Maternal and Child Health Services Title V Block Grant

Michigan

FY 2025 Application/ FY 2023 Annual Report

Created on 5/2/2024 at 8:27 PM

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I. General Requirements

I.A. Letter of Transmittal

A Letter of Transmittal will be uploaded prior to submission.

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix 2 of the 2026 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the 2021 Title V application/Annual Report guidance.

II. MCH Block Grant Workflow

Please refer to figure 3 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms", OMB NO: 0915-0172; Expires: December 31, 2026.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Michigan's Title V Maternal and Child Health (MCH) program supports critical MCH programming and services across the state. Its overarching goal is to improve the health and well-being of mothers, infants, children, and adolescents including children with special health care needs (CSHCN). The Michigan Department of Health and Human Services (MDHHS) administers the Title V block grant through the Division of Maternal and Infant Health (DMIH). The Children's Special Health Care Services (CSHCS) Division serves as the Title V CSHCN program. The Division of Child and Adolescent Health (DCAH) oversees Title V funding to local health departments (LHDs). Collectively, the DMIH, DCAH, and CSHCS Division provide leadership on MCH programs and policies, including oversight of program-specific work and statewide multisystem collaboratives, as discussed throughout this application. Since March 2020, Michigan's MCH programs have responded to the impact of the COVID-19 pandemic on the MCH population, as discussed in detail in prior Title V applications.

Michigan's Fiscal Year (FY) 2021-2025 state priorities were determined by the five-year needs assessment completed in early 2020, prior to the COVID-19 pandemic. The assessment identified needs for preventive and primary care services for women, mothers, infants, children, and services for CSHCN. Stakeholders and community members representing the Title V population domains were engaged in the process. The goals of the assessment were to:

- Use multiple types of data to understand health outcomes, health behaviors, and health disparities, as well as underlying causes that drive inequity.
- Strengthen partnerships and strategies for achieving health equity.
- Engage diverse populations and system partners in describing and understanding the needs and strengths of the MCH population.
- Identify state priority needs and performance measures for Title V.
- Identify opportunities to address needs beyond the scope of Title V.

Based on the needs assessment, the current Title V state priorities are:

- Develop a proactive and responsive health system that equitably meets the needs of all populations, eliminating barriers related to race, culture, language, sexual orientation, age, and gender identity.
- Improve access to high-quality community health and prevention services in the places where women, children, and families live, learn, work, and play.
- Ensure children with special health care needs have access to continuous health coverage, all benefits they are eligible to receive, and relevant care where they learn and live.
- Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems.
- Improve oral health awareness and create an oral health delivery system that provides access through multiple systems.
- Create and enhance support systems that empower families, protect and strengthen family relationships, promote care for self and children, and connect families to their communities.
- Create safe and healthy schools and communities that promote human thriving, including physical and mental health supports that address the needs of the whole person.

In response to Title V requirements, National Performance Measures (NPMs) and State Performance Measures (SPMs) were chosen to align with the priority needs and are discussed below by population domain. The needs assessment also identified three key “pillars” across population domains: achieving equitable health outcomes; engaging families and communities; and delivering culturally and linguistically appropriate health education.

State action plans for NPMs and SPMs (as identified through the 2020 needs assessment) in Section III.E. include information on objectives and strategies, metrics, program planning and improvement, and family and consumer engagement. A summary of each NPM and SPM is presented below. In addition to these measures, all states are required to include state action plans in FY 2025 to address the new “universal” NPMs for Postpartum Visit, Medical Home for Children, and Medical Home for CSHCN. Those plans are discussed within the relevant population domains.

Women/Maternal Health

The first goal in this domain is to decrease the percent of cesarean deliveries among low-risk first births. Michigan’s percentage of low-risk cesarean deliveries has consistently been higher than the US and has been slower to decrease over time. Michigan has seen increases in low-risk cesarean deliveries to Black birthing individuals (from 29.1% in 2013 to 31.5% in 2022), while the percentage of low-risk cesarean deliveries to White birthing individuals has decreased (from 29.5% in 2013 to 27.9% in 2022) (MDHHS, Division for Vital Records & Statistics). However, both Black and White individuals saw small decreases in low-risk cesarean deliveries from 2021 to 2022 (from 32.2% to 31.5% for Black; from 28.2% to 27.9% for White). The Title V plan focuses on reducing the overall rate of low-risk cesarean deliveries with focus on disparities among women of color. Strategies include working with Regional Perinatal Quality Collaboratives (RPQCs) to implement the Michigan Alliance for Innovation on Maternal Health (MI AIM) bundle, providing bias and equity training for providers, and increasing the number of birthing hospitals participating in MI-AIM.

The second goal in this domain is to increase the percent of individuals with a preventive dental visit during pregnancy. In 2021, 53.6% of Michigan women had their teeth cleaned during their most recent pregnancy, an increase over the 40.8% who reported doing so in 2020 (MI PRAMS). However, Non-Hispanic Black individuals saw a decrease in preventive dental care during pregnancy during the COVID-19 pandemic, dropping from 41.3% in 2019 to 35.2% in 2020, although these numbers increased to 41.6% in 2021 (MI PRAMS). Strategies to increase dental visits include training for medical and dental providers who treat and refer pregnant people; increasing the number of socioeconomically disadvantaged pregnant people receiving oral health care services; and exploring alternative models of care for service delivery.

The third goal is to increase the percent of individuals who have an intended pregnancy. While Michigan has seen a modest increase in the rates of pregnancy intention from 2012 (52.2%) to 2021 (59.0%), White mothers (68.5%) were 1.7 times as likely as Black mothers (40.2%) to report their most recent pregnancy was intended (2021) (MI PRAMS). The state action plan focuses on increasing access to contraception by making most or moderately effective contraceptive methods readily available and by improving the quality of contraceptive care by assessing client-centeredness and offering equity trainings for reproductive health care providers.

Perinatal/Infant Health

The first perinatal/infant health goal is to increase the percent of infants who are ever breastfed, and the percent of infants breastfed exclusively through six months of age. While breastfeeding rates have increased in Michigan, exclusivity rates still fall short of state goals. In Michigan, 82.8% of infants are ever breastfed (2020) and 23.9% are exclusively breastfed through six months (National Immunization Survey 2020 Breastfeeding Report Card; NSCH). According to PRAMS, initiation rates among Black mothers continue to be 12% lower than White mothers (2020). To

increase breastfeeding rates, MDHHS will support and promote access to breastfeeding professionals and peer counseling and increase the number of Baby-Friendly© hospitals. To address disparities, Michigan will support non-Hispanic Black individuals who initiate breastfeeding through promotion of culturally responsive messages, diverse breastfeeding professionals, and community-based breastfeeding organizations.

The second goal is to increase the percent of infants placed to sleep in safe sleep environments (i.e., infants placed to sleep on their backs in cribs without objects) (NPM 5). In 2021, 158 sleep-related infant deaths occurred in Michigan (Centers for Disease Control and Prevention Sudden Unexpected Infant Death Case Registry, 2010 to 2021, Michigan Public Health Institute, 2023). Sleep-related infant deaths are a leading type of death for infants aged 1-12 months old (2020-2022 Michigan Resident Infant Death File, Division for Vital Records & Health Statistics, MDHHS). Data between 2016 and 2021 reveal state level improvements in infants reported as sleeping with no soft objects and in a separate approved sleep surface, although there has been a decline in back sleep position among Hispanic respondents (90.3% in 2016 to 72.9% in 2021, MI PRAMS). MDHHS strategies focus on increasing safe sleep behaviors by all families, while addressing the disparity for non-Hispanic Black infants. Strategies include supporting local safe sleep activities; working with providers on education and resources for families; developing tools for client/patient centered safe sleep conversations; promoting protective factors; and working with hospitals in areas with high rates of sleep-related infant deaths.

Child Health

Michigan continues to focus on increasing the percent of children who have a preventive dental visit (NPM 13.2). The percentage of Michigan children ages 1-17 who receive preventive dental care in the previous year dropped slightly from 77.9% in 2016-2017 to 76.2% in 2020-2021 (National Survey of Children's Health). A key objective in Michigan's Title V plan is to increase the number of students who receive preventive dental screenings in a school-based dental sealant program. MDHHS will administer the SEAL! Michigan program and promote the program through school health professionals. To address disparities in access to care, MDHHS will also work with and support Detroit Public Schools Community District to increase dental screenings and sealants.

A second goal is to increase the percent of children less than 72 months of age who receive a venous lead confirmation testing within 30 days of an initial elevated capillary test (SPM 1). Between 1998 and 2022, the percentage of birth to six-year-old children in Michigan with blood lead levels >5 ug/dL decreased from 44.1% to 2.1%. Yet some communities still experience higher rates of lead poisoning. Confirming elevated capillary results with a venous test is key to facilitating follow up. Progress has been made, with a rise in venous confirmation testing within 30 days of an initial elevated capillary test from 16.1% in 2013 to 49.2% in 2022 (MDHHS). The COVID-19 pandemic and recalls in blood lead testing kits led to a significant drop in blood lead testing for children under 6 years old. To continue to make progress, Michigan will screen for lead exposure risk factors in children; conduct provider education; and work to increase blood lead testing for all children, especially those who are Medicaid-enrolled.

MDHHS is working to increase the percentage of children ages 19-35 months who are up to date with all recommended vaccines (SPM 2). The estimated percentage of children in this age group who received all age-appropriate recommended vaccines was 66.4% in 2022 (Michigan Care Improvement Registry). The COVID-19 pandemic negatively impacted childhood vaccination rates in Michigan. Strategies to increase vaccination rates include targeted outreach to parents of children who are overdue for a vaccine; vaccine outreach to areas with a high social vulnerability index; working with local health departments to reach under-vaccinated populations; and working with stakeholders to promote vaccine confidence among parents of this age group.

Adolescent Health

The first goal in this domain is to decrease the percent of adolescents who are bullied or who bully others (NPM 9). From 2011 to 2019, just under one-third of Michigan adolescents reported being bullied at school or online, but this dropped to 24.2% in 2021 (Youth Risk Behavior Survey). Among CSHCN, the percentage rises to 52.6% (2021 NSCH). Key objectives for MDHHS are to work with secondary schools to implement bullying prevention initiatives; provide schools with guidance on state laws and model policies with protections for LGTBQ+ youth; and support bullying prevention activities for CSHCN.

A second goal is to increase the percent of adolescents who have received a completed HPV vaccine series (SPM 3). As of June 2023, 72.9% of adolescents ages 13 through 17 years were current with immunizations, but that percentage dropped to 42.6% when HPV series completion was included (MCIR). However, Michigan has improved the percentage of adolescents receiving at least one dose of the HPV vaccine, and in 2021 64.7% of Michigan adolescents were up to date with the HPV series (NIS-Teen). To boost HPV completion rates and increase protection from HPV-related diseases, MDHHS will update HPV materials to support an equitable approach to vaccine hesitancy; increase vaccine confidence among parents and adolescents; and work with local health departments, providers, and health systems to implement quality improvement strategies and measures.

Children with Special Health Care Needs (CSHCN)

A goal is to increase the percent of adolescents with special health care needs who receive services necessary to make transitions to adult health care (NPM 12). In Michigan, 20.0% of CYSHCN reported they received services necessary to transition to adult health care, which is comparable to the US at 20.5% (NSCH, 2020-21). To improve transitions to adult care, efforts will include expanding Health Care Transition (HCT) activities to students through school-based clinics; marketing the revised CSHCS website and the Got Transition health professional course; revising MHP contract language to incorporate additional HCT activities; and expanding the assessment of health care transition activities to include additional partner organizations.

Another goal is to increase the percent of CSHCN enrolled in CSHCS who receive timely medical care and treatment without difficulty (SPM 4). CSHCN often require and use more health care services than other children. Health care costs can pose significant burdens for families, even with private insurance. CSHCS helps to cover the costs of specialist medical care and treatment. Strategies to increase access to high-quality services include covering specialty care and treatment costs for qualifying conditions; expanding access to specialty clinics; improving outreach and advocacy services; and enhancing the CYSHCN system of care.

Cross-Cutting

The needs assessment identified unmet mental health needs in the women/maternal health, adolescent health, and CSHCN domains. A goal across these domains is to support access to developmental, behavioral, and mental health services (SPM 6). In 2022, 25.5% of Michigan women ages 18-44 years reported more than two weeks of poor mental health during the prior 30 days (Behavioral Risk Factor Surveillance System). Postpartum depression symptoms were reported by 16.5% of mothers in 2021 (MI PRAMS). In 2021, 40.3% of adolescents reported two or more weeks of sad or hopeless feelings and 19.0% considered suicide (YRBS). Among CSHCN with a mental or behavioral health diagnosis, 68.1% received appropriate treatment in 2019-2020 (NSCH). The Title V program will support the work of local health departments in addressing behavioral health needs; support perinatal screenings among RPQCs; increase collaboration between Title V CSHCS and behavioral health partners; and support the Handle with Care initiative for school-aged children and adolescents.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

The Title V MCH block grant provides critical funding for Michigan's MCH priorities, in conjunction with state funds and other federal funds. Title V funding addresses needs across the MCH pyramid of services (e.g., direct services, enabling services, and public health services and systems) and supports the delivery of core MCH services, as well as new or expanded programs. In accordance with federal requirements, a minimum of 30% of Title V funding supports services for Children with Special Health Care Needs (CSHCN) and a minimum of 30% of Title V funding supports preventive and primary care services for children ages 1 through 21 years. To meet these requirements, Title V funding in Michigan is used to support comprehensive medical care and treatment for CSHCN and a variety of services for children, adolescents, and young adults including immunizations, oral health initiatives that include a school-based dental sealant program, childhood lead poisoning prevention, fetal alcohol spectrum disorder services, bullying prevention, Handle with Care, and reproductive health and prevention services. Services for women and infants are also supported by Title V funding, including infant safe sleep, breastfeeding, Regional Perinatal Quality Collaboratives (RPQCs), Pregnancy Risk Assessment Monitoring System (PRAMS), and fetal infant mortality review. Additionally, Title V supports public health services and systems through needs assessment, parent leadership, staff support, and health equity initiatives.

Title V funding also supports the MCH work of all 45 Local Health Departments (LHDs). Collectively, LHDs are allocated approximately 36% of Michigan's Title V dollars through the Local MCH (LMCH) program which awards annual, noncompetitive grants to each LHD. LHDs serve as Michigan's local public health "arm" through community-based services and systems. Title V funding administered through the LMCH program helps to ensure the delivery of core MCH services while addressing state identified priorities and locally identified needs. These local activities complement the state's public health infrastructure and state-led work in supporting the health of the MCH population. For example, Title V funding at the local level provides the MCH population with increased access to and provision of gap-filling services such as immunizations and childhood lead screening. Title V funding is also used for enabling services such as breastfeeding support and safe sleep training for parents and providers. Public health services and systems are supported through health promotion campaigns, health equity practices, needs assessments, and collaborative program planning and implementation with local partners.

III.A.3. MCH Success Story

Michigan's 45 local health departments (LHDs) each receive a portion of the state's Title V funding through the Local Maternal Child Health (LMCH) program to support the health of women, children, adolescents, and families across Michigan. In total, approximately $6.9 million of Michigan's Title V funding (~36% of the total grant award) supports the LMCH program. LMCH funds are used to address local and state MCH priorities through a performance measure framework. The Financial Narrative in this application provides details related to LHD expenditures by performance measures and by the MCH pyramid of services. Additionally, a synopsis of LMCH activities is included in the State Action Plan introductions for each population domain. Three examples are shared here to demonstrate the impact of Title V at the local level.

Detroit Health Department launched SisterFriends Detroit (SFD) in 2017 with support from LMCH funds. The goals of SFD are to reduce preterm births, low birth weight babies and infant mortality in Detroit. Pregnant and postpartum people are connected to a volunteer mentor creating a circle of caring around Detroit families. Enrollees in the program receive services from Community Health Workers, Social Workers, a Nurse Care Coordinator and a Lactation Specialist. In FY 2023, 319 people were enrolled in the program. Of the 173 participants who gave birth, 85% were full term. Of participants who initiated breastfeeding, 53% were still breastfeeding at six months. To date, there have been no infant deaths for any mother enrolled in SFD.

Seven LHDs in the Northern Michigan Public Health Alliance (NMPHA) collaborated on NPM 4 (Breastfeeding) through a Continuous Quality Improvement (CQI) project to increase the percentage of infants who are breastfeeding at six months. The NMPHA is a team of health care agencies and providers in northern lower Michigan who have joined together to strengthen public health across the region. Each of the seven LHDs in the NMPHA used a portion of their LMCH funding for breastfeeding support during the project. The CQI project interventions included training for home visiting and hospital staff; home visits targeting critical times when breastfeeding rates drop; and advocacy and education for employers and employees about workplace laws and best practices. During the timeframe of the CQI project, all seven LHDs saw increases in their six-month breastfeeding rates.

Kent County Health Department (KCHD) utilized LMCH funding for health equity systems work. KCHD's goal is to strengthen and standardize health equity and inclusion practices within the health department while continuing to foster strong relationships with community. KCHD created a summary report for an internal health equity team, developed a community newsletter describing current health equity initiatives, engaged with new partners to enable equitable knowledge sharing of health information in the community, and met with non-traditional partners to discuss countywide efforts to address health equity.

These examples provide a snapshot of the important role of the LMCH program in local public health and the delivery of MCH programs and services. More information about the role of LHDs and the LMCH program is included throughout this application.

III.B. Overview of the State

Geography, Demographics, and Economy

Michigan is the only state made up of two peninsulas and has the longest freshwater shoreline in the world. Comprised of 83 counties, Michigan is the 10th most populous state and 11th largest state by total square mileage. Approximately 10 million people live in the state per the 2023 Vintage Census. Compared to other states, Michigan had the 35th lowest rate of population change from 2022 to 2023 and estimated 37th lowest birth rate in 2023. Most of Michigan's population resides in the southern half of the Lower Peninsula, with approximately half of the population residing in Southeast Michigan (2022 Vintage Census). The state's largest cities are Detroit, Grand Rapids and Warren. Over 1.8 million people live in rural areas (2020 Census). The median age of the population is 39.9 years (2018-2022 American Community Survey). Out of the total population, approximately 21.4% are ages 0-17 and 78.6% are ages 18 and over. Michigan's population is 75.7% White, 13.6% Black or African American, 3.3% Asian, 5.4% two or more races, and 0.5% American Indian and Alaska Native. Out of the total population, 5.5% identify as Hispanic or Latino. Michigan has the country's second largest population of residents who identify as Middle Eastern or North African (2020 Census).

Michigan's economy saw improvements over the nine years leading up to 2020. While the seasonally adjusted unemployment rate decreased from 14.0% in June 2009 to 3.8% in January 2019, the unemployment rate spiked to 22.6% in April 2020 at the start of the COVID-19 pandemic (U.S. Bureau of Labor Statistics). The economic impact of COVID-19 was significant, but Michigan's 2023 labor market continued to show improvement with an annual jobless rate one-tenth of a percentage point below the 2019 pre-pandemic rate of 4.1 percent. Michigan's seasonally adjusted unemployment rate of 4.3% remained unchanged from December 2022 to December 2023. Michigan's labor force participation rate reached a 14-year high of 62.2% at the end of 2023.

However, economic recovery has been uneven across the state. According to the 2023 ALICE (Asset Limited, Income Constrained, Employed) report, 39% of households in Michigan struggled to afford the basic needs of housing, childcare, food, technology, health care and transportation. The 2021 poverty rate in rural Michigan was 12.9%, compared with 13.1% in urban areas (USDA Economic Research Service). According to the 2023 Kids Count, Michigan ranks 26th in health, 32nd for economic and overall child well-being, and 42nd in education for children. The percent of children ages 0-17 who live in poverty is 17.6% for the state, with a poverty range of 5.7% (minimum) to 42.3% (maximum) across counties and major cities. Statewide, 53.3% of students receive free and reduced-price lunch.

Roles and Priorities of the State Health Agency

The Title V program is located in the Division of Maternal and Infant Health (DMIH), which is housed in the Bureau of Health and Wellness (BHW) in the Public Health Administration. DMIH includes the Family Planning program, Maternal Infant Health Program, Michigan Perinatal Quality Collaborative, Early Hearing Detection and Intervention program, infant safe sleep, breastfeeding, maternal and fetal morbidity and mortality reduction, Fetal Infant Mortality Review, the Doula Initiative, Safe Delivery of Newborns, Fetal Alcohol Spectrum Disorder efforts, and more. DMIH works in partnership with the Children's Special Health Care Services (CSHCS) Division and the Division of Child and Adolescent Health (DCAH) to administer Title V. CSHCS includes CSHCS Customer Support, Policy and Program Development, Quality and Program Services, and the Family Center for Children and Youth with Special Health Care Needs (Family Center). DCAH oversees school-based health centers, oral health for children and pregnant women, teen pregnancy prevention, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, the Early Childhood Comprehensive Systems grant, and Title V funding to Michigan's 45 local health departments. Title V works collaboratively with other programs in the Michigan Department of Health and Human Services (MDHHS) which includes Medicaid; environmental health; emergency preparedness and response;

communicable and chronic disease; food and cash assistance; and Child Protective Services (CPS) and foster care.

MDHHS and MCH Goals

The MDHHS vision to "Deliver health and opportunity to all Michiganders, reducing intergenerational poverty and promoting health equity" is supported by 11 goals:

- Public health investment
- Racial equity
- Address food and nutrition, housing, and other social determinants of health
- Improve the behavioral health service system for children and families
- Improve maternal-infant health and reduce outcome disparities
- Reduce lead exposure for children
- Reduce child maltreatment and improve rate of permanency
- Implement the Families First Preservation Services Act
- Expand and simplify safety net access
- Reduce opioid and drug-related deaths
- Manage to outcomes and invest in evidence-based solutions

Michigan's MCH programs align with several of these goals. The 2020-2023, Mother Infant Health & Equity Improvement Plan (MIHEIP) guided the work of Michigan's stakeholders and MDHHS over the last several years. Michigan has implemented strategies to address the social determinants of health and equity, worked to build strong collaborative relationships statewide and, together with partners, has improved maternal and infant outcomes. The 2024 – 2028 Advancing Healthy Births: An Equity Plan for Michigan Families & Communities is the next iteration of the plan and focuses on sustainable actions and multifaceted approaches to advance outcomes for birthing people and their infants. Michigan continues to strive toward the strategic vision of "zero preventable deaths, zero health disparities." The new plan was developed collaboratively by MDHHS and stakeholders and was informed by input garnered from regional town hall meetings, Mother Infant Health and Equity Collaborative (MIHEC) meetings, Regional Perinatal Quality Collaboratives (RPQCs), Michigan families, healthcare providers, community leaders and maternal infant health stakeholders. In 2024, Michigan was also selected to participate in the National Governors Association *Improving Maternal and Child Health in Rural America State and Territory Policy Learning Collaborative* and the Health and Human Services *Postpartum Maternal Health Collaborative*. These initiatives will provide further opportunity to address maternal, infant, and child health outcomes.

Advancing maternal and infant health outcomes continues to be a priority for Gov. Whitmer. In 2020, Gov. Whitmer released the Healthy Moms, Healthy Babies initiative to address health disparities and provide all women with access to high-quality health care. Expansion of Healthy Moms, Healthy Babies continues through allocations in the state budget. The 2021 and 2022 budgets allocated funds to increase access to evidence-based home visiting and continuous postpartum Medicaid coverage for 12 months postpartum. The 2023 budget allocated funds to support doula infrastructure and increase investment in Early On. The Governor's FY 2024 budget allocated funding for Healthy Moms, Healthy Babies and also expanded access to family planning services, support for the Michigan Perinatal Quality Collaborative, expansion of CenteringPregnancy, support for birthing hospitals' participation in Levels of Maternal Care verification, and additional support for birthing hospital participation in the Michigan Alliance for Innovation on Maternal Health (AIM) program. In 2023, Gov. Whitmer also signed the Reproductive Health Act to help remove barriers to healthcare and retain access to reproductive health.

A Home Visiting Leadership team and a Home Visiting Advisory are charged with building an integrated home

visiting system for families. Michigan's evidence-based home visiting (EBHV) system includes the Maternal Infant Health Program, Nurse-Family Partnership, Healthy Families America, Early Head Start-Home Based, Parents as Teachers, Infant Mental Health, Play and Learning Strategies, and Family Spirit. The Leadership team includes funders of all EBHV in Michigan, aligning activities such as professional development and supporting coordinated referrals. Michigan hired a statewide home visiting professional development coordinator and has utilized technical assistance to develop and pilot family outreach strategies. The Home Visiting Advisory has an active role in system development through discussions about centralized access, professional development, and equity. Title V participates in the Advisory.

Michigan is expanding EBHV to better support families who have been impacted by child welfare involvement and family separation. Eleven HV programs have expanded to support families through the Families First Prevention Services Act. Thirteen programs are new or have expanded to specifically serve families impacted by substance use, a leading cause of child welfare involvement. Professional development is being provided to programs to ensure staff have access to information and training that will improve service delivery for families. Michigan is piloting peer navigators within the healthcare system to break down barriers of shame and stigma. Peer navigators with lived experience will connect families to resources, including EBHV, and will provide support 12 weeks postpartum. Seven agencies are currently implementing the program, supporting pregnant and postpartum people, with up to five additional agencies planned for FY 2024.

Early childhood partnerships and systems building are also critical to support children and their families. In 2023, the state experienced a shift in early childhood systems building. The Office of Great Start (OGS) within the Michigan Department of Education (MDE) was moved to a new department, Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP). MiLEAP is tasked with mobilizing resources to collaborate with leaders at the local, regional, and state level to put every Michigander on a path to prosperity from preschool through postsecondary. During this transition, the Great Start Operations Team which has been Michigan's convening body of state agencies and partners to provide strategic direction for early childhood coordination, was put on hold. MDHHS remains in partnership with both MiLEAP and MDE as a new structure to develop early childhood systems building is created. It is anticipated that several MDHHS program areas, including public health and home visiting, will be included on the new convening body.

In 2021, Michigan was awarded an Early Childhood Comprehensive Systems (ECCS) Grant which is housed in DCAH. The five-year project is intended to foster the development and integration of maternal and early childhood systems of care that are equitable, sustainable, comprehensive, and inclusive of the health system. The ECCS Advisory Committee is developing a strategic plan for infrastructure and fiscal supports to aid alignment between early childhood partners, including Title V and MIHEIP staff, and to achieve integration rather than duplication. The draft plan recognizes the role of trauma in systems of care, the need for systemic support of family leadership, and a push for an early childhood fiscal vision.

Advancing Equity

Advancing equity is a priority within the State of Michigan and MDHHS. At the state level, Gov. Whitmer has implemented many initiatives to address equity. Executive Directive 2019-09 established Equity and Inclusion Officers within each state department. Executive Directive 2020-07 required implicit bias training for licensed health care professionals. Racism was recognized as a public health crisis in August 2020 through Executive Directive 2020-09. As part of that directive, all state employees must complete an implicit bias training. Related goals have included building Diversity, Equity, and Inclusion (DEI) infrastructure and leadership and measuring DEI efforts across state departments. Several DEI initiatives were also created in direct response to the COVID-19 pandemic. The Michigan Coronavirus Task Force on Racial Disparities was created in April 2020 to investigate causes of

COVID-19 racial disparities and recommend actions to address disparities. Results of these efforts, which included transparency in data reporting and the establishment of neighborhood testing sites, are discussed in prior Title V applications. The Taskforce released a final report in February 2023.

At the departmental level, MDHHS continues to assess and support DEI. The MDHHS DEI Plan details the Department's "commitment to eliminating systematic inequities and promoting diversity, equity and inclusion." A DEI Council was created to promote and foster a culture that values DEI throughout MDHHS and the diverse communities it serves. The Race, Equity, Diversity, and Inclusion (REDI) Office was created in 2020 "to address racial, health, social and wealth disparities, that impact both internal and external partners." REDI released its Inaugural Report in 2023 to highlight community engagement strategies and other initiatives to address health disparities. The MDHHS Office of Equity and Minority Health (OEMH) is part of REDI. The OEMH provides training and technical assistance to the MDHHS workforce on implicit bias, systemic racism, cultural and linguistic competency, health equity, and equitable community engagement. A DEI newsletter provides information and resources on topics like implicit bias, racial identity, organizational change, and DEI studies. In 2023, the OEMH partnered with the Public Health Administration to discuss race and ethnicity data collection standards that would both align with federal reporting requirements and reflect the diversity of Michigan.

Starting in 2021, all MDHHS job postings require a Valuing Diversity and Inclusion competency in the posting questions, as well as DEI questions in the interview. A Countering Bias in the Interview training is required for all MDHHS interview panelists. Within annual performance plans, a DEI objective is required. "Introduction to Health Equity" and "Systemic Racism" trainings are required for all MDHHS staff. These trainings address factors that contribute to inequities; the impact of health inequities; how systems may perpetuate inequitable outcomes; and how MDHHS can help to achieve health equity. Since 2022, training related to Michigan's Tribal Governments is mandatory for MDHHS employees to support tribal relations and address disparities.

The MDHHS Office of Policy and Planning also led development of a collaborative, statewide Social Determinants of Health (SDOH) Strategy. The goal of the SDOH Strategy is to "Improve the health and social outcomes of all Michigan residents while working to achieve health equity by eliminating disparities and barriers to social and economic opportunity." Phase 1 of the SDOH Strategy included the release of "Michigan's Roadmap to Healthy Communities" in 2022. The initial focus areas were health equity, housing stability, and food security. Phase 2 of the SDOH Strategy launched with a virtual summit in January 2023 and focused on community health worker expansion, community information exchanges, food security, and housing stability. Phase 3 launched in January 2024 with the 2nd Annual SDOH Summit. It focuses on SDOH Hubs to foster collaboration and support community-driven work; aligning efforts using a Health in All Policies approach; and continuing to build on equity partnerships.

A range of SDOH initiatives are underway through MDHHS, including the Produce Prescription Pilot Program to address food security in partnership with Michigan Tribes; SDOH Hub Pilots; the Rural Health Equity plan, led by the Michigan Center for Rural Health; the SDOH Community Influencer Program; and the "Good Housing = Good Health" program, a partnership between MDHHS and the Michigan State Housing Development Authority to address housing stabilization and SDOH. Gov. Whitmer also proclaimed January 2024 as Social Determinants of Health (SDOH) Month. Notably, to support preventive care and address health disparities, MDHHS expanded Medicaid coverage to include Community Health Worker services as of January 1, 2024. In March 2024, MDHHS requested public input on potential services designed to address health-related nutrition needs through health plans participating in the Medicaid and Healthy Michigan Plan.

Equity is also being addressed within MCH programs, including but beyond Title V. In addition to equity strategies discussed in Title V state action plans, MCH activities include:

- The Medicaid doula reimbursement policy went into effect January 1, 2023. The policy allows for reimbursement of doula services for individuals covered or eligible for Medicaid insurance. A Doula Advisory Council with diverse statewide representation, including tribal doulas, was created to inform the advancement of doula services in Michigan.
- The Infant Safe Sleep program allocates funds and provides technical assistance in an equitable, data-driven manner. Funding is allocated to five local health departments (LHDs) and the Inter-Tribal Council of Michigan (ITC). The counties where the five LHDs are located account for 51% of sleep-related infant deaths in the state and experience racial disparities among the deaths. ITC serves American Indian families throughout the state; American Indian babies die at 2.6 times the rate of white babies.
- The Maternal Infant Health Program (MIHP) holds monthly Health Equity Meetings to create program documents and services using an equity lens. At the local level, MIHP agency staff are required to take a Health Equity and Systemic Racism course so that staff are equipped to provide equity-based services tailored to family needs. Licensed social workers and registered nurses who provide MIHP case management services are required to pursue education on implicit bias and its effect on service delivery. They also assist in referring families to community supports like healthy food, transportation, and housing.
- The Early Hearing Detection and Intervention (EHDI) DEI plan aims to reduce the number of children who are "lost to follow up" after a failed hearing screen, particularly in medically underserved areas or populations. A study analyzing five years of data was conducted to identify the characteristics of infants who are more likely to be lost to follow-up. EHDI plans to use the findings to create focused outreach and education strategies. Additionally, EHDI is working in collaboration with external partners to pilot a telehealth project. The project will assess the impact of remote audiology diagnostic services in supporting follow-up care in underserved areas or populations.
- To advance birth outcomes, Regional Perinatal Quality Collaboratives (RPQCs) actively address disparate outcomes, health inequities and social determinants of health through quality improvement efforts, convening diverse partners to support efforts and collaborate with regional partners, and authentically engaging families as key partners so that efforts address the root cause and resonate with communities.
- The DMIH DEI Council was formed in September 2022. The council meets monthly to move health equity in the division forward. The DMIH DEI Council developed two resources for managers to utilize when onboarding new employees to the Division, including an onboarding checklist and a slide deck. These items contain pertinent information related to mandatory and supplemental training opportunities on health equity, systemic racism and implicit bias. It also introduces the Division’s culture of equity and inclusion.
- The DMIH received $500,000 to raise awareness of uterine fibroid disparities through education and outreach programming. A social media and education campaign was developed and launched. Education infographics and posters are available in the internal clearinghouse. Additionally, through partnership with the Region 9 Perinatal Quality Collaborative, people with lived experiences with uterine fibroids participated in a storytelling project and produced videos. National uterine fibroid expert and physician, Dr. Erica Marsh, was a keynote speaker at the 2023 Maternal Infant Health Summit and served as a content specialist for this project.
- An initiative to support DMIH strategic planning efforts is being developed to use a common process and SMARTIE goals in the creation of the strategic plan. Each DMIH program area will undergo a strategic plan review and revision process to ensure that health equity goals are developed as SMARTIE goals.
- A mandatory three-part learning series on implicit bias and microaggressions was facilitated by Dr. Vicki Sapp for DMIH staff in 2023.
- DCAH is working with two home visiting programs that participated in the MIECHV Health Equity CoIIN to understand what family goals/supports are being achieved with the program’s increased knowledge about the history of racial inequities in their counties. This knowledge has prompted changes in policy for practices such as transportation support, access to health care, and improved family interviews to ask better questions about

access to resources within neighborhoods.

- DCAH convenes a 17-member Diversity, Equity, and Inclusion committee and is using a variety of resources, including a division specific DEI Survey, to establish goals and create a key driver diagram to move toward impacting those DEI goals. All Division staff and other colleagues will be invited to participate in the implementation of improvement projects. The DEI Committee has implemented a robust Communications Plan to share committee activities, resources, and opportunities across the division and within MDHHS.
- The Bay Area Regional Health Inequities Initiative framework was incorporated into ECCS grant activities. An ECCS Family Coordinator was contracted to help embed family leadership across government systems and throughout the ECCS grant.
- DCAH expanded use of the Rapid Adolescent Prevention Screening tool + additional SDOH questions within CAHCs to assess need and connect to local resources.
- The Expanding Health Equity in CSHCS initiative began in FY 2022. The goal is to eliminate racial, ethnic, and geographic disparities in CSHCS. The project team has reviewed extensive data and is creating a valid and reliable system to quantify racial and ethnic disparities to identify gaps in care. In partnership with the Managed Care Plan Division, CSHCS will work to identify performance standards to address barriers to care. Policy and contracting levers will be established to sustainably address disparities. Throughout the process, transparency and accountability will be promoted to drive improvements in disparities. The project mirrors work underway in the MDHHS Managed Care Plan Division.
- WIC has implemented a new webinar series 'Exploring Cultural Practices.' Attendees become familiar with common foods, meal preparation, and traditional meals of different cultures. This training helps staff be culturally responsive and appropriate, and to use effective methods to communicate nutrition messages. Recordings of past webinars are available in the WIC Webcast Catalog.

Within Title V, the 2020 five-year needs assessment identified three key "pillars" that are important to all MCH populations: achieving equitable health outcomes, engaging families and communities, and delivering culturally and linguistically appropriate health education. Strategies related to these pillars are included in the NPM and SPM state action plans.

Strengths and Challenges that Impact the MCH Population

The Title V five-year needs assessment was completed in 2020 prior to the COVID-19 pandemic. It identified strengths and challenges that impact the MCH population which are discussed in detail in the FY 2021 application. Strengths include longstanding relationships with local public health, commitment to addressing health disparities and pursuing equity, elevation of family voices to serve CSHCN, a robust home visiting network, health campaigns that leverage technology and community voice, recognition of the impact of social determinants on health, and resources and services to meet basic needs.

Challenges identified through the 2020 needs assessment included the impact of poverty coupled with system limitations to address poverty as a driver of health disparities; gaps in capacity and access to services for basic needs like transportation, childcare, and healthcare; inconsistent distribution of culturally or linguistically relevant health information; gaps in respite care for caregivers of CSHCN; barriers to accessing behavioral health services; and racism and other drivers of health inequity.

Since March 2020, the most significant public health challenge has been the COVID-19 pandemic. Detailed information about the pandemic is included in the four prior Title V applications. In 2021 and 2022, Title V conducted assessments to gauge the pandemic's impact on the MCH population. In 2023, assessment activities focused on the impact of the pandemic on local public health. Findings are included in prior Needs Assessment Updates.

Information on COVID-19 including vaccination, testing, and treatment is available on the State's Coronavirus website. Data confirmed and probable cases, trends, demographics, and laboratory testing is available on the COVID-19 Data Dashboard. Efforts to address COVID-19 vaccination and other routine vaccination among the MCH population are discussed in the Needs Assessment Update of this application.

Components of the State's Systems of Care

Health Services Infrastructure and Financing

Michigan's health care infrastructure includes 176 hospitals, including 37 critical access hospitals that serve rural areas (Michigan Health & Hospital Association). The state has 78 birthing hospitals and 21 Neonatal Intensive Care Units. Michigan also has six children's hospitals (Children's Hospital Association). The health care system includes 39 Federally Qualified Health Centers with over 250 delivery sites (Michigan Primary Care Association); 122 school-based/school-linked health centers (MDHHS); 34 Family Planning agencies providing services at 94 clinic sites (MDHHS); and 230 rural health clinics (Michigan Center for Rural Health). According to HRSA data on Health Professional Shortage Areas (HPSAs), as of March 2024, Michigan had 252 primary care HPSAs (versus 285 in 2023); 241 dental health HPSAs (versus 248 in 2023); and 232 mental health HPSAs (versus 257 in 2023). These include facility, geographic area, and population group HPSAs.

The public health infrastructure to protect and promote community health is supported by MDHHS and 45 local health departments (LHDs) that serve all 83 counties and the City of Detroit. MDHHS works closely with LHDs to provide comprehensive public health services. This decentralized structure allows for local efforts to address local needs while staying connected to the state for support, funding, and other resources.

Coverage expansions under the Affordable Care Act (ACA) provided Michigan consumers with two new options: Healthy Michigan Plan (HMP) and Health Insurance Marketplace (Marketplace). Eligible individuals above 133% of the federal poverty level (FPL) could enroll in private health insurance coverage through the Marketplace. In April 2014, Michigan expanded HMP to cover residents who were at or below 133% of the FPL and who were not previously eligible for traditional Medicaid. According to the HMP website, the plan provides health care coverage to Michigan residents who:

- Are age 19-64 years.
- Have income at or below 133% of the FPL.
- Do not qualify for or are not enrolled in Medicare.
- Do not qualify for or are not enrolled in other Medicaid programs.
- Are not pregnant at the time of application.

As of January 2024, 897,289 beneficiaries are enrolled in HMP (HMP County Enrollment Report) which is an increase from March 23, 2020 (674,853 beneficiaries). The Medicaid program kept Medicaid eligibility cases open until the end of the COVID-19 Public Health Emergency, which is discussed in the Needs Assessment Update.

The Healthy Michigan Plan (HMP) provides beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors. HMP benefits include preventive/wellness services, chronic disease management, prenatal care, oral health, and family planning services.

ACA consumer protections improved access to private insurance for CSHCN by eliminating preexisting condition exclusions and discrimination based on health status, the two most frequent enrollment barriers. The ACA also expanded access to parent employer coverage for adults 19-26 years of age. The number of individuals dually enrolled in CSHCS and Healthy Michigan Plan for January 2024 was 1,875. LHDs, Family Resource Centers, and

designated state staff work with families and community partners to help families understand and access private and publicly funded resources to meet needs.

CSHCN 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. Health care costs can include deductibles, cost sharing, and premium payments. Private insurance may not include any covered benefit for a specific, medically necessary service. In other cases, only a limited benefit may be available. 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. CSHCS helps to limit costs to families and continues to be a resource for achieving appropriate and equitable health and specialist care. Steady CSHCS enrollment following ACA's implementation reflects the value of CSHCS to families even when private insurance is available.

In FY 2024, the CSHCS program expanded age eligibility from up to age 21 to up to age 26. This expansion will improve access to health care services for young adults with chronic or complex health conditions who need specialty medical care. In addition, the expansion will provide critical support for young adults as they transition to adult services. With the program's expansion, it is expected that an additional 9,000 individuals will have access to CSHCS.

Integration of Services

MDHHS and Michigan's MCH programs recognize the importance of integrating physical and behavioral health services to improve health and address individual or family needs. In March 2022, MDHHS announced a behavioral health restructuring (described in the Cross-Cutting/Systems Building plan) to support services across community-based, residential, and school locations. MDHHS initiatives to address behavioral and mental health needs include:

- The Michigan Peer Warmline is a statewide, anonymous line for any Michigander experiencing a mental health or substance use condition. The warmline is staffed by certified peer support specialists and recovery coaches. Additionally, the Michigan Crisis and Access Line (MiCAL) is now available statewide after being piloted in the Upper Peninsula and Oakland County in 2021. MiCAL is staffed 24/7 and provides crisis and warmline services, information, and coordination with local systems of care such as Community Mental Health Services Programs.
- In January 2024, MDHHS announced a Request for Proposal (RFP) to establish a capacity building center to support training and workforce development for individuals who provide behavioral health services. MDHHS issued a separate RFP to establish a program to provide stipends for student interns in Michigan's public behavioral health system.
- The Expanding, Enhancing Emotional Health (E3) model helps to address the need for mental health services for children and youth. E3 is a designated model through the Child & Adolescent Health Center (CAHC) Program. E3 programs provide on-site comprehensive mental health services from mild to moderate severity of need by a licensed Mental Health Professional. Services include assessments, brief intervention, ongoing therapy, referrals, and follow-up. E3 sites are open year-round and provide telehealth when school is not in session. Services are designed for children and adolescents 5-21 years of age when access to behavioral health resources are limited or inaccessible in a community. Currently, 102 E3 sites operate in 40 counties.
- The Child & Adolescent Health Center program is continuing to expand in new communities in 2024 through an annual $25 million investment from the state budget. This will expand primary care, nursing, and mental health services to underserved children and adolescents throughout the state. An additional 44 new partner sites were brought on in 2023, and an additional 20 are anticipated in 2024.

- Michigan continued to roll out expanded coverage for nursing and mental health services for general education students through a CMS approved Medicaid waiver. The Caring 4 Students (C4S) expansion allows schools that provide mental health and nursing services to general education students to receive Medicaid reimbursement. All 56 Intermediate School Districts participate in C4S. Michigan is one of 16 states that have expanded eligibility to include general education students.
- In August 2020, MDHHS was approved for a two-year CMS Certified Community Behavioral Health Clinic (CCBHC) Demonstration. In 2021, the demonstration was extended an additional four years. CCBHC demonstration sites provide nine core behavioral health services, including care coordination with primary care providers, and must meet standards for service provision, staffing, governance, and quality and financial reporting. Gov. Whitmer's FY 2025 budget proposal includes $193.3 million to strengthen Michigan's CCBHC demonstration program by expanding CCBHC sites and increasing program support. The proposal would expand access for up to 50,000 additional Michigan residents.
- The Michigan Child Collaborative Care (MC3) provides psychiatry support to primary care providers who have patients with behavioral or mental health concerns. Behavioral Health Consultants provide guidance to providers on diagnostic questions, medication recommendations and appropriate psychotherapy. Recommendations for local resources are also provided. MC3 provides behavioral health education for primary care providers, including cultural sensitivity. MC3 is administered collaboratively by MDHHS, the University of Michigan, and Michigan State University.
- An MC3 Perinatal Patient Care pilot program is also being implemented in six counties. The program offers free same-day access to behavioral health consultants who provide virtual counseling, case management and care coordination for perinatal patients. Patients complete an electronic screening tool and same-day brief intervention. The screening results are used to create short-term plans of care which may include virtual counseling, case management, and care coordination.
- DMIH received State Opioid Settlement funds to support ongoing efforts at three health systems to implement 'rooming in' programs in the hospitals' birthing units. The family-centered model encourages parent-infant bonding and uses non-pharmacological care of infants born substance-exposed, ensuring they remain with their parent or caregiver in a private hospital room. Hospital staff provide support for breastfeeding, skin-to-skin contact, calming techniques, and referrals to services. The funds will also support expansion of the program to two additional hospitals in 2024.
- CSHCS continues to work with Behavioral Health partners to identify challenges accessing services experienced by populations served by the mental/behavioral health, intellectual/developmental disabilities, and physical health systems. Work includes regular meetings to discuss program changes and brainstorm how to address systemic access issues.

Title V and Medicaid

Michigan's Title V and Title XIX programs are both housed within MDHHS and share the common goal to improve the health and well-being of the MCH population through implementation of affordable health care delivery systems, expanded coverage, and strategies to address social determinants of health and reduce health disparities. Areas of collaboration include maternal and infant care, perinatal care, child and adolescent health, developmental screening and referral, home visitation, oral health, and CSHCS. Key partnerships are discussed in the Title V–Title XIX section of this application.

In January 2024, 2,015,936 Medicaid beneficiaries were enrolled in Medicaid Health Plans and 867,271 beneficiaries were enrolled in fee for service. Medicaid uses a managed care delivery system to maximize the health status of beneficiaries, improve beneficiary experience, and lower cost. Medicaid contracts with nine Medicaid Health Plans (MHPs) to achieve these goals through evidence- and value-based care delivery models; health

information technology; strategies to prevent chronic disease; and coordination of care that includes assessing social determinants of health such as transportation, housing, and food access. MDHHS requires MHPs to annually report the Healthcare Effectiveness Data and Information Set (HEDIS) and uses a Pay for Performance Incentive Program with access, process, and outcome metrics for all managed care populations, including women and children. Each MHP governing body must either have a minimum of 1/3 representation of Medicaid enrollees or the plan must establish a consumer advisory council that reports to the governing body. The council must include at least one Medicaid enrollee, one family member or legal guardian of an enrollee, and one consumer advocate. MHPs must recruit CSHCS beneficiary parents/guardians to participate in non-compensated governing bodies or consumer advisory councils.

To help achieve integrated care, MHPs are required to work with MDHHS to develop initiatives to better align services with Community Mental Health Services Programs/Prepaid Inpatient Health Plans (PIHPs) to support behavioral health. Medicaid incentivizes performance by MHPs and PIHPs on shared populations and metrics. MHPs must also provide or arrange for the provision of community health worker (CHW) or peer-support specialist services to enrollees who have behavioral health needs and complex physical co-morbidities. CHWs serve as a key resource for services and information needed for enrollees to have healthier, more stable lives. CHW services include home visits; participating in office visits; arranging for social services; and helping enrollees with self-management skills.

The DMIH and Michigan Medicaid jointly oversee several programs for the Medicaid-eligible MCH population. One of the largest collaborations is the Maternal Infant Health Program (MIHP), Michigan's largest population-based home visiting program available to all pregnant people and infants up to age one eligible for Medicaid insurance. MIHP services provided to beneficiaries enrolled in an MHP are administered by the MHPs. In FY 2023, MIHP provided services to 11,299 adults and 14,515 infants.

Another area of coordination is for CSHCN. In January 2024, CSHCS program data indicate that 29,309 CSHCS beneficiaries were dually enrolled in an MHP. MHPs are responsible for the medical care and treatment of CSHCS members while community-based services beyond medical care and treatment are provided through an LHD's CSHCS office. MHPs are responsible for coordinating and collaborating with LHDs and Children's Multidisciplinary Specialty Clinics to provide a range of essential health care and support services to enrollees. MHPs are also responsible for coordination and continuity of care for enrollees who require integration of medical, behavioral health and/or substance abuse services.

Information Systems

MDHHS uses CareConnect360 (CC360), a statewide web-based care management system that allows for the bi-directional exchange of health care information. CC360 allows for the identification and coordination of services to Medicaid beneficiaries by sharing information between state health plans and Prepaid Inpatient Health Plans. CC360 makes it possible to analyze healthcare program data, manage and measure programs, and improve enrollee health outcomes. CC360 will help to improve communication among MIHP agencies by sharing care elements to support successful case management, so MIHP home visitors are engaged as part of the care team. It will also allow for comparison of population health data across counties or regions.

MI Bridges is also a key component of the MDHHS service platform to meet consumer needs. MI Bridges is an online site managed by MDHHS that enables users to apply for benefits (including healthcare, food and cash assistance, childcare, and state emergency relief) and to find resources such as transportation, food, and utility assistance. MI Bridges users can review and access their benefits information; renew benefits; and share beneficiary information. In 2020, functionality was built into MI Bridges to include home visiting. In 2022, the self-

referral function was updated so that families now receive a custom list of home visiting models in their community for which they are eligible. Information on each model, including program descriptions and parent testimonials, are provided to help identify a model to best fit their needs.

MDHHS also uses health information systems to support the care and services provided to the MCH population. The Michigan Care Improvement Registry (MCIR) allows for the identification of children who are not up to date on Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well child visits according to the American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care periodicity schedule. All MHPs have access to MCIR, and it is an approved data source for Medicaid HEDIS immunization and lead testing data. MIHP providers also have access to MCIR to facilitate referrals and access to preventive services.

State Statutes Relevant to Title V (Effective August 1, 2023)

The Michigan Public Health Code, Public Act 368 of 1978, governs public health in Michigan. The law indicates the state health department shall “continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs” (MCL 333.2221). Furthermore, it shall “promote an adequate and appropriate system of local health services throughout the state and shall endeavor to develop and establish arrangements and procedures for the effective coordination and integration of all public health services including effective cooperation between public and nonpublic entities to provide a unified system of statewide health care” (MCL 333.2224).

For the fiscal year ending September 30, 2024, state funding for MCH and CSHCS programs was appropriated through Public Act 119 Enrolled House Bill 4437, Article 6, Department of Health and Human Services. 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 funds for MCH programs are itemized in Sec. 116, Family Health Services, of Public Act 119 of 2023, and CSHCS is addressed in Sec. 117.

Additional MCH funding requirements and legislative reporting relate to evidence-based programs to reduce infant mortality (Sec. 1308); family planning/pregnancy prevention; health outcomes before, during, after pregnancy (Sec. 1301, 1312, 1314); grants to local collaborators in perinatal quality collaboratives to improve maternal and infant health outcomes (Sec 1325); prenatal care outreach and rural home visiting (Sec. 1311); fetal alcohol syndrome services (Sec. 1313); oral health initiatives (Sec. 1315-1316, 1343); drinking water declaration of emergency fund support services (Sec. 1306); healthy exercise programs for school-age children (Sec. 1342); and statewide immunization media campaign (Sec. 1349).

Requirements in the FY 2024 Health and Human Services budget for CSHCS included criteria in Sec. 1360 for MDHHS to provide services; Sec. 1361 authorizes that some funding be used to develop and expand telemedicine capabilities and to support chronic complex care management.

III.C. Needs Assessment
FY 2025 Application/FY 2023 Annual Report Update

Ongoing and emerging issues that impact the MCH population are discussed in this section, including infant and maternal mortality, Congenital Syphilis, COVID-19 vaccination, COVID-19 and pregnancy, priority childhood vaccinations, the unwinding of the Public Health Emergency and Medicaid enrollment, and fluoridation. Health concerns specific to Children and Youth with Special Health Care Needs (CYSHCN) are also discussed and include children with medical complexity, Sickle Cell Disease, and respite care for families with CYSHCN.

Michigan's Title V program is in the process of implementing the next five-year needs assessment, which is due in July 2025. This has included developing the needs assessment framework, goals, structures, and processes and implementing assessment activities. Additionally, the Title V program has been identifying ways to address the new universally required National Performance Measures (Perinatal Care Discrimination in the Women/Maternal Health Domain; Medical Home in the Child Health Domain; and Medical Home in the CSHCN Domain) which are included as state action plans in this application and will also be included in the next five-year cycle for FY 2026-2030.

Ongoing and Emerging Issues that Impact MCH

Infant and Maternal Mortality

MDHHS closely monitors infant and maternal mortality and has seen the following trends and emerging concerns. The infant mortality rate (IMR) in Michigan for 2022 was 6.4 deaths per 1,000 live births. This is a slight increase from the lowest on record IMR in 2021 at 6.2 deaths per 1,000 live births. Racial and ethnic disparities remain a major contributor to Michigan's infant mortality rates. Although the gap between the Black and White infant mortality rate decreased slightly since 2021, when the Black infant mortality rate was more than three times greater than the corresponding White infant mortality rate, the 2022 gap is still higher than the disparity in 2020. In 2022, the Black Non-Hispanic infant mortality rate was 2.8 times that of the White Non-Hispanic infant mortality rate (13.3 versus 4.8 per 1,000 live births). The pregnancy-related mortality ratio in Michigan for 2020 was 43.2 maternal deaths per 100,000 live births[[1]]. As with infant mortality, disparities between Black and White mothers exist, with the Black pregnancy-related mortality ratio 2.2 times that of the White ratio (36.5 versus 16.3 per 100,000 live births based on 2016-2020 data). In addition to maternal deaths caused by pregnancy-related issues, addressing pregnancy-associated, not related mortality[[2]] remains important: 35.7% of all pregnancy-associated, not related deaths from 2016-2020 were caused by accidental poisoning/drug overdose.

Michigan's maternal mortality review committee has focused on developing recommendations to help prevent current and expecting mothers from developing substance use disorders. In 2024, a new report Maternal Deaths in Michigan Data Update, 2016-2020 was released and provides a high-level overview of Michigan's pregnancy-associated deaths, including determination of pregnancy-relatedness, demographics, disparities, causes of death, preventability and recommendations to prevent future deaths. Additionally, Michigan's fatality review programs have been working together to create a process for coordinating, collaborating, and elevating aligned prevention recommendations. The newly released report Michigan Maternal Mortality Surveillance (MMMS) and Fetal Infant Mortality Review (FIMR) Aligned Recommendations is intended to amplify shared/aligned strategies for prevention of maternal, fetal, and infant deaths.

Congenital Syphilis

Michigan, like much of the nation, is experiencing an alarming increase in Congenital Syphilis (CS) cases. The debilitating outcomes of untreated Syphilis in utero include deformed bones, severe anemia (low blood count), enlarged liver and spleen, jaundice (yellowing of the skin or eyes), and brain and nerve problems including blindness

or deafness. In 2023, Michigan saw an increase of 238% since 2019 with 54 cases, three stillbirths and one infant death reported. This vertical transmission, from mother to infant, parallels the increase in female syphilis cases due to increased heterosexual exposure. The geographic, race, and ethnicity distribution of these cases is 55% Black with 40% residing in Detroit, reflecting a large disparity among African Americans. The maternal age group most affected is 20-39. Michigan data suggest that a lack of adequate prenatal care is the most common factor contributing to CS, as two thirds of cases received little or no prenatal care.

CS is preventable if a pregnant person receives appropriate and timely testing and treatment. Early identification of syphilis through a serology test is crucial. Initiation of syphilis treatment in a pregnant person at least 30 days before delivery averts CS. Therefore, it is important for clinicians to adhere to Michigan's Perinatal Screening Guidelines that require screening in the first trimester, again in the early third trimester (28 weeks), and at delivery if no record of previous testing or declination is documented. Notably, this law applies to all pregnant persons in Michigan, and all settings where pregnant persons access medical care, not just traditional prenatal providers.

MDHHS is committed to supporting community partners to prevent CS. Efforts include:

- Print resources for clinicians and their patients can be found here.
- Partner with MDHHS Medicaid Program to develop pregnancy screening performance measures that follow Michigan's perinatal guidelines for managed health care plans.
- Fund an Electronic Medical Record (EMR) Best Practice Alerts (BPA) project in Southeastern Michigan. The alerts will indicate whether an emergency department patient may be indicated for an HIV, HCV, and/or syphilis test based on algorithms that will flag individuals most likely to benefit from related services.
- Support an HIV/syphilis clinician consult program through a major health system.
- Enhance patient follow up services to support clinicians.
- Awareness building by providing physician detailing and large group presentations for clinicians.

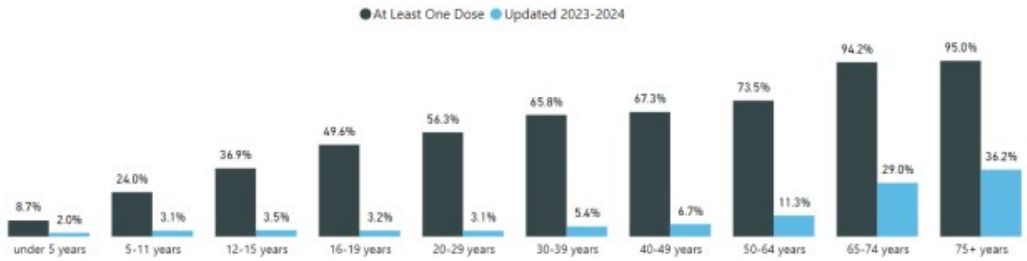
Michigan's Maternal and Congenital Syphilis Fact sheet can be found here.

COVID-19 Vaccination

Table 1 provides Michigan COVID-19 vaccine coverage percentages by age group as of January 3, 2024. At Least One Dose is defined as the percentage of Michigan residents who have ever received any type of COVID-19 vaccine in their lifetime; Updated 2023-2024 is defined as the percentage being up-to-date based on the CDC recommendation for the 2023-2024 season. Nearly 33% of Michigan residents aged 5-11 years have had at least one COVID-19 vaccine in their lifetime, but only 5% of this group are up to date on their COVID-19 vaccinations for the 2023-2024 season.

The percentage of ever having received a COVID-19 vaccination increases steadily with age and is the highest, at 95%, among those aged 75+ years. The updated 2023-2024 percentage also increases with age, but at a slower rate. Less than 12% of Michigan residents aged 64 years or less are fully vaccinated based on the current CDC recommendations. Michigan residents aged 75+ years have the highest percentage for up-to-date COVID-19 vaccinations at just over 36%.

Table 1. COVID-19 Vaccine Coverage Percentages by Age Group



COVID-19 and Pregnancy

With the completion of the 2021 cohort, Michigan has concluded its participation in the CDC COVID-19 Pregnancy and Neonate Surveillance Project. For the project, women who received a confirmed diagnosis of COVID-19 during pregnancy during 2020 and/or 2021 were identified through the Michigan Disease Surveillance System (MDSS) which was then linked with birth and death certificates to track pregnancy outcomes. After each pregnancy outcome occurred, medical records for both mother and infant were requested to obtain details regarding the impacts of COVID-19 on the health of mother and infant.

For the 2020 cohort, 1,378 Michigan women were identified with a confirmed COVID-19 diagnosis during pregnancy. A pregnancy outcome was confirmed for 1,288 (93.5%) with the remaining 90 women (6.5%) lost to follow-up. The 1,288 documented pregnancy outcomes resulted in 1,316 live births and less than five fetal deaths. Black pregnant persons were 3.4 times more likely to have a COVID-19 complication than White pregnant persons. Infants of Black parenting persons that were diagnosed with COVID-19 during pregnancy were 2.5 times more likely to be low birthweight compared to infants of White parenting persons that were diagnosed with COVID-19 during pregnancy. Additional results from the 2020 cohort can be found within the full COVID-19 and Pregnancy factsheet. Plans are in place to analyze the 2021 cohort data and develop another factsheet.

Priority Childhood Vaccinations

Table 2 provides Michigan child vaccination percentages for July through September 2023. When compared to the US average, Michigan reports lower immunization percentages for each of the main childhood vaccinations. Table 3 provides information on child vaccination percentages in Michigan over time. Since the third quarter of 2021 (October-December 2021), Michigan has experienced consistent decreases in each of the priority childhood vaccinations.

Table 2. Michigan Childhood Vaccination Rates in Comparison to US

Child Vaccination (19 through 35 months)		
	Michigan Coverage (%)	US Average (%)
4313314*	66.8	75.4
43133142*	54.3	-
2+ Hepatitis A	56.1	77.4
4+ DTap (Diphtheria/Tetanus/Pertussis)	69.7	87.2
PCV Complete (Pneumococcal)	74.9	86.0

Table 3. Michigan Childhood Vaccination Rates Over Time

	Percentage by end calendar year quarter								
	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3
4313314*	70.4	69.9	68.5	67.5	67.7	66.1	65.8	65.9	66.8
43133142*	57.6	56.8	55.4	54.5	55.4	53.3	52.8	52.4	54.3
4+ DTap	73.0	72.6	71.1	70.2	70.5	69.1	68.9	68.9	69.7
PCV Complete	79.2	79.0	77.6	76.4	76.5	75.0	74.5	74.4	74.9

*4313314(2): 4 DTaP, 3 Polio, 1 Measles/Mumps/Rubella (MMR), 3 Hib, 3 Hepatitis B, 1 Varicella, 4 PCV, (2 Hepatitis A)

MCH Vaccination Efforts

To address and support COVID-19 vaccination as well as other routine vaccination among the MCH population, MCH program activities include the following:

- Child and Adolescent Health Centers (CAHCs) provide school-based or school-linked comprehensive primary and preventive health and mental health services for children and adolescents ages 5-21 years. CAHCs help students keep vaccination status up to date by providing any needed vaccines. CAHCs directly supported influenza and COVID-19 vaccination efforts during the pandemic. In FY 2023, CAHCs provided 23,674 immunizations to students.
- The Division of Maternal and Infant Health hired a Public Health Nurse Consultant (PHN) in 2021 within the Maternal Infant Health Program (MIHP) to focus on immunization efforts. In 2022, the PHN worked with a marketing firm to develop and launch a campaign to increase awareness of immunizations. In 2023, a training module was developed to provide education related to immunization among pregnant people, infants, and their families. This module is required for all MIHP home visitors and includes information related to immunization recommendations, motivational interviewing, vaccine hesitancy, and disparities in vaccination rates. The consultant also reviews and develops immunization content for the MIHP Bi-Weekly Update email newsletters and for the phone application Pregnancy+. To increase awareness and share resources, federal immunization awareness campaigns such as National Immunization Awareness Month and National Infant Immunization Week are shared. The PHN also provided an Immunization Update webinar in February 2024. Assessment of immunization status has been integrated into MIHP protocols and a Quality Assessment review that took place from 2023-2024. Additionally, a comprehensive vaccine education toolkit is under development in 2024 to provide home visitors with a user-friendly tool for enhancing communication with families.
- The CSHCS Vaccine Initiative addresses vaccination gaps in CYSHCN and their families. Funding was provided to LHDs to improve access to COVID-19 vaccines; expand vaccination education, messaging, and partnerships; and improve understanding of barriers to vaccination. The funding for this project ended in June 2023.

Unwinding of the Public Health Emergency and Medicaid Continuous Enrollment

During the COVID-19 Public Health Emergency (PHE), state Medicaid agencies were required to continue health care coverage for all medical assistance programs, even if a person's eligibility changed. The end of the PHE on May 11, 2023, triggered the unwinding of the Medicaid continuous enrollment provision. Starting in June 2023, Michigan Medicaid beneficiaries had to renew their coverage as the state resumed eligibility redeterminations. MDHHS took many steps to make beneficiaries aware of the redetermination requirements and to help individuals retain Medicaid coverage if eligible. Those activities were discussed in detail in last year's Title V application.

Current information on renewals is available on the Michigan Medicaid Renewals Data website. A press release

issued by MDHHS on January 31, 2024, indicates that more than 1.1 million Michigan Medicaid beneficiaries had their coverage renewed six months into the renewal process. Several strategies have been used to ease the renewal process and mitigate the risk of coverage loss, including extending renewals to May 2024 for beneficiaries undergoing life-saving treatment and providing beneficiaries an extra month to submit paperwork. Michigan's MCH programs will continue to monitor the unwinding and redetermination processes and assist partners and clients, as needed, so that individuals who are eligible for Medicaid benefits continue to receive them.

In particular, the potential loss of Medicaid coverage could have cost implications for the CSHCS program. The CSHCS program hosted Medicaid partners at a CSHCS Advisory Committee meeting to provide an overview of the unwinding and redetermination process. The Advisory Committee includes organizations (providers, disease-specific organizations, etc.) and parent/family members with a focus on children with special needs. The discussion included general information on the unwind process and the anticipated impacts on CSHCS clients. CSHCS continues to monitor enrollment trends closely. CSHCS dual enrollment with Medicaid increased during the PHE. Current data indicate total enrollment is trending toward pre-COVID levels with decreases in CSHCS clients dually enrolled in Medicaid.

Fluoridation

In 1945, Community Water Fluoridation (CWF) began in Grand Rapids, Michigan. Over the last 79 years, it has been a safe and effective strategy in the prevention of cavities. The US Surgeon General states that CWF is one of the most cost-effective, equitable, and safe measures communities can take to prevent tooth decay and improve oral health. Over the past few years, anti-fluoridation groups have grown more visible. In a northern Michigan community, the city council recently voted to discontinue community water fluoridation due to the lack of supply and increased costs despite community support of fluoridation. The once robust School Mouth Rinse Program has ended with the last manufacturer discontinuing production. The removal of this fluoride delivery system leaves many children at risk of tooth decay and poorer oral health outcomes. MDHHS is continuing to monitor fluoridation activities around the state.

Children with Special Health Care Needs

Nationwide, there is an emerging focus on Children with Medical Complexity (CMC) who suffer from one or more chronic conditions and experience high healthcare utilization. CSHCS estimates that CMC make up less than 4% of the CSHCS population but are estimated to account for 40% of Medicaid's pediatric spending. To address the complex needs of this population, CSHCS is collaborating with Michigan Medicaid, Michigan Medicine, Michigan-based Children's Hospitals, and stakeholders to explore the establishment of a targeted case management benefit for CMC in Michigan. The goals of the CMC program are to improve patient outcomes, increase patient and family satisfaction, and reduce healthcare costs by enhancing the systems of care for CMC and, more broadly, CYSHCN.

Sickle Cell Disease (SCD) is a chronic condition which disproportionately affects African Americans. An estimated 3,500 to 4,000 Michiganders are living with SCD. Individuals with SCD are prone to higher rates of hospitalization, emergency room utilization, and premature death. In FY 2021, CSHCS partnered with the Lifecourse Epidemiology and Genomics Division (LEGD) to submit a proposal to the Governor's Office to expand CSHCS eligibility to adults with SCD, expand clinical services, and enhance the system of care serving clients with SCD. The proposal was embraced by the Governor and enacted in the FY 2022 budget appropriation. By FY 2023, 578 adults with SCD have been enrolled with CSHCS. The program continues to implement outreach strategies to reach adults who can benefit from the CSHCS eligibility expansion, while also partnering with colleagues in LEGD to enhance clinical capacity to serve individuals with SCD. In addition, CSHCS is implementing strategies to expand the CMDS clinic model to include adult clinics caring for patients with SCD. Since FY 2022, six CMDS clinics have been added with the hematology/oncology specialty type. Additionally, in FY 2023, the CSHCS transition specialist started working

with LEGD and one clinic site to develop toolkits for transition programs to improve the transition to adulthood for SCD patients.

Improved access to respite care for families with CSHCN was identified as a need in the 2020 Needs Assessment. According to the 2019-2020 National Survey of Children's Health, parents/caregivers of children with special health care needs in Michigan are five times more likely to have left a job, requested a leave of absence, or reduced their work hours due to the stress of their child's health or health conditions. In response, CSHCS engaged with Partners for Children which completed a survey of 15 states to identify respite gaps and reached out to the Catalyst Center for additional evidence to support a policy change for CSHCS respite. CSHCS convened an internal workgroup with representation from Program Review Division, CSHCS, Office of Medical Affairs, and other partners to review and revise existing CSHCS respite policy. The committee has identified eligibility criteria and is in the process of estimating the population that would benefit from this policy change.

In FY 2023, MDHHS utilized American Rescue Plan Fiscal Recovery Funds to issue relief grants for family caregivers who provided continuous direct care support for a family member during the Public Health Emergency. CSHCS utilized claims data to identify families who met eligibility criteria between March 1, 2020, and May 11, 2023. The grant was provided to families to reimburse a caregiver of their choice for respite services or to help them afford a form of "relief or respite" that meets their needs. Approximately 3,000 CSHCS beneficiaries received a one-time payment of $2,840.

[[1]] Includes maternal deaths while pregnant or within 1 year of the end of a pregnancy from any cause related to or aggravated by the pregnancy or its management. Data source: Maternal Deaths in Michigan, 2016-2020 Data Update. MDHHS. Michigan Maternal Mortality Surveillance Program.

[[2]] Includes maternal deaths while pregnant or within 1 year of the end of a pregnancy due to a cause unrelated to pregnancy.

Click on the links below to view the previous years' needs assessment narrative content:

2024 Application/2022 Annual Report – Needs Assessment Update

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D.1. Expenditures

Financial Narrative Overview

Title V federal funding, in conjunction with non-federal state funding and other federal funds, is budgeted and expended to support Michigan's MCH priority needs and Title V requirements. Over one-third of Title V funding supports medical care and treatment for Children with Special Health Care Needs (CSHCN) and over one-third supports the MCH work of all 45 local health departments across the state. Title V funding also supports other state priorities such as immunizations, childhood lead poisoning prevention, oral health for children, infant safe sleep, breastfeeding, reproductive health, Fetal Alcohol Spectrum Disorders (FASD), Regional Perinatal Quality Collaboratives (RPQCs), needs assessment, and surveillance mechanisms such as PRAMS and Fetal Infant Mortality Review (FIMR). State general funds are used for Michigan's required state match. Title V state match funding includes state funds for CSHCS medical care and treatment, home visiting, infant safe sleep, infant mortality reduction, RPQCs, adolescent parenting support, and staff support for MCH programs. To ensure alignment with Title V requirements, Title V leadership and the MDHHS Budget liaison meet throughout the year to review Michigan's MCH expenditures. Expenditures for FY 2023 and budget plans for FY 2025 are discussed in Sections III.D.1 and III.D.2, respectively.

Expenditures (FY 2023 Annual Report Year)

In FY 2023, $18,395,974 in Title V funds were spent on MCH programs and initiatives. This represents Title V funding from the Federal Fiscal Year (FFY) 2023 grant period (i.e., the two-year grant period from October 1, 2022 to September 30, 2024) that was spent down in the state Fiscal Year (FY) 2023 (i.e., October 1, 2022 to September 30, 2023). Per section 503(b) of Title V legislation, states have the authority to spend down Title V funds over a two-year grant period. The FFY 2023 grant was not fully expended in FY 2023 but will be fully expended in FY 2024 (the second year of the grant period). Michigan experienced increased carryover in FY 2020-FY 2023 in large part due to the COVID-19 pandemic. Some programs that traditionally delivered in-person health services were unable to do so and/or were operating at decreased capacity as staff were reassigned to COVID-19 mitigation activities.

Michigan's Title V state match of approximately $52 million exceeds federal match and Maintenance of Effort requirements. Approximately 81.6% of Michigan's State MCH Funds were comprised of state general funds for CSHCS medical care and treatment and 3.5% were comprised of other CSHCS-related funds (non-emergency medical transportation for CSHCN, CSHCN administration, and bequests for care and services for CSHCN). The remaining 14.9% includes state general funds that support MCH appropriations for family planning local agreements; family, maternal and children's health administration; pregnancy prevention services; and prenatal care and outreach. Fluctuations in State MCH Funds expended can occur each year based on significant one-time costs for CSHCS medical care and treatment.

