV series</p>	<p>D1) Notify parents of adolescents enrolled in MCIR who have not completed the HPV series</p> <p>D2) Partner with the MDHSS Cancer Program and the Cancer Consortium</p> <p>D3) Conduct outreach to all colleges and universities in Michigan to encourage complete vaccination of all students</p>	
	<p>E) Increase outreach to adolescent immunization providers with low immunization rates</p>	<p>E1) Using MCIR data, generate a list of adolescent providers and their MCIR completion rates</p> <p>E2) Prioritize provider outreach to larger practices with the lowest immunization rates</p> <p>E3) Offer quality improvement visits to provide a comprehensive assessment of immunization rates and provide recommendations for practice improvements</p>	

To address the priority area of “Invest in prevention and early intervention strategies, such as screening,” MDHHS developed an SPM related to Immunizations. This SPM includes two measures: A) Percent of children 19 to 36 months of age who have received a completed series of recommended vaccines (4:3:1:3:3:1:4 series) and B) Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus (HPV) vaccine. Within some populations, Michigan has experienced declining immunizations rates and has not met the Healthy People 2020 goal for child immunizations. For example, the percent of 19 to 35 month olds who received a full schedule of age appropriate immunizations (Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B) fell from 82% to 74.8% between 2008 and 2014. Additionally, two dose hepatitis A vaccination rates for children are low in Michigan. The Advisory Committee on Immunization Practices (ACIP) routinely recommends two doses of hepatitis A, and Michigan has started tracking completion rates for children to measure progress.

In the most recently published data for immunization waiver rates for Kindergarten children, Michigan has the 11th highest percentage of kindergarten exemptions for one or more vaccines required for school entry. This rate varies greatly across the state. Michigan has successfully increased the coverage rate for Michigan’s 13 to 18 year olds to 76% for all vaccines except HPV vaccine. While the coverage rate for HPV vaccine for all 13 to 18 year old adolescents has increased significantly over the last year, it is still significantly lower than the Healthy People 2020 goal of 80% coverage for all adolescents. The current coverage rate for all adolescents in Michigan is 36% for a completed series. Establishing an immunization SPM aligns with work at both the state and local level. For example, several local health departments use MCH funding

for both direct services and enabling services, particularly to support childhood immunization efforts. Additionally, several of the National Outcome Measures (NOMs) focus on immunizations.

The mission of the MDHHS Division of Immunization is to minimize and prevent the occurrence of vaccine-preventable diseases in Michigan. The program seeks to fulfill its mission through coordinated program efforts designed to:

- Promote high immunization levels for children and adults
- Provide vaccines through a network of public and private health care providers
- Facilitate the development, use and maintenance of immunization information systems
- Support disease surveillance and outbreak control activities
- Provide educational services and technical consultation for public and private health care providers
- Promote the development of private and public partnerships to improve immunization levels across the state
- Promote provider and consumer awareness of immunization issues

The vision of the MDHHS Division of Immunization is to implement effective strategies and to strengthen partnerships with our stakeholders to eliminate vaccine preventable diseases in Michigan.

The National Immunization Surveys (NIS) are a group of telephone surveys sponsored and conducted by CDC's National Center for Immunization and Respiratory Diseases (NCIRD). In 1994, the NIS began to monitor child immunization coverage in all 50 states and select local

areas for sampling. The NIS is the only standardized sampling method that can show differences and disparities from one state to another. The NIS uses random-digit-dialing to identify households with children ages 19 through 35 months. A parents or guardian is interviewed on child immunization status and vaccination providers are mailed a survey to verify immunizations. NIS currently measures: 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 HepB, 1 Varicella, 4 PCV (4313314). The most recent NIS data from 2015 shows that the point estimate for Michigan is 67.6 which is up 2.6% from the prior year for the 4313314 series.

The Division of Immunization operates the Michigan Care Improvement Registry (MCIR). The MCIR is a regionally based, statewide immunization registry that contains over 124 million shot records administered to 9.2 million individuals residing in Michigan. MDHHS is currently working through subcontracts with six MCIR regions to enroll and support every immunization provider in the state. Current enrollments include: 6,259 health care providers and pharmacies; 4,185 schools; and 3,852 licensed childcare programs. The MCIR system is used routinely by over 30,000 users to access and determine the immunization records of both children and adults. In 2016, the MCIR generated over 448,513 recall letters notifying responsible parties whose children had missed shots and encouraged them to visit their immunization providers to receive needed vaccines. In addition, over 3 million reports were generated by users of the MCIR system in 2016.

The MCIR has the ability to forecast needed doses of vaccine for all children who are contained in the system. All children should have completed the recommended pediatric vaccines by the time the child reaches 19 months of age. Data from the MCIR show that 75% of children who reside in Michigan have received the routinely recommend 4313314 series by the time they

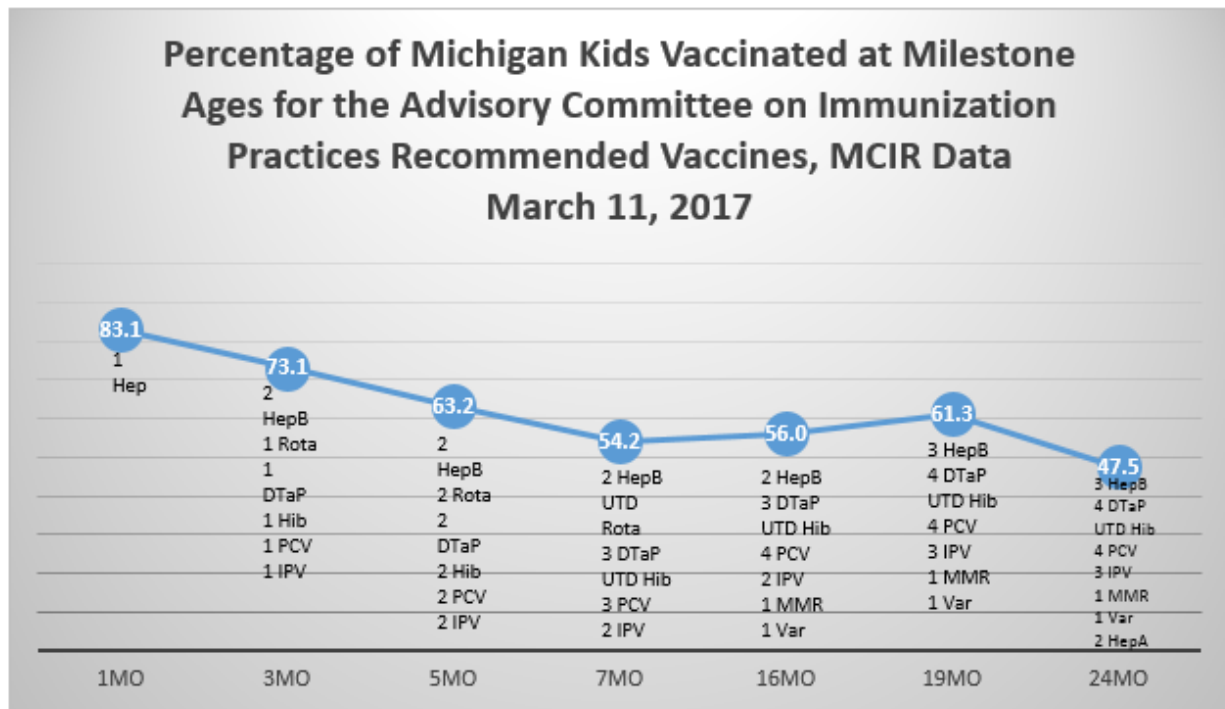
reach 36 months of age which is up by 1% from 2015. MCIR rates have experienced gradual decreases in compliance rates for children enrolled in Medicaid and in WIC. Although the 75% vaccination level is higher than the rate reported by the National Immunization Survey, the Healthy People 2020 goal is 80%.

Adolescent immunization rates for most diseases are similar to national numbers and, in some cases, Michigan meets the Healthy People 2020 objectives. However, Michigan needs to make significant improvements in HPV vaccination rates. The HPV vaccine has the potential to save thousands of lives every year, yet our adolescent completion rates are far below national goals. Over the past two years, Michigan has doubled the completion rate for adolescents 13 through 18 years of age from 18% to 36%. This was primarily accomplished using the MCIR to generate letters to parents of all adolescents who had not yet completed the HPV series. Funding for this project was through a special grant from the CDC that focused on increasing HPV rates. MDHHS will be seeking funding to continue this successful effort.

Objective A: Increase the percentage of children 19-36 months of age who receive recommended vaccines.

Data obtained from the MCIR show that children are not receiving vaccines on schedule, and many of these children never catch up on all needed vaccines. By seven months of age, only 54% of children in MCIR are current with all recommend vaccines, which is up from 51% reported out last year (see Figure 4). This puts our population at risk, with nearly half of the children susceptible to these serious diseases.

Figure 4. Percentage of Michigan Kids Vaccinated at Milestone Ages



The MCIR has the ability to assess existing immunization data for children and forecast needed doses. This functionality greatly assists clinicians in determining any needed doses of vaccine during a clinical encounter. This same forecasting functionality can be used at a system level to determine any children who are in need of vaccines. To increase vaccination rates, the Division of Immunization has initiated an effort to notify parents of all children 6 months through 18 months of age who are overdue for one or more vaccines. In the past, efforts have been targeted at children who are 2 to 3 years of age, but this effort will attempt to impact parents of children less than 19 months of age who are not staying on schedule. Data from the MCIR show that children who stay on schedule are twice as likely to complete all needed vaccines as those who fall behind early. A central strategy to address this objective is to generate notices to parents of children who are overdue for vaccines. These notices are not intended to replace

other efforts that may be underway in provider offices or local health departments, but are meant to enhance existing efforts to remind parents of the importance of immunizations.

In FY 2018, MDHHS will continue to promote and utilize the new [IVaccinate campaign](#) to the extent possible, depending on funding and resources. The campaign went live in March 2017 to provide information and tools based on research and medical science to help Michigan parents protect their children through vaccinations. MDHHS and the Franny Strong Foundation have partnered to provide financial and program support for the campaign. Approximately 17 other state and national groups are supportive of the campaign, including the Michigan Association of Health Plans, the Michigan Association of Local Public Health, the Michigan Chapter of the American Academy of Pediatrics, and the Michigan Health and Hospital Association.

Objective B: Make quality improvement reports (AFIX reports) available to immunization providers using the MCIR.

The MCIR system has grown to be a robust source of data and can be a useful tool to assure children are vaccinated. For a number of years, AFIX reports were available to local health department staff (via MCIR) which in turn could generate the reports for vaccination providers in their jurisdiction. A new enhancement to the MCIR in 2016 now allows a provider to directly generate their own AFIX reports. In FY 2018, the Division of Immunization will promote this new feature with local partners and providers. The AFIX report includes information such as a listing of children who are incomplete for one or more doses of vaccine; a listing of individuals who could be complete with one more visit or one more dose of vaccine; and a listing of individuals

who had a missed opportunity to vaccinate during a previous visit. The report also includes coverage level data for the practice, which provides detailed data by vaccine type.