Michigan's MCH work was supported by a variety of other federal funds in FY 2023 including: Preventive Health and Health Service Block Grant, Women, Infants and Children (WIC); State Systems Development Initiative (SSDI); Title XIX (Medicaid); Immunization; Lead Poisoning Prevention; Abstinence Education Grant Program; Personal Responsibility Education Program (PREP); Home Visiting; Early Hearing Detection; Awareness and Access to Care for Children and Youth with Epilepsy; Universal Newborn Hearing Screening; Pregnancy Risk Assessment; and Title X (Family Planning).

30/30/10 Requirement

Michigan tracks expenditures to comply with the Title V 30/30/10 legislative requirements. A minimum of 30% of total

funding must be expended for CSHCN; a minimum of 30% of total funding must be expended for preventive and primary care for children ages 1-21; and a maximum of 10% of total funding can be expended for Title V administration. In FY 2023, expenditures were tracked by CSHCN; preventive and primary care for children ages 1-21; pregnant women, mothers, and infants; and others. Expenditures track the required amount, variance, percent of total and percent required to assure legislative compliance. In FY 2023, 37.4% of Title V FFY 2023 expenditures were for preventive and primary care for children; 37.8% of expenditures were for services for CSHCN; and 3.3% of expenditures were for Title V administrative costs. The remaining 21.5% of expenditures were for pregnant women, mothers, infants, and others (including men and non-pregnant women).

The Comprehensive Agreement for Local Health Departments (LHDs) in FY 2023 outlined contractual boilerplate language, the annual budget and financial requirements and program specific assurances and requirements. To document expenditures related to the 30/30/10 requirement within the Local MCH (LMCH) program and to record expenditures by the types of individuals served, the LMCH program has specific assurances and requirements for agencies to allocate and record expenditures in the Electronic Grants Administration & Management System (EGrAMS). The LMCH Year End Report also has one table to capture the types of individuals served and another table that mirrors the federal reporting of the MCH Types of Services. The FY 2023 budget project titles in EGrAMS were “MCH–Children” and “MCH–All Other.”

For the 30% children requirement, Michigan tracks related expenditures at the state and local level including immunizations for children and adolescents, oral health services for school-age children, family planning and reproductive health for adolescents and young adults, teen pregnancy prevention and parenting support, childhood lead poisoning prevention and case management, bullying prevention, special projects such as services for children with FASD, and other LMCH activities. For the 30% CSHCN requirement, Michigan tracks expenditures paid to providers for medical care and treatment billed through CHAMPS. Also, local health department care coordination expenditures for CSHCN are part of the Comprehensive Agreement for LHDs which include care coordination, CSHCS Medicaid Elevated Blood Lead Case Management, CSHCS Medicaid Outreach, CSHCS Outreach and Advocacy, and CSHCS Vaccine Initiative.

Local MCH

Title V funding is allocated to each of the 45 local health departments (LHDs) in Michigan through the LMCH program. Each LHD receives a fixed amount of funds, with annual allocations ranging from $15,490 to $1,709,654. LMCH funds are available to support one or more of the Title V national and state performance measures plus locally identified needs. Each LHD completes a work plan for selected national, state and/or local performance measures. Activities and expenditures within the work plan are categorized by population characteristic. Expenditures are also reported on by the MCH Pyramid of Services.

Table 1 summarizes spending by LHDs in FY 2023 by the MCH Pyramid of Services (i.e., direct, enabling, and public health services and systems).

Table 1. LMCH Spending by MCH Pyramid of Services

Types of Services	FY 2023 Expended
1. Direct Services (sum of A, B, & C)	$1,514,037
A. Preventive and primary care services for pregnant women, women, mothers, and infants up to age one	$191,016
B. Preventive and primary care services for children 1-21	$1,242,953
C. Services for CSHCN	$80,068
2. Enabling Services	$3,430,296
3. Public Health Services and Systems (i.e., Infrastructure)	$1,714,384
Total (sum of lines 1, 2, & 3)	**$6,658,717**

For FY 2023, each LHD was encouraged to select one to two national or state performance measures and/or locally identified measures. All 45 LHDs chose at least one national performance measure or state performance measure[1]. Almost one third of LHDs selected a local performance measure.

In total, 9 LHDs chose one performance measure; 17 chose two performance measures; 10 chose three performance measures, 3 chose four performance measures; 4 chose five performance measures; and 2 chose six performance measures. Table 2 summarizes the number of LHDs expending funds in each performance measure, the amount expended, and the number of clients served.

Table 2. LMCH Spending by Performance Measure in FY 2023

Performance Measure	Number of LHDs selecting	Amount Expended	Number of Clients Served
NPM 2 (Low-risk Cesarean Delivery)	0	$0	0
NPM 4 (Breastfeeding)	19	$779,098	5,276
NPM 5 (Safe Sleep)	13	$822,358	16,412
NPM 9 (Bullying Prevention)	0	$0	0
NPM 12 (Transition)	2	$20,000	189
NPM 13 (Preventive Dental Visit)	4	$167,978	15,221
SPM 1 (Lead Poisoning Prevention)	13	$812,058	11,467
SPM 2 (Children Immunizations)	17	$778,969	31,534
SPM 3 (Adolescent Immunizations)	11	$573,141	38,744
SPM 4 (Medical Care and Treatment for CSHCN)	4	$209,578	491
SPM 5 (Intended Pregnancy)	3	$130,584	1,393
SPM 6 (Behavioral/mental Health)	6	$265,007	2,883
Local Performance Measure defined by Local Health Department (See Table 3 for details)	16	$2,099,946	75,275
Total		**$6,658,717**	**198,885**

As noted in the table above, 16 LHDs chose a local performance measure. The priority areas for those locally defined measures are highlighted in Table 3.

Table 3. Local Priority Area for LHDs Selecting a Local Performance Measure

Local Priority	Expenditures
Adolescent well visit (2 LHDs)	$45,862
Adverse Childhood Experiences	$20,989
Car seat safety	$3,000
Childbirth education (2 LHDs)	$19,439
Community Health Needs Assessment (4 LHDs)	$302,371
COVID-19 vaccination in pregnancy	$5,701
FIMR (2 LHDs)	$256,126
Health education in schools (physical activity, obesity prevention, reproductive health topics); Menstrual product distribution	$46,590
Health Equity	$30,400
Healthy Family America (gap-filling support)	$136,746
Hearing and Vision (3 LHDs)	$373,247
Linking families to resources (telephone call line)	$411,599
Peer to Peer pregnancy mentoring program (2 LHDs)	$437,876
Tobacco treatment services	$10,000
TOTAL	$2,099,946

Payer of Last Resort

Michigan supports Title V regulations to use Title V funds as the payer of last resort. The comprehensive contract for each local health department includes contractual language which emphasizes this payment structure for programs that provide direct or enabling services to individuals such as LMCH, lead poisoning prevention, immunizations, oral health, and CSHCS programs. The remaining Title V funds are used for systems-level work in infrastructure or related to the ten essential services, which are non-claims related reimbursement.

[1] Michigan is retaining use of the prior NPM and SPM numbering system through the FY 2025 application cycle, for administrative purposes and continuity in the current five-year cycle (FY 2021-FY 2025).

III.D.2. Budget

Together with state general funds and other federal funds, the Title V MCH block grant is used to address the state's MCH priority needs, improve performance related to the targeted MCH outcomes, and expand systems of care for the MCH and CSHCN populations. The Title V state action plan narrative includes information on how Title V funding is utilized within each population domain. Michigan's Title V Leadership Team, which includes the Title V MCH director, Title V CSHCN director, and key Title V administrative staff, meets on a regular basis to discuss all aspects of Title V, including the budget and how federal and non-federal funds are used to address the state's MCH needs.

The estimated FY 2025 budget amount of $19,132,100 is based on the Federal Fiscal Year (FFY) 2022 award amount. In FY 2025, Michigan will also spend down any unspent funds (i.e., carryover) from the FFY 2024 federal award as allowable by Section 503(b) of the Title V legislation.

Based on the estimated federal award and the state's Executive Budget recommendation, Title V funding is projected to be used for the following MCH appropriations in FY 2025:

- Local MCH Program (Local Health Departments)
- Medical Care and Treatment for CSHCN
- Family Planning Local Agreements
- Childhood Lead Poisoning Prevention Program
- Immunization Program
- Oral Health Programs for Children
- Sudden Infant Death Syndrome Prevention
- Pregnancy Prevention Services
- Bequests for Care and Services for CSHCN
- Administration
- MCH Special Projects (including FASD, breastfeeding, bullying prevention, regional perinatal quality collaboratives, Handle with Care, and needs assessment)

The largest amounts of Title V funding support the Local MCH Program (~36% of funding is awarded to Local Health Departments through non-competitive contracts) and Medical Care and Treatment for CSHCN (~36% of funding). The remaining Title V funding (~28%) is used for the programs and services listed above which impact all five Title V population domains.

As previously discussed, Michigan's 2020 Title V needs assessment identified a set of state priority needs and performance measures. Through state level work and/or local health department activities, it is anticipated that Title V appropriations will support activities related to federally defined National Performance Measures[1] (NPMs) in FY 2025:

- NPM 2 (Low-risk Cesarean Delivery)
- NPM 4 (Breastfeeding)
- NPM 5 (Safe Sleep)
- NPM 9 (Bullying Prevention)
- NPM 12 (Health Care Transition for CYSHCN)
- NPM 13 (Preventive Dental Visit)

The annual LMCH Plans for FY 2025 are not available at the writing of this application. In FY 2024, Local Health Departments (LHDs) selected NPMs 4, 5, 12 and 13. In FY 2021, the format of the LMCH plan and workplan

changed to better align with federal Title V requirements. Technical assistance through webinars, learning labs and sample workplans was offered to all LHDs to provide ideas and examples on how LHDs might operationalize activities to address these measures. The 30/30/10 requirement was emphasized because LHDs, which collectively receive over one-third of Title V funding, contribute to meeting the 30% children 1-21 requirement.

At the state and local level, Title V funds will also be used to directly support the work of Michigan's six State Performance Measures (SPMs):

- SPM 1 (Childhood Lead Poisoning Prevention)
- SPM 2 (Immunizations—Children)
- SPM 3 (Immunizations—Adolescents)
- SPM 4 (Medical Care and Treatment for CSHCN)
- SPM 5 (Intended Pregnancy)
- SPM 6 (Developmental, Behavioral, and Mental Health)

All state-based SPM program areas have allocations in the FY 2025 Title V budget. The programs and activities that will support work on the above NPMs and SPMs in FY 2025 are detailed in the Title V state action plans. Although FY 2025 LMCH plans are not yet available, it is anticipated that local health departments will also implement work across all SPMs, based on current FY 2024 LMCH plans. LHDs use a Community Health Needs Assessment to inform the creation of FY 2025 LMCH plans, including a focus on the state's identified NPMs and SPMs as well as locally identified priorities and needs.

30/30/10 Requirement

Michigan's commitment to adhere to the 30/30/10 Title V legislative requirement was discussed in the preceding Expenditures section. For FY 2025, 33.5% of the total Title V budget is designated for preventive and primary care for children; 36.6% is designated for Children with Special Health Care Needs; and 3.5% is designated for administrative costs. Title V leadership will hold discussions throughout the fiscal year (in coordination with the MDHHS Budget Division) to assure that the budget and spending are on track, and to address any new or unplanned MCH needs.

State Match

MDHHS meets and monitors the required Title V state match which is a $3 match in non-federal funds for every $4 of federal Title V funds expended. Michigan exceeds the required match in expenditures and budgeting. Michigan's state match is composed of state general funds for the following appropriations: medical care and treatment for CSHCN; Family Planning local agreements; prenatal care and outreach (which includes infant safe sleep, infant mortality, and home visiting activities); pregnancy prevention services (which includes the Michigan Adolescent Pregnancy and Parenting Program); CSHCS and Family, Maternal and Child Health administration; and bequests for care and services. Approximately 80% of the "State MCH Funds" are related to medical care and treatment for CSHCN and other CSHCS-related funds. Along with other federal funds, these state MCH dollars provide a critical component of Michigan's MCH infrastructure.

Types of Services and Individuals Served

Each year, Michigan's Title V administrative staff also completes an assessment of "Types of Individuals Served" and "Types of Services" provided by Title V funding at the state and local level.

For example, Title V funding supports the Local Maternal Child Health Program. The LMCH Plan was transformed in

2021 to align more closely with Title V reporting. The LMCH ‘Count and Allocation’ table was further revised for FY 2024 by adding a population measure to track expenditures intended to impact the health and wellness of children 1-21. LHDs are required to report types of individuals served and amount expended by population classifications. Additionally, LHDs are required to report expenditures as identified in the Title V MCH Pyramid of Services (i.e., direct services, enabling services, and public health services and systems) in a “Types of Services” table.

At the state level, Title V funding is budgeted across MCH population groups and is in alignment with the 30-30-10 rule. For example, Title V allocations that address Bullying Prevention, Oral Health for Children, Childhood Lead Poisoning Prevention, and Immunizations for Children and Adolescents contribute to the 30% requirement for primary and preventative services for children 1-21. Medical care and treatment for CSHCN supports the 30% requirement for CSHCN. For state level activities, Title V allocations are assessed to determine where activities fall in the MCH Pyramid of Services.

[1] Michigan is retaining use of the prior NPM and SPM numbering system through the FY 2025 application cycle, for administrative purposes and continuity in the current five-year cycle (FY 2021-FY 2025).

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Michigan

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Partnership and Leadership Roles

MDHHS has a longstanding history that aligns with the Title V goal to "promote and improve the health and well-being of the nation's mothers and children, including children with special needs, and their families." The Title V program is administered by the Division of Maternal and Infant Health (DMIH), which is housed in the Bureau of Health and Wellness within the Public Health Administration. The Children's Special Health Care Services (CSHCS) Division serves as the Title V CSHCN program. CSHCS is housed in the Bureau of Medicaid Care Management and Customer Service within the Behavioral and Physical Health and Aging Services Administration (BPHASA). The Title V leadership team includes the Title V MCH director, the Title V CSHCN director, the Child and Adolescent Health (CAH) Division director, and the Title V coordinator. A Title V steering committee includes managers and program staff who represent each of Michigan's national and state performance measures. Title V activities and services in Michigan align with Title V national goals of:

- Assuring access to quality MCH services for mothers and children, especially those with low incomes or limited availability of care.
- Reducing infant mortality.
- Providing access to prenatal, delivery, and postnatal care to women, especially pregnant people, who are low income and at-risk.
- Providing regular screenings and follow-up diagnostic and treatment services for children.
- Providing access to preventive and primary care services for children who are low income and rehabilitative services for children with special health needs.
- Implementing family-centered, community-based, systems of coordinated care for children with special health care needs.

To achieve these and other MCH goals, Michigan's MCH programs serve as coordinators and conveners of initiatives and partnerships that support and guide the MCH work. As discussed throughout this application, many recent and current initiatives have focused on health equity as an urgent and core driver of MCH work. MCH program areas have convened or contributed to much of this work for initiatives that impact the MCH population. For example, the DMIH hosts quarterly Mother Infant Health and Equity Collaborative (MIHEC) meetings, which have been held virtually since March 2020. The purpose of the MIHEC is to convene cross-sector stakeholders, community members, and families in group discussion and sharing to align maternal and infant health goals and strategies, facilitate collaboration and networking, and provide guidance on achieving health equity.

MCH program areas within MDHHS also coordinate and/or partner with the Michigan Alliance for Innovation in Maternal Health, Maternal Infant Health Summit, Michigan Oral Health Coalition, Safe Sleep Advisory Council, Michigan Home Visiting Advisory, Michigan Home Visiting Annual Conference, Michigan Breastfeeding Network, Child & Adolescent Health Advisory, Michigan Model for Health State Steering Committee, and many other program-specific initiatives. The DMIH also funds and coordinates the Michigan Perinatal Quality Collaborative comprised of Regional Perinatal Quality Collaboratives. The Division of Child and Adolescent Health provides funding and oversight to the state's Child and Adolescent Health Centers and oversees comprehensive school health education through its regional school health network. CSHCS provides leadership and coordination for the CSHCS Advisory Committee (CAC). The CAC is comprised of professionals and family members involved in the care of children with special needs. The CAC makes policy recommendations and promotes public awareness of CSHCS.

The Family Center is the statewide parent-directed center within the Children's Special Health Care Services

Division. Its mission is to support and connect Michigan families of CYSHCN, provide family-centered leadership throughout Michigan's healthcare settings, and partner in decision-making within the systems of care for CYSHCN. All employees of the Family Center must have experience as a parent or caregiver of a child with special health care needs. Before FY 2023, all Family Center staff were contract employees through a partnership with SEMHA. In FY 2023, a new Family Center section manager was hired as a state employee and all other positions will be shifting to civil service positions moving forward. This represents a significant investment to embed patient and family voices in state government and the CSHCS program. The Family Center contributes to CSHCS programs and policies; supports the statewide Parent-to-Parent Network; maintains the statewide Family Leadership Network; and administers the Family Phone Line, which provides support and information to families of children with special health care needs.

The CSHCS Division Director, who is also the Title V CSHCN Director, is a member of the Michigan Developmental Disabilities Council, representing Title V. The mission of the Developmental Disabilities Council is "to support people with developmental disabilities to achieve life dreams." The CSHCS Division Director ensures that the activities and efforts of the Developmental Disabilities Council are not exclusively focused on adults with developmental disabilities but are also responsive to the needs of children and youth with developmental disabilities and their families. The Developmental Disabilities Council is comprised of 21 members who are appointed by the governor. Members include people with disabilities; family members and advocates of people with disabilities; and representatives from state and local agencies that serve people with developmental disabilities.

In addition to these initiatives, the Title V program works with a broad range of partners including community health service systems, such as local public health; Federally Qualified Health Centers; the private sector; managed care plans; community-based organizations; MCH advocates; faith-based organizations; schools; and universities. Within MDHHS, program and policy activities are coordinated with Medicaid, behavioral health and substance use, chronic disease, communicable disease, injury prevention, child welfare, public health preparedness and others.

Across population domains, many of Michigan's MCH and Title V programs work collaboratively with MDHHS behavioral health partners. Several of those partnerships are described throughout this application. In March 2022, MDHHS announced a behavioral health restructuring to support services across community-based, residential, and school locations. The changes are intended to benefit people of all ages; to prioritize addressing the needs of children and their families; to streamline and coordinate resources; and to improve policies and processes to make them more effective. Additional information about the restructuring is included in the Cross-cutting/Systems Building state action plan.

Title V Framework

Michigan's Title V program recognizes that a wide range of factors shape health outcomes, including health and social context. Therefore, efforts to achieve optimum health for all Michigan families require developing and applying a health equity lens; recognizing and addressing the impact of social determinants of health; implementing evidence-based programs and promising practice programs and interventions; addressing behavioral and physical health; focusing on outcomes; and engaging families and consumers. Michigan's Title V five-year needs assessment (completed in 2020) identified three broad and overarching drivers of health outcomes and system effectiveness across all five Title V population domains. These were recognized as Title V "pillars" as follows:

1. Build capacity to *achieve equitable health outcomes* by understanding and addressing the role of implicit bias and macro-level forces such as racism, gender discrimination, and environmental degradation, on the health of women, infants, children, adolescents, and children with special health care needs.
2. Intentionally and routinely find opportunities to *seek the knowledge and expertise of communities and*

families in all levels of decision-making to build trust and create policies and programs that align with family and community needs.

3. *Deliver culturally, linguistically, and age-appropriate health education* that reflects customer feedback, effectively uses technology, and reaches multiple audiences.

These Title V pillars support the goals of Title V and have been used to inform NPM and SPM state action plans and other Title V activities. For example, the FY 2021 ongoing Title V needs assessment included a review of NPM and SPM state action plans using a health equity rubric, with the goal to further strengthen health equity strategies within plans. The FY 2022 ongoing needs assessment included a review of state action plans using a family and community engagement rubric. For both reviews, program staff were provided with feedback on strengths, potential strategies for improvement, and information on research and best practices (e.g., white papers, data briefs, federal or state guidance).

Ongoing MCH projects beyond Title V have also begun to incorporate social determinants of health and geographic measures of inequity, such as the Concentrated Disadvantage Index (CDI) and Social Vulnerability Index (SVI) to better target program resources to marginalized communities with high degrees of need across the life course, but especially for maternal and child health. For example, CDI data was used to inform identification of sites in need of home visiting programs and SVI data was applied to Michigan's COVID-19 response. MDHHS also released Phase I of the 2022-2024 MDHHS Social Determinants of Health (SDOH) Strategy, entitled *Michigan's Roadmap to Healthy Communities*, in April 2022. The document states, "MDHHS will continue to administer and support SDOH efforts in all domains; however, a focused effort on health equity, housing stability, and food security will allow Michigan to align efforts at the state, local, and community level for a greater impact as well as allow for more in-depth policy and program review" (p. 4). In January 2023, Phase II was released, entitled *Michigan's Roadmap to Healthy Communities Phase II: The Holistic Phase*. According to the document, "Phase II of the SDOH Strategy focuses on four structural interventions to positively support the social drivers of health, including Community Information Exchange, Community Health Workers, a SDOH Accelerator Plan to Reduce Chronic Disease Social Drivers, and partnerships to advance health equity. These interventions serve as 'vehicles' to drive this work forward and promote equity in opportunity" (p. 4). In January 2024, *Michigan's Roadmap to Healthy Communities Phase III: The Innovation Phase*, was released. Phase III "will launch innovative SDOH Hubs, piloting the infrastructure needed for meaningful collaboration to better identify, understand, and address the root causes of health inequities. Its implementation will also support Health in All Policies multi-sectoral initiatives and build on health equity partnerships to close the gap in health disparities" (p. 6).

The life course model, which emphasizes that early life experiences have a lasting impact on health and development, is also recognized by the Title V program. While each MCH program area concentrates on its respective stage of the life course, programs also coordinate with and complement adjacent life stages. As discussed throughout this application, MCH programs work with an array of partners across state and local systems, including early childhood, behavioral health, child welfare, Medicaid, and local health departments.

Foundation for Family and Community Health

The Title V program's commitment to the MCH population is broad-based and aligns with the MDHHS vision to "Deliver health and opportunity to all Michiganders, reducing intergenerational poverty and promoting health equity." The Title V program also supports several of the department's strategic priorities, which include investing in public health; improving maternal and infant health and reducing outcome disparities; reducing childhood lead exposure; expanding safety nets; addressing social determinants of health; reducing opioid and drug-related deaths; and utilizing evidence-based solutions.

The public health functions of assessment, policy development, and assurance are shared between MDHHS and local health departments. Legal and legislative requirements support quality services through codification (the Michigan Public Health Code) and MCH fiscal obligations are supported through the annual budget process. The Title V program supports coordinated, comprehensive systems of care at the state and local levels, as described in the Health Care Delivery System section. The creation of MDHHS in 2015, which resulted from a merger of the Departments of Community Health and Human Services, reflects the state's commitment to effective, customer-focused systems that support physical and behavioral health and safety.

The state's MCH efforts utilize research and evidence-based practices and rely on the national care standards from the American College of Obstetrics and Gynecology, American Academy of Pediatrics, American Dental Association, the Centers for Disease Control and Prevention, and others. Our commitment to continuous quality improvement is reflected in the monitoring of population data; investigation of and response to emerging health issues, such as the COVID-19 pandemic and outbreaks of Hepatitis A and measles; and education and empowerment around public health issues such as infant safe sleep, breastfeeding, and immunizations. To assure assessment across population groups, especially those negatively impacted by health and social disparities, monitoring of subpopulation groups is conducted to capture data by geography, race, ethnicity, age, and other demographics. The MCH program also recommends and develops policy; promotes best practices and service models among local public health and clinical care systems; advocates for increased capacity within communities to provide high quality, accessible, culturally competent services; and supports the MCH workforce.

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

A strong workforce is the backbone of public health. To best serve the MCH population, the Title V and public health workforce must include personnel with MCH subject expertise and strong program leadership. Michigan's MCH programs include a range of personnel, including public health consultants, epidemiologists, departmental specialists, program managers, and division directors who carry out the state's MCH work. Additional information related to the MCH workforce is included in the prior year's Needs Assessment Update and the 2020 Five-Year Needs Assessment.

Title V and MCH Staff

A core group of MDHHS staff work on Title V as well as other MCH programs and initiatives. Key positions that support Title V include the following:

- **Director, Division of Maternal and Infant Health**, serves as Title V MCH director and leads other key maternal and infant health programs including Title X Family Planning, Maternal Infant Health Program, Early Hearing Detection and Intervention, infant safe sleep, and the Michigan Perinatal Quality Collaborative.
- **Director, Children's Special Health Care Services Division,** serves as Title V CSHCN director and provides oversight for the CSHCS program and policy, customer support, quality improvement, contract management, and the Children with Special Needs Fund.
- **CSHCS Family Center for Children and Youth with Special Health Care Needs, Section Manager,** leads a statewide comprehensive family resource center utilizing a family-centered care model, in which all Family Center staff are parents of a child(ren) with a special health care need.
- **Director, Division of Child and Adolescent Health,** provides leadership for programs and services related to child, adolescent, and school-based health; early childhood; teen pregnancy prevention and teen parent support; home visiting; the Title V local MCH (LMCH) program; and oral health.
- **CSHCS Policy and Program Development Section Manager**, provides oversight to staff responsible for policy, health care transition services, specialty clinics, contracts, insurance premium payment program, and billing assistance.
- **CSHCS Transition Specialist**, provides resources and technical assistance to families, providers, local health departments, and Medicaid Health Plans to help adolescents transition from pediatric to adult health care.
- **Title V MCH Block Grant Coordinator,** coordinates all activities related to the Title V block grant, including oversight of grant application and annual reporting activities across the department.
- **LMCH Nurse Consultant and LMCH Program Coordinator,** two positions that provide oversight, contract management, and technical assistance to the Local MCH (LMCH) program which administers Title V funding to all 45 local health departments (LHDs).
- **MCH Epidemiology Section Manager**, manages several MCH epidemiology staff and provides epidemiologic analysis and interpretation to inform and guide MCH program leaders and policy makers about population health.
- **Child, Adolescent & School Health (CASH) Epidemiologist,** provides epidemiological and data support to child, adolescent and school health programs along with support to the Title V program, including needs assessment activities and annual reporting.

Four of these positions are currently supported by Title V funding to provide administrative support to the Title V block grant. The LMCH nurse consultant and LMCH program coordinator are the only administrative positions fully funded by Title V. The block grant coordinator and CASH epidemiologist are supported through blended funding

(e.g., Title V, state general funds, other federal funds) as the positions have responsibilities in addition to Title V.

Title V funding is also used for MCH and CSHCN programmatic positions. Title V supports an Oral Health Coordinator assigned to Detroit Public Schools, two nurse consultants for the Childhood Lead Poisoning Prevention Program, part of an Oral Health epidemiology position, part of a Home Visiting epidemiology position, and staffing for the Family Center. Title V funding also supports epidemiology staff who oversee Michigan's PRAMS.

Many other MCH staff, including managers, program staff, epidemiologists, public health consultants, and budget and contract specialists, support Title V activities and implementation of Title V state action plans as part of their broader work, but without Title V funding for state-level staffing. Local health departments can also use Title V funding to support critical MCH positions in their community (e.g., public health nurse, health educator, epidemiologist).

MDHHS Hiring Practices

To help the workforce deliver services that are informed by equity-related knowledge and practices, MDHHS developed the Diversity, Equity, and Inclusion (DEI) Plan recognizing that a "diverse workforce will be an essential asset for developing and providing health and human services that are culturally proficient to address existing and emerging health and social issues." MDHHS launched mandatory "Introduction to Health Equity" and "Systemic Racism" online trainings in 2019 for all staff. In 2021, MDHHS implemented a new requirement that all MDHHS position postings include a Valuing Diversity and Inclusion competency in the posting questions as well as a standard set of DEI interview questions. All interview panelists must complete a "Countering Bias in the Interview" training prior to participating in an interview panel, and a standard scoring rubric is used to assess candidates' DEI responses. In 2022, the MDHHS DEI Council's Recruitment, Hiring and Retention Action team introduced the MDHHS Toolkit for Managers: *Recruiting, Hiring, and Retaining a Diverse and Inclusive Workforce*. The toolkit provides practical information, tips, and resources for integrating DEI into hiring and retention processes. The toolkit is available for all managerial levels and work areas. To recruit and retain qualified staff, MCH programs work with MDHHS Human Resources to post positions through the State of Michigan job postings website in addition to MCH listservs.

Training and Professional Development for MCH Staff and Partners

Opportunities and training needs for Title V and MCH program staff, including family leaders from the Family Center, are continuously assessed to identify areas for professional development. Many staff development activities have built upon core concepts introduced through the Health Equity Learning Labs and Guiding NEAR (neuroscience, epigenetics, ACEs and resilience) trainings that began in 2018. The Learning Labs focused on health equity education and how to assess policies, programs, and hiring practices through a health equity lens. Several MCH equity initiatives have grown out of those initial trainings, as discussed below. MCH program areas also provide a wide range of training and workforce development opportunities for state and local MCH partners.

Maternal and Infant Health

As Michigan's Title V MCH lead, the Division of Maternal and Infant Health (DMIH) provides training, technical assistance, and workforce development activities to support the MCH workforce and health equity. Activities include the following:

- On-demand trainings and resources are available on the DMIH webpage for use by anyone visiting the website (e.g., internal staff, partner networks, community members).
- Training and consultation to the MCH workforce in local communities occurs through Regional Perinatal Quality Collaboratives (RPQCs). RPQCs are required to address health inequities, the social determinants of

health and disparate outcomes. RPQCs provide opportunities for robust discussions and trainings during Collaborative meetings or through funding support for members to attend other training opportunities.

- The Breastfeeding and Infant Safe Sleep Programs partnered with the WIC Division and the Division of Child and Adolescent Health to create an online breastfeeding course for MCH professionals that presents breastfeeding rates, disparities, and the systemic causes behind them; identifies health benefits; and shares best practices and resources to promote breastfeeding. The course has been promoted through a variety of MDHHS partners and email lists. As of December 31, 2023, nearly 200 individuals have completed the course.
- Quarterly Mother Infant Health and Equity Collaborative Meetings create a space that fosters learning, the elevation of community-driven solutions, and collaboration aimed at achieving equity. Meetings uplift community projects and initiatives by providing an opportunity for organizations to share their work with a broader audience, ensuring that multi-sector partners have a space to work together to address upstream inequities and to identify opportunities to collaborate, build on successes, or replicate the models. Between November 2022 and November 2023, five virtual MIHEC meetings were held, with a total of 744 attendees.
- Maternal Infant Health and Equity Updates are shared on a regular basis (at least twice monthly) via a listserv that is distributed to over 47,000 primary contacts and an additional 2,000 individuals through secondary sharing by MDHHS programs and professional organizations. The listserv reaches a broad array of state and local partners, including practitioners and parents. Additionally, the listserv offers another opportunity to uplift community-driven solutions, by including updates on innovative projects and initiatives from across Michigan and highlighting opportunities to collaborate.
- In April 2023, MDHHS hosted two Public Health Nursing 101 Conferences in Livonia and Gaylord, MI with 126 total participants. The conference was intended for nurses in their first three years of public health nursing practice. Participants attended six sessions, including The History of Public Health Nursing, The Expansive Public Health Landscape and Scope, Promoting Vaccine Confidence, a Public Health Nursing Leaders Panel Discussion, Protecting Ourselves, and Workplace Harmony & Conflict Communication. The conference was well received and will be repeated in Livonia and Gaylord in April 2024.
- In 2024, DMIH is partnering with the Michigan Alliance for Innovation on Maternal Health to educate Michigan health care providers and maternal infant health stakeholders on the urgent maternal warning signs. Educational materials and trainings will be provided to help birthing persons, their support persons, and providers to identify the signs and symptoms of severe maternal events that could lead to complications and/or death. “Badge buddies” were created with information about the warning signs and links to materials that help patients communicate with medical professionals about their condition. Badge buddies will be distributed statewide to health care providers, hospital staff, local health departments, doulas, home visitors and others.
- The MDHHS Michigan Maternal Mortality Surveillance (MMMS) program has partnered with the Michigan Alliance for Innovation on Maternal Health (MI AIM) to coordinate Maternal Mortality Review Committee recommendations with MI AIM initiatives to ensure alignment. The MMMS program and MI AIM are partnering to disseminate the National AIM badge buddies to WIC, home visitors, healthcare providers, and local health departments. Additionally, MI AIM resources are available on the Michigan Hear Her Campaign website.

Since its inception in 2018, the Maternal Infant Health Summit has centered its keynote and breakout sessions on health equity. The conference provides a unique opportunity for multidisciplinary collaboration, convening national and statewide stakeholders working to improve maternal, infant, and family health. The inclusive opportunity provides a stage to exchange innovative ideas and stories, while uplifting families and communities as changemakers and leaders. For example, the 2021 and 2022 Summits included presentations on Advancing Black Maternal Health, Rights and Justice, Integrated Infant Mental Health, Birth Justice, the Role of Doula and Midwifery Care, and Using

Your Power and Privilege. Over 600 attendees participated in both the 2021 and 2022 Summits.

In 2023 the Summit was held in-person for the first time in three years and sold out with over 650 attendees. The theme was “Taking Action Today for an Equitable Tomorrow.” Presenters focused on actionable solutions to maternal infant health’s most pressing concerns. Keynote speakers presented on health equity, disparities in birth outcomes, inclusivity, structural racism, and implicit bias, which were suggested topics from the previous year’s attendees. In support of Michigan’s Medicaid coverage of doula services, the Summit highlighted the importance of doula services and provided continuing education for doulas. The event also incorporated a networking event for doulas to better understand the needs of the community and the doula workforce. To further uplift Michigan’s community-based organizations, each keynote was introduced by a local organization doing similar work in their community, to introduce their projects and describe how they are making a difference.

The theme for the 2024 Summit, *Advancing Healthy Births: From Stories to Action,* will build on the successes of the past several years. It will integrate elements of storytelling to illuminate how systems of oppression perpetuate inequities; illustrate the strength and resilience of historically marginalized communities; and move attendees to create meaningful action. The Summit will also highlight Michigan’s new *Advancing Healthy Births* plan.

The MDHHS Doula Initiative formed in late 2022 to support Michigan’s Medicaid policy reimbursing for doula services, increase the doula network in Michigan, and support doulas, families, and partners to prioritize and expand doula service access. As part of the initiative, a Michigan Doula Advisory Council formed to guide the doula initiative and advise on doula related activities. A Michigan Doula Registry was created to confirm that a doula wanting to enroll in Medicaid had completed one of the MDHHS approved doula trainings. As of January 2024, 303 doulas are on the registry and 185 doulas have been enrolled in Medicaid. The Doula Initiative also sponsored doula trainings to expand the doula workforce and trained an estimated 250 new doulas in 2023 via 11 trainings.

Children with Special Health Care Needs

The CSHCS Division, which serves as Michigan’s Title V CSHCN lead, established a Health Equity Workforce Development Committee which produces a monthly virtual bulletin board for state and local CSHCS staff. The virtual bulletin board content includes diagnoses that CSHCS families live with and through every day; disparities that different communities face; and awareness days to honor and acknowledge different cultures and health conditions. The virtual bulletin board is shared with LHD CSHCS partners across the state.

In FY 2022, CSHCS participated in Boston University’s Care Coordination Academy which provided the opportunity to learn about care coordination best practices and the use of evidence to measure system improvements. The CSHCS team included CSHCS and Medicaid staff as well as family, LHD, and university partners. The focus of the project is children with medical complexities.

Building upon Michigan’s participation in the Care Coordination Academy and the work around children with medical complexity, CSHCS was invited in FY 2023 to participate in Project ACCELERATE (**A**dvancing **C**are **C**oordination *through* **E**vidence; **L**everaging **E**xisting **R**elationships **A**round **T**ransforming Practic**E**). The project teams included MCH Title V Directors, Medicaid Medical Directors, and patient advocates. The project included the review of the latest Patient-Centered Outcomes Research Institute (PCORI) supported findings for enhanced care coordination for CYSHCN.

In part due to past participation in the above projects, CSHCS was invited to participate in the National Center for a System of Services for CYSHCN Phase 1 Pilot Learning Collaborative to help inform and develop the Blueprint Implementation Roadmap. The CSHCS team will participate in testing innovations and strategies related to the systems of care for CYSHCN. In addition, team members will learn from other states about innovative ways to

implement the *Blueprint for Change*.

Child and Adolescent Health

The Division of Child & Adolescent Health (DCAH) also serves an important role within Michigan's Title V program. Training, professional development, and other activities that support the MCH workforce include the following:

- The DCAH convened a Diversity, Equity, and Inclusion (DEI) Committee starting in April 2023, composed of 17 members. The DEI committee has created an operating agreement; worked to establish trusting relationships and to identify a common vision and purpose; conducted a Division-wide DEI survey to document the diversity within the Division; and updated the Committee membership based on survey results. The Committee is now building a key driver diagram to guide future QI projects, has offered Lunch & Conversation sessions about pronoun use, and will host a Book Club.
- The DCAH provides technical assistance and program support to all 45 local health departments through the Local MCH (LMCH) program. Support ranges from administrative aide in implementing the LMCH program to identification of best practices for specific MCH program areas or performance measures.
- The FY 2023 state budget included an additional $25 million to start up to 100 school based/linked health centers (Child & Adolescent Health Centers) in new and existing counties in Michigan. These additional dollars support primary care, nursing and mental health services in new schools and community locations. The FY 2024 budget included $45 million in one-time dollars to fund construction and renovations in existing CAHC sites as well as fund an IT infrastructure project. DCAH provides support and technical assistance to these centers across the state.
- In FY 2024 funds were allocated to support a home visiting system professional development coordinator to support local and state needs, enhancing the quality of home visiting programs. Michigan updated the Home Visiting system Core Knowledge Framework and is working to utilize the core knowledge areas as the framework for training and professional development activities across the state.
- DCAH works with Behavioral Health to provide Early Childhood Mental Health Consultation to home visiting programs across the state to support staff who work with families impacted by the child welfare system and/or substance use, who have experienced trauma, and who are experiencing mental health challenges.
- As part of efforts to support families living in rural areas, beginning in January 2024 DCAH will partner with the University of Michigan School of Social Work to develop and pilot a user guide for home visitors to introduce app-based Cognitive Behavioral Therapy for women who have given birth and are experiencing low mood or depression. The app is not designed to replace mental health services but is a tool home visitors could use to support women who have self-identified or screened as having low-mood or mild depression.
- A staff person from DCAH is one of eight individuals from Michigan participating in the Region V Public Health Leadership Institute 2024 cohort. The other participants are from local health departments, Michigan Medicine, University of Michigan School of Public Health, University of Michigan Preventive Medicine Residency and Corktown Health Detroit.

MCH staff also participate in a wide range of conferences and professional development opportunities. For example, MDHHS hosts conferences attended by MCH staff and statewide partners, including the Child, Adolescent, School Health (CASH) Conference, Michigan Home Visiting Conference, Maternal Infant Health Summit, and Teen Parent Summit. MCH staff participate in the Mother Infant Health and Equity Collaborative (MIHEC). An MCH team from Michigan (including a family leader) participates in the annual AMCHP conference. The Family Center hosts an annual meeting for the Family Leadership Network (FLN). Each year, the CSHCS Division also invites a parent to attend a CSHCS Division meeting to share their family's story with staff, which is a powerful way for staff to see the impact of their work. CSHCS provides regular workforce development opportunities for LHDs through annual

meetings, regular technical assistance, monthly calls, and the CSHCS LHD Advisory Council. In response to significant turnover in local health department CSHCS staff, due in part to the COVID-19 pandemic, CSHCS developed and is implementing a series of peer-led training sessions for new local staff to learn from more experienced local staff on various program implementation topics.

Staffing Structures and Workforce Financing

Michigan utilizes innovative financing mechanisms to support administrative and program staff who work on a variety of MCH initiatives. For example, administrative match is leveraged for state staff working on Medicaid-financed programs including the Child and Adolescent Health Centers (CAHCs), Local Health Department Medicaid Outreach, Oral Health, and Maternal Infant Health Program. Shared positions between MDHHS and MDE have enabled a funding structure to support staff that benefit both agencies including Michigan's State School Nurse Consultant and a state-level Mental Health Consultant. MCH funding also supports epidemiology staff who are housed in the Bureau of Epidemiology and Population Health but directly support and work with MCH programs.

The Family Center for Children and Youth with Special Health Care Needs (Family Center) utilizes an innovative staffing structure. The Family Center requires that all staff hired within the Family Center are parents of children with special health care needs. In addition, the Family Center has a paid Youth Consultant which improves the Family Center's ability to provide a family and youth perspective to CSHCS programming. In FY 2024, the Family Center section manager is participating in the MCH Leadership Lab Family Leaders Cohort. The Leadership Lab provides an opportunity for state staff to accelerate their professional development in a way that is framed by MCH Leadership Competencies and guided by adult learning principles.

Lastly, MDHHS has a unique partnership with the Michigan Public Health Institute (MPHI). MPHI is a non-profit corporation established by Public Act 264 of 1989 to advance health in the state. Services include assessment and planning, project management, program development, evaluation, and research. Several of Michigan's MCH programs work closely with MPHI, especially through the Center for Healthy Communities and the Center for Health Equity Practice. Projects have included the 2020 Title V needs assessment, the 2020 Maternal Infant Early Childhood Home Visiting (MIECHV) needs assessment, the Preschool Development Grant Needs Assessment and Evaluation, the Early Childhood Comprehensive Systems Grant and Strategic Plan, Parent Leadership in State Government trainings, Health Equity Learning Labs, and home visiting evaluation. MPHI also partners with CSHCS and the Family Center to host online education modules for transition and parent mentor trainings. More broadly, MDHHS partners with MPHI on public health projects which have included the State Innovation Model, the Local Public Health Accreditation Program, and the State Health Assessment/State Health Improvement Plan (the latter of which includes Title V representation).

MPHI has also worked with the Maternal Infant Health Program (MIHP) within the Division of Maternal and Infant health to develop intervention-based strategies for supporting families who may have experienced Adverse Childhood Experiences (ACEs). Known as the Preventing Adverse Childhood Experiences (PACE) initiative, it is focused on prevention through public education campaigns and incorporating ACEs into plans of care developed for families as well as training on ACEs and trauma-informed care for home visiting staff. A journey mapping evaluation commenced in January 2024 which includes interviews with families who have received PACE interventions as well as the home visiting staff who provided care. The MPHI team has funding to continue to support MIHP providers and agencies through 2024.

III.E.2.b.ii. Family Partnership

The importance of family and consumer partnership in MCH programs was highlighted across population domains during the Title V Five-Year Needs Assessment. Stakeholders identified the need to collaborate, partner, and seek advisement from clients, families, and communities to address needs and find solutions. This need was reflected in a newly established Title V pillar to "intentionally and routinely find opportunities to seek the knowledge and expertise of communities and families in all levels of decision-making to build trust and create policies and programs that align with family and community needs." Effective partnership includes respecting a person's culture, language, and history, and considering those factors in program development and service provision. Understanding unique family and community needs helps to improve trust, outcomes, and the elimination of service barriers.

Strategies to partner with families and clients are discussed within each Title V state action plan. Numerous committees, coalitions, and advisory boards across the MCH population domains support and inform programs and services, through elevating the voices of families, providers, and community members. These include the Children's Special Health Care Services Advisory Committee; Family Leadership Network; Michigan Maternal Mortality Surveillance Committee; Michigan Oral Health Coalition; and Regional Perinatal Quality Collaboratives. Additional examples include the following:

- The Michigan Early Hearing Detection & Intervention (EHDI) Program's goals are to provide better outcomes for Michigan newborns and young children with hearing loss and their families. EHDI utilizes the Michigan Hands and Voices (MHV) Guide By Your Side™ (GBYS) program to foster family-to-family supports after a child has been identified as Deaf or Hard of Hearing (D/HH). Families are connected with Parent Guides who have a child who is D/HH. Families may also choose to speak with an adult who is D/HH to learn through their lived experiences. Families are involved when updating EHDI materials, which are available in Spanish and Arabic. EHDI supported the creation of a video highlighting a family's experience and the importance of screening in the community birth setting. EHDI is currently redesigning the website to improve access to information. EHDI is partnering with MHV to host a Family Matters 2024 conference aimed at families with children who are D/HH. EHDI also sponsors an annual scholarship for a parent to attend the national EHDI conference.
- MDHHS provides funding to local health departments (LHDs) and the Inter-Tribal Council (ITC) of Michigan to develop and implement community-based infant safe sleep activities. Since FY 2023, contracts for LHDs and the ITC require that activities include input from families at highest risk for sleep-related infant death. Grantees are also required to participate in or coordinate a local/regional advisory team (that includes community members) to oversee their safe sleep efforts. Parents are often involved as parent educators and speakers. Additionally, MDHHS regularly partners with several parents with an infant loss, most recently via three family stories of sleep-related loss and the development of the *Family Stories of Sleep-Related Loss: A Facilitation Guide for Using their Digital Stories*.
- The Parent Leadership in State Government (PLISG) initiative is an interagency effort to recruit, train, and empower parents to be change agents who help shape programs and policies at the state and local level. When parents are engaged as partners and leaders, programs and services better meet family needs, make services more effective, increase fiscal responsiveness and lead to more equitable outcomes. Since 2007, several state agencies (including MDHHS) have collaboratively funded the PLISG. Title V funding supports the PLISG initiative on an annual basis. The PLISG Advisory Board includes representatives from funding agencies plus at least 51 percent parents of children ages birth-18 who have been or are eligible to utilize specialized public services. A primary role of the PLISG is to deliver the "Parents Partnering for Change" (PPC) leadership training. Training topics include leadership skills; how to use your voice to tell your story; effective meetings; and handling conflict. Since 2008, 1,592 parents have participated in the training. In

2023, PPC participants reported utilization of the following MCH-related services: WIC (59%); food assistance (35%); Healthy Kids (11%); Healthy Kids Dental (28%); MI Child (48%); and home visiting (11%). The PLISG training continues to be virtual and shared at a variety of times throughout the year, so that families can find a time that best suits their schedule. PLISG training evaluations are completed immediately after each training and three months post-training.

- The MDHHS Home Visiting Unit has integrated parent and caregiver involvement into federally funded (Maternal, Infant, and Early Childhood Home Visiting) and state-funded home visiting initiatives. Communities convene a home visiting Local Leadership Group (LLG) which is comprised of representatives from Head Start, substance abuse, child abuse and neglect councils, public health, mental health, education, Great Start Collaborative staff, and parents who have participated in home visiting. To include consumer voice as part of decision-making and policy development, parents participate in quality improvement teams within LLGs and local home visiting programs. At the state level, Michigan is building parent voice into home visiting initiatives so that parents are partners in policy and programming decisions. Michigan convenes a Home Visiting Advisory, a broad stakeholder group designed to advise on building a comprehensive and coordinated home visiting system. At least 20% of members must be parents of children ages five or younger who have or are currently receiving evidence-based home visiting services. Michigan also created an advisory consisting of parents who have been impacted by the child welfare system to inform state efforts to engage parents in home visiting, especially parents impacted by substance use and/or the child welfare system. Parent leaders in these activities are financially compensated for their time. A Parent Coordinator staff position (filled by a parent who received home visiting services) was also created within MDHHS to develop and support parent leaders and parent leadership initiatives.

Children's Special Health Care Services (CSHCS) uses a multifaceted approach to ensure that services reflect the needs of the CYSHCN population. A critical component of administering services is the intentional involvement of families of CYSHCN in decision making. To achieve this goal, CSHCS works closely with the CSHCS Advisory Committee (CAC) and the Family Center for Children and Youth with Special Health Care Needs (Family Center). The CAC is comprised of professionals and family members who are involved in the care of children with special needs, with approximately 50% of CAC members being parents or family members of CYSHCN. The CAC makes policy and program recommendations to the CSHCS Division and promotes awareness to ensure 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 is a section within CSHCS. In addition to serving as a resource and liaison to children with special health care needs and their families, the Family Center assists in recruiting family members to serve on the CAC, the Children with Special Needs Fund (CSN Fund) Advisory Committee, and other committees within the CSHCS Division as needed. The Family Center also compensates family members who serve on these advisory committees. The Family Center serves functionally as a sounding board for all CSHCS programming and administration and ensures the family perspective is integrated at all levels of the program. Sharing and promoting leadership opportunities within Michigan is an important role of the Family Center. The Family Center has supported family members from the CAC and the CSN Fund Advisory Committee to attend AMCHP's annual conference. The Family Center also recognizes the importance of providing Family Center staff with leadership opportunities. The Family Center Manager and the CSHCS Division Director also attend AMCHP's annual conference. The Division Director (also the Title V CSHCN Director) previously served as an active member of the AMCHP Family Leadership, Education, and Development (Family LEAD) Committee. The Family Center Manager was accepted to serve on this committee and remains an active participant.

The goals of The Family Center are to provide a family perspective to help shape CSHCS policies and procedures and to help families in Michigan navigate the systems of care for CYSHCN. The Family Center's parent-to-parent program is Michigan's statewide Parent to Parent Support Network. The Family Center is an alliance member of Parent-to-Parent USA which is the national center for parent-to-parent mentoring and matching. This partnership allows Michigan to connect with other states that are also Alliance Members, enabling the Family Center to have a broader reach when seeking out mentor matches for parents in Michigan. Michigan's parent-to-parent program network consists of parents who have been trained as Parent Mentors through the Family Center to support other parents who have a child with the same or similar diagnosis as their own child. Parent-to-parent connections provide emotional and informational support to Michigan parents.

In addition to the Parent-to-Parent Support Network, the Family Center provides emotional support and information to families of children with special needs through a variety of other programs. Families can access 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 offer immediate help to families navigating systems of care which includes identifying needs, referral to resources, and connecting parents to educational and emotional supports. The Family Center's statewide Family Leadership Network also provides a diverse community-based perspective on programs and policies as well as a platform for the development of new family leaders. The Family Leadership Network functions on a regional level to inform families of resources and services.

The Family Center works in partnership with many statewide and local organizations, including the Michigan Family to Family Health Information Center and Michigan Family Voices. For example, the Family Center and Family to Family co-produce a quarterly newsletter called *Michigan Family Connections*. In partnership, the two entities lead the Family Leadership Network and have ongoing planning and partnership meetings. The Family Center also contributes to the Michigan Family to Family online repository of resources. In FY 2024, Michigan Family to Family, Michigan Family Voices, and the CSHCS Family Center will be hosting a virtual resource fair for families of children with special health care needs. CSHCS Division leadership, including leadership from the Family Center, meets regularly with Michigan Family Voices to identify collaboration opportunities. Michigan Family Voices has helped share Family Center information, recruit family leaders, and co-present on topics relevant to children with special health care needs and their families.

The Family Center creates significant impact through several projects:

- The Family Center Section Manager and a Parent Consultant serve on the quality improvement efforts within the CSHCS Division related to program evaluation and care coordination.
- Based on the most recent Title V Needs Assessment, and the selection of the Title V National Performance Measure to address Bullying, the Family Center and the Policy and Program Development sections have continued to implement a grant opportunity for local school districts to create or expand evidenced-based peer support models to reduce bullying for CYSHCN.
- CSHCS offices within local health departments have established in-person and/or virtual parent support groups. The Family Center supports these efforts by providing annual grant opportunities for local health departments to hire parents to facilitate these support groups. The groups connect parents and family members of CYSHCN to resources and support from other families.
- The Family Center offers Sibshop grants to support siblings of children with special health care needs using the evidence-based Sibshop model. The goal of the grant is to provide statewide opportunities for brothers and sisters of children with special health and developmental needs to obtain peer support and education within a recreational context with a certified Sibshop.

In response to the COVID-19 pandemic, the Family Center began offering virtual trainings for both the Parent Mentor

and Bereaved Parent Mentor Trainings. Based on family feedback during the pandemic, the Family Center offers regular opportunities for parents to connect through Parent Connect Calls and Professional Connect Calls. These calls feature speakers from several different areas including disability, education, and other state initiatives. Families that participate in the meetings provide input and assist the Family Center with decisions regarding topics, frequency, and other factors for the meetings.

Lastly, Michigan's Leadership Education in Neurodevelopmental and Related Disabilities (MI-LEND) program is an interdisciplinary leadership training program, funded under the Autism Collaboration, Accountability, Research, Education and Support (CARES) Act. MI-LEND is coordinated by the Michigan Developmental Disabilities Institute (MI-DDI) in partnership with the Family Center and eight Michigan universities. Since its start in 2017, MI-LEND has trained 7,085 graduate and/or professional students, family members, and self-advocates in interdisciplinary leadership and culturally competent, family-centered care. Training includes information about health care transition and the role pediatric health care providers have in supporting youth and families as they transition to adult systems of care.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

Michigan Department of Health and Human Services (MDHHS) epidemiologists are primarily housed within the Bureau of Infectious Disease Prevention (BIDP) and the Bureau of Epidemiology and Population Health (BEPH). Each Bureau includes three Divisions. Within BIDP are Immunization, HIV & STI Programs, and Communicable Diseases. Within BEPH are Vital Records and Health Statistics, Environmental Health, and Lifecourse Epidemiology and Genomics. Most of the MCH Epidemiology workforce capacity for MDHHS is housed within the Maternal and Child Health Epidemiology (MCH Epi) Section, which is housed within the Lifecourse Epidemiology and Genomics Division. Roles and responsibilities for epidemiologist positions within the MCH Epi Section are summarized below.

Maternal and Child Health Epidemiology Section Manager (1.0 FTE)

Chris Fussman, MS, became the MCH Epi Section Manager in November 2016. Chris received his Master of Science in Epidemiology from Michigan State University in 2004. As the MCH Epi Section Manager, Chris provides scientific, administrative, and program direction and leadership to MCH Epi Section staff. He meets with Title V leadership and program staff to assist with Title V needs assessment processes, including establishing projections for Title V performance measures and evaluating Michigan's progress on performance measures. Chris also works with the MCH Epi team to expand data analyses associated with the Minimum/Core indicators and has routine discussions with internal partners regarding data linkages to improve Michigan's Title V program efforts. Chris and the MCH Epi team remain focused on the expansion of data collection efforts associated with MCH emerging issues, including neonatal abstinence syndrome, maternal mortality, COVID-19 mortality, and the impact of COVID-19 among mothers and babies. This position is funded by a combination of State Systems Development Initiative (SSDI) funding and other state infant mortality funding.

Child, Adolescent, and School Health (CASH) Epidemiologist (1.0 FTE)

Lindsay Townes, MPH, started as the CASH Epidemiologist in August 2018. Lindsay received her MPH from the University of Michigan in 2011. As the CASH Epidemiologist, Lindsay is responsible for providing epidemiological analysis and support to Michigan's Child and Adolescent and School Health Sections, which includes teen pregnancy prevention, school based/linked health centers, school nursing, comprehensive health education, and coordinated school health programs. Lindsay also provides epidemiological and statistical support to Michigan's Title V MCH Block Grant efforts, providing data analysis and support for needs assessments, annual reports/applications, and performance measure reporting and goal setting. This position is funded by Title V and other federal funding sources.

Infant Health Epidemiologist (1.0 FTE)

Haifa Haroon, MPH, started as the Infant Health Epidemiologist in May 2021. Haifa received her Master of Public Health from the University of Michigan in 2013. As the Infant Health Epidemiologist, Haifa is responsible for analyzing infant health statistics for Michigan, including infant mortality, preterm birth, low birthweight, feto-infant mortality, stillbirths, and neonatal abstinence syndrome rates. These indicators have been incorporated into the *Advancing Healthy Births: An Equity Plan for Michigan Families & Communities a*nd are integrated into Title V state action plans and measures. Haifa also presents the latest infant health data to Michigan's Regional Perinatal Quality Collaboratives on an annual basis. This position is funded by state-level infant mortality funding.

Newborn Screening Epidemiologist (1.0 FTE)

Isabel Hurden, MPH, started as the Newborn Screening (NBS) Epidemiologist in August 2017. Isabel received her Master of Public Health from Grand Valley State University in 2016. As the NBS Epidemiologist, Isabel is responsible for linking NBS records to birth certificate records, generating quarterly reports for birthing hospitals, creating yearly NBS annual reports, pulling specimens for BioTrust research projects, assisting the University of Michigan with the sickle cell registry, and all other data analysis related to NBS records. This position is funded by state newborn screening funds.

Home Visiting and ECHO Epidemiologist (1.0 FTE)

Carlotta Allievi, MPH, started as the Home Visiting/ECHO Epidemiologist in August 2018. Carlotta received her Master of Public Health from Grand Valley State University in 2018. Carlotta is responsible for analyzing Home Visiting program data for annual reports such as the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) report and Michigan's Public Act 291 Home Visiting Legislative Report, as well as updating the county-level Needs Assessment for the MIECHV Initiative. Carlotta also conducts regular Kitagawa analyses to assist communities in determining the populations in greatest need of home visiting services. Data from these reports are used to inform related MCH activities. This position is funded by Title V and other HRSA and NIH grants.

Pediatric Genomics and Early Hearing Epidemiologist (1.0 FTE)

Amy Rakowski, MS, transitioned into the Pediatric Genomics and Early Hearing Epidemiologist role in June 2022. Amy received her master's degree from The University of Iowa in 2018. As the Pediatric Genomics and Early Hearing Epidemiologist, Amy is responsible for surveillance of pulse oximetry screening practices throughout the state, conducting research regarding pulse oximetry screening for critical congenital heart diseases, providing analyses for EHDI populations to illustrate the public health impact of hearing loss, and to assist with surveys and studies that evaluate and monitor the health status of EHDI populations. This position is funded through state newborn screening funds and two federal grants that support Michigan's EHDI activities.

Birth Defects and Family Planning Epidemiologist (1.0 FTE)

Kenneth Hanson, MPH, started as the Birth Defects and Family Planning Epidemiologist in August 2022. Ken received his master's degree from Grand Valley State University in 2022. He is responsible for the analysis of birth defects trends within the state of Michigan. Ken is also working on the linkage of birth defects data with other internal data sources, including immunizations, hospital discharge data, Children's Special Health Care Services, congenital syphilis, and substance use data. This position is also responsible for the annual analysis of Family Planning Annual Report (FPAR) data and is involved in our transition to family planning encounter-level data collection. This position is funded by the CDC and the Office for Population Affairs.

PRAMS Data Analyst (0.75 FTE)

Peterson Haak, BS, (MS and PhD pending) started as the PRAMS Data Analyst in January 2015. Pete received his bachelor's degree from Grand Valley State University in 2002 and has completed all coursework in support of an MS and PhD in epidemiology from Michigan State University. As the PRAMS data analyst, Pete conducts most of the data analyses based on Michigan PRAMS data. PRAMS provides data on Title V performance measures for infant safe sleep and state-level measures for breastfeeding and perinatal substance use. Pete will also be responsible for analyzing data from the Kent County and City of Detroit PRAMS for Dads surveys when it becomes available. This position is funded by the CDC PRAMS cooperative agreement and through other state and federal funding sources.

Adverse Childhood Experiences Epidemiologist (0.3 FTE)

Kim Hekman, MPH, started as the Adverse Childhood Experiences (ACEs) Epidemiologist in January 2021. Kim received her MPH in epidemiology from the University of Michigan in 2010. As the ACEs Epidemiologist, Kim is responsible for building capacity for the surveillance, statistics and reporting of ACEs at the state and local levels. ACE indicators that are generated through this work may be included in future Title V action plans for the Child and Adolescent Health Domain. This position is funded entirely by the CDC through a cooperative agreement led by the Michigan Public Health Institute.

Preventable Mortality Epidemiologist (1.0 FTE)

Heidi Neumayer, MPH, started as the Preventable Mortality Epidemiologist in March 2019. Heidi received her Master of Public Health degree from Grand Valley State University in 2016. As the Preventable Mortality Epidemiologist, Heidi is responsible for monitoring and analyzing severe maternal morbidity, maternal mortality, and sleep-related infant deaths. Infants safely sleeping and healthy girls, women and mothers are priorities within the Advancing Healthy Births: An Equity Plan for Michigan Families & Communities. Statistics related to these priorities are also utilized within Title V action plans. This position is funded by CDC and HRSA grants.

The remaining positions within the MCH Epi Section focus on PRAMS operations, and maternal mortality surveillance. PRAMS operations and maternal mortality surveillance are partially supported through Title V. Title V funding is used within PRAMS to help support web, mail, and phone data collection activities.

In addition to positions within the MCH Epi Section, epidemiology positions in other MDHHS Divisions also play a critical role in advancing the state's MCH epi data capacity. Roles and responsibilities for these positions are summarized below.

Vaccine Preventable Disease (VPD) Epidemiologist (1.0 FTE)

Thrishika Balasubramanian, MPH, started as the VPD Epidemiologist in June 2021. Ms. Balasubramanian received her MPH from the Tulane University School of Public Health and Tropical Medicine in 2021. As the VPD Epidemiologist, Thrishika coordinates testing and activities relating to disease prevention and control; conducts analyses of vaccine preventable disease occurrence, disease trends, and risk factors; and provides other analyses and reports as requested. Child and adolescent vaccination coverage have been incorporated into the MIHEIP and are integrated into Title V performance measures. This position is funded by a CDC Core Component grant.

Michigan Care Improvement Registry (MCIR) Epidemiologist (1.0 FTE)

Hannah Forsythe, PhD, started as the MCIR Epidemiologist in December 2020. Dr. Forsythe received her PhD from Michigan State University in 2018. As a MCIR Epidemiologist, Dr. Forsythe is responsible for analyzing, interpreting, and disseminating data from the MCIR to identify pockets of need, immunizations levels by antigen, and other analyses or reports as requested. Child and adolescent vaccination coverage have been incorporated into the MIHEIP and are regularly integrated into Title V work plans. This position is funded under a CDC Core Component grant.

Oral Health Epidemiologist (0.5 FTE)

Alaina White, MPH, started as the Oral Health Epidemiologist in July 2022. Alaina received her Master of Public Health in Global Health Epidemiology from University of Michigan School of Public Health in 2022. As the Oral Health Epidemiologist, Alaina is responsible for analyzing oral health statistics for Michigan, including school-based dental sealants, community water fluoridation rates, oral health utilization of pregnant people and adults, Medicaid dental claims and HIV dental utilization. These indicators have been incorporated into Oral Health Program activities and

Title V oral health work plans. This position is funded by Title V and private funding.

Childhood Lead Poisoning Prevention Program (CLPPP) Epidemiologist (1.0 FTE)

RoseAnn Miller, MS, started as a CLPPP Epidemiologist in October 2016. RoseAnn received her MS from Michigan State University in 2004. As the CLPPP Epidemiologist, RoseAnn is responsible for analyzing various child health statistics, including blood lead surveillance metrics, blood lead levels in Michigan residents, and risk factors associated with elevated blood lead levels in children. These indicators have been incorporated into the MDHHS Lead Strategy and are integrated into the Title V work plan. This position is funded by state-level Flint Supplemental funding and the CDC Childhood Lead Poisoning Prevention grant.

Childhood Lead Poisoning Prevention Program (CLPPP) Epidemiologist (1.0 FTE)

Nivea Brown, MPH, started as a CLPPP Epidemiologist in July 2022. Nivea received her Master of Public Health from the University of Michigan in 2021. As the CLPPP Epidemiologist, Nivea is responsible for analyzing child health statistics, including information about childhood blood lead testing, confirmatory testing, and elevated blood lead levels. These indicators have been incorporated into the MDHHS Lead Strategy and are integrated into the Title V work plan. This position is funded by state-level Flint Supplemental funding.

WIC Epidemiologist (1.0 FTE)

Madhur Chandra, PhD, started as the WIC Epidemiologist in October 2021. Dr. Chandra received her PhD in Epidemiology from Michigan State University in 2020. In her role as WIC Epidemiologist, Dr. Chandra is responsible for the design, conduct, and evaluation of epidemiological surveys assessing WIC participant experience and provides epidemiological guidance to the WIC Division for the MCH population it serves. She also creates, manages, and links multiple datasets related to Pregnancy and Pediatric Nutrition Surveillance Systems (PNSS & PedNSS) and USDA Participant Characteristics. Data generated by the WIC Epidemiologist are integrated into WIC-related activities that intersect with other MCH programs (e.g., breastfeeding). This position is fully funded by WIC.

Birth Outcomes Epidemiologist (1.0 FTE)

Kate Busen, MPH, started as the Birth Outcomes Epidemiologist in October 2022. Kate received her Master of Public Health from Grand Valley State University in 2020. As the Birth Outcomes Epidemiologist, Kate is responsible for using public health data to analyze the impact of environmental hazards on birth outcomes. Kate is also responsible for conducting birth defects/adverse birth outcome cluster investigations that occur within Michigan. This position is funded by state-level funding.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

Michigan's goals and objectives for the State Systems Development Initiative (SSDI) project align with state priorities to enhance data and analytic capacity to identify priorities; inform program resource allocation, needs assessment and program evaluation; and provide MCH programs and state and local workgroups with in-depth data analysis and interpretation to guide efforts to improve health among MCH populations.

Michigan's SSDI activities are primarily aimed at strengthening our capacity to collect, analyze, and use reliable data to inform Title V MCH Block Grant data-driven programming. The MCH Epidemiology Section Manager and the Child, Adolescent and School Health (CASH) Epidemiologist routinely meet with core Title V staff to ensure that epidemiologic needs are met for Title V activities. The CASH Epidemiologist has analyzed a multitude of MCH indicators for the upcoming five-year Title V Needs Assessment which will play a critical role in our selection of national and state performance measures for the next funding cycle. Other epidemiologists within the MCH Epidemiology Section work closely with Title V staff to provide epidemiologic support to Title V action plans and regularly review and update performance measures and annual objectives.

In addition to ongoing needs assessment activities, the MCH Epidemiology Section continues to provide the Bureau of Health and Wellness with routine statistics in support of Michigan's Title V and other MCH activities. The MCH Epidemiology Section has placed a focus on expanding the depth and breadth of the infant and maternal health statistics provided to the Title V program. These expanded statistics are also presented to the state's regional perinatal quality collaboratives on an annual basis. The CASH Epidemiologist has also presented data related to specific national performance measures to local health department staff as a way of promoting the integration of performance measures into local Title V plans. The MCH Epidemiology Section assists in the evaluation of selected performance measures and will provide input into the selection of new performance measures for the next five-year cycle.

Direct and timely access to MCH health data is another important component of the Title V performance monitoring process. Michigan Vital Records files (e.g., Live Birth, Fetal Death, linked infant death/live birth files, linked Maternal Mortality Files) and other data sources housed in the Division for Vital Records and Health Statistics (DVRHS), such as the Michigan Birth Defects Registry and Michigan Inpatient Database, remain important data sources for monitoring maternal and child health and providing adequate Title V performance monitoring. The MCH Epidemiology Section has established several data sharing agreements with DVRHS which allow for direct access to these data files. The Michigan Pregnancy Risk Assessment Monitoring System (PRAMS) is housed within the MCH Epidemiology Section and is routinely used for performance monitoring within Title V, as well as *Advancing Healthy Births: An Equity Plan for Michigan Families and Communities*. Furthermore, access to and use of national survey data in conjunction with state and program data has steadily improved over the course of the SSDI project.

As part of the Michigan SSDI project, the MCH Epidemiology Section routinely assesses its access to needed MCH data linkages. Although regular and/or direct access to a multitude of MCH data sources has already been established (see Form 12 of this application), the MCH Epidemiology Section Manager continues to meet with MCH program staff on a routine basis to discuss additional data that could further support the Title V program or other MCH programs. The MCH Epidemiology Section documents the barriers that prevent these linkages and regularly reaches out to data owners to set up meetings to discuss these barriers and how to resolve them.

The Michigan SSDI Project remains focused on enhancing the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming. MCH Epi Section staff continuously examine existing datasets and modify data collection instruments to maximize the collection of health equity and SDoH metrices for MCH populations. The MCH Epi Section will also put a greater emphasis on the

inclusion of these expanded health equity and SDoH metrics within future MCH publications. MCH Epi Section staff will continue their discussions with the Division for Vital Records and Health Statistics and other MDHHS epidemiology staff to develop a more accurate method for collecting race and ethnicity information within our administrative datasets.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

The SSDI funds that are received by MDHHS are used to cover a portion of the MCH Epidemiology Section Manager's salary. Although these funds do not directly support any other positions within the MCH Epidemiology Section, they do provide the framework for managing the data needs of the MCH program. Numerous MCH Epidemiology Section staff, which are funded by sources other than SSDI, are involved with the Title V needs assessment, performance monitoring, and work plan development activities.

- The Child, Adolescent and School Health (CASH) Epidemiologist is responsible for compiling MCH data for the Title V needs assessment, establishing annual objectives for national performance measures, assisting with state performance measures and evidence-based strategy measures, and evaluating annual progress on Title V related measures.
- The Infant Health Epidemiologist is responsible for calculating Michigan infant mortality, preterm birth, low birthweight, prenatal care, and neonatal abstinence syndrome statistics for inclusion in Advancing Heathy Births: An Equity Plan for Michigan Families and Communities and for presentation to the regional perinatal quality collaboratives.
- The Preventable Mortality Epidemiologist is responsible for the development and dissemination of Michigan infant safe sleep, maternal morbidity, and maternal mortality statistics.
- The Newborn Screening Epidemiologist is responsible for calculating statistics for newborn screening disorders that are tested for in Michigan.
- The Home Visiting Epidemiologist is responsible for calculating a multitude of indicators for Michigan's home visiting population and data required by the state's home visiting program.
- The Pregnancy Risk Assessment Monitoring System (PRAMS) team is responsible for calculating numerous MCH indicators that are collected through this surveillance system and used to measure performance on various Title V activities.
- The Pediatric Genomics and Early Hearing Epidemiologist is responsible for calculating trends for critical congenital heart disease and assessing early hearing testing lost to follow-up.
- The Birth Defects and Family Planning Epidemiologist is responsible for calculating Michigan birth defects trends and analyzing the data collected by Michigan's family planning agencies.
- The Adverse Childhood Experiences (ACEs) Epidemiologist is responsible for analyzing ACEs data from different data sources and assisting in the development of a dashboard that can be used by child and adolescent health partners throughout the state.

In addition to the epidemiologic activities described above, the MCH Epidemiology Section is also responsible for managing Michigan's maternal mortality surveillance program. SSDI supports the MCH Epidemiology Section Manager's role in managing the data component of the Michigan Maternal Mortality Surveillance (MMMS) project. The MMMS Project Coordinator and Case Abstractor coordinate maternal death case identification, case summary development, committee review, and recommendation development and implementation activities.

The MCH Epidemiology Section also led various MCH-related activities during the COVID-19 pandemic, including the Michigan COVID-19 mortality review project and COVID-19 Pregnancy and Neonate Surveillance Project.

For the COVID-19 Mortality Review, medical records were requested, and next-of-kin interviews were conducted for a sample of COVID-19 deaths that occurred in Michigan. This information was then reviewed by a panel of subject matter experts to identify contributing factors, assess COVID relatedness and preventability of the death, and develop recommendations that may help prevent future deaths due to COVID-19. The findings from this process and the recommendations developed by this committee have been compiled into a report and provided to administration to develop implementation strategies.

For the COVID-19 Pregnancy and Neonate Surveillance Project, women with a confirmed diagnosis of COVID-19 during pregnancy were identified through a link between the Michigan Disease Surveillance System and Vital Records. These women were then followed through the end of pregnancy to determine the impact of COVID-19 on pregnancy outcomes (e.g., infant mortality, preterm birth, and maternal mortality), maternal and infant ICU admissions, and infant COVID-19 infections. Michigan has completed project cohorts for 2020 and 2021. The 2020 cohort data have been analyzed and a summary fact sheet has been published. Another fact sheet for the 2021 cohort is forthcoming. Furthermore, MCH Epidemiology Section staff continue to work with the Michigan Care Improvement Registry (MCIR) Epidemiologist to assess the COVID-19 vaccination status of Michigan's MCH population.

The MCH Epidemiology Section also continues to work on expanding its data analyses associated with the Minimum/Core indicators and other MCH-related priority metrics. The MCH Epi Section also continues to have discussions with internal partners regarding data linkages that could be used to improve Title V program efforts and other MCH activities. The MCH Epidemiology Section is currently working to establish several new MCH-related data linkages, including Birth Defects Registry data linked to Immunizations, CSHCS, and hospital discharge data, PRAMS data linked to hospital discharge data, and Medicaid data linked to Vital Records and Immunizations. Furthermore, the MCH Epidemiology Section continues to work with MCH data owners to improve data collection among marginalized populations that are currently underrepresented within many MCH data sources. Examples include the Michigan PRAMS team recently implementing a PRAMS for Dads survey among minority populations within Kent County and the City of Detroit. Furthermore, the MCH Epi Section is working with the Division for Vital Records and Health Statistics and other epidemiology staff to develop a more accurate way of collecting race and ethnicity data within administrative datasets.

Timely data sharing is another focus area for the MCH Epidemiology Section. MCH Epidemiology Section staff present the most current MCH indicator data to internal and external MCH partners on a regular basis. These presentations provide a forum for MCH program staff to ask questions about the data and request additional data analyses which in turn support the development of data-driven Title V action plans. The MCH Epidemiology Section also houses current MCH data on an MDHHS website to make the data accessible to local MCH partners that MDHHS staff work with on a routine basis.

Ongoing MCH Epidemiology Workforce Activities

While Michigan has developed a strong MCH epidemiology workforce, there is always room for improvement. Michigan still has a few MCH program areas that do not have specific epidemiologist positions in place to support program activities. Furthermore, the utilization of the Medicaid data warehouse by MCH programs is still not optimal. Obtaining funding to hire additional epidemiologists and data analysts to fill these important roles will allow Michigan to further its MCH data capacity in future years.

The MDHHS MCH Epidemiology Section is also committed to continue our work to identify and develop new data sources, improve data quality, effectively measure health outcomes, and develop stronger MCH performance metrics. Equally important is the need to communicate findings in a participatory manner to MCH programs and partner organizations. A coordinated data-to-action approach provides the foundation for systems and outcomes evaluation, data-based information to educate policy makers, and support for the state's goal of improving the health and wellness of people across the life course. Capacity within Michigan's MCH epidemiology workforce and coordination with MCH programs must continuously be strengthened to maximize the ability to provide meaningful data analysis, interpretation, and communication.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The Michigan Department of Health and Human Services (MDHHS) recognizes the importance and necessity of strong emergency planning. The COVID-19 pandemic illustrated the critical role of emergency preparedness and response and its impact on the lives of all people, including the MCH population. MDHHS has an Emergency Operations Plan (EOP) that is reviewed annually and updated as needed based on lessons learned, real world experiences, new guidance, and best practices. According to the plan, “The EOP was developed using a functional approach in accordance with the Federal Emergency Management Agency (FEMA) Comprehensive Preparedness Guide (CPG) 101, Version 2.0 titled: *Developing and Maintaining Emergency Operations Plans,* published November 2010. It is organized around critical functions that the department will perform in response to an actual, imminent or potential emergency.”

The Michigan Emergency Management Plan (MEMP) was updated in April 2023 and describes planning consideration and outreach for “persons with access and functional needs” which includes young children, individuals with disabilities, and low-income individuals. The MEMP notes, “Populations with access and functional needs are especially vulnerable in catastrophic incidents and will require specialized and particular attention in response and recovery for appropriate assistance” (p. 39). Staff from the MDHHS Bureau of Health and Wellness (BHW) have been involved in both the planning and response to emergencies and disasters. The WIC Director is part of MDHHS Executive Leadership Team that reviews the EOP when it is updated. Additionally, WIC is involved with local MDHHS offices that provide human services to community members, which may include recipients of Title V services or other MCH services, such as safe sleep or breastfeeding support, immunizations, lead screening, or CSHCS. The BHW also falls within the Incident Command Structure (ICS), as a key team member of the Community Health Emergency Coordination Center (CHECC). The CHECC structure is in accordance with the National Incident Management System (NIMS).

Following the response to any incident resulting in the participation of subject matter experts (SMEs), which includes the Bureau of Health and Wellness, an After-Action Report (AAR) is developed, along with an Improvement Plan (IP) that is based on lessons learned. These AARs and IPs are reviewed on a regular basis so that processes are amended to improve efficacy and efficiency of programs’ response activities during an emergency or disaster. Improvement action items are then integrated into training and exercises to enable MDHHS to better respond to future incidents. Additionally, the MDHHS Preparedness Program began collecting information on community engagement initiatives at the local health department level in 2018. The purpose is to inform community engagement and inclusion efforts in the next budget period beginning in July 2024. During the initial five-year period, the preparedness program collected information on community engagement initiatives that were specific to COVID, informing state and local partners of response activities.

The Bureau of Emergency Preparedness, EMS and Systems of Care within MDHHS also produces a monthly newsletter called *The Guardian of Public Health*. *The Guardian* provides readers with relevant content on topics that affect the public health of Michigan's citizens and communities. For example, the January edition included information on PFAS in Firefighters of Michigan Surveillance and the NACCHO three-part webinar series on Inclusive Public Health Preparedness Planning.

The Title V and MCH role in emergency preparedness and response was evident in the response to the COVID-19 pandemic. Title V leadership and MCH staff participated in departmental COVID-19 response efforts including staffing provider hotlines; contact tracing; standing up alternative care sites; convening and participating on COVID-19 workgroups and committees; and other projects as needed. The Director of the Bureau of Health and Wellness, which houses the Title V program, led the Department’s efforts with local health departments, which included testing, contact tracing, and vaccine distribution and promotion. The Title V Local MCH (LMCH) program provided guidance to local health departments that receive Title V funding which allowed them to redirect Title V funds to support

COVID-19 response activities in their communities, if needed, in accordance with federal guidelines.

Pregnant and parenting families were identified as a potential vulnerable population early in the pandemic. As a result, a “Pregnant and Parenting” workgroup was created with members representing Title V, home visiting, Medicaid, WIC, Behavioral Health and other MCH areas. The workgroup shared relevant information and routed critical and/or emerging issues to the Michigan Community Health Emergency Coordination Center (CHECC). In partnership with the CHECC, COVID-19 resources for families were developed and made available. Assuring timely communication with Maternal and Infant Health (MIH) partners was also critical and resulted in Maternal Infant Health & Equity updates being emailed to thousands of MIH partners on a regular basis.

During the pandemic, CSHCS worked with the Medical Services Administration to create policies and procedures to support access to care and continuity of services for CSHCS program enrollees. Policy and procedure adjustments were designed to remove barriers to program participation (i.e., enrollment and renewals), protect clients from unnecessary viral exposure by eliminating face-to-face requirements, and increase the utilization of telemedicine. Adjustments were also made to support access to medications and durable medical supplies (by adjusting prior authorization requirements and modifying requirements related to obtaining durable medical equipment and medications) and to support compliance with Centers of Medicare/Medicaid Services and with the Governor’s executive orders. CSHCS maintained ongoing communication with local health departments (LHDs), providing guidance and information when relevant to the CSHCS program. In 2023, CSHCS worked with Medicaid to unwind COVID-related policies and communicated with LHDs to minimize the impact of the policy unwind.

As part of the Emergency Preparedness and Response Division’s Risk Communications Team efforts, the Whole Community Inclusion Plan for LHDs was created to expand their reach to at-risk populations within their jurisdiction, including CYSHCN. The goal is to bring at-risk groups to the table regarding emergency preparedness planning and develop an exercise to test the system’s capabilities.

The Title V program participates in the development of coordination plans with other MCH programs to enhance statewide preparedness efforts, as needed. For example, MDHHS staff who are part of Title V and/or Michigan’s broader MCH programs worked with state and local partners to develop program specific guidance and best practice recommendations to address COVID-19 within their respective programmatic and funding parameters. Examples include CHECC-approved program guidance for Child & Adolescent Health Centers (school-based health centers); school-based hearing and vision screening; home visiting (including MIECHV, state, and Medicaid funded models); teen pregnancy prevention programs; and school-based dental sealant programs.

More recently, the Infant Safe Sleep program formed a collaboration with the MDHHS Bureau of Emergency Preparedness, EMS and Systems of Care to train first responders in promoting safe sleep practices and provide other supports. According to MDHHS, “The innovative collaboration supports the development of education plans, provider trainings, access to infant safe sleep resources and connections to local safe sleep experts, and it provides wraparound services for families in need. Among other things, providers are trained to identify unsafe infant sleep environments, inform families about infant safe sleep practices and set up pack and plays in the home.” Since July 2022, 13 fire departments and EMS agencies have been Infant Safe Sleep Certified and additional agencies are in the process of becoming certified. Through the program, over 670 EMS personnel and firefighters have been trained on infant safe sleep. In addition, at least 140 families with infants have been reached.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Michigan's Title V program provides health services across Title V population domains and works with internal and external partners to support a statewide system of services to deliver comprehensive, community-based care. The 2020 Title V Needs Assessment identified relationships between MDHHS, public and private organizations, and service providers as a strength that enables collaborative and coordinated work to meet MCH needs.

Internal partners include Behavioral Health, Chronic Disease and Injury Control, Equity and Minority Health, HIV and STI Programs, Local Health Services, Medicaid, Substance Use Prevention and Treatment, Vital Records, and WIC. MCH partners with other state departments, including the Michigan Department of Education (MDE) and the Department of Lifelong Education, Advancement, and Potential. MDE is a partner in programs supporting maternal and infant health, child health, school-based health, and CSHCS. MDE and MDHHS integrate funding for early childhood, school nursing, school mental health, Child and Adolescent Health Centers, Hearing and Vision screenings, and shared positions.

Partnerships with external entities are described throughout this application and include health care systems, provider organizations, universities, community-based organizations (CBOs), advocacy organizations, and local health departments (LHDs). These partnerships support service delivery, evaluation, pilot projects, community engagement, and training.

Strengthening Integration of Health Care Delivery

Michigan's MCH programs continually seek strategies to strengthen and integrate services through new or enhanced partnerships, as highlighted below.

Maternal and Infant Health

- High Touch, High Tech (HT2) is an electronic tool based on evidence-based Screening, Brief Intervention and Referral to Treatment (SBIRT) in prenatal care clinics and some family planning clinics. The tool is used for universal behavioral health screening prior to obstetric intake appointments, with subsequent linkage to services and treatment. HT2 is supported by Regional Perinatal Quality Collaboratives, Michigan State University and Opioid Settlement funds and is expanding in prenatal care clinics.
- The Michigan Alliance for Innovation on Maternal Health (MI AIM) is part of the national quality improvement initiative to prevent maternal morbidity and mortality through evidence-based safety bundles. Over half of Michigan birthing hospitals are engaged in MI AIM to implement the obstetric hemorrhage, severe hypertension in pregnancy, and sepsis safety bundles.
- DMIH received Opioid Settlement funds to support implementation of 'rooming in' at three health systems' birthing units. The family-centered model encourages parent-infant bonding and uses non-pharmacological care of infants born substance-exposed to remain with their parent/caregiver in a private hospital room. Hospital staff provide support for breastfeeding, skin-to-skin contact, calming techniques, and referrals. Funds will support expansion to two additional hospitals in 2024.
- The Michigan Health Endowment Fund provided funding to DMIH to implement a three-year Maternal & Infant Vitality project in the City of Detroit and Wayne, Oakland, and Macomb counties. An asset-based approach builds on regional strengths and uplifts the stories of families and providers to better understand how policies and systems impact infant and maternal health. DMIH partnered with three CBOs and four LHDs, holding over 49 discussion sessions in Metro Detroit to identify action steps to inform systems and programs.
- The Michigan Health Endowment Fund also provided funding to DMIH for "Grief & Bereavement Infrastructure:

Maternal & Infant Health Response" to address the need for family and community support following the death of a mother or infant. Activities include a partnership with Michigan 211 to develop a webpage with resources for families; an online grief and bereavement training for healthcare workers and family support professionals; and 17 mini awards to create local bereavement networks.

- The Early Hearing Detection and Intervention program (EHDI) is collaborating with the University of Michigan to pilot a telehealth project that will test the effect of remote EHDI diagnostic services on loss to follow-up rates.
- DMIH provides funding to 12 LHDs and the Inter-Tribal Council of Michigan to conduct Fetal Infant Mortality Review (FIMR) programs to identify factors that contribute to fetal and infant death. FIMR recommendations are collected and analyzed to identify themes. Recommendations and themes are included in state reports, presented to partners, and aligned with Michigan Maternal Mortality Surveillance (MMMS) program recommendations. The state FIMR program also partnered with four local FIMR programs to create a FIMR Strategic Storytelling Team; a toolkit was developed to incorporate storytelling into the FIMR process to elevate family voices.
- The MDHHS MMMS program partnered with StoryCenter to host a maternal health digital storytelling workshop with three providers and five persons with lived experience to elevate their stories about pregnancy or postpartum challenges. The digital stories will be included on the Michigan Hear Her website to empower women and their support networks (including family and providers) to recognize and act on urgent maternal warning signs.

Child and Adolescent Health

- MIECHV and state-funded home visiting programs are expanding partnerships with the child welfare system so that families whose children are at risk of entering foster care are provided voluntary referrals to home visiting. Home visiting has worked collaboratively with child welfare, healthcare, and substance use treatment systems to launch a Plan of Safe Care protocol in 2024 for families impacted by substance use. Peer navigator positions have been embedded in birthing hospitals, high-need OB clinics, and substance use treatment centers to help connect families to home visiting. Expansion of these positions will occur in 2024, due in part to collaboration with Michigan State Police and the Opioid Affected Youth Initiative grant.
- A partnership between law enforcement, schools, human services, and local mental health is leveraged through Michigan's Handle with Care Initiative which provides trauma-informed support within schools to students who had an experience in which law enforcement was involved.
- The Child & Adolescent Health Center program continues to expand in new communities in 2024 through an annual $25 million investment in the state budget. This will expand primary care, nursing, and mental health services to underserved children and adolescents across the state. In 2023, 44 new partner sites were onboarded; 20 more are anticipated in 2024. The program is a partnership between healthcare, education, and behavioral health networks in over 270 K-12 schools.
- MDHHS partners with the Michigan Organization on Adolescent Sexual Health (MOASH) which mobilizes youth, engages community partners, and informs decision makers. MOASH Youth Advisory Councils help to identify ways to improve access to sexual and reproductive health care.

CSHCN

- In partnership with Michigan Medicine, Michigan Medicaid, and Michigan-based children's hospitals, CSHCS is exploring a Children with Medical Complexity benefit to improve health outcomes, increase patient and family satisfaction, and decrease costs associated with care.

- CSHCS partnered with MDHHS Public Health Genomics and the Sickle Cell Disease Association of America (SCDAA-MI) to investigate health inequities related to Sickle Cell Disease (SCD). As a result, a proposal was submitted to the Governor's Office to support a CSHCS adult benefit expansion, long-term services provided by SCDAA-MI, and expanded clinical services. The collaboration will create a list of providers who treat SCD; catalog state activities to support collaboration and efficiency; and address transition services for adolescents with SCD. The proposal was enacted in the FY 2022 budget appropriation. In January 2024, 544 adults with SCD were enrolled in the CSHCS program.
- In FY 2021, CSHCS launched a bullying prevention initiative aimed at decreasing bullying in the CYSHCN population. The effort is a collaboration between CSHCS Policy and Program Development, the CSHCS Family Center, Adolescent and School Health, and MDE. Activities included a focus group with parents of CYSHCN and a small grants program for schools.
- The Family Center's Parent-to-Parent program is Michigan's statewide Parent to Parent Support Network. The Family Center is also an alliance member of Parent-to-Parent USA which allows Michigan to have a broader reach when seeking mentor matches for parents in Michigan. The Family Center's network consists of Parent Mentors who are trained to provide emotional and informational support to other caregivers of children with the same or similar diagnosis as their own child's.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

MCH programs and the Behavioral and Physical Health and Aging Services Administration (BPHASA), which administers the Michigan Medicaid Program (Medicaid), have a longstanding collaborative relationship to deliver preventive and chronic health services, treatment, and follow-up care for the MCH population. MCH collaborations with Medicaid, Medicaid Health Plans (MHPs), local health departments (LHDs), and community providers include maternal and infant care; child and adolescent health; perinatal and postpartum care; Children's Special Health Care Services (CSHCS); dental care; and home visiting. Key partnerships are discussed in this section.

The Title V/Medicaid agreement is contained in the Medicaid State Plan (Sections E and F). Discussions with MDHHS legal counsel determined that the document outlines the relationship between the two entities which are both housed in MDHHS. However, Title V leadership is currently exploring options for an updated agreement.

One of the largest partnerships is between Medicaid and CSHCS. In January 2024, 77.1% of CSHCS enrollees were dually enrolled in Medicaid and approximately 83% of those dual enrollees were served through an MHP. CSHCS determines programmatic eligibility for CSHCS; provides case management in coordination with LHDs and Children's Multidisciplinary Specialty (CMDS) clinics; authorizes providers; and utilizes the same payment mechanism as Medicaid (CHAMPS). BPHASA determines eligibility for Medicaid; conducts CSHCS medical reviews for prior authorizations and medical eligibility; pays CSHCS providers; and provides IT support. Medicaid is responsible for the medical care and treatment of Medicaid enrollees dually enrolled in CSHCS. Assistance with community-based services beyond medical care and treatment is provided by the LHD CSHCS office. MHPs are responsible for coordinating with LHDs and CMDS clinics to provide essential health care and support services for enrollees. MHPs are also responsible for coordination and continuity of care for enrollees who require integrated medical, behavioral health, and/or substance abuse services. CSHCS has been integrated into the MHP contract compliance review process. In 2023, CSHCS completed MHP site visits focused on health equity, transportation, therapy services, and health care transition.

Several programs support maternal and infant care, dental health, and children and youth through cooperative program planning and monitoring; referrals; and program standards and guidelines. The MCPD requires all MHPs to ensure home visiting for pregnant people and families with infants enrolled in managed care. The Maternal Infant Health Program (MIHP) is available to all pregnant people and infants up to age one who are Medicaid eligible. In FY 2023, MIHP provided services to 11,299 adults and 14,515 infants. MIHP promotes healthy pregnancies, positive birth outcomes, and healthy infant development with the goal of reducing infant mortality and morbidity. MIHP is jointly managed by the Division of Maternal and Infant Health (DMIH), the MCPD, and the Medicaid Program Policy Division (MPPD). DMIH develops MIHP procedures, monitors program fidelity, and provides technical assistance to MIHP providers. MPPD promulgates Medicaid policies. MCPD helps providers implement Medicaid policies, monitors MHP contracts and makes payments to Medicaid providers.

The Healthy Kids Dental (HKD) program is available for children enrolled in Medicaid and CHIP. HKD provides coverage to approximately 1 million qualifying individuals including infants, children, and pregnant people under the age of 21. Eligible beneficiaries are offered two HKD plans. Since April 2023, all Medicaid beneficiaries aged 21 and older, including pregnant women, receive dental benefits through managed health care plans. MCH and BPHASA coordinate oral health outreach via multiple avenues including MIHP and home visiting networks. Infants and children receive preventive services through the Varnish Michigan and SEAL! Michigan programs. Healthy Michigan Plan beneficiaries receive dental benefits through MHP managed dental networks.

MCH programs and Medicaid also collaborate on a range of quality improvement initiatives:

- *Medicaid Eligibility:* MDHHS extended Medicaid eligibility for postpartum women to 12 months beginning

April 1, 2022, and began covering doula services January 1, 2023. To become Medicaid enrolled, doulas must complete a MDHHS approved doula training and be listed on the state's doula registry. As of January 31, 2024, 305 doulas were listed on the doula registry and 187 are Medicaid enrolled. Medicaid enrolled doulas are in each region of the state. MDHHS has focused on expanding the doula workforce to serve Medicaid eligible families. In 2023, MDHHS sponsored nine doula trainings and trained 161 new doulas. In 2024, MDHHS plans to sponsor 11 trainings to train an estimated 250 new doulas.

- *Community Health Worker (CHW) Services:* CHWs are now eligible for Medicaid reimbursement. CHW services are designed to be person-centered and patient-driven with a focus on building patient self-advocacy skills. Conditions that may support CHW services include pregnancy and up to 12 months postpartum, unmet health-related social needs, or diagnosis of one or more chronic health conditions. Services include health system navigation and resource coordination, health promotion and education, and screening and assessment.
- *CenteringPregnancy*: Michigan is partnering with the Centering Healthcare Institute (CHI) to increase adoption of the CenteringPregnancy model in Michigan. Evidence shows that the CenteringPregnancy model improves health outcomes for pregnant people and their babies, including reducing racial health disparities in preterm births. Michigan is investing $10 million to fund grants for hospitals and clinics to implement CenteringPregnancy.
- *Michigan Alliance for Innovation on Maternal Health (MI AIM):* Statewide birthing hospital implementation of MI AIM patient safety bundles improves outcomes and reduces disparities. MI AIM also supports birthing hospital implementation of the Maternal Levels of Care (MLoC). MLoC provide standards that ensure pregnant and postpartum people receive care in a facility that has the appropriate resources available for their level of risk. Michigan is investing $10 million to support MI AIM and MLoC.
- *EPSDT or Well Child Services:* Medicaid Managed Care is an important payor for preventive health care services for children and youth. The Division of Child and Adolescent Health works to improve well care rates for adolescents with Medicaid through Child & Adolescent Health Centers.
- *Lead Poisoning Prevention Projects:* Medicaid Health Plans and CLPPP partner to distribute "lead cleanup kits" to eligible enrollees and offer lead exposure education; coordinate care on complex cases with high blood lead levels to address social determinants of health; and are revising materials to increase provider engagement and venous confirmatory testing.
- *Caring for Students (C4S):* Expanded coverage for nursing and mental health services for general education students continued through a CMS approved Medicaid waiver that expanded existing school-based services. The C4S coverage enables schools that provide mental health and nursing services to general education students to receive Medicaid reimbursement. All 56 Intermediate School Districts participate in C4S, and 800,000 students are eligible to receive services.
- *MI Kids Now:* MI Kids Now is a statewide effort to improve behavioral health services for children and youth with Medicaid coverage and/or in the foster care system by ensuring access to behavioral health services and support when needed. CSHCS continues to participate and provide a voice for children with special health care needs and their families.
- *Quality Monitoring:* In 2023, MDHHS began using Performance Monitoring Reports to track Medicaid health plan performance on several measures related to maternal and infant heath, including immunization status; depression screening and follow up; prenatal and postpartum care; and contraceptive care.
- *Medicaid Comprehensive Quality Strategy (CQS):* The CQS provides the framework to design and implement a coordinated and comprehensive system to proactively drive quality across all Michigan Medicaid managed care programs, including the CSHCS managed care program. CSHCS participates in this effort to assess and improve the quality of care and services provided to CSHCS clients.
- *Expanding Health Equity in CSHCS*: This project is a collaboration between CSHCS, Medicaid, and MPHI.

The project’s goal is to eliminate racial and ethnic disparities in healthcare and health outcomes by focusing on key populations in managed care and CSHCS. Utilizing data, the project will create a reliable system to quantify and monitor disparities and identify gaps in care. In FY 2024, CSHCS will begin to expand partners of this initiative.

III.E.2.c State Action Plan Narrative by Domain

State Action Plan Introduction

State Action Plan Introduction

The following state action plans provide comprehensive information including objectives, strategies, and performance metrics regarding Michigan's Title V MCH priority areas. Per Title V requirements, the state action plans are organized within five population domains: women/maternal health; perinatal/infant health; child health; adolescent health; and children with special health care needs (CSHCN). Michigan also has one measure within the optional cross-cutting/systems building domain. For the FY 2025 application year, Michigan is continuing to use the numbering system (below) for National Performance Measures (NPMs) and State Performance Measures (SPMs) from the current five-year cycle (FY 2021-FY 2025). The state action plans focus on the following NPMs and SPMs:

- NPM 2 (Low-risk Cesarean Delivery)
- NPM 4 (Breastfeeding)
- NPM 5 (Safe Sleep)
- NPM 9 (Bullying)
- NPM 12 (Transition)
- NPM 13.1 (Preventive Dental Visit—Women)
- NPM 13.2 (Preventive Dental Visit—Children)
- SPM 1 (Childhood Lead Poisoning Prevention)
- SPM 2 (Immunizations—Children)
- SPM 3 (Immunizations—Adolescents)
- SPM 4 (Medical Care and Treatment for CSHCN)
- SPM 5 (Pregnancy Intention)
- SPM 6 (Developmental/Behavioral/Mental Health)

These NPMs and SPMs were chosen based on Michigan's five-year needs assessment completed in 2020 for the FY 2021-2025 cycle. This is also the third year of reporting for the current five-year cycle. Therefore, FY 2023 annual reports are provided for the NPMs and SPMs listed above. The NPM/SPM annual reports include a discussion of activities and outcomes; health equity strategies; family and community engagement strategies; and successes and challenges. *Note: The 2022 PRAMS data are not yet available to populate the 2023 reporting period, and therefore the Title V system is populating prior years' reporting data for NPMs that utilize PRAMS.*

In addition to the NPMs and SPMs identified through the 2020 needs assessment, the FY 2025 application includes state action plans for the new "universal" NPMs that are required for all states and jurisdictions starting in FY 2025. These universal NPMs focus on Postpartum Visit in the Women/Maternal Health domain; Medical Home in the Child Health domain; and Medical Home in the CSHCN domain.

Each domain includes a brief overview of key MDHHS activities and leadership within the domain as well as information on how local health departments (LHDs) utilized Title V funding in FY 2023 to address national, state, and local performance measures. LHDs complete an annual Local Maternal Child Health (LMCH) plan that describes the jurisdiction's priority maternal and child health needs; the action steps that will be used to address the needs; and the service categories from the MCH pyramid of services.

Local MCH needs and priorities vary across the state, and communities may have locally identified needs that they address via Title V funding which are not captured by the state priorities or performance measures. In addition to

Michigan's identified NPMs and SPMs, 17 LHDs selected a Local Performance Measure (LPM) which collectively accounted for 32% of total LMCH expenditures in FY 2023. A summary of local priorities (addressed through an LPM) and related expenditures is included in the Expenditures section of this application.

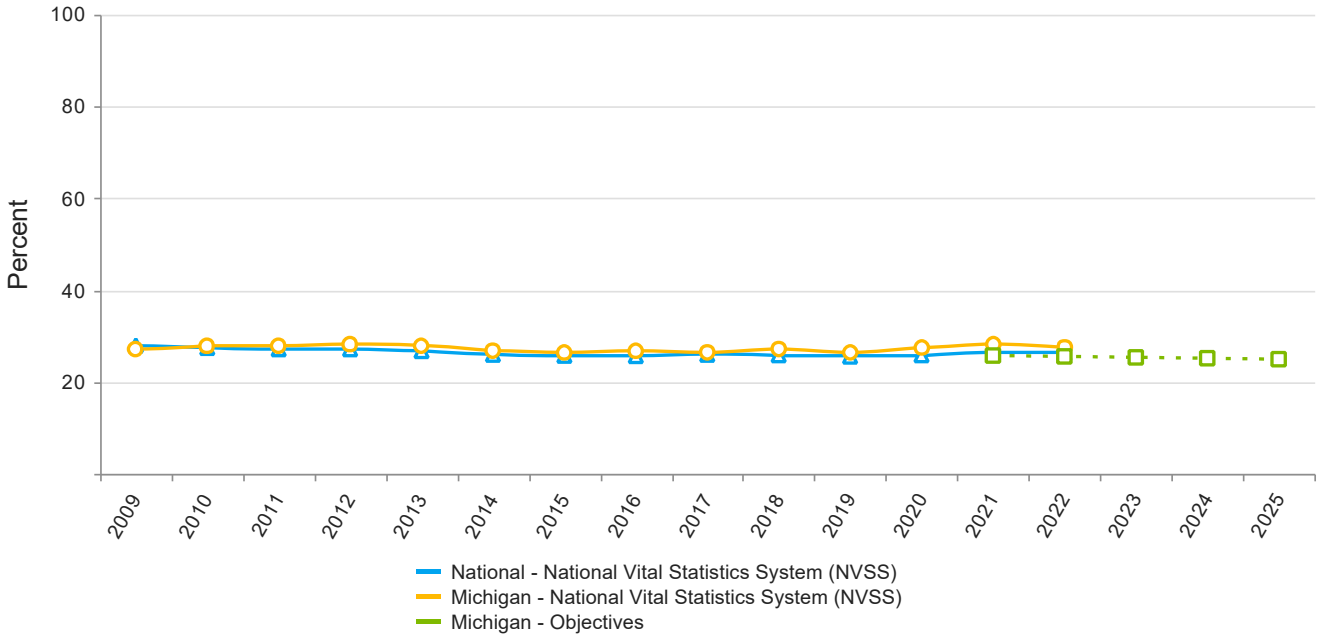
LHDs continue to report an unprecedented rate of staff turnover and vacancies since the COVID-19 pandemic which have persisted into 2024. A loss of institutional knowledge across all levels (e.g., administrative and programming) is a consequence of large staff turnover.

Women/Maternal Health

National Performance Measures

NPM - Percent of cesarean deliveries among low-risk first births (Low-Risk Cesarean Delivery, Formerly NPM 2) - LRC

Indicators and Annual Objectives



Federally Available Data					
Data Source: National Vital Statistics System (NVSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			25.8	25.6	25.4
Annual Indicator	27.3	26.5	27.4	28.1	27.7
Numerator	9,510	9,054	9,173	9,273	9,045
Denominator	34,845	34,117	33,452	33,009	32,607
Data Source	NVSS	NVSS	NVSS	NVSS	NVSS
Data Source Year	2018	2019	2020	2021	2022

Annual Objectives		
	2024	2025
Annual Objective	25.2	25.0

Evidence-Based or –Informed Strategy Measures

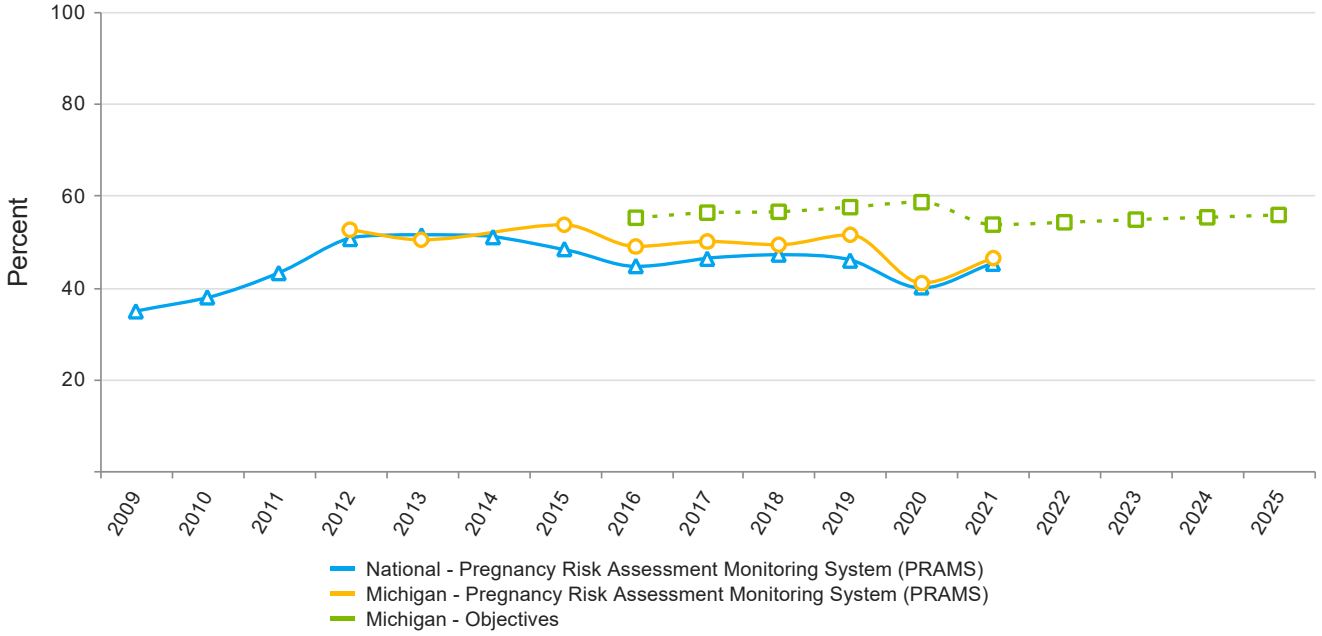
ESM LRC.1 - Number of birthing hospitals participating in Michigan AIM

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			72	74	73
Annual Indicator		50	62	65	63
Numerator					
Denominator					
Data Source		Michigan AIM/Michigan Hospital Association	Michigan AIM/Michigan Hospital Association	Michigan AIM/Michigan Hospital Association	Michigan AIM/Michigan Hospital Association
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	74.0	75.0

NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy
Indicators and Annual Objectives



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	57.4	58.5	53.6	54.7	54.7
Annual Indicator	49.2	51.3	40.8	46.4	46.4
Numerator	51,874	53,228	40,909	46,889	46,889
Denominator	105,470	103,825	100,195	101,072	101,072
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

Annual Objectives		
	2024	**2025**
Annual Objective	55.2	55.7

Evidence-Based or –Informed Strategy Measures

ESM PDV-Pregnancy.1 - Number of medical and dental professionals who receive perinatal oral health education through MDHHS

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	390	410	430	450	470
Annual Indicator	401	423	439	253	409
Numerator					
Denominator					
Data Source	FY2019 MDHHS Tracking Database	FY2020 MDHHS Tracking Database	FY2021 MDHHS Tracking Database	FY 2022 MDHHS tracking database	FY 2023 MDHHS tracking database
Data Source Year	FY2019	FY2020	FY2021	FY2022	FY2023
Provisional or Final ?	Final	Final	Final	Final	Final

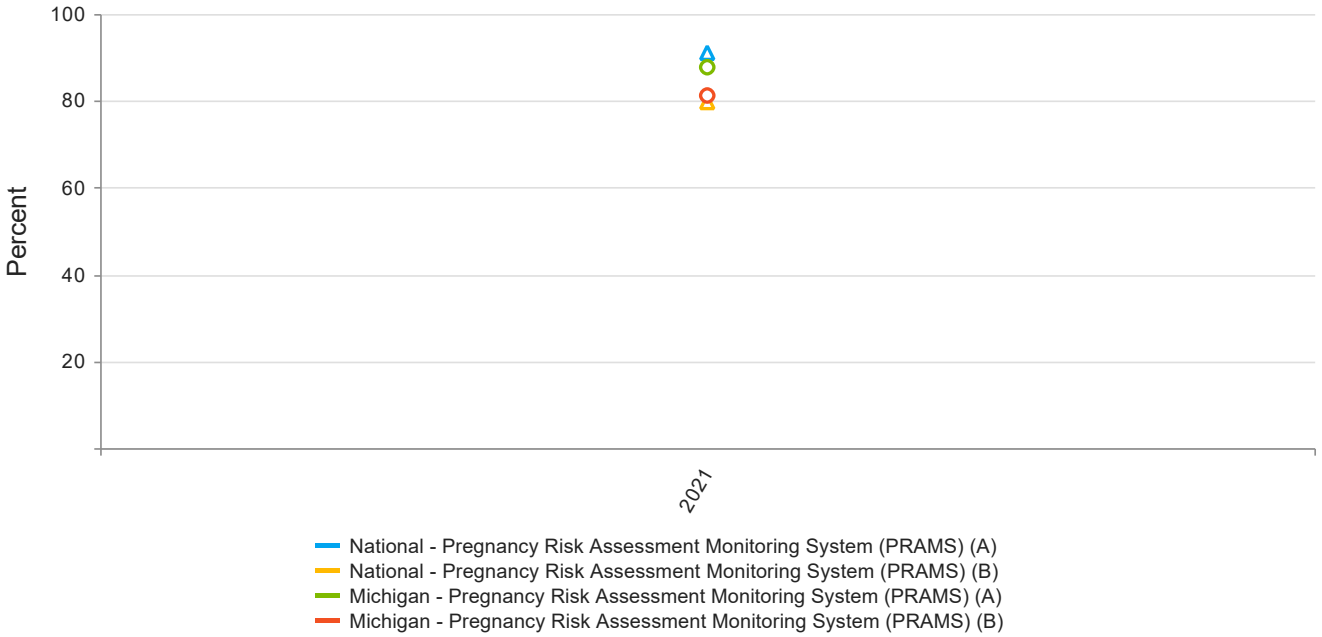
Annual Objectives		
	2024	**2025**
Annual Objective	490.0	510.0

ESM PDV-Pregnancy.2 - Percent of pregnant people who receive at least one oral health service through Medicaid during the perinatal period

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			40	41	42
Annual Indicator			21.2	20	18.8
Numerator			8,466	7,722	7,067
Denominator			39,940	38,517	37,614
Data Source			Medicaid Data 2020	Medicaid Data 2021	Medicaid Data 2022
Data Source Year			FY2020	FY2021	FY2022
Provisional or Final ?			Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	43.0	44.0

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV
Indicators and Annual Objectives



NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	87.5
Numerator	87,683
Denominator	100,262
Data Source	PRAMS
Data Source Year	2021

NPM - B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Federally Available Data	
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)	
	2023
Annual Objective	
Annual Indicator	81.0
Numerator	70,192
Denominator	86,624
Data Source	PRAMS
Data Source Year	2021

Evidence-Based or –Informed Strategy Measures

None

State Performance Measures

SPM 5 - Percent of people assigned female at birth who had a live birth and reported that their pregnancy was intended

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			59.8	60.9	61.9
Annual Indicator	57.2	59.8	59.8	62.5	
Numerator	59,915	61,665	59,813	63,024	
Denominator	104,673	103,197	100,096	100,758	
Data Source	PRAMS	PRAMS	PRAMS	MI PRAMS	
Data Source Year	2018	2019	2020	2021	
Provisional or Final ?	Final	Final	Final	Final	

Annual Objectives		
	2024	**2025**
Annual Objective	63.0	64.0

State Action Plan Table

State Action Plan Table (Michigan) - Women/Maternal Health - Entry 1	
Priority Need	
Develop a proactive and responsive health system that equitably meets the needs of all populations, eliminating barriers related to race, culture, language, sexual orientation, age and gender identity	
NPM	
NPM - Percent of cesarean deliveries among low-risk first births (Low-Risk Cesarean Delivery, Formerly NPM 2) - LRC	
Five-Year Objectives	
A) By 2025, reduce the percentage of cesarean deliveries among all Michigan low-risk births to 27%	
B) By 2025, reduce the percentage of low-risk cesarean births in African American, American Indian and Asian/Pacific Islander pregnant people to 28%, 29.3% and 28.4% respectively	
Strategies	
A1) Educate the Regional Perinatal Quality Collaboratives (RPQCs) regarding low-risk Cesarean data A2) Regional representatives will share ongoing information with RPQCs regarding the Obstetrics Initiative (OBI) and Alliance for Innovation on Maternal Health (AIM) bundle on safe reduction of primary cesarean birth A3) Continue partnering with the American College of Obstetricians and Gynecologists (ACOG) Alliance for Innovation on Maternal Health (AIM) and work through MI-AIM to increase the number of birthing hospitals participating in MI-AIM	
B1) Include bias and equity training as part of the MI-AIM hospital designation criteria B2) Encourage and support ongoing bias and equity training for MI-AIM Steering and Operations Committee members B3) Support ongoing education and training regarding bias and equity for the Michigan Maternal Mortality Surveillance Review Committee members	
ESMs	**Status**
ESM LRC.1 - Number of birthing hospitals participating in Michigan AIM	Active
NOMs	
NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM	
NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM	

State Action Plan Table (Michigan) - Women/Maternal Health - Entry 2

Priority Need

Improve oral health awareness and create an oral health delivery system that provides access through multiple systems

NPM

NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy

Five-Year Objectives

A) Increase the number of medical and dental providers trained to treat, screen, and refer pregnant people and infants to equitable oral health care services

B) Increase the number of socioeconomically disadvantaged pregnant people receiving oral health care services

Strategies

A1) Offer and evaluate training for medical and dental professionals that includes health equity components A2) Create and disseminate updated Perinatal Oral Health promotional and educational materials that feature health equity

B1) Develop a plan from Medicaid utilization data and PRAMS racial and ethnic healthcare data to address oral health and health equity issues B2) Collaborate with diverse partners to facilitate alternative models of care for integrating oral health into pregnancy B3) Provide education to pregnant people via targeted training efforts

ESMs	Status
ESM PDV-Pregnancy.1 - Number of medical and dental professionals who receive perinatal oral health education through MDHHS	Active
ESM PDV-Pregnancy.2 - Percent of pregnant people who receive at least one oral health service through Medicaid during the perinatal period	Active

NOMs

NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS

State Action Plan Table (Michigan) - Women/Maternal Health - Entry 3

NPM

NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV

Five-Year Objectives

A) Conduct planning and assessment activities related to Postpartum Visit

B) Increase awareness about the importance of postpartum visits among pregnant and postpartum people

Strategies

A1) Assess data related to postpartum visits A2) Explore evidence-based and evidence-informed strategies and best practices related to postpartum visits

B1) Develop an article in the Philips Pregnancy+ smart application (app) about the postpartum visit and conduct a survey in the Philips Pregnancy+ app to obtain information about pregnant peoples' attitudes about the importance of postpartum visits B2) Recruit up to 25 new and 8 existing CenteringPregnancy sites to increase adoption of the CenteringPregnancy model B3) Support development and implementation of a postpartum module in the High Touch, High Tech (HT2) Pregnancy Checkup app for new and existing HT2 sites B4) Promote the Michigan Hear Her website and resources

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

State Action Plan Table (Michigan) - Women/Maternal Health - Entry 4

Priority Need

Develop a proactive and responsive health system that equitably meets the needs of all populations, eliminating barriers related to race, culture, language, sexual orientation, age and gender identity

SPM

SPM 5 - Percent of people assigned female at birth who had a live birth and reported that their pregnancy was intended

Five-Year Objectives

A) Increase the percent of females (i.e., assigned at birth) aged 15 to 44 who use a most or moderately effective contraceptive method from 77% to 82% by 2025

B) Increase the percent of females (i.e., assigned at birth) aged 15 to 19 who use a most or moderately effective contraceptive method from 84% to 89% by 2025

C) By 2025, increase by 10% percent the number of Family Planning clients who rate their experience of care with a score of 4 or 5

Strategies

A1) Support the provision of contraception to low-income, uninsured, and underinsured people who can get pregnant in the Family Planning Program A2) Facilitate long-acting reversible contraceptive (LARC) training opportunities for Family Planning and other health care providers A3) Support the integration of telehealth best practices across Family Planning's provider network A4) Translate regional listening session findings into action for people of reproductive age who can get pregnant

B1) Support at least 6,500 individuals' access to publicly funded contraception B2) Translate regional listening session findings into action for youth and young adults B3) Translate youth input into action on the Family Planning website

C1) Include the person-centered contraceptive counseling (PCCC) measure on Family Planning's annual statewide consumer survey C2) Analyze the PCCC measure, share key findings with the Family Planning network, and promote data-driven decision-making C3) Promote MDHHS's updated Contraceptive Counseling Modules with the Family Planning network, other healthcare providers, and related public health programs

Women/Maternal Health Overview

The health of women and mothers is a key focus of the Division of Maternal and Infant Health (DMIH), which includes the Reproductive Health Unit and Michigan's Title X program. The Maternal Infant Health Program (MIHP), which is Michigan's statewide evidence-based home visitation program for Medicaid eligible pregnant people, is also housed in the DMIH. Title V funding supports programs and services designed to improve women's pre- and interconception health, specifically through family planning and preventative health services. Title V funds are also used to understand and address women's health issues more broadly as they relate to factors that drive disparities in maternal outcomes. For example, Title V funding supports the Pregnancy Risk Assessment Monitoring System (PRAMS). To address additional health needs of women, Michigan leverages other federal funds, such as the Preventive Health and Health Services Block Grant (CDC) and partners with chronic disease, cancer prevention, substance abuse prevention, and injury and violence prevention programs within MDHHS. Additional partnerships that impact women's health include Local Health Departments, the Michigan Council for Maternal and Child Health, Regional Perinatal Quality Collaboratives, Family Planning service providers, and the Michigan Primary Care Association.

Title V funding also supports the Local Maternal Child Health (LMCH) program which provides funding to all 45 Local Health Departments (LHDs). In FY 2023, Title V funds via the LMCH program were expended on NPM 13.1 (oral health-women), SPM 5 (intended pregnancy), SPM 6 (behavioral/mental health), and Local Performance Measures (LPMs) in the women/maternal health domain. Two LHDs worked on engaging pregnant women regarding oral health (NPM 13.1) through education, referrals, and community outreach. Three LHDs supported intended pregnancy (SPM 5) and an LPM for adolescent well-visit activities through gap-filling reproductive health services and media campaigns with reproductive health topics. Three LHDs expended funds on SPM 6 (behavioral/mental health) including gap-filling depression and behavioral risk screening and treatment referrals for women and pregnant women, staff development, and participation in coalition meetings.

Six LHDs chose LPMs in the women/maternal health domain with activities that included gap-filling immunizations, including COVID-19 for childbearing women, childbirth education classes, a peer mentor initiative for pregnant people, gap-filling Healthy Families America support, support for MCH telephone information/referrals, tobacco cessation services and a social media campaign on vaccinations during pregnancy. Many meetings and educational events remained virtual until mid-year when restrictions were lifted, and some in-person events occurred. LHDs reported that the pandemic impacted referral rates, trust in public health, as well as the acceptance of services.

Michigan's approach to women's health through Title V state action plans emphasizes improving access to high quality health services for this population—including reproductive, preventative, and oral health services—based on the concept that access to care that is high quality can be preventative across a variety of health needs.

Low-risk Cesarean Delivery (FY 2023 Annual Report)

Recent data trends suggest that low-risk cesarean deliveries among all Michigan births have decreased from calendar year 2021 to 2022. To continue this trend, partnerships and collaborations with key internal and external partners are vital and will need to be continuously strengthened. Examples of partnerships include Michigan families, the Michigan Perinatal Quality Collaborative (MI PQC)/Regional Perinatal Quality Collaboratives (RPQCs); Michigan's chapter of American College of Obstetrics and Gynecologists' (ACOG) Alliance for Innovation on Maternal Health (AIM); Obstetric Initiative (OBI); Michigan Department of Health and Human Services (MDHHS) Maternal and Child Health (MCH) Epidemiology; Michigan Maternal Mortality Surveillance program; Michigan birthing hospitals; and Michigan Public Health Institute (MPHI).

The impacts of the COVID-19 pandemic continued to be felt across maternal and child health programs in FY 2023. Hospitals continued to face staffing shortages and thus had limited bandwidth to take on additional tasks, meetings, or trainings, including those related to quality improvement and patient safety bundle implementation. However, staff have continued to recognize the importance, and strive toward the incorporation, of quality improvement within maternal and infant health. Two Regional Perinatal Quality Collaboratives with historically low MI AIM participation continued to encourage engagement of additional birthing hospitals in their respective regions. Health equity remained at the forefront of all efforts, including those of the Regional Perinatal Quality Collaboratives, MI AIM, and the Michigan Maternal Mortality Review Committee. Implicit bias education of providers was supported through multiple maternal health entities.

Michigan families are the most important partner in MDHHS efforts. Therefore, RPQCs are expected to authentically engage families and community members from their respective regions in their ongoing efforts. Hosting regional townhalls is one example of how RPQCs have engaged community members. In 2023, Michigan held in-person townhall meetings for the first time in three years. Twelve townhall meetings were held across the state in the months of April and May 2023. As in previous townhall meetings, community members and families came together to provide feedback and give direction to efforts of the RPQC and MDHHS. Individuals shared powerful personal birthing experiences, including those who were forced to have a cesarean delivery out of convenience for the provider or due to the decision of the provider to utilize higher-cost birthing interventions. Reducing rates of low-risk cesarean deliveries is dependent upon providers and community understanding the adverse outcomes that may result from low-risk cesarean births (i.e., hemorrhage, infection, uterine rupture, cardiac arrest, and anesthesia complications).

Objective A: By 2025, reduce the number of cesarean deliveries among all Michigan low-risk births to 27%.

Collaboration between the Regional Perinatal Quality Collaboratives (RPQCs), MI AIM and the Obstetric Initiative continue to be important in Michigan's efforts to reduce the overall percentage of low-risk cesarean deliveries. Updated state data show that low-risk cesarean deliveries decreased from 29.1% in 2021 to 28.9% in 2022[1]. RPQCs are continually encouraged to create better alignment with MI AIM and their respective regional birthing hospitals to strengthen relationships between community and clinical efforts in addressing maternal, infant, and family health. In FY 2022, MDHHS was awarded a 5-year grant from the Centers for Disease Control and Prevention to expand and enhance participation of birthing hospitals with MI AIM and the RPQCs, as well as support quality improvement efforts of birthing hospitals. RPQCs also receive financial support from MDHHS, a portion of which is Title V federal funding, as well as staff support in the form of a direct consultant and a Michigan PQC Coordinator.

Michigan utilized several strategies to increase awareness of the importance in reducing low-risk cesarean births. Statewide and regional data illustrating low-risk cesarean births rates were shared during the FY 2023 data meeting. In addition, the RPQCs received region-specific low-risk Cesarean delivery data as part of their FY 2023 data packet. A representative from the Obstetrics Initiative (OBI) presented at an RPQC leadership meeting, sharing data, the efforts of OBI, Quality Improvement capacity and creating a culture shift. The goal of the presentation was not only education, but to also encourage RPQC leadership to think of ways in which their Collaborative could support efforts in reducing low-risk cesarean delivery rates.

The importance of this NPM is further illustrated through identification as an area of focus by the Michigan Maternal Mortality Review Committee (MMRC). As the MMRC reviews maternal mortality cases, recommendations aimed to prevent future deaths are drafted and shared through various avenues, including the Regional Perinatal Quality Collaboratives (RPQCs). Implementation of the Safe Reduction of Primary Cesarean Birth Safety Bundle was also identified as a Michigan Maternal Mortality Review Committee (MMRC) priority recommendation.

Each of Michigan's 10 prosperity regions are represented by an RPQC and have an assigned MI AIM representative. As part of the ongoing alignment between the RPQCs and MI AIM, the MI AIM regional representatives are required to provide bi-annual MI AIM and OBI updates to their respective RPQC membership. In FY 2023, most RPQCs received at least two updates from their MI AIM representative. Updates include the status of regional birthing hospitals on implementation of the Obstetric Hemorrhage, Severe Hypertension in Pregnancy and Maternal Sepsis safety bundles, as well as OBI performance indicators. General MI AIM updates are also provided. Participation in the RPQC and OBI activities is further encouraged through MI AIM designation criteria. In 2023, criteria included points associated with birthing hospital participation in their respective RPQC, as well as points for an OBI metric.

The ESM for this NPM, which aligns with this objective, is the number of birthing hospitals participating in MI AIM. Ongoing support for the Michigan chapter of this national data-driven safety and quality improvement initiative is a key component in decreasing the percentage of low-risk cesarean deliveries in Michigan. MI AIM is working to decrease maternal mortality and morbidity in Michigan through the implementation of the Obstetric Hemorrhage, Severe Hypertension in Pregnancy and Sepsis in Obstetric Care safety bundles, as well as supporting the Safe Reduction of Primary Cesarean Birth through the Obstetric Initiative. MDHHS provides support to MI AIM through participation by the Director of the Division of Maternal and Infant Health/Title V MCH Director in the MI AIM Steering Team and the Michigan Perinatal Quality Collaborative Coordinator serving as a liaison between the RPQCs and MI AIM, as well as participating on the MI AIM Operations Team. As mentioned above, MDHHS also received grant funds to support birthing hospital engagement with the RPQCs and MI AIM. The initiatives supported by this grant will boost current efforts and further enhance participation, bundle implementation and other quality improvement efforts.

The COVID-19 pandemic impacted the participation of birthing hospitals with MI AIM. Continued staff turnover and limited unit staffing, resulting from effects of the COVID-19 pandemic, impacted the ability of some hospitals to fully engage in bundle implementation and/or data abstraction. Two Michigan RPQCs continued to work with birthing hospitals in their respective regions to engage them in MI AIM. These regions historically had low participation with MI AIM. In FY 2023, Region 10 (southeast Michigan) was able to obtain a commitment from 19 of 21 birthing hospitals to participate in MI AIM. In previous years, only 12 hospitals had been actively participating. Additionally, in Region 1 (Upper Peninsula) six of eight birthing hospitals committed to participate in MI AIM, whereas previously, only three hospitals actively participated. The most recent data available for this ESM is from 2022. In 2022, 63 out of 79 birthing hospitals actively participated in MI AIM.

Objective B: By 2025, reduce the percentage of low-risk cesarean births in African American women, American Indian women and Asian/Pacific Islander women to 28%, 29.3% and 28.4% respectively.

From 2021 to 2022 low-risk cesarean deliveries in Michigan decreased in African American pregnant people (from 32.2% to 31.5%) and in American Indian pregnant people (from 31% to 29.1%). In the same year, however, low-risk cesarean deliveries increased (from 32.6% to 35.2%) in Asian/Pacific Islander pregnant people[2]. Despite a reduction in the rate for African American and American Indian pregnant people, the data for each population is still illustrative of a persistent disparity. One approach that Michigan is taking to reduce the racial disparity in low-risk cesarean deliveries is to support ongoing bias and equity training and education in birthing hospital staff and providers, MI AIM members and leaders, and the Michigan Maternal Mortality Review Committee members.

Every year Michigan birthing hospitals are assessed for their level of participation and commitment to implementing AIM safety bundles. The safety bundles are standardized approaches for condition specific, evidence-based practices, which when delivered in a consistent manner, result in improved patient outcomes. To assess individual birthing hospitals, MI AIM uses a set of 'designation criteria' in which points are assigned to various criteria yielding

a final tally and corresponding score. Bias and equity trainings continued as a priority in the 2023 MI AIM designation criteria.

As mentioned above, bias and equity trainings are a priority area for MI AIM. The MI AIM Steering and Operations Committee members are comprised of practicing obstetric and gynecologic providers across Michigan, who are leaders in the field and committed to improving maternal outcomes. Ensuring that these leaders are knowledgeable in health equity and systemic racism is critical as they are expected to be change agents within their health care organizations. As the webinars offered in FY 2022 were rich in details and popular with birthing hospital participants, MI AIM again offered two webinars in 2023 on health equity, which were hosted by Region 10 Perinatal Quality Collaborative leadership. The webinars shared tools available for individual and system equity work, as well as using an equity lens in maternal care. The webinars were available live and were also recorded and posted on the MI AIM website, which can be accessed at any time for those who want to re-visit the webinar or for those who may have missed it live.

The Health Equity Action Committee was one of five Mother Infant Health Action Committees that were launched by MDHHS in FY 2021. Leadership of the Health Equity Action Committee felt that membership's time would be best spent by integrating health equity into the goals and objectives of other Action Committees to further strengthen those priorities. As a result, the Health Equity Action Committee has disbanded.

Michigan's Maternal Mortality Review Committee (MMRC) was selected to pilot the Discrimination, Assessment and Social Determinants of Health Tool (DASH tool) in FY 2022. The DASH tool was developed by the Texas Maternal Mortality and Morbidity's Subcommittee on Maternal Health Disparities to better address and identify the role of bias and discrimination in maternal mortality. Michigan's MMRC continued to use the tool in FY 2023 to guide committee deliberations around the presence and contributions of discrimination within maternal death case reviews. Integrating a health equity framework into the Michigan MMRC remains a priority. As such, in FY 2023, the Michigan Maternal Mortality Surveillance Program, of which the MMRC resides, partnered with Henry Ford Health Office of Community Health, Equity & Wellness (CHEW) to conduct a two-part training, *Reducing Unconscious Bias – an imperative (RUBI)*. The purpose of the training was to address unconscious bias, dive deeper into conversations on bias, respectful care and their impact on racial disparities in maternal health.

Michigan's Maternal Mortality Review Committee (MMRC) is committed to ensuring its membership is diverse and comprised of representatives from various disciplines and geographic locations throughout the state. Examples of disciplines represented include public health, obstetrics and gynecology, maternal-fetal medicine, nursing, midwifery, forensic pathology, mental health, behavioral health, and community-based organizations.

In the previous fiscal year, the Michigan Maternal Mortality Surveillance (MMMS) program convened an advisory group, referred to as the MMMS Recommendations Workgroup, which is tasked with acting on the prevention recommendations developed by the MMRC. The MMMS Recommendations Workgroup's diverse members represent various specialties, facilities, and systems that interact with and impact maternal health. While current recommendations aren't directly aimed at reducing low-risk cesarean births, certain recommendations are nonspecific, including encouraging pregnant people and families to utilize support programs and services (e.g., doulas and home visiting), improving communication between providers and patients, and promoting the use of respectful care. These recommendations apply to several morbidity and mortality causes, including low-risk cesarean births.

Oral Health – Women/Maternal Health (FY 2023 Annual Report)

In FY 2023, the Michigan Oral Health Program (OHP) worked diligently to address challenges, improve oral health awareness, and utilize an oral health delivery system to improve access to equitable care for pregnant people.

Michigan continues to struggle with severe oral health workforce shortages, which have caused considerable strain on Michigan's oral health safety net. Resources remain limited and wait times for care may be measured by months. HRSA estimates that 1.6 million Michiganders have inadequate access to dental services and that an additional 400 dentists are needed to serve them. Despite these challenges, the OHP has worked to provide comprehensive programming and technical assistance to its partners across the state and has maintained a successful perinatal oral health initiative. FY 2023 saw new, diverse partnerships and continued opportunities for education and system transformation through data driven strategies. In combination with other funding, Title V supports an Oral Health epidemiologist who analyzes PRAMS data and Medicaid utilization data within NPM 13.1. The epidemiologist also assists in survey development, needs assessments, dashboard creation, and other data needs as required by the perinatal oral health program.

NPM 13.1 continued to play a vital role in multiple state and national partnerships, specifically with the Association of State and Territorial Dental Directors (ASTDD), the Michigan Initiative for Maternal and Infant Oral Health (MIMIOH), and the Network for Oral Health Integration (NOHI). The OHP worked with these programs to improve oral health for pregnant women and children through technical support and assistance. The OHP maintained working relationships with WIC, Head Start, advisory committees, local coalitions, and refugee organizations to further promote and advise on issues within perinatal oral health. New partnerships were also developed with Regional Perinatal Quality Collaboratives and health departments. New Medicaid policy was enacted which increased covered treatment options for Medicaid recipients in Michigan, including pregnant people. In partnership with stakeholders and program such as these, the OHP continued to see success in FY 2023 in educating professionals (with 409 trained); continuing to utilize a first-of-its-kind data methodology that is now serving as a national model; working with refugee entities, continuing to utilize educational modules for clients; and launching new projects which have helped to educate and inform new partners serving some of Michigan's most vulnerable populations.

Objective A: Increase the number of medical and dental providers trained to treat, screen and refer pregnant people and infants to equitable oral health care services.

In FY 2023, the MDHHS Oral Health Program continued to expand efforts to train and educate the medical and dental communities on the importance of perinatal oral health, as well as methodologies and best practices to integrate perinatal oral health into practice. The evidence-based or informed strategy measure (ESM), which is the number of medical and dental professionals who receive perinatal oral health education through MDHHS within a 12-month period, is part of this objective. FY 2023 focused on maintaining current relationships with the University of Michigan College of Nursing and Central Michigan University's Public Health program as well as expanding into new partnerships. Of particular significance was extensive work with Michigan's refugee populations and home visiting entities. By participating in webinars with organizations such as home visiting, WIC, and SisterFriends the Perinatal Oral Health Initiative was able to speak not only to public health professionals but also engage directly with parents and community members. During FY 2023, 409 health professionals were trained on culturally competent, practical perinatal oral health practices. This is an increase over FY 2022. In FY 2023, the OHP program expanded education to multiple classes of Detroit SisterFriends, a pregnancy support organization in Detroit. SisterFriends work to improve birth outcomes and infant mortality rates in Detroit by connecting volunteer mentors to people who are pregnant or recently had a baby to gain access to services and resources while creating support around Detroit families. Feedback from participants has been overwhelmingly positive, and the OHP has been able to help connect clients to dental care while also providing education to participants.

In FY 2023 the OHP worked to revitalize our Perinatal Oral Health Advisory Committee through the recruitment and additional participation of medical, dental, and public health professionals. The addition of new members has allowed the OHP to form new strategic partnerships with relevant organizations and determine priorities as the program moves forward. This group was also able to assist in applying to future funding opportunities for perinatal oral health related projects.

Lastly, the Perinatal Dashboard continued into FY 2023 and was featured in an educational session held by CMS. By being able to show specific utilization rates and health inequalities within Michigan's different regions, the Perinatal Oral Health Initiative has been able to engage with organizations and provide applicable, real-life information regarding the populations they serve. The interactive dashboard is also published on the MDHHS website for public use. This dashboard and Medicaid utilization measure informs an ESM for this strategy, which is the number of pregnant people on Medicaid who have at least one dental encounter during the perinatal period. The goal for FY 2023 was 41% and in FY 2023 the utilization rate was 19%. For comparison, pre-COVID statewide rates hovered around 24% which is typical of overall Medicaid utilization rates in Michigan for adult dental. The FY 2023 numbers (using FY 2022 data) show the continued impacts of COVID on dental utilization.

Objective B: Increase the number of socioeconomically disadvantaged pregnant people receiving oral health care services.

In FY 2023, the OHP analyzed PRAMS and Medicaid utilization data to assess differences in dental care among different races and ethnicities. Although the capacity to delineate between many races and ethnicities is limited, the data show disparities between people who identify as Black, White, and Hispanic. In the last available reporting data, white, non-Hispanic individuals were more likely to have received dental care (20%) during their pregnancy than those who were Hispanic (17.5%). Geographic data indicates that the Detroit area has some of the lowest dental utilization during pregnancy with only 17% percent of pregnant people having any type of dental care. This is a slight increase (3%) from 2021. In comparison, Southwestern Michigan has utilization rates of nearly 26%. These data have offered tremendous insight into geographic disparities. FY 2023 focused on targeting specific areas through education as well as identifying barriers and opportunities that may have influenced differences in rates across the state.

In FY 2023 the OHP continued to work closely with Michigan's refugee community to help educate staff and families as well as help link incoming Afghan nationals to dental care. The OHP presented at the National Oral health Conference with a panel of Michigan refugee experts on efforts to connect new arrivals to oral health care. Public health as well as medical and dental professionals from across the country were given an overview of the refugee process, insurances, and tools to take back to their states to facilitate collaboration with state dental entities and refugee programs.

A FY 2023 highlight was the expansion of new, enhanced adult dental Medicaid benefits in Michigan with a dramatic increase in additional services like periodontal coverage, crowns, and root canals. Coverage for pregnant people is available up to a year postpartum as part of Healthy Moms, Healthy Babies funding. The OHP conducted extensive education efforts for both the medical and dental communities, as well as Medicaid recipients surrounding these enhancements. Nearly half of all births in Michigan are covered by Medicaid, and pregnancy is an opportune time to address oral health needs as a pregnant person may now have dental insurance due to their pregnancy. As this and other Medicaid enhancements become established, the oral health program will report on the impact on the number of pregnant people who utilize care.

In FY 2023, the Michigan Initiative for Maternal and Infant Oral Health (MIMIOH) worked to maintain participating sites and share results from its comprehensive evaluation. Its continued goal is to improve the oral health of mothers and children in the state of Michigan, with particular focus on patients within Federally Qualified Health Centers. Dental workforce shortages have made this program difficult to operate, as sites have been forced to pull staff from OBGYN clinics back into traditional practice due to short staffing. Regardless, Michigan continues to serve as a model on interprofessional practice and other entities are in the process of replicating adding dental hygienists into the medical team.

Lastly, in FY 2023 the MDHHS Oral Health Program continued to provide education to women via the Perinatal Oral

Health WIC module. Since its inception, the Perinatal Oral Health WIC module developed by MDHHS has been completed by over 70,000 women across the United States. Wichealth.org continues to provide stage-based, client-centered, nutrition education and an anticipatory guidance model in which WIC clients can successfully complete educational lessons in English and Spanish, with women completing lessons to receive their WIC benefits. Participants received personalized feedback and educational materials as well as nurse follow up on any questions raised during the training. This model continues to allow for consumer engagement and feedback from participants. By partnering with WIC, the Oral Health Program can continue to target a diverse range of women who may be impacted by health disparities.

Intended Pregnancy (FY 2023 Annual Report)

In FY 2023, Title V funding helped to support access to reproductive health care services and contraception through local Family Planning agencies with a focus on serving young adults. MDHHS focused on strategies to maintain access to reproductive health services across the state, including provider training for long-acting reversible contraceptives (LARC) and supporting the expansion of telehealth services with a cohort of eight local agencies. MDHHS relies heavily on its local public health system to deliver affordable and confidential reproductive health care services. While full-service delivery has now resumed that the COVID-19 public health emergency (PHE) has ended, challenges spurred during the PHE remain, including clinical staffing shortages (e.g., nurses, mid-level providers) and/or turnover, rebuilding community trust, and navigating governing boards (i.e., Boards of Commissioners), thus affecting service delivery capacity and strategies.

While MDHHS was able to gather youth input on enhancements that would support a more youth-friendly Family Planning website, it was not able to conduct its planned regional listening sessions due to limited staffing capacity in FY 2023. Thirteen regional listening sessions will be conducted in FY 2024 in partnership with the Michigan Public Health Institute (MPHI). MDHHS continued to support provider training on systemic racism across the reproductive span by sponsoring the opening plenary speaker, Loretta Ross, at the 2023 Maternal Infant Health Summit. MDHHS worked to integrate aspects of the reproductive justice framework into Family Planning by requiring agencies to include at least one health equity, health disparities, or social determinants of health objective in their project work plans.

The Family Planning Program also engages consumers by soliciting feedback through state and local client satisfaction surveys and participation on state and local Advisory Boards. In FY 2023, MDHHS included the person-centered contraceptive counseling measure on its annual client satisfaction survey to assess new clients' experiences with contraceptive counseling. Youth voice is incorporated into policies, programs, and practices by collaborating with Michigan Youth (MY) Voice, a statewide youth council coordinated by the Michigan Organization on Adolescent Sexual Health. The quality of reproductive health care is assessed by monitoring local agency quality assurance mechanisms (i.e., abnormal pap follow-up) and improvement efforts (i.e., PDSA cycles).

Objective A: Increase the percent of females aged 15 to 44 who use a most or moderately effective contraceptive method from 77% to 82% by 2025.

The first strategy to aid in achieving this objective is to support the provision of contraception to low-income and un/underinsured individuals who can get pregnant in the Family Planning Program. Having access to client-centered counseling and a broad range of effective contraceptive methods allows each person who can get pregnant the opportunity to choose the method that is right for them to successfully delay or prevent pregnancy. In 2023, 71.6% of female (i.e., assigned at birth) Family Planning clients aged 15 to 44 years old chose a most effective (sterilization, vasectomy, or LARC) or moderately effective (pills, patch, ring, cervical cap, or diaphragm) method, with 21.5% choosing LARC. The integration of approximately half of Family Planning and Sexually Transmitted Infection (STI) clinics has resulted in more comprehensive services for clients, while concurrently increasing the number of females

(i.e., assigned at birth) aged 15 to 44 who report external condoms as their primary method of contraception, resulting in an increase in use from FY 2022 of over 200%. In FY 2023, MDHHS worked to maintain access to a broad range of contraception, while balancing individuals' contraceptive needs and preferences. Preserving access to a broad range of contraception, particularly for low-income and un/underinsured individuals who often face multiple barriers (e.g., financial, transportation, paid leave, etc.) to contraceptive care is critical to making informed decisions about reproductive health. In FY 2023, MDHHS's Family Planning Program served 38,748 female (i.e., assigned at birth) clients, along with 45% low-income (≤100% federal poverty level (FPL)) clients and 24% uninsured clients.

The second planned strategy was to facilitate long-acting reversible contraceptive (LARC) training opportunities for Family Planning and other health care providers to support on-site access to provider-dependent FDA-approved contraceptive methods. To bolster provider proficiency and client access, MDHHS's Family Planning Program provided one LARC clinical practicum focused on the insertion and removal of Paragard a non-hormonal intrauterine device (IUD), in conjunction with its annual conference on September 30, 2023. Six mid-level clinicians attended. The Paragard clinical practicum had an 83% evaluation response rate (n= 5). Practicum evaluations demonstrated 100% of respondents now have the skills necessary to insert and remove Paragard and will offer this method at their clinic within the next six months. The Family Planning Program surveys its network of providers annually to assess clinical practicum needs and guide future training offerings.

Supporting the continued integration of telehealth as a service delivery tool across Family Planning's provider network was the third strategy to aid this objective. Telehealth visits are delivered directly to clients by telephone, video, or messaging technologies. In 2023, approximately 6% of all family planning encounters were virtual. To bolster access, a cohort of eight local Family Planning agencies utilized $700,000 in one-time funds for telehealth enhancement and expansion. Key technology successes included two Family Planning providers being able to offer virtual visits for the first time with integrated telehealth technology and the implementation of telehealth technology upgrades for two other providers to enhance and streamline patients' virtual service delivery experience. A key staffing capacity success included the addition of 100 telehealth appointment spots per week for another Family Planning provider. In addition, this provider was able to utilize these funds to lay the groundwork for offering telePrEP. Approximately 94,450 Michiganders were reached by this cohort of providers via promotional media/social campaigns and boots-on-the-ground outreach aimed at increasing awareness of telehealth service availability.

MDHHS was unable to conduct its fourth strategy for this objective, regional listening sessions with individuals of reproductive age across the state to learn more about their reproductive and sexual health needs in FY 2023 due to limited staffing capacity. Regional listening sessions will proceed in FY 2024 and MDHHS will partner with the Michigan Public Health Institute (MPHI) to facilitate and conduct 13 regional listening sessions with participant incentives. Listening session design, recruitment strategies, and facilitation guide/protocol will be developed in early 2024 with listening sessions being held in spring/summer 2024. MPHI will analyze the data and interpret the results with MDHHS staff to inform recommendations for clinical service delivery improvements and future program decision-making. Key findings will be disseminated to state/local partners and stakeholders.

Objective B: Increase the percent of females (i.e., assigned at birth) aged 15 to 19 who use a most or moderately effective contraceptive method from 84% to 89% by 2025.

The first strategy to achieve this objective was to support at least 10,000 individuals' (i.e., 18 to 21 years old) access to publicly funded contraception. In Michigan, sexually active adolescents encounter multiple barriers to accessing affordable contraception. An estimated 147,450 sexually active women <20 years old need publicly supported contraception (Guttmacher Institute, 2019). In 2021, 67% of sexually active high schoolers did not use a most effective reversible method (IUD or implant) or moderately effective method (shot, pills, patch, or ring) and 14% reported not using any methods to prevent pregnancy at last intercourse (Michigan YRBS, 2021). To support

progress toward this objective, 14.2% (6,414) of Family Planning clients ages 15 to 19 years old in 2023, of which 84.4% being female clients (i.e., assigned at birth) chose a most or moderately effective method and 20.8% chose LARC. The best contraceptive option is one that will be used consistently and correctly. Approximately 10.2% of female clients (i.e., assigned at birth) aged 15 to 19 years old chose an external condom as their primary method, the only method that provides dual protection against pregnancy and STIs.

MDHHS was unable to conduct its second strategy for this objective, regional listening sessions with minors and young adults across the state to learn more about their reproductive and sexual health needs in FY 2023 due to limited staffing capacity. As part of the aforementioned 13 regional listening sessions planned for FY 2024, a virtual statewide listening session will be conducted in partnership with the Michigan Organization on Adolescent Sexual Health's (MOASH) Sexual Health for Adolescents Rooted in Equity (SHARE) youth advisory council, which is comprised of young people aged 16 to 21 years, who identify as lesbian, gay, bisexual, and queer (LGBTQ); are part of Black, Indigenous, and other people of color (BIPOC) communities; or reside in rural areas across the state. Results will be used to develop adolescent specific recommendations for clinical service delivery improvements and future program decision-making. Key findings will be disseminated to state/local partners and stakeholders.