By making the reports available directly to the provider, the intention is for staff to take ownership of the vaccine program, empower the practice, and encourage development of a plan to improve immunization rates. MDHHS staff are available to work with any practices that need assistance. To support these efforts, the Immunization Program is in the process of training provider office staff on the functionality and use of the data on the AFIX reports, which will continue in FY 2018. All local health department staff are encouraged to provide information to providers on the use of the AFIX reports during the routine visits to provider offices.

Objective C: Enable local health departments to better track successes or shortfalls for their health jurisdiction.

The Immunization Program recently began distributing population-based county “report cards” for local health departments to better understand immunization issues and areas for improvement within their communities. In FY 2018, the MCIR epidemiologist will generate county report cards on a quarterly basis, which will be posted on the website. The report card will contain coverage level information in several key areas including pediatric, adolescent and adult coverage levels. Report cards rank each county in the state, so a county can also compare its progress to other counties.

Objective D: Increase the percentage of adolescents who have completed the HPV series.

In 2014, the Immunization Program received grant funding to increase HPV immunization rates

for adolescents in Michigan. At the beginning of the grant period, the HPV coverage rate was 18% for all adolescents (male and female) 13 to 18 years of age. The Division of Immunization used the majority of funding to send out notifications to parents of adolescents 11 to 18 years of age who were overdue for one or more doses of HPV vaccine. Given the impact of this strategy, in FY 2018 the Immunization Program will continue to seek funding for and use this strategy as a way to increase adolescent HPV immunization rates.

The first round of notices went to adolescents who had received two doses of HPV vaccine but had not yet received their third dose. In that round, 34,890 notifications were distributed and 4,496 adolescents (12.89%) were vaccinated with HPV within two months of receiving the notice. The second round of notices was sent to adolescents who had received one dose of HPV vaccine but had not yet received their second dose. For this round, 60,745 notifications were distributed and 8,826 adolescents (14.53%) were vaccinated with HPV within two months. The third round of notices was sent to adolescents who had never received any HPV vaccine. For this round, 400,139 notifications were distributed and 13,195 adolescents (3.30%) were vaccinated with HPV within two months. Through this grant, 26,517 adolescents were vaccinated with HPV vaccine. Adolescent rates moved up to 27% in 2015 and to 36% to 2016.

A second strategy in FY 2018 is for the Adult and Adolescent Coordinator in the Division of Immunization to continue partnering with the cancer programs working toward a common goal of increasing HPV coverage rates and decreasing the incidence of cancers caused by Human Papillomavirus. The Division of Immunization has partnered with these programs to promote the message about cancer prevention using social media and public advertising. The

Immunization Program will also conduct outreach to colleges and universities regarding the importance of student vaccination. Michigan does not have vaccination requirements for colleges and universities. Some have immunization requirements in place for some or all students, but it is not universal. The Immunization Program will reach out to these institutions to determine their current requirements and to encourage their administration to promote immunizations to all students and faculty. This outreach will not be exclusively for HPV vaccine, but will also include the importance of other vaccines such as Tdap, meningococcal, and influenza vaccines.

Objective E: Increase outreach to adolescent immunization providers with low immunization rates.

In FY 2018, the Division of Immunization epidemiologist will generate a monthly list of all immunization providers submitting data to MCIR who are vaccinating adolescents. The list will show how many adolescents are being seen by the practice and how many adolescents are receiving all needed vaccines. Staff will review this list and identify the largest providers with the lowest immunization rates and reach out to those providers. Follow up will include providing a comprehensive AFIX report and working with the practice to develop a plan to increase immunization rates. Through direct outreach to the provider, we will have the opportunity to customize a practical quality improvement plan to help improve immunization rates as well as the quality of care.

Immunizations FY 2016 Annual Report

Many successes were achieved in FY 2016. For example, several indicators used to measure immunization rates in Michigan moved in the right direction. Michigan saw a 1% increase in pediatric coverage rates from 74% to 75% for the complete series. Michigan also saw an increase in the adolescent coverage rates which did not include HPV vaccine. Those rates increased from 74% to 76%. The adolescent immunization rates for HPV coverage saw a significant increase. HPV coverage rates over the last year for 13 to 18 year old adolescents increased by 9%. While much work was done to increase these rates, the increase was in part due to the change in the ACIP recommendations for the use of that vaccine. The new recommendation for children under 15 years of age is that the series can be completed with only two doses of appropriately spaced vaccine rather than the traditional three-dose schedule. Michigan experienced a 7% increase in rates due to the way vaccine coverage was measured. Lastly, Michigan saw a 35.4% decrease in the immunization waiver rates from the previous year. This led to over 9,000 more children reporting complete immunizations for school entry.

Objective A: Increase the percentage of children 19-36 months of age who receive recommended vaccines.

In FY 2016, Michigan continued to experience a significant problem keeping children on schedule. Only 54% of children who are seven months of age were on schedule with all recommended vaccines. This means that children are susceptible to diseases for a longer period of time when they are most vulnerable. Data also shows that those children who fall behind are less likely to complete the schedule. In an effort to keep children on schedule, in FY 2016 Michigan began sending out letters to all children overdue for a vaccine. These notices went out to all children between the ages of 6 and 18 months of age on a quarterly basis. In 2016,

notices were issued in April, September and December to over 68,000 children. Overall in 2016, immunization rates increased by 1% to 75% for the complete coverage of vaccines.

One outreach activity to consumers was to partner with the WIC program on a media campaign targeted to parents with children enrolled in WIC. This activity was in response to a decrease in immunization levels over the past three years for children enrolled in WIC. Target areas for the campaign were Detroit, Flint and Oakland County. Marketing strategies to reach the target audience included radio ads, posters in bus stops, ads on the sides of busses, and billboards. In preparation for a statewide media campaign called IVaccinate (which began in March of 2017), MDHHS conducted focus groups with young mothers who were hesitant to vaccinate their children. We wanted to learn about their concerns and what types of information and messaging would most impact their decision to vaccinate their children. We also asked these mothers how they receive information. This information was used to create the IVaccinate Campaign.

Objective B: Make quality improvement reports (AFIX reports) available to immunization providers using the MCIR.

The Division of Immunization was able to document all needed changes to make the AFIX reports available to the end user in an immunization provider office using MCIR. In FY 2016, all documentation was completed and programmed into MCIR. AFIX reports are now available for use by provider offices. Several trainings were held for provider practices to learn about the functionality of the reports. The trainings included an emphasis on how to utilize the reports to improve immunization rates and overall quality improvement. MCIR regional staff were also trained to further support providers in the community.

Objective C: Enable local health departments to better track successes or shortfalls for their health jurisdiction.

In 2016, County Report Cards were generated and put on the MDHHS public-facing website on a quarterly basis. The report cards were generated to reflect immunization rates of each county in Michigan and ranked them with other counties in the state. The report cards have been modified several times to better meet the needs of local health departments. The goals of the report card data are to provide each county with an understanding of how well they are doing vaccinating individuals in their respective communities, as well as to identify areas for improvement.

Objective D: Increase the percentage of adolescents who have completed the HPV series.

Michigan’s CDC grant to improve HPV vaccination rates for adolescents ended in September of 2016. Through this grant and by using data in the MCIR system, a total of 683,093 notices were mailed to parents of adolescents who had not completed the HPV series. Fifteen percent of the individuals who received a notice were vaccinated within 60 days of receiving the notice. Of the individuals who received the notices, 9.2% received a dose of HPV vaccine. As a result of this overall effort, Michigan’s HPV coverage rate increased from 18% to 29% for both males and females. See Table 6 for additional details.

Table 6. HPV Letter Distribution

<i>Updated May 3, 2017</i>	Round 1 - 3rd HPV	Round 2 - 2nd HPV	Round 3 - 1st HPV	Round 4- 2nd & 3rd HPV	Round 5 - 3rd HPV	Project Total
Total Recalls Sent	34,890	60,745	400,139	142,028	45,291	683,093
Number Return to Sender Letters	3,353	6,792	47,682	14,955	2,737	75,519

RTS letters able to be forwarded	90	169	645	245	141	1,290
Percentage Returned to Sender	9.61%	11.18%	11.92%	10.53%	6.04%	11.06%
Total # of people vaccinated that were sent a recall letter	6,097	12,753	39,404	28,108	17,238	103,600
% of people vaccinated that were sent a recall letter	17.47%	20.99%	9.85%	19.79%	38.06%	15.17%
Total # of people vaccinated with HPV that were sent a recall letter	5,410	12,861	16,272	27,783	472	62,798
% of people vaccinated with HPV that were sent a recall letter	15.51%	21.17%	4.07%	19.56%	1.04%	9.19%

In FY 2016, the Division of Immunization also partnered with the Cancer Program and the Cancer Consortium on several activities. The Immunization Adult and Adolescent Coordinator presented a workshop at the annual Cancer Consortium meeting as well as a webinar focused on HPV vaccination. Immunization providers and groups that work in the Cancer Program participated in these learning opportunities.

The Division of Immunization sent a letter to all colleges and universities in Michigan reminding them of the importance of immunizations as they enroll students into their institutions. This letter had a focus on Meningococcal B vaccine since it was a newly available vaccine; however, all relevant vaccines were discussed in the letter.

Objective E: Increase outreach to adolescent immunization providers with low immunization rates.

In FY 2016, MDHHS analyzed adolescent immunization coverage levels from the MCIR to target outreach to large immunization providers with the lowest immunization rates. The focus of

these coverage rates has been on HPV vaccination rates but all adolescent vaccines are discussed. Staff conducted outreach to these providers to meet in person and offer quality improvement tools to assist the practice in increasing immunization rates. AFIX reports were provided and reviewed and areas of focus are identified. In southeastern Michigan, a provider meeting was held with several guest speakers to discuss the importance of HPV vaccine and the need to increase immunization rates. This meeting provided practical tools to assist practices with increasing immunization rates.

II.F.1.b. Other Programmatic Activities

Michigan allocates approximately one-third of its Title V funds (\$6,875,050 in FY 2016) to the Local Maternal and Child Health (LMCH) Program. Funding is distributed to each of the 45 local health departments (LHDs) in Michigan. LMCH funds are available to LHDs to support one or more of the Title V Maternal and Child Health Block Grant national and state performance measures. LHDs can also identify a local MCH need or priority. LHDs complete a needs assessment which identifies their MCH priorities and any disparities noted in their jurisdiction. FY 2016 was a transitional year for the LMCH program. LHDs were able to select some programmatic categories (as they did in previous years) and some Title V pyramid service categories (which is what they will select in the next fiscal year) as budget categories for LMCH funding. In FY 2016, LHDs could choose to budget their MCH needs into 13 categories. See Table 7 for the budget categories, the number of LHDs selecting each category, the amounts expended in each category and the number of clients served in each category. Note that LHDs expended 96% of the allocated funding.