The third strategy to aid this objective was obtaining youth input on Family Planning's website content to support it serving as a trusted sexual and reproductive health information resource for Michigan youth. In FY 2023, MDHHS partnered with two of MOASH's youth advisory councils (YACs) on March 11, 2023, to facilitate the virtual evaluation of its website content using a semi-structured protocol. MDHHS staff provided YAC participants a guided tour of Family Planning's website where participants noted their reactions for each section on a Google Jamboard. Key themes included emphasizing confidentiality and minors' medical rights; inclusive language use for populations served and services offered; highlighting the program's commitment to non-discrimination and clinic efforts to create welcoming/affirming environments; and incorporating sexually transmitted infection (STI) exposure and treatment information (e.g., what to do if STI suspected). Overall, YAC participants would have preferred to have seen brighter colors on the website, less text, more educational content (e.g., puberty, healthy relationships/consent, talking with healthcare providers), and more graphics, especially for birth control methods. In FY 2024, MDHHS will translate this youth input into action to create a more youth-friendly Family Planning website.

Objective C: By 2025, increase by 10% percent the number of Family Planning clients who rate their experience of care with a score of 4 or 5.

The first strategy to achieve this objective was to include the person-centered contraceptive counseling (PCCC) measure on Family Planning's annual client satisfaction survey. Research in Family Planning has demonstrated that contraceptive counseling has an influence on a client's contraceptive method selection. When contraceptive quality is solely focused on access, there is risk of inadvertently incentivizing coercion for most or moderately effective methods, especially for BIPOC, low-income, and incarcerated individuals who have experienced historical and present-day reproductive oppression. In FY 2023, MDHHS's Family Planning Program implemented the PCCC measure on its annual client satisfaction survey to assess new clients' experiences with contraceptive counseling. The four-item PCCC measure assessed the quality of contraceptive care domains Family Planning clients receive from their provider: interpersonal connection, adequate information, and decision support. Overall, 98% of new clients selected 'excellent' (95%) or 'very good' (3%) across all four PCCC items. Annual client satisfaction survey results were presented at Family Planning's October 2023 Advisory Council meeting. MDHHS will utilize this measure to monitor client experiences over time and inform quality improvement efforts.

The second strategy was to convene at least one training for 50 health care professionals on systemic racism and reproductive health. During the 2023 Maternal Infant Health Summit, Family Planning supported Loretta Ross' opening plenary presentation, *Health Equity in Maternal Infant Care*, which was attended by more than 500 public

health and health care professionals. Ms. Ross' opening plenary focused on the impacts of systemic racism on health care practices across the reproductive span and bodily autonomy within the context of the current maternal and infant mortality crises experienced primarily by Black and Indigenous women and infants. Summit evaluations indicated 89% of respondents (n=169) were highly satisfied, overall, with Ms. Ross' opening plenary, with 82% of respondents having reported they would have her back as a speaker at a future Summit.

The third strategy was to apply a reproductive justice framework within Family Planning and related maternal/infant health projects. In FY 2023, all local Family Planning agencies (34) were required to include at least one health equity, health disparities, or social determinants of health objective in their project work plans. Overall themes for this objective and related activities were provider and staff training on implicit bias and cultural humility; screening clients for social determinants of health needs; and making appropriate referrals and partnering with community-based agencies serving marginalized or vulnerable populations (e.g., foster care, LGBTQ+) to expand access to sexual/reproductive health care services. During FY 2023, progress on objective achievement and activity completion was reported on a quarterly basis to MDHHS and was evaluated via program monitoring/oversight mechanisms (e.g., comprehensive site reviews). Additionally, at the end of FY 2023, a small team of Family Planning staff and the Division's Health Equity Specialist completed participation in the Reproductive & Sexual Health Equity Peer Learning Group facilitated by the Reproductive Health National Training Center.

[1] Michigan Resident Live Birth Files; MDHHS Division of Vital Records and Health Statistics. Maternal and Infant Health program staff use Michigan Vital Records data more regularly than NVSS data, as the Michigan data are accessible on a more immediate and regular basis.
[2] Michigan Resident Live Birth Files; MDHHS Division of Vital Records and Health Statistics.

Women/Maternal Health - Application Year

Low-risk Cesarean Delivery (FY 2025 Application)

Percent of cesarean deliveries among low-risk births (NPM 2) was selected as a measure for the Women/Maternal Health domain to address the state priority need of developing a proactive and responsive health system that equitably meets the needs of all populations and eliminates barriers. In some situations, and for some medical indications, cesarean deliveries can be a life-saving measure. However, for many low-risk pregnancies, a cesarean delivery can lead to preventable causes of maternal mortality and morbidity outcomes. Such outcomes include mortality due to hemorrhage and morbidities, such as infection, uterine rupture, cardiac arrest, and anesthesia complications. In Michigan from 2016-2020, 7.5% of pregnancy-related deaths were due to hemorrhage and 14.2% were due to infection or sepsis. Overall, 74.5% of pregnancy-related deaths in Michigan from 2016-2020 were deemed preventable[1]. In 2022, 28.9% of all live births[1] in Michigan were low-risk cesarean deliveries. The 2022 percentage of low-risk cesarean deliveries (28.9%) is above both the Healthy People 2030 goal of 23.6% and the 2022 average for the United States (US) which was 26.3%[2]. While the percentage of low-risk cesarean deliveries has decreased in Michigan from 2021 to 2022, the percentage still remains higher than national and state goals.

As with other birth outcomes, racial disparities are evident in low-risk cesarean births. In 2022, of all live births, 31.5% of black pregnant people had low-risk cesarean deliveries, as did 29.1% of American Indian pregnant people and 35.2% Asian/Pacific Islander pregnant people, compared to 27.9% of white pregnant people[1,[3]]. In addition to the data portraying disparities in low-risk cesarean deliveries, anecdotal qualitative data suggest that black and brown pregnant people may feel coerced into delivering via cesarean section. Research has documented the negative feelings and self-perception that can be experienced when birth plans go awry. This can further contribute to experiences of post-traumatic stress disorder, postpartum depression, and anxiety. The Michigan Maternal Mortality Surveillance Review Committee identified common themes across maternal deaths and drafted recommendations which included increasing access to education for providers and systems related to culturally competent care; reducing stigma, bias, and barriers; and integrating a health equity framework to address systemic inequities. The strategies for this NPM will continue to focus on reducing the number of low-risk cesarean deliveries, as well as the racial disparity that exists in this delivery method.

Each of Michigan's 10 prosperity regions are represented by a Regional Perinatal Quality Collaborative (RPQC) making up the statewide Michigan Perinatal Quality Collaborative. The RPQCs are focused on advancing perinatal outcomes for birthing people, babies, and families. They are tasked with leading implementation of data-informed quality improvement efforts, authentically engaging with families and community members, convening regular meetings with diverse, cross-sector stakeholders, conducting systems change work and implementing evidence-based and promising practice interventions. This work is also inclusive of addressing disparities in birth outcomes. The RPQCs are well-respected and comprised of clinical and community leaders, community-based organizations, families, and community members. RPQCs prioritize authentically engaging families, which assists in creating culturally appropriate and community-informed services. Efforts aimed at reducing low-risk cesarean births will be approached in the same manner. Title V funding has directly supported the RPQCs and/or corresponding MCH initiatives.

The COVID-19 pandemic has had lasting impacts on hospitals across Michigan, including birthing hospitals, as seen through continued staffing turnover rates and low staffing levels. Increasing alignment between the RPQCs, the Michigan chapter of the Alliance for Innovation on Maternal Health (AIM) and the Obstetrics Initiative, encourages birthing hospital participation and accountability with the AIM safety bundles, as well as addresses the disparate outcomes in low-risk cesarean deliveries by bringing awareness of the issue to Collaborative members, and offering a platform for garnering feedback, lived experiences and other anecdotal qualitative data.

Objective A: By 2025, reduce the number of cesarean deliveries among all Michigan low-risk births to 27%.

The number of low-risk cesarean deliveries will be tracked utilizing data from Michigan's Vital Records and three strategies will be used to address this objective. The first strategy is to provide information and data related to this NPM to the RPQCs. Increasing the knowledge of RPQC leadership and members related to rates of low-risk cesarean delivery and associated adverse outcomes will create broad, baseline understanding across many different agencies, organizations, and health systems. Voices of families, especially those with lived experience, will enrich the understanding and stimulate discussion on efforts and interventions, including nonpharmacological interventions, that can be implemented to reduce the incidence of utilizing cesarean delivery for low-risk births. In addition to the opportunity to garner the voices of families during RPQC quarterly meetings, annual Regional Town Hall meetings, hosted by the RPQCs and MDHHS, provide an additional opportunity for families and birthing people to share their experience with cesarean delivery. The feedback garnered is shared with MDHHS, providers and those leading efforts to reduce Michigan's number of low-risk cesarean deliveries.

The second strategy includes continual updates to RPQC membership by regional representatives related to the Obstetrics Initiative (OBI) and the Alliance for Innovation on Maternal Health (AIM) bundle. These national initiatives are evidence-based and are recognized as best practices for safely reducing low-risk, primary cesarean births. RPQC members will continue to become well-versed in these initiatives and will be an asset in providing and technical assistance and education related to data and implementation. In addition to supporting implementation of MI AIM bundle and OBI project components, RPQCs will be encouraged to provide bias training opportunities for providers in their region. Michigan's disparities in low-risk cesarean delivery rates are attributed to biases and systemic racism. The intent is that as more providers are routinely trained in these topics, they will become increasingly aware of their personal biases, and, therefore, work toward preventing biases from affecting their clinical judgement, especially when faced with decisions related to low-risk cesarean deliveries. As such, it is expected that this strategy will begin to decrease the disparity observed with this measure.

Continued partnership with Michigan AIM (MI AIM) and the Obstetrics Initiative (OBI) is the third strategy toward reducing the number of primary low-risk cesarean deliveries. Partnering with stakeholders and professional organizations has allowed Michigan to work toward improved maternal morbidity and mortality outcomes, as well as a reduction in disparities of adverse maternal outcomes. Several staff members from the Michigan Department of Health and Human Services (MDHHS) are working with MI AIM, including the Michigan Title V Director who actively participates on the MI AIM Executive and Steering Teams. In 2022, 63 birthing hospitals in Michigan received a designation status award (e.g., bronze, silver) which corresponds to a certain level of participation in MI AIM. MDHHS will continue to support and encourage all birthing hospitals to participate in MI AIM and OBI through work with MI AIM members and the RPQCs. The number of birthing hospitals participating in Michigan AIM is the ESM for this measure.

Objective B: By 2025, reduce the percentage of low-risk cesarean births in African American, American Indian, and Asian/Pacific Islander pregnant people to 28%, 29.3% and 28.4% respectively.

As discussed above, Michigan has disparities in the number of low-risk cesarean deliveries by race. To achieve parity while reducing low-risk cesarean births across all racial/ethnic groups, Michigan's goal is to achieve by 2025 a 10% relative decline in low-risk cesarean rates for African American, American Indian and Asian/Pacific Islander pregnant people, which equates to 28%, 29.3% and 28.4%, respectively. Three strategies will be used to address the disparities that exist in this birth outcome measure. The first strategy is to include bias and equity training as an annual criterion for MI AIM hospital designation. While each hospital is responsible for providing the training to their respective staff, the MDHHS Division of Maternal & Infant Health webpage houses resources and trainings that

hospitals can utilize. Each year Michigan birthing hospitals are assessed for their level of participation and commitment to implementing the AIM safety bundles and subsequently, their commitment to improving maternal birth outcomes. Including bias and equity training in the MI AIM hospital designation criteria ensures it becomes and remains a priority area of focus for birthing hospital staff, eventually creating sustained change in policies and care for pregnant people of all races and ethnicities.

Encouraging and supporting ongoing bias and equity training of MI AIM Steering and Operation committee members is the second strategy. These two committees are comprised of practicing obstetric and gynecologic providers throughout Michigan who are leaders in the field and committed to advancing maternal outcomes. The goal of this strategy is to ensure these leaders are engaged and knowledgeable in the arena of health equity, including the root causes of disparate outcomes, to encourage growth of knowledge, as well as policy and culture change within their respective health care organizations and broadly throughout hospitals participating in MI AIM.

The third strategy focuses on supporting ongoing health equity and implicit bias education and training for Michigan Maternal Mortality Review Committee (MMRC) members. This committee is comprised of providers, epidemiologists, other content experts, and most importantly family and community members, who review annual maternal deaths in Michigan. The MMRC was recently restructured to assure diverse membership and equitable, regional member distribution. The team reviews the circumstances surrounding each death, categorizes the death as either ‘pregnancy-related’ or ‘pregnancy-associated, not related’, and determines if the death was preventable. The MMRC also releases recommendations specific to the broad categories of maternal deaths. The intention is that if the recommendations are followed, and changes are made by providers and health systems, more maternal deaths will be prevented. To ensure the committee is cognizant of the role unconscious bias and health inequity plays in birth outcomes, committee members are required to complete annual bias training for continued participation in the MMRC.

Oral Health – Women (FY 2025 Application)

The Title V needs assessment identified need among Michigan’s MCH population related to gaps in dental services for certain populations including young children and pregnant people. Focus group respondents identified a need for more standardized care practices for dental professionals to offer treatment options in an equitable manner as well as an overall shortage of dental providers that will accept Medicaid. As a result, a state priority need was established to “improve oral health awareness and create an oral health delivery system that provides access through multiple systems.” Title V funding provides partial support of an Oral Health Epidemiologist who is responsible for analyzing oral health statistics, community water fluoridation rates, oral health utilization of pregnant people and adults, and Medicaid dental claims.

Leadership for Michigan’s MCH oral health programs and initiatives is located within the Oral Health Section. The Oral Health Section and Perinatal Oral Health Initiative are housed in the Child and Adolescent Health Division within the Bureau of Health and Wellness in the Population Health Administration, allowing for significant collaboration, particularly on issues related to women’s oral health. The Perinatal Oral Health Initiative partners not only with state programs such as the Maternal Infant Health Program and WIC, but also with Michigan medical and dental schools, nurse practitioner programs, community organizations, refugee entities, and local health departments. These partnerships focus on serving populations with the highest level of need and promoting health equity. The Perinatal Oral Health Initiative also continues to partner with Medicaid in the enhanced dental benefit for pregnant people, which now includes coverage for services for one year postpartum. In FY 2025 the enhanced adult dental Medicaid benefit continues to be implemented. The promotion and outreach regarding these changes will continue to play a key role in programmatic activities in FY 2025.

In FY 2025, the Perinatal Oral Health Initiative will continue to maintain educational efforts for the health community and expecting mothers while also continuing to explore additional data to help implement new programs that further address oral health disparities and access to care issues. Current Medicaid data indicate that disparities exist and were further exacerbated by the COVID-19 related dental shutdown in 2020. Currently, less than 1 in 5 pregnant people on Medicaid in Michigan received any dental care during their pregnancy. As in 2024, less than 5% of pregnant people statewide had any restorative care. In addition, significant racial inequalities persist. African American or Latino pregnant people continue to be less likely to have a dental visit than white pregnant people. Existing strategies that educate providers as well as new strategies that focus on alternative practice models and recent Medicaid enhancements will be harnessed to address disparities. Mapping from the University of Michigan that shows racial and ethnic disparities by prosperity region will be shared with stakeholders in local communities and utilized for targeted interventions. The data will also continue to be used to bring awareness to the state of Medicaid utilization in Michigan, workforce shortages, and how to create a path forward to address the oral health needs of pregnant people in Michigan. A potential new activity in 2025 is the MI-Mom's Mouth (MIMM) Project. If the project is awarded funding by HRSA, it would place Community Health Workers (CHWs) into OBGYN departments across Michigan as well as launch a comprehensive educational initiative for providers and patients.

Objective A: Increase the number of medical and dental providers trained to treat, screen, and refer pregnant people and infants to equitable oral health care services.

In FY 2025, the MDHHS Oral Health Program (OHP) will continue to expand efforts to train and educate the medical and dental communities on the importance of perinatal oral health, as well as methodologies and best practices to integrate perinatal oral health into practice. The program has adapted to a virtual modality and has systems in place to accommodate virtual trainings, but also completes in person trainings as needed. Data collected from a statewide provider survey indicates that many 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. Current educational efforts are being evaluated at a 99% approval rating, with professional students indicating that this is the first time they have had comprehensive education surrounding perinatal oral health. In FY 2022, new educational efforts began at a new public health program (Central Michigan University) with a commitment to continue these perinatal oral health lectures into 2025. PRAMS and Medicaid data indicate that continued education efforts must also occur in the dental community surrounding pregnancy, as utilization rates remain low among pregnant women. FY 2025 will see a concerted effort with private practice dentists and Dental Associations to further target these providers, utilizing the new, enhanced Medicaid benefit as a tool to engage the dental community. Data driven efforts will continue to focus on health disparities and equity in specific Michigan regions. If awarded the MIMM HRSA Grant, the OHP will launch a comprehensive, statewide effort to interface with OBGYN providers and other medical professionals and provide targeted oral health education. While this is currently occurring, the award of those funds would dramatically increase populations served.

The Evidence-based or -informed Strategy Measure (ESM), which is the number of medical and dental professionals who receive perinatal oral health education through MDHHS within a 12-month period, is part of this objective. Departmental trainings and workshops will increase provider knowledge of perinatal oral health as well as provider comfort in discussing the importance of oral health with patients. Trainings include health equity components including but not limited to disparities in access to care and cultural competency. A database of training records continues to be utilized, with the output defined as the number of medical and dental professionals trained by MDHHS. The Perinatal Oral Health Initiative will continue to encourage provider feedback and engagement regarding these trainings with the intention to continue hybrid trainings as applicable.

Another strategy is dissemination of perinatal promotional and educational materials. Together with a variety of medical and dental professionals and other stakeholders, MDHHS developed Perinatal Oral Health Guidelines to create a unifying voice that emphasizes the importance of perinatal oral health to perinatal care and dental providers. The guidelines provide state-specific resources and tools; provide a summary of the issues surrounding perinatal oral health; and promote the consistent delivery of medical and dental service. Other materials will focus on health equity, best practices, specific health disparities by region, and proposed recommendations to address health inequities and access to care issues with providers. MDHHS will continue to utilize nationally recognized American Academy of Pediatrics (AAP) materials that are co-branded with both agency logos. MDHHS will continue to develop and distribute promotional and education materials that promote dental visits during pregnancy and infant oral health to health entities across the state as well as directly to pregnant people. These materials will continue to be developed in partnership with community stakeholders and distributed to local health departments, Federally Qualified Health Centers (FQHCs), WIC clinics, dental offices, the Office of Great Start, home visiting, medical offices (including obstetric providers) and other entities. Material promotion has been a successful strategy and will continue in FY 2025. Efforts may focus on virtual methods of dissemination where applicable. Any new materials created will be reviewed with a health equity lens.

The final strategy will include the continuation of communication efforts for dental health providers surrounding changes in Medicaid benefits for pregnant people as well as the entire adult Medicaid benefit. MDHHS allotted funds to increase the adult dental Medicaid benefit for pregnant people in FY 2022, and in FY 2023 increased reimbursement and allowable services. This increase in benefits is addressing a critical need in access to care and increasing the number of pregnant people with a dental visit. The number of pregnant people on Medicaid who have at least one dental encounter during the perinatal period is a second ESM. Through a data use agreement and IRB with Child Health Evaluation and Research (CHEAR) Center at the University of Michigan, the oral health program will be able to obtain data as needed. CHEAR has access to the data warehouse and the technical ability to analyze the data. Medicaid utilization data that became available in FY 2022 will be crucial to continue to measure the impact of the benefit and guide further educational efforts in FY 2025. This strategy aligns with other statewide efforts by focusing on data-driven solutions, addressing the need for comprehensive care, and reducing poor health outcomes.

Objective B: Increase the number of socioeconomically disadvantaged pregnant people receiving oral health care services.

In FY 2025, the OHP will continue to analyze PRAMS data and new Medicaid data to assess disparities in healthcare access by race and ethnicity. Data will be examined by geographic area which will help to determine targeted interventions and a new data dashboard will be updated to reflect perinatal oral health trends geographically. The targeted interventions will be viewed through a health equity lens and will be adjusted according to the population and groups they address. Efforts will continue to be made to integrate community voice as data efforts move forward and focus on engaging with specific communities across the state through local oral health coalitions. These coalitions are made of local professionals and community members representing the populations that are being served. This strategy aligns with the statewide focus on data integration and population identification components.

In FY 2025, the OHP will continue to take the lessons learned from previous medical dental integrations efforts such as the Michigan Initiative for Maternal Infant Oral Health and will look to promote the best practices discovered surrounding efforts to integrate medical and dental professionals. The MIMM HRSA grant (which the OHP applied for in 2024) uses the MIMIOH model but capitalizes on community health workers to assist pregnant people navigating the dental care system. If awarded, the OHP will develop tools and utilize the CHW community to increase the number of pregnant people within high need areas who receive care. These areas include a clinic in downtown

Detroit and two FQHCs (one in southwestern Michigan and one in the Upper Peninsula). New partnerships with refugee entities will continue to be fostered to facilitate models of care to improve oral health service acquisition, with the OHP playing an active role in assisting new arrivals, particularly pregnant people in receiving care.

In FY 2025, the OHP will also continue to provide education to pregnant people and engage directly with the local communities via partnerships with different agencies and groups in the state. SisterFriends Detroit is a volunteer effort to support healthier women and babies that helps women who are pregnant gain access to services and resources in Detroit. They aim to improve birth outcomes and infant mortality rates in Detroit by connecting mentors to women who are pregnant. The OHP started holding oral health educational sessions in FY 2022 with the intention to continue into 2025. Feedback from pregnant people and their mentors has been extremely positive and this practical presentation helps to not only answer common questions and address concerns, but also provides a chance to hear the consumer voice and engage authentically with Michiganders. For example, feedback from pregnant people has helped to shape the presentation and add more relevant content. In addition, in FY 2025 the OHP intends to continue its collaboration with the Office of Great Start within the Michigan Department of Education to share relevant information with different parent and community advisor groups, as a continuation of previous efforts. This collaboration allows the OHP to receive even more community feedback and develop connections and partnerships that help pregnant people receive the care they need.

***NEW:* Postpartum Visit (FY 2025 Application)**

FY 2025 is the first year of the new universally required Postpartum Visit measure. Postpartum care is critical to helping birthing people stay healthy and should be tailored to each person's individual needs. In addition to being a time of joy, the time after birth – "the fourth trimester" – can present challenges for individuals including lack of sleep, fatigue, pain, breastfeeding challenges, stress, and new or existing mental health concerns. To support birthing individuals, postpartum care should be ongoing versus a single visit. The American College of Obstetricians and Gynecologists (ACOG) recommends that all individuals have contact with their provider within the first three weeks postpartum followed by a comprehensive postpartum visit within 12 weeks after birth.

Prior to 2018, Michigan had higher rates of postpartum checkups than the US. However, since then, Michigan has seen significant declines in postpartum checkups, from 91.2% in 2017 to 87.6% in 2021 (MI PRAMS). While both non-Hispanic white and non-Hispanic Black mothers have also seen significant declines over the period, non-Hispanic Black mothers (80.3%) were almost a full ten points less likely than non-Hispanic white mothers (90.1%) to report postpartum checkups in 2021, which represents a slight improvement of the disparity between those two groups over the previous year (88.6% vs 75.3% in 2020, MI PRAMS). Given that Black mothers in Michigan were 2.2 as likely to die from pregnancy-associated causes as white mothers, closing the care gap is essential for improving maternal mortality rates in the state (MDHHS, Michigan Maternal Mortality Surveillance Program, 2011-2020).

Additionally, the postpartum checkup serves as an important touchpoint for discussions related to health needs and concerns. Conversations with health care providers include if the birthing person felt down or depressed (91.9%) and postpartum birth control options (87%). Other information frequently covered includes information about prescription medications (71.8%), current emotional or physical abuse (68.7%), cigarette use (62.4%) and other topics. 16.5% of PRAMS respondents reported experiencing significant postpartum depression.

As part of Michigan's Healthy Moms, Healthy Babies initiative, Michigan expanded Medicaid coverage to 12 months postpartum to support the health and well-being of postpartum people and their babies. Other key components of the Healthy Moms, Healthy Babies Initiative includes Medicaid doula coverage and expanding evidence-based home visiting. Michigan's initial strategies to address postpartum visit are discussed below.

Objective A: Conduct planning and assessment activities related to Postpartum Visit.

In FY 2025, which is the first year of the new universal Postpartum Visit NPM, Michigan's team will assess the landscape of data and activities that impact postpartum visits. This assessment will inform the next five-year Title V state action plan for FY 2026 – FY 2030. As an initial strategy, staff within the Division of Maternal and Infant Health (DMIH) and the Division of Lifecourse Epidemiology & Genomics will assess data related to postpartum visit. The data review will include PRAMS; Fetal Infant Mortality Review (FIMR) data with a focus on postpartum visits; and maternal mortality data, specifically on timing among pregnancy-related deaths with a focus on the postpartum period by cause and contributing factors. The team will also determine whether any other hospital or provider data are available for review. Furthermore, the team will review the aligned Michigan Maternal Mortality Surveillance (MMMS) and Fetal Infant Mortality Review (FIMR) recommendations to identify any themes that focus on postpartum visits, care, etc. The results of the data review will be summarized to inform the FY 2026 – FY 2030 state action plan.

As a second strategy, Michigan will explore evidence-based and evidence-informed strategies and best practices related to postpartum visit. It is anticipated that the Strengthen the Evidence for MCH Programs consortium will provide tools and resources (including evidence-based strategies) to assist states in relation to postpartum visit and best practices. Michigan will review the information and identify areas of alignment with work that is either already underway or could be implemented in the future. Michigan will also identify at least one evidence-based or informed Strategy Measure (ESM) which will be required as part of the FY 2026 Title V application. Additionally, a review will be conducted using the Title V Information System (TVIS) website and its search functions to determine whether other states have identified strategies to address postpartum visit. The strategies related to this objective will also be informed by any activities completed through Michigan's Title V needs assessment which is occurring in 2024.

Objective B: Increase awareness about the importance of postpartum visits among pregnant and postpartum people.

Michigan partners with Philips, the creators of the Pregnancy+ mobile application (app), to tailor the app with Michigan-specific articles and connections to Michigan resources. The Pregnancy+ app is the most downloaded pregnancy app in the world, with one-third of Michigan pregnant people using it. The Pregnancy+ app has daily articles, strategies for staying healthy during pregnancy, and interactive 3D models for tracking development.

App users who are Michigan-based and report receiving Medicaid or not having insurance coverage gain free access to premium Pregnancy+ content, including videos regarding exercise, mental health, and nutrition. Philips also runs quarterly surveys of their Michigan users to assess areas of interest. Philips has developed over a dozen articles related to Michigan-specific resources and services in the app. As a first strategy for Objective A, Philips will develop an article for Michigan users related to the importance of the postpartum appointment and what to expect at the postpartum appointment. The MDHHS team will also work with Philips to develop a survey to assess the understanding and perspective of Michigan users related to the postpartum appointment.

The second strategy within this objective is to recruit up to 25 new and eight existing CenteringPregnancy sites to increase access to the CenteringPregnancy model. CenteringPregnancy has been reported to reduce preterm and low birth rates and NICU admissions, while increasing prenatal and postpartum visit attendance. It has also been shown to improve access to high-quality and patient-centered maternity care for people living in historically marginalized communities. In August of 2023, Governor Whitmer and the Michigan legislature passed HB 4437, which appropriated $5 million to increase access to the CenteringPregnancy model of prenatal care for Michigan families. This effort will contract with the Centering Healthcare Institute (CHI) to recruit, support, and implement and sustain the CenteringPregnancy model in new and existing sites throughout Michigan.

The third strategy is to support development and implementation of a postpartum module in the High Touch, High

Tech (HT2) Pregnancy Checkup app. As of Spring 2024, 17 sites across four Regional Perinatal Quality Collaboratives have implemented universal electronic screening for mental and behavioral health. These clinical sites provide obstetric and/or preconception care and currently offer the screening tool to all new OB intake patients utilizing the Pregnancy Checkup application (app). Mental and behavioral health concerns don't disappear once a pregnant person gives birth; in fact, some mental and behavioral health concerns can become exacerbated in the postpartum period. In Michigan, between 2016 and 2020, most pregnancy-related deaths occurred 1-42 days postpartum (38.7%), followed by 43 days or more postpartum (34%)[4]. In those same years, 11.3% of pregnancy-related deaths were due to substance use disorder and 6.6% were due to mental health conditions[1]. As the third strategy for this objective, Michigan will provide support in the development and implementation of a postpartum component for the Pregnancy Checkup app. The team at Michigan State University, which oversees the Pregnancy Checkup app, will create a postpartum module that includes evidence-based screening tools for mental and behavioral health, brief interventions specific to common postpartum mental and behavioral health concerns, and some educational modules with related content. The postpartum module will be available to the sites already utilizing the app, as well as any new prenatal and postpartum care sites interested in the intervention.

As a fourth strategy, the Lifecourse Epidemiology & Genomics Division (LEGD) and Division of Maternal Infant Health (DMIH) will increase awareness about the importance of postpartum visits though the *Michigan Hear Her* campaign website and media efforts. This campaign mirrors the CDC's Hear Her campaign and focuses on elevating urgent maternal health warning signs and providing links to statewide maternal health resources. We anticipate there will be increased awareness of urgent maternal health warning signs, resources for birthing persons and their support people, as well as information aligned with the leading causes of maternal morbidity in Michigan. The Michigan Maternal Mortality Surveillance (MMMS) program will promote the campaign through organizations, agencies, and community groups that serve or represent populations disproportionately affected by pregnancy-related mortality in Michigan.

Intended Pregnancy (FY 2025 Application)

The percent of people assigned female at birth, who had a live birth and reported their pregnancy was intended, was selected to address the priority need to "develop a proactive and responsive health care system that equitably meets the needs of all populations, eliminating barriers related to race, culture, language, sexual orientation, and gender identity." According to Michigan's Pregnancy Risk Assessment Monitoring System (PRAMS), 62.5% of pregnancies were intended in 2021, an all-time high for the state. All Michiganders who can get pregnant deserve access to high-quality, client-centered care that is free from bias, racism, and coercion.

For most people who can get pregnant, their first encounter with the health care system is driven by reproductive health needs with nearly three decades spent avoiding an unintended pregnancy (Sonfield, Hasstedt, & Gold, 2014). Equipping individuals who can get pregnant and their partners, regardless of life circumstances or ability to pay, with knowledge and access to reproductive health services can improve health outcomes and reduce health care costs over the life course when delivered equitably.

FY 2025 objectives are concentrated on improving 1) contraceptive access and 2) quality of contraceptive care. Strategies seek to address Michigan's Title V pillars of 1) equitable health outcomes, 2) seeking the knowledge and expertise of communities and families, and 3) delivering culturally, linguistically, and age-appropriate health education. Strategies that can drive improved performance include translating regional listening sessions, integrating telehealth best practices, supporting access to publicly funded contraception, measuring the person-centeredness of contraceptive care, using client input to improve service delivery, and promoting contraceptive counseling best practices. Additionally, this state action plan directly supports related priorities in MDHHS's *Advancing Healthy Births: An Equity Plan for Michigan Families and Communities (2024 – 2028)*, as well as the

Governor's "Healthy Moms Healthy Babies" initiative. MDHHS supports contraceptive access at local agencies through a variety of funding sources, including Title X Family Planning. Title V funding helps to support contraceptive access through local clinics with a focus on serving individuals 15 to 21 years of age at no or low cost.

Objective A: Increase the percent of females (i.e., assigned at birth) aged 15 to 44 who use a most or moderately effective contraceptive method from 77% to 82% by 2025.

Contraception is a highly effective clinical preventive service that assists people who can get pregnant in achieving their reproductive health goals, such as preventing unintended pregnancy and achieving healthy spacing of births. While there is not a single method of contraception that is right for everyone, the type of contraceptive method used by a person who can get pregnant is strongly associated with their risk of unintended pregnancy. Having access to a full range of effective contraceptive methods allows each person the opportunity to choose the method that is right for them to successfully delay or prevent pregnancy. In 2023, 71.6% of female (i.e., assigned at birth) Family Planning clients aged 15 to 44 years old chose a most effective (sterilization, vasectomy, or LARC) or moderately (pills, patch, ring, cervical cap, or diaphragm) effective method, with 21.5% choosing LARC.

The first strategy—support the provision of contraception to low-income, uninsured, and underinsured people who can get pregnant in the Family Planning Program—will focus on providing client-centered counseling and a broad range of FDA-approved contraceptive methods to reproductive aged people who can get pregnant at no-cost or low-cost. A focus will be working to ensure that Michigan's Family Planning network of 33 local agencies and 91 clinical sites offer contraceptive services in accordance with *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Populations Affairs*. Family Planning providers are required to have a broad range of contraceptives available, including LARCs. In FY 2025, MDHHS will monitor local agency provision of contraception through semi-annual Family Planning Annual Report (FPAR) submissions.

The second strategy is to facilitate long-acting reversible contraceptive (LARC) training opportunities for Family Planning and other health care providers. This strategy will focus on supporting on-site access to provider-dependent FDA-approved contraceptive methods. Stocking all methods, including LARC, is necessary to ensuring full access to care. In FY 2025, MDHHS's Family Planning Program will offer at least one clinical practicum, promoting it with local Family Planning providers and other safety-net providers (e.g., Medicaid Health Plan, Federally Qualified Health Centers). Providers participating in the clinical practicum will receive training on present and historical coercion of marginalized communities and people of color. Additionally, MDHHS's Family Planning Program can assist local providers by connecting them with pharmaceutical company representatives for individual clinic and/or regional trainings.

The third strategy is to support the integration of telehealth best practices across Family Planning's provider network. This strategy will focus on continuing to scale up telehealth practices across Michigan's Family Planning providers, while working to mitigate the unique challenges telehealth presents for ensuring equitable access to care. In FY 2025, MDHHS will focus on incorporating telehealth best practices and promoting project successes from the cohort of eight local Family Planning agencies that received one-time funding to expand and enhance access to telehealth. MDHHS will utilize its program newsletter, annual events, and other standing meetings throughout the year to disseminate best practices and project successes. MDHHS will provide targeted technical assistance to local Family Planning agencies, as requested.

The fourth strategy, to translate regional listening session findings into action for people of reproductive age, who can get pregnant, will focus on creating actionable strategies to meet identified needs and remove barriers that impede access to sexual and reproductive health care across Michigan. Achieving equitable health outcomes for people who can become pregnant begins with incorporating their knowledge and expertise into the programs designed to serve

them. In FY 2024, MDHHS will partner with the Michigan Public Health Institute (MPHI) to facilitate and conduct 13 regional listening sessions. MPHI will analyze the data and interpret the results with MDHHS staff, and in collaboration with the Michigan Family Planning Advisory Council, to inform recommendations for clinical service delivery improvements and future program decision-making. Key findings will be disseminated to state/local partners and stakeholders. In FY 2025, MDHHS will develop and disseminate actionable strategies based upon the findings from the listening sessions, focused on client expansion and retention, and service delivery improvement resulting from the listening sessions.

Objective B: Increase the percent of females (i.e., assigned at birth) aged 15 to 19 who use a most or moderately effective contraceptive method from 84% to 89% by 2025.

In Michigan, sexually active adolescents encounter multiple barriers to accessing affordable contraception. Contraception is critical because it protects against disease transmission and unintended pregnancy while enhancing future reproductive health. In 2021, 67% of sexually active high schoolers did not use a most effective reversible method (IUD or implant) or moderately effective method (shot, pills, patch, or ring) and 14% reported not using any methods to prevent pregnancy at last intercourse (Michigan YRBS, 2021). The teen birth rate for 15- to 19-year-old females (i.e., assigned at birth) was 12.2 per 1,000 in 2021, which is a historic low. Despite improvements in Michigan's teen birth rate, teens and young adults (i.e., 18 to 21) have unmet reproductive and related preventive health needs. During 2023, 14.2% or 6,414 of Family Planning clients were teens (i.e., <15 to 19 years old), with 84.4% of female (i.e., assigned at birth) clients aged 15 to 19 years old choosing a most or moderately effective method and 20.8% choosing LARC. The best contraceptive option is one that will be used consistently and correctly. Approximately 10.2% of female clients (i.e., assigned at birth) aged 15 to 19 years old chose an external condom as their primary method in 2023, the only method that provides dual protection against pregnancy and sexually transmitted infections (STIs).

The first strategy to achieve this objective, to support at least 6,500 individuals' access to publicly funded contraception, will focus on providing client-centered counseling and a broad range of FDA-approved contraceptive methods to sexually active adolescents (i.e., ≤15 to 21 years old) at no-cost or low-cost. In FY 2025, MDHHS will monitor local Family Planning providers' provision of contraception semi-annual clinical service delivery data submissions. Service delivery is routinely informed by youth voice for continuous quality improvement.

The second strategy, to translate regional listening session findings into action for youth and young adults, will focus on creating actionable strategies to meet identified needs and remove barriers that impede access to sexual and reproductive health care across Michigan. Achieving equitable health outcomes for young people begins with incorporating their knowledge and expertise into the programs designed to support them. In FY 2024, MDHHS will partner with the Michigan Public Health Institute (MPHI) to facilitate and conduct a virtual statewide listening session with the Michigan Organization on Adolescent Sexual Health's (MOASH) Sexual Health for Adolescents Rooted in Equity (SHARE) youth advisory council, which is comprised of young people aged 16 to 21 who identify as lesbian, gay, bisexual, and queer (LGBTQ); are part of Black, Indigenous, and other people of color (BIPOC) communities; or reside in rural areas across the state. MPHI will analyze the data and interpret the results with MDHHS staff, and in collaboration with the Michigan Family Planning Advisory Council, to inform recommendations for clinical service delivery improvements and future program decision-making. Key findings will be disseminated to state/local partners and stakeholders. In FY 2025, MDHHS will develop and disseminate adolescent specific recommendations resulting from the listening sessions focused on clinical service delivery improvements and future program decision-making.

The third strategy is to translate youth input into action on the Family Planning website to be more youth-friendly in content and visual appeal. Adolescents deserve to know their rights regarding access to sexual and reproductive health services in Michigan; medically accurate information about contraceptive and barrier methods; and what to

expect at a Family Planning clinic visit. In FY 2025, MDHHS will translate this youth input into action to create a more youth-friendly Family Planning website.

Objective C: By 2025, increase by 10% percent the number of Family Planning clients who rate their experience of care with a score of 4 or 5.

Research in Family Planning has demonstrated that contraceptive counseling has an influence on a client's family planning outcomes. The clinical encounter provides an opportunity to equip Family Planning clients with quality contraceptive services and counseling for informed decision-making. It also has the potential to improve the experiences of clients seeking Family Planning services, particularly when historical and contextual barriers to care that impact disparities are considered. Provision or access to contraception is only one aspect of quality. Given the historical and present-day context of reproductive coercion and oppression experienced by Black, Indigenous, and People of Color, low-income, and incarcerated persons in the United States, there is risk of promoting a position that prioritizes certain methods to clients when the sole focus of contraceptive quality is on access to most or moderately effective contraceptive methods. Person-centered contraceptive counseling is an important mechanism for contraceptive access and evaluates the domains of interpersonal connection, adequate information, and decision support between the provider and client.

The first strategy is to include the person-centered contraceptive counseling (PCCC) measure on Family Planning's annual statewide consumer survey. This strategy will focus on measuring the quality of contraceptive care Family Planning clients receive from their provider such as interpersonal connection, adequate information, and decision support. Following a visit at which contraceptive counseling was received, clients will be asked to complete the survey before leaving the clinic. MDHHS collects Family Planning client input annually through a statewide consumer survey administered at each clinic site. Local Family Planning agencies routinely collect consumer input for continuous quality improvement. In FY 2025, MDHHS's Family Planning clinics will document the patient-centeredness of contraceptive care with all clients receiving family planning services (adult and teen) using the PCCC on its annual statewide consumer survey. Local Family Planning agencies will aggregate survey results and submit to MDHHS for analysis and dissemination.

The second strategy, analyze the PCCC measure, share key findings with Family Planning network, and promote data-driven decision-making, will focus on evaluating the client-centeredness of contraceptive counseling within MDHHS's Family Planning network and supporting continuous quality improvement of the client experience, as needed. In FY 2025, MDHHS will analyze the PCCC measure to assess contraceptive counseling strengths and disparities at the program and local agency levels. Key findings and implications for practice will be shared with the Family Planning network and partners via the program's Advisory Council meeting and other standing meetings. At a minimum, MDHHS will utilize key findings to inform its annual training plan to support client-centered contraceptive counseling across the Family Planning provider network. MDHHS will offer technical assistance to local Family Planning agencies on utilizing quality improvement techniques to address disparities in quality of contraceptive care and improve the client experience, as needed.

The third strategy is to promote MDHHS's updated Contraceptive Counseling Modules with Family Planning network, other healthcare providers, and related public health programs (i.e., home visitors). This strategy will focus on reaching a broad audience of healthcare providers and public health professionals to encourage the utilization of contraceptive counseling best practices. Client-centered contraceptive counseling techniques assist clients with identifying a method that best fits their needs and preferences, free from coercion. Contraceptive methods that meet client preferences are more likely to be used correctly and consistently. In FY 2025, MDHHS will utilize program (i.e., newsletter) and partner (i.e., listserv) communication mechanisms to promote its updated Contraceptive Counseling Modules with its Family Planning network, other healthcare providers, and staff in related public health programs.

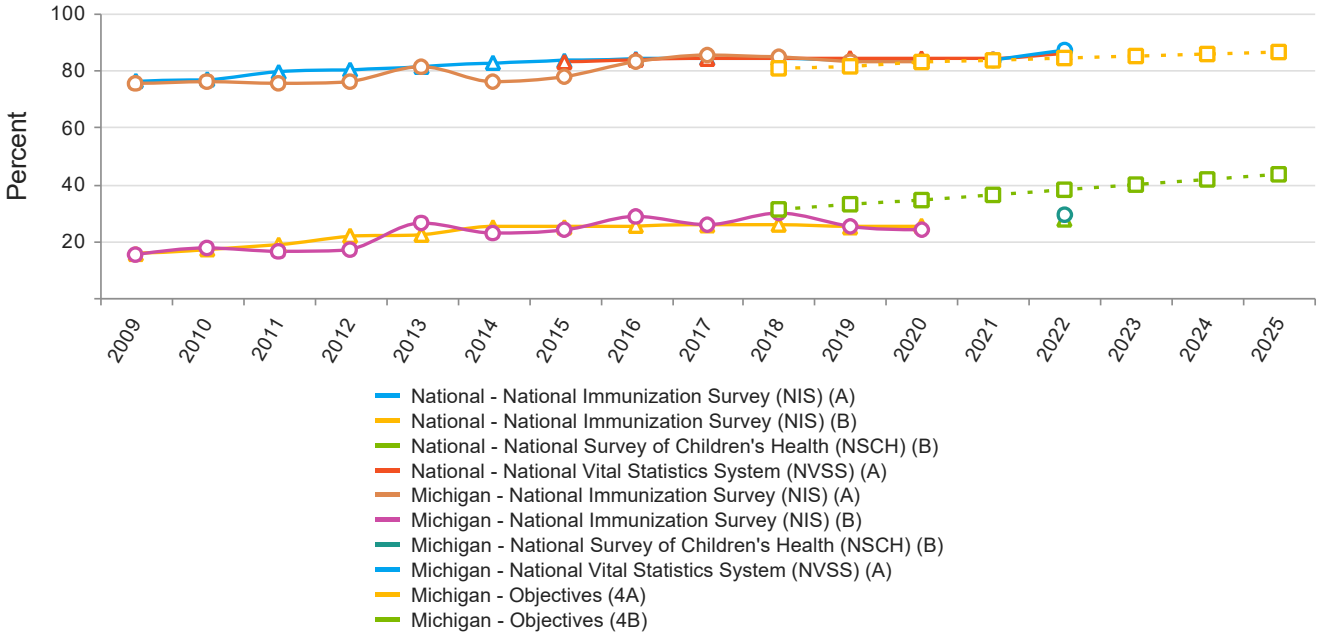
Continuing education credits will be offered to incentivize participation. MDHHS will monitor module completion rates and participant satisfaction on a quarterly basis.

[1] Michigan Resident Live Birth Files; MDHHS Division of Vital Records and Health Statistics. Maternal and Infant Health program staff use Michigan Vital Records data more regularly than NVSS data, as the Michigan data are accessible on a more immediate and regular basis.
[2] National Vital Statistics Report, Volume 70, Number 17. Birth: Final Data for 2020.
[3] Michigan is increasingly adopting a health equity framework for MCH outcomes. Utilizing only 1-2 years of race-stratified data from NVSS reduced opportunities to regularly review how these rates were changing for Women of Color and White mothers in Michigan; therefore, Michigan Vital Records data were utilized.
[4] Michigan Department of Health and Human Services, Division for Vital Records and Health Statistics, Resident Death Files, 2016-2020.

Perinatal/Infant Health

National Performance Measures

NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF
Indicators and Annual Objectives



NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	81.2	82.7	83.3	84.1	84.8
Annual Indicator	83.0	85.3	84.4	83.1	82.8
Numerator	86,380	88,053	90,193	75,064	74,293
Denominator	104,098	103,283	106,835	90,038	89,742
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data			
Data Source: National Vital Statistics System (NVSS)			
	2021	**2022**	**2023**
Annual Objective	84.8	84.8	84.8
Annual Indicator	86.7	86.7	86.7
Numerator	85,989	85,989	85,989
Denominator	99,230	99,230	99,230
Data Source	NVSS	NVSS	NVSS
Data Source Year	2022	2022	2022

Annual Objectives		
	2024	**2025**
Annual Objective	85.5	86.2

NPM - B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	32.9	34.4	36.2	38.0	39.8
Annual Indicator	28.4	25.8	29.8	25.1	23.9
Numerator	28,764	25,629	30,994	22,387	20,958
Denominator	101,206	99,495	103,862	89,287	87,780
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2016	2017	2018	2019	2020

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2021	**2022**	**2023**
Annual Objective	39.8	39.8	39.8
Annual Indicator	29.2	29.2	29.2
Numerator	76,255	76,255	76,255
Denominator	261,076	261,076	261,076
Data Source	NSCH	NSCH	NSCH
Data Source Year	2021_2022	2021_2022	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	41.6	43.4

Evidence-Based or –Informed Strategy Measures

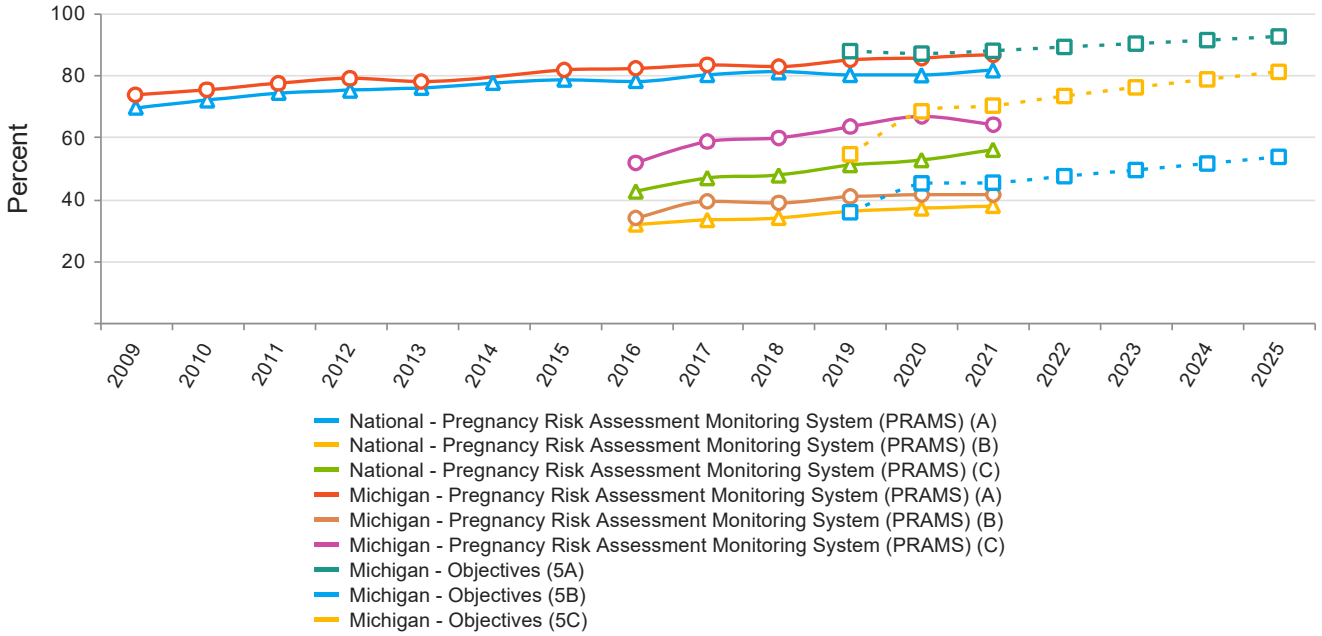
ESM BF.1 - Percent of Baby-Friendly designated birthing hospitals in Michigan

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	23	26	29	18	19
Annual Indicator	18.8	18.8	16.3	16.5	16.9
Numerator	15	15	13	13	13
Denominator	80	80	80	79	77
Data Source	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	20.0	21.0

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS
Indicators and Annual Objectives



NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	87.6	86.8	87.7	90	90
Annual Indicator	82.5	84.9	85.4	86.5	86.5
Numerator	85,511	85,912	83,784	86,102	86,102
Denominator	103,596	101,194	98,121	99,546	99,546
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	87.6	86.8	87.7	88.9	90
Annual Indicator	82.5	84.9			
Numerator	85,511	85,912			
Denominator	103,596	101,194			
Data Source	PRAMS	PRAMS			
Data Source Year	2018	2019			
Provisional or Final ?	Final	Final			

Annual Objectives		
	2024	2025
Annual Objective	91.1	92.3

NPM - B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	35.7	45	45.2	49.3	49.3
Annual Indicator	38.9	40.6	41.5	41.3	41.3
Numerator	38,781	39,451	38,620	39,876	39,876
Denominator	99,669	97,218	92,994	96,467	96,467
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	35.7	45	45.2	47.3	49.3
Annual Indicator	39.2	38.9			
Numerator	39,142	38,781			
Denominator	99,861	99,669			
Data Source	PRAMS	PRAMS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives		
	2024	**2025**
Annual Objective	51.4	53.5

NPM - C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) - SS

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	54.4	68.2	70.0	75.9	75.9
Annual Indicator	59.8	63.1	66.7	64.1	64.1
Numerator	59,314	61,216	62,663	61,800	61,800
Denominator	99,167	96,949	93,957	96,411	96,411
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020	2021	2021

State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	54.4	68.2	70	73.1	75.9
Annual Indicator	58.3	59.8			
Numerator	58,277	59,314			
Denominator	99,994	99,167			
Data Source	PRAMS	PRAMS			
Data Source Year	2017	2018			
Provisional or Final ?	Final	Final			

Annual Objectives		
	2024	**2025**
Annual Objective	78.5	80.9

NPM - D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Federally available Data (FAD) for this measure is not available/reportable.

Evidence-Based or –Informed Strategy Measures

ESM SS.1 - Increase the number of Maternal Infant Health Program agencies that have staff trained to use the concepts of motivational interviewing with safe sleep

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	85	84	83	73	72
Annual Indicator	83	83	78	72	69
Numerator					
Denominator					
Data Source	Maternal Infant Health Program (MIHP) staff	Maternal Infant Health Program (MIHP) staff	Maternal Infant Health Program (MIHP) staff	Maternal Infant Health Program (MIHP) staff	Maternal Infant Health Program (MIHP) staff
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	66.0	66.0

ESM SS.2 - Increase the number of agencies that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			10	20	10
Annual Indicator			1	5	11
Numerator					
Denominator					
Data Source			Infant Safe Sleep Program	Infant Safe Sleep Program	Infant Safe Sleep Program
Data Source Year			2021	2022	2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	15.0	20.0

ESM SS.3 - Increase the number of hospitals that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			2	4	6
Annual Indicator			2	3	7
Numerator					
Denominator					
Data Source			Infant Safe Sleep Program	Infant Safe Sleep Program	Infant Safe Sleep Program
Data Source Year			FY2021	FY2022	FY2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	8.0	10.0

State Action Plan Table

State Action Plan Table (Michigan) - Perinatal/Infant Health - Entry 1	
Priority Need	
Create and enhance support systems that empower families, protect and strengthen family relationships, promote care for self and children, and connect families to their communities	
NPM	
NPM - A) Percent of infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	
Five-Year Objectives	
A) Increase the percent of infants who are breastfed exclusively until 6 months to 41.1% by 2025	
B) To impact breastfeeding disparity, increase percent of non-Hispanic black women who initiate breastfeeding from 74.4% to 78.4% by 2025	
Strategies	
A1) Require breastfeeding education of MDHHS Maternal Infant Health staff which includes recognizing systemic racism as a root cause of breastfeeding inequities A2) Support and promote increased access to breastfeeding support professionals and peer counseling services in programs serving families A3) Increase the percent of Baby Friendly Hospitals in Michigan from 16% to 18%	
B1) Increase training opportunities to improve the number, availability, opportunities for professional advancement, and racial and cultural diversity of breastfeeding professionals B2) Normalize and promote culturally congruent and responsive breastfeeding messages for MDHHS and breastfeeding supporter use B3) Promote resources, created by BIPOC-led community organizations, that address the most common breastfeeding barriers	
ESMs	**Status**
ESM BF.1 - Percent of Baby-Friendly designated birthing hospitals in Michigan	Active
NOMs	
NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM	
NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal	
NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID	

State Action Plan Table (Michigan) - Perinatal/Infant Health - Entry 2

Priority Need

Create and enhance support systems that empower families, protect and strengthen family relationships, promote care for self and children, and connect families to their communities

NPM

NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS

Five-Year Objectives

A) Increase the percent of infants put to sleep on their backs from 84.9% in 2019 to 92.3% by 2025

B) Increase the percent of infants put to sleep on a separate approved sleep surface from 40.6% in 2019 to 53.5% by 2025

C) Increase the percent of infants placed to sleep without soft objects or loose bedding from 63.1% in 2019 to 80.9% by 2025

D) Increase the percent of non-Hispanic Black infants put to sleep on their backs, put to sleep on a separate approved sleep surface, and put to sleep without soft objects or loose bedding

Strategies

A1, B1, C1, D1) Support safe sleep activities of local health departments and the Inter-Tribal Council of Michigan

A2, B2, C2, D2) Support providers to implement safe sleep policies/ protocols/programming so families receive infant safe sleep education and access to resources

A3, B3, C3, D3) Develop and share tools with providers, staff, and families regarding client/patient centered conversations about safe sleep

A4, B4, C4, D4) Provide professionals and families with culturally congruent guidance on protective factors (e.g., smoking cessation, breastfeeding, immunizations) and evidence-based programs (e.g., community-based doula support, home visiting) to enhance the overall health and well-being of moms and babies

A5, B5, C5, D5) Engage hospitals in areas with a high rate of sleep-related infant deaths and disparities to explore needed policies and resources to support families of NICU infants in practicing safe sleep behaviors after discharge

ESMs	Status
ESM SS.1 - Increase the number of Maternal Infant Health Program agencies that have staff trained to use the concepts of motivational interviewing with safe sleep	Active
ESM SS.2 - Increase the number of agencies that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol	Active
ESM SS.3 - Increase the number of hospitals that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol	Active

NOMs
NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM
NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal
NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

Perinatal/Infant Health Overview

Perinatal and infant health is a central focus of the Division of Maternal and Infant Health (DMIH), which supports programs designed to ensure infants are born healthy and ready to thrive. The Women and Maternal Health Section and Perinatal and Infant Health Section within DMIH oversee many programs including the Michigan Perinatal Quality Collaborative, Maternal Infant Health Program (MIHP), Infant Safe Sleep, Breastfeeding, Fetal Infant Mortality Review (FIMR), Safe Delivery of Newborns, and the Early Hearing Detection and Intervention program. Title V funding supports a variety of programs and initiatives related to perinatal and infant health, including infant safe sleep, breastfeeding, PRAMS, and infant mortality reduction. Title V funding is also used as a gap-filling funding source for Regional Perinatal Quality Collaboratives (RPQCs). DMIH provides funding, staff support, and infrastructure for the RPQC network that uses quality improvement methods to implement strategies to improve maternal and infant health. Other federal funding is used to identify and meet the needs of this population, such as WIC (USDA), Universal Newborn Hearing Screening and Intervention (HRSA), and PRAMS (CDC). Perinatal and infant health is promoted through a network of partnerships, including those with health care providers, labor and delivery hospitals, universities, the Mother Infant Health and Equity Collaborative, and the Michigan Association for Infant Mental Health.

Title V funding also supports the Local Maternal Child Health (LMCH) program which provides funding to all 45 Local Health Departments (LHDs). In FY 2023, Title V funds via the LMCH program were expended on NPM 4 (breastfeeding), NPM 5 (infant safe sleep), and Local Performance Measures (LPMs) in the perinatal/infant health domain. Nineteen LHDs implemented breastfeeding (NPM 4) activities including breastfeeding support in a variety of settings for pregnant people and women to provide infants with human milk. Other activities included staff development and lactation training; participation in virtual community breastfeeding coalition meetings; promoting breastfeeding friendly businesses; social media posts; and community outreach events. Twelve LHDs addressed infant safe sleep (NPM 5) through education in a variety of ways such as prenatal/postnatal classes, home visits, social media posts, and community events. Infant safe sleep, breastfeeding, and tobacco dependance treatment education was provided to childcare, faith-based entities, emergency management, and nursing students. Sleep sacks, pack-n-plays, and books were distributed to families with an assessed need.

Four agencies selected an LPM based on local priorities. Activities included FIMR team processes, gap-filling administration of infant immunizations, and Healthy Families America program support for infants. For half of the fiscal year, COVID-19 safety precautions continued to cause disruptions in agencies' ability to conduct in-person visits and in-person services at provider offices. A significant number of agencies reported unprecedented staff turnover which impacted institutional knowledge and the ability to provide services.

Michigan's approach to perinatal and infant health through Title V emphasizes implementation of strategies that prevent maternal and infant morbidity and mortality, which are critical indicators of the degree to which a community takes care of its women and children. Focus areas for Title V are infant safe sleep and breastfeeding.

Breastfeeding (FY2023 Annual Report)

The American Academy of Pediatrics (AAP) recommends all infants are exclusively breastfed for six months to support optimal growth and development. Additionally, in 2022 the AAP published updated guidance supporting continued breastfeeding for two years or beyond, as long as mutually desired by mother and child. Breastfeeding has health benefits for infants and mothers, including mental health benefits for both mothers and babies. For infants, breastfeeding can reduce risk of asthma, obesity, sudden infant death syndrome (SIDS), diabetes, ear infections, childhood leukemia, and some respiratory diseases. For mothers, breastfeeding can reduce feelings of anxiety and postnatal depression, reduce post-partum hemorrhage, lower the risk of type 2 diabetes, and may decrease the

likelihood of developing breast, uterine, and ovarian cancers. Human milk remains the optimal source of nutrition for the first months of life.

The Title V needs assessment revealed that breastfeeding is still a critical maternal and child health (MCH) issue for Michigan's mothers and infants. Needs assessment themes showed that families want more breastfeeding support and education and that families are having difficulty accessing breastfeeding support professionals and providers that support breastfeeding. During the Title V needs assessment, stakeholders identified the priority need to "Create and enhance support systems that empower families, protect and strengthen family relationships, promote care for self and children, and connect families to their communities" as an important way to achieve breastfeeding initiation and duration. The COVID-19 pandemic highlighted the need for emergency preparedness plans to support access to human milk especially in Black, Indigenous, and People of Color (BIPOC) communities that were disproportionately impacted by COVID-19. MDHHS will continue to expand collaboration with BIPOC-led organizations and communities that lead in addressing this health equity work, especially in relation to dismantling barriers to breastfeeding.

According to the National Immunization Survey (NIS), in 2020 Michigan's initiation rate was 82.8% (CI 76.4-87.7). This meets the annual objective set of 82.7%. Michigan's breastfeeding exclusivity rate through six months was 23.9%, and Michigan's goal is to reach 41.1% by 2025.

Data from the Michigan Pregnancy Risk Assessment Monitoring System (MI PRAMS) can supplement what is learned from the NIS and help inform Michigan's strategies to reach breastfeeding-related goals for Title V. Since MI PRAMS does not collect data through 6 months postpartum or ask about feeding exclusivity, the survey does not measure breastfeeding in a way that allows for direct comparison against Healthy People 2030 goals. Still, MI PRAMS provides timely information at the state level for initiation and duration through about three months postpartum, in addition to information about barriers to initiation and duration. Michigan cannot achieve its goals of increasing the percent of infants who are breastfed exclusively until 6 months without first having supported mothers through initiation and the 3-month duration that is measured by MI PRAMS. Title V funding is used to support PRAMS in Michigan.

PRAMS data through the 2021 birth year continue to tell a story of relatively static rates of initiation (88.4%), as well as 1-month (76.3%), 2-month (67.0%), and 3-month (56.9%) breastfeeding duration. PRAMS has shown that Michigan's initiation rate had increased steadily from 2009 to 2014, rising from 73.2% to 84.3%. However, from 2014 through 2021, there has been a leveling out in breastfeeding initiation, with no significant increase nor decrease across these years. It is possible that 2021 initiation numbers (88.4%) reflect the start of an increase in initiation at the state level, but this cannot be determined reliably from a single year of data.

Across a time period where breastfeeding statistics have remained relatively static in Michigan (2016-2021), about nine in ten non-Hispanic white mothers initiated breastfeeding (88.5%; 95% CI: 87.3% - 89.6%). Initiation was comparable for Hispanic mothers (87.8%; 95% CI: 83.6% - 91.1%) and those in the non-Hispanic "Other" category (87.3%; 95% CI: 80.4% - 92.0%), yet relatively lower for non-Hispanic Black mothers (75.1%; 95% CI: 73.7% - 76.6%). Mothers from the non-Hispanic Asian and Pacific Islander subgroup had the highest proportion who initiated breastfeeding (95.6%; 95% CI: 90.8% - 97.9%). By incorporating birth certificate information on maternal ancestry categories and also looking at paternal race / ethnicity / ancestry, we are able to describe two other groups. Initiation among mothers of Infants with Native American / American Indian / Alaskan Native ancestry was quite high, at 93.7% (95% CI: 88.5% - 96.6%). The final group is one that can likely only be found at sufficient numbers in Michigan, which is mothers of infants with Middle Eastern / North African ancestry. Among these mothers, initiation was also very high at 92.7% (95% CI: 88.5% - 95.4%).

The Title V state action plan continues to focus on reducing disparities in breastfeeding rates among women of color.

In alignment with the plan, MDHHS has continued to prioritize using culturally responsive, evidence-based images and messages within public health campaigns to support the normalization of breastfeeding. The plan also focuses on increasing breastfeeding knowledge among maternal and infant health professionals who work with pregnant or postpartum people by offering breastfeeding educational opportunities statewide through a webinar series and online breastfeeding training course. The evidence continues to support that babies born in Baby-Friendly designated hospitals are more likely to be breastfed; therefore, increasing the percent of Baby-Friendly hospitals in Michigan remains the Evidence-based Strategy Measure (ESM) for this NPM.

MDHHS receives and shares parent and community input on breastfeeding-related issues through several means, including through a series of townhall meetings held in 2023 across Michigan, as well as collaboration with the Michigan Breastfeeding Network. MDHHS recruits and encourages local breastfeeding clinicians and advocates to speak at maternal child health conferences. In addition, MDHHS team members attend state and local breastfeeding conferences in order to support breastfeeding networks.

Objective A: Increase the percent of infants who are breastfed exclusively until 6 months to 41.1% by 2025.

Since its public release in February 2021, the *Michigan Breastfeeding Plan* has continued to set a common agenda necessary for a collaborative approach to support breastfeeding in Michigan. One of the key initiatives outlined in the *Michigan Breastfeeding Plan* was the creation of a breastfeeding training course for maternal child health professionals in Michigan. The free online course, “Breastfeeding for Professionals Working with Families” was released in June 2023, and 88 participants have completed the course through the end of FY 2023. Content in the training course covers breastfeeding disparities in Michigan, the root causes of breastfeeding inequities and how to address them, information to support consistent messaging about breastfeeding, and community-based, culturally responsive breastfeeding resources to support families and professionals. In accordance with the vision of the *Michigan Breastfeeding Plan*, MDHHS has promoted the training course widely and will continue to work toward improving the knowledge of breastfeeding support among staff working in maternal and infant health programs.

A key activity to train maternal and infant health staff is the Great Lakes Breastfeeding Webinar Series, a project of the Michigan Breastfeeding Network. These webinars have continued to be offered every month at no cost to participants and are available on demand for up to one year after their initial release dates. Participation in the webinars varies, but most webinars have over 1,700 attendees nationally. During FY 2023, nearly 500 participants from Michigan viewed the webinars, with a combined total of over 4,700 unique webinar participants during FY 2023. Statistics show that among webinar participants from Michigan, about 18% work for WIC and nearly 20% work for a state or local health department.

Evidence shows that access to professional and peer support can increase breastfeeding duration. MDHHS has directly supported this activity through mini-grants, awarded in partnership with the Michigan Breastfeeding Network, to Black and Indigenous-led breastfeeding organizations that provide breastfeeding support to families. As part of the project, a resource guide was created, which linked to all of the resources created by the 10 organizations. Over 30 resources were created, which included videos, infographics, and informational documents that can be used to inform and support breastfeeding families. Throughout FY 2023, MDHHS continued to promote and share these resources. In addition, access to local breastfeeding and peer support has been placed on the MDHHS website and distributed to local partners and families. The WIC Division also leads efforts to increase access to breastfeeding support by funding peer counselors and a warmline.

MDHHS continues to work with Michigan Birthing hospitals to encourage, support, and acknowledge hospitals achieving Baby-Friendly status. This is Michigan’s ESM for this NPM. MDHHS staff promote the implementation of

breastfeeding-friendly maternity care practices through trainings and in FY 2023, MDHHS hosted an informational webinar about the Baby-Friendly accreditation. MDHHS continues to remain engaged with partners that support Baby-Friendly efforts across the state. The Great Lakes Breastfeeding Webinar series is promoted with hospital staff, and it is estimated that over 15% of participants identify maternity care nurse as their primary job function. Unfortunately, one birthing unit in Michigan closed in February 2023, and a second birthing unit closed in June 2023, bringing the total number of birthing hospitals from 79 to 77. One birthing hospital in Michigan achieved initial Baby-Friendly designation in FY 2023, however one of the birthing units that closed was also a Baby-Friendly facility. Therefore, at the close of FY 2023 the total number of Baby-Friendly Hospitals in Michigan has remained at 13, with the percent of Baby-Friendly designated birthing hospitals also staying about the same at 16.9%. A variety of challenges related to the COVID-19 pandemic have continued to place incredible strain on Michigan's hospitals in recent years, which has impacted their ability to meet and/or maintain the Baby Friendly USA standards.

Objective B: To impact breastfeeding disparity, increase percent of non-Hispanic black women who initiate breastfeeding from 74.4% to 78.4% by 2025.

To reduce ongoing breastfeeding disparity gaps, MDHHS continues to partner and support the Great Lakes Breastfeeding webinar series, a project of the Michigan Breastfeeding Network, which offers breastfeeding-specific information every month at no cost to participants. Michigan Breastfeeding Network continues to offer expanded options for continuing education through the webinars for a variety of professionals, including nurses, social workers, lactation consultants, community health workers, certified health education specialists, physicians, and dietitians. In FY 2023, the Michigan Breastfeeding Network began hosting the webinars through a new online learning platform, which now provides instant access to continuing education certificates after completion of the post-webinar evaluation. This free, easy-to-access education allows all providers the ability to receive advanced training, which diversifies and strengthens Michigan's lactation workforce. Topics have a strong focus on health equity and supporting community-driven work in BIPOC communities. The webinars have been viewed by participants in 23 countries; in the U.S., there have been participants from all 50 states and the District of Columbia. Webinar participants report a variety of job functions including peer counselors, maternity care nurses, home visitors, other breastfeeding services, nutrition, childbirth support, and nurse practitioners.

In August 2023, the State of Michigan issued a proclamation recognizing August 2023 as Breastfeeding Month in Michigan. This proclamation recognized that breastfeeding is a racial equity and public health imperative.

MDHHS continues to identify new and innovative methods, including via social media, to promote breastfeeding within the communities most affected by breastfeeding-related disparities. After a successful social media campaign in FY 2022, MDHHS began developing plans for campaigns focused on promoting breastfeeding and infant safe sleep among young parents in Michigan in FY 2023 and FY 2024, supported by Title V funding.

For the FY 2023 media campaign, materials were developed by first having the Michigan Organization on Adolescent Sexual Health (MOASH) complete education sessions and focus groups on safe sleep and breastfeeding with a diverse group of youth ages 13-21. Themes that emerged in the focus groups were used to develop media (social media posts and audio streaming app ads) that ran in the last quarter of FY 2023. The campaign targeted zip codes with the greatest poverty in select areas of the state and people of color under the age of 21. Through audio streaming, over 740,000 impressions were delivered; through Facebook/Instagram, almost 1.5 million impressions were delivered; mobile display ads resulted in over 5 million impressions, and paid search resulted in over 27,000 impressions.

As a continuation and expansion of this work, the FY 2024 media campaign will focus on reaching young (13-21 years) Black, Indigenous, and People of Color in zip codes with the highest poverty levels and relatively higher rates

of sleep-related deaths and lower rates of breastfeeding initiation. The FY 2024 campaign will be discussed in next year's annual report.

The MDHHS Communications team has continued to prioritize creating and posting breastfeeding promotional messages on the department's social media accounts. MDHHS has over 150,000 Facebook followers, over 34,000 Twitter followers, and over 14,000 followers on Instagram. As part of breastfeeding awareness commemorations during August, MDHHS created and shared nine posts promoting breastfeeding across all MDHHS social media pages. Social media posts were created to recognize specific groups and celebrations throughout the month of August, including Indigenous Milk Medicine providers, Asian American, Native Hawaiian and Pacific Islander Breastfeeding Week, and Black Breastfeeding Week.

MDHHS continues to work with the Genesee County Health Department to increase breastfeeding rates within Genesee County and the City of Flint. Of Genesee County WIC clients enrolled prenatally, 72% initiated breastfeeding in FY 2023, which was a 2% increase from the previous fiscal year. Genesee County has continued to expand efforts to promote breastfeeding, including through the Supporting Mothers In Lactation Efforts (SMILE) Club, which is a program that encourages moms to breastfeed by offering support and breastfeeding-related rewards for breastfeeding efforts. Throughout FY 2023, about 160 breastfeeding mothers remained engaged in the SMILE Club. In addition, during FY 2023 a series of videos promoting breastfeeding in Genesee County were created, which featured both WIC clients and clinic staff members. While local health department activities have been impacted by the COVID-19 pandemic in recent years, breastfeeding promotion progress has resumed.

Safe Sleep (FY 2023 Annual Report)

Michigan's safe sleep strategies and activities promote three key messages to parents and caregivers: infants should sleep 1) alone, 2) on the back, and 3) in a crib, bassinet or pack and play. These behaviors are critical to the prevention of sleep-related infant death. Of the leading causes of infant death, sleep-related causes are considered the most preventable. In FY 2023, Title V federal funding was used for activities that support Michigan's safe sleep work, including PRAMS, infant mortality communication, Fetal Infant Mortality Reviews, breastfeeding support, and funding to local health departments to support community-based safe sleep prevention efforts.