Table 7. LHD Expenditures in FY 2016

MCH Budget Category	Number of LHDs Selecting	Amount Expended	Number of clients served
Direct Services Children	11	\$448,594	73,349
Enabling Services Children	17	\$1,505,641	109,394
Direct Services Women	2	\$7,380	245
Enabling Services Women	21	\$1,102,673	28,365
Public Health Functions & Infrastructure	11	\$1,118,982	5,260
Children's Special Health Care Services	8	\$168,150	2,657
Family Planning – Adolescents	10	\$263,384	2,050
Family Planning – Women	7	\$492,229	5,277

MCH Budget Category	Number of LHDs Selecting	Amount Expended	Number of clients served
Immunization – Children	7	\$680,983	25,088
Immunization – Women	2	\$90,350	805
Maternal Infant Health Program – Women	8	\$394,857	2,454
Maternal Infant Health Program – Children	8	\$199,402	1,346
Nurse Family Partnership	1	\$129,505	0

These budget categories were further refined for FY 2017 LMCH expenditures, based on the Title V funding categories. An updated report will be provided with next year’s Title V grant application/report.

II.F.2. MCH Workforce Development and Capacity

In this five-year cycle, Michigan is focusing workforce development efforts on strengthening state-level staffing infrastructure across key areas of Maternal and Child Health (MCH).

Michigan has historically used only a small amount of Title V funding for state-level workforce infrastructure. Thus, it has been challenging to maintain and grow the MCH workforce across key positions such as administrative and program support, epidemiology and data analysis. In this five-year cycle, Michigan plans to both 1) maintain and support the local MCH delivery system and infrastructure and 2) utilize Title V funding to support state MCH needs and priorities, including workforce infrastructure.

During year one, an advanced Nurse Consultant position was created within the Child, Adolescent and School Health Section. The position was filled in 2016 and is administratively responsible for oversight and coordination of MCH funding to local health departments and in alignment with MCH Block Grant priorities. This position provides leadership and strategic guidance in meeting programmatic and fiduciary responsibilities of the grant. The position is also responsible for implementing a continuous quality improvement framework, monitoring key outcomes and impacts on state MCH priorities and objectives. In year one, MDHHS also supported .40 full-time equivalent (FTE) of an epidemiologist position to assist with data collection and analysis and creation of performance measures. This position has been vital and will continue to be supported through the Title V grant.

In year two, MDHHS built upon this increased capacity by creating 2.0 full-time positions: a Safe Sleep Program Coordinator (within the Division of Maternal and Infant Health) and a Public

Health Consultant (within the Division of Environmental Health). The Safe Sleep Program Coordinator was posted in April 2017 and will be responsible for development of a statewide, comprehensive strategy to inform families, caregivers and professionals about sleep practices to prevent infant sleep-related deaths. The position will also provide leadership for the MDHHS strategic plan; a state-level advisory committee; funding support and coordination of state and local efforts; promotion of best practices; and monitoring of available data to evaluate progress and impact.

The Public Health Consultant position was hired in FY 2017 in the Division of Environmental Health to support the Childhood Lead Poisoning Prevention Program (CLPPP). The position facilitates planning, implementation and evaluation of CLPPP objectives and activities associated with blood lead screening and testing of children, interventions to reduce lead exposure, and case management of children with elevated blood lead levels. This position operates under the guidance and supervision of the Manager for the Environmental Health Surveillance Section and as part of the CLPPP team. The work is aligned with other activities supported by the MCH Block grant as well as activities supported by Medicaid and in coordination with Medicaid managed care health plans.

In addition to increasing capacity within the state-level MCH workforce, MDHHS has seen growth in areas that impact the workforce and service delivery. Areas of progress include integrating life course theory into its structure and MCH related work; engaging in meaningful trainings and practical application of health disparities and health equity; continuous quality improvement efforts in home visitation programs and Child and Adolescent Health Centers; and

professional development in Motivational Interviewing and Positive Youth

Development/Resiliency. However, there is still a need for advanced professional development and training in these key areas as well as cultural competence, health equity, and outcome-based work.

II.F.3. Family & Consumer Partnership

Background

The Michigan Department of Health and Human Services (MDHHS) strives to put the MCH service recipient—whether a family or infant, child, adolescent or adult—at the center of programs, policies and plans. MDHHS respects the dignity of each individual and their respective culture and language, and considers these factors in program development and service provision. Within individual programs, family and consumer input is used to identify and address unique population needs. Understanding issues and challenges helps MDHHS improve programs and minimize or eliminate challenges and service barriers.

Examples of family and consumer partnerships within Michigan’s MCH programs include the following:

- The Early Hearing Detection and Intervention (EHDI) program utilizes the Michigan Hands and Voices Guide By Your Side™ (GBYS) program. GBYS enables families who recently learned of a child's hearing loss to meet with another parent of a child who is deaf or hard of hearing. Families are involved in updating EHDI materials, which are available in Spanish and Arabic. Efforts to promote health equity through the EHDI program include diverse parent representation on advisory committees.
- The Michigan Infant Safe Sleep State Advisory Committee includes parents as active partners. Parents and caregivers are also involved in advocacy projects including sharing their stories at public events and creating training videos. The program funds 14 local health departments (LHDs) and the Inter-Tribal Council to develop and implement

community-based infant safe sleep awareness and outreach activities. Many LHDs involve parents and caregivers in funded activities as parent educators, speakers and outreach workers. When revising or developing educational materials or programming, parent and caregiver input is highly valued, both to obtain the parent/caregiver perspective and to consider cultural and linguistic competence.

- The Parent Leadership in State Government (PLISG) initiative is an interagency effort designed to recruit, train and support parents so their voices can help shape programs and policies at the local and state level. Since 2007, several state agencies have collaboratively funded the PLISG which is governed by the Parent Leadership Advisory Board. The Board includes representatives from funding agencies plus 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 aged 0-18 who have been or are eligible to utilize specialized public services. A primary role of the PLISG is to provide the “Parents Partnering for Change” leadership training which targets any family whose child is using specialized services. As of July 2016, over 830 parents have participated in the training. Approximately 45% of participants reported utilization of or involvement in an MCH program or service.
- Michigan’s Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants have integrated parent and caregiver involvement. MIECHV patterned its approach to parent involvement on previous state-level collaboration with parents for Part C, Great Start Parent Coalitions, and Project LAUNCH. MIECHV communities receive funding to

convene a home visiting Local Leadership Group (LLG), which is connected to their local Great Start Collaborative. The LLGs are comprised of representatives from Head Start, substance abuse, child abuse and neglect councils, public health, mental health, education, Great Start staff, and parents who have participated in home visiting programs. Parents help to assure that the consumer voice is part of local decision-making and policy development.

- Children’s Special Health Care Services (CSHCS) uses a multifaceted approach to ensure that services reflect the needs of the population served. A critical component to administering services is the involvement of families of children and youth with special health care needs (CYSHCN) in decision making. 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). The CAC is comprised of professionals and family members who are involved in the care for children with special needs. The CAC makes policy recommendations to the CSHCS Division and promotes awareness to assure that services reflect the voices of CYSHCN 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; and identify strengths and gaps in services.
- The Family Center provides families with an even greater opportunity to contribute to CSHCS 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 statewide Parent-to-Parent Support Network,

the Family Center also provides emotional support and information to families of children with special needs. Families can access Family Center support through the Family Phone Line, which is a service provided to any family that has a child with special needs. Parent Consultants within the Family Center help families navigate the systems of care which includes identifying needs; referral to resources at the national, state and local levels; and connecting parents to emotional support opportunities. The Family Center also works in partnership with the Michigan Family to Family Health Information Center and has communications with Michigan Family Voices.

While these and other examples of current family and consumer engagement are plentiful, Title V leadership determined that an important next step to strengthen these efforts is to better understand the nature and extent of family and consumer engagement across MCH programs. To obtain this “baseline” information, MDHHS and the Michigan Public Health Institute (MPHI) conducted a survey of state-level MCH programs in the spring of 2017. Results of the survey will help to ensure that the family and consumer engagement strategies used by Michigan’s MCH programs are accurately represented and that opportunities for future expansion are identified.

Survey Methods

The Family and Consumer Engagement Survey was adapted with permission from a family engagement survey administered in 2014 and 2015 by the Association of Maternal and Child Health Programs. Michigan’s survey included 31 questions. MPHI distributed the survey via Qualtrics online survey software in March and April 2017. A survey link was emailed to MCH and CSHCS program managers. MPHI staff downloaded and analyzed the data using SPSS statistical software. The survey had a total of 37 responses representing 32 programs within the

Bureau of Family Health Services (Child and Adolescent Health; Maternal and Infant Health; Women, Infants, and Children; and Immunization); three programs within Children’s Special Health Care Services; the Childhood Lead Poisoning Prevention Program; and Oral Health.

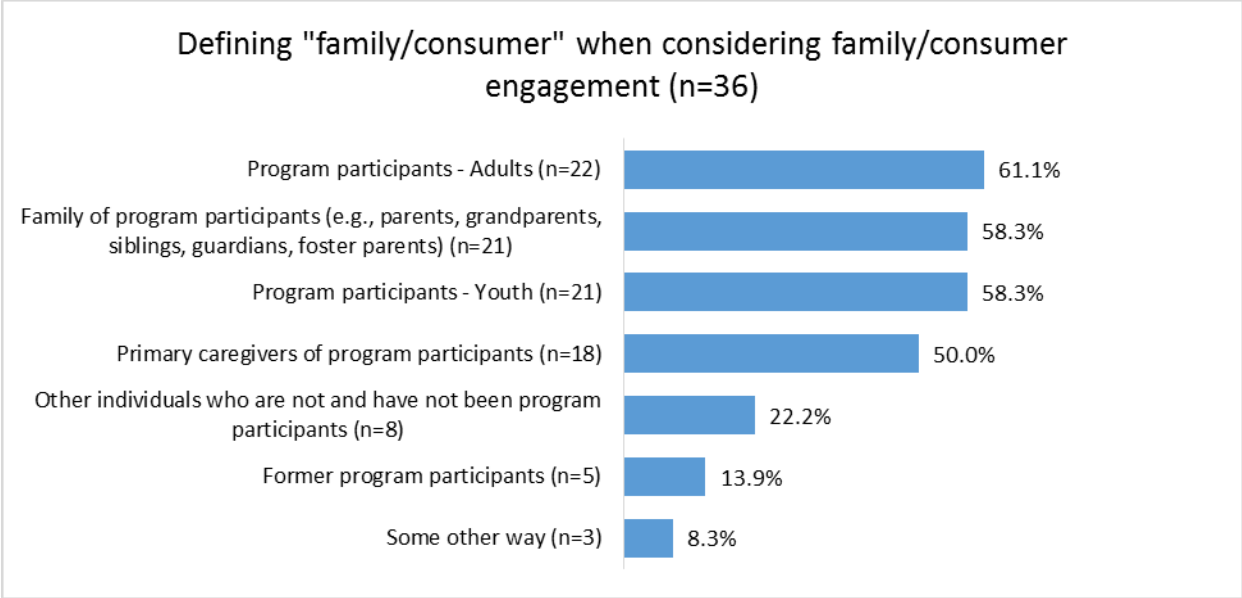
Responses included (but were not limited to) MCH program areas that are the focus of a Title V performance measure and/or receive Title V funding.

Analysis consisted of primarily descriptive statistics for both individual and multiple response questions. Staff examined responses to open-ended questions, noting themes that emerged. Preliminary findings are presented here; a more in-depth analysis of the full survey results will occur to identify challenges and opportunities to strengthen family and consumer engagement.