There was a slight increase in the proportion of Michigan mothers placing their infants to sleep exclusively on their backs in 2021 (86.5%) versus 2020 (85.4%). Looking back to 2016 (81.9%), there has been a clear and sustained improvement in back sleeping in Michigan since that time. About 2/3 of Michigan mothers in 2021 report that their infants were usually placed to sleep in a space without soft or loose bedding or objects (64.1%). This is relatively close to what was seen in 2019 (63.1%) and 2020 (66.7%). While this measure did not increase in 2021, it shows that the general improvement Michigan has seen since 2016 (51.8%) has been sustained. Across the last three years, the measure of a separate approved sleep surface has been somewhat resistant to change, remaining just above 40% (40.6% in 2019, 41.5% in 2020, 41.3% in 2021). This remains an improvement from what was seen starting in 2016 (34.0%), when this measure began being based on the combination of five different sleep risk factors, including whether infants sleep in a car seat or swing. Michigan has seen a notable and sustained improvement in the proportion of mothers who are not sleeping their infants in car seats or swings (from 47.4% in 2016 to 56.9% in 2021), but smaller year-by-year changes in other components seem to be offsetting changes in the composite measure.

While four distinct objectives for infant safe sleep were identified, the strategies to address them are combined, since the safe sleep behaviors are so closely related. All strategies and activities will promote the key messages to parents, caregivers, and providers that infants should sleep alone and without objects on the back, in a crib, bassinet or pack and play and will continue to address ways to increase those behaviors by all families, while also addressing

the disparity for non-Hispanic Black families.

Objective A: Increase the percent of infants put to sleep on their backs from 84.9% in 2019 to 92.3% by 2025.

Objective B: Increase the percent of infants put to sleep on a separate approved sleep surface from 40.6% in 2019 to 53.5% by 2025.

Objective C: Increase the percent of infants placed to sleep without soft objects or loose bedding to from 63.1% in 2019 to 80.9% by 2025.

Objective D: Increase the percent of non-Hispanic Black infants put to sleep on their backs, put to sleep on a separate approved sleep surface, and put to sleep without soft objects or loose bedding.

In FY 2023, activities occurred within five strategies:

1. Support safe sleep activities of local health departments and the Inter-Tribal Council of Michigan.
2. Support providers to implement safe sleep policies/protocols/programming so that families receive infant safe sleep education and access to resources.
3. Develop and share tools with providers, families, and workers regarding having client/patient centered conversations regarding safe sleep.
4. Promote protective factors (i.e., smoking cessation, breastfeeding, immunizations) and evidence-based programs (i.e., home visiting, community-based doula support) to enhance the overall health and well-being of moms and babies.
5. Engage hospitals in areas with a high rate of sleep-related infant deaths and disparities to explore needed policies and resources to support families of NICU infants in practicing safe sleep behaviors after discharge.

The first strategy is to support the safe sleep activities of local health departments (LHDs) and the Inter-Tribal Council of Michigan (ITC) to increase the capacity of communities to implement infant safe sleep education, awareness, and outreach activities. In FY 2023, the Detroit Health Department received $125,000 in funding, four other LHDs received $70,000 in funding, and the ITC received $45,000 in funding. The counties where the five LHDs are located account for 51% of sleep-related infant deaths in the state and experience racial disparities among the deaths. ITC serves American Indian families throughout the state. American Indian babies die at 2.6 times the rate of white babies. Grantees are required to participate in or coordinate a local/regional advisory team to oversee their safe sleep efforts. The teams are required to include community members. The grants allowed communities to develop programming that targeted the highest-risk areas and that were informed by the community. Activities ranged from providing safe sleep education sessions; purchasing billboards and bus ads; providing group classes; conducting community awareness events; creating public service announcements; engaging families; and promoting protective factors such as breastfeeding and smoking cessation. A portion of the grant funds were used to purchase pack and plays, sheets, and/or sleep sacks.

Changes that were made due to the COVID-19 pandemic have continued. Grantees have moved to a hybrid approach to be flexible on whether events are in-person or virtual. Several LHDs planned to implement the Society for Public Health Education (SOPHE) SCRIPT® (Smoking Cessation and Reduction in Pregnancy Treatment) Program but still were unable to due to only seeing families virtually. Despite challenges, grantees were able to provide infant safe sleep education to over 15,000 individuals (parents, caregivers, professionals, and community members) through virtual and in-person classes and community events.

Social Determinants of Health (SDOH) are drivers in the disparity of sleep-related infant deaths. In addition to

community members, the local/regional advisory teams are required to include partners that can address SDOH. This includes partners that can meet resource needs of families, as well as partners that work further upstream to address systemic policies and practices that drive disparities.

A second strategy was to support providers in implementing and updating existing safe sleep policies or protocols so that families receive infant safe sleep education and access to resources. An evidence-based or -informed strategy measure (ESM) was established to increase the number of agencies that received technical assistance on updating or implementing a policy. Two agencies and four health departments requested the recommendations for how agencies serving families can support infant safe sleep (that were developed in FY 2021). MDHHS Housing and Homeless Services program shared the recommendations with all their housing providers. In addition, all Maternal, Infant, and Early Childhood Home Visiting (MIECV) Programs were required to implement a safe sleep policy by the end of FY 2023.

A continued strategy was to develop and share tools with providers and family support workers on how to have client/patient centered conversations regarding safe sleep. This strategy included continuing to promote the *Helping Families Practice Infant Safe Sleep (Safe Sleep 201)* training and incorporating the core tenets of this training into other educational venues: how to have more effective conversations with families by starting where the family is at, educating on safe sleep guidelines and helping the family evaluate their current risk and explore strategies for risk reduction. A related ESM is to require all new MIHP staff to complete the online *Helping Families Practice Infant Safe Sleep* training. In FY 2023, all 69 MIHP agencies have staff trained to use the concepts of motivational interviewing with safe sleep by requiring the *Safe Sleep 201* training for all staff.

To reach professionals who work with pregnant and parenting families, the MDHHS ISS Program continued to build upon connections with existing partners, such as the Women, Infants and Children (WIC) Program, home visiting programs (MIECV and MIHP), child welfare, the Regional Perinatal Quality Collaboratives, MDHHS Tobacco, and MDHHS Bureau of Emergency Preparedness, EMS and Systems of Care. These continued collaborations led to training on the safe sleep basics, how to support families, and access to resources for a variety of professionals. In FY 2023, over 500 individuals attended a virtual or in-person safe sleep training and over half of those individuals received training on how to support families. In addition, over 13,500 individuals completed one of the three online infant safe sleep trainings; almost 300 hospital nurses and other staff took the online training *Infant Safe Sleep: The Basics and Beyond*; and over 200 participants attended one of four safe sleep webinars. Providers were also supported with access to free educational materials; over 240,000 educational items were distributed by MDHHS in FY 2023. By the end of FY 2023, over 8,900 professionals were subscribed to the infant safe sleep email listserv, a 55% increase over FY 2022.

In FY 2022, the MDHHS ISS Program established a partnership with MDHHS Bureau of Emergency Preparedness, EMS, and Systems of Care to implement an Infant Safe Sleep Certification Program for EMS Agencies and Fire Departments. As of the end of FY 2023, 13 EMS agencies and fire departments were certified, resulting in over 650 providers trained on safe sleep.

As an additional tool to integrate safe sleep education into prenatal visits, the High Touch, High Tech (HT2) e-screening tool, which delivers a brief motivational intervention and helps connect families to additional supports, was expanded to include screening for safe sleep knowledge and behaviors. The safe sleep education modules were rolled out in May 2022. To date, over 1,400 patients participated in the prenatal safe sleep intervention.

Another strategy is to promote protective factors (i.e., smoking cessation, breastfeeding, immunizations) and evidence-based programs (i.e., home visiting) to enhance the overall health and well-being of moms and babies. As noted above, outreach to and coordination with other MDHHS programs continued.

A media campaign on breastfeeding and infant safe sleep was continued in FY 2023 and was supported by Title V funding. The media campaign was developed by first having the Michigan Organization on Adolescent Sexual Health (MOASH) complete education sessions and focus groups on safe sleep and breastfeeding with a diverse group of youth ages 13-21. The themes that emerged in the focus groups were used to develop media (social media posts and audio streaming app ads) that ran in the last quarter of FY 2023. The campaign targeted zip codes with the greatest poverty in select areas of the state and people of color under the age of 21. Through audio streaming, over 740,000 impressions were delivered; through Facebook/Instagram, almost 1.5 million impressions were delivered; mobile display ads resulted in over 5 million impressions, and paid search resulted in over 27,000 impressions.

MDHHS ISS Program continued to explore other ways to engage families directly in the work, including support of the MIH Infant Safe Sleep Action team which included two parent members. In FY 2023, the parent members were active at meetings and helped plan Infant Safe Sleep Awareness month activities for October 2023. In addition, the ISS Program worked with three families, who wanted to share their stories of losing an infant due to unsafe sleep. This work resulted in the families creating a digital story and a supplemental guide on using those stories: *Family Stories of Sleep-Related Loss - A Facilitation Guide for Using their Digital Stories*. In addition, through MOASH, youth ages 13-21 years provided feedback on the infant safe sleep brochure and website. They were asked if the materials encouraged them to follow safe sleep, about the level of information provided regarding the risk of unsafe sleep practices, if the materials were inclusive, and for any recommendations for changes to the materials.

The final strategy is to engage hospitals in areas with a high rate of sleep-related infant death and disparities to explore needed policies and resources to support families of NICU infants in practicing safe sleep behaviors after discharge. In FY 2021, with the help of nurses from two hospitals, the MDHHS Infant Safe Sleep Program developed sample infant safe sleep protocols and crib audit forms for hospitals to use as a guide in creating or updating safe sleep policies. These resources are available online for any hospital that wants to utilize them to develop or update a policy.

An ESM was utilized to track the number of hospitals that received technical assistance and support on updating or implementing a policy. Technical assistance was provided to one hospital regarding the use of hats after birth per the updated AAP recommendations, and to another on their development of a Lotus Birth policy. One hospital implemented an updated safe sleep policy in January 2023, and another updated their safe sleep policy after taking the online training and receiving technical assistance.

The Infant Safe Sleep program worked with two hospitals to devise a way to track staff participation in the online training for hospital nurses and staff, *Infant Safe Sleep: The Basics and Beyond*. In FY 2023, both hospitals mandated this training for staff.

Finally, the program continues to host quarterly meetings for hospitals. The informal meetings are intended to be an avenue for hospitals to learn what other hospitals are doing to support safe sleep, learn about MDHHS activities, problem solve, and share resources.

Breastfeeding (FY 2025 Application)

The American Academy of Pediatrics (AAP) recommends all infants are exclusively breastfed for six months to support optimal growth and development. Additionally, in 2022 the AAP published updated guidance supporting continued breastfeeding for two years or beyond, as long as mutually desired by mother and child. Breastfeeding has health benefits for infants and mothers, including significant benefits to the mental health of both mothers and babies. For infants, breastfeeding reduces risk of asthma, obesity, sudden infant death syndrome (SIDS), diabetes, ear infections, childhood leukemia, and some respiratory diseases. For mothers, breastfeeding can reduce feelings of anxiety and postnatal depression, reduce post-partum hemorrhage, and decrease the likelihood of developing breast, uterine and ovarian cancers. Human milk remains the optimal source of nutrition for the first months of life.

The Title V needs assessment revealed that breastfeeding is a critical maternal and child health (MCH) issue for Michigan's mothers and infants. Needs assessment themes showed that families want more breastfeeding support and education and that families are having difficulty accessing breastfeeding support professionals and providers that support breastfeeding. During the Title V needs assessment, stakeholders identified the priority need to "create and enhance support systems that empower families, protect and strengthen family relationships, promote care for self and children, and connect families to their communities" as a way to achieve breastfeeding initiation and duration. The COVID-19 pandemic highlighted the need to ensure that emergency preparedness plans support access to human milk, especially in Black, Indigenous, and People of Color (BIPOC) communities that have been disproportionately impacted by COVID-19. MDHHS will continue to identify opportunities to expand collaboration with BIPOC-led organizations and communities that lead in addressing this health equity work, especially in relation to dismantling barriers to breastfeeding.

According to the National Immunization Survey (NIS), in 2020 Michigan's initiation rate was 82.8% (CI 76.4-87.7). This meets the annual objective set of 82.7%. Michigan's breastfeeding exclusivity rate through six months was 23.9%, and Michigan's goal is to reach 41.1% by 2025.

Data from the Michigan Pregnancy Risk Assessment Monitoring System (MI PRAMS) can help inform Michigan's strategies to reach its breastfeeding-related goals for Title V. PRAMS data through the 2021 birth year continue to tell a story of relatively static rates of initiation (88.4%), as well as 1-month (76.3%), 2-month (67.0%), and 3-month (56.9%) breastfeeding duration. PRAMS has shown that Michigan's initiation rate had increased steadily from 2009 to 2014, rising from 73.2% to 84.3%. However, from 2014 through 2021, there has been a leveling out in breastfeeding initiation, with no significant increase nor decrease seen across these years. It is possible that 2021 initiation numbers (88.4%) reflect the start of an increase in initiation at the state level, but this cannot be determined reliably from a single year of data.

Across a time period where breastfeeding statistics have remained relatively static in Michigan (2016-2021), about nine in ten non-Hispanic white mothers initiated breastfeeding (88.5%; 95% CI: 87.3%-89.6%). Initiation was comparable for Hispanic mothers (87.8%; 95% CI: 83.6%-91.1%) and those in the non-Hispanic "Other" category (87.3%; 95% CI: 80.4%-92.0%), yet relatively lower for non-Hispanic Black mothers (75.1%; 95% CI: 73.7%-76.6%). Mothers from the non-Hispanic Asian and Pacific Islander subgroup had the highest proportion who initiated breastfeeding (95.6%; 95% CI: 90.8%-97.9%). By incorporating birth certificate information on maternal ancestry categories and also looking at paternal race/ethnicity/ancestry, we are able to describe two other groups. Initiation among mothers of Infants with Native American/American Indian/Alaskan Native ancestry was high, at 93.7% (95% CI: 88.5%-96.6%). The final group can likely only be found at sufficient numbers (for data analysis) in Michigan, which is mothers of infants with Middle Eastern/North African ancestry. Among these mothers, initiation was also high at 92.7% (95% CI: 88.5%-95.4%).

The Title V state action plan continues to focus on reducing disparities in breastfeeding rates among women of color. In alignment with the plan, MDHHS has continued to prioritize using culturally responsive, evidence-based images and messages within public health campaigns to support the normalization of breastfeeding. Action plan strategies focus on increasing breastfeeding knowledge among maternal and infant health professionals who work with pregnant or postpartum women; offering free breastfeeding educational opportunities statewide through a webinar series and online breastfeeding training course; supporting and promoting access to breastfeeding support resources; normalizing breastfeeding in culturally responsive ways; and promoting community-driven resources that address common breastfeeding barriers. The evidence continues to support that babies born in Baby-Friendly designated hospitals are more likely to be breastfed. Therefore, increasing the percent of Baby-Friendly hospitals in Michigan remains the Evidence-based Strategy Measure (ESM) for this NPM. Title V funding supports breastfeeding promotion efforts, including social media activities.

Objective A: Increase the percent of infants who are breastfed exclusively until 6 months to 41.1% by 2025.

The first strategy is to provide MDHHS Maternal Infant Health (MIH) staff with an appropriate level of breastfeeding education. The free online course “Breastfeeding for Professionals Working with Families” was released in June 2023 and serves as a key resource to increase MIH staff knowledge on the health benefits of breastfeeding to parents and infants; common barriers to breastfeeding; root causes of breastfeeding disparities among racial and ethnic groups; information to support consistent messaging about breastfeeding; and community-based, culturally responsive breastfeeding resources to support both Michigan families and professionals. The training also discusses how to have honest and non-judgmental conversations about risk reduction strategies for safe sleep. This strategy, in tandem with the next two strategies, will help to achieve the state priority need by enhancing support systems that empower families, promote care for self and child, and connect families to resources in their communities. It also supports the strategy of promoting breastfeeding across programs within MDHHS. In 2025, this breastfeeding course will continue to be promoted to MCH professionals and partner agencies across the state. Going forward, the breastfeeding course will be updated as needed to reflect current guidance and recommendations.

Evidence demonstrates access to professional and peer support can increase breastfeeding duration. For the second strategy, MDHHS will continue to promote increased access to breastfeeding support professionals and peer counseling services in programs serving families. MDHHS will promote sources of breastfeeding support and disseminate the information to maternal and infant health programs and other partners through multiple communication modalities (e.g., newsletters, listservs, social media).

The third strategy, increase the percent of Baby-Friendly Hospitals in Michigan from 16% to 18%, is Michigan’s ESM for this NPM. Activities will focus on continuing to leverage and develop partnerships with organizations that promote and support hospitals’ ability to achieve and maintain Baby-Friendly designation. MDHHS will continue to encourage the benefits of Baby-Friendly designation and maintaining Baby-Friendly standards beyond designation through routine data collection, monitoring of practices, and quality improvement activities, which can support breastfeeding duration. In 2023, MDHHS worked with a community partner to develop a two-page resource that shared information about opportunities to support Michigan hospitals in achieving and maintaining the Baby-Friendly designation. This resource will continue to be promoted widely in FY 2025. Breastfeeding content will be included at the 2025 Maternal Infant Health Summit, which is broadly attended by MIH professionals, including hospital and clinic staff. Additionally, MDHHS will recognize hospitals that adopt breastfeeding-supportive maternity care and infant feeding as best practices. Michigan hospitals’ response to the COVID-19 pandemic has continued to place incredible strain on hospital resources in recent years and has impacted their ability to meet and/or maintain the Baby Friendly USA standards.

Objective B: To impact breastfeeding disparity, increase percent of non-Hispanic black women who initiate breastfeeding from 74.4% to 78.4% by 2025.

Disparities in breastfeeding initiation rates persist and this objective seeks to achieve more equitable health outcomes by addressing this disparity. PRAMS data will be used to measure and track the objective. The first strategy is to support training opportunities that improve the racial and cultural diversity of breastfeeding professionals. One example is the Great Lakes Breastfeeding Webinar Series hosted by the Michigan Breastfeeding Network. This webinar series provides monthly on-demand online training opportunities for professionals who serve families, at no cost to participants. The Michigan Breastfeeding Network has expanded the types of continuing education offered through the webinars and now provides contact hours for nurses, social workers, lactation consultants, community health workers, certified health education specialists, physicians, and dietitians. In 2025, it is expected that the webinars will continue to be hosted through an online learning platform that provides instant access to continuing education certificates after completion of the post-webinar evaluation. Not only do the webinars remove barriers such as travel and cost, but webinar topics have an intentional health equity focus.

The second strategy is to promote breastfeeding promotion campaigns to normalize breastfeeding in culturally responsive ways. At a minimum, in FY 2025 social media messages promoting breastfeeding will be identified and used on MDHHS social media channels. These social media messages will aim to integrate community voice by reflecting the input and preferences shared by community-based organizations. MDHHS will also work with partners to recognize observances such as, but not limited to, Breastfeeding Awareness Month, Indigenous Milk Medicine Week, Black Breastfeeding Week, and Asian American, Native Hawaiian and Pacific Islander Breastfeeding Week. Through non-Title V funding sources, MDHHS will also continue to work with the Genesee County Health Department to increase breastfeeding rates within the City of Flint and Genesee County. Past work with Genesee County has supported efforts to develop breastfeeding education animated “shorts” and print materials using evidence-informed curriculum to provide tailored breastfeeding education via social media and local advertising.

The final strategy will be to promote breastfeeding educational resources that focus on common breastfeeding barriers at the dyad. Resources were developed through a partnership with local BIPOC-led breastfeeding support organizations to address latch, milk supply, and pain, which were identified through PRAMS data as top reasons for stopping breastfeeding. The content in these resources was determined by community organizations and the families they serve to better address the needs of families. These resources will continue to be promoted widely with Maternal and Infant Health partners for statewide use.

Safe Sleep (FY 2025 Application)

Infant deaths from sleep-related causes continue to be a persistent concern. The Title V NPM for safe sleep is linked to Michigan’s state priority need to “create and enhance support systems that empower families, protect and strengthen family relationships, promote care for self and children, and connect families to their communities.” The MDHHS Infant Safe Sleep Program (ISS Program) is housed in the Division of Maternal and Infant Health and provides training, technical assistance, and resources to professionals and families in Michigan. It also oversees ISS grants to local agencies.

In Michigan, sudden unexpected infant deaths (SUID) are a leading type of death for infants 1-12 months old (2020-2022 Michigan Resident Infant Death File, Division for Vital Records & Health Statistics, MDHHS), with suffocation being the most common cause of SUID. Statewide 1.3 sleep-related infant deaths occur per 1,000 live births [Centers for Disease Control and Prevention (CDC) Sudden Unexpected Infant Death (SUID) Case Registry – 2010-2021, Michigan Public Health Institute (MPHI), 2023] and there is no clear trend showing either an increase or a

decrease in the state rate. Rates across the state vary widely, with some jurisdictions experiencing rates as high as 3.5 and some as low as 0.6 (CDC SUID Case Registry – 2010 to 2021, MPHI, 2023).

Significant racial disparities exist among sleep-related infant deaths. In Michigan, non-Hispanic Black (NHB) infants are 4.0 times more likely to die of sleep-related causes than non-Hispanic white (NHW) infants. Compared to NHW infants, American Indian infants are 2.6 times more likely to die of sleep-related causes (CDC SUID Case Registry – 2010 to 2021, MPHI, 2023).

Additionally, data show infants born preterm and low birth weight babies are also at increased risk for sleep-related infant deaths. Pre-term infants experience a sleep-related infant death rate 2.5 times higher than infants born at 37 weeks or greater gestation. Moreover, infants born with low birth weight have a 3.1 times greater risk of dying due to sleep-related causes as compared to infants with a birth weight of 2,500 grams or higher (CDC SUID Case Registry – 2010 to 2021, MPHI, 2022).

Most sleep-related infant deaths are preventable with safe sleep practices. Data from the Michigan Pregnancy Risk Assessment Monitoring Survey (PRAMS) often take several years to reach statistically significant change. Since 2016, there has been a clear and sustained improvement in back sleeping in Michigan since that time (81.9% in 2016 to 86.5% in 2021). About 2/3 of Michigan mothers in 2021 report that their infants were usually placed to sleep in a space without soft or loose bedding or objects (64.1%). As with back sleeping, this measure has shown sustained improvement since 2016 (51.8%). Across the last three years, the measure of a separate approved sleep surface has been somewhat resistant to change, remaining just above 40% (41.3% in 2021), but this remains an improvement from 2016 (34.0%). As this single performance measure is a composite of five different component measures, Michigan will be taking a closer look at all five components (infant always or often sleeps alone; sleeps in a crib; does not sleep on a couch or sofa; does not sleep in a car seat or swing; does not sleep on a twin or larger mattress) to see where future improvements may be found. Michigan has seen a notable and sustained improvement in the proportion of mothers who are not sleeping their infants in car seats or swings (from 47.4% in 2016 to 56.9% in 2021), but smaller year-by-year changes in other components seem to be offsetting changes in the composite measure.

Data show that the behaviors described above do impact deaths. One example is when looking at sleep location. According to the CDC SUID Case Registry, three in four (74.7%) sleep-related infant deaths in Michigan occurred in an unsafe sleep location, including adult beds (49.9%) and couches or chairs (14.1%). Only 22.2% of infants who died of sleep-related causes were placed to sleep in a crib, bassinet, or portable crib. Of the infants who die of sleep-related causes in Michigan, 57.5% of deaths occur while an infant is sharing a sleep surface with an adult(s), another child(ren), and/or an animal(s) (CDC SUID Case Registry – 2010 to 2021, MPHI, 2023).

The disparity gap in back sleeping was relatively constant through 2014. Starting in 2014, a seven-year period was observed in which back sleeping remained statistically unchanged among Black mothers. In combination with modest improvements among white mothers, this has resulted in a widening disparity gap for back sleep. According to 2021 PRAMS data, there is a disparity gap of 19.8% for the behavior of infants usually being placed to sleep on their backs between Non-Hispanic white (NHW) and Non-Hispanic Black (NHB) individuals , 91.3% and 71.5%, respectively. There are also growing and/or persistent disparities in some safe-sleep performance measures that have just recently become clear upon examination of the 2020 and 2021 PRAMS data. In 2016, the proportions of NHW and NHB mothers sleeping their infants on separate approved surfaces and in spaces without loose objects or bedding were about equivalent. A single digit disparity gap opened in 2017-2018 and grew to double digits for each measure by 2020. Now, in 2021, there remains a 16.1% disparity gap of infants being put to sleep without soft objects or loose bedding (68.8% for NHW as compared to 52.7% for NHB). NHW mothers also reported a higher proportion of infants sleeping on a separate approved sleep surface (44.0% for NHW compared to 38.7% for NHB;

disparity gap 5.3%) which is close to the average disparity gap (6.0%) seen for this measure across 2016-2021. These disparities all reached statistical significance.

However, the difference in sleep behaviors by NHW and NHB infants does not account for all differences in sleep-related infant death rates between the two groups. It is important to note that social determinants of health (SDOH) and systemic policies and practices rooted in racism and oppression drive these disparities and interfere with a family's ability to practice infant safe sleep behaviors and ultimately to achieve optimal health.

Objective A: Increase the percent of infants put to sleep on their backs from 84.9% in 2019 to 92.3% by 2025.

Objective B: Increase the percent of infants put to sleep on a separate approved sleep surface from 40.6% in 2019 to 53.5% by 2025.

Objective C: Increase the percent of infants placed to sleep without soft objects or loose bedding from 63.1% in 2019 to 80.9% by 2025.

Objective D: Increase the percent of non-Hispanic Black infants put to sleep on their backs, put to sleep on a separate approved sleep surface, and put to sleep without soft objects or loose bedding.

The strategies to address Michigan's safe sleep objectives are combined and will promote key messages to parents, caregivers, and providers: infant sleeps on the back, alone and without objects in a crib, bassinet or pack and play. Activities will be designed to increase the behaviors by all families, while focusing specifically on decreasing the disparity for NHB families and other historically disadvantaged groups including American Indians.

The first strategy is to support safe sleep activities of Local Health departments (LHDs) and the Inter-Tribal Council of Michigan (ITC) by offering grants to increase the capacity of those communities to implement infant safe sleep education, awareness, and outreach activities, with a focus on populations within their jurisdiction that experience high rates of sleep-related infant death and disparity. In FY 2025, five LHDs and ITC will be offered grants. The jurisdictions served by the five LHDs account for 51% of the sleep-related infant deaths in Michigan and all experience significant racial disparities among the deaths. Grantees, as experts in their own communities, are given the latitude to design, direct and conduct their work.

As SDOH are known to contribute to infant outcomes, the grantees will be asked to explore how to address SDOH impacting families they serve and to consider how to address upstream causes of disparity. As part of grant requirements, grantees will continue to be required to have an advisory team to guide their work. That advisory team will be required to include members that can address SDOH. In addition, grantees will continue to be required to include community members on their advisory team. Grantees will be asked to document their efforts obtaining input and feedback from families.

Since 2020, the COVID-19 pandemic has changed how LHDs and ITC conduct safe sleep activities. They had to be creative in overcoming the challenges the pandemic presented and many of their solutions have remained a permanent part of their programming, such as continuing to offer virtual options for events. They will be encouraged to continue to be creative in their efforts to meet program objectives.

The second strategy is to continue to support agencies in implementing and/or updating existing safe sleep policies or protocols so that families interacting with those agencies receive up-to-date infant safe sleep education; have access to tangible resources for safe sleep; and are given referrals to supportive programs such as home visiting, WIC and lactation support. The support to agencies will continue to be customized to fit their needs and will include

access to recommendations that outline how agencies serving families can support infant safe sleep. Success at connecting with agencies in the last several years has been challenging, particularly due to other competing program needs. The ISS Program will continue to recruit agencies, including agencies serving historically marginalized and underserved populations. ISS Program staff will continue to provide support to other federal and state programs including the Maternal Infant Health Program (MIHP), the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV), and WIC to support and enhance infant safe sleep education and awareness with staff and clients. The ESM tied to this strategy will continue to count the number of agencies supported and provided technical assistance in implementing or updating a policy.

The third strategy is to provide education and share tools with providers on how SDOH impact safe sleep and how to have client/patient centered conversations regarding safe sleep. This includes trainings (i.e., virtual, online and in-person) for providers who work with pregnant and parenting families in programs such as home visiting, WIC, childcare, child welfare, CPS, emergency medical services and prenatal care. In FY 2025, motivational interviewing concepts and risk reduction techniques will continue to be included in trainings conducted with professionals who work with families. The trainings help professionals better understand the challenges a family may face in following the guidelines by having honest and open conversations; equip professionals to help the family evaluate their current risk and explore strategies for risk reduction; and identify needed supports. The ESM to require all new MIHP staff to take the online *Helping Families Practice Infant Safe Sleep* training will continue in FY 2025. In FY 2023, MIHP agencies served approximately 11,300 adults and 14,515 infants on Medicaid. Focusing on MIHP providers allows mothers and families at higher risk to be reached.

In 2022 the ISS program established a partnership with MDHHS Bureau of Emergency Preparedness, EMS and Systems of Care to implement an Infant Safe Sleep Certification Program for EMS Agencies and Fire Departments. The program requires the fire departments and EMS agencies to train providers as well as connect with local safe sleep contacts to access supportive services for families. This program will continue in FY 2025. The High Touch, High Tech (HT2) e-screening tool delivers a brief motivational intervention, notifies the healthcare provider, and helps connect families to additional supports. Its expansion to include screening for safe sleep knowledge and behaviors continues to be available. Opportunities to expand and enhance this project will continue to be explored in FY 2025.

Support for professionals will also be continued through the email listserv and webinars. Resources for infant safe sleep and infant care will continue to be available through the Infant Safe Sleep website and the MDHHS Clearinghouse. Images used in educational materials will continue to reflect the diversity of families in Michigan and most materials are offered in a variety of languages. Other languages will be added as necessary. The ISS Program will continue to explore how to develop safe sleep messaging that resonates with families and can include information about risk reduction.

Another strategy is to provide professionals and families with guidance on protective factors (i.e., smoking cessation, breastfeeding, immunizations) and evidence-based programs (i.e., community-based doula support, home visiting) to enhance the overall health and well-being of moms and babies. Information on protective factors is incorporated into safe sleep messaging and educational materials when possible. In FY 2025, the Infant Safe Sleep and Breastfeeding Programs will continue to integrate their work more closely. Quarterly calls with MDHHS programs such as Immunizations, WIC, Tobacco, and Home Visiting will maintain collaborations that work to infuse infant safe sleep into all aspects of work with families.

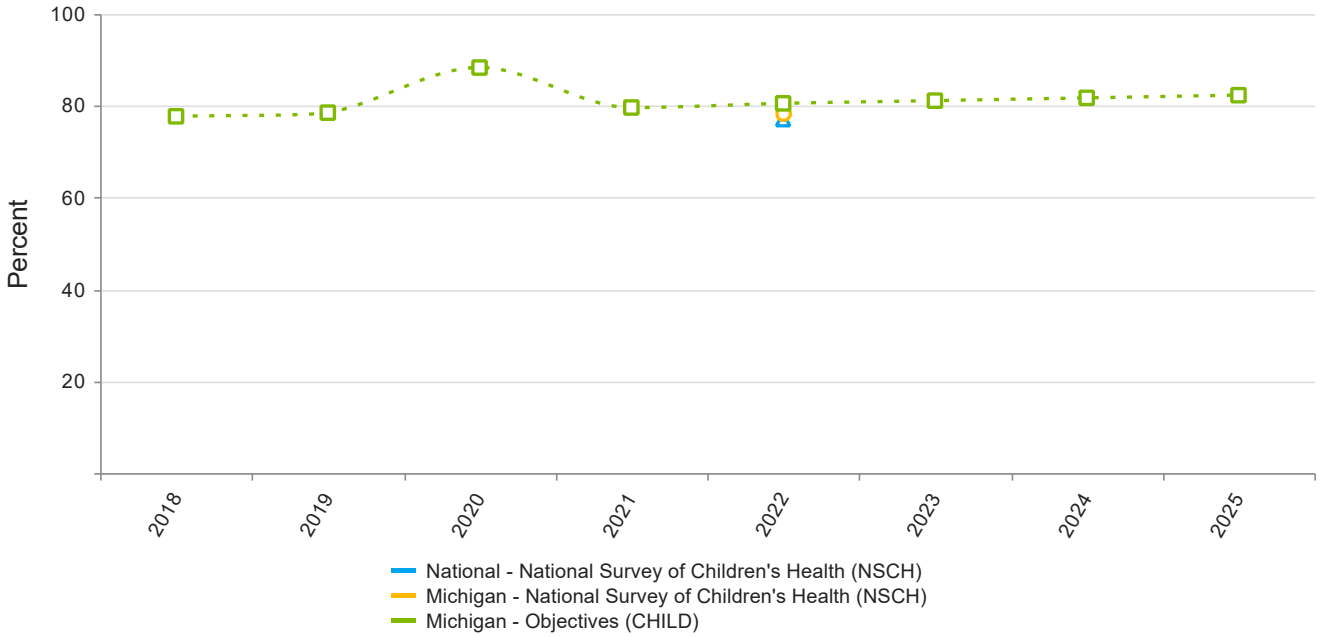
The final strategy is to continue to recruit hospitals to work with the Infant Safe Sleep Program to explore ways each hospital can educate and support families of infants, including NICU infants, to support their practice of safe sleep behaviors after discharge. The model hospital policy/procedure document and audit forms will continue to be utilized in this work. The support provided to each hospital will be customized to fit the needs of the hospital. The ESM tied to

this strategy will track the number of hospitals that have been supported. A challenge with this ESM is the competing priorities of a hospital setting. Hospital staff invested in safe sleep may not have the administrative support needed to implement changes.

Child Health

National Performance Measures

NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child
Indicators and Annual Objectives



NPM PDV-Child - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	78.4	88.2	79.5	80.4	81
Annual Indicator	77.7	76.5	76.6	76.2	78.3
Numerator	1,618,664	1,574,401	1,556,280	1,540,558	1,601,392
Denominator	2,083,849	2,058,613	2,032,403	2,020,499	2,045,756
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	81.6	82.2

Evidence-Based or –Informed Strategy Measures

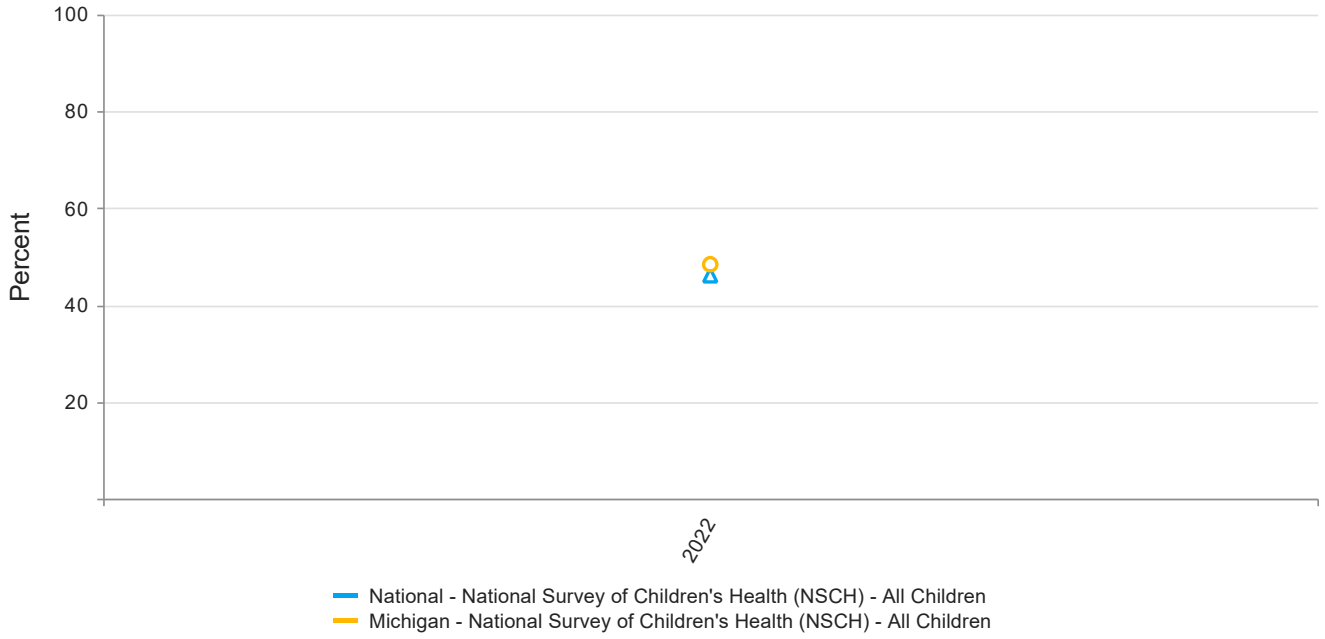
ESM PDV-Child.1 - Number of students who have received a preventive dental screening through the SEAL! Michigan program

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	6,327	6,527	6,727	6,927	6,927
Annual Indicator	6,897	6,168	3,639	9,396	9,382
Numerator					
Denominator					
Data Source	SEAL MI 2019 All Grantees Data	SEAL MI 2020 All Grantees Data Report	SEAL MI 2021 All Grantees Data Report	SEAL MI 2022 All Grantees Data Report	SEAL MI 2023 All Grantees Data Report
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	7,127.0	7,327.0

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Child Health - All Children

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - All Children	
	2023
Annual Objective	
Annual Indicator	48.3
Numerator	1,028,529
Denominator	2,129,813
Data Source	NSCH-All Children
Data Source Year	2021_2022

Evidence-Based or –Informed Strategy Measures

None

State Performance Measures

SPM 1 - Percent of children less than 72 months of age who receive a venous lead confirmation testing within 30 days of an initial elevated capillary test

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	27.1	29.6	50	52.5	55
Annual Indicator	45.8	48.1	45.3	49.2	46.6
Numerator	1,671	994	718	636	1,584
Denominator	3,646	2,068	1,586	1,293	3,400
Data Source	MDHHS Data Warehouse	MDHHS Data Warehouse	MDHHS Data Warehouse	MDHHS Data Warehouse	MDHHS Data Warehouse
Data Source Year	2019	2020	FY2021	FY2022	FY2023
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives		
	2024	**2025**
Annual Objective	57.5	60.0

SPM 2 - Percent of children 19 to 36 months of age who have received a completed series of recommended vaccines (4313314 series)

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective	75	76	77	78	79
Annual Indicator	74.1	70.7	69.4	66.1	69.8
Numerator	121,707	119,786	113,259	107,075	114,804
Denominator	164,167	169,474	163,218	162,076	164,430
Data Source	Michigan Care Improvement Registry	Michigan Care Improvement Registry	Michigan Care Improvement Registry	Michigan Care Improvement Registry	Michigan Care Improvement Registry (MCIR)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	80.0	80.0

State Action Plan Table

State Action Plan Table (Michigan) - Child Health - Entry 1	
Priority Need	
Improve oral health awareness and create an oral health delivery system that provides access through multiple systems	
NPM	
NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	
Five-Year Objectives	
A) Increase the number of students who have received a preventive dental screening within a school-based dental sealant program	
B) Increase dental sealant placement on children enrolled in Detroit Public Schools Community District (DPSCD)	
Strategies	
A1) Utilize the Qualtrics SEAL! Michigan electronic database to track the number of students annually receiving a preventive dental screening A2) Promote dental sealant programs through school health professionals A3) Prepare and analyze the annual SEAL! Michigan all grantee reports to monitor for annual growth of students receiving a preventive dental screening A4) Examine ongoing trends to identify geographic areas experiencing a high burden of disease and identify populations that will benefit from an increase in dental sealant placement in proportion to disease and population	
B1) Increase access to dental consent forms for students' caretakers B2) Provide oral health education to all nurses at DPSCD on a semi-annual basis B3) Increase the number of dental providers and their services at DPSCD to allow additional access to care and increase sealant placement	
ESMs	**Status**
ESM PDV-Child.1 - Number of students who have received a preventive dental screening through the SEAL! Michigan program	Active
NOMs	
NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC	
NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC	
NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS	

State Action Plan Table (Michigan) - Child Health - Entry 2

NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Five-Year Objectives

A) By September 30, 2025, MDHHS will complete an environmental scan, including an equity gap analysis to identify Title V's role for the Medical Home for Children system

Strategies

A1) Identify and convene a group of multisector partners and stakeholders alongside parents of children aged 0 to 17 who have lived experience with the Medical Home for Children system A2) Design and conduct an environmental scan, including an equity gap analysis for the Medical Home for Children system across the state A3) Select at least one identified equity gap related to the Medical Home for Children system to focus Title V support

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

State Action Plan Table (Michigan) - Child Health - Entry 3

Priority Need

Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems

SPM

SPM 1 - Percent of children less than 72 months of age who receive a venous lead confirmation testing within 30 days of an initial elevated capillary test

Five-Year Objectives

A) By 2025, increase screening for lead exposure risk factors for children less than 72 months of age

B) By 2025, increase the percentage of Medicaid-enrolled children less than 72 months of age receiving blood lead testing by 10%

C) By 2025, increase by 10% the percent of all children less than 72 months of age with an elevated blood lead level (EBLL) from a capillary test who receive a venous lead confirmation test

Strategies

A1) Improve notification to health care providers of patients' blood lead levels and need for blood lead testing A2) Conduct provider education activities to encourage providers to screen all children less than 72 months of age for lead exposure risk factors A3) Partner with agencies to provide culturally-appropriate and audience-specific lead education to populations at risk of lead exposure

B1) Provide local health departments with monthly data reports of Medicaid-enrolled children that have not had blood lead testing B2) Conduct provider education activities to encourage providers to provide blood lead tests to Medicaid-enrolled children at the recommended times

C1) Provide local health departments with quarterly data reports C2) Conduct family engagement to obtain information to improve nursing case management outcomes and process C3) Conduct provider education activities to encourage providers to order a venous test after an elevated capillary test

State Action Plan Table (Michigan) - Child Health - Entry 4

Priority Need

Improve access to high-quality community health and prevention services in the places where women, children, and families live, learn, work, and play

SPM

SPM 2 - Percent of children 19 to 36 months of age who have received a completed series of recommended vaccines (4313314 series)

Five-Year Objectives

A) By 2025, increase the percentage of children 19-36 months of age who receive recommended vaccines to 80%

B) Assist local health department immunization staff with targeting outreach to under-served populations in their jurisdiction

Strategies

A1) Use Michigan Care Improvement Registry (MCIR) data to identify all children 24 months of age who are overdue for a vaccine A2) Generate and disseminate annual recall letters using the MCIR to parents of children 24 months of age who are overdue for a vaccine A3) Use MCIR data to conduct a root cause analysis and identify high social vulnerability index (SVI) areas within the state and conduct targeted vaccine outreach in those areas A4) Work with internal and external partners to promote vaccine confidence among parents of this age group through resources, media, and presentations A5) Work with the Alliance for Immunization in Michigan Coalition to better engage families and communities through education and improvements to the aimtoolkit.org website

B1) Produce and share a quarterly report card for each county showing vaccination rates and rankings compared to other counties across the state for multiple pediatric and adolescent age groups, including children 19-36 months of age B2) Produce County coverage levels by race for children 19-36 months of age and make the information available to local health departments to identify and address disparities

Child Health Overview

Meeting the health needs of children requires coordination and strategic action across multiple systems. The Division of Child and Adolescent Health (DCAH) provides leadership through the Early Childhood Health Section; Child and Adolescent Health Services Section; Adolescent and School Health Section; Home Visiting Section; and Oral Health Section. The Oral Health Section plays a key role in promoting children's health and expanding access to dental screening and services for young children and school-aged youth. Oversight of the local MCH (LMCH) program that provides Title V funding to local health departments is also located within DCAH. DCAH collaborates with the Michigan Department of Education, the Children's Service Agency, Division of Maternal and Infant Health, and Children Trust Michigan to implement evidence-based home visiting and to strengthen early childhood systems at the state and local level. Through the Preschool Development Grant Birth through Five (PDG), Michigan is working to ensure smooth transitions for families throughout the early childhood system, including home visiting and Early On. Michigan was also awarded an Early Childhood Comprehensive Systems (ECCS) grant which is housed in DCAH. Michigan supports Infant and Early Childhood Mental Health, ensuring social emotional development of the child and family is considered as well as using a trauma-informed lens when working with families.

Other MDHHS divisions also support Michigan's Title V priorities. The Division of Immunization is housed in the Bureau of Infectious Disease Prevention and is focused on tracking immunization rates, improving access to immunization services, and improving the uptake of all Advisory Committee on Immunization Practices (ACIP) recommended vaccines for children. The Childhood Lead Poisoning Prevention Program (CLPPP) is housed in the Lead Services Section within the Division of Environmental Health in Bureau of Epidemiology and Population Health. CLPPP carries out mandated blood lead surveillance and lead poisoning prevention activities. Both the Immunization Program and CLPPP work closely with local health departments to implement these services for children.

Title V funding supports programs for children that improve childhood lead screening, increase access to dental care, address Fetal Alcohol Spectrum Disorder (FASD), and improve immunization rates for children and adolescents. Other federal funding that improves children's health includes the Early Hearing Detection and Intervention Program (CDC), the State and Local Healthy Homes and Childhood Lead Poisoning Prevention Program (CDC), and the Maternal, Infant, and Early Childhood Home Visiting Program (HRSA). State and local partnerships that support child health include the Early Childhood Investment Corporation, Great Start System, local health departments (LHDs), Early On, Healthy Start, Head Start, the Michigan League for Public Policy, the Michigan Council for Maternal and Child Health, and others.

Title V funding also supports the Local Maternal Child Health (LMCH) program which provides funding to all 45 Local Health Departments (LHDs). In FY 2023, Title V funds via the LMCH program were expended on NPM 13.2 (oral health-children), SPM 1 (childhood lead poisoning prevention), SPM 2 (childhood immunizations), SPM 6 (behavioral/mental health), and Local Performance Measures (LPMs) in the child health domain. Three LHDs supported oral health for children (NPM 13.2) by providing gap-filling dental services, fluoride varnish, and education through outreach events and social media posts. Childhood lead poisoning prevention (SPM 1) was selected by 13 LHDs. Activities included gap-filling lead screening and case management, venous confirmation follow-up, lead packet distribution in high-risk zip codes, community/provider education, and environmental risk assessments. Traditionally, much lead screening is conducted in WIC clinics. WIC in-person certification was not mandatory through August 2023 due to the COVID-19 pandemic which reduced the opportunity to screen for lead at in-person visits. Seventeen LHDs selected SPM 2 (childhood immunizations). Agencies facilitated gap-filling immunization services, recall notifications, waiver education, social media education, and a PSA campaign. Some agencies noted that vaccine waivers also increased. LHDs report that mistrust of government has increased since the

pandemic. Families who have previously vaccinated their children are now requesting waivers to decline vaccines for their children. One agency worked on SPM 6 (behavioral/mental health) by providing presentations on mental health to elementary school age children. The same agency worked on an LPM related to obesity/nutrition.

Three LHDs worked on an LPM for gap-filling hearing and vision screening. One agency implemented a LPM for car seat safety training. LHDs reported staff vacancies that also impacted the ability to complete planned activities.

Michigan's approach to improving child health under the Title V block grant emphasizes improving access to care and preventing blood lead poisoning; improving childhood immunization rates; and improving children's oral health.

Oral Health – Children (FY 2023 Annual Report)

The MDHHS Oral Health Program (OHP) provides population-based oral health prevention efforts and effective utilization of the dental workforce in implementing and improving oral health access. Recognizing oral health's impact on overall wellbeing, the OHP has expanded collaborations with partners to advance prevention and access efforts. The activities of NPM 13.2 in FY 2023, as discussed below, illustrate these strengthened partnerships. Title V funding was used to support the activities of the SEAL! Michigan program through local school-based dental sealant programs. In combination with other funding, Title V also supports an oral health epidemiologist who analyzes SEAL! Michigan program data and prepares reports for grantees and partners.

In the fall of 2022, the School Oral Health Consultant position was vacated and was filled in May 2023, over halfway through the fiscal year. The new appointee immediately focused on key initiatives, prioritizing meetings with MDHHS personnel, conducting local site visits, and establishing connections with existing funded programs. A significant effort was made to collaborate with the oral health epidemiologist to explore methods for transitioning SEAL! Michigan data forms to electronic formats using specific software. Plans were made to conduct training sessions in FY 2024 to introduce and implement this new software among SEAL! Michigan programs and DPSCD dental providers.

Beginning January 2023, the Michigan Medicaid dental policy underwent a revision, now covering reimbursement for primary and premolar sealant placement, a service previously excluded. This change has the potential to bolster future program funding and increase access to sealants among Michigan children.

SEAL! Michigan programs face ongoing challenges stemming from rising operational costs of Personal Protective Equipment and fuel. A significant number of hygienists have left the profession since 2020, complicating recruitment and retention efforts. Private practices offering substantial pay increases and hiring incentives further challenge retaining hygienists. The Michigan Healthcare Workforce Index (Michigan Health Council) underscores the acute need for dental hygienists and assistants in the state. The absence of a dental hygiene program in Northern Michigan furthers the uneven distribution of oral health labor in rural areas.

The annual SEAL! Michigan Workshop aligned with the MDHHS Child and Adolescent School Health (CASH) conference for the second consecutive year as a preconference session. This joint effort aimed to foster school-dental program collaboration. Although traditionally scheduled in September, the conference occurred in October 2023 due to conflicting schedules. This timing, amidst a busy period for SEAL! Michigan programs coupled with constrained funds for attendance, hindered provider participation. Consequently, separating these events in the future is under consideration to better accommodate diverse schedules and other constraints.

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

The first strategy to achieve this objective was to utilize the SEAL! Michigan database to track the number of students annually receiving a preventive dental screening. The number of students receiving a preventive dental screening through SEAL! Michigan is also the ESM for this NPM. The SEAL! Michigan data forms and all grantee reports continued to be used to monitor the number of students receiving a preventative dental screening in FY 2023. Data forms were collected at the end of the fiscal year; data was cleaned; and grantee reports were developed and submitted for publication.

In FY 2023, nine SEAL! Michigan programs were funded using Title V funding. Across the SEAL! Michigan programs, 9,382 students were screened. Most of the students screened were in kindergarten and 2nd grade. The average age of students was 8 years old, with the range of students screened between 2 and 25 years of age. The older students screened were in alternative education locations, such as youth centers and special education locations.

The racial and ethnic backgrounds of students served included Arab American, Hispanic, and Black. Over 75% of the students were white, 18.8% were black, and 14.7% were multiracial. These rates are in proportion to where programs provided services during the reporting period. Rural areas in the state, such as the Upper Peninsula, have a higher population of white families, whereas more urban areas (e.g., Detroit, Oakland County, Ingham County) have more diverse populations.

Approximately one-quarter of students served had special health care needs which included those needing additional medical care and students receiving special therapy, counseling, or treatment. Over half of students were enrolled in the Healthy Kids Dental Insurance program (Medicaid dental managed care program), 19.2% had private insurance, and 17.8% had no dental insurance.

The second strategy involved the promotion of dental sealant programs among school health professionals. These professionals vary widely, including community school health coordinators, school nurses, and sometimes shared nursing staff across district schools. In some cases, administrative personnel, such as secretaries, serve as crucial points of contact in the school setting. The SEAL! Michigan programs actively engage and partner with these professionals, ensuring that children in urgent need of dental care receive timely attention. The collaboration extends beyond engagement; it involves sharing pertinent updates, providing education materials tailored for families, furnishing information about Medicaid dental provider resources, and effective practices relating to oral health initiatives. These materials are made readily accessible to students, parents, and school staff, aiming to increase awareness and promote oral health practices within the school community. In addition, feedback is encouraged from school health professionals regarding the program's effectiveness and areas for improvement which fosters a sense of ownership and investment in the success of the program.

The final strategies included preparing and analyzing the annual SEAL! Michigan all grantee reports to monitor screening growth and identify high need areas and populations that would benefit from increased dental sealants proportional to disease burden. In FY 2022, surveys to students in Head Start and third grade were completed and published in 2023. The surveys are completed every five years and provide data and benchmarks on oral health data trends in certain regions of the state.

Michigan Head Start oral health data indicated the COVID-19 pandemic significantly worsened children's oral health in Michigan from 2017-2018 to 2021-2022, with marked increases in decay experience (35% to 45%) and untreated tooth decay (22% to 31%). Head Start children experienced tooth decay at a rate of 45%, surpassing the national average of 28% for ages 3-5, with 31% having untreated decay, more than double the national average of 12%. Disparities were evident, particularly among lower-income schools and Black/African American children. Michigan's Head Start children exhibited notably worse oral health than the national averages across decay experience and untreated decay measures. The data underscore significant oral health challenges among low-income children in

Michigan, likely exacerbated during the pandemic.

Michigan's third-grade oral health data reveal that 58% of surveyed children had experienced tooth decay and 28% had *untreated* tooth decay, surpassing national averages. Only 34% had protective dental sealants, notably lower than the national average of 42%. Disparities were evident, with lower-income schools and Black/African American children experiencing higher decay rates and limited access to sealants compared to white children. Furthermore, 17% suffered from decay in permanent teeth, with 7.4% left untreated, leading to potential issues such as pain, malnutrition, speech problems, and school absenteeism. Although decay experience aligns with national figures, untreated decay prevails among Michigan's third graders, highlighting disparities linked to income and race.

The recent oral health data across various age groups, as indicated by both survey reports, underscores the ongoing necessity to bolster school-based sealant programs in Michigan. The deficiency in sufficient protective dental sealants, particularly among lower-income and minority children, highlights the crucial role these programs play in addressing oral health disparities and averting potential oral health issues among the state's youth.

Objective B: Increase dental sealant placement on children enrolled in Detroit Public Schools Community District (DPSCD).

The 2016 Count Your Smiles (CYS) report in Michigan found alarming oral health disparities among third-grade children in Detroit. Around 82% had active dental issues, while only 28.3% had at least one dental sealant—the lowest in Michigan. These disparities emphasize the urgency for robust oral health programs and improved care coordination within the Detroit Public Schools Community District (DPSCD) to achieve health equity for Michigan's children. DPSCD, serving around 50,000 students, stands as one of the state's largest districts, with approximately 82% of its students being of African American descent (per the Michigan Department of Education report).

The primary strategy to increase dental sealant placement in DPSCD, is to continue to utilize the 0.75 FTE (Full-Time Equivalent) Oral Health Coordinator (OHC), overseeing oral health initiatives. Supported by Title V funding, this unique MDHHS and DPSCD collaboration operates within the MDHHS Oral Health Program in Detroit, alongside other DPSCD school health staff.

The OHC's responsibilities encompass managing DPSCD's dental services partners, conducting site visits to oversee school dental clinics, ensuring compliance with infection control standards, and prioritizing safety measures. Additionally, this role involves supporting oral health education for school nurses, students, and families, while facilitating swift treatment of children with urgent dental needs.

The second strategy to support this objective was to organize parent and student focus groups at DPSCD schools with historically low participation rates. These sessions hosted by the OHC aimed to address ways to increase the usage of no-cost dental services available at DPSCD and gathered feedback on improving positive utilization. To encourage participation, incentives were offered, resulting in a total of 76 student and parent participants across six groups held at various school locations. Seven groups were held, with four for parents and three for students, conducted through both virtual and in-person sessions.

During these sessions, the Oral Health Coordinator (OHC) provided valuable oral health education, shared dental resources, and discussed the effects of vaping. The conversations also yielded the following insights: parents revealed how best to engage them in signing up their children for dental services, while students recommended educating a student organization to reach classrooms and increase student sign-ups. Additional suggestions emerged, such as utilizing the school's communication systems to notify parents about visiting dental providers, showcasing the dental team servicing a school on the school website, and developing online consent forms. Several of the recommendations are slated to commence FY 2024.

The third strategy involved upholding reporting requirements for all DPSCD oral health providers. The annual DPSCD provider data forms were vital for tracking the number of students receiving dental services in FY 2023. Data was collected, cleaned, and utilized to create individual reports for each provider's program. A comprehensive report merging program data was shared with DPSCD leadership and other dental providers.

In FY 2023, the DPSCD dental providers collectively screened 6,608 students at 90 sites in Detroit. Most of the students screened were in 1st grade, 2nd grade, and 3rd grade. The average age of students was 8.6 years old, with an age range between 1 and 25 years of age. Almost half of students (42.2%) screened had a reported race of Black/African American; however, race information was absent for 51% of students.

Only 2.8% of students screened in Detroit had special health care needs which included needing additional medical care or receiving special therapy, counseling, or treatment. Over three-quarters of students were enrolled in Healthy Kids Dental insurance program, while 4.5% of students had private insurance and 10.8% of students did not have dental insurance.

The third and fourth strategies were to record webinars for DPSCD school nurses focused on oral health education and provide recorded oral health webinars for DPSCD school nurses at their new employee orientation. In 2021, the MDHHS School Health Consultant developed and recorded oral health training sessions tailored for DPSCD school nurses. These recorded videos serve as an ongoing educational resource, providing on-demand learning opportunities for new DPSCD school nurses. The DPSCD OHC conducts in-person oral health education and resource sessions for school nurses biannually during school orientation workshops, complementing the recorded training sessions.

The OHC ensures DPSCD nurses are well-equipped with essential oral health supplies readily available for distribution to students. Moreover, the OHC empowers nurses by providing them with the necessary tools to conduct oral health checks when students report dental issues and raises awareness about the dangers of vaping through posters in schools and nurse offices.

It is important to note the data concerning DPSCD dental providers does not pertain to Objective A. The providers in Objective A received funding to facilitate service provision, whereas those in Objective B are DPSCD-contracted. Objective B's funding sustains the DPSCD OHC position, as outlined in the Memorandum of Agreement (MOA) between MDHHS and DPSCD.

In FY 2023, the Memorandum of Understanding (MOU) among DPSCD, the State of Michigan, and dental providers underwent a thorough review and update. These MOUs are annually reviewed to align with the partnership, allowing adjustments in school assignments for the next academic year to meet the needs of both providers and individual school buildings.

Childhood Lead Poisoning Prevention (FY 2023 Annual Report)

The Michigan Childhood Lead Poisoning Prevention Program (CLPPP) has carried out mandated blood lead surveillance and lead poisoning prevention activities since 1998. Childhood lead poisoning has steadily declined in Michigan, but elimination has not yet been attained. The Michigan Department of Health and Human Services (MDHHS) definition of an elevated blood lead level is ≥ 3.5 µg/dL, aligned with the Centers for Disease Control and Prevention blood lead reference value (BLRV). At a level of 3.5 µg/dL or greater, lead education, nursing case management, environmental investigations, and additional medical monitoring should be established to lower the blood lead level. In FY 2023, CLPPP continued collaboration with local health departments, physicians, Medicaid Health Plans, and others to spread awareness and education about the importance of blood lead testing and the

services/resources available for children with an elevated blood lead level.

This report describes CLPPP activities undertaken in FY 2023 to improve screening for risk factors and increase blood lead testing, specifically confirmatory venous testing. In 1998 (the first complete year of required reporting EBLLs above 10 µg/dL) for children under the age of six tested for lead, 44.0% of children had EBLLs (29,165 of 66,204 children tested). Due to MDHHS adopting the CDC's new BLRV of 3.5 µg/dL in May 2022, we will report data at both BLRVs of 3.5 µg/dL and 5 µg/dL.

In 2022 (which is the most recent non-provisional data), 2.1% (2,312 of 108,265) of children under the age of six who had a blood lead test had an EBLL at a BLRV of 5 µg/dL, while 3.7% (4,021 of 108,265) children had an EBLL at a BLRV of 3.5 µg/dL. There was no significant change from 2.0% (1,921 of 98,088) at a BLRV of 5 µg/dL or 3.5% (3,439 of 98,088) at BLRV of 3.5 µg/dL in 2021. The percent of children with elevated capillary tests with a confirmatory venous test within the 30-day window (confirmatory venous testing rate) in 2022 was 49.9% at the BLRV of 5 µg/dL. The percent of children with elevated capillary tests with a confirmatory venous test within the 30-day window (confirmatory venous testing rate) in 2022 was 40.0% at the BLRV of 3.5 µg/dL.

Blood lead testing rates remain low in Michigan. Since the start of the COVID-19 pandemic, deferred care and increased use of telemedicine has negatively impacted blood lead testing. The pandemic also resulted in children spending more time at home, which increased the risk of exposure for children living in homes with lead contamination. MDHHS continued to follow a public health response plan to address the decrease in testing rates, with strategies around education, outreach, and data surveillance. In FY 2023, CLPPP grantees focused on activities related to community outreach and education to continue to improve awareness around sources of lead exposure and the importance of testing. Grantees also included in their workplans more activities around provider education and outreach. In FY 2023, many local health departments were able to resume testing in their WIC clinics. Through CLPPP grant funding, many local health departments increased messaging through social media and other communication mediums to increase community awareness that testing is once again available through WIC clinics. It is expected that blood lead testing will continue to increase over the next year as families continue to become aware that this resource is available again.

In response to the decreased testing rates, CLPPP also identified three local health departments to participate in a blood lead testing pilot project during FY 2023. These health departments have done environmental scans and assessments of the current gaps for testing in their grant region and will implement targeted interventions in FY 2024 in response to their assessment findings. Those communities received funding to implement innovative strategies to increase testing rates in their areas. Additionally, in FY 2023 13 local health departments were awarded grants to focus on provider education, parent education, and outreach to at-risk populations, with the goal of increasing testing rates and addressing the three objectives outlined in this state action plan. These 13 grants cover the 13 "prosperity regions" across the state, which includes all 83 counties in Michigan. Using this regional approach, the grantee health departments implement grant activities throughout their entire grant region. These grants are supported by Title V funding. Activities funded by the grants included:

- Developing and implementing a protocol to increase confirmatory testing rates by outreach and education to families of children with capillary elevated blood lead levels. This includes coordination with the child's primary care provider, Medicaid Health Plan, and family to address any barriers to getting the confirmatory test.
- Distributing materials, providing education, and presenting at community events.
- Developing messages to distribute to their community via social media, media campaigns, local radio/TV shows, and mailings.
- Supporting lead testing at WIC clinics and local health departments.
- Convening lead poisoning prevention partners to coordinate efforts and messaging.

- Education to health care providers about lead testing recommendations for children and pregnant persons.
- Education to students in health care programs.
- Nursing Case Management services for home visits not covered under Medicaid.
- Ensure staff are trained on the Magellan Lead Care II machine to provides onsite blood lead testing clinics.
- Coordinate with clinics and community partners to provide blood lead testing clinics, as well as widely promoting these event(s) to targeted demographics to encourage testing.
- Create an evaluation tool to be used at each site to determine successes/concerns and assess each clinic after it occurs.
- Identify strategies to increase access to blood lead testing in pediatric and primary care offices.
- Assemble and distribute resources and educational information and mail to families with a child with an elevated blood lead level.

The Title V state action plan for SPM 1 focused on the following objectives and related strategies.

Objective A: By 2025, increase screening for lead exposure risk factors for children less than 72 months of age.

The first strategy to achieve this objective was to flag children in the Michigan Care Improvement Registry (MCIR) who need to be screened for blood lead risk factors. Currently MCIR displays blood lead test results for children when providers access their patients' immunization records which allows providers to see if a child needs to be tested. When a child has an EBLL, MCIR flags the results and provides the recommended follow up for medical management. Provider offices can use this information during visits with patients and order necessary testing. During FY 2023, CLPPP worked with partners to develop a proposal and objectives to create a new interface that will allow providers to directly obtain blood lead test results from within their health system EMR. The project proposal and budget information are currently within Department review. This project will kick off with the planning phase and requirements gathering in FY 2024 and development and implementation scheduled for FY 2025. This will be an additional strategy to assist providers in determining children who need lead testing and to ensure children received proper follow-up for an elevated lead level.

A second strategy was to provide education activities to encourage providers to screen all children less than 72 months of age for lead exposure risk factors. Provider education activities continued in FY 2023 through utilizing a team of two public health detailers to focus on increasing education to providers. The physician education team completed seven presentations, attended five conferences with exhibit tables promoting lead services and resources, and reached 358 providers.

Additionally, CLPPP initiated a Chelation Collaborative group to convene providers throughout Michigan to identify opportunities for improvement around chelation cases. This group also serves as a provider advisory group to identify innovative strategies to engage and educate providers around the importance of blood lead screening and capillary to venous follow-up testing for children less than 72 months of age. This group will also be consulted when CLPPP prepares to distribute an updated provider education plan to providers throughout Michigan.

An online module for health care providers went live in August 2020 and was updated in FY 2022 to reflect the changes to the blood lead reference value. During FY 2023, 125 health care providers completed the course, including pediatricians, social workers, nurses, and students. The module covers the sources of lead exposure, recommendations for screening and testing for children, and medical management of children identified as having an elevated blood lead level.

To achieve equitable health outcomes, a third strategy was to partner with agencies to provide culturally appropriate

lead education to at-risk populations. In FY 2023, CLPPP continued a contract with a community advocate to provide education and outreach to the Arab American community in Southeast Michigan, specifically newly resettled refugee families. According to the CDC refugee toolkit, newly resettled refugee children have a higher prevalence of EBLLs compared to US born children. Through this project, the consultant provides trainings to health care providers and resettlement agencies in Wayne, Macomb, and Oakland counties about the CDC recommendation for lead testing for all refugee and immigrant children within 90 days of arriving to the USA, and within 3 to 6 months of finding a permanent residence. The consultant also partners with faith-based and community-based partners to provide educational materials like handouts, calendars, and posters in both English and Arabic.

Objective B: By 2025, increase by 10% the percent of Medicaid-enrolled children less than 72 months of age that receive blood lead testing.

To bring all Medicaid Health Plans in line with the Medicaid goal of 100% of continuously enrolled children tested by age 3, CLPPP made reports available to local health departments and foster care workers with information about blood lead testing status for Medicaid children. The ad hoc reports can be pulled at any time through a Medicaid care coordination portal called CareConnect360. This report also includes information about which Medicaid Health Plan the child is enrolled in. These reports replace previous data summary reports of testing status of Medicaid-enrolled children that included data by Medicaid Health Plans that was sent monthly to local health departments. This project allows health departments and foster care workers to access blood lead testing status for Medicaid children as needed.

A second strategy was to conduct a range of provider education activities to encourage providers to provide blood lead tests to Medicaid-enrolled children at the recommended times. Activities discussed above under Objective A also encouraged providers to provide blood lead tests to Medicaid-enrolled children at the recommended times.

During FY 2023, CLPPP also initiated a formal quality improvement project with one of Michigan's Medicaid Health Plans and the Detroit Health Department to identify and pilot strategies to improve blood lead testing within their patient population. This project is led by quality improvement specialists at the Michigan Public Health Institute to facilitate the Plan-Do-Study-Act process and document the project as well as lessons and successes learned so that they can be adapted and expanded to other regions and Medicaid Health Plans throughout the state. It is anticipated that this project will be completed in FY 2024.

Additionally, the relationship established between CLPPP and the Medicaid Health Plans has provided the opportunity to invite health plan representatives to present at grantee meetings. This has created stronger relationships between the health plans and local health departments. Initiating this connection between health plans and local health departments has opened dialogue between these entities and provided an opportunity for innovative problem solving around improving blood lead testing. The health plans have offered and provided support to local health departments including the use of Medicaid Health Plan Community Health Workers to support outreach to families, sending lead cleaning kits to local health departments, and supporting the creation of provider education materials.

Objective C: By 2025, increase by 10% the percent of all children less than 72 months of age with an elevated blood lead level (EBLL) from a capillary test who receive a venous lead confirmation test.

In FY 2023, the local health department quarterly report bundle was finalized and posted to the CLPPP data sharing application for health departments. The reports include both annual and monthly data at the state, local health department, county, target city, and zip code levels. Presentations and training were also provided to local health departments on how to access and use the reports.

As discussed above, local health departments continued to use their weekly blood lead testing reports to conduct outreach via phone, mail, and e-mail to families and providers to encourage confirmatory blood lead testing for elevated capillary tests. Many local health departments have protocols in place to do this follow up. Activities discussed under Objective A also encouraged providers to order a venous test after an elevated capillary test.

During FY 2023, CLPPP continued to participate with Medicaid staff on intensive focus studies with Medicaid Health Plans (MHPs) across the state. This partnership enabled an opportunity to provide technical assistance to MHPs on innovative strategies to support their families that have children with an elevated blood lead level. It has also been an important tool for CLPPP to identify the activities MHPs provide to enrollees that can be shared with local health departments. This collaboration has been instrumental in helping CLPPP to connect MHP staff with local health department staff to partner on encouraging families to pursue confirmatory blood lead testing for an elevated capillary test.

CLPPP developed a Provider Education Plan in FY 2021 with the intention of implementing a standardized and data-driven approach to improving provider education throughout the state. In FY 2023, CLPPP initiated efforts to update this plan in response to the change of Michigan's blood lead reference value from 5 µg/dL to 3.5 µg/dL. In FY 2023, Michigan's governor signed legislation to make Michigan a universal testing state. Physicians must test, or order a test, for lead in blood for all children at 12 and 24 months of age, or between age 24 and 72 months if there is no record of a previous test. Children living in geographic areas of the state determined by MDHHS to pose a high risk for lead poisoning must be tested additionally at age 4. The revised provider education plan will also focus on ensuring providers have the support and informational resources necessary for this new universal testing law to be implemented successfully when it goes into effect in FY 2024.