Findings

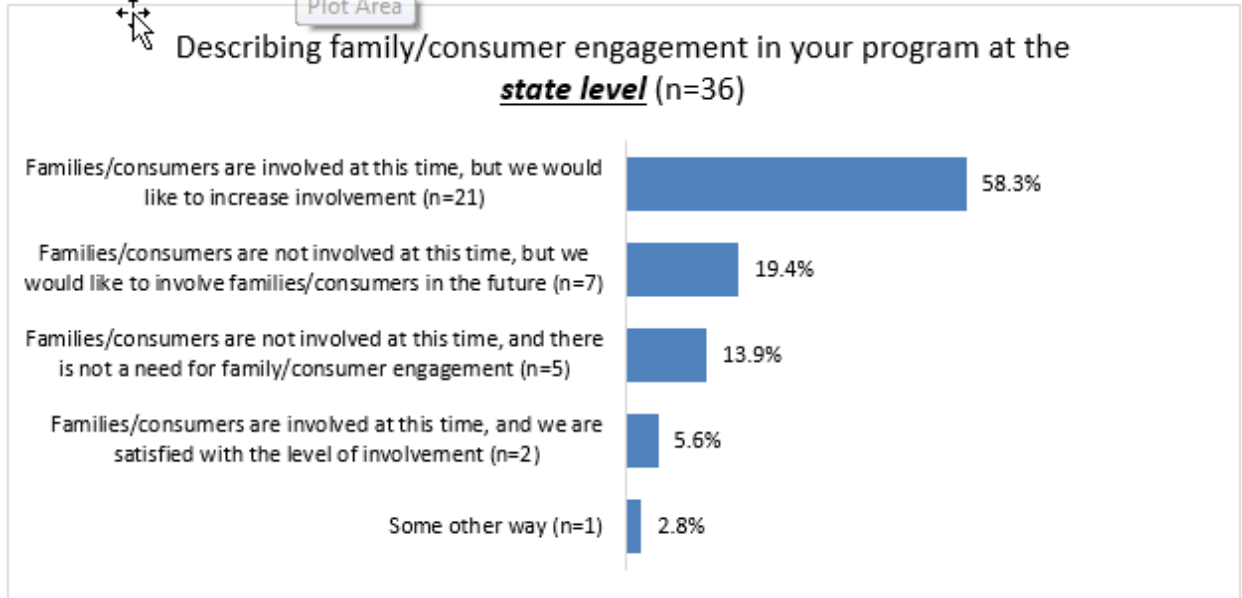
Findings are presented for all respondents for a sub-set of survey questions. When respondents were asked *how their program defines ‘family/consumer’ when considering family/consumer engagement*, the majority of survey respondents (61.1%) defined family/consumer as ‘adult program participants.’ The next most frequently selected definitions (58.3%) were ‘Family of program participants (e.g., parents, grandparents, siblings, guardians, foster parents)’ and ‘Youth program participants.’ Respondents were able to choose multiple responses when answering this question. See Figure 5.

Figure 5: Defining ‘family/consumer’



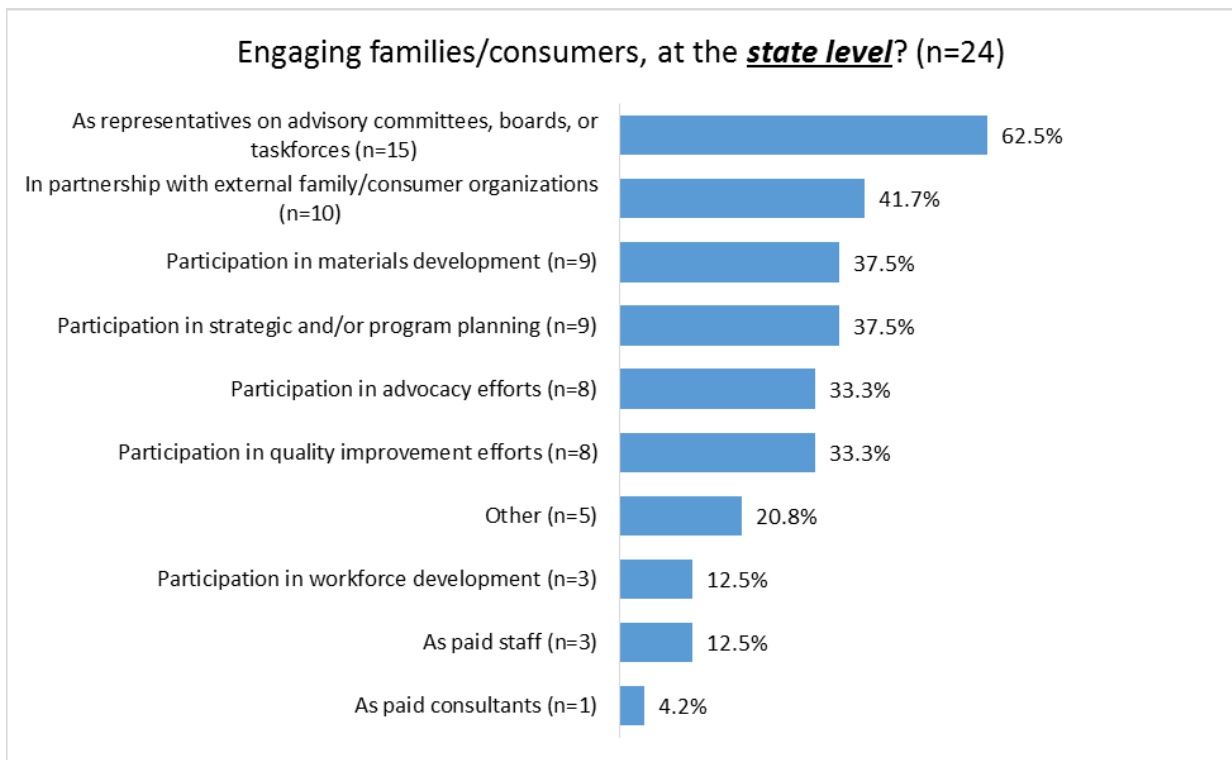
When respondents were asked to think about their program at the state level, and *choose the statement that best describes family/consumer engagement in their program today*, most survey respondents (58.3%) indicated that families/consumers are involved at this time, but the program would like to increase involvement. See Figure 6.

Figure 6: Level of family/consumer engagement



When respondents were asked to think about *how their program operates at the state level, and select ways their program engages families/consumers*, a majority of survey respondents (62.5%) indicated that families/consumers are engaged as representatives on advisory committees, boards or taskforces. Only respondents who reported that their program engages families answered this question (i.e., respondents who indicated “Families/consumers are not involved at this time” were not directed to this question). Respondents were able to choose multiple responses to this question. See Figure 7.

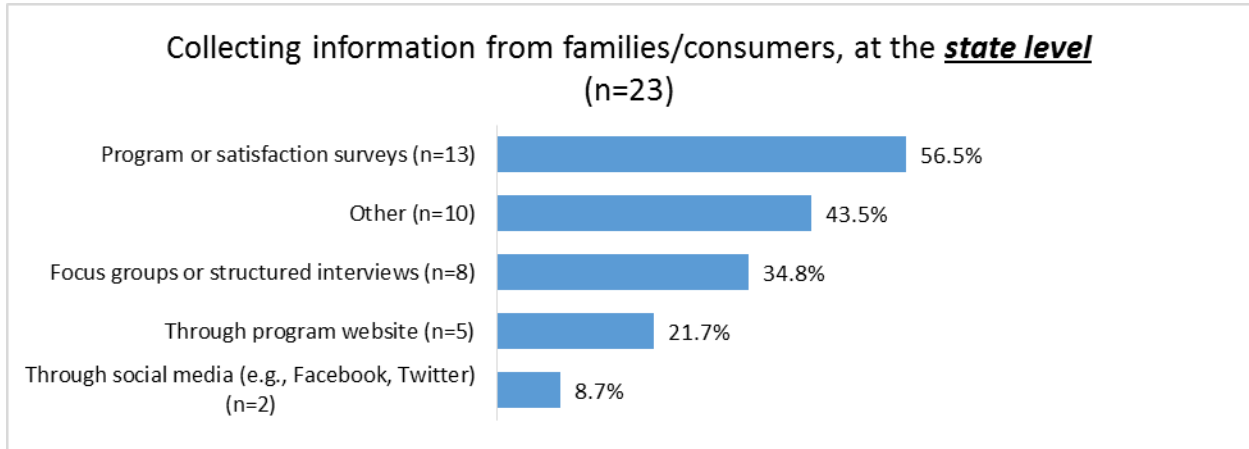
Figure 7: Engagement strategies



When respondents were asked to think about *how their program operates at the state level, and select which ways their program collects information from families/consumers*, a majority of survey respondents (56.5%) selected via program or satisfaction surveys. Only respondents

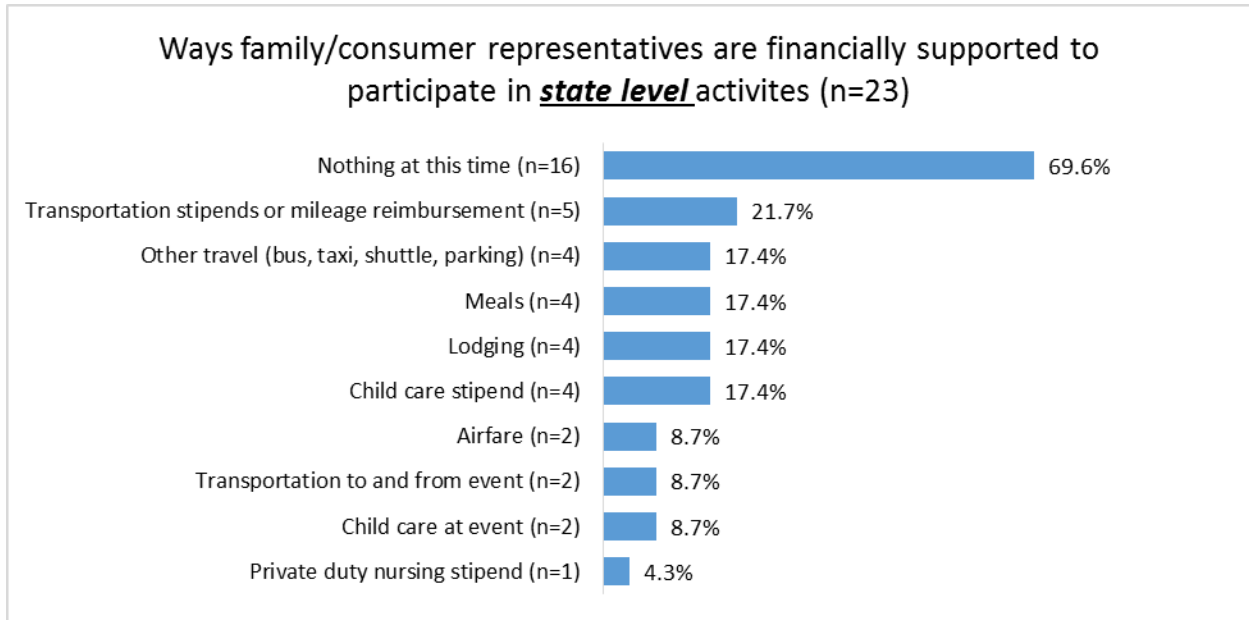
who reported that their program engages families received this question. Respondents were able to choose multiple responses to this question. See Figure 8.

Figure 8: Gathering input from families/consumers



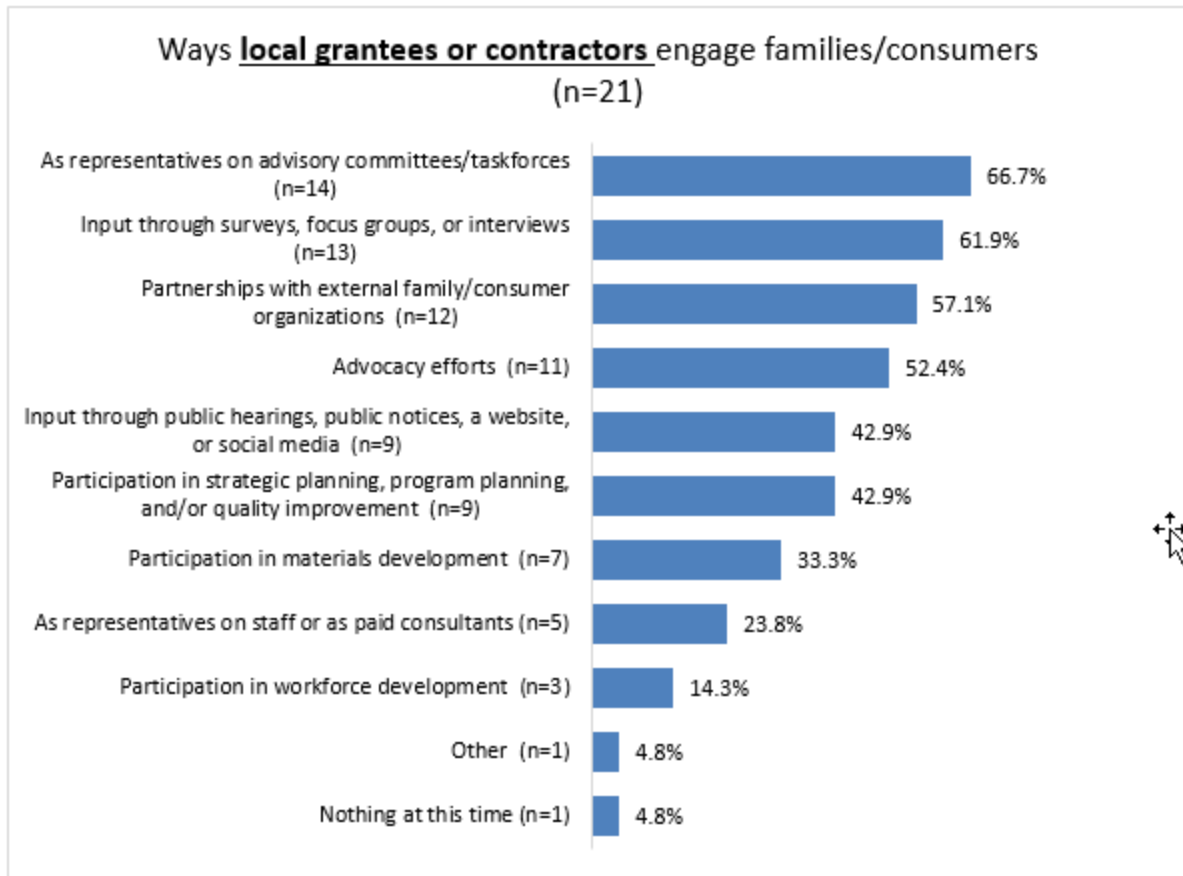
When respondents were asked to *select the ways in which family/consumer representatives are financially supported to participate in state level activities*, the majority (69.6%) indicated that family/consumer representatives are not financially supported at this time. Only respondents who reported that their program engages families received this question. Respondents were able to choose multiple responses to this question. See Figure 9.

Figure 9: Financial support for family/consumer representatives



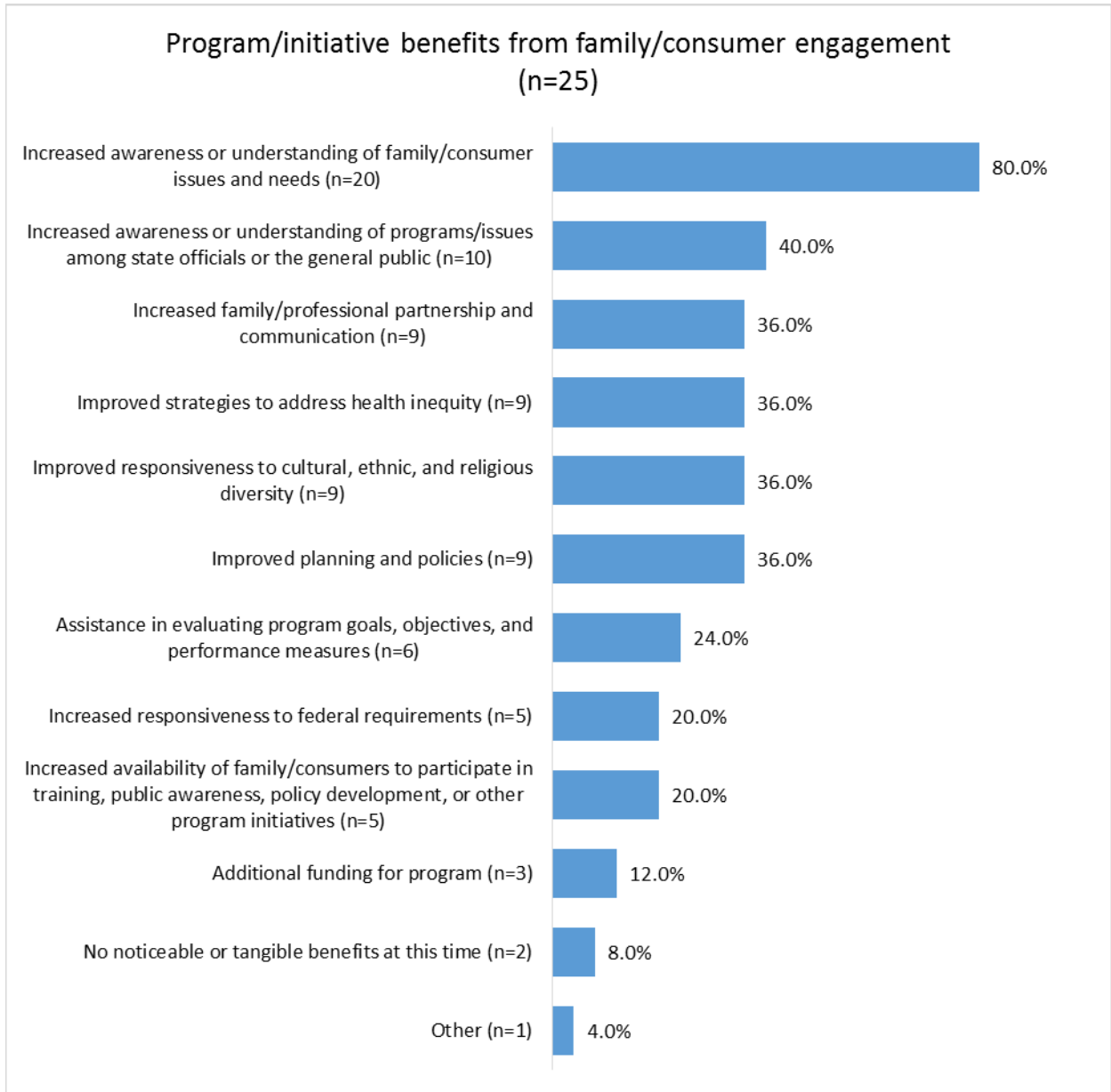
While most of the survey focused on the state level, a subset of questions focused on family and consumer engagement strategies used at the local level. When respondents were asked to select *what ways local grantees or contractors engage families/consumers*, the majority (66.7%) selected ‘as representatives on advisory committees/taskforces.’ Respondents were able to choose multiple responses to this question. See Figure 10.

Figure 10: Ways local grantees or contractors engage families/consumers



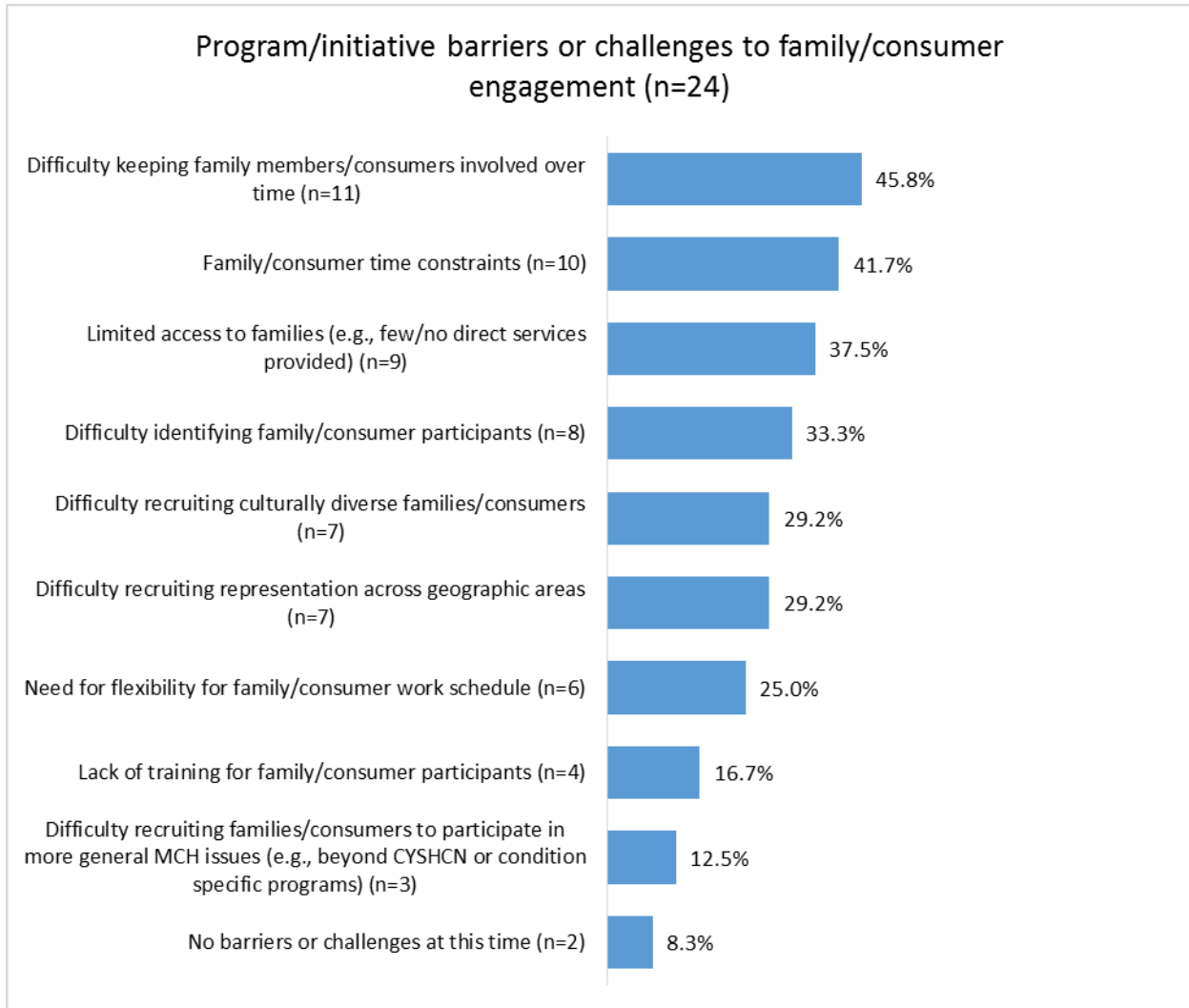
When respondents were asked *what benefits their program has received or experienced from family/consumer engagement*, the majority (80%) indicated that they have an increased awareness or understanding of family/consumer issues and needs. Respondents were able to choose multiple responses to this question. See Figure 11.