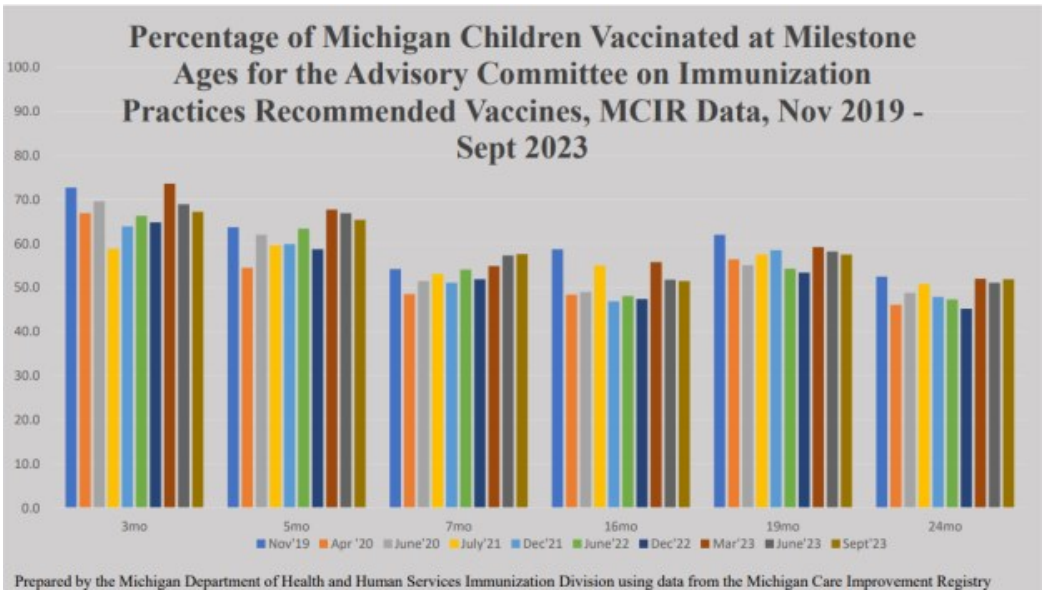
Immunizations – Children (FY 2023 Annual Report)

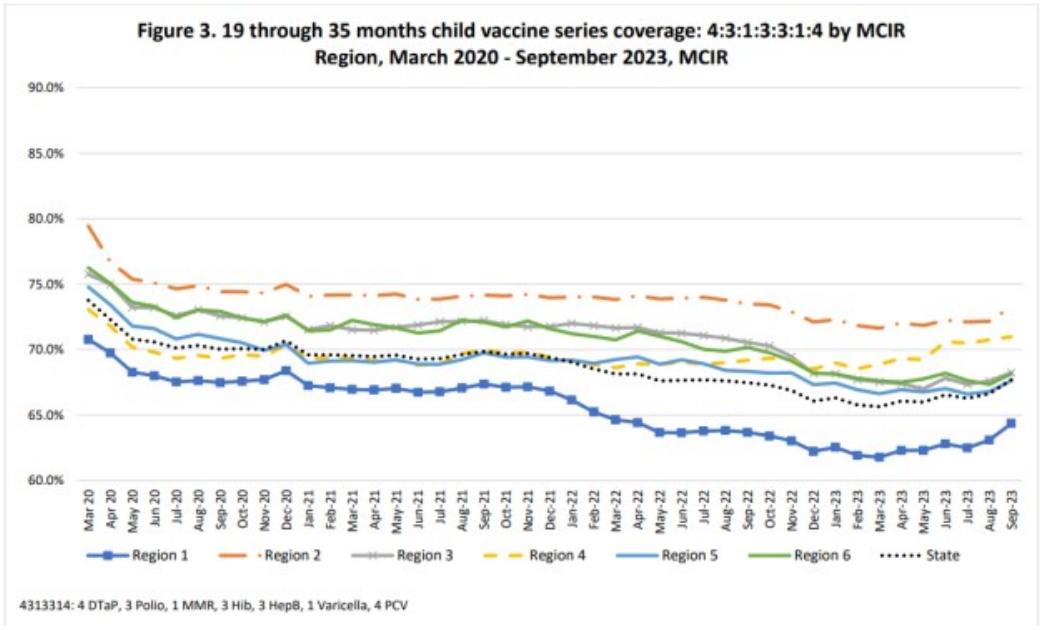
The MDHHS Division of Immunization is focused on improving the uptake of all Advisory Committee on Immunization Practices (ACIP) recommended vaccines among Michigan children 19-35 months of age. Specifically, the Immunization Division closely monitors the pediatric series vaccination rate which includes 4 doses of DTaP, 3 polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 varicella, and 4 pneumococcal conjugate (4313314 series) for Michigan children 19-35 months of age. Michigan immunization rates for the pediatric series increased from 66% in FY 2022 to 69.8%% in FY 2023. Although this increase is noteworthy, prior to the COVID-19 pandemic, in FY 2019, the vaccine coverage rate for the 4313314 series was 74%. The pandemic presented numerous challenges to both healthcare and public health and has led to an overall increase in vaccine hesitancy, thus negatively impacting vaccination rates in Michigan and nationwide.

To highlight the impact of the COVID-19 pandemic, the Immunization Division disseminates a report to monitor non-COVID non-Influenza immunization administration and reporting patterns to the Michigan Care Improvement Registry **(**MCIR) and the resulting effect on immunization coverage estimates. This report is created by the MDHHS Division of Immunization, in collaboration with the University of Michigan Child Health Evaluation and Research Center (CHEAR) team. To better illustrate the impact that COVID-19 pandemic has had on childhood immunization rates, two figures from the report are included below.

As of September 30, 2023, MCIR data show that the vaccination coverage for children under 2 years at milestone ages is approaching the pre-pandemic coverage levels for all age groups with the coverage exceeding the pre-pandemic levels for 5-, and 7-month-old-kids. Statewide coverage for children 19 through 35 months with the 43133142 series (4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 HepB, 1 Varicella, 4 PCV, 2 HepA;) in September 2023 (55.2%) remains 3 percentage points below pre-pandemic levels (58.2% in Jan 2020). A similar pattern holds for the same series without HepA (4313314; Figure 3), which fell from the pre-pandemic level of 73.6% in Jan 2020 to 67.7% in

September 2023. Parents' hesitancy for COVID-19 vaccine in children may have a spillover effect to other routine immunizations leading to continued decreased coverage levels for most age groups.



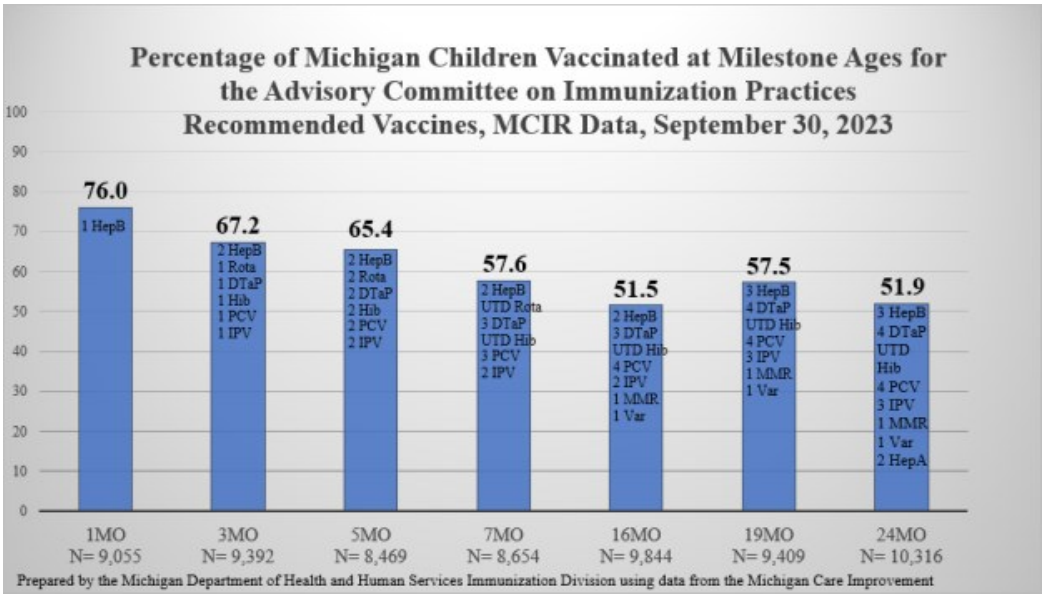


The pandemic brought many challenges for pediatric providers, and vaccine hesitancy among parents has also been in the spotlight. To combat the decline of pediatric vaccination rates, the Immunization Division is working diligently with providers, health care associations, and local public health to catch children back up on vaccines they may have missed due to the COVID-19 pandemic.

Objective A: By 2025, increase the percentage of children 19-36 months of age who receive

recommended vaccines to 80%.

The first strategy to support this objective involved using the Michigan Care Improvement Registry (MCIR) data to identify all children 24 months of age who are overdue for a vaccine. The Immunization Division has closely monitored vaccination uptake for this age as part of our Falling Behind Data (see figure below). As of September 30, 2023, approximately 48% of Michigan children, age 24 months, have not yet received all of their recommended vaccines.



The second strategy to assist this objective included taking the data presented above one step further. This strategy discussed generating and disseminating annual recall letters using the MCIR to parents of children 24 months of age who are overdue for a vaccine. Due to competing priorities, staff turnover and large modifications undergoing the Michigan Care Improvement Registry system, recall letters were not generated during this reporting period. The Immunization Division plans to initiate a recall for this age group in FY 2024.

The third strategy to support this objective was to use MCIR data to conduct a root cause analysis and identify high social vulnerability index (SVI) areas within the state and conduct targeted vaccine outreach in those areas. The epidemiologist team in the Immunization Division has undergone many staffing changes, so research into high SVI areas using MCIR data has just begun during this grant reporting period. Recent enhancements to the MCIR system have allowed for the collection of race data, and the team of epidemiologists has begun analyzing these data in comparison to SVI data for a more targeted approach in efforts to improve vaccination uptake.

The final strategy to support this objective entails working with MDHHS Office of Communications to promote vaccine confidence among parents of this age group through resources, media, and presentations. The Immunization Program partnered with I Vaccinate/Brogan & Partners to launch a multi-media plan to promote catch-up vaccination of all vaccines. This media plan focused on areas with the lowest vaccination rates and included connected TV, YouTube, audio streaming and podcasting, rich media and display/video, native display, gas station TV, posters, doctor offices, and paid ads in search engines. The overall creative targeted parents and highlighted several themes as ways to “catch up” on your child’s vaccines after the COVID pandemic to better protect them for the future. A large portion of Title V funds (approximately $380,000) was used to support this communication campaign for FY 2023.

Further, using Title V funding the Immunization Program hosted a Pink Book Conference which focused on provider education. The two-day conference provided physicians, nurses, nurse practitioners, physician assistants, pharmacists, and other healthcare professionals throughout Michigan with the most comprehensive information on routinely used vaccines and the diseases they prevent. A representative from the Centers for Disease Control and Prevention presented on the Pink Book and the overall conference was very well attended. The Immunization Division acknowledged that in this post-pandemic era where vaccine hesitancy is at an all-time high, it is crucial to bring all the players in the immunization neighborhood together, in-person, to learn and discuss ways to improve vaccination uptake in Michigan.

Objective B: Assist local health departments in targeting outreach to under-vaccinated populations in their jurisdiction.

The first strategy to support this objective was to produce a quarterly report card for each county showing vaccination rates and rankings compared to other counties across the state for multiple age groups, including children. MDHHS County Immunization Report Cards are shared and posted on a quarterly basis. The overall goals of the report card data are to 1) provide each county with an understanding of vaccination rates in their respective communities and 2) identify areas for improvement. County report cards have been published every quarter and highlighted during several conferences. The county report cards highlight vaccination coverage rates for pediatric, adolescent, and adult residents within each county and highlight their overall rank among all counties in Michigan. In addition, the report cards highlight both school and childcare waiver rates for each county and indicate their rank on this measure. The Immunization Division uses this rate and rank system to foster awareness among local health departments with the goal of improving vaccination uptake across the state.

The second strategy took this work one step further by including county coverage levels by race for children 19-36 months of age and making this information available to local health departments to identify and address disparities. The MDHHS County Immunization Report Cards now includes a row on the vaccination rate of the childhood vaccination series 4313314 by race. This is calculated using the mother's race, as indicated on the report card, and highlights the vaccination coverage for those who are of Asian/Pacific Islander descent, White, Black, or unknown.

The final strategy to support this objective highlights the work done in collaboration with the City of Detroit Health Department to target high SVI areas and assist with increasing the overall vaccination rates in Detroit. The Immunization Division is working closely with Detroit Health Department (DHD) and Detroit Public School Community District (DPSCD) to implement the Vaccines for Children (VFC) Program to increase access to vaccines. Further, they are holding school-located vaccine clinics to better reach this community. DPSCD enrolled as a VFC provider during the 2021-2022 school year to increase vaccination rates among their student population and has remained a VFC provider to-date. The Immunization Division meets regularly with DHD and DPSCD ensuring VFC provider needs are met. The Immunization Division assists in further strengthening the collaboration between DHD and DPSCD to ensure that all children, especially those who are school-aged, have access to immunizations.

Oral Health – Children (FY 2025 Application)

National Performance Measure (NPM) 13.2 focuses on oral health in children and is linked to the state priority need to “Improve oral health awareness and create an oral health delivery system that provides access through multiple systems.” In the needs assessment, focus group participants reported several needs and challenges related to oral health. These included a need for more school-based oral health services; an overall shortage of dental providers that will accept Medicaid beneficiaries; and a lack of access to dental services in communities. The health status assessment also identified a disparity between oral health outcomes for Black children and non-Hispanic White children, as discussed in Objective B of this state action plan.

The MDHHS Oral Health Program (OHP) provides population-based oral health prevention efforts and effective utilization of the dental workforce in implementing and improving oral health access. With the increased awareness of the impact of oral health on overall health—which is illustrated by the fact that this NPM is linked to Title V National Outcome Measure 19, the percent of children in excellent or very good health—the OHP has increased its collaborations with community partners to improve oral health through prevention activities and direct access programs.

Currently there are 241 designated Dental Health Professional Shortage Areas (DHPSA) for dental care in Michigan. Of these, 176 are facility designations and 65 are special population groups. HRSA estimates that 1,560,302 people live in Michigan’s DHPSAs. To remove the dental shortage designation, 297 additional dental professionals would be needed. Only 38% of Medicaid-eligible children in Michigan receive dental services. Children under the age of five are the least likely to have visited a dentist. The Michigan 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. The Healthy Kids Dental Plan now utilizes Delta Dental, Blue Cross Blue Shield and DentaQuest 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. This program assists children and adolescents, ages 0-21, with access to dental care.

The Healthy People 2030 target goal is to have 42.5% of children ages 3 to 19 with one or more dental sealants in place. Between 2005 and 2016 there was an increase in the percent of third grade students in Michigan with one dental sealant or more. In 2005, 23.3% of third grade students had one or more dental sealants; in 2010 it was 26.6%; and in 2016 it was 37.6%. This increase is attributed in part to the MDHHS SEAL! Michigan school-based dental sealant program which piloted in 2007 and has expanded within the state over the last several years. Until the fall of 2018, SEAL! Michigan was funded through Title V, CDC Cooperative Agreements, HRSA grants (as available), and annual gifts received from the Delta Dental Foundation of Michigan. Beginning in the fall of 2018, the SEAL! Michigan program experienced a loss of federal grants, and is now primarily funded through a Medicaid match, Title V, and annual gifts from the Delta Dental Foundation. This blended funding supports direct services delivered in schools across Michigan, a School Oral Health Consultant to manage SEAL! Michigan at the state level, and a 0.75 FTE Oral Health Coordinator at Detroit Public School Community District (DPSCD). Although less funding is currently available for sealant programs, the loss of federal grant funding did result in the state Medicaid program supporting the School Oral Health Consultant position which adds significant sustainability to the program overall.

Historically the SEAL! Michigan program was entirely school-based and/or school-linked, focusing only on permanent molars; additionally, students served were in the first, second, sixth, or seventh grade in the Lower

Peninsula, minus Wayne County, and all students (K-12) were served in Wayne County and the Upper Peninsula. During the COVID-19 pandemic, SEAL! Michigan programs were school-based and school-linked when possible, and when not possible, were allowed to provide services in alternative locations (i.e., daycare centers, WIC, head start centers, YMCA, churches, Boys & Girls Club, sporting arenas, youth homes, group foster homes, community centers, township halls, city halls, food pantries) and set up external service areas in retail and health center parking lots. Student seen are between the ages of 1-21. These changes have been maintained in response to so many students in Michigan not having access to preventive dentistry in a dental home or lacking dental services in a school environment. Essentially, SEAL! Michigan programs have been given the flexibility to think 'outside the box' on how, where, and when to provide dental screenings, sealants, and other preventive treatments.

Effective January 1, 2023, the Michigan Medicaid Program expanded dental sealant coverage for beneficiaries under age 21 for the prevention of pit and fissure caries. In addition to fully erupted first and second permanent molars (2, 3, 14, 15, 18, 19, 30, 31), the expanded coverage includes fully erupted first and second primary molars (A, B, I, J, K, L, S, T) and fully erupted first and second permanent premolars (4, 5, 12, 13, 20, 21, 28, 29). This change will increase the number of sealants allowable for SEAL! Michigan programs and improve the oral health of Michigan children. It will also allow for a more fiscally sustainable model for participating SEAL! Michigan programs.

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 Oral Health NPM: Percent of children, ages 1-17, who had a preventive dental visit in the past year. Implementing a school-based dental sealant program will support progress toward an increased number of children with a preventive dental visit. SEAL! Michigan is focused on providing preventive oral health care to students through assessment, education, dental sealants, and fluoride varnish application. To best align preventive efforts to highest areas of need, the SEAL! Michigan programs target schools that have 50% or more students enrolled in the Free and Reduced Lunch Program (FRLP).

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 provides dental screening and places dental sealants for students at no cost to families. In addition to dental sealants, students receive a dental screening, oral health education and (over 90% of the time) 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, which is increasingly more accessible with the expansion of Healthy Kids Dental.

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 each individual program expanding into more schools annually. Currently the program has eight grantees across the state, plus programs operating in DPSCD (which will be determined by DPSCD but ideally will be no less than four programs at a time). Although the SEAL! Michigan program provided service to 212 schools in FY 2023, most schools in Michigan do not offer a dental sealant program to students. Dental sealants ultimately decrease dental disease in youth as they are nearly 100% effective in preventing dental decay when they are retained on the tooth. Reaching children through school-based services is efficacious and is a recognized best practice approach by the CDC and the Association of State and Territorial Dental Directors.

Effective program management and growth are intrinsically tied to robust data collection processes. SEAL! Michigan has consistently refined and enhanced its data collection methods to ensure accuracy and efficiency. In FY 2023, a pivotal shift was made from traditional paper collection to the adoption of Qualtrics, a web-based electronic

data collection system. This transition empowers the program with real-time data reporting capabilities and is subjected to thorough analysis by the oral health epidemiologist. Annual reports are written and released for each local program as well as aggregated into a statewide report. Data serves as a powerful indicator of program success, showcasing annual growth in the number of schools and students served, as well as the quantity of sealants placed. This information is effectively communicated through a regularly updated year-end infographic by each program. The infographic proves invaluable for sharing program achievements with stakeholders, school administrators, and additional funders, offering a comprehensive visual overview of the program's impact. In addition, data will be captured by the Michigan Basic Screening Survey of third grade students (completed every five years), Count Your Smiles Report, to demonstrate the rates of dental sealant placement and dental decay in children across the state.

The SEAL! Michigan program attempts to reach the target population through family and consumer outreach and engagement. As stated previously, programs focus on schools with a high number of children enrolled in the FRLP. The program relies on parent and guardian awareness of the program; thus, parents' consent for their children to receive the preventive oral health services is a key component of the program. To reach families and consumers, staff from the funded programs attend back-to-school nights and Parent Teacher Organization (PTO) meetings. A satisfactory rate of parental consent is achieved among currently established SEAL! Michigan programs. New programs will assess parent engagement strategies, as discussed in Objective B. All student consent forms are delivered home with an informational brochure on the SEAL! Michigan program and the benefits of dental sealants. The brochure was initially developed by professional health literacy specialists and was written at a third grade reading level to accommodate varying literacy levels. The brochure was updated in the summer of 2020 by the MDHHS Communications Office and will continue to be used in FY 2025. The brochure strives to deliver linguistically and age-appropriate health information.

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. This strategy reflects the measure's ESM, which is the number of students who have received a preventive dental screening through the SEAL! Michigan program. 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 School Oral Health Consultant 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 strategy 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 (students and parents, school administrators, teachers, school nurses, health professionals, social workers etc.) through evaluation will assist in directing the SEAL! Michigan program towards continued success. In FY 2017, a full SEAL! Michigan program evaluation was conducted by the Michigan Public Health Institute, and the final evaluation provided program improvement strategies. Recommendations continue to be implemented by individual programs to the extent possible.

A fourth strategy is to examine ongoing health trends to identify geographic areas experiencing a high burden of disease, and then use the information to identify populations that will benefit from an increase in dental sealant placement in proportion to disease and population. This strategy will help assess whether oral health programs are

funded in areas of high need and to maximize access and preventive potential to the populations with the highest need. This strategy will help build the OHP's capacity to achieve equitable health outcomes. In addition, MDHHS will partner with data and evaluation entities to build systems to measure the impact of increased sealant coverage in Michigan.

Objective B: Increase dental sealant placement on children enrolled in Detroit Public Schools Community District (DPSCD).

Detroit Public Schools has incorporated BLUEPRINT 2023 into their system to help "establish a sense of normalcy at Detroit Public Schools Community District." Oral health is included in the plan and falls under the Whole Child Commitment, as students receiving dental care will have less toothaches and will be more likely to achieve their full potential. The DPSCD system is one of the largest school districts in the state and provides educational services to approximately 48,000 students. According to DPSCD website, the majority of students (approximately 82%) are African American and 13.6% are Hispanic/Latino. In total, 78% of students are eligible for free and/or reduced lunch.

Michigan's 2016 Count Your Smiles (CYS) report collected data from open mouth screenings of third grade children across Michigan. According to the report, the City of Detroit data indicated that approximately 82% of third grade children had active dental disease (18.3% had no obvious problems, 59.6% needed early dental care, and 22.1% needed immediate dental care). Additionally, only 28.3% of children had at least one dental sealant, which is the lowest percentage by region in Michigan. The City of Detroit also reported the highest percentage of children who had a toothache in the past six months. Additionally, more recent data from the National Survey of Children's Health (2020-2021) indicates that in Michigan 78.4% of Non-Hispanic White children received a preventive dental visit in the last year compared to 70.5% Non-Hispanic Black children. Given these disparities in oral health outcomes and access to care, establishing stronger oral health programs and follow-up care coordination in DPSCD will help to improve the oral health of Michigan's children.

During the COVID-19 pandemic, dental care was not provided in DPSCD school buildings due to school closings. In March 2022, dental service returned full time. Administrators took the opportunity to pause and create an oral health plan that provides more clarity on which providers serve the schools. This improvement enables DPSCD to have more oversight over which programs are coming in and out of each school building. Historically, DPSCD did not have a designated position to oversee all oral health activities and lacked the oversight to ensure that students receive preventive and restorative care as well as urgent follow up care. Therefore, the MDHHS OHP collaborated with DPSCD to establish and finance a half-time Oral Health Coordinator (OHC) position dedicated to supervising oral health initiatives across all DPSCD facilities. The OHC assumed the role in August 2020. In FY 2024, the funded position for the OHC was expanded to 0.75 FTE, and this funding will continue into FY 2025. The OHC plays a crucial role in overseeing dental programs and ensuring that students in DPSCD have access to both preventive and restorative care.

The first strategy is for the OHC to provide multiple ways to access a dental consent form. The dental consent form is given to the student to take home for the parent/guardian to complete and return to the school. However, this delivery method sometimes requires consent to be sent home several times. In FY 2025, the OHC will work with school administration staff, parents, and students to identify alternative methods to help increase receipt of positive consent forms. This could involve making them available online, distributing them at Parent-Teacher Association (PTA), offering dental packages during 104 open enrollments and open houses. As part of the comprehensive strategy, the OHC plans to provide dental provider profiles on school websites. This initiative aims to empower parents and guardians by offering insights into the dental care providers serving their children.

The second strategy is to provide bi-annual oral health education to all DPSCD nurses, enhancing their knowledge and ensuring readiness to address students' oral health concerns. The OHC is committed to equipping DPSCD

nurses with essential oral health supplies for seamless distribution to students. In FY 2024, the OHC aimed to extend oral health education to the Behavioral Health Counselors in each school to enhance their understanding of the impact of oral health on children's behavior. Unfortunately, due to the discontinuation of funding for Behavioral Health Counselor positions, this training initiative was left incomplete.

The third strategy is to increase the number of dental providers and their services at DPSCD to allow additional access to care and increase sealant placement. At the time of this writing, DPSCD has approximately 48,000 students enrolled. In FY 2025, the OHP will work towards the goal of having five dental providers offering comprehensive services, alongside one dedicated to preventive care. Acknowledging the significance of fostering positive relationships between students and healthcare providers, the OHP envisions a future where students can trust and build connections with a broader network of dental professionals. This initiative not only ensures that students have regular interactions with dental professionals every six months but also cultivates an understanding of quality dental care. The anticipated outcomes include increased sealant placement and expanded access to various dental services. As the number of positive dental consent forms increase, ongoing assessment of service data will guide the determination of how many additional providers are needed in the future, aligning with the OHP's commitment to delivering optimal oral health care within DPSCD.

NEW: **Medical Home – Children (FY 2025 Application)**

Medical Home for Children has been assigned to states as a universal National Performance Measure starting in FY 2025, specifically intended to accelerate progress with the Children and Youth with Special Health Care Needs (CYSHCN) and Child Health population domains. According to the 2020-2021 National Survey of Children's Health, Children in Michigan (51.4%) are more likely than children in the US overall (47.7%) to receive care in a medical home. The Healthy People 2030 target seeks to increase the proportion of children and adolescents who receive care in a medical home from 48.6% (Baseline: 2016-2017) to 53.6%. Despite Michigan's overall performance, racial disparities for children and adolescents receiving care in a medical home exist. Non-Hispanic white children (57.7%) are significantly more likely than non-Hispanic Black (38.0%) and Hispanic (35.4%) children to have a medical home (NSCH, 2020-21). Non-Hispanic white children are most likely to have excellent or very good health reported (93.8%) compared to 80.0% of Hispanic and 85.6% of non-Hispanic Black children (NSCH, 2020-21). Non-Hispanic white children are also significantly more likely to have a preventive care visit in the previous year (82.2%) than non-Hispanic Black (74.0%) and Hispanic children (70.8%) (NSCH, 2020-21).

Access to quality, family-centered, and comprehensive health care is critical for all children and adolescents to grow and thrive. The American Academy of Pediatrics (AAP) defines the seven qualities essential to medical home care as accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective. Provision of care to children in a medical home is the standard of pediatric practice. Research demonstrates an association between access to and utilization of pediatric medical homes to improved health outcomes for the population, increased satisfaction for children and families, and decreased cost of care (AAP, 2022).

Michigan has been working toward the implementation of Medical Homes over the past decade. Since 2009, Blue Cross Blue Shield of Michigan's Patient-Centered Medical Home (PCMH) designation program has implemented primary care as a team-based approach centered around the patient. PCMH is cost-effective in preventing disease, reducing hospitalizations and emergency room visits, and managing chronic medical conditions to keep patients healthy. PCMH-designated providers are prevalent across Michigan, located in 96% of counties that have primary care providers. In 2010, Michigan participated in a demonstration project known as the Michigan Primary Care Transformation Demonstration Project (MiPCT), which was a multi-payer project aimed at reforming primary care payment models and expanding the capabilities of the state's PCMH. During the project period, approximately 1 million people were served by 1,900 providers in 400 practices. MiPCT demonstrated consistent savings over the

project period, with a net Medicare savings of $336 million. Centers for Medicare & Medicaid Services provided funding thru 2016, after which MiPCT was integrated into an existing initiative.

In 2015, through a Michigan Association of United Ways (MAUW) grant, the Michigan Children's Health Access Program (MI-CHAP) was initiated to connect children and families to a medical home and address needs related to the social determinants of health in eight Michigan communities. Two key MI-CHAP goals were to improve the quality of and access to medical homes and lower the total cost of care by reducing emergency department visits and inpatient hospital admissions among children on Medicaid. Parents and caregivers of children who received CHAP services reported fewer missed appointments, increased comfort with health providers, and improved use of healthcare services (Public Sector Consultants, 2019). Of the seven MI-CHAP sites evaluated, 4,000 children aged one through 17 years old received services, with emergency department visits dropping by 17% and inpatient hospitalization having decreased 37% in the year following enrollment (Public Sector Consultants, 2019). After 2018-2019, only half of the MI-CHAP locations were able to sustain operations once MAUW funding ceased. While Michigan has worked to implement Medical Homes over the past decade, disparities in access and quality persist for children, adolescents, and their families.

The FY 2025 objective is concentrated on identifying Title V's role for the Medical Home for Children system in Michigan. To accelerate progress, Title V must understand the current pediatric medical home landscape and equity gaps present across Michigan for children, adolescents, and their families to effectively inform decision-making for FY 2026 – FY 2030 and best utilize Title V's capacity. Noted FY 2025 state action plan strategies seek to address Michigan's current Title V pillars: 1) equitable health outcomes, 2) seeking the knowledge and expertise of communities and families, and 3) delivering culturally, linguistically, and age-appropriate health education. Additionally, this state action plan directly supports key priorities indicated in the Health Resources & Services Administration's (HRSA) *Blueprint for Change* and the Michigan Department of Health & Human Services' (MDHHS) *Advancing Healthy Births Plan* and the Governor's *Healthy Moms Healthy Babies* initiative.

Objective A: By September 30, 2025, MDHHS will complete an environmental scan, including an equity gap analysis to identify Title V's role for the Medical Home for Children system.

For children and adolescents to grow and thrive in Michigan, access to quality, family-centered, and comprehensive health care is critical. While the provision of care to children in a medical home is the standard of pediatric practice, approximately two-thirds of non-Hispanic Black and Hispanic children and adolescents in Michigan do not receive this standard of care, along with just over one-third of non-Hispanic White children and adolescents. To accelerate progress, best utilize Title V's capacity, and effectively inform decision-making for FY 2026 – FY 2030, a planning objective – identifying Title V's role in the medical Home for Children system in Michigan – will be implemented by MDHHS with key strategies focused on 1) convening a group of multisector partners and stakeholders alongside parents of children aged 0 to 17, 2) designing and conducting an environmental scan, including equity gap analysis, and 3) utilizing members' collective expertise and lived experiences to interpret and prioritize results.

The first strategy – identify and convene a group of multisector partners and stakeholders alongside parents of children aged 0 to 17 who have lived experience with the Medical Home for Children system from across Michigan – will utilize members' collective expertise and lived experiences to provide guidance and oversight in identifying the role Title V will play in advancing pediatric medical homes across the state. In FY 2025, MDHHS will recruit and assemble approximately 20 to 30 members for this group, where parents of children aged 0 to 17 will comprise 20% of members. A diverse array of partners and stakeholders will be recruited to serve as content experts, including but not limited to, private providers (e.g., pediatric, family medicine), safety-net providers (e.g., local health departments, school-based health centers, FQHCs), community-based medical homes (e.g., Mid-MI Community Health Access Program, Arab Community Center for Economic and Social Services), public (e.g., Medicaid) and private payors

(e.g., Blue Cross Blue Shield), Children's Special Health Care Services, pediatric and medical organizations (e.g., MI Chapter of the AAP), non-profits serving underrepresented populations/communities (e.g., Tribes, LGBTQIA+, Asian American & Pacific Islanders), and advocacy organizations (e.g., MI Council for Maternal & Child Health, School Community Health Alliance of MI) working to advance maternal, child, and adolescent health. Parents of children aged 0 to 17 who have experience with accessing, navigating, receiving care, and/or lack thereof from the Medical Home for Children system will be recruited from across Michigan to be engaged and share in the decision-making process for identifying Title V's role in this system. Parents will be compensated for their participation and expertise. MDHHS staff will provide support with member recruitment, meeting convening, and parental compensation.

The second strategy – design and conduct an environmental scan, including equity gap analysis for the Medical Home for Children system across the state – will focus on utilizing members' collective expertise and lived experiences to determine the environmental scan methodology, equity gap analysis priorities, and provide data collection oversight. In FY 2025, a facilitated process will be employed to guide members through the environmental scan design, including identification of key inquiry questions and primary (e.g., listening sessions) and secondary (e.g., surveillance) data sources of interest. Existing scans, assessments, and/or other relevant data collection efforts recently completed with the population and/or health systems will be leveraged for the design process, as appropriate, to provide historical or present-day context and/or incorporate relevant findings. The equity gap analysis will be conducted in concert with the environmental scan and will be focused on assessing the extent to which the Medical Home for Children system is experienced equitably by children aged 0 to 17 and their families across race, gender, language, ability, income, geographic location, and any other differentiating factors of inquiry. Equity will be examined within the context of the medical home system overall and its five sub-components (e.g., usual source of sick care, family centered care, care coordination, etc.). MDHHS will contract with the Michigan Public Health Institute (MPHI) to facilitate and conduct the environmental scan, including equity gap analysis. The environmental scan scope, including equity gap analysis will be tailored to fit within the constraints of the project budget. A feedback loop will be utilized to collaboratively engage members with data collection oversight for the identified primary and secondary data sources. MDHHS staff will provide support with meeting convening, facilitation, and data gathering, as needed.

The third strategy – select at least one identified equity gap related to the Medical Home for Children system to focus Title V's support – will be centered on utilizing members' collective expertise and lived experiences to interpret and prioritize the results of the environmental scan, including equity gap analysis. In FY 2025, MPHI will serve as the lead for analyzing the data collected from the environmental scan, including equity gap analysis with members providing a check on the identified results (i.e., patterns, themes). A facilitated process will be utilized with members to guide the interpretation and prioritization of the results where Title V's role for the Medical Home for Children system will be identified and at least one equity gap will be selected to focus Title V's support. Identification and prioritization are needed to make effective use of Title V's capacity and budget parameters, as well as inform decision-making for FY 2026 – FY 2030. Key findings from the environmental scan, including equity gap analysis will be summarized in a report and disseminated to members, Title V leadership, state/local partners and stakeholders, and others interested in supporting the Medical Home for Children system across the state. MDHHS staff will provide support with meeting convening, facilitation, and data analysis, as needed.

Childhood Lead Poisoning Prevention (FY 2025 Application)

Lead poisoning prevention and intervention continues to be a critical need in Michigan. Michigan has made significant progress over time in reducing the percentage of children who have elevated blood lead levels. However, several of Michigan's cities (including Highland Park, Detroit, Hamtramck, Grand Rapids, and Muskegon) have significantly higher rates of elevated blood lead levels. Additionally, the COVID-19 pandemic negatively impacted

blood lead testing rates due to deferred care and increased use of telemedicine. Children spending more time at home increased the risk of exposure for those living in homes with lead contamination. In addition, blood lead testing rates decreased even more in 2021 due to a recall of LeadCare II capillary test kits. LeadCare II capillary testing is the main method used for majority of capillary testing in Michigan. With that testing method unavailable, testing rates decreased across the state. A review of LeadCare II data was reviewed by MDHHS epidemiologists and it was determined that LeadCare II is still an effective screening tool, as long as an elevated capillary test is followed up with a confirmatory venous test. In FY 2025 LeadCare II tests will continue to be monitored for accuracy and education will be provided to providers concerned about the recall.

The State Performance Measure (SPM) addressed in this state action plan measures the percent of children less than 72 months of age who receive a venous lead confirmation test within 30 days of an initial positive capillary test. The SPM is linked to the state priority need to expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems.

Michigan’s lead prevention activities, as they relate to the MCH population, are carried out by the Childhood Lead Poisoning Prevention Program (CLPPP). CLPPP resides in the Division of Environmental Health-Lead Services Section to better strengthen the health/housing partnership at the state and local levels. Title V funding supports the childhood lead programs administered by CLPPP. CLPPP staff work collaboratively with MCH staff and Medicaid, particularly on issues related to case management and blood lead testing. In FY 2025, CLPPP will continue to focus on implementing innovative strategies to increase blood lead testing across the state. Strategies will include new and continued partnerships with the Medicaid Health Plans (MHPs) and Federally Qualified Health Centers (FQHCs) as well as continued support of long-standing partnerships with the Women, Infant & Children’s (WIC) program and local health departments (LHDs).

Three focus areas of CLPPP include data surveillance, nursing assistance, and community education and engagement. Title V funding directly supports nursing assistance and community education. Data surveillance supports CLPPP to better target areas for needed nursing assistance and community education. Through collaboration with local health departments and the Community Outreach and Engagement Unit within the Division of Environmental Health, CLPPP provides statewide community outreach to parents, health care providers, childcare providers, public schools, homeowners, and tenants on the prevention of lead exposure and the importance of blood lead testing. CLPPP also provides technical nursing assistance for LHDs and health care providers to support the management and coordination of services for children with elevated blood lead levels (EBLL).

An EBLL is defined as a blood lead level (BLL) equal to or greater than 3.5 micrograms per deciliter of blood (µg/dL). Children with an EBLL should have interventions such as 1) in-home nursing case management, 2) environmental investigations to mitigate health effects of lead exposure and identify and remove sources of lead in their environments, and 3) referrals to health and human services and appropriate resources.
During FY 2022, the Michigan Department of Health and Human Services updated its definition of an elevated blood lead level for children from 5 µg/dL to 3.5 µg/dL, following the Centers for Disease Control and Prevention updating their blood lead reference value (BLRV). At a level of 3.5 µg/dL or greater, lead education, nursing case management, environmental investigations, and additional medical monitoring should be established to lower the blood lead level.

With a lowered BLRV, additional children are being identified as having an EBLL, both through capillary and venous testing. Title V funding and support is critical to ensure that resources are available for MDHHS and local health departments to provide outreach and services to families of children with EBLLs. Additionally, outreach and education is needed for health care providers, laboratories, and partners to share the information on the new BLRV

and that capillary results at a level of 3.5 µg/dL should be followed up as an EBLL and a venous test is needed.

In addition to the lowered BLRV, Michigan's governor signed legislation in FY 2023 to make Michigan a universal testing state. Physicians must test, or order a test, for lead in blood for all children at 12 and 24 months of age, or between age 24 and 72 months if there is no record of a previous test. Children living in geographic areas of the state determined by MDHHS to pose a high risk for lead poisoning must be tested additionally at age 4. As a result of this new legislation, CLPPP is initiating extensive work to expand provider education, create new media campaigns, build new programs, and develop other strategies to support the implementation of universal testing. These activities will require additional staff time and funding to make the efforts effective and meaningful.

Objective A: By 2025, increase screening for lead exposure risk factors for children less than 72 months of age.

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. All children covered by Medicaid are considered at high risk for blood lead poisoning. In Michigan, prior to the implementation of universal testing, all Medicaid children are required to receive blood lead testing at 12 and 24 months of age, or between 36 and 72 months of age if not previously tested. MDHHS also recommends targeted testing for other children who are especially at risk of lead exposure. This risk is determined by screening the child using the Michigan blood lead risk assessment tool. Assessment questions include:

- Does the child live in or regularly visit a home built before 1978?
- Does the child live in or regularly visit a home that had a water test with high lead levels?
- Does the child have a brother, sister, or friend that has an elevated blood lead level?
- Does the child come in contact with an adult whose job or hobby involves exposure to lead?
- Does the child's caregiver use home remedies that may contain lead?
- Is the child in a special population group such as foreign adoptee, refugee, migrant, immigrant, or foster child?
- Does the child's caregiver have a reason to believe the child is at risk for lead exposure?

If the answer is "yes" or "don't know" to any of the above questions, then blood lead testing is recommended.

A strategy to increase blood lead screening is to improve notification to health care providers of patients' blood lead levels and the need for blood lead testing. Activities include work with the Michigan Care Improvement Registry (MCIR) team. MCIR is the state immunization registry, accessed by local health departments, health care providers, Medicaid health plans, and schools throughout the state. In FY 2022, CLPPP worked with MCIR to determine the best way to add functionality in the registry to flag or alert a MCIR user that blood lead screening should be done by going through the blood lead risk assessment questions. Expanding on this in FY 2023, CLPPP has also partnered with the Altarum Institute to research how to improve provider notification of elevated blood lead results and improve their ability to determine if a child is due for a blood lead test. In FY 2024, in partnership with Altarum Institute, CLPPP began a pilot project to develop a direct interface between EHR systems and the CLPPP data to populate blood lead levels and build in alerts when testing or follow-up is necessary. This interface will call attention to any child who has not had a blood lead test; will support health care providers, local health departments, schools, and Medicaid health plans to go through the risk assessment; determine if testing is needed; coordinate care; help arrange transportation as needed; and address any other barriers to blood lead testing.

Another strategy is education and outreach to health care providers in Michigan. Health care providers play a vital role increasing screening, testing, and confirmatory testing rates. CLPPP will undertake several efforts to educate

and connect with health care providers, including:

- The development of a Provider Education Program managed by CLPPP staff to work collaboratively across functions within DEH to improve provider education with the goal of increasing blood lead testing throughout the state
- Creation of Blood Lead Testing Coordinator position to work with Physicians throughout the state to provide education and encourage screening and follow-up testing
- Conduct surveys and an environmental scan of the current state of provider awareness around blood lead testing, resources, and referrals.
- Expanded outreach to health care providers in Michigan to ensure awareness of the new BLRV and that levels of 3.5 µg/dL are considered elevated.
- Continued connection between the MDHHS physician consultant and public health detailer with health care provider offices across the state to provide education about blood lead testing recommendations, discuss testing options for offices (including point of care testing), and build partnerships.
- Partner with the Michigan Chapter of the American Academy of Pediatricians (MI-AAP) to present to pediatricians at annual conferences and during a webinar series.
- Continued dissemination of an online training module for health care providers, in partnership with the Michigan Public Health Institute. Continuing education credits are available for social workers, nurses, physicians, and pediatricians. The goal of the course is to increase knowledge, understanding, and behaviors to reduce the health impacts of lead exposure in children under the age of six. Training content focuses on understanding how children are exposed to lead, the health impacts of lead, blood lead testing requirements and the risk assessment questions, the importance of working with local health departments and other resources.
- Provide grants to local health departments to connect with and build partnerships with local health care providers within their jurisdiction. The coordination of care between local health departments and health care providers is critical when a child has been identified as having an EBLL. It is important that these partnerships are developed ahead of time and both parties recognize the other's services and resources.

The third strategy is partnering with agencies to provide culturally appropriate and audience-specific lead education to populations at increased risk for lead exposure, as follows:

- CLPPP will continue to provide educational materials to daycare providers throughout the state.
- A project by the Genesee Health Coalition Community Health Access Program to partner with area health care providers, specifically OBGYNs, to recommend testing for pregnant women identified as being at risk for lead exposure and refer them to health and human services and resources.
- CLPPP has partnered with a consultant in Southeast Michigan to provide trainings and equip staff with tools and materials to conduct environmental assessments, screenings, and education in Arabic for immigrant and refugee clients. This work will be based on the CDC's Lead Poisoning Prevention in Newly Arrived Refugee Children toolkit.
- CLPPP plans to continue to have lead poisoning prevention materials available in commonly used languages including Spanish, Arabic, and Bengali. CLPPP will work with the Language Access Coordinator in the Division of Environmental Health (DEH) to interpret documents into various languages. In FY 2025, CLPPP will work to have additional languages available, both electronically and for mailing.

Objective B: By 2025, increase the percentage of Medicaid-enrolled children less than 72 months of age receiving blood lead testing by 10%.

As mentioned above, all Medicaid-enrolled children are considered at high risk for blood lead poisoning. Specifically focusing on Medicaid-enrolled children can help to increase equitable health outcomes across the population. Medicaid policy requires blood lead testing at 12 and 24 months of age, or between 36 and 72 months of age if not previously tested. This population is a priority target for CLPPP to increase testing rates overall.

The first strategy for this objective is to provide local health departments with a monthly report that includes all Medicaid-enrolled children within that local health department's jurisdiction. The report includes all children less than 72 months of age and their blood lead testing status. Local health departments can use this report as a tool to identify children who need follow up to encourage blood lead testing.

The second strategy is to improve health care provider education and outreach, as discussed under Objective A. The same activities and efforts will be used here, specific to encouraging blood lead testing to Medicaid-enrolled children.

A third strategy is to expand partnerships with other programs serving Medicaid enrolled children. In FY 2023, CLPPP began meetings with the Michigan Primary Care Association to partner on a Lead Testing Initiative to support increased blood lead testing efforts at Federally Qualified Health Centers across the state. Another important partnership with Medicaid has resulted in CLPPP's participation in the Medicaid Health Plan focus studies. These focus studies will take place during the summer of FY 2025. A goal of CLPPP's involvement in the focus studies has been to increase blood lead testing rates and increase education to their provider network. This important partnership has resulted in additional support for local health departments by increasing communication with MHPs about services they provide to families we are both serving. These partnerships will continue and expand in FY 2025.

Objective C: By 2025, increase by 10% the percent of all children less than 72 months of age with an elevated blood lead level (EBLL) from a capillary test who receive a venous lead confirmation test.

Two sample types are used in blood lead testing: a capillary draw and a venous draw. Any blood lead test that is done on a capillary drawn sample must be confirmed by a venous drawn sample. This is because oftentimes a capillary blood lead test can be falsely elevated, and a venous test is needed to confirm that the blood lead level is truly elevated. Additionally, a child who has an elevated blood lead level confirmed with a venous test qualifies for services like nursing case management, the Lead Safe Home Program, and Early On. This objective will use MDHHS data warehouse data to track progress through 2025.

The first strategy for Objective C is to continue to send local health departments quarterly spreadsheets for each county within their jurisdiction. The spreadsheet will include a venous follow-up testing status for all capillary EBLLs, deduplicated by month, as well as a line list of children with a capillary EBLL with no venous follow-up. Local health departments will be able to use these quarterly reports to conduct phone calls, mailings, and home visits to encourage the venous confirmatory test.

A second strategy CLPPP plans to implement in FY 2025 is working with the families who have received nursing case management, to get feedback and ideas for improving the case management process. Once nursing case management is completed, the child's BLL has declined, and the family is connected with resources, CLPPP is planning to work with the family to understand how and if nursing case management is helping, whether the service met families' expectations, and whether the desired outcomes are being achieved. CLPPP plans to conduct a family satisfaction survey to collect data to inform quality improvement efforts within the CLPPP program moving forward.

The third strategy is health care provider education and outreach, as discussed under Objective A. The same activities and efforts will be used, specific to encouraging that all elevated blood lead test results from a capillary test

are followed up with a venous confirmation test.

An additional strategy relates to our increased partnership with the MHPs as mentioned in Objective B. In FY 2023, CLPPP, Molina and the Detroit Health Department (DHD) met to identify how to coordinate case management, education, and outreach efforts among shared clients. In FY 2024, a Plan-Do-Study-Act (PDSA) cycle is being implemented to increase the number of children receiving a venous confirmatory test. The DHD partnered with Molina's outreach and case management team to reinforce and more closely monitor how many children receive a venous confirmatory test. The DHD identified current zip codes with the highest rate of elevated blood lead levels. Once the zip code was identified, both the health department and Molina developed an engagement strategy to decide on the best method to track and share data to measure how many children received a venous confirmatory using the decided upon strategy. CLPPP will assess the progress of this initiative and adapt any relevant lessons learned statewide during FY 2025 with other LHDs and additional MHPs.

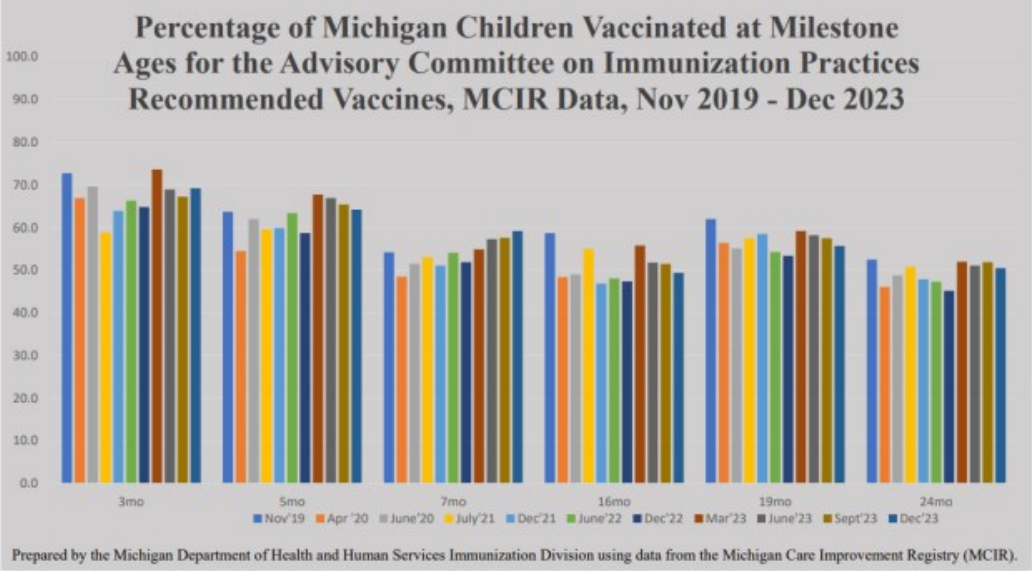
Immunizations – Children (FY 2025 Application)

Based on the Title V needs assessment, a state performance measure (SPM) for FY 2021-2025 was established to measure the "percent of children 19 to 36 months of age who have received a completed series of recommended vaccines (4313314 series)." The 4313314 series represents 4 doses of DTaP, 3 doses of polio, 1 dose of MMR, 3 doses of Hib, 3 doses of HepB, 1 dose of varicella, and 4 doses of PCV vaccines. In the 2020 needs assessment provider survey, when asked "which of the following healthcare-related needs are most often unmet among the families you serve?" 37.8% of respondents across population domains identified immunizations as an unmet need. The need was identified as highest among respondents who serve Children with Special Healthcare Needs (CSHCN) (46%) and children and adolescents (40.6%). The forces of change assessment also identified an increasing focus on individual choice (including vaccine refusal) versus community benefits as a factor that impacts population health. Notably, those needs assessment findings were obtained prior to the COVID-19 pandemic but are still impacting beliefs and decisions today.

Michigan continues to experience significant impacts to its immunization rates. However, as of December 31, 2023, Michigan Care Improvement Registry (MCIR) data show that the vaccination coverage for children under 2 years at milestone ages is approaching the pre-pandemic coverage levels for all age groups with the coverage exceeding the pre-pandemic levels for 5- and 7-month-old children. Statewide coverage for children 19 through 35 months with the 43133142 series (4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 HepB, 1 Varicella, 4 PCV, 2 HepA; Figure 2) in December 2023 (57.3%) is 2.1 percentage points higher than September 2023 (55.2%) and is about 1 percentage point below pre-pandemic levels (58.2% in January 2020). A similar pattern holds for the same series without HepA (4313314; Figure 3), which has higher coverage in December 2023 (69.8%) as compared to last quarter (67.7% in September 2023) but is still 3.8 percentage points lower than the pre-pandemic levels (73.6% in January 2020).

In addition to the vaccine coverage challenges typically experienced in Michigan, the impact of the COVID-19 pandemic has created new, unique challenges. Image 1 indicates falling vaccination rates at several milestone ages over time.

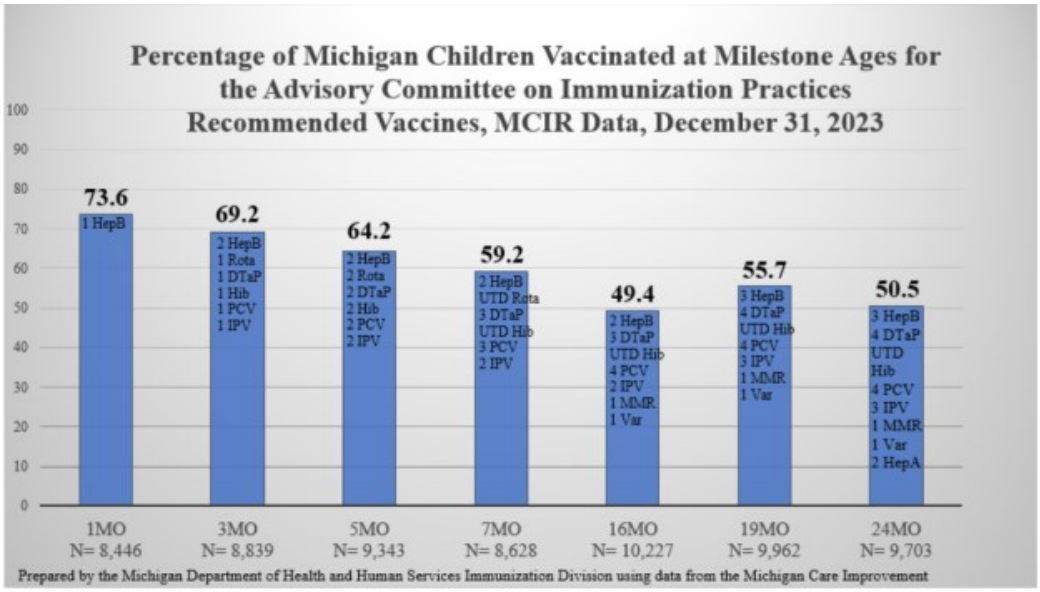
Image 1. Percentage of Michigan Children Vaccinated at Milestone Ages



Michigan has experienced declining immunizations rates and has not met the Healthy People 2030 goal of 80% for child immunizations. Parent vaccine hesitancy has greatly increased even though many published scientific articles show that vaccines are safe and effective. Michigan continues to have high vaccine exemption rates for kindergarten children. Michigan has worked hard to educate providers on the importance of immunizations as a standard of care and the importance of talking with parents about any questions or concerns they may have. Michigan has also partnered with a non-profit organization called the Franny Strong Foundation to provide information for parents through the I Vaccinate campaign to learn facts about immunizations and the risks of not vaccinating. Further, the Program continues to work closely with MDHHS Office of Communication and I Vaccinate on communication campaigns aimed at reducing vaccine hesitancy and improving vaccination uptake. These campaigns occur statewide, with a focus on areas with lower vaccination rates. MDHHS will continue to work with internal and external partners to provide educational messages to the public to promote timely vaccinations.

Michigan's Immunization Information System, MCIR, can forecast needed doses of vaccine across the lifespan. Ideally, all children should have completed the recommended pediatric vaccine series by 19 months of age. Data from MCIR indicate that approximately 50% of children who reside in Michigan have received the routinely recommended 4313314 series by the time they reach 24 months of age. Image 2 identifies the percentage of Michigan children vaccinated at milestone ages for the recommended pediatric vaccines series. This indicates the need to utilize MCIR to inform parents of children who are overdue for vaccines at 24 months of age.

Image 2: Percentage of Michigan Children Vaccinated at Milestone Ages for ACIP Recommended Vaccines, MCIR, December 31, 2023



The Immunization Program intends to use Title V funds in FY 2025 to support program work to address declining immunization rates and to increase vaccine confidence among providers and parents. The funds will be used to target areas with low vaccination rates, while working collaboratively with internal and external partners to increase vaccination rates through communication campaigns, targeted outreach, and sending vaccine recall letters using the MCIR for those overdue for any vaccine.

Objective A: By 2025, increase the percentage of children 19-36 months of age who receive recommended vaccines to 80%.

Data obtained from MCIR show that children are not receiving vaccines on-schedule, and many of these children never catch up on all needed vaccines, as previously illustrated in Image 1. This puts children at risk, with nearly half of children susceptible to these serious diseases. From birth to 2 years of age, children are recommended up to 25 vaccinations to prevent 14 infectious diseases. The vaccination schedule is designed to protect children when they are most vulnerable. Recommendations based on ages of vaccines are shown to be safe and effective. There are no known benefits to delaying vaccinations.

MCIR can also 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 population level to determine any children who need vaccines. To increase vaccination rates, the Immunization Program will notify parents of all children 24 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 2 years of age who are not staying on schedule. Data from MCIR show that children who stay on schedule are twice as likely to complete all needed vaccines as those who fall behind early in life. 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 at local health departments but are meant to enhance existing efforts to remind parents of the importance of immunizations.

In Michigan, disparities exist in immunization rates. The Immunization Program aims to use MCIR data to conduct a root cause analysis and identify high social vulnerability index (SVI) areas within the state and conduct targeted vaccine outreach in those areas. It is of the utmost importance that vaccine access is equitable to all Michigan children. Identifying high SVI areas within the state and conducting targeted vaccine outreach in those areas will

assist in addressing the disparities in vaccination coverage.

Furthermore, the COVID-19 pandemic has contributed to an increase in vaccine hesitancy for all vaccines. In FY 2025, the Immunization Program will work with national partners, including Centers for Disease Control and Prevention (CDC), internal and external partners to promote vaccine confidence among parents of this age group through resources, media and presentations. As previously stated, the Immunization Program will work closely with MDHHS Office of Communication and I Vaccinate on communication campaigns aimed at reducing vaccine hesitancy and improving vaccination uptake. These campaigns will occur statewide, with a focus on areas with lower vaccination rates. While most parents choose to vaccinate their children according to the recommended schedule, some parents may still have questions about vaccines and getting answers they can trust may be hard. It is vital that the Immunization Program works with these partners to address any questions or concerns Michigan parents may have with childhood vaccinations and promote vaccine confidence among this group.

Finally, the Immunization Program aims to work more directly with the Alliance for Immunization in Michigan Coalition (AIM) to better engage families and communities through education and improvements to the aimtoolkit.org website. AIM's mission is to promote immunizations across the lifespan through a coalition of health care professionals and agencies. The AIM coalition continues its focus on improving all facets of immunization services in Michigan. As a result of the COVID-19 pandemic, the AIM coalition was essentially put on hold. As immunization rates continue to drop statewide, it is more important than ever to re-ignite this coalition and work collaboratively with private and public stakeholders to address vaccine hesitancy and improve vaccine uptake. AIM's website, aimtoolkit.org is a place that provides education and promotes vaccination for both healthcare professionals and individuals and families. The Immunization Program has been working with AIM chairpersons to re-vamp AIM through the hiring of a new Immunization Coalition Coordinator. This Coordinator will be in his/her position and actively working to rebuild AIM in FY 2025. Utilizing the partnership, the Immunization Program will better connect resources directly with consumers.

Objective B: Assist local health department immunization staff with targeting outreach to under-served populations in their jurisdiction.

Michigan's Immunization Program will continue to distribute population-based county "report cards" for local health departments to better understand immunization barriers and opportunities for improvement in their communities. MCIR epidemiologists will generate county report cards on a quarterly basis, which will be posted on the MDHHS Immunization website (www.michigan.gov/immunize). The immunization 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.

Another key report which will continue to be made available to local health departments is the COVID-19 Impact Report. This report shows how COVID-19 has impacted childhood and adolescent immunization rates, while encouraging providers to catch Michigan children up on recommended vaccines. The Immunization Program will continue to make the data available to local health departments so they can be better informed on areas for improvement as they work with immunization providers in their jurisdiction. These reports not only identify immunization rates by age but also show immunization rates by age broken down by vaccine types. Local health departments can identify immunization levels by vaccine type to determine areas where immunization providers may not be offering all recommended vaccines.

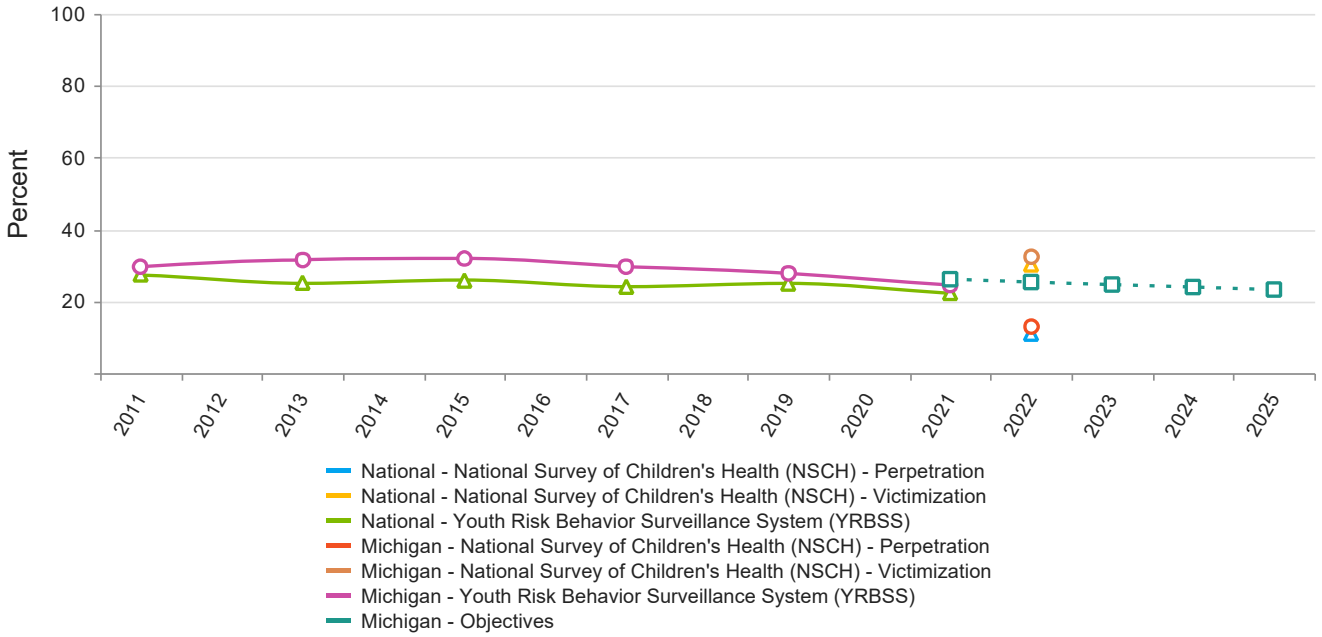
The Michigan Immunization Program will continue to share reports showing immunization rates by race for each local health jurisdiction. On the county immunization report cards, counties can view their 4313314 series by race (based on mother's race) for Asian/Pacific Islander, White, Black and unknown. These data are being made available to

local health departments to bring more focus to issues of health equity and health disparities as a key strategy to achieving equitable health outcomes related to vaccine coverage.

Adolescent Health

National Performance Measures

NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY
Indicators and Annual Objectives



NPM BLY - Adolescent Health

Federally Available Data					
Data Source: Youth Risk Behavior Surveillance System (YRBSS)					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			26.2	24.7	24.7
Annual Indicator	29.8	28.0	28.0	24.4	24.4
Numerator	127,314	117,383	117,383	100,011	100,011
Denominator	426,596	418,810	418,810	410,595	410,595
Data Source	YRBSS	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2019	2019	2021	2021

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Perpetration					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			26.2	25.4	24.7
Annual Indicator	20.0	16.1	12.6	11.9	12.9
Numerator	145,381	116,534	92,956	88,231	94,769
Denominator	727,587	723,002	735,046	741,127	735,947
Data Source	NSCHP	NSCHP	NSCHP-All Adolescents	NSCHP-All Adolescents	NSCHP-All Adolescents
Data Source Year	2018	2018_2019	2019_2020	2020_2021	2021_2022

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - Victimization					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			26.2	25.4	24.7
Annual Indicator	48.0	44.5	37.4	32.8	32.3
Numerator	349,295	321,323	274,732	242,215	237,219
Denominator	727,587	721,708	733,815	738,767	735,185
Data Source	NSCHV	NSCHV	NSCHV-All Adolescents	NSCHV-All Adolescents	NSCHV-All Adolescents
Data Source Year	2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	24.0	23.3

Evidence-Based or –Informed Strategy Measures

ESM BLY.1 - Number of secondary schools implementing the Michigan Model for Health™ Social and Emotional Health Module with 80% fidelity

Measure Status:	Active

State Provided Data					
	2019	2020	2021	2022	2023
Annual Objective			5	11	16
Annual Indicator			5	5	6
Numerator					
Denominator					
Data Source			Classroom Implementation Logs	Classroom Implementation Logs	Classroom Implementation Logs
Data Source Year			2020-2021	2021-2022	2022-2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	2025
Annual Objective	22.0	28.0

State Performance Measures

SPM 3 - Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus vaccine

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	44	54	56	58	60
Annual Indicator	52.4	44.1	42.8	44.2	44.1
Numerator	334,188	331,995	326,193	334,398	328,969
Denominator	637,751	752,019	762,977	756,464	746,245
Data Source	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	62.0	64.0

State Action Plan Table

State Action Plan Table (Michigan) - Adolescent Health - Entry 1	
Priority Need	
Create safe and healthy schools and communities that promote human thriving, including physical and mental health supports that address the needs of the whole person	
NPM	
NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who bully others (Bullying, Formerly NPM 9) - BLY	
Five-Year Objectives	
A) By October 2025, 30 secondary schools will implement schoolwide bullying prevention initiatives emphasizing social emotional health (SEH) education and creating safe schools for LGBTQ+ students	
B) By October 2025, provide 1,050 schools with guidance on state laws and model policies on bullying prevention with protections for LGBTQ+ youth	
C) Explore bullying prevention campaigns for CSHCS and determine goals for bullying prevention initiatives in Michigan	
Strategies	
A1) Six secondary schools per year will implement the Michigan Model for Health™ SEH module in all health education classrooms A2) Provide intensive training and technical assistance to six secondary schools per year on creating safe schools for LGBTQ+ students	
B1) Facilitate professional development for schools and school health coordinators on PA 241 and State Board of Ed Model Anti-Bullying policy B2) Provide technical assistance to school health coordinators working directly with schools B3) Support and promote professional development for schools on the creation and sustainability of Gender and Sexuality Alliances (GSAs)	
C1) Implement the CSHCS Bullying Prevention Initiative grant program C2) Assess lessons learned from the grant program and evaluate how these lessons can be embedded across the state C3) Disseminate information, successes, and lessons learned from the grant program to organizations at the state and national levels	
ESMs	**Status**
ESM BLY.1 - Number of secondary schools implementing the Michigan Model for Health™ Social and Emotional Health Module with 80% fidelity	Active

NOMs

NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide

State Action Plan Table (Michigan) - Adolescent Health - Entry 2

Priority Need

Improve access to high-quality community health and prevention services in the places where women, children, and families live, learn, work, and play

SPM

SPM 3 - Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus vaccine

Five-Year Objectives

A) By 2025, increase the percentage of adolescents who have completed the HPV series to 64%

B) Emphasize routine assessment of all recommended vaccines for adolescents to increase influenza and meningococcal vaccine rates by 3%, by 2025, among this age group

Strategies

A1) Update current HPV materials to reflect up-to-date vaccine changes and effective communication strategies to promote vaccination and make materials available for providers A2) Provide updated translations of HPV materials to ensure a more equitable approach in addressing HPV vaccine hesitancy A3) Work with internal and external partners, including the Michigan HPV Alliance, to promote timely HPV vaccination A4) Work with the Alliance for Immunization in Michigan Coalition to better engage families and communities through education and improvements to the aimtoolkit.org website

B1) Work with internal and external stakeholders on a statewide influenza campaign to improve influenza vaccination coverage among all ages, including adolescents B2) Generate and distribute a letter to Michigan healthcare providers highlighting the importance of catching children and adolescents back up on routine vaccines that they may have missed due to the COVID-19 pandemic B3) Offer quality improvement visits (virtual or in-person) to provide a comprehensive assessment of immunization rates and offer strategies for practice improvements B4) Work with external stakeholders to conduct targeted outreach to improve Meningitis B vaccination rates for adolescents 16 through 18 years of age

Adolescent Health Overview

The needs of adolescents are addressed at the state and local level in Michigan through a diffuse network of governmental and non-governmental organizations. Within MDHHS, the Division of Child and Adolescent Health (DCAH) plays a central role in meeting the health needs of Michigan's adolescents. DCAH includes programs designed to build healthy relationship skills among adolescents, prevent unintended pregnancy, and address bullying. It houses programs designed to meet adolescents' physical health needs in school settings through Child and Adolescent Health Centers and school nursing. The Division of Immunization includes sections focused on adolescent outreach and education, as well as assessment and local support. The Children's Special Health Care Services (CSHCS) Division administers programs that impact adolescents and young adults with special health care needs, especially as they relate to transition.

Title V funding supports a variety of programs and services for adolescents through state and local organizations—including immunization, reproductive health services and prevention of unintended pregnancy, and bullying prevention—as well as services for adolescents who have special health care needs. Other federal MCH funds that impact adolescents include the State Abstinence Education Program (Administration for Children and Families), the State Personal Responsibility Education Program (Administration for Children and Families), and an Epilepsy grant (HRSA). In addition, critical partnerships in the state that impact adolescent health include those with school-based health centers, the Michigan Department of Education, the Youth Risk Behavior Survey and its state-based counterpoint (the Michigan Profile for Healthy Youth), the Michigan Organization on Adolescent Sexual Health, the Michigan Council for Maternal and Child Health, and the School-Community Health Alliance of Michigan.

Title V funding also supports the Local Maternal Child Health (LMCH) program which provides funding to all 45 local health departments (LHDs). In FY 2023, Title V funds via the LMCH program were expended on NPM 13.2 (oral health), SPM 3 (adolescent vaccinations), SPM 5 (intended pregnancy and reproductive health), SPM 6 (behavioral/mental health), and Local Performance Measures (LPMs) in the adolescent health domain. Two LHDs worked on oral health for adolescents (NPM 13.2) by providing gap-filling mobile dentistry services and oral health education at community outreach events. Eleven LHDs completed activities related to adolescent immunization (SPM 3) which included media campaigns, provision of gap-filling adolescent vaccinations, waiver education, recalls and reminders, and provider surveys. LHDs reported an increase in vaccine hesitancy and mistrust in government related to the pandemic. Three agencies worked on SPM 5 related to adolescent reproductive health services. Three LHDs selected SPM 6 (behavioral/mental health) and activities included gap-filling suicide and depression screening, provision of mental health education to middle/high school youth, gatekeeper trainings to community schools and other organizations, and social media posts about behavioral/mental health.

Four LHDs worked on LPMs related to adolescent health with gap-filling activities such as well-visit physical exams, health education, hearing/vision screening for adolescents, links to community services, and Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infection (STI) counseling and testing.

Michigan's approach to adolescent health through Title V focuses on increasing wellness through bullying prevention; suicide prevention; promotion of HPV vaccination; and access to reproductive health services, including contraception.

Bullying Prevention (FY 2023 Annual Report)

To address the state priority need to create safe and healthy schools for Michigan students, NPM 9 was selected and ESM 9.1 was developed. In FY 2023, activities undertaken to address NPM 9 included intensive intervention within

six secondary schools that provided access to content experts for direct consultation as well as the implementation of health education curriculum designed to teach the knowledge and skills necessary to curb bullying and create a safe and healthy school environment. The project is titled, “3Cs- Culture, Climate, Curriculum: Improving the Health and Well-Being of LGBTQ+ Students.” In addition to this focused intervention, a series of learning opportunities were made available to all schools throughout the state with the goal of preparing more schools to jumpstart their bullying prevention efforts or grow what is already in place. These opportunities were virtual and well attended. The statewide efforts were extended to include focused support for schools on creating and sustaining a Gender and Sexuality Alliance (GSA). Combining this focused and broad approach garners momentum for the work and meets schools where they are while also pushing for progress.

Title V funding supported the work of two project consultants who provided one-on-one consultation with six secondary schools to address the needs of LGBTQ+ students within their schools, particularly around creating safe and supportive environments. Funding also provided each of these schools with $5,000 to implement the strategies identified in consultation with the project consultants. Schools received resources relevant to their bullying prevention efforts. Funding also supported a portion of the salary of a project consultant working to help schools throughout the state create and sustain GSAs.

Focusing on the LGBTQ+ student population addresses health inequities while also recognizing that improved school environments for this population mean improved environments for ALL students. Partners interested in bullying prevention, especially as it relates to the experiences of the LGBTQ+ student population, found common ground in the objectives and strategies for NPM 9. Partnering with the Michigan Department of Education (MDE) LGBTQ+ Students Project was essential as the goals of the two projects aligned and the work of the project consultants was shared between the two programs. These consultants have extensive expertise and a proven track record helping schools create safe and supportive environments for LGBTQ+ students. The goal of the LGBTQ+ Students Project is to build the capacity of Michigan schools to impact the health, well-being, and educational outcomes of LGBTQ+ students.

Partnering with the Michigan Organization on Adolescent Sexual Health (MOASH) was also essential given the alignment of its mission to our project goals. MOASH staff bring extensive expertise in centering youth voices, especially LGBTQ+ youth voices, and are leaders within Michigan on the formation and sustaining of impactful Youth Advisory Councils. Their expertise facilitating youth councils, GSAs, and training school personnel provided a partnership to ensure that youth voice and youth engagement would be an integral component of the project. The involvement of the Michigan School Health Coordinator’s Association (MISHCA) was key due to their work with schools across the state training teachers and supporting implementation of the *Michigan Model for Health* curriculum (MMH), along with other school health initiatives. They are the local representatives for school health education in Michigan.

The most significant challenge to the project was political pushback toward inclusionary policies and practices that address the needs of LGBTQ+ youth. As a result, some school leaders are wary of implementing this work. This backlash against affirming policies and practices harms students and plays a role in creating a stressful environment in which teaching and learning are compromised.

Michigan’s CYSHCN population also experienced bullying at a higher rate, with 57.0% of CYSHCN being bullied compared to 23.8% of general population students in Michigan (2020-2021 National Survey of Children’s Health). During focus groups and listening sessions in the 2020 Title V Needs Assessment, youth and their parents described a need for activities and support groups to address a sense of social segregation and stigma within the community for CYSHCN. In response to this data and feedback, CSHCS utilized $150,000 of Title V funding in FY 2023 to implement a bullying prevention initiative within the CYSHCN population to promote peer support and

inclusion.

Objective A: By October 2025, 30 secondary schools will implement schoolwide bullying prevention initiatives emphasizing social emotional health (SEH) education and creating safe schools for LGBTQ+ students.