Figure 11: Benefits of family/consumer engagement



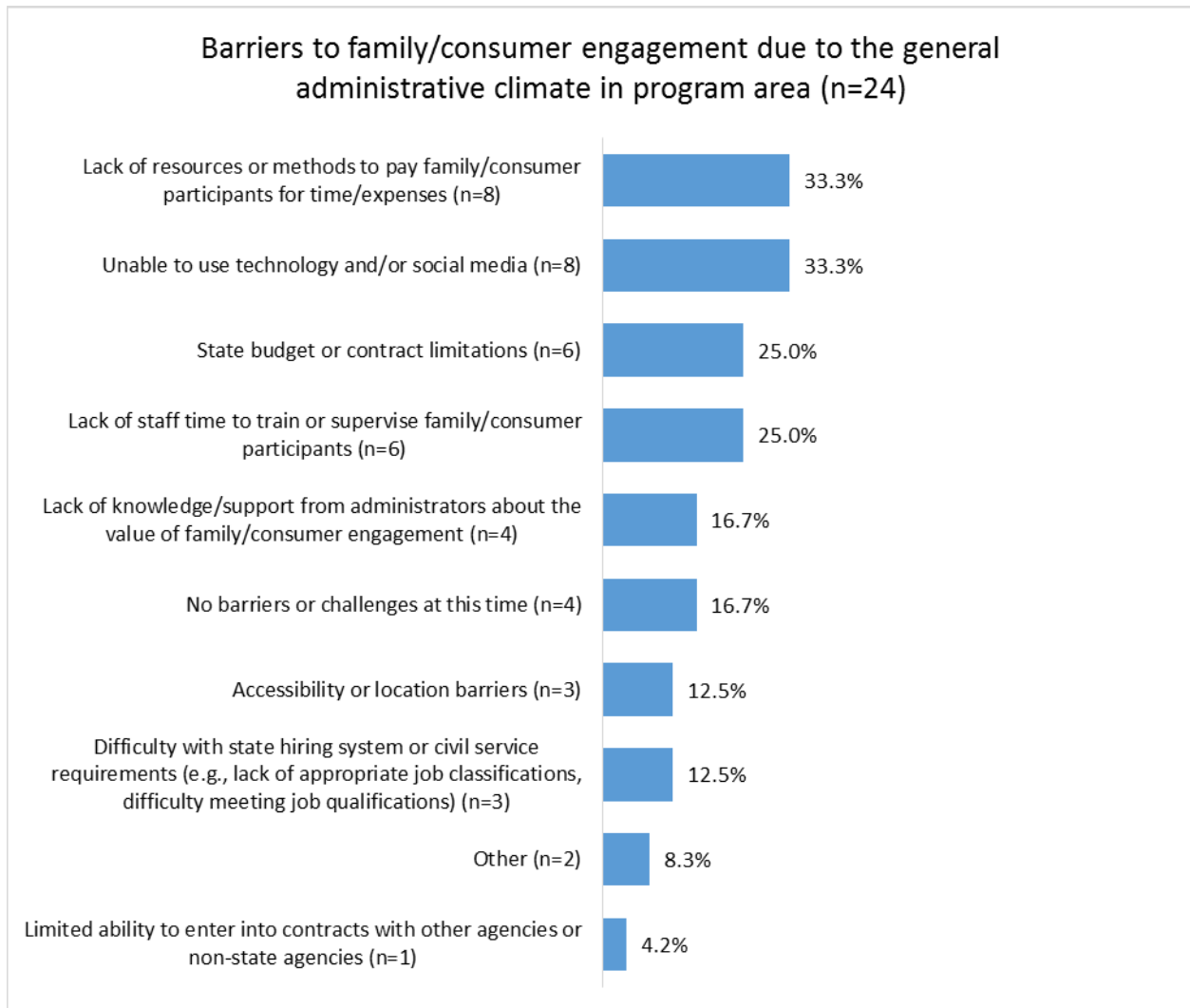
When respondents were asked about *barriers to family/consumer engagement*, almost half (45.8%) indicated difficulty keeping family members/consumers involved over time. Respondents were able to choose multiple responses to this question. See Figure 12.

Figure 12: Barriers to family/consumer engagement



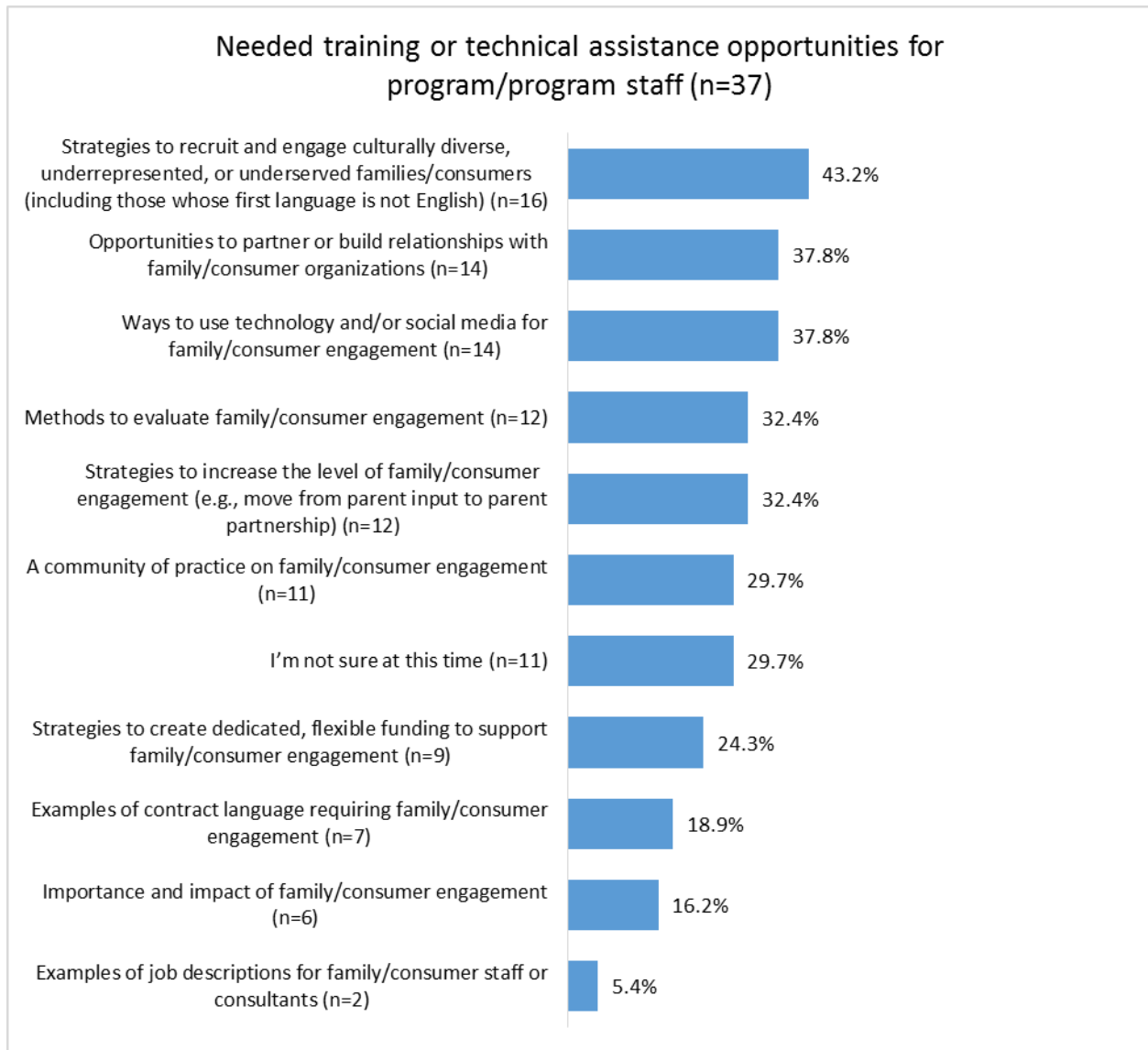
When respondents were asked to think about *barriers to family/consumer engagement within the general administrative climate*, a third of respondents (33.3%) indicated that lack of resources or methods to pay family/consumer participants was a barrier in addition to the inability to use technology and/or social media (33.3%). Respondents were able to choose multiple responses to this question. See Figure 13.

Figure 13: Barriers or challenges due to the general administrative climate



When respondents were asked what *opportunities for training or technical assistance their program or program staff need*, almost half of respondents (43.2%) selected ‘strategies to recruit and engage culturally diverse, underrepresented, or underserved families/consumers (including those whose first language is not English). Respondents were able to choose multiple responses to this question. See Figure 14.

Figure 14: Training or technical assistance needs



Summary and Conclusions

These findings suggest that many MCH programs engage families and consumers at the state level and that the benefits of this partnership are recognized. The findings also indicate there is a high level of interest in strengthening family and consumer engagement. Most respondents are also interested in strategies to better recruit and engage families and consumers.

Findings also suggest there are opportunities to expand and deepen family and consumer engagement in MCH programs. Very few programs financially support family/consumer engagement, and a lack of resources or methods to pay family/consumer participants was identified as a top barrier. Additionally, families and consumers are more widely engaged in an advisory capacity than as partners in program development or improvement.

In FY 2018, the full survey results will be explored in depth. Particular attention will be given to barriers as well as training and technical assistance needs. Based on the findings and available resources, Title V leadership will identify the most appropriate next steps to strengthen family and consumer engagement in Michigan's MCH programs.

II.F.4. Health Reform

MDHHS has supported health care reform efforts through the Affordable Care Act (ACA) and is monitoring current activity related to repealing and replacing the legislation. Repealing the ACA would significantly impact Michigan's healthcare delivery system as well as other federal grants tied to the legislation. To date, 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 (FPL) could enroll in private health insurance coverage through the Marketplace. As of March 2016, an estimated 533,000 Michiganders were enrolled in the marketplace.

In April 2014, Michigan also expanded its Medicaid program to cover residents aged 19-64 who were at or below 133% of the FPL, and who were not previously eligible for traditional Medicaid. As of March 2016, 649,000 individuals were enrolled in this new Medicaid program (called Healthy Michigan Plan) and 1,800,000 individuals were enrolled as traditional Medicaid beneficiaries. The ACA also 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. Repealing ACA would potentially leave Michigan ill-equipped to cover services for vulnerable citizens who rely on their coverage for critical health care services.

In addition to health care reform, MDHHS has been involved in other health care innovation efforts. MDHHS 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, guides the state as it strives for better care coordination, lower costs and improved health outcomes. The Blueprint focuses on transforming service delivery and payment models by concentrating on patient-centered medical homes and integration among health care and community resources.

Communities that participate in the Michigan SIM will focus on the priority issues of Emergency Department Utilization, Maternal and Infant Health, and Individuals with Multiple Chronic Conditions. MDHHS is working with payers, providers, and community social service agencies to build community-level capacities that better assess patients' non-healthcare needs and treat the social determinants of health that relate to poor health outcomes among the SIM priority populations.

II.F.5. Emerging Issues

Flint Water Crisis

MDHHS continues to collaborate with federal, state and local partners to address the Flint water crisis. To improve the coordination of services related to lead exposure and elevated blood lead (EBL) in Flint and statewide, in 2016 the Childhood Lead Poisoning Prevention Program (CLPPP) was moved from the Division of Family and Community Health to the Division of Environmental Health (DEH) in the Bureau of Epidemiology and Population Health. This reorganization places CLPPP in the same division as the Lead Safe Home Program, which oversees environmental inspections in homes and lead abatement services, and the toxicology program. CLPPP staff collaborate with WIC and the Medical Services Administration (MSA) to promote access to blood lead testing in Flint. This includes testing children at ages one and two in accordance with Medicaid policy and AAP Bright Futures recommendations, as well as venous lead confirmation of capillary tests and appropriate follow-up testing for a child or adult who has an elevated blood lead level (EBLL). In particular, CLPPP is focused on confirming EBLLs from capillary tests with venous tests, related to our State Performance Measure.

Children in Flint with confirmed EBLLs are provided with EBL nursing case management services. In October 2015, Michigan's Legislature appropriated new state funding for case management for children with EBLLs in Flint. CLPPP oversees the contract with the Greater Flint Health Coalition to administer EBL nursing case management. Nurses and social workers collaborate with families to identify and mitigate potential sources of lead exposure. Activities include assessing children's health, nutrition, and development; developing and implementing a

plan of care to address any issues for the family such as housing, transportation, and access to food or water; facilitating additional blood lead testing to monitor the child's status; and supporting access to environmental investigations to abate or fix identified hazards.

Because long-term support and monitoring are critical, EBL case management is being followed by [Family Supports Coordination](#) (FSC) services under a Waiver approved by the Centers for Medicare and Medicaid Services (CMS) through MSA that went into effect in 2016. FSC is designed to connect children and families with medical, educational or other needed services. FSC is also available to a broader population of children and pregnant women exposed to Flint water (not dependent upon the results of a blood lead test). CLPPP staff coordinate efforts with MSA to assure that EBL case management and FSC will be aligned and coordinated.

Additionally, CLPPP staff are working with the Adult Blood Lead Epidemiology and Surveillance program at Michigan State University to support follow-up with adults in Flint with EBLs to ensure awareness of available medical and social services.

CLPPP has also worked with Medicaid and CSHCS to modify the state protocol for EBL case management and to train local health departments (LHDs) in delivering EBL case management under a new Medicaid reimbursement rate. In January 2017, almost all LHDs signed contracts for this program. New educational materials developed for Flint regarding blood lead testing, nutrition and safety have been modified for statewide use and integrated into the improved EBL case management process.

The Bureau of Family Health Services (BFHS) has also continued to work on issues related to children in Flint after the reorganization of CLPPP. BFHS worked collaboratively with the Michigan Department of Education to expand school nursing, behavioral health and school-

based health center capacity in Flint's K-12 public and charter schools. Two additional school-based health centers opened and are providing comprehensive primary care and behavioral health services to students, with an additional center slated to open by August 2017.

Additionally, nine full-time school nurses were hired and placed in Flint public school buildings in 2016 to provide nursing support, chronic disease case management and acute care. In FY 2017, four Master's level mental health providers were hired to help support the school nursing sites. These sites provide onsite Medicaid outreach and enrollment to students and families.

BFHS continues to support the expansion of evidence-based home visiting programs in Flint.

Michigan's Maternal Infant Health Program (MIHP) is a state service available to all pregnant women or their infants newly enrolled in Medicaid under expanded eligibility (up to 400% of the FPL). The Michigan Legislature also appropriated state general funds to double the size of the existing Nurse Family Partnership program, and the federal Administration for Children and Families provided funding to expand Early Head Start home visiting in Flint. In coordination with HRSA, staff that manage the Maternal, Infant and Early Childhood Home Visiting (MIECHV) federal grants are reviewing current and future budgets to determine if additional home visiting services could be funded in Flint.

BFHS has also focused on activities to educate and enhance safety and nutrition. This includes working with the Flint emergency response structure to develop and distribute educational materials about lead for families and health care providers; online modules about nutrition to mitigate the impact of lead exposure; exploring the expansion of WIC; and promoting access to fresh produce and summer food programs.

Zika

Michigan maintains a vigilant prevention and response approach to the Zika virus for potential impacts to maternal and child health (MCH) populations. Our multi-pronged approach includes active surveillance and monitoring, testing capacity, and education and information dissemination. In May 2016, the MDHHS state laboratory began conducting diagnostic testing for Zika, dengue and chikungunya. Michigan participates in the Centers for Disease Control and Prevention (CDC) Zika Pregnancy Registry. As of April 2017, Michigan has entered three women and two infants into the registry. Multiple communication efforts are underway to disseminate information to the MCH population and providers in the form of MDHHS Emerging Diseases website linkage to the CDC Zika Virus webpage; communication with local health departments and other MCH stakeholders; Michigan Health Alert Network alerts; and memorandums, press releases and speaking engagements.

Children with Special Health Care Needs

Michigan currently screens newborns for more than 50 disorders, with all newborn screening (NBS) disorders medically eligible for CSHCS enrollment. Given new testing and treatment, Michigan's NBS panel will continue to expand, significantly impacting the CSHCS program. The addition of critical congenital heart disease in 2014 added 12 serious heart conditions needing treatment and often multiple-staged surgeries in the first year of life. Michigan added Pompe disease (glycogen storage disease type 2) to the panel in 2014, with screening scheduled to begin in the summer of 2017. Two babies with early onset disease and seven with late onset disease are expected to be identified 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 care.

Mucopolysaccharidosis type I (MPS I) and X-linked adrenoleukodystrophy (X-ALD) were added to the panel in 2016, with screening for MPS I expected to begin in the summer of 2017. One to two newborns a year with MPS I are expected, typically requiring treatment with ERT and hematopoietic stem cell transplant (HSCT). Screening for X-ALD is expected to identify four children annually who will need HSCT in addition to other services. Screening for these new disorders will also identify not only some X-ALD carrier females but also individuals with later onset or milder forms of Pompe, MPS I and X-ALD who will need long-term diagnostic monitoring to ensure appropriate medical intervention⁶. Newborn screening for X-ALD will commence once Food and Drug Administration (FDA) approved laboratory test kits become available (expected in 2018).

Another development is availability of a new drug, Spinraza, which recently received FDA approval for use in the treatment of spinal muscular atrophy (SMA). The drug's manufacturer, Biogen, has recently met with representatives from Michigan Medicaid/CSHCS and a policy for coverage is under consideration. The drug is costly (~\$750,000 for the first year of treatment). Based on predicted population incidence, Michigan would expect to have 10-11 children diagnosed with SMA annually⁷.

With the continual increase in the number of conditions included on the NBS panel and availability of new treatments, CSHCS expects to enroll newborns with rare conditions that were not previously identifiable early in the course of the illness. While the number of

⁶ Interventions may include aggressive monitoring for early CNS signs through frequent MRI in the case of X-ALD.

⁷ The condition is not currently on the federal Recommended Uniform Screening Panel (RUSP) but was recently nominated and is pending consideration for expert review by the federal Advisory Committee on Heritable Disorders in Newborns and Children.

newborns will be relatively small, the cost to treat will be potentially high, which could further strain Michigan's CSHCS resources.

Opioid Use and Neonatal Abstinence Syndrome

Michigan continues to experience an increase in opioid use during pregnancy and, as a result, an increase in the number of infants diagnosed with Neonatal Abstinence Syndrome (NAS). The number of drug exposed infants increased by 67% from FY 2010 to FY 2013, from 2,589 to 3,866 infants⁸. Additionally, infants hospitalized and treated for drug withdrawal symptoms has increased⁹. In 2008, 232 infants in Michigan had a diagnosis code of 779.5 and needed treatment for withdrawal from a drug, not specifically identified as opioids. In 2014, that number increased to 813 infants. This represents a jump from 19.14 per 10,000 live births in 2008 to 71.03 in 2014.

To improve systems collaboration and policy development, MDHHS was selected to participate in the Substance Abuse and Mental Health Administration (SAMHSA) 2017 Policy Academy: Improving Outcomes for Pregnant and Postpartum Women with Opioid Use Disorders and Their Infants, Families and Caregivers. The Michigan Policy Academy team includes representation from multiple systems¹⁰. As a result of the Policy Academy, Michigan's goals include the following: promote opioid use disorder prevention for pregnant and parenting women, and women of childbearing age; increase screening and identification of opioid use disorder; maintain data collection and reporting on opioid use disorder; optimize resource allocation to

⁸ Based on data from Michigan's Services Worker Support System (SWSS).

⁹ Based on data from Michigan Inpatient Hospitalization Files.

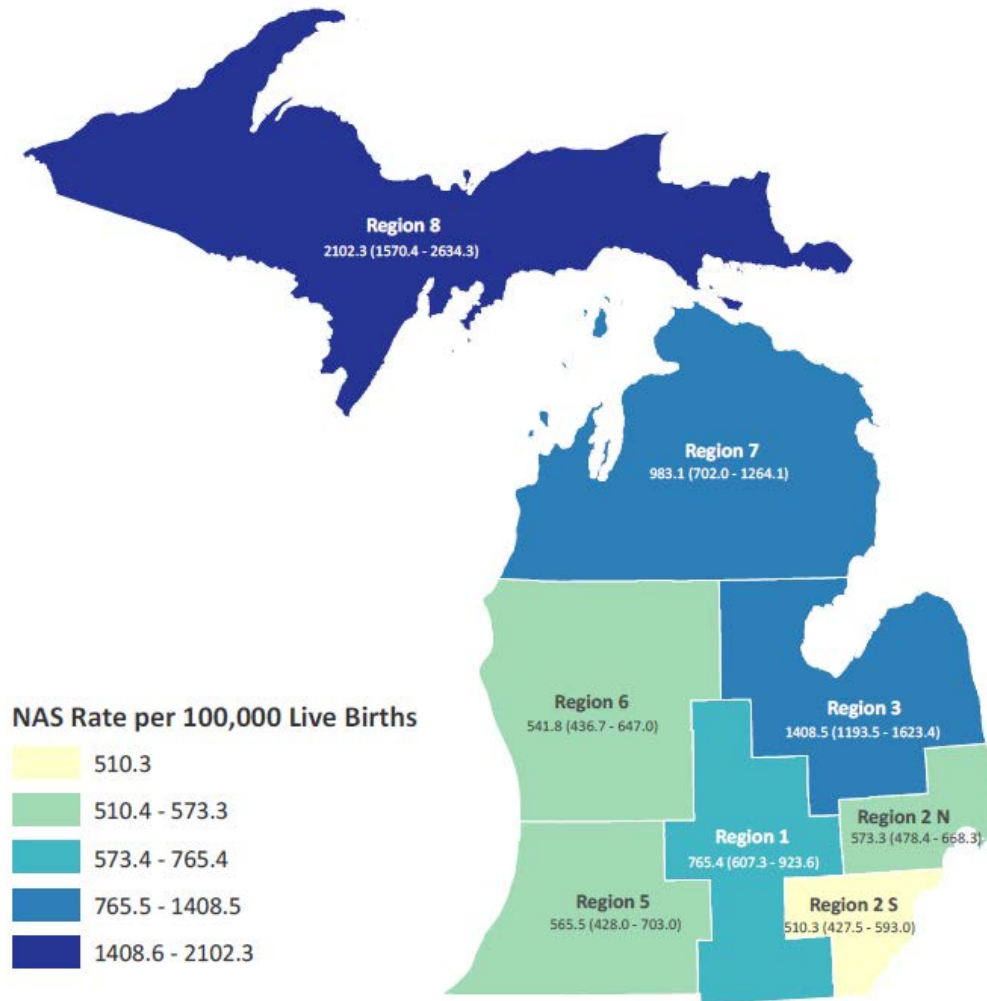
¹⁰ Membership includes Behavioral Health Treatment, Maternal and Child Health/Public Health, Child Welfare, Justice and Medicaid.