The first strategy involves participating secondary schools fully implementing (defined in ESM 9.1 as 80% of lessons taught) the *Michigan Model for Health* SEH modules/lessons in their health education classrooms. In FY 2023, six participating secondary schools provided a solid foundation for bullying prevention efforts in their buildings. Students practiced and learned skills foundational to treating one another with respect and care. MMH SEH curriculum modules were purchased for participating schools (through another funding source) and implementation logs completed to ensure fidelity. MISHCA partners provided curriculum training and support for teachers.

For the second strategy, training and technical assistance (TA) was provided to secondary schools to help create safe schools for LGBTQ+ students. Title V funding supported intensive TA with project consultants who worked with school teams (team members were designated at the beginning of the project year) to provide hands on support and learning opportunities to create change within their schools. School teams developed visions, goals and strategies around schoolwide bullying prevention that focused on safe schools for LGBTQ+ students. Feedback received indicated that educators found this consultation extremely beneficial. Several districts with participating schools expanded their programing by beginning implementation at the middle school level and reapplying the next year for their high school to reinforce support and create continuity.

Each school team used their stipend ($5,000 per school) to support planning expenses, program implementation costs, substitute teacher coverage or staff stipends to attend curriculum trainings, workshops and/or meetings, and other relevant bullying prevention activities, such as attendance at bullying prevention conferences.

The partnership with the MDE LGBTQ+ Students Project enabled participating schools to take full advantage of the suite of learning opportunities offered. Providing relevant and impactful professional development was a shared goal of both projects.

Objective B: By October 2025, provide 1,050 schools with guidance on state laws and model policies on bullying prevention with protections for LGBTQ+ youth.

Through the partnership with MDE, MOASH, MISHCA and the Child, Adolescent and School Health (CASH) conference, schools across Michigan are learning about state laws and model policies along with a variety of other issues surrounding safe and supportive schools for ALL students. Youth panels and Youth Advisory Councils are providing learning opportunities as well as informing the overall work of the projects making up this partnership.

To support this objective, one strategy was to conduct training for schools and MISHCA members on relevant guidance on PA 241 and the State Board of Education Model Anti-Bullying policy. During this project year, MISHCA partners provided schools with technical assistance through their ongoing work supporting schools and districts to bolster healthy schools for students and staff. MOASH staff members also worked closely with MISHCA members to support their work with schools. Coordinators who are well versed in bullying prevention laws and policies is an important strategy as more schools faced resistance to LGBTQ+ supportive policies.

Another strategy addresses learning opportunities for schools on supporting the LGBTQ+ student population in general and GSAs specifically. The Child, Adolescent and School Health or CASH conference was held in October and included several sessions relevant for educators supporting the LGBTQ+ student population. A pre-conference session and both the keynote and closing keynote focused on building skills related to communicating and managing

conflict across differences. A total of 397 participants joined the conference with 13 exhibitors.

MOASH partners led the effort on GSA activities in FY 2023. They provided TA to school staff, parents, students, and other key stakeholders. Contacts often involved requests for resources, strategies, and guidance, both generally and regarding school/district specific scenarios. As a part of broader TA efforts, the project continues to develop and update a TA manual that includes example responses and resources to send for commonly asked questions regarding GSAs. The project is also working to develop a GSA assessment tool to aid in the evaluation of a GSA's functioning. The project also maintains a Google folder of resources that can be shared with GSA advisors. The resources cover a range of information about club formation and sustainability. While many resources are from state or national organizations, the project is working to expand the number of examples shared by GSA advisors within Michigan. The project also maintains a list of GSA advisors that have opted in to receiving information about new resources or upcoming GSA related opportunities. Resources/opportunities are sent to this list as they become available, roughly five times per school year.

Additionally, the 10th annual Building a Movement for Michigan (BAMM) Pride Youth Summit was held in May 2023 and reached 380 LGBTQ+ youth and supportive adults. The summit included youth-led sessions, including workshops from three of MOASH's youth advisory councils. MOASH also collaborated with Northern Michigan University to assist their development of "UPride", a summit for LGBTQ+ youth in the Upper Peninsula (UP). The summit was held on Oct 10, 2023 with youth participants from 23 schools across the UP. Title V funds helped support MOASH project consultant staff time and resource development and distribution to rural communities.

It is difficult to determine duplicate schools given the cross section of partners providing learning opportunities and varying levels of tracking attendance, but it is estimated that more than 300 schools were reached through these activities in FY 2023.

Objective C: Explore bullying prevention campaigns for CSHCS and determine goals for bullying prevention initiatives in Michigan.

As discussed above, Michigan's 2020 needs assessment also identified a need to address bullying within the CYSHCN population. For the first strategy, CSHCS utilized the Family Center's Family Leadership Network (FLN) Annual Meeting to hold a focus group with families to evaluate the CSHCS Bullying Prevention Initiative (BPI) grant opportunity for Michigan schools. FLN is comprised of parents of CYSHCN representing each of Michigan's 10 Prosperity Regions. The bullying prevention focus group included 16 participants who were parents or caregivers of CYSHCN. CSHCS presented content, data, and questions to the FLN committee to facilitate dialogue and obtain program feedback. The FLN focus group identified the following items as potential considerations for future BPI grant cycles:

1. Utilize the Parent Advisory Committees (PACs) that are housed within each school district to assist with disseminating applications. FLN also offered to promote the BPI application within their regions.
2. Send alternative funding opportunity resources with grant applications that receive a denial letter.
3. Encourage schools to promote acceptance among all students and educate on disabilities within their school and/or district.

For the second strategy, CSHCS administered a third year of grants to address bullying for CYSHCN. Title V funding was allocated to school districts and/or schools for grants up to $10,000 to create or expand Peer to Peer (P2P) support programs. The objectives of the grant program are:

1. Contribute to safe cultures within school communities for CYSHCN.

2. Provide or enhance the school environment for peer support for CYSHCN.
3. Increase social and emotional support for CYSHCN.
4. Expand bullying prevention efforts for CYSHCN.

For the FY 2023 grant cycle, 35 grant applications were received and 16 organizations were granted a total of $128,164. CSHCS continued the partnership with Grand Valley State University's START (Statewide Autism Resources & Training) Program to provide support to grantees via collaborative monthly virtual webinars and an in person annual meeting. Twelve of the 16 school grantees were represented at the annual meeting which hosted approximately 30 attendees. Grantees participated in robust discussion regarding positive outcomes, challenges, and specific solutions they had identified throughout their program year. Grantees reported positive outcomes such as growing participation, increasing student confidence, improving leadership capacity of participants, and witnessing positive cultural shifts and inclusion both during and outside of school. Grantees also offered feedback on the CSHCS grant application, activities, and processes.

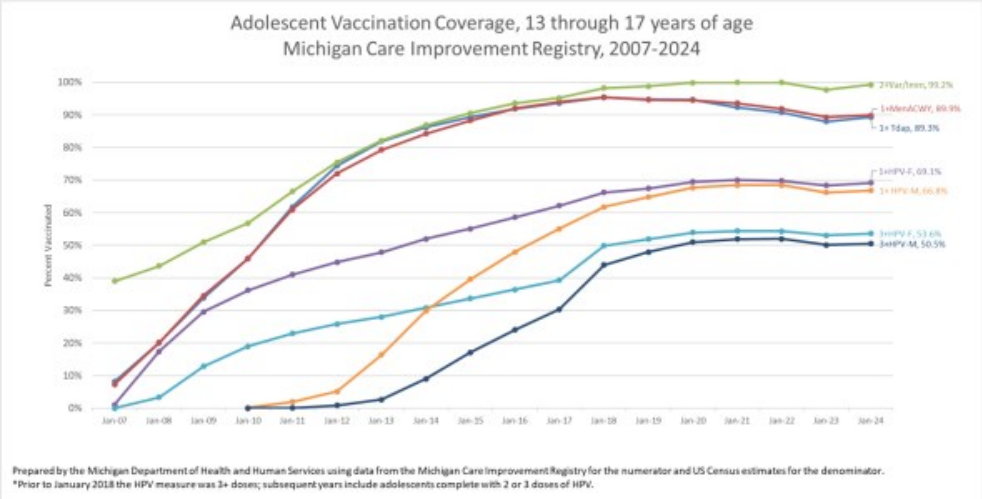
The third strategy for this objective is for CSHCS to continue serving on the HRSA Region IV/V workgroup. In May 2021, states from across HHS Regions 4 (AL, FL, GA, NC, TN) and 5 (IN, MI, MN, OH, WI) created a workgroup to share strategies for bullying prevention among CYSHCN. The collaborative met quarterly throughout FY 2021 and FY 2022 to discuss topics such as data capacity, youth advisory councils, and policies. In FY 2023, the Maternal Child Health Bureau (MCHB) facilitated meetings with state representatives to determine the future of the collaborative. CSHCS remains committed to supporting collaborative opportunities to learn and share best practices with other states surrounding inclusion and peer-to-peer support for CYSHCN.

During FY 2023, CSHCS continued to explore youth advisory councils as a mechanism to infuse youth perspective and feedback into CSHCS programming, including Bullying Prevention, which aligns with the final strategy of creating a Peer Leadership Network. Given the significant staffing and leadership changes within the CSHCS Family Center in FY 2023, a new internal committee was established. Activities for FY 2023 included researching youth councils within other organizations, redefining goals for the CSHCS youth advisory council, and creating the foundational framework for this project. CSHCS will continue to move this work forward in FY 2024.

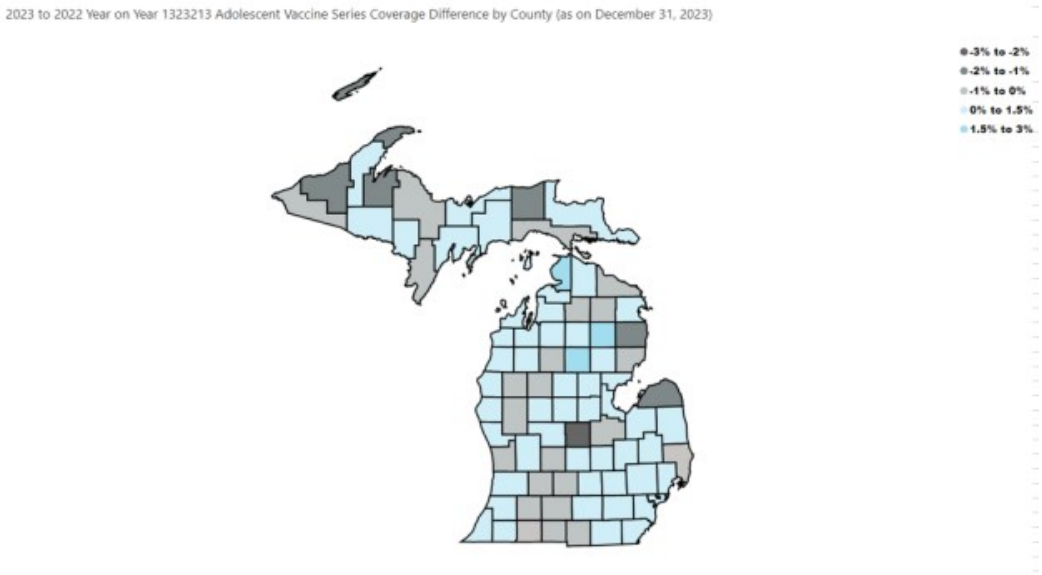
Immunizations – Adolescents (FY 2023 Annual Report)

The MDHHS Division of Immunization is focused on improving the uptake of all Advisory Committee on Immunization Practices (ACIP) recommended vaccines among Michigan adolescents 13 to 18 years of age. Specifically, the Immunization Program closely monitors the percent of adolescents in this age group who have completed the Human Papillomavirus (HPV) vaccine series. Michigan saw a decline in HPV vaccination rates from 44.1% in FY 2020 to 42.8% in FY 2021; largely attributed to the COVID-19 pandemic. For reference, pre-pandemic levels were a 52.4% HPV completion rate in FY 2019. In FY 2022, however the HPV completion rate at 17 years of age increased to 44.2%. In FY 2023, the HPV completion rate remained relatively stable at 44.1%. While this number is still below pre-pandemic levels of 52.4% HPV completion rate in FY 2019, this trend upward is a good sign that coverage is steadily improving.

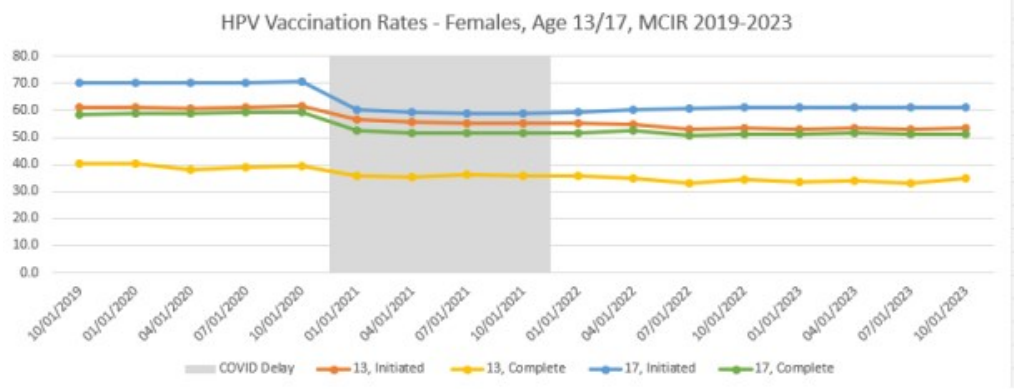
The Division of Immunization regularly monitors adolescent statewide coverage for adolescents 13 through 17 years of age for the 1323213 series (1 Tdap, 3 Polio, 2 MMR, 3 HepB, 2 Varicella, 1 MenACWY, 2 or 3 HPV) as noted in the figure below. The overall 1323213 series vaccination rate increased from 43.2% in January 2020 to 45.6% in November 2023. Coverage for the same series without HPV (132321 series) decreased by about 3 percentage points from 77% in January 2020 to 74.5% in November 2023. However, coverage has been steadily increasing, from 72% in November 2022 to 74.5% in November 2023. This upward trend post-pandemic is noteworthy, especially due to the impact of the COVID-19 pandemic and the overall increase of vaccine hesitancy nationwide.

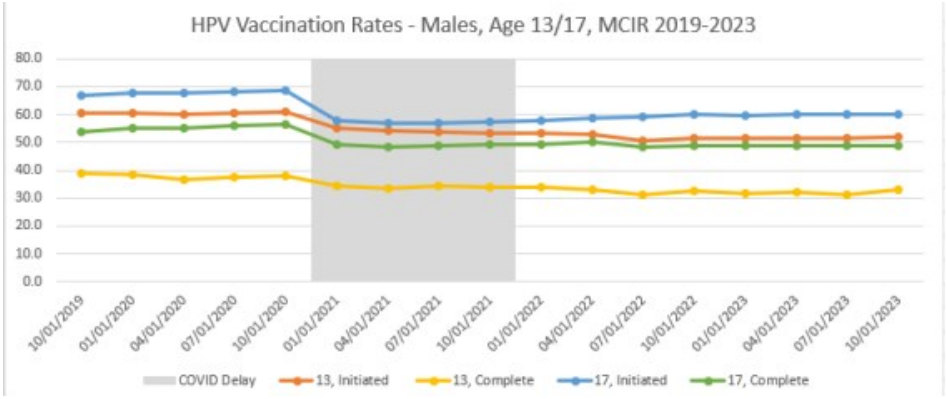


The figure below shows “Year on Year” 1323213 adolescent vaccine series coverage by county from 2023 to 2022, as of December 31, 2023. Across all counties in Michigan, adolescent vaccine series has been steadily increasing.



The following two figures highlight HPV initiation and completion rates among 13- and 17-year-old females and males in Michigan. Notably, these have also been on an upward trend. As stated above, from FY 2020 to FY 2021, Michigan saw a decline in HPV vaccination rates from 44.1% to 42.8%. In FY 2023, the HPV completion rate at 17 years of age for males was 49% and for females was 51.3%, as illustrated in the figures below. While these numbers are still below the pre-pandemic levels of 52.4% overall HPV completion rate in FY 2019, this trend upward is a good sign that coverage is finally improving in this post-pandemic era.





Objective A: By 2025, increase the percentage of adolescents who have completed the HPV series to 64%.

The first strategy to support this objective focused on updating current HPV materials to reflect up-to-date vaccine changes and effective communication strategies to promote vaccination, and to make materials available for providers. The Immunization Division has been actively updating documents located the MDHHS Clearinghouse, www.healthymichigan.com, and several thousand resources (many of which included information on the HPV vaccine) were distributed by the Clearinghouse during this reporting period. Further, several new publications were stocked at the clearinghouse and numerous publications were provided in an online format via the website.

The second strategy to support this objective focused on providing updated translations of HPV materials to ensure a more equitable approach in addressing HPV vaccine hesitancy. The Immunization Division ran into a few barriers on translation services and did not translate any materials during this reporting period. The goal was to update the current HPV materials prior to translating, however due to staff turnover and competing priorities, many of the HPV-focused materials are still going through the updating process.

The third strategy to support this objective involved offering quality improvement visits to providers, emphasizing on-time HPV vaccination, and providing a comprehensive assessment of immunization rates and recommendations for practice improvements. Throughout this grant reporting period, approximately 600 QI visits occurred with Vaccines for Children providers. At these site visits, site visit reviewers discussed all immunization rates for the provider office and identified ways to improve those rates, while emphasizing the importance of timely vaccination.

Objective B: Emphasize routine assessment of all recommended vaccines for adolescents to increase influenza and meningococcal vaccine rates by 3%, by 2025, among this age group.

The first strategy to support this objective involved working with internal and external stakeholders on a statewide influenza campaign to improve influenza vaccination coverage among all ages, including adolescents. The Immunization Program partnered with I Vaccinate/Brogan & Partners to launch a multi-media plan to promote catch-up vaccination of all vaccines. This media plan focused on areas with the lowest vaccination rates and included connected TV, YouTube, audio streaming and podcasting, rich media and display/video, native display, gas station TV, posters, doctor offices, and paid ads in search engines. In addition to catch-up messaging, there was also a flu vaccine-focused campaign that emphasized the importance of “layers of protection” and “don’t go viral” which can be obtained by getting your flu vaccine, every flu season. This creative also included many of the same media avenues as listed above and targeted similar areas with low vaccination rates. A large portion of Title V funds (approximately $380,000) were used to support this communication campaign for FY 2023.

The second strategy included generating and distributing a letter to Michigan healthcare providers highlighting the importance of catching children and adolescents back up on routine vaccines they may have missed due to the COVID-19 pandemic. Instead of writing a letter during FY 2023, the Immunization Program used Title V funding to host a Pink Book Conference, which focused on provider education. This two-day conference provided physicians, nurses, nurse practitioners, physician assistants, pharmacists, and other healthcare professionals throughout Michigan with the most comprehensive information on routinely used vaccines and the diseases they prevent. A representative from the Centers for Disease Control and Prevention presented on the Pink Book and the overall conference was very well attended. In this post-pandemic era where vaccine hesitancy is at an all-time high, it is crucial to bring all the players in the immunization neighborhood together, in-person, to learn and discuss ways to improve vaccination uptake in Michigan.

The third strategy to support this objective included offering quality improvement visits (virtual or in person) to provide a comprehensive assessment of immunization rates and offer strategies for practice improvements. As stated above, approximately 600 QI visits occurred with Vaccines for Children providers during this grant reporting period. At these site visits, site visit reviewers discussed all immunization rates for the provider office and identified ways to improve those rates, while emphasizing the importance of timely vaccination. Providers are required to choose quality improvement strategies that they can implement in their practices to assist in improving their immunization rates.

The final strategy for this objective highlighted working with external stakeholders to conduct targeted outreach to improve Meningitis B vaccination rates for adolescents 16 through 18 years of age. Although targeted outreach did not occur during this time, the Immunization Division further strengthened its partnerships with stakeholders, especially those working with adolescents through an HPV Alliance, and identified ways to improve these rates. Meningitis B rates are also monitored closely and disseminated to partners as part of the MDHHS County Immunization Report Cards.

To note, the Immunization Division is also closely monitoring the newly FDA-approved vaccine PENBRAYA which is indicated for active immunization to prevent invasive disease caused by Neisseria meningitidis serogroups A, B, C, W, and Y. While the Division of Immunization will not promote this vaccine until it is recommended by the Advisory Committee on Immunization Practices, this vaccine could assist in improving meningitis B vaccination rates.

Bullying (FY 2025 Application)

The percent of adolescents, ages 12-17, who are bullied or who bully others (NPM 9) was selected to address Michigan's priority need to "Create safe and healthy schools and communities that promote human thriving, including physical and mental health supports that address the needs of the whole person."

A variety of data sources point to why NPM 9, with a focus on the health of LGBTQ+ students, is a good fit for the current five-year cycle. Michigan saw a decline in overall bullying rates of high school students who reported in-school or online bullying from 27.7% in 2019 to 24.2% in 2021 (YRBS). However, LGBT students remain at significantly higher risk of being bullied than their non-LGBT counterparts (40.8% vs 21.3%).

Bullying is strongly associated with adverse mental health outcomes. Michigan students who reported any bullying in the previous year were significantly more likely than students who did not experience bullying to report: feeling sad/hopeless for 2+ weeks in the past month (1.9x as likely); considering suicide in the past year (2.7x as likely); attempting suicide in the past year (2.5x as likely); a suicide attempt requiring medical attention in the past year (3.1x as likely); and engaging in self-harming behaviors (2.4x as likely).

Students who identify as LGBTQ+ disproportionately and inequitably experience the harmful consequences of bullying. Compared with other students who report being bullied, who themselves report higher levels of adverse mental health outcomes, LGBT students are even more likely to report considering and attempting suicide. The 2021 Michigan YRBS found that LGBT students are more likely to report suicidal thoughts (3.5x more likely to consider suicide) and behaviors (4.0x more likely to attempt suicide) than their high school peers.

Multiple data sources point to school often being an unsafe place for LGBTQ+ youth in Michigan. According to the Gay, Lesbian and Straight Education Network's (GLSEN) 2021 Michigan State Snapshot, 64% LGBTQ+ students experienced at least one form of anti-LGBTQ+ victimization (verbal, online, physical) at school. The State Snapshot also found that only 33% of LGBTQ+ youth had access to a Gender and Sexuality Alliance, or GSA. Only 8% of LGBTQ+ students attend a school with a comprehensive anti-bullying policy. Especially concerning is the finding that 55% of LGBTQ+ students heard school staff make homophobic remarks and 70% heard negative remarks from school staff about someone's gender expression. Furthermore, when LGBTQ+ survey respondents reported victimization at school only 22% reported that it resulted in effective staff intervention.

A significant threat to LGBTQ+ students feeling safe and supported in school involves the nationwide trend of exclusionary legislation and policies. Some school leaders are wary of implementing LGBTQ+ supportive policies due to political pressure. This backlash against affirming policies and practices harms students and plays a role in creating a stressful environment in which teaching and learning are compromised. This is demonstrated by the GLSEN State Snapshot for Michigan, which found that only 35% of LGBTQ+ students reported that their school administration was somewhat or very supportive of LGBTQ+ students.

GLSEN's school climate research points to four core supports for LGBTQ+ students that lead to more healthy and supportive school environments that, in turn, lead to improved academic outcomes, mental well-being and fewer incidents of harassment and discrimination. These supports include comprehensive school policies, supportive educators and other adult allies, inclusive curriculum and access to GSAs. The following strategies help schools provide these supports to LGBTQ+ students along with all students attending their schools.

Objective A: By October 2025, 30 secondary schools will implement schoolwide bullying prevention initiatives emphasizing social emotional health (SEH) education and creating safe schools for LGBTQ+

students.

Robust health education programs, in which social emotional health (SEH) is foundational, enhances the skills needed to prevent bullying behavior and helps to achieve equitable health outcomes. Addressing this need, efforts will center around bullying prevention through health education in the classroom with added supports for LGBTQ+ students. In FY 2025, Michigan will select six schools to implement an approach to bullying prevention that includes teaching health education and creating safe schools for all students. All grade levels within selected schools will implement the social and emotional health skills module of the *Michigan Model for Health*™(MMH) curriculum. School teams will receive extensive training and customized support on creating safe schools for LGBTQ+ students. Schools will also receive training and support for the establishment, growth, and sustainability of Gender and Sexuality Alliance (or Gay-Straight Alliance) student clubs. This whole school approach will help move the needle on all students feeling safe and supported at school. Title V funding, via $5,000 stipends to each school, will fund curriculum implementation; cover costs associated with participation in workshops (sub costs, staff stipends, etc.); and costs to implement strategies related to creating safe and supportive schools for LGBTQ+ youth, including GSA support. Funds will also be used to partially fund the consultants, employed by the Michigan Organization for Adolescent Sexual Health (MOASH), working directly with the school teams, facilitating workshops, and providing customized technical assistance.

The ESM for this NPM will be all classrooms in six selected schools implementing the *MMH*™ social and emotional health lessons with at least 80% fidelity. Both the middle and high school lessons focus on the development of skills that directly address bullying and cyber-bullying. Additional lessons addressing anti-bullying skills will be added from other curriculum units. Health teachers will complete fidelity lesson logs documenting the implementation of lessons.

The *MMH*™ is a pre-K-12 comprehensive school health education curriculum that is evidence-based and recognized by the Collaborative for Academic, Social and Emotional Learning (CASEL). Other funds are being leveraged to update the curriculum with a focus on inclusivity. Michigan's 22 regional School Health Coordinators provide training and technical assistance for the *MMH*™ and other school health initiatives. They partner with schools on creating safe schools for all students, addressing the needs of LGBTQ+ students, and addressing the role of adults in an inclusive learning environment. Inclusivity is an ongoing priority as updates and revisions are made to the curriculum.

The second strategy involves intensive training and customized technical assistance for a team of staff members from each school focusing on creating safe schools for LGBTQ+ students and implementing schoolwide strategies to improve the school climate. This includes the establishment, growth, and sustainability of a GSA. A series of workshops, along with individualized technical assistance and networking with other schools, builds the skills of educators so they can lead the effort to improve the school climate for all youth, especially those who identify as LGBTQ+. The trainings/workshops, as well as the customized support, are facilitated by skilled consultants who have worked with schools and LGBTQ+ youth in a variety of settings. These consultants, employed by MOASH, work with the Michigan Department of Education (MDE) on the MDE LGBTQ+ Students Project.

The workshop series, offered by the MDE LGBTQ+ Students Project, includes sessions devoted to understanding the identities and experiences of LGBTQ+ students; recognizing and addressing barriers to supporting LGBTQ+ students and families; legal and policy issues; LGBTQ+ youth panels; the power of GSAs; safe, supportive and inclusive classrooms; practical strategies for affirming LGBTQ+ students; school-wide policies and best practices; accurately reflecting student gender identities in student information systems, supporting this population in athletics and physical education; and partnering with parents, caregivers, and families. The workshops include youth panels, and the training content is developed with youth through youth advisory councils facilitated by MOASH. Drop-in technical assistance sessions are regularly scheduled and open to all interested schools in Michigan.

Research indicates that school policies supportive of LGBTQ+ youth combined with the presence of a GSA help create school environments where not only LGBTQ+ youth experience peer and teacher support, but the entire student body experiences less bullying and a more supportive school environment. MOASH project consultants will provide school teams with training and support specifically related to GSA establishment, growth, and sustainability. MOASH has significant expertise working with youth advisory councils and supporting GSAs. MOASH will partner with schools to lend expertise in moving through the five stages of GSA development and functioning: Initiation and Organizing, Establishment, Implementation, Recruitment and Participation, and Sustainability. The MOASH annual statewide summit for LGBTQ+ youth (BAMM – Building a Movement for Michigan) is well attended (380 participants, primarily youth, attended in 2023). GSA participants from these schools will be encouraged (and financially supported with Title V funds) to attend.

Partnering with MDE, MOASH, and School Health Coordinators ensures that schools will receive the training and technical assistance needed for schoolwide *MMH*™ curriculum implementation; that youth voice will be centered; and that school teams will be provided with the training and support needed to create systemic change. The comprehensive and in-depth nature of these strategies, combined with the demonstrated expertise of our partners and the foundation of youth input supports schools in advancing the goal of creating safe and supportive environments for LGBTQ+ students.

Objective B: By October 2025, provide 1,050 schools with guidance on state laws and model policies on bullying prevention with protections for LGBTQ+ youth.

School districts benefit from guidance on Michigan's laws and policies to better equip staff to appropriately address bullying. Most school staff members understand that it is imperative to intervene when bullying occurs, but surveys show that many feel ill-equipped to do so, resulting in unhelpful or even harmful staff response. This is especially true when the bullying involves LGBTQ+ students. Michigan's Public Act 241 mandates that schools develop a district anti-bullying policy. The law includes multiple components, based on best practices, required to be included in the policy. However, many school districts neither fully understand the law nor fully implement it. Michigan's State Board of Education (SBE) has a model anti-bullying policy in place to help school districts meet the law. While Michigan is a local control state—meaning the SBE Model Policy is a recommendation for schools rather than a requirement—the policy helps schools understand what should be included in a bullying prevention policy.

For legislation to be effective as a means of decreasing bullying and cyberbullying, it is necessary for schools to adopt (and fully implement) policies. School Health Coordinators will work with their local schools to provide guidance on Michigan law and anti-bullying policies. Project partners will support their work to create awareness and understanding in the education community by facilitating professional development opportunities on the laws in Michigan and why adopting, and fully implementing, the SBE Model Anti-Bullying Policy is an essential component of bullying prevention efforts.

An additional strategy for promoting safe and supportive school environments for ALL students involves extending the learning opportunities on GSAs to school teams and staff members outside of the six project schools. Increasing the number of GSAs will help create school environments where not only LGBTQ+ youth experience peer and teacher support but the entire student body experiences a safe, supportive, and inclusive climate where all students can thrive. Project consultants will provide learning opportunities in a variety of formats: webinars, lunch and learns, workshops, and one-on-one technical assistance on the establishment, growth, and sustainability of GSAs.

Objective C: Explore bullying prevention campaigns for CSHCS and determine goals for bullying prevention initiatives in Michigan.

The first strategy for this objective is to continue implementing the CSHCS Bullying Prevention Initiative grant program. During focus groups with the FLN, parents of CYSHCN identified peer-to-peer support groups as one of the most helpful strategies to decrease bullying for their children. In response to this finding, CSHCS launched the Bullying Prevention grants opportunity in FY 2020 and will continue this strategy in FY 2025. Grants of up to $5,000 are available to schools and school districts to create or expand a peer-to-peer support program within their school. Peer-to-peer programs are evidenced-based and result in decreased anxiety, increased sense of belonging and confidence, increased level of engagement in the school community, and friendships that extend beyond the school building. CSHCS will continue to partner with the Statewide Autism Resources and Training (START) project to provide resources and support to grantees. In addition, CSHCS will promote Family Center Parent Connect and Professional Connect calls to grant recipients.

The second strategy for this objective is to assess lessons learned from the grant program and determine opportunities to apply these lessons learned at a systemic level. In FY 2025, CSHCS will convene strategic evaluation sessions with the Bullying Prevention Initiative Committee members, and other stakeholders as identified, to assess current school bullying prevention policies, initiatives, and activities. The Bullying Prevention Committee includes youth and parent consultants, Michigan Department of Education, CSHCS Division Director, and CSHCS staff within the sections of the Family Center, Quality and Program Services, Customer Support, and Policy and Program Development. The committee will utilize the evaluation sessions to identify opportunities for lessons learned from the grant program to be embedded in the school/educational system to have a greater impact on bullying prevention across the state.

The final strategy is to share the grant program with Michigan organizations and other states. The Michigan ACE Initiative increases awareness about Adverse Childhood Experiences (ACE), implements strategies to prevent ACEs from occurring, and develops trauma-informed organizations across Michigan. In FY 2025, CSHCS will partner with the Michigan ACE Initiative to highlight the CSHCS Bullying Prevention Initiative. CSHCS will also submit the initiative to the MCH Innovations Database for consideration as an effective practice for decreasing bullying for CYSHCN.

This objective aligns with the “Blueprint for Change: A National Framework for a System of Services for CYSHCN” (“Blueprint”) in Health Equity and Family & Child Well-Being and Quality of Life critical areas of focus. Specifically, providing grants to schools aligns with Health Equity Principle 2 which encourages funding, delivering, and monitoring services and supports to reduce health disparities and improve health outcomes. The Peer-to-Peer aspect of the program aligns with the Family & Child Well-Being and Quality of Life Principle 1, specifically 1b, by promoting and supporting flourishing and peer-to-peer social connects and support for CYSHCN and their families.

Immunizations – Adolescents (FY 2025 Application)

Based on the 2020 Title V five-year needs assessment, the state performance measure (SPM) was retained, which is the “percent of adolescents 13 to 18 years of age who have received a completed series human papillomavirus (HPV) vaccine.” The HPV vaccine has the potential to save thousands of lives from HPV-related cancers. While Michigan has made progress increasing the timely uptake of HPV vaccination for adolescents, much more progress is needed. Further, the COVID-19 pandemic has greatly impacted vaccination rates across the lifespan.

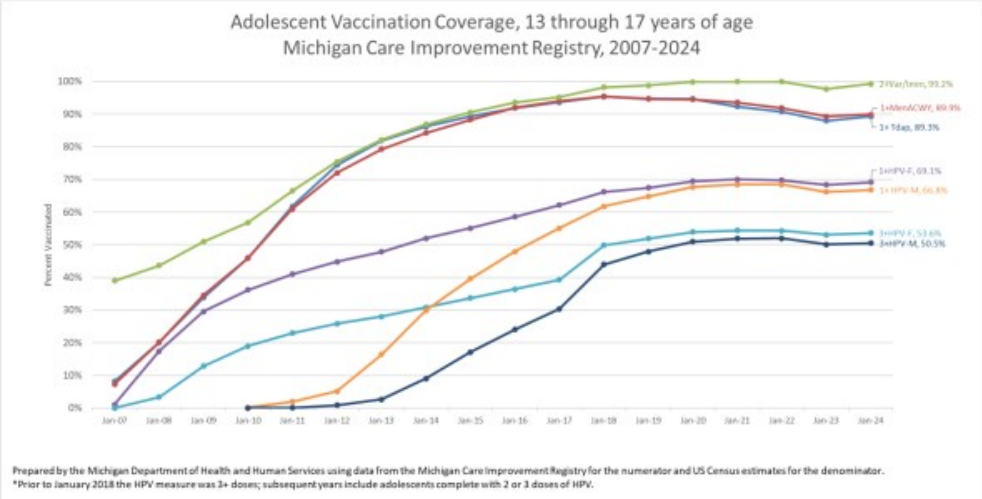
According to the Michigan Care Improvement Registry (MCIR), Michigan saw a decline in HPV vaccination rates from 44.1% in FY 2020 to 42.8% in FY 2021; largely attributed to the COVID-19 pandemic. For reference, the pre-pandemic level was 52.4% HPV completion rate in FY 2019. In FY 2022, however the HPV completion rate at 17 years of age increased to 44.2%. In FY 2023, the HPV completion rate remained relatively stable at 44.1%. While this number is still below pre-pandemic levels of 52.4% HPV completion rate in FY 2019, this trend upward is a good

sign that coverage may be steadily improving.

More specifically, data from the MCIR show as of January 2023, only 32.7% of adolescents have received a completed HPV series by 13 years of age. HPV vaccine is routinely recommended at age 11 or 12 years to protect against HPV infections that can cause cancers later in life. Timely vaccination of HPV vaccine remains a top priority for MDHHS and low HPV completion rates at this ideal age is concerning.

As seen in Image 1, HPV vaccination remains the lowest among all adolescent series vaccines, however, the disparity between males and females has decreased.

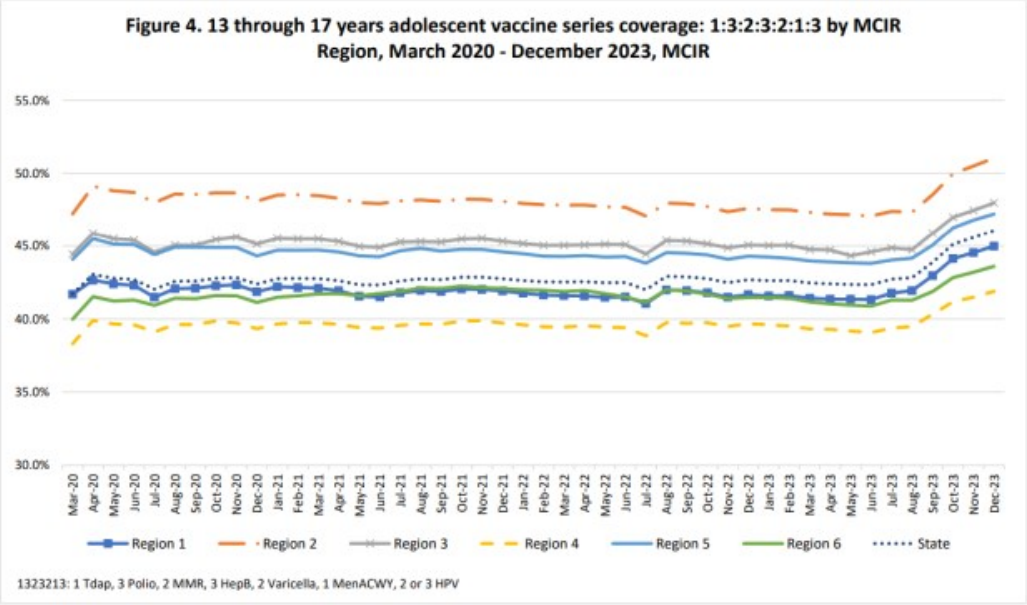
Image 1: Adolescent Vaccination Coverage, by Vaccine, 13-17 Years



Due to the impact of COVID-19 on all adolescent vaccinations, the Immunization Program plans to target all recommended vaccines for adolescents in FY 2025, with a focus on HPV vaccine. The pandemic has illustrated how diseases can severely impact the health of communities. Vaccines are developed to protect the health and well-being of individuals and minimize community spread. On-time vaccination of all recommended vaccines will lead to healthier Michigan adolescents.

According to MCIR, as of September 2023, 72.6% of adolescents 13-18 years of age who reside in Michigan have received the routinely recommended 1:3:2:3:2:1 adolescent vaccine series. The 1:3:2:3:2:1 vaccine series represents 1 dose of Tdap vaccine, 3 polio doses vaccine, 2 doses of MMR vaccine, 3 doses of hepatitis B vaccine, 2 doses of varicella vaccine, and 1 dose of meningococcal vaccine. When a complete series of HPV vaccine is added to the same series, the rate drops to 43%. Image 2 indicates that the adolescent vaccine series 1:3:2:3:2:1:3 falls below the desired protection for all recommended adolescent vaccines.

Image 2: Adolescent Series Vaccination Coverage, 13-17 Years



Specifically, two other adolescent-focused vaccines are concerning to the Immunization Program: influenza and meningitis B (MenB) vaccine. As illustrated by the COVID-19 pandemic, respiratory illnesses such as influenza are highly communicable and can be deadly. Every year Michigan's vaccination rates for influenza are sub-optimal and leave the community susceptible to disease. According to MCIR and data made available at www.michigan.gov/flu for the 2022-2023 influenza season, the vaccination coverage for all Michigan residents was 26.32%. Current season estimates, as of February 24, 2024, for the 2023-2024 influenza season indicate a statewide vaccination coverage of 25.14%. In addition, as of September 2023, adolescent vaccination coverage for 1+ MenB for adolescents 16-18 years was 27.1% (www.michigan.gov/immunize). It is critical to assess for all recommended vaccines and to collectively improve all adolescent vaccination rates. The Immunization Program plans to use Title V funds to support program work in improving HPV vaccination uptake and working with internal and external partners to improve influenza and meningitis B vaccination rates as illustrated in the activities below. Receiving all recommended vaccines, on-time, protects the health and well-being of Michigan adolescents and their communities.

Objective A: By 2025, increase the percentage of adolescents who have completed the HPV series to 64%.

The Forces of Change assessment in the 2020 needs assessment revealed that for some racial and ethnic groups, cultural barriers (such as historical trauma, language, or norms) may impact accessing mainstream health care. The System Capacity assessment also indicated that the MCH system has an opportunity for improvement in working with providers to establish trust with patients, especially minority families. It is important to address these concerns related to health equity and access to care, including vaccinations. The Michigan Immunization Program will assess possible strategies for engaging families and communities in the vaccine dialogue. Seeking expertise from families and consumers can help MCH systems and providers identify barriers to vaccine uptake and create vaccination messages that are culturally sensitive and linguistically appropriate, which may include different messages targeted to different population groups or geographical regions.

Using this information, the Immunization Program will update current HPV materials to reflect up-to-date vaccine changes and effective communication strategies to promote vaccination and make these materials available for providers. The Program will work with the MDHHS Office of Equity and Minority Health to ensure materials are culturally and linguistically inclusive. The Program will also provide updated translations of HPV materials to ensure a

more equitable approach in addressing HPV vaccine hesitancy. Providers and the public will be able to review these materials on the MDHHS Immunization website, www.michigan.gov/Immunize, and order materials for free at the MDHHS Clearinghouse, www.healthymichigan.com.

The COVID-19 pandemic has contributed to an increase in vaccine hesitancy for all vaccines. The Immunization Program will work with national partners, including Centers for Disease Control and Prevention, internal and local external partners to promote vaccine confidence among parents of this age group and adolescents themselves through resources, media, and presentations. Further, the Program will work closely with MDHHS Office of Communication and I Vaccinate on communication campaigns aimed at reducing vaccine hesitancy and improving vaccination uptake. These campaigns will occur statewide, with a focus on areas with lower vaccination rates.

MDHHS continues to be an active member in the Michigan HPV Alliance which includes partners from health systems, American Cancer Society, Karmanos Cancer Institute, local public health, and universities. The goal of this alliance to work collaboratively among the public and private sector to promote timely HPV vaccination, with the plan of hosting annual HPV Summits to provide education on HPV vaccine and HPV disease. It is vital that the Program works with partners to address any questions or concerns parents or adolescents may have about vaccinations and to promote vaccine confidence.

Further, the Program has made it routine to provide data and information to local health department clinic staff on coverage levels for patients in their immunization clinics and coverage levels at the county population level with the Michigan Immunization Report Cards. The Immunization Report Cards are posted on the MDHHS website at www.michigan.gov/Immunize and provide population-based immunization coverage levels for each county with rankings compared to other counties in Michigan.

The Michigan Immunization Program will analyze the MCIR data to identify disparities between the adolescent vaccines and to monitor the uptake of HPV vaccine and the adolescent vaccine series. The Program will emphasize that providers that see adolescents for vaccine visits need to assure they are strongly recommending all recommended vaccines and not missing an opportunity to administer the HPV vaccine.

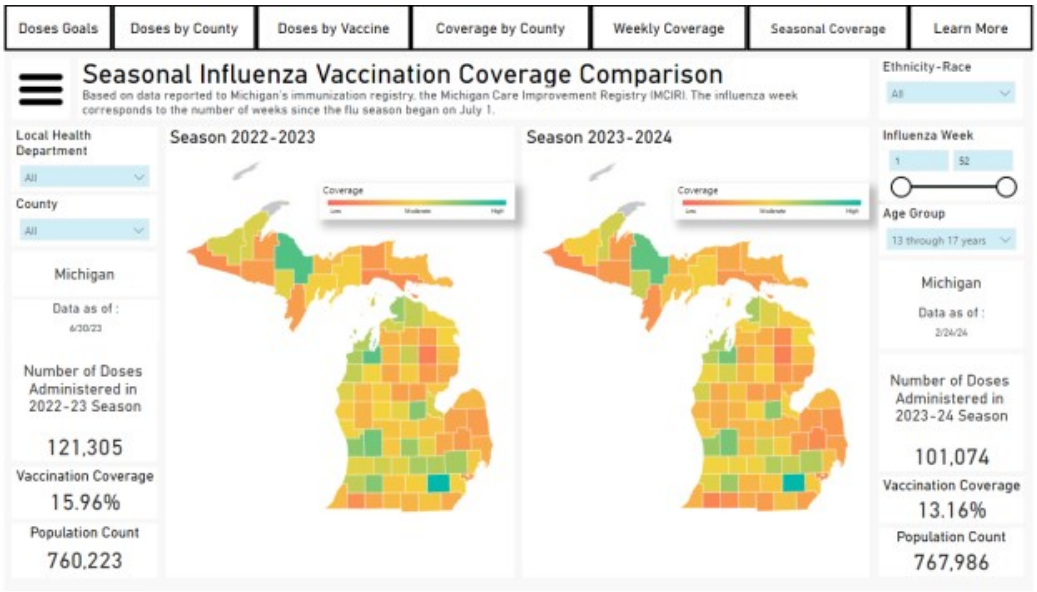
Finally, the Immunization Program aims to work more directly with the Alliance for Immunization in Michigan Coalition (AIM) to better engage families and communities through education and improvements to the aimtoolkit.org website. AIM's mission is to promote immunizations across the lifespan through a coalition of health care professionals and agencies. The AIM coalition continues its focus on improving all facets of immunization services in Michigan. As a result of the COVID-19 pandemic, the AIM coalition was essentially put on hold. As immunization rates continue to drop statewide, it is important to re-ignite this coalition and work collaboratively with private and public stakeholders to address vaccine hesitancy and improve vaccine uptake. AIM's website, aimtoolkit.org, is a place that provides education and promotes vaccination for both healthcare professionals and individuals and families. The Immunization Program has been working with AIM chairpersons to re-vamp AIM through the hiring of a new Immunization Coalition Coordinator. This Coordinator will be in his/her position and actively working to rebuild AIM in FY 2025. Utilizing the partnership, the Immunization Program will better connect resources directly with consumers.

Objective B: Emphasize routine assessment of all recommended vaccines for adolescents to increase influenza and meningococcal vaccine rates by 5% among this age group.

As discussed above, due to the impact of COVID-19 on all adolescent vaccinations, the Immunization Program plans to target all recommended vaccines for adolescents, in addition to HPV vaccine. The pandemic has illustrated how diseases, especially respiratory illnesses, can be deadly and wreak havoc on the health of communities. Vaccines are developed to protect the health and well-being of individuals and to minimize community spread. On-time vaccination of all recommended vaccines will lead to healthier Michigan adolescents.

In FY 2025, the Immunization Program will work with internal and external stakeholders on a statewide respiratory virus focused campaign to improve vaccination coverage among influenza, RSV and COVID-19 among all applicable ages. Every year Michigan's vaccination rates for influenza are sub-optimal and leave the community susceptible to disease. According to MCIR and data made available at www.michigan.gov/flu for the 2022-2023 influenza season, the vaccination coverage for all Michigan adolescents, 13-17 years of age, was 15.96%, below the statewide average of 26.32%. Current season estimates for the 2023-2024 influenza season indicate a statewide vaccination coverage of 13.16% among this age group, as illustrated in Image 3. This is extremely concerning to the Immunization Program and emphasizes that now is the time to target influenza vaccine, in addition to offering to COVID-19 vaccine, among this age group.

Image 3: Influenza Dashboard, Seasonal Influenza Vaccination Coverage, 13-17 Years



The COVID-19 pandemic has significantly impacted immunization rates at every age. The Immunization Program continues to produce a COVID-19 Impact Report to illustrate the impact the pandemic has had on childhood and adolescent immunization rates, while encouraging providers to catch Michigan children back up on recommended vaccines. The Immunization Program will continue to make the data available to local health departments so they can be better informed on areas for improvement as they work with immunization providers in their jurisdiction. Using the data from this report, the Program will generate and distribute a letter to Michigan healthcare providers highlighting the importance of catching adolescents back up on routine vaccines that they may have missed due to the COVID-19 pandemic. The Program will work collaboratively with organizations such as Michigan Chapter of the American Academy of Pediatrics and the Michigan Academy of Family Physicians to generate, distribute, and promote this letter among healthcare personnel in the state.

Various studies and Michigan's experience indicate that clinical staff tend to overestimate the immunization rates for their practice. Offering vaccination coverage feedback during annual quality improvement visits, based on MCIR data, is insightful to provider offices and enables staff to consider recommendations to improve how vaccines are promoted and administered. The Immunization Program will work with local public health to offer quality improvement visits to providers, emphasizing on-time HPV vaccination, and provide a comprehensive assessment of

immunization rates and recommendations for practice improvements.

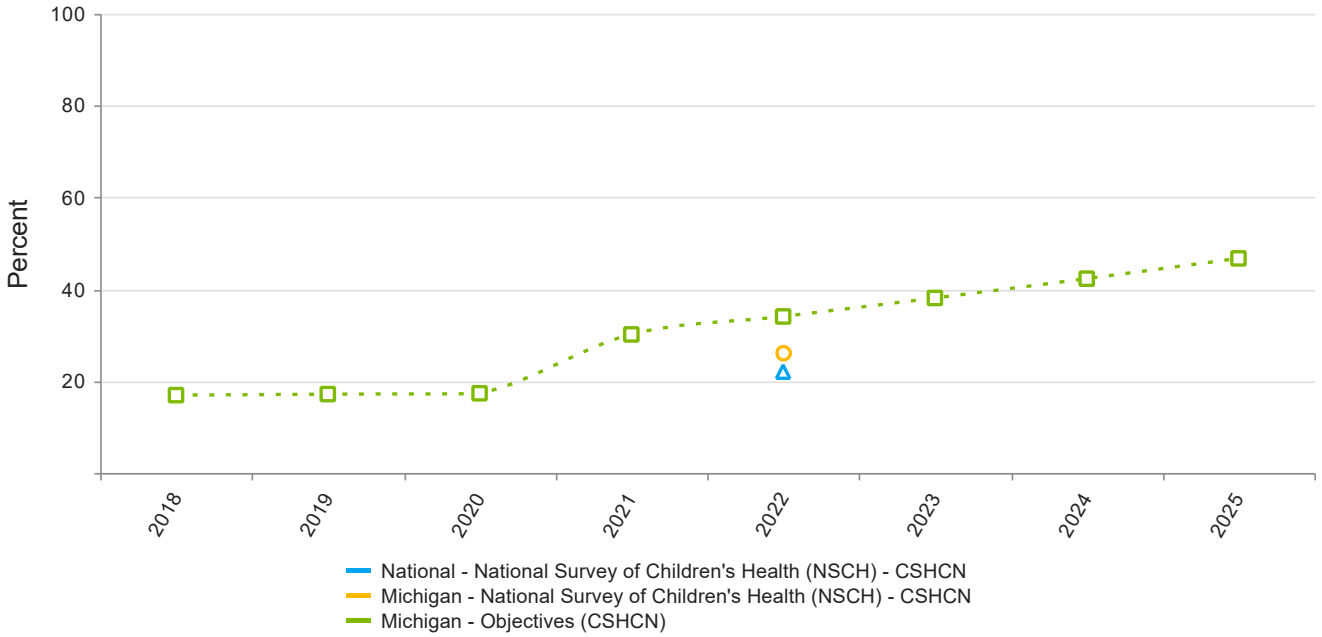
Finally, the Immunization Program will work with external stakeholders to conduct targeted outreach to improve meningitis B vaccination rates for adolescents 16 through 18 years of age. Although it is uncommon, meningitis B (MenB) is a serious infection caused by the bacterium Neisseria meningitidis group B, which can cause an infection of the membrane that surrounds the brain and spinal cord. Although most people recover, even with appropriate treatment, up to 1 in 10 patients will die, sometimes within 24 hours after the onset of symptoms. Further, up to 1 in 5 survivors of meningitis will experience long-term consequences including hearing loss, skin scarring, neurological problems, or limb loss. While most people are familiar with MenACWY vaccine, many are unaware that there are two meningitis vaccines needed to protect adolescents from all serotypes of meningitis. The Michigan-based Emily Stillman Foundation has combined forces with the Meningitis B Action Project to raise awareness for Meningitis B vaccine. The Immunization Program plans to work with these organizations to conduct targeted outreach to Michigan adolescents and their parents to improve Meningitis B vaccination rates. As of September 2023, adolescent vaccination coverage for 1+ Meningitis B for adolescents 16-18 years was only 27.1% (www.michigan.gov/immunize). In comparison, the vaccination rate for 1+ MenACWY for adolescents 13-17 years of age was 76.6%.

It is important to assess for all recommended vaccines and to collectively improve all adolescent vaccination rates. Michigan plans to use statewide quarterly immunization report cards to monitor vaccination uptake for HPV vaccine, adolescent series (1:3:2:3:2:1:3) vaccination coverage, 1+MenB and 1+ Flu (6 months – 17 years) to assess the impact of these strategies.

Children with Special Health Care Needs

National Performance Measures

NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR
Indicators and Annual Objectives



NPM TR - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	17.2	17.4	30.2	34.1	38.1
Annual Indicator	21.6	32.3	26.7	20.0	26.2
Numerator	48,634	69,326	54,089	40,729	54,973
Denominator	225,148	214,341	202,891	204,129	209,680
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2017_2018	2018_2019	2019_2020	2020_2021	2021_2022

Annual Objectives		
	2024	**2025**
Annual Objective	42.3	46.7

Evidence-Based or –Informed Strategy Measures

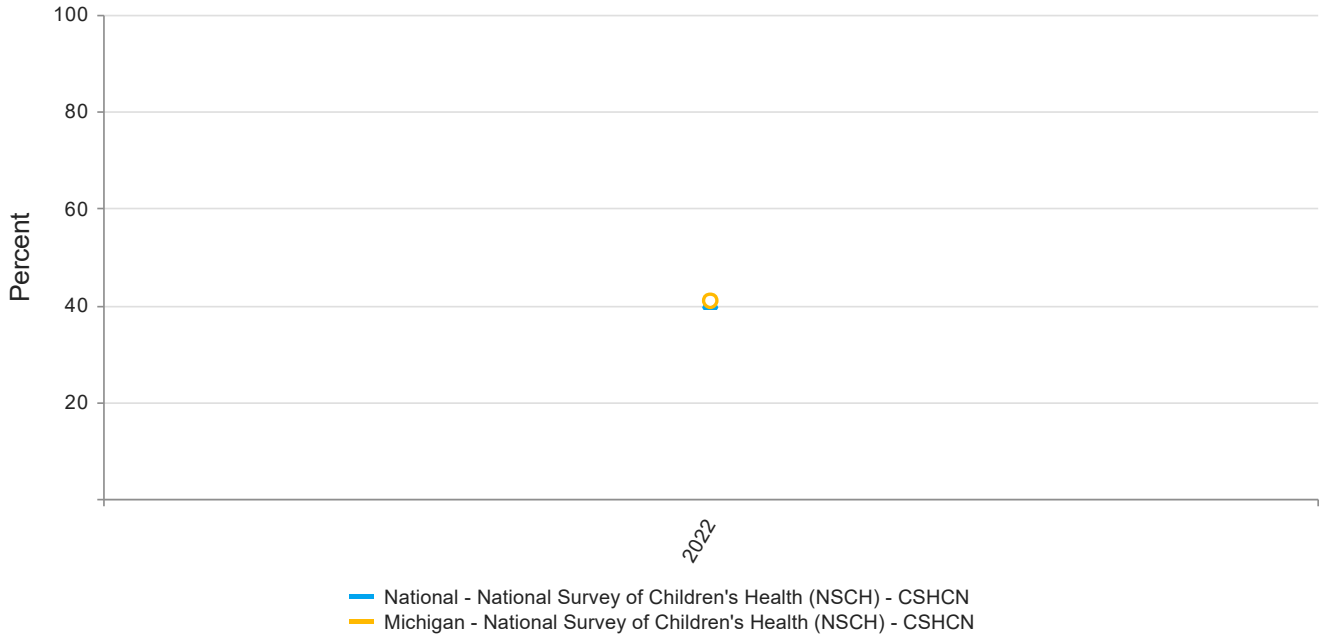
ESM TR.2 - Percentage of CSHCS partner organizations whose total score increased on the Assessment of Health Care Transition Activities.

Measure Status:	Active

State Provided Data		
	2022	2023
Annual Objective		
Annual Indicator		48.9
Numerator		22
Denominator		45
Data Source		Health Care Transition Activities Survey
Data Source Year		2023
Provisional or Final ?		Provisional

Annual Objectives		
	2024	2025
Annual Objective	40.0	50.0

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH
Indicators and Annual Objectives



NPM MH - Children with Special Health Care Needs

Federally Available Data	
Data Source: National Survey of Children's Health (NSCH) - CSHCN	
	2023
Annual Objective	
Annual Indicator	41.0
Numerator	179,054
Denominator	436,273
Data Source	NSCH-CSHCN
Data Source Year	2021_2022

Evidence-Based or –Informed Strategy Measures

None

State Performance Measures

SPM 4 - Percent of children with special health care needs enrolled in CSHCS that receive timely medical care and treatment without difficulty

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective	91.9	92.9	89.5	90	90.5
Annual Indicator	88	88	88.6	88.4	87.7
Numerator	10,365,782	7,297,774	4,977,264	5,731,114	7,007,152
Denominator	11,783,520	8,289,380	5,616,000	6,481,200	7,993,764
Data Source	CAHPS	CAHPS	CAHPS	CAHPS	CAHPS
Data Source Year	2019	2020	2021	2022	2023
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	91.0	91.5

State Action Plan Table

State Action Plan Table (Michigan) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Ensure children with special health care needs have access to continuous health coverage, all benefits they are eligible to receive, and relevant care where they learn and live	
NPM	
NPM - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	
Five-Year Objectives	
A) By 2025, increase the percent of CYSHCN ages 12 and older receiving services necessary to transition from pediatric to adult health care from 21.6% to 25%	
B) By 2025, increase by 10% the number of partner organizations that reach the next level on the Got Transition "Assessment of Health Care Transition Activities"	
Strategies	
A1) Establish a Transition Advisory Collaborative to guide the development of a Michigan HCT framework for health care providers A2) Continue serving on the Michigan Interagency Transition Taskforce (MITT) to ensure HCT is included in the Michigan Model for Secondary Transition and collaborate on creating transition resources A3) Provide HCT resources and education to partners and stakeholders and promote the CSHCS Transition to Adulthood website A4) Continue to contract with U of M CHEAR to monitor transition data A5) Utilize the MHP contract, site review, and compliance review processes to improve HCT for CYSHCN enrolled in MHPs A6) Utilize the LHD accreditation processes to improve HCT for CSHCS enrollees	
B1) Annually implement the "Assessment of Health Care Transition Activities" with CSHCS partner organizations and provide HCT resources and education based on need reflected in assessment data B2) Develop and track an Evidence-informed Strategy Measure (ESM) for the "Assessment of Health Care Activities"	
ESMs	**Status**
ESM TR.1 - Percent of CSHCS clients age 18 to 21 years in selected diagnosis groups that have transferred care from a pediatric to an adult provider	Inactive
ESM TR.2 - Percentage of CSHCS partner organizations whose total score increased on the Assessment of Health Care Transition Activities.	Active

NOMs

NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC

State Action Plan Table (Michigan) - Children with Special Health Care Needs - Entry 2

NPM

NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH

Five-Year Objectives

A) By 2025, explore existing medical home activities in Michigan and identify program opportunities

Strategies

A1) Analyze medical home metrics for disparities A2) Collaborate with statewide partners to identify strategies to increase utilization of the medical home model for clinics in Michigan A3) Develop an action plan to increase the number of clinics that meet medical home criteria

ESMs	Status

No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.

NOMs

This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.

State Action Plan Table (Michigan) - Children with Special Health Care Needs - Entry 3

Priority Need

Ensure children with special health care needs have access to continuous health coverage, all benefits they are eligible to receive, and relevant care where they learn and live

SPM

SPM 4 - Percent of children with special health care needs enrolled in CSHCS that receive timely medical care and treatment without difficulty

Five-Year Objectives

A) By 2025, increase the percentage of CSHCS CAHPS' respondents who rate their health care with a top box score of 9 or 10 from 71.9% (2019) to 75%

B) By 2025, increase by 10% the number of meaningfully engaged community partners (families, youth, LHDs, CAC members, contractors, clinic sites, health care providers, other professionals, etc.) to improve knowledge of the CSHCS program

C) By 2025, improve the percentage of CSHCN who report receiving care in a well-functioning system from 17.8% to 20.3%

Strategies

A1) Continue implementing special programs to reduce financial burdens for CSHCS-eligible families A2) Expand the capacity of specialty clinics to provide delivery of patient-centered, family-friendly, equitable care through Children's Multi-Disciplinary Specialty (CMDS) clinics A3) Disseminate findings and project successes of the HRSA-funded Children and Youth with Epilepsy (CYE) grant

B1) Continue building and implementing a coordinated and systematic approach to family engagement B2) Continue implementation of a multi-staged approach to improve provider engagement B3) Maintain a competent workforce that is knowledgeable about CSHCS and able to assist families accessing the system of care

C1) Implement a statewide targeted case management benefit to improve care for children with medical complexity (CMC) C2) Continue monitoring the comprehensive evaluation to assess and improve CSHCS's capacity and ability to provide effective, efficient, and high-quality services to clients C3) Implement initiatives so that CSHCS families receive care coordination in a high-quality, family-centered, and well-functioning system C4) Improve the system of care by identifying and responding to health inequities

CSHCN Overview

Children with special health care needs (CSHCN) include children with a wide variety of physical, emotional, and behavioral conditions, some of which qualify to receive support through the Children's Special Health Care Services (CSHCS) program within MDHHS. CSHCS annual program enrollment has grown to more than 50,000 beneficiaries. Although there is an annual fee to enroll in CSHCS, the fee is waived if the client has Medicaid, MIChild, Healthy Michigan Plan, a court-appointed guardian, or lives in a foster home. The fee, which includes six possible payment levels paid through a payment agreement, is based on family income and family size. The lowest payment level is $120 for individuals below 20% of the Federal Poverty Level (FPL), and the highest level is $2,964 for those above 500% of FPL.

The CSHCS Division is housed in the Bureau of Medicaid Care Management and Customer Service. The CSHCS Division includes the Family Center for Children and Youth with Special Health Care Needs (Family Center), which is parent-directed and designed to support and connect families with the care they need using a family-centered approach. CSHCS also includes sections focused on customer support, policy and program development, quality and program services, and the special needs fund.

For the CSHCN population, Title V funds are primarily used to support medical care and treatment for CSHCN. This could also include dental services when related to a qualifying diagnosis for which CSHCS covers dental care. Title V funds are also used to support bullying prevention activities specific to CSHCN. Other federal funds that support CSHCS include a HRSA Epilepsy grant and Medicaid. Key partners include Medicaid, Medicaid Health Plans, local health departments (LHDs), service providers, CSHCN and their families, the CSHCS Advisory Committee, the Family Leadership Network, Michigan Family to Family Health Information Center, and Michigan Family Voices.

In addition to direct CSHCS funding, LHDs can elect to expend additional Local MCH (LMCH) dollars for CSHCN. In FY 2023, two LHDs selected NPM 12 (transition) to identify enrollees of transition age and provide education and plans of care for gap-filling transition services. Additionally, four LHDs used LMCH funds to address SPM 4 (medical care and treatment for CSHCN) by providing gap-filling case management services, assistance with CSHCS enrollment, outreach, and monthly newsletters. Agencies report staff burnout and loss of program staff during the year which also impacted services. One agency planned to provide mental health services (SPM 6) for CSHCN but was only able to provide limited services because it was difficult to fill the position.

Michigan's approach to improving the health and well-being of CSHCN focuses on access to care coordination/case management, continuous health coverage, and program benefits. Services offered are patient-centered/family friendly, culturally appropriate and coordinated. These attributes are reflected in all CSHCS services, including those specific to health care transition. In the current five-year cycle, the CSHCS program also began to work on bullying prevention for CSHCN which is included in the NPM 9 (Bullying) state action plan.

Transition (FY 2023 Annual Report)

The Title V Maternal & Child Health Needs Assessment Report completed in 2020 identified opportunities related to transition to adult health care for CYSHCN in Michigan. According to the 2020-2021 National Survey of Child Health (NSCH), only 20.0% of CYSHCN in Michigan had the support needed to transition to adult care. Focus groups and encounter surveys noted silos in communication across providers and provider turnover as challenges that contribute to difficulties with transition to adult health care.

To address this NPM, CSHCS created and implemented a comprehensive strategic plan to improve health care

transition across the state. Accomplishments in FY 2023 include Medicaid Health Plan (MHP) contract revisions to expand Health Care Transition (HCT) activities, creation of a HCT Resource Manual for Local Health Departments (LHDs), and administration of an Assessment of HCT Activities survey with LHD and MHP partners. CSHCS also presented on HCT for the Family Center (FC) Parent Connect Call, FC Parent Mentor Meeting, LHD collaborative call, CSHCS Advisory Council, and was invited by Got Transition to co-present at AMCHP. CSHCS continued collaboration efforts with the Michigan Interagency Transition Taskforce (MITT) to integrate health care transition into the Michigan Secondary Transition Model.

Key collaborations and partnerships include the Michigan Interagency Transition Taskforce (MITT), MHPs, LHDs, MDHHS Child and Adolescent Health Centers (CAHC), The Family Center for Children and Youth with Special Health Care Needs (Family Center), Children and Youth with Epilepsy (CYE) grant recipients, and Got Transition. Title V funds support the partnership with LHDs through care coordination and case management services, which include health care transition activities. Transition is also included as a Minimum Program Requirement during the LHD accreditation process.

Staff shortages and turnover for LHDs continued to create challenges in moving health care transition work forward. LHD staff resources continued to be redirected to the COVID-19 pandemic response, limiting their availability to work with youth on health care transition services. In response, CSHCS focused on streamlining transition resources that are available in the virtual environment and adjusting strategies to allow flexibility for partners.

Objective A: By 2025, increase the percent of CYSHCN ages 12 and older receiving services necessary to transition from pediatric to adult health care from 21.6% to 25%.

The first strategy was to establish the foundation to expand the school wellness center learning collaborative to promote HCT to students, grades 9-12, through school-based health clinics. Due to the significant growth within the Child and Adolescent Health Center programs in FY 2023, which included onboarding many new site partners, there was a delay in the collaborative efforts on HCT. During this time, CSHCS connected with the Michigan Association of School Nurses and the State School Nurse Consultant to provide program and transition to adulthood information to school nurses across the state at their annual meeting. More than 85 school nurses attended. As a result of the presentation, CSHCS continues to meet regularly with the State School Nurse Consultant and provide information to school nurses.

The second strategy for this objective was to launch and promote the revised CSHCS Transition to Adulthood website with HCT resources. CSHCS formed a committee in FY 2021 that included youth, family, and stakeholder representation to provide diverse input into the website format and content. The new homepage was simplified with links to access the following four categories: Youth and Young Adults; Parents, Caregivers and Family; Health Care Teams (Providers, LHDs, and MHPs); and Resources. Content for HCT was updated to be consistent with Got Transitions Six Core Elements of Health Care Transition 3.0 and the website was expanded to include non-health care transition resources. The revised webpage was launched in FY 2022. In FY 2023, the CSHCS transition webpage was reviewed, and additional links were added. The transition webpage was promoted during internal and external agency meetings and all HCT presentations, including AMCHP.

The third strategy was to continue the partnership with the University of Michigan Child Health Evaluation and Research (UM-CHEAR) unit to provide ongoing analyses of the transition ESM 12.1. This ESM provides data on the percent of CSHCS clients ages 18 to 21 years of age in selected diagnosis groups that have transferred care from a pediatric to adult provider. The measure is based upon selected groups that include cardiology, endocrinology, gastroenterology, hematology-oncology, nephrology, neurology, pulmonology, and rheumatology. The measure combines data from three sources: 1) CSHCS database; 2) CHAMPS (Medicaid claims); and 3) UM-CHEAR

provider database which includes providers statewide. In FY 2023, UM-CHEAR reported 43.8% of targeted clients had encounters with only adult providers indicating those clients had a successful transition to the adult model of care.

Although there was a slight increase in ESM 12.1 for FY 2023, the ESM data has collectively shown incremental decreases in successful transition from pediatric to adult providers. The decrease in ESM 12.1 data corresponds with a change in the transition transfer of care policy at Michigan Medicine. In 2019, Michigan Medicine moved the target transition age from age 18 to age 21. Since this ESM targets transfer of care by age 21, this policy directly impacts the ESM results. In FY 2023, CSHCS retired this specific ESM due to this policy change. CSHCS will continue to collaborate with CHEAR to monitor transition work and evaluate additional ESM opportunities.

The fourth strategy for this objective was to pilot an automated HCT letter for 14-year-old enrollees to align with the recommendations from Got Transition, utilizing the CSHCS database. In FY 2022, the automated letter was finalized and piloted successfully in the CSHCS database system. To improve consistency and enable the creation of transition reports for LHDs, the next phase of this project included changing the generation of the existing automated transition letters (for ages 16, 17, 18 and 21) from the Community Health Automated Medicaid Processing System (CHAMPS) database to the CSHCS database system. This phase is currently on hold due to anticipated database changes and funding limitations. Transition reports will continue to be manually created for LHDs to guide their health care transition activities.

The final strategy for this objective was to utilize the MHP contract, site review, and compliance review processes to improve HCT for CYSHCN enrolled in MHPs. The CSHCS Transition Specialist was a panelist for the FY 2023 site reviews to discuss HCT with each MHP. Contract language was revised to expand HCT activities for CYSHCN and align with Got Transition's "Medicaid Managed Care Contract Language to Expand the Availability of Pediatric-to-Adult Transitional Care" document. Additional compliance review requirements on HCT were also added. These changes were approved in FY 2023 with implementation to begin in FY 2024.

Objective B: By 2025, increase by 10% the number of health care professionals who have received training on transition from pediatric to adult health care.

The first strategy for this objective was to implement a marketing plan to promote Got Transition's health professional courses to providers across the state. CSHCS convened with key team members from Got Transition in FY 2023. Due to changes within Got Transition, the professional course, and Continuing Education Unit (CEU) certification were not able to be updated. CSHCS will research alternative methods in FY 2024 to move forward with this strategy.

The second strategy included supporting the HRSA CYE grant partners in their activities to improve transition for children and youth with epilepsy in rural and underserved communities. During FY 2023, one-on-one calls were conducted with each CYE clinic partner to discuss strategies and resources they use to support their adolescent patients with successful transition. Project partner clinics are using a variety of methods to support their patients such as incorporating readiness assessments into their EMR, developing and distributing brochures and patient folders, and implementing new clinic workflows. The cross-site provider survey indicated 56% of partner clinic sites increased the number of transition readiness assessments completed in the prior year; however, across all sites the overall number of transition readiness assessments decreased by 14.5% from FY 2022 to FY 2023. Both pediatric and adult providers continue to face challenges with the integration of the health care transition assessment due to competing priorities and assessments.

The third strategy for this objective was to identify opportunities to improve transition to adult health care for patients with sickle cell disease. In October 2021, CSHCS expanded enrollment eligibility to include individuals aged 21 and

over with sickle cell disease. By FY 2023, this expansion resulted in the CSHCS enrollment of 578 adults with sickle cell disease. The CSHCS transition specialist is a member of the Hemoglobinopathy Quality Improvement Program and formed a collaboration with a sickle cell transition clinic lead from Detroit Children's Hospital to work towards completion of a sickle cell disease clinic toolkit. The goal of the toolkit is to provide health care transition guidance and sickle cell disease specific resources. Work will continue in FY 2024 to finalize the clinic toolkit and commence a pilot project for implementation of the toolkit with sickle cell clinics in FY 2025.

The final strategy for this objective was to continue working with the Michigan Interagency Transition Taskforce (MITT) to ensure HCT is included within the Michigan Model for Secondary Transition. This taskforce is a state level collaborative infrastructure that align supports and services to ensure a seamless transition for all students with disabilities in the K-12 system (up to age 26) into adult life. Committee representation includes the Department of Education, Disability Rights Michigan, Developmental Disabilities Council, Department of Labor and Economic Opportunity, the Arc Michigan, Michigan Alliance for Families, Statewide Independent Living Council, Wayne State University Developmental Disabilities Institute, Statewide Autism Resources and Training (START), Michigan Transition Services Association, and Michigan Disability Rights Coalition. In FY 2022, the taskforce finalized the model, which included a section on HCT. The CSHCS transition specialist continued to serve as a member of MITT and was an integral part of creating a Youth Engagement Subcommittee to embed youth voice into the Michigan Model. Subcommittee members include representation from the Developmental Disabilities Council, Statewide Independent Living Council, and the Family Center youth consultant. In FY 2023, focus group sessions were held to obtain parent/caregiver feedback, and a compilation of resources for the creation of a Youth and Family Transition guide were obtained. Plans for FY 2024 include continued integration of youth and parent voice and initiation of a pilot site to rollout the Michigan Model for Secondary Transition.

Objective C: By 2025, increase by 10% the number of partner organizations that reach the next level on the *Got Transition* "Current Assessment of Health Care Transition Activities."

To improve the ability to measure improvements in transition related activities, CSHCS' first strategy was to implement Got Transition's Assessment of Health Care Transition Activities with LHD partners. With the guidance and approval of Got Transition, the HCT assessment was revised to accurately depict transition activities performed by LHDs. CSHCS further collaborated with Michigan State University-Institute for Health Policy (MSU-IHP) to create an electronic version of the assessment in Qualtrics, distribute the assessment survey to LHDs, and analyze the results. In FY 2022 the electronic survey was created and sent to all 45 LHDs, which generated 100% participation. FY 2023 activities included analysis of the FY 2022 baseline data, disseminating individualized data reports to each LHD, and co-presenting the data findings with MSU-IHP during an LHD collaborative call. The feedback received from the FY 2022 survey was utilized to make enhancements, such as revisions of CSHCS transition documents and the creation of an LHD Transition Resource Manual. Year two of the HCT Assessment Survey was also disseminated in FY 2023 and generated 100% participation. Comparison of the data results reflect 22 of the 45 LHDs (more than 48%) showed improvement in their overall assessment score from FY 2022 to FY 2023, as indicated in ESM 12.2.

Additionally, the CSHCS Transition Specialist was invited by Got Transition to co-present on "What Does Health Care Transition Look Like in Your State?" during the 2023 Association of Maternal & Child Health Programs (AMCHP) annual conference. The session explored the latest national data, five years of state care coordination assessment results, and the innovative work on HCT assessments in Michigan. The session was well attended with 51 attendees. Due to the interest received, CSHCS and Got Transition hosted a second webinar, which was promoted by both AMCHP and Got Transition and had 95 attendees. Replication of the HCT assessment process will be initiated with MHPs and a third year for LHDs in FY 2024.

The Assessment of HCT Activities was also implemented with clinical partners at the annual CYE meeting. CSHCS

continues to support the HRSA CYE grant partners in this second strategy. Each year, the CYE committee hosts a meeting to discuss upcoming components of the grant, hear from an epilepsy panel which includes youth with epilepsy and their parents, and share best practices identified in their individual projects. The CSHCS Transition Specialist presented information on HCT and shared how MHPs, LHDs, and providers could collaborate on transition for youth. Each year clinical partners complete an Assessment of HCT Activities survey and progress is monitored. Analysis of the data reflected a 40% increase in the number of level three and four (with four being the highest rating) scores that were obtained from the annual transition assessment from FY 2020 to FY 2023.

Medical Care and Treatment for CSHCN (FY 2023 Annual Report)

The mission of CSHCS is to find, diagnose, and treat children and some adults who have chronic illnesses or disabling conditions, enabling them to achieve improved health outcomes and enhanced quality of life. CSHCS accomplishes this mission by reducing barriers to medical care and treatment for CYSHCN and minimizing financial burdens for families. Michigan's SPM for the CYSHCN population measures the percentage of CYSHCN enrolled in the CSHCS program that receive timely medical care and treatment without difficulty. CSHCS utilizes two survey questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to measure this SPM. In FY 2023, 87.7% of CSHCS CAHPS respondents gave top box ratings of 'usually' or 'always' to questions related to getting care and treatment when needed.

Accomplishments in FY 2023 included beginning the process of incorporating the Family Center into civil service from contract status, continuing enrollment of adults with sickle cell disease into the CSHCS program, continuing the Expanding Equity in CSHCS Project that included data analysis for health disparities, expanding Children's Multi-Disciplinary Specialty (CMDS) clinics, and continuing progress towards establishing a Children with Medical Complexity (CMC) benefit.

Key CSHCS partners include the Project ACCELERATE, Family Voices, MDHHS Lifecourse Epidemiology and Genomics Division (LEGD), Bureau of Children's Coordinated Health Policy and Services (BCCHPS), Michigan State University-Institute for Health Policy (MSU-IHP), Medicaid Health Plans (MHPs), and Local Health Departments (LHDs). Approximately 35% of Michigan's Title V FFY 2023 expenditures supported 10,783 CYSHCN that are not eligible for Medicaid and experience broad system coverage gaps.

Challenges faced this fiscal year included provider and LHD staff shortages which continued to create challenges for the CSHCS population, navigating the intricacies of a complex system of care, and understanding the pros and cons of the various Medicaid authorities and opportunities to support CMC.

Objective A: By 2025, increase the percentage of CSHCS CAHPS' respondents who rate their health care with a top box score of 9 or 10 from 71.9% (2019) to 75%.

The first strategy was to continue implementing the CSHCS program to improve access to specialty medical services, case management, and care coordination while reducing financial burdens for CSHCS clients and families. The CSHCS program provides a medical care and treatment benefit to improve access to specialty care for a client's qualifying condition. In FY 2023, CSHCS covered an average of 46,396 individuals each month. Enrollees had at least one of the more than 2,500 qualifying diagnoses with 31.1% of enrollees having more than one severe, chronic health condition. Average monthly CSHCS enrollment increased by 13% from FY 2022.

The Insurance Premium Payment Benefit (IPPB) assists clients in maintaining comprehensive private health insurance coverage by paying the client's portion of the insurance premium. Determination is based on financial need and cost-effectiveness for CSHCS. In FY 2023, CSHCS provided $303,504 in health insurance premium payments for 168 families.

The Non-Emergency Medical Transportation (NEMT) benefit assisted clients in accessing specialty care by covering qualifying travel expenses. The 2023 CAHPS survey indicated that 7.9% of respondents requested transportation assistance from CSHCS. Of these, 83.2% of respondents reported the assistance "Usually" or "Always" met their needs. In FY 2023, CSHCS processed $187,350 in claims to commercial vendors and $1,262,388 to clients/families for NEMT.

The Michigan Children with Special Needs Fund (CSN Fund) is a privately funded program within CSHCS that was created to help CYSHCN when other funding sources are not available. The Fund helps children obtain necessary equipment they cannot afford. In FY 2023, the fund awarded $480,587 to assist 134 CYSHCN with specialized equipment and services.

The second strategy was to expand the capacity of specialty clinics to support the delivery of patient-centered, family-centered, equitable care through CMDS clinics. These clinics offer a highly coordinated, interdisciplinary approach to the management of specified complex medical diagnoses. CSHCS supports 36 CMDS clinics in nine tertiary care and teaching hospitals. In FY 2022, CMDS clinics reported 4,041 client encounters with more than $421,000 of enhanced reimbursement provided to clinics. In FY 2023, five additional CMDS clinics were added to the CSHCS network.

In October 2021, Michigan expanded CSHCS eligibility to include adults with sickle cell disease (SCD). The goal is to improve health outcomes and reduce health disparities for this population, especially young adults who have experienced challenges transitioning to adult medical care. As of September 2023, 578 adults with SCD were enrolled in CSHCS who were not eligible before the expansion. Through a partnership with the Michigan Sickle Cell Data Collection (MiSCDC) program, CSHCS will work to identify additional individuals eligible for CSHCS in FY 2024.

The final strategy for this objective is to expand and support the use of telemedicine to improve access to specialty care in rural and underserved areas. This is accomplished through the HRSA Children and Youth with Epilepsy (CYE) grant which utilizes telehealth strategies to increase access to care for youth with epilepsy. During one-on-one calls, the CYE leadership team discussed each of the project focus areas with clinic teams including the use of telehealth. Seventy percent of clinic partners utilize telehealth for patients facing issues such as transportation, chronic illness, distance, last-minute appointment cancellations, and consultations. All CYE clinic partners indicated an interest in sustaining telehealth as an option for patients in varying circumstances.

Objective B: By 2025, increase by 10% the number of meaningfully engaged community partners (families, youth, LHDs, CAC members, contractors, clinic sites, health care providers, other professionals, etc.) to improve knowledge of the CSHCS program.

The first strategy was to continue building a coordinated and systematic approach to family engagement which is accomplished through the work of the Family Center. The Family Center is a statewide, parent-directed center within CSHCS that offers emotional support, information, and connections to community resources for families of CYSHCN. In FY 2023, the Family Center fielded over 8,500 calls for information and resources from families, LHDs, and providers.

The Family Center includes a youth consultant who helps to embed youth voice into the CSHCS program and assists with outreach efforts. The youth consultant serves on the CYE advisory committee and the Youth Engagement Program planning committee. In FY 2023, the youth consultant presented on "improving clinical team participation for CYE" at the AMCHP conference, and "shared decision making" at both the AAP National Coordinating Center for Epilepsy Advisory Committee Conference and at the Epilepsy Foundation of Michigan's Back to School conference.

The Family Center continued to facilitate quarterly meetings with the Family Leadership Network (FLN) in collaboration with the MI Family to Family Health Information Center to obtain diverse perspectives from families of CYSHCN. The FLN is composed of up to two FLN members from each of Michigan's 10 Prosperity Regions to provide caregiver input on programs and special projects.

The Family Center offered Parent and Professional Connect Calls and other trainings in a virtual environment during this grant cycle. The Family Center offered 52 trainings and presentations in FY 2023 which provided families and professionals with support, resources, and information on caring for CYSHCN. In addition, 31 parents were trained as parent mentors, and 11 parent-to-parent matches were made.

To promote education and advocacy, the Family Center continued to offer scholarships for camp and conferences to CYSHCN families. Conference scholarships were available for parents/youth to attend a conference related to the CYSHCN's diagnosis. In FY 2023, 14 conference scholarships were granted. Summer camp scholarships provide up to $250 for CYSHCN to attend a Michigan-licensed summer camp. In FY 2023, 60 camp scholarships were awarded.

The second strategy was to continue implementing a multi-staged approach to improve provider engagement. In FY 2023, the CSHCS Outreach and Engagement Analyst utilized an electronic mailing list to disseminate satisfaction surveys and provide additional resources to CSHCS providers. In FY 2023, 447 individuals participated in Family Center Provider Connect Calls.

CSHCS leveraged the relationships built and lessons learned through the provider survey activities in FY 2019-FY 2021 to engage providers in conversations about the proposed CMC program. Facilitated by MSU-IHP, CSHCS held three stakeholder sessions with C.S. Mott, Helen DeVos, and Children's Hospital of Michigan to obtain feedback on the CMC model. Participants were asked about anticipated challenges to implementing a CMC program, their ability to make eligibility determinations, the anticipated timeframe required for beneficiary enrollment, the role of telemedicine in providing CMC services, and suggestions for the current CMC program description draft.

The final strategy was to maintain a competent workforce that is knowledgeable about the CSHCS program and able to assist families in accessing the system of care. This is accomplished through monthly LHD calls, orientation webinars, written informational and alert communication, CSHCS website, and annual regional trainings for LHDs and MHPs. In FY 2023, the CSHCS annual training focus was leukemia. This virtual training included specialist providers detailing treatment guidelines and palliative care; a social worker who shared information on social care and support; and a family panel which provided both parent and teen perspective on living with leukemia. Post-meeting surveys indicated 100% of survey respondents agreed or strongly agreed that the training improved their knowledge of the complexities of caring for individuals with leukemia. CSHCS collaborates with MSU-IHP for this training.

Objective C: By 2025, improve the percentage of CSHCN who report receiving care in a well-functioning system from 17.8% to 20.3%.

The CSHCS team continued to develop a model of care for Michigan's CMC to improve health outcomes and quality of life while minimizing hospitalizations and reducing healthcare costs. In FY 2023, CSHCS completed participation in Project ACCELERATE (Advancing Care Coordination *through* Evidence; Leveraging Existing Relationships Around Transforming PracticE). The CSHCS team for Project ACCELERATE included the CSHCS Division Director, the Physician Manager for MDHHS Office of Medical Affairs, the Section Manager for the CSHCS Family Center, and other key CSHCS team members responsible for the CMC program. The team learned about the latest PCORI-supported findings for enhanced care coordination for CYSHCN. Also, in FY 2023, CSHCS was invited to

participate in the National Center for a System of Services for CYSHCN Phase 1 Pilot Learning Collaborative to help inform and develop the Blueprint Implementation Roadmap by testing innovations and strategies related to systems of services for CYSHCN.

In FY 2023, CSHCS committed to moving forward with establishing a CMC program through a Targeted Case Management Medicaid State Plan Amendment. CSHCS completed many action steps from the CMC Workplan. This included meetings with the Actuarial Division, Medicaid Implementation, Medicaid Policy, BCCHPS, and other targeted case management programs across the state. These meetings were instrumental in drafting the program description language for Medicaid policy and the State Plan Amendment for the CMC program.

The second strategy was to complete a comprehensive evaluation plan to measure CSHCS's capacity and ability to provide effective, efficient, and high-quality services to clients. In FY 2021-2022, CSHCS utilized the Centers for Disease Control and Prevention's framework for program evaluation in public health to identify key metrics that aligned with established evaluation questions. In FY 2023, a program dashboard was created that allows specific metrics to be monitored in real-time. The dashboard includes data on Title V enrollment, NEMT utilization, CSHCS enrollees in the foster care system, utilization of CMDS clinics, out-of-state services provided, and clients served by both CSHCS and behavioral health. This dashboard is utilized to track trends over time and prompt investigation when new trends are identified.

The third strategy is to ensure CSHCS families are receiving care coordination in a high-quality, family-centered, and well-functioning system. This strategy is accomplished through site visits with CMDS Clinics and MHPs, and accreditation visits for LHDs. CSHCS conducted five virtual CMDS clinic site visits in FY 2023. Site visits highlighted that CMDS clinics expand their specialty provider network as needed to meet the needs of families. Clinics also excelled at providing patient/family education. The most frequent recommendations provided to clinics were related to transition to adult providers, documentation, and recruitment of specialty staff.

Additionally, CSHCS orchestrated MHP site visits with Managed Care Plan division staff, Office of Medical Affairs (OMA) physician staff, and other program areas across MDHHS. In FY 2023, CSHCS visited with all nine MHPs with a focus on health equity, transportation, therapy services, and healthcare transition. LHD accreditation resumed in FY 2023 after a pause during the COVID-19 pandemic. LHD Accreditation occurs on a three-year cycle, with a team from the CSHCS Division, including Family Center representation, evaluating LHD performance on a set of six minimum program requirements and indicators.

The final strategy for this objective is to ensure equitable care by applying a health equity lens to all activities within the CSHCS Division. In FY 2023, CSHCS recognized that young adults with special health care needs ages 21-25 experienced significant challenges transitioning to adult providers. These challenges were more acutely experienced by young adults from lower-income families and historically underserved populations. In FY 2023, CSHCS proposed raising the cutoff age from 21 to 26 to bring CSHCS eligibility in line with Michigan's special education services, the Foster Care Transitional Medicaid program, and dependent insurance coverage benefits through the Affordable Care Act. The proposal was adopted by Governor Gretchen Whitmer's FY 2024 budget and implementation of the eligibility expansion will occur in FY 2024.

The CSHCS Health Equity, Diversity, and Inclusion workgroup educates and engages CSHCS staff and stakeholders to identify health inequities, remove institutional barriers, and advance equitable policies and practices to achieve a reduction in health disparities for CYSHCN. The workgroup creates monthly Health & Cultural Awareness bulletins that highlight rare diseases and provide education on diversity and inclusion topics. These bulletins are shared with the Division and LHDs. In FY 2023, workgroup members met with individual LHDs to discuss health equity and ways CSHCS can support their work. The workgroup also reviewed the National CLAS

(Culturally and Linguistically Appropriate) Standards. In FY 2024, information from this review will be utilized to create a work plan to improve CLAS within CSHCS.

Finally, CSHCS continued the Expanding Equity in CSHCS through Managed Care project. The goal of this project is to support MDHHS in eliminating racial and ethnic disparities in healthcare and health outcomes by focusing on key vulnerable populations in managed care and CSHCS. Metrics were selected for analysis and statistical testing was performed on these metrics. Metrics included HEDIS measures (lead screening, developmental screening, well-care visits by age, and childhood immunizations) and three CSHCS measures (hearing aids, wheelchairs, and continuous glucose monitors). Health disparities that are identified by the statistical testing will be prioritized and a Stakeholder Engagement plan created to address the disparities in collaboration with Managed Care Plan Division.

Transition (FY 2025 Application)

Through the Title V five-year needs assessment process, the state priority need to "Ensure CYSHCN have access to continuous health coverage, all benefits they are eligible to receive, and relevant care where they live and learn" was 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.

In Michigan, 20.0% of CYSHCN reported they received services to transition to adult health care (NSCH, 2020-2021). While Michigan's performance mirrors the national percentage, the data indicates that more than three-fourths of Michigan's CYSHCN are not receiving necessary Health Care Transition (HCT) services, making them vulnerable to worsening chronic health conditions, behavioral health issues, and underutilization of needed health care services.

Based on the needs assessment and NSCH data, two objectives and accompanying strategies were developed to address this state priority need. These strategies align with the Michigan Title V needs assessment pillars of improving capacity to achieve equitable health outcomes; intentionally seeking opportunities for family and community engagement; and delivering culturally, linguistically, and age-appropriate health education. Plans for FY 2025 include reviewing HCT processes within Local Health Departments (LHDs), Medicaid Health Plans (MHPs), health care professionals, and schools throughout Michigan and providing content, education, and resources to align best practices for consistency while simultaneously bridging connections between siloed transition services. The CSHCS Family Center for Children and Youth with Special Health Care Needs (Family Center) will continue to be integral in providing family and youth perspective in these HCT efforts.

Through strong partnerships, CSHCS ensured stakeholder input was integrated in objectives and strategies. Key collaborations and partnerships include local health departments (LHDs), Medicaid Health Plans (MHPs), Michigan State University-Institute for Health Policy (MSU-IHP), The University of Michigan Child Health Evaluation and Research (CHEAR) Center, MDHHS Child and Adolescent Health Centers (CAHCs), and Got Transition. Title V funding is used to provide care coordination services through contracts with local health departments, which includes HCT services. HCT is also integrated in the LHD accreditation process as a Minimum Program Requirement.

Objective A: By 2025, increase the percentage of CYSHCN ages 12 and older receiving services necessary to transition from pediatric to adult health care from 21.6% to 25%.

CSHCS recognizes the underutilization of structured HCT processes within clinics and siloed transition services across domains, specifically between HCT and other transitional services such as education, employment, and independent living. As a result, youth and young adults have inequitable access to transition services, resources, and supports. Therefore, the first strategy to meet this objective is to establish a Transition Advisory Collaborative to guide the development of a structured Michigan HCT framework for health care providers. In FY 2025, CSHCS will collaborate with the CSHCS Advisory Council (CAC) to assist with identifying key partners, such as pediatric and adult provider clinics, school-based health clinics, parent and youth consultants, and state agencies to establish a Transition Advisory Collaborative. The advisory members will assess current HCT processes and utilize the input to shape the development of a HCT framework to address identified gaps and barriers to implementing HCT processes in the clinic setting. Moving into FY 2026, the advisory collaborative will create a Michigan HCT framework that will utilize evidence-based and *Blueprint for Change* strategies; include expanded guidance and collaborative materials for both pediatric and adult clinics; integrate resources to assist youth and families/caregivers with navigating across transitional domains; and address the varying levels of support needed for youth transitioning to adult life. CSHCS will select 2-4 clinics to pilot the framework, make modifications as warranted, and expand the

finalized framework to additional clinics across the state in future grant cycles. This strategy aligns with the *Blueprint* Access to Services, Principle 1d, “Public health programs connect and collaborate with stakeholders in the private sector to invest in and advance the system for CYSHCN and families.”

To extend HCT resources to Michigan schools, CSHCS will continue to serve on the Michigan Interagency Transition Taskforce (MITT) to ensure HCT is represented in the finalized secondary education transition model and collaborate on developing and sharing of resources. This taskforce is a state level collaborative infrastructure that align supports and services to ensure a seamless transition for all students with disabilities in the K-12 system (up to age 26) into adult life. Committee representation includes the Department of Education, Disability Rights Michigan, Developmental Disabilities Council, Department of Labor and Economic Opportunity, the Arc Michigan, Michigan Alliance for Families, Statewide Independent Living Council, Wayne State University Developmental Disabilities Institute, Statewide Autism Resources and Training (START), Michigan Transition Services Association, and Michigan Disability Rights Coalition. In FY 2025, the transition specialist will continue to ensure HCT is included as a tenant in the Michigan State Model for Secondary Transition and a recognized step on a pathway towards independence. In addition, the CSHCS Transition Specialist will leverage existing relationships built within MITT to assist in evaluating and integrating equitable transition resources into the Michigan HCT framework by applying a health equity lens to ensure all populations are included. Transition resources will include the creation of a Michigan Transition Roadmap to assist youth and parents/caregivers with navigating across transitional domains and address the varying levels of supports needed for youth throughout all the transition stages. The Michigan Transition Roadmap will be included in the Michigan HCT framework for clinics and embedded within the school resource transition guide. This strategy aligns with the *Blueprint* Access to Services, Principle 1a, “CYSHCN and their families receive services that anticipate their needs and provide service options and guidance and includes a roadmap to care.”

The third strategy for this objective is to provide HCT resources and education to partners and stakeholders and promote the CSHCS Transition to Adulthood website. In FY 2023, content for health care transition was updated to be consistent with Got Transitions Six Core Elements of Transition 3.0 and expansion of non-health care transition resources were added. Youth, family, and stakeholder representation provided diverse input into the website format and content updates. In FY 2024, CSHCS expanded program eligibility from up to age 21 to age 26. Extending eligibility up to age 26 aligns the CSHCS system of care with young adult/dependent coverage through the Affordable Care Act, Michigan’s special education services (which are available to qualifying young adults until age 26), and the Foster Care Transitional Medicaid program. Continuing CSHCS coverage for these young adults with complex health conditions offers them access to continuous specialty health care coverage and extends support to young adults through the health care transition process. Due to this expansion, CSHCS performed a deeper review of the transition content on the website and updated and expanded materials to encompass transition guidance up to age 26. In FY 2025, through the work of the Family Center and the CSHCS Transition Specialist, CSHCS will offer a variety of education and training opportunities to LHDs, MHPs, youth and young adults, families, and providers on HCT and include promotion of the CSHCS website and revised resources. CSHCS will also promote the revised transition website through collaborative partners and stakeholders, such as the CAC and MITT.

As a fourth strategy, MDHHS will continue to contract with the University of Michigan Child Health Evaluation and Research (CHEAR) Unit to provide ongoing analyses and support related to the CSHCS program. CSHCS and CHEAR will continue to evaluate HCT data criteria and collection efforts to identify opportunities for improvement and implement program changes in response to the data. Consideration for employing an additional ESM will be a topic of discussion for this collaboration in FY 2025.

The fifth strategy for this objective is to utilize the MHP contract, site review, and compliance review processes to improve HCT for CYSHCN enrolled in MHPs. In FY 2023, following the guidance provided by Got Transition’s “Medicaid Managed Care Contract Language to Expand the Availability of Pediatric-to-Adult Transitional Care,”

CSHCS implemented MHP contract revisions on HCT. These revisions included a definition of HCT, the utilization of consistent HCT language throughout the contract, inclusion of HCT information in the MHP member handbook, and providing an age requirement for the initiation of HCT processes that align with the requirements of other CSHCS partners. In FY 2024, CSHCS implemented additional MHP contract changes and compliance review requirements to further strengthen HCT efforts. These revisions include MHPs surveying adult provider networks annually to assess availability of adult providers for CYSHCN, encouraging providers as part of EPSDT/well-visits to conduct HCT/self-care assessments, and to annually submit the MHP's comprehensive HCT policy, number of CSHCS enrollees assisted with HCT, and the number of non-CSHCS members assisted with HCT. In FY 2025, CSHCS will evaluate and track MHPs required HCT reporting during the compliance review process, attend site visits to engage with MHPs, and provide additional resources and technical assistance.

The final strategy for this objective is to review the Minimum Program Requirement (MPR) transition indicator utilized for the LHD three-year accreditation cycle and make revisions if applicable. In FY 2025, CSHCS will review the transition indicator and revise language and documentation requirements for LHDs to align best practices for consistency across CSHCS partners and to strengthen HCT processes for CSHCS enrollees. Strategies five and six align with *Blueprint* Health Equity, Principle 2a, "entities that serve CYSHCN and their families coordinate policies, practices, and procedures across sectors to mitigate the health effects of societal oppression."

Objective B: By 2025, increase by 10% the number of partner organizations who reach the next level on the Got Transition "Assessment of Health Care Transition Activities."

The first strategy for this objective is to implement Got Transition's "Assessment of Health Care Transition Activities" annually with CSHCS partner organizations. In FY 2022 and FY 2023, CSHCS collaborated with MSU-IHP to create an electronic version of the assessment in Qualtrics, distribute the assessment to LHDs, and analyze the results. Baseline data was documented, and the results were utilized to determine HCT training topics and program development for local health departments. In FY 2024, CSHCS replicated this HCT assessment process with MHPs and completed year two assessment with LHDs. The HCT survey will continue to be implemented annually to LHDs and MHPs to document trends and provide valuable feedback into the CSHCS program. HCT resources and education will be provided to both LHDs and MHPs based on the need reflected in the assessment survey data collected.

In FY 2024, CSHCS implemented a new ESM to monitor HCT activities within CSHCS partner organizations. The ESM reflected the percentage of CSHCS partners whose total score increased on Got Transition's "Assessment of Health Care Transition Activities" annual survey. CSHCS utilized a Quality Improvement (QI) approach by implementing the assessment survey to gauge the programs' current HCT activities, provide education and technical assistance for the respective program based on the feedback and scores received, and replicate the assessment process annually. The goal of this ESM is to 1) assist CSHCS partners with implementing additional activities that utilize Got Transitions Six Core Elements of HCT, 2) increase CSHCS partner organizations' scores on the HCT assessment survey, and 3) increase the percentage of CYSHCN in Michigan who receive services necessary to transition to adult health care. CSHCS will continue collaborative efforts with MSU-IHP to annually execute the electronic HCT assessment and analyze results.

***NEW:* Medical Home (FY 2025 Application)**

Starting in FY 2025, the Medical Home NPM is a universally required measure for Title V programs. In the dynamic landscape of healthcare, the concept of the medical home has gained significant traction as a model for delivering comprehensive, family-centered, culturally effective care. This is not a new concept to Michigan. Until 2018, Michigan's CYSHCN program adopted the Medical Home NPM, "Percent of Children with and without Special Health Care Needs with a Medical Home." Initiatives at that time included supporting the Children's Multi-Disciplinary

Specialty (CMDS) Clinics in providing comprehensive coordinated care through an enhanced reimbursement model, providing outreach and training to families regarding the medical home concept, and implementing a survey of patients and their families to assess care coordination and family partnership in the CMDS clinic model. Medical Home was not identified as a priority in the 2020 Title V Needs Assessment process.

A review of NSCH data from 2016-2017 to 2020-2021 indicates a need to elevate medical home initiatives in Michigan. The 2020-2021 NSCH data reflected that 43.4% of Michigan CSHCN reported care received in a medical home and 69.2% reported excellent or very good health. This represents a decline when compared to NSCH data from 2016-2017 which indicated that 49.9% of Michigan CSHCN reported care received in a medical home and 73.9% reported excellent or very good health. Further analysis of NSCH data reflects that CSHCN in Michigan were statistically significantly less likely to report having a medical home compared to non-CSHCN in 2022 (35.4%, compared to 50.6% respectively).[1]

The Healthy People 2030 goal for children and adolescents under 18 who receive care in a medical home setting is 53.6%. Performance continues to fall short of this goal and is trending in a negative direction (*National Survey of Children's Health (NSCH) - Healthy People 2030 | Health.gov*, n.d.).[2] Increasing the percentage of Michigan's CSHCN who receive care in a medical home setting is vital to improving the overall health of this vulnerable population.

In FY 2025, CSHCS will continue to analyze medical home data, complete a landscape analysis to identify existing medical home initiatives, collaborate with statewide partners to identify strategies to increase the number of clinics providing care that meets medical home criteria, and develop a comprehensive action plan for the Medical Home NPM that will start with the next five-year Title V cycle (FY 2026). The CSHCS Family Center for Children and Youth with Special Health Care Needs (Family Center) will be integral in providing family and youth perspective in the development of this initiative.

Objective A: By 2025, explore existing medical home activities in Michigan and identify program opportunities.

The first objective for this strategy is to analyze data available on medical home to identify existing health disparities. An initial review of National Survey of Children's Health data indicate health disparities based on race for medical home. In all reporting years (2018-2023), Black or African American CSHCS enrollees were statistically significantly less likely to report their child's overall health with a top box score compared to the White CSHCS enrollee population (Michigan Department of Health and Human Services, 2022). In 2023, 2020, and 2019, CSHCS enrollees reporting "Other" for their race were statistically significantly less likely to report their child's overall health with a top box score compared to the White CSHCS enrollee population (Michigan Department of Health and Human Services, 2022). In FY 2025, CSHCS will review available program data including CAHPs results and utilization data from the MDHHS Data Warehouse to further explore and validate these racial disparities.

The second objective is to collaborate with statewide partners to assist in developing strategies to increase utilization of the medical home model for clinics in Michigan. CSHCS will utilize internal partners who worked on recent statewide health care system reform and integration initiatives and external partners such as regional health planning collaboratives, Medicaid Health Plans (MHPs), and Local Health Departments (LHDs) to identify existing medical homes, establish an understanding of current initiatives, and review medical home best practices from other states. Strategies that align with *Blueprint for Change* principles to increase utilization of the medical home model will be identified.

The final objective for this strategy is to develop an action plan to increase the number of clinics that meet medical home criteria serving CYSHCN. CSHCS will utilize information collected in the previous strategies to create an

action plan that will increase utilization of the medical home model for clinics in Michigan and improve access to comprehensive, family-centered, culturally effective care for CYSHCN. The comprehensive action plan for the Medical Home NPM will start with the next five-year Title V Needs Assessment cycle (FY 2026).

Medical Care and Treatment for CSHCN (FY 2025 Application)

Children's Special Health Care Services (CSHCS) was created to find, diagnose, and treat children who have chronic medical conditions. The Family Center for Children and Youth with Special Health Care Needs (Family Center) is housed within the CSHCS Division and provides ongoing support, education, and resources to families of CSHCN. All families of CSHCN can utilize Family Center services, regardless of CSHCS enrollment status. In FY 2025, Title V funding will be used to support medical care and treatment for Children and Youth with Special Health Care Needs (CYSHCN).

The CSHCS benefit, while not intended to cover all the care a child needs, helps to ensure that necessary specialty care for a child's qualifying condition will not create undue financial burden for families. CSHCS is the payer of last resort and requires families to utilize their primary and secondary insurance. If a family's income indicates that they may be eligible for Medicaid, they are required to apply. Most CSHCN who qualify for Medicaid and the CSHCS program continue to receive care through Medicaid Health Plans (MHP). Children who are enrolled in Medicaid are automatically enrolled in CSHCS if determined to be medically eligible for CSHCS. Automatic enrollment for these clients into CSHCS without a separate application streamlines the enrollment process for families and increases family access to care coordination and case management services. CSHCS works with local health departments (LHD), hospital systems, and MHPs to ensure continued enrollment.

The 2020 Title V needs assessment indicated CSHCS beneficiaries experience barriers, including transportation, that impact access to timely health care services. Respite care was identified as a significant need to reduce stress and alleviate caregiver fatigue within families of CSHCN. Language and cultural barriers, as well as a lack of specialty providers and insurance challenges, were also identified. The health status assessment revealed almost one-third of CSHCN with complex health needs did not receive needed care coordination, and CSHCN are more than twice as likely as non-CSHCN to report that they did not receive care coordination (National Survey of Child's Health, 2016- 2017). The encounter survey (a component of the community themes and strengths assessment) highlighted financial burdens for families created by a complex healthcare system.

Based on the needs assessment and NSCH data, the state performance measure "percent of CSHCN enrolled in CSHCS that receive timely medical care and treatment without difficulty" was chosen to align with the identified priority needs. Strategies to address this SPM include implementation of a targeted case management benefit for children with medical complexity (CMC), explore policy changes for the CSHCS respite benefit, and expand the capacity of Children's Multi-Disciplinary Specialty (CMDS) clinics. CSHCS will continue the "Expanding Health Equity in CSHCS" project to identify healthcare disparities, engage stakeholders, and identify and implement potential solutions.

CSHCS key partners include CSHCN and their families, Medicaid, Medicaid Health Plans (MHPs), local health departments (LHDs), service providers, the CSHCS Advisory Committee, the Family Leadership Network, Michigan Family to Family Health Information Center, and Michigan Family Voices. In FY 2025, CSHCS will continue participation in the National Center for System Services for CYSHCN Learning Collaborative to identify innovative solutions to implementing the *Blueprint for Change* for CYSHCN.

Objective A: By 2025, increase the percentage of CSHCS CAHPS' respondents who rate their health care with a top box score of 9 or 10 from 71.9% (2019) to 75%.

The first strategy for this objective is to continue implementing special programs to reduce financial burdens for CSHCS-eligible families. Through the Insurance Premium Payment Benefit program, CSHCS can pay for all or part of the beneficiary's private health insurance premiums when families demonstrate financial need, and it is cost-effective for CSHCS. This strategy addresses the *Blueprint* critical area of Financing services, specifically Principle 3b, "Service sectors . . . identify and assess family hardship and eliminate or reduce cost-sharing payments for medically necessary services, supplies, and equipment."

Transportation continues to be a challenge for families and creates barriers to accessing care. CSHCS will continue to provide the transportation benefit, which provides reimbursement for mileage, lodging, and vendor-provided transportation. The treatment requiring transportation must be related to the qualifying medical condition and be provided by a CSHCS-approved provider. This strategy addresses the *Blueprint's* critical area of access to care, specifically Principle 1b, "CYSHCN and their families receive the appropriate accommodations and technologies they need to access services and supports."

The Children with Special Needs Fund (CSN Fund) is a privately funded program within CSHCS. The CSN Fund was created to help CSHCN when other funding sources are not available. CSHCS promotes the CSN Fund through LHDs, Family Center networks, and other stakeholders. The CSN Fund can assist children across Michigan in obtaining the necessary equipment and home modifications that they need but cannot otherwise afford. This strategy addresses the *Blueprint* critical area of Financing services, specifically Principle 3b, "Service sectors . . . identify and assess family hardship and eliminate or reduce cost-sharing payments for medically necessary services, supplies, and equipment."

The second strategy is to expand the capacity of specialty clinics to deliver medical care through CMDS clinics. Efforts in FY 2025 will continue to focus on recruiting additional pediatric and adult clinics in the specialties of hematology/oncology (sickle cell disease). In FY 2025 CSHCS will work with Medicaid colleagues to explore the addition of CMDS services into the Michigan Medicaid State Plan, thereby allowing the cost of these Title V services to be shared with Medicaid. This process will include a review of reimbursement levels to confirm they are adequate to incentivize multi-disciplinary care for CYSHCN. CSHCS will create new billing resources and conduct billing reviews to ensure the system is reimbursing providers appropriately. CSHCS staff will also seek opportunities to streamline billing and authorization processes. The CMDS clinic model addresses the *Blueprint* critical area of financing of services, specifically Principle 3c, "Care integration across service sectors is adequately financed."

The third strategy is to disseminate findings and project successes of the HRSA-funded Children and Youth with Epilepsy (CYE) grant. Although funding for this activity ends on August 31, 2024, CSHCS has requested to carry unspent funds from previous years over to FY 2025. This funding will be utilized to share the findings of the previous grant cycle through manuscripts and state and national conference presentations. The CYE project increased access to care for CYE, expanded telemedicine in participating clinics, and improved transition to adult serving systems for CYSHCN with epilepsy which impacts and informs our broader CSHCS work. The Family Center Youth Consultant is integrally involved with the project and will review presentations and manuscripts as well as participate in the dissemination of findings in FY 2025.

Objective B: By 2025, increase by 10% the number of meaningfully engaged community partners (families, youth, LHDs, CAC members, contractors, clinic sites, health care providers, other professionals, etc.) who improve knowledge of the CSHCS program.

The first strategy is to continue building and implementing a coordinated and systematic approach to family engagement. This will be accomplished through the work of the Family Center. In FY 2025, the Family Center will provide the following programs to support, inform, and engage youth and families:

- Family Phone Line: This hotline staffed by parents of CYSHCN is available for families to call for peer support, information, and resources
- Trainings and educational webinars: Parent/Professional Connect Calls, Navigating Healthcare, and Growing as Leaders provide opportunities for parents and professionals to connect and share information
- Statewide Parent to Parent USA Network: Train and support parents to serve as peer supports to other families of CYSHCN
- Sibling Support: Grants to support local Sibshops and biannual Sibling Facilitator trainings
- Youth engagement: Youth Consultant on team provides youth perspective to CSHCS initiatives
- Camp and Conference Scholarships: increase access and support the inclusion of CYSHCN in summer recreational programs with their peers
- Partnership with MI Family to Family Health Information Center: Cultivate and maintain statewide resource repository; quarterly newsletters
- Family Leadership Network: Statewide family representatives provide input to CSHCS initiatives, Title V needs assessment activities, and share resources statewide with other families and community organizations

The Family Center and its programs address the *Blueprint* area of family and child well-being and quality of life. In FY 2025, utilizing the 2025 Needs Assessment results and through participation in the National Center for System Services for CYSHCN Learning Collaborative, CSHCS will continue to evaluate current alignment with the *Blueprint* and identify innovative solutions to address *Blueprint* principles.

The second strategy for this objective is to continue the implementation of a multi-staged approach to improve provider and partner organization engagement. As part of this strategy, an Outreach and Engagement Plan has been developed and is being implemented. Monthly Professional Connect calls have raised awareness and understanding of CSHCS among various partner organizations. Other outreach efforts have targeted rural health providers and behavioral health providers. In addition, CSHCS and the Michigan State University Institute for Health Policy (MSU-IHP) have facilitated key informant meetings with executive leadership at three children's hospitals, implemented an electronic satisfaction survey, and convened four stakeholder sessions to obtain feedback on the CSHCS Children with Medical Complexity (CMC) initiative. In FY 2025, outreach and engagement efforts will continue among various providers, including organizations that support individuals with intellectual disabilities. In addition, provider engagement opportunities are planned to better understand the data findings from the Expanding Health Equity project and further inform action steps to impact heath disparities. These activities will address the *Blueprint's* critical area of health equity, specifically Principle 2a, "Entities that serve CYSHCN and their families coordinate policies, practices, and procedures across sectors to mitigate the effects of societal oppression."

The final strategy is to maintain a competent workforce that is knowledgeable about CSHCS and able to assist families in accessing services. MDHHS will continue to contract with MSU-IHP to design and offer regional training opportunities to LHDs and MHPs. In FY 2025, a mix of statewide and regional trainings will be provided to meet the needs of LHDs and MHPs. CSHCS leadership regularly attends various MHP meetings to share updates on CSHCS initiatives and offers monthly LHD calls to provide education, updates, and technical assistance.

Objective C: By 2025, improve the percentage of CSHCN who report receiving care in a well-functioning system from 17.8% to 20.3%.

The first strategy is to implement a statewide targeted case management benefit to improve care for children with medical complexity (CMC). In FY 2025, CSHCS will promote the program to eligible providers across the state, provide technical assistance to help providers enroll, and develop information for families regarding the benefit. The CMC benefit addresses the *Blueprint* critical area of health equity, specifically Principle 1f, "Service sectors support

care models … and other approaches that serve the needs of children with medical complexity and their families."

In the 2020 Title V Needs Assessment, families of CYSHCN reported challenges accessing respite care. The current CSHCS respite benefit provides a maximum of 180 hours of respite care services per year for families caring for beneficiaries with complex health care needs that require skilled nursing services. Statewide provider shortages are compounded by challenges in identifying providers to work for limited hours. In FY 2025, CSHCS will continue exploring opportunities to support non-licensed providers, including family members or individuals trained by the family, to provide CSHCS respite. CSHCS will also explore increasing the number of available hours to 300 hours per year. These activities will address the *Blueprint's* critical area of financing of services, specifically Principle 1d, "Financing mechanisms support innovative approaches to delivering quality care, for example, by paying families for medical services they provide."

The second strategy is to continue monitoring the comprehensive evaluation to assess and improve CSHCS's capacity and ability to provide effective, efficient, and high-quality services to clients. In FY 2025, the team will analyze the evaluation dashboard to ensure metrics are accurate and relevant, establish benchmarks for identified metrics, and share the program evaluation with stakeholders. CSHCS will review the evaluation and identify additional metrics to align this activity with the *Blueprint* critical area of access to services, specifically Principle 1c, "Surveillance systems identify, track, and cross-share data on social risk factors, including discrimination, that impact health outcomes and their consequences across the life course."

The third strategy is to implement initiatives so that CSHCS families receive care coordination in a high-quality, family-centered, and well-functioning system. This is accomplished through site reviews with CMDS clinics, focus studies and compliance reviews with MHPs, and accreditation of LHDs. CMDS clinics are visited on a four-year cycle and evaluated on staffing structure, documentation, multi-disciplinary approach, and family-centeredness. CSHCS participates in annual focus studies with each MHP to assess compliance with MHP contract obligations for CYSHCN, which in FY 2024 includes an assessment of family involvement within the MHP's advisory structure. Accreditation of LHDs occurs on a three-year cycle, with a team that consists of a parent/caregiver from the Family Center and other CSHCS Division staff that evaluate the LHDs performance on a set of six minimum program requirements. The LHD requirements and associated indicators are reviewed and updated every three years. These activities align with the *Blueprint* critical area of health equity, specifically Principle 2, "Sectors, systems and programs that fund, deliver, and monitor services and supports for CYSHCN are designed and implemented to reduce health disparities and improve health outcomes for CYSHCN."

The final strategy for this objective is to improve the system of care by identifying and responding to health inequities. In response to identified disparities in the population impacted by sickle cell disease, the Michigan legislature authorized an expansion of CSHCS eligibility to adults with sickle cell disease beginning in FY 2022. To reduce barriers to enrollment, CSHCS allowed for modified requirements for this population. CSHCS will consider medical reports from primary care, urgent care, and emergency room providers for an initial two-year CSHCS enrollment. The expectation is that individuals will establish treatment with a specialist for ongoing monitoring of their sickle cell disease during this two-year enrollment period. In FY 2025, CSHCS will continue outreach to adults with sickle cell disease in Michigan. In addition, CSHCS will create an evaluation plan to monitor metrics such as enrollment, hospitalizations, emergency room utilization, and the number of individuals establishing care with a specialist provider.

As part of this final strategy, CSHCS will continue the "Expanding Health Equity in CSHCS" project that was launched in FY 2022. The goal of this project is to support MDHHS in eliminating racial and ethnic disparities in healthcare. The project has created a valid/reliable system to quantify and monitor racial/ethnic disparities and identify gaps in care experienced by CSHCS clients, initially focusing on clients in MHPs. In FY 2025 and in partnership with the

Medicaid Managed Care Plan Division and MHPs, health plan financial performance incentives will be developed to incentivize MHP behavior to address the disparities identified through the project. In addition, enhanced MHP contract expectations will be developed to address these disparities. These activities align with the *Blueprint* critical area of health equity, specifically Principle 2c, “Entities that serve CYSHCN and their families develop and implement performance and outcomes measures, ensuring system accountability for equitable, high-quality services for CYSHCN.”

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[1] Child and Adolescent Health Measurement Initiative. 2022 National Survey of Children’s Health (NSCH) data query. Data Resource Center for Child and Adolescent Health supported by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). Retrieved [11/2023] from [www.childhealthdata.org].
[2] *National Survey of Children’s Health (NSCH) - Healthy People 2030 | Health.gov*. (n.d.). https://health.gov/healthypeople/objectives-and-data/data-sources-and-methods/data-sources/national-survey-childrens-health-nsch

Cross-Cutting/Systems Building

State Performance Measures

SPM 6 - Support access to developmental, behavioral, and mental health services through Title V activities and funding

Measure Status:				Active	
State Provided Data					
	2019	**2020**	**2021**	**2022**	**2023**
Annual Objective			Yes	Yes	Yes
Annual Indicator			Yes	Yes	Yes
Numerator					
Denominator					
Data Source			State Title V and MCH Programs	State Title V and MCH Programs	State Title V and MCH Programs
Data Source Year			FY2021	FY2022	FY2023
Provisional or Final ?			Final	Final	Final

Annual Objectives		
	2024	**2025**
Annual Objective	Yes	Yes

State Action Plan Table

State Action Plan Table (Michigan) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems
SPM
SPM 6 - Support access to developmental, behavioral, and mental health services through Title V activities and funding
Five-Year Objectives
A) Support the work of local health departments in addressing developmental, behavioral, and mental health needs in their jurisdictions through 2025
B) Support the work of Regional Perinatal Quality Collaboratives in addressing behavioral and mental health in their respective Prosperity Region through 2025
C) Support increased collaboration and engagement between Title V and behavioral health partners
D) Support students' mental health and wellness through implementation of Handle with Care (HWC)
Strategies
A1) Provide Title V funding to local health departments to address developmental, behavioral, and mental health needs
B1) Provide resources to Regional Perinatal Quality Collaboratives to implement and expand use of universal perinatal screening at prenatal care clinics within their respective regions B2) Provide resources and support to Regional Perinatal Quality Collaboratives to address behavioral and mental health needs
C1) Ensure the challenges of CYSHCN and their families are reflected in the discussions and decisions related to the MDHHS behavioral health restructuring C2) Continue providing CSHCS, Family Center and CSN Fund educational sessions at conferences for the community mental health workforce C3) Continue collaborative efforts between CSHCS and BCCHPS to process Tax Equity and Fiscal Responsibility Act (TEFRA) applications for families
D1) Enhance and expand an online system to track HWC notices D2) Monitor HWC notices among counties participating in the initiative D3) Provide training and onboarding support to new schools and counties to assist in expanding HWC

Cross-Cutting Overview

Public health can play a key role in mental health promotion and providing linkages to systems of intervention and treatment. Recognizing that physical and mental health are closely related at the individual and population levels, Michigan is working toward integration of these systems. In March 2022, MDHHS announced a restructuring to ensure that services are supported across community-based, residential, and school locations. The changes make addressing the needs of children and families a priority, while benefitting people of all ages. As part of the restructuring, the MDHHS Health and Aging Services Administration was renamed to the Behavioral and Physical Health and Aging Services Administration (BPHASA). This administration, in addition to current responsibilities administering Medicaid and services for aging adults, now oversees community-based services for adults with intellectual and developmental disabilities, serious mental illness, and substance use disorders. The Substance Use, Gambling and Epidemiology Section within the Bureau of Specialty Behavioral Health Services in BPHASA is responsible for clinical services within the Substance Use Disorder Treatment System. Services include those specifically for women, adolescents, and young adults.

The restructuring also created the Bureau of Children's Coordinated Health Policy and Supports to improve and build upon the coordination and oversight of children's behavioral health services and policies. The Bureau of Children's Coordinated Health Policy and Supports manages the implementation of the Infant Mental Health program, a home visiting model that is a needs-driven, relationship-focused intervention for perinatal women, infants, and toddlers and coordinates with public health home visiting programs. MDHHS and the Michigan Department of Education have partnerships related to early childhood mental health, adolescent/school mental health, and Infant and Early Childhood Mental Health Consultation (IECMHC) in childcare.

Intensive Crisis Stabilization Services (ICSS) for Children is a current Medicaid service in the Medicaid Provider Manual. MDHHS identified ICSS for Children as a key service in the MI Kids Now Service Array, a statewide effort to improve behavioral health services for children and youth with Medicaid coverage and/or in the foster care system. According to the MDHHS ICSS website, "Community Mental Health Service Providers (CMHSP) currently operate or are developing Intensive Crisis Stabilization Services (ICSS). This Medicaid covered service is intended to help children and families get through crisis situations, including figuring out the next steps to access mental health services. These could include a referral for acute psychiatric hospitalization or developing a safety plan in the child's home. This service is available to all children/families…. They do not have to have Medicaid insurance and do not have to be active in treatment with the Community Mental Health Service Provider." MDHHS provided grant funds to CMHSPs to expand ICSS for Children and established a learning community to support grantees in implementation and to encourage peer-to-peer sharing of best practices. The program will allow CMHSPs to test different models using state general funds, and the "lessons learned" will be integrated into Medicaid policy as permissible under federal law and regulations.

As described above, the MDHHS infrastructure and core funding mechanisms for behavioral health are primarily located outside of the Title V program. However, many Title V and MCH program areas coordinate and intersect with behavioral health initiatives. Additionally, the Title V 2020 needs assessment identified gaps in behavioral health services across MCH population domains. To be responsive to the findings and the needs of the MCH population, a cross-cutting state performance measure (SPM 6) was created in 2020. The role of Title V in addressing behavioral health needs across population domains is discussed in the SPM 6 state action plan. The Title V plan focuses on providing local health departments with funding to implement a range of behavioral health supports for women, children, and adolescents in their jurisdictions; supporting the work of Regional Perinatal Quality Collaboratives in addressing behavioral and mental health in their respective Prosperity Region; strengthening collaboration and engagement between Title V and behavioral health partners for children with special health care needs; and

supporting children's mental health through the trauma-informed Handle with Care initiative.

Behavioral/Mental Health (FY 2023 Annual Report)

Through the 2020 Title V needs assessment, a new state priority need was identified to "Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems." To align with this priority need, a new SPM was created for the 2021-2025 cycle to "Support access to developmental, behavioral, and mental health services through Title V activities and funding." The annual objective in this state action plan signifies the ongoing commitment to mental and behavioral health initiatives within Title V systems work and community-based work that is funded by Title V. The annual yes/no objective was chosen to capture and reflect, in one state action plan, the array of work across Title V programs, population domains, and local initiatives. This approach (i.e., the use of a yes/no objective) is an option in the Title V Information System (TVIS) and is used by other states for cross-domain or systems-focused SPMs.

In FY 2023, this SPM and the objectives in the state action plan focused on work across population domains that was directly supported or funded by Title V: 1) the work of local health departments (LHDs) in addressing behavioral and mental health needs in their communities; 2) the efforts of Regional Perinatal Quality Collaboratives (RPQCs) in addressing behavioral and mental health; 3) increased engagement between Children's Special Health Care Services (CSHCS) and behavioral health partners; and 4) Handle with Care. Activities and outcomes related to this work are discussed below.

Objective A: Support the work of local health departments in addressing developmental, behavioral, and mental health needs in their jurisdictions through 2025.

This objective illustrates how Title V funds support local jurisdictions and their identified needs. Each health department has the flexibility to use Title V funds to align with their local MCH strategic priorities. Some LHDs work on mental/behavioral health with Title V funds; other LHDs may work on mental/behavioral health with other funds or in broader MCH program areas and therefore their activities may not be captured in Title V LMCH workplans. Of the 45 local health departments (LHDs) in Michigan, five LHDs addressed some aspect of mental health as a performance measure in their FY 2023 annual plans through the Title V funded Local Maternal Child Health (LMCH) Program.

Every LHD completes an annual LMCH plan which gives an overview of the jurisdiction; an MCH Needs Assessment update; description of the involvement of families, consumers and stakeholders in ongoing needs assessment activities; and a work plan detailing objectives, activities and deliverables for each selected performance measure. Of the five LHDs selecting the behavioral/mental health performance measure in FY 2023, work plan activities completed and reported in the agencies' LMCH Year-End Report included: mental health education to school youth through in-person presentations in schools and to women, pregnant women and adolescents during home visits; staff attendance at suicide prevention initiatives addressing resiliency and mental health workgroups, mental health trainings for staff and the community; gap-filling depression screening/referrals for adolescents, women and pregnant people; and gap-filling mental health services to CSHCS families. Agencies provided community educational resources through social media and community events on behavioral/mental health and through suicide data reports. These LHDs served 633 women, 283 pregnant women, and 1,442 children aged 1-21, including CYSHCN. In total, $253,001 in LMCH funds was expended for behavioral/mental health.

The federal COVID-19 public health emergency declaration ended on May 11, 2023, and state epidemic orders were rescinded at the same time. Medicaid beneficiaries had to renew their coverage as Michigan resumed Medicaid eligibility redeterminations to comply with federal legislation. 2023 saw a return of in-person home visits

and face-to-face presentations in schools instead of virtually. Community outreach events resumed in-person as well.

One agency noted that presentations at schools related to mental health continue to rise in priority as more is learned about the impact of the pandemic on youth well-being. New relationships were formed as school mental health presentations increased community interest. Schools and health educators agree that in-person education is preferred for engaging students and fostering positive discussion and connection.

In FY 2023, the LMCH program provided support, guidance, and technical assistance to health departments. LMCH created an “Evidence-Based Strategies by Performance Measures for Local MCH” document to provide guidance and technical assistance to LHDs as they created their action plans. The LMCH action plan contains a column to identify evidence-base/informed strategies. The document provides some potential evidence-based/informed or promising practice strategies that may be used in action plans, including SPM 6. As planned, the LMCH program tracked count/expenditures for Title V spending on behavioral and mental health activities.

Objective B: Support the work of Regional Perinatal Quality Collaboratives in addressing behavioral and mental health in their respective Prosperity Region through 2025.

Behavioral and mental health outcomes continue to impact Michigan’s maternal and infant populations. In 2022, 8.5% of birthing individuals in Michigan with a live birth indicated they smoked while pregnant; in 2021, the most recent year available, the Neonatal Abstinence Syndrome (NAS) rate in Michigan was 6.5 per 1,000 live births with individual regions ranging from 27.1 per 1,000 live births to 3.3 per 1,000 live births; and in the years 2015-2019, 37.9% of pregnancy-associated, not related deaths were attributed to substance use disorder and 4.5% were attributed to suicide.[1]

Michigan supports the Regional Perinatal Quality Collaboratives (RPQCs) through direct consultation; overall leadership of the Michigan Perinatal Quality Collaborative by a designated coordinator; and financial support including through Title V federal funds, which serve as gap-filling funds for the RPQCs. In FY 2023, three RPQCs and the High Touch High Tech (HT2) team supported the expansion and ongoing implementation of a universal electronic behavioral and mental health screening tool and app in 16 prenatal care clinics and one local health department, for a total of 17 clinics. Overall management is through Michigan State University (MSU). The app, called the Pregnancy Checkup app, utilizes evidence-based Screening, Brief Intervention and Referral to Treatment (SBIRT), as well as evidence-based screening tools for depression and trauma. Specific screening tools are based on clinic preference. The app offers patients the opportunity to share their screening results with their provider. If the patient agrees, results are sent via encrypted email to the clinic. This allows providers/clinics to make further referrals to treatment and resources. If patients decide not to share their screening results, they still can receive a brief intervention, which is consistent with best practice recommendations. Approximately 92% of patients agree to share their screening results.

Access to the Pregnancy Checkup app through personal devices continues to be an efficient option for clinics, especially as some clinics have adapted to shorter times spent in waiting rooms. A web-based link and QR access code were created in response to restrictions put in place during the COVID-19 pandemic in which patients waited in their vehicles prior to their appointment. Clinics continue to utilize the QR code and link as an option for patients to complete prior to arrival, as they streamline the check-in process for appointments. At the conclusion of every screening session, patients are asked to complete an evaluation, providing an opportunity for feedback on the screening tool and app. Patients consistently rate the app ‘easy to use’ and are satisfied with the methodology used.

Continued funding in FY 2023 allowed the MSU team to expand implementation of the Pregnancy Checkup app and universal screening tool; provide continued support to clinics after initial implementation; and build enhancements to

the app. At the end of FY 2023, 17 clinics were utilizing the Pregnancy Checkup app, with additional clinics having expressed interest. Implementation of additional clinics will be pursued in FY 2024. The team integrated a live chat feature in the app that is currently linked to the National Maternal Health Hotline. A public facing version of the Pregnancy Checkup app was developed in FY 2023, which includes a brief, low-risk version of the screener and additional information and resources such as a smoking cessation brief intervention and home visiting enrollment. The team was also able to upgrade the software that supports the app and data dashboard. The new software platform is more stable, reliable, and easier to edit. The dashboard now allows clinics to see aggregate rates of risk at their site and track changes in risk prevalence over time.

The Michigan Child Collaborative Care (MC3) is a virtually based program that provides psychiatry support to primary and prenatal care providers in Michigan who are managing patients with behavioral and mental health concerns. Through the Governor's Healthy Moms, Healthy Babies initiative, MC3 has expanded engagement of perinatal providers in the program, as well as offered short-term telehealth consultation and care coordination between patients and behavioral health consultants. In FY 2023, 245 patients have been referred to consultation, of which 91% became engaged in the program and 76% enrolled in consultation with a behavioral health consultant. MDHHS and the RPQCs support MC3 through sharing program information, hosting program presentations and promoting informational MC3 webinar opportunities.

As a result of the COVID-19 pandemic, many in-person childbirth education and breastfeeding classes were canceled. Even as things began to return to a 'new normal', patient education classes didn't always return, often due to staffing challenges. Many pregnant and postpartum people continued to be left without options for education and support. The Region 8 PQC (Southwest Michigan) recognized this need and began offering virtual childbirth and breastfeeding education and support classes for pregnant and postpartum individuals and families in the region. The feedback received was positive and many individuals indicated that these classes were either their only option for education based on their geographic location, or the classes were convenient since they didn't have to arrange for transportation or childcare. The Region 8 PQC continued to offer and support these courses in FY 2023. Based on feedback received, toward the end of FY 2023, the Region 8 PQC combined the two courses into one course titled "Childbirth and Beyond." The new format is one course with six classes – three on childbirth and one each on postpartum care, newborn care and breastfeeding with mental health intertwined throughout. The course continues to provide opportunities for participants to review pregnancy and childbirth education, ask questions of the course instructor, and connect with other pregnant and postpartum people in their cohort. Other RPQCs have identified education needs in their respective regions and therefore, beginning in FY 2024, two additional RPQCs will support childbirth education courses for pregnant individuals and families in their region.

Objective C: Support increased collaboration and engagement between Title V and behavioral health partners.

In FY 2023, MDHHS continued restructuring how behavioral health services are delivered across community-based, residential, school locations, and other settings. The Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) was created to improve the coordination and oversight of children's behavioral health services and policies. The Bureau continues to work with other MDHHS administrations to address children's behavioral health care, including access to timely crisis care, and expand dedicated partnerships. CSHCS and BCCHPS leadership meet monthly to discuss barriers to behavioral health care for CYSHCN and best practices for collaboration.

CSHCS had established the Children's Special Health Care Services, Behavioral Health, and Intellectual and Developmental Disabilities Collaborative. The goal of the Collaborative is to identify opportunities and implement activities to better support families with children receiving services through both CSHCS and the community mental health system. Due to significant organizational restructuring within the behavioral health area along with ongoing

impact COVID-19 pandemic response, collaborative meetings were on hold for FY 2023. However, CSHCS continued to provide presentations at the quarterly Community Mental Health Association conferences. The conferences attract more than 400 board members, CEOs, COOs, CFOs, medical directors, clinical directors, case workers, supports coordinators, and supervisors from Michigan Community Mental Health Service Providers and Provider Agencies. CSHCS presents information on the benefits and enrollment processes for the CSHCS program, resources available through the Family Center, and information on how to appropriately utilize resources available through the Children with Special Needs Fund (CSN Fund).

CSHCS works closely with BCCHPS to coordinate care and transitions for clients served through both systems of care. The CSN Fund is a privately funded program within CSHCS and was created to help CYSHCN obtain equipment and services not covered by insurance or other programs. When an applicant to the CSN Fund indicates their child is receiving behavioral health services at a local CMH but their request has been denied, the CSN Fund staff connects with colleagues within BCCHPS to review the application and determine which entity is appropriate to fulfill the request. Another example of coordination occurs for young adults receiving Private Duty Nursing. The CSHCS Transition Specialist works with BCCHPS waiver coordinators and families to ensure these young adults get enrolled in appropriate systems of care and continue to receive private duty nursing without gaps in service.

CSHCS and the Michigan Developmental Disabilities (MI-DD) Council continued their strong partnership in FY 2023. The CSHCS Division Director continues to serve by gubernatorial appointment on the Michigan Developmental Disabilities Council, representing Title V. This provides an opportunity for the CYSHCN Director to ensure the DD Council focus includes children with special health care needs. In addition, the CYSHCN Director establishes and maintains relationships with many other organizations, as well as family- and self-advocates who support Michigan residents with a developmental and/or intellectual disability. The CSHCS Policy Specialist represents CYSHCN on the MI-DD Council Policy workgroup.

Objective D: Support students' mental health and wellness through implementation of Handle with Care (HWC).

The Handle With Care (HWC) program promotes safe and supportive homes, schools and communities that protect children and help traumatized children heal and thrive. HWC first came to Michigan in 2014 with the establishment of a HWC program in Jackson County, Michigan. Since that time, 50 communities have taken on this work at the local level with more expressing interest each year. Due to this rapid program expansion, MDHHS was approached by local HWC implementors seeking statewide infrastructure and staffing support for this initiative. The Division of Child and Adolescent Health (DCAH) took on this role in 2019 using existing staff support. Since that time, a state-level advisory committee was formed, a state website created, and a formal implementation guide and training approach developed. Through feedback from the HWC advisory committee, a need was expressed by local communities for a statewide online application that would streamline the submission of HWC notices from law enforcement agencies and the receipt of notices from designated HWC school personnel. With the support of the Title V MCH Block Grant, funding was designated for the development of this online application in 2022.

Planning for this process began with assistance and support from colleagues at the Michigan Department of Technology, Management and Budget (DTMB) who solicited bids from AI design firms. After reviewing the bids, the HWC state team opted to use BlueVector.AI to design and build the HWC application. This began an ongoing weekly meeting with Blue Vector, DTMB and HWC state staff for a 9-month period in which the system was designed, built, and tested. The online application also had to undergo a lengthy internal testing process to validate its use and compatibility with the state's overall system and security standards. The HWC online application received final approval to "go live" in the Spring of 2022 which led to the final stage of development, a pilot process. Two HWC communities agreed to be trained on the new online system and pilot it over a 6-month period. In FY 2023, a

considerable amount of time was spent raising awareness of the new HWC application, providing demos to communities interested in onboarding, and providing support and technical assistance to new implementors. To increase the efficiency of the onboarding process, all the user manuals and training videos were updated to be more user friendly. The onboarding trainings were also adapted and made into a self-paced learning style of instruction, to increase accessibility for new users. A total of seven new counties have onboarded over the past year. Overall, 411 HWC notices have been submitted by law enforcement agencies to schools through the online app, with a total of 524 students impacted. A total of 193 schools and 22 law enforcement agencies are currently utilizing the system. Bi-monthly office hours calls with the pilot communities were expanded to include all implementing counties.

With financial support from Title V, a part-time contractor was hired to help provide support to counties using the online system. This position was hired in Spring 2023. The contactor assisted in the marketing of the new online system and onboarding new counties. The contractor resigned from the position in October 2023. The HWC state team is undergoing internal discussions on whether to repost the position with the original scope of work or restructure the team responsibilities and use this position for training and related tasks, as there are many communities interested in this program and requesting training. Lastly, a limited number of HWC communities utilizing the online system accepted a small stipend to support the administration, training, and marketing of their local HWC program.

[1] Source: Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services

Cross-Cutting/Systems Building - Application Year

Behavioral/Mental Health (FY 2025 Application)

The findings from the Title V needs assessment led to a new state priority need in 2020 to “Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems.” While work that aligns with this priority is present within other state action plans, a new SPM was also created for the 2021-2025 cycle to “Support access to developmental, behavioral, and mental health services through Title V activities and funding.”

Creation of this new SPM was intended to better capture existing and new work across population domains related to behavioral and mental health. For the state action plan, the Title V program initially focused on three specific areas that are either directly supported or funded by Title V: 1) the work of local health departments in addressing developmental, behavioral, and mental health needs through Title V funding; 2) the work of Regional Perinatal Quality Collaboratives in addressing behavioral and mental health; and 3) increased engagement between the Title V CSHCN program and behavioral health partners. In FY 2022, a fourth objective was added for the Handle with Care (HWC) initiative. HWC focuses on students’ mental health and well-being and is supported by Title V funding.

The annual objective in this state action plan signifies the ongoing commitment to mental and behavioral health initiatives within Title V systems work and community-based work that is funded by Title V. The annual yes/no objective was chosen to capture and reflect, in one state action plan, the array of work across Title V programs, population domains, and local initiatives. This approach (i.e., the use of a yes/no objective) is an option in the Title V Information System (TVIS) and is used by other states that created cross-domain or systems-focused SPMs. Michigan’s SPM 6 state action plan is not an exhaustive reflection of efforts to better integrate or expand mental and behavioral health access or services. Other MCH initiatives and partnerships are underway but are not discussed in this state action plan, as the intent is to capture cross-domain work related to Title V activities and/or funding.

Objective A: Support the work of local health departments in addressing developmental, behavioral, and mental health needs in their jurisdictions through 2025.

Mental health was a strategic priority identified by approximately one-third (12) of Michigan’s local health departments (LHDs) in the 2017 Local Maternal Child Health (LMCH) needs assessment. Mental health challenges continue to impact women, children and families across the lifespan. One in seven women will experience a Perinatal Mood and Anxiety Disorder[1]. In the 12 months before pregnancy, 14.2% of Michigan women experience depression/anxiety, 19.3% of women experience depression during pregnancy, and 16.5% experience significant post-partum depression[2]. The COVID-19 pandemic exacerbated stressors that many women and families faced prior to the pandemic. It also led to new stressors such as social isolation, job loss, and housing insecurity.

The CDC Youth Risk Behavior Survey Data Summary & Trends Report[3] includes the first data collected since the start of the COVID-19 pandemic. As seen in the decade before the COVID-19 pandemic, mental health among students overall continues to worsen. Findings indicate that more than 40% of high school youth felt so sad or hopeless that they could not engage in their regular activities for at least two weeks during the previous year.

There were increases in the percentage of youth who considered suicide, made a suicide plan, and attempted suicide. Teen suicide in Michigan between 2013-2019 increased from 10.5 deaths perf 10,000 adolescents ages 15-19 to 12.9.[4.] The data also reflect stark disparities in outcomes for female and LGBTQ+ students. Some providers are noting dramatic increases in depression and anxiety among patients, including at younger ages. Additionally, mental health service needs in Michigan outweigh the number of providers available, especially in rural areas, leading to long wait times for treatment.

Simultaneously, the COVID-19 pandemic was a major cause of stress for public health professionals and led to staff burnout.[4] LHDs have noted an unprecedented rate of staff turnover and multiple staff vacancies which have persisted into 2024. A loss of institutional knowledge across all levels is a consequence of large staff turnover.[4] The Michigan State Health Assessment noted there is increased need for affordable and accessible mental health and substance misuse treatment. There is a shortage of available mental health providers in the state.[4.]

Strategies to Achieve Objective A include the continued flexibility of the 45 LHDs to select SPM 6, mental/behavioral health, in their LMCH work plans to align with their local MCH strategic priorities. Some LHDs work on mental/behavioral health with Title V funds; other LHDs may work on mental/behavioral health with other funds or in broader MCH program areas and therefore their activities may not be captured in their Title V LMCH workplans. The objective in this FY 2025 state action plan helps to illustrate how behavioral/mental health needs are being addressed through the Local Maternal Child Health (LMCH) program.

During the first four years of the five-year cycle (2021-2025), ten LHDs used LMCH funds to address the state performance measure (SPM) of mental/behavioral health. Five LHDs addressed this SPM each of the four years, one LHD addressed the SPM for three consecutive years, and two for two consecutive years. The remaining two LHDs only selected the measure in the first year of the cycle. As of this writing, the LMCH Plans for FY 2025 are in progress. LMCH Plans address depression screening and referral, adverse childhood experiences, and suicide prevention within the women and adolescent domains.

Many LHDs report having a long and rich history of being active partners with established community groups, advisory boards, collaboratives, and coalitions such as Community Mental Health, Child Abuse and Neglect Prevention Councils, child advocacy, school nurses, county courts, and law enforcement. LHDs describe receiving family feedback on services through paper and telephone surveys. LHDs value and elevate parent and adolescent voices by recruiting and promoting consumer involvement in decision making on collaboratives, councils, and advisory boards.

State strategies to support LHD work on this measure in FY 2025 will include provision of guidance and technical assistance from the MDHHS LMCH consultants. Annually the LMCH program provides webinars and learning labs to assist LHDs in completing their annual plans and year-end reports. A specific workplan that integrates SPM 6 was created as part of a FY 2025 sample LMCH Plan and was incorporated into the webinars provided. Lunch and Learns were added in 2024 for additional support. To support the Title V pillars, LHDs will be encouraged to use a health equity lens in the formation of workplans and to involve families and clients as partners in their work. Sample LMCH workplans and webinars will be provided to LHDs to demonstrate inclusion, equity, and family engagement strategies.

The LMCH program will continue to track Title V spending on behavioral and mental health activities in FY 2025. LMCH data gathered from this performance measure will provide a local perspective, which will be important for informing future Title V behavioral/mental health strategies and activities.

Objective B: Support the work of Regional Perinatal Quality Collaboratives in addressing behavioral and mental health in their respective Prosperity Region through 2025.

Behavioral and mental health has a significant impact on maternal and infant morbidity and mortality. Several different health indicators illustrate the poor behavioral and mental health in some of Michigan's pregnant people. For example, in 2022, 8.5% of individuals in Michigan with a live birth indicated that they smoked while pregnant; in 2021, the Neonatal Abstinence Syndrome (NAS) rate for Michigan was 6.5 per 1,000 live births; and from 2016-2020, 35.7% of pregnancy associated, not related, deaths were attributed to accidental poisoning/drug overdose

and 3.0% were attributed to suicide[4]. Furthermore, 69.9% of individuals with a live birth in 2021 stated they had experienced one or more life stressors (i.e., homelessness, close family member sick or died, loss of job, etc.) in the 12 months prior to delivery and 18.6% stated they had one or more unmet basic needs (i.e., skipped meals because there was not enough money for food; did not have safe housing; could not keep basic utilities on; etc.) during pregnancy.[5]

Michigan is working to address behavioral and mental health concerns through efforts of the Regional Perinatal Quality Collaboratives (RPQCs). The aim of the RPQCs is to develop innovative strategies to regionally address the drivers of adverse birth outcomes. Several RPQCs have been addressing perinatal substance use disorder (PSUD) through implementation of universal prenatal screening, increasing treatment capacity in their respective region, supporting nonpharmacological treatment of infants born substance-exposed, and offering educational opportunities in unconscious bias and stigma reduction. Depending on the availability of other funding sources, Title V funding is used as a gap-filling funding source for RPQCs. Title V MCH leadership is also closely involved in the work of RPQCs.

Strategies to achieve Objective B focus on providing resource supports through the RPQCs to implement and expand universal screening, as well as other services and resources to improve care and treatment of mental and behavioral health in pregnant people and their infants. Previous surveys of prenatal care clinics illustrated a lack of consistent or universal screening of patients for perinatal substance use and/or mental health conditions such as depression and anxiety. Universal screening of all pregnant people is the first step in addressing behavioral and mental health in this population, as well as the related stigma that surrounds these conditions in general. Subsequent linkage to behavioral and mental health professionals, treatment, and other supportive services is the essential next step for those identified through universal screening