target resources to those in greatest need; develop a quality improvement system; and improve workforce development and training programs.

Michigan also has a strong foundation of family support services within the community and hospital setting. For example, home visiting services are critical in addressing opioid use disorders among pregnant and parenting women. It is also imperative to address NAS at the time of delivery. MDHHS supported the Michigan Collaborative Quality Initiative, a voluntary initiative of 25 birthing hospitals, which created and implemented standardized NAS guidelines that include standardized screening and treatment, family education on NAS symptoms, strategies for caring for babies when discharged and referrals for support services.

Figure 15 details the incidence of NAS by region. Rural areas of Michigan have been hardest hit by this epidemic.

Figure 15. Map of NAS Rates



Prepared by the MCH Epidemiology Section
Data Source: MDHHS Division for Vital Records and Health Statistics. Michigan Resident Live Birth File linked to the Michigan Inpatient Hospital Database, 2014. Michigan Resident Inpatient Files, created using data from the Michigan Inpatient Database obtained with permission from the Michigan Health & Hospital Association Service Corporation
Neonatal Abstinence Syndrome Symptomatic and needed pharmacologic treatment (ICD9 779.5)

Maternal Infant Health Program (MIHP)

MIHP is Michigan’s evidence-based home visiting program for all Medicaid covered pregnant women and infants. MIHP is operated, monitored and evaluated through a partnership between the Division of Maternal and Infant Health (DMIH) and the Medical Services

Administration. In FY 2016, MIHP served approximately 23,296 Medicaid enrolled pregnant women and 24,962 infants.

In January 2017, MIHP became part of the benefits provided through Medicaid Health Plans (MHPs), with funding included in capitation rates. Prior to that time, MIHP was a Medicaid State Plan service provided through fee-for-service. As of January 2017, MIHP providers that serve MHP enrollees have become part of the MHP provider network. This transition was implemented to:

- Increase the number of women and infants enrolled in the program, by making referral to the program mandatory for the MHPs
- Strengthen service quality through contracting directly with MHPs as part of their respective provider networks (in addition to the monitoring, evaluation and quality improvement activities through DMIH)
- Strengthen the coordination and shared care planning between OB/GYN and primary care providers for women, infants and MIHP providers
- Improve the coordination and alignment of community-based resources, particularly social and economic determinants that impact birth outcomes
- Decrease disparities in maternal and infant death rates in Michigan
- Support more innovative payment arrangements

A year of cooperative planning between Population Health Administration, Medicaid, the MIHP provider community and the MHPs resulted in a successful transition in 2017. Ongoing support

and technical assistance continues, as will quality improvement activities. Outcomes will be evaluated to assure objectives of the transition—as well as health outcomes for women and infants in MIHP—are occurring and improving.

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. In 2014-2015, MDHHS completed a statewide five-year needs assessment to identify strategic issues and priority needs to drive creation of the 2016-2020 state action plan. 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 five-year application.

In 2017, a draft of the Title V FY 2018 application/FY 2016 annual report narrative 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. Public input will be shared with the Title V steering committee for review and consideration prior to the July 2017 submission date. The number and nature of public comments received, and how they were addressed, will be included in the final grant submission.

After the application has been submitted, MDHHS will continue to 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. 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 also 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, MDHHS 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.

II.F.7. Technical Assistance

In FY 2017 and during completion of the grant application, the Title V core team discussed potential areas of training and/or technical assistance that may be needed in the future. The following areas were identified:

- Best practices and tools related to Michigan’s ongoing needs assessment priorities, specifically: performance monitoring for National Performance Measures (NPMs) and Evidence-based or -informed Strategy Measures (ESMs); broader understanding and implementation of family and consumer engagement practices among the state’s Maternal and Child Health programs; and support of local health partners in implementing new requirements and priorities as they relate to Title V;
- Sharing of best practices and other peer learning opportunities (e.g., between states or within regions) for NPMs; and
- Ongoing learning opportunities and technical assistance related to identification, refinement, and assessment of ESMs.

Additionally, any training or technical assistance provided by HRSA or AMCHP—especially in relation to ESMs, NPMs, TVIS, and other Title V priorities or requirements—will be shared with relevant programs and staff in FY 2018.

III. Budget Narrative

Expenditures

In 2016, a Title V budget workgroup reviewed Michigan's MCH expenditures across all program and budget areas, to better align expenditures with the definitions contained in the MCH Pyramid of Services (i.e., Direct Services, Enabling Services, and Public Health Services and Systems).

The Local Maternal and Child Health (LMCH) Program was in a transitional stage in FY 2016 related to budget categories reported. In FY 2015, the state accounting system changed the way it tracked expenditures in EGrAMS (Electronic Grants Administration & Management System) to reflect, by budget, the population characteristics of individuals served (e.g., child versus woman). In FY 2016, a shift in the budget categories by program category to service category (e.g. direct, enabling, public health functions) also began. This assured that the 30% match was properly documented and expenditures were properly recorded by the MCH Pyramid of Services. In FY 2016, the budget project titles for LMCH were as follows:

- Direct Services Children – MCH
- Enabling Services Children – MCH
- Direct Services Women – MCH
- Enabling Services Women – MCH
- Public Health Functions & Infrastructure – MCH
- Children's Special Health Care services – MCH

- Family Planning – Adolescents – MCH
- Family Planning – Women – MCH
- Immunization – Children – MCH
- Immunization – Women – MCH
- Maternal Infant Health Program (MIHP) Women – MCH
- Maternal Infant Health Program (MIHP) Children – MCH

In FY 2017 the budget project titles were condensed to the following five categories:

- Direct Services Children – MCH
- Enabling Services Children – MCH
- Direct Services Women – MCH
- Enabling Services Women – MCH
- Public Health Functions & Infrastructure – MCH

Please refer to the TVIS budget forms for details related to the Title V budget and expenditures.

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 Michigan is 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.

The following notes provide clarification to Form 2:

- The “State Funds” line item primarily represents funding that is used to support CSHCS medical care and treatment, and significant fluctuations in expenditures can occur each year (e.g., based on significant one-time costs for medical care). Other “State Funds” include Prenatal Care Outreach and Service Delivery, Health and Wellness and Family Planning.
- The "Other Funds" line represents the Children with Special Needs Fund. The difference in the budgeted versus expended amounts occurs because approximately \$1 million is authorized each year (i.e., budgeted), but the CSHCS division typically only spends the earnings of the fund (which is approximately \$500,000 per year).

In addition to Title V, other funding sources that support MCH programs and services include Title X (Family Planning); Women, Infants, and Children (WIC); Title XIX (Medicaid); General Fund, Healthy Michigan Fund; and grants from other federal sources (CDC, HRSA, etc.). Refer to

Form 2 for additional details related to the Title V budget and expenditures that support MCH programs and services.

Form 2
MCH Budget/Expenditure Details

State: Michigan

	FY18 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 18,959,000	
A. Preventive and Primary Care for Children	\$ 6,370,800	(33.6%)
B. Children with Special Health Care Needs	\$ 7,177,900	(37.8%)
C. Title V Administrative Costs	\$ 817,400	(4.4%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 49,488,500	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 500,000	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 68,201,100	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 118,189,600	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 13,507,900		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 137,148,600	
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(Subtotal of all funds under item 9)	\$ 373,225,553	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 510,374,153	

OTHER FEDERAL FUNDS	FY18 Application Budgeted
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) > State Oral Disease Prevention Program	\$ 310,700
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	\$ 8,912,238
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 6,819,039
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	\$ 130,459,200
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 Adolescent Health > Support for Pregnant and Parenting Teens	\$ 1,588,215
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)	\$ 213,252,100
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 1,493,165
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 2,123,209
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 470,687
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 97,000

	FY16 Annual Report Budgeted		FY16 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 18,734,500		\$ 18,705,857	
A. Preventive and Primary Care for Children	\$ 5,987,600	(32%)	\$ 6,816,523	(36.4%)
B. Children with Special Health Care Needs	\$ 7,157,200	(38.2%)	\$ 7,276,177	(38.8%)
C. Title V Administrative Costs	\$ 589,000	(3.1%)	\$ 793,583	(4.3%)
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	\$ 0		\$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 42,520,600		\$ 41,384,612	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 1,008,900		\$ 478,187	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 67,996,600		\$ 62,550,223	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 111,526,100		\$ 104,413,022	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 13,507,900				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	\$ 130,260,600		\$ 123,118,879	
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 (Subtotal of all funds under item 9)	\$ 309,508,839		\$ 303,421,934	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 439,769,439		\$ 426,540,813	

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 1,530,244	\$ 1,515,764
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	\$ 3,074,727	\$ 1,925,104
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	\$ 200,000	\$ 187,852
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	\$ 175,000	\$ 168,218
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 120,542	\$ 106,414
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	\$ 370,345
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	\$ 102,261,903
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	\$ 9,543,065
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Early Childhood Comprehensive Systems (ECCS): Building Health Through Integration	\$ 140,000	\$ 111,003
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 97,000	\$ 99,501
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 250,000	\$ 289,799
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 7,275,000	\$ 6,739,438

OTHER FEDERAL FUNDS	FY16 Annual Report Budgeted	FY16 Annual Report Expended
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 190,163,631	\$ 175,653,534
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 430,521	\$ 372,969
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Ryan White	\$ 1,057,813	\$ 1,256,724
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Oral Health	\$ 309,250	\$ 314,584
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Expectant and Parenting Teens		\$ 1,546,216
Department of Health and Human Services (DHHS) > Substance Abuse and Mental Health Services Administration > Transforming Youth Suicide Prevention in MI		\$ 789,714
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Block		\$ 169,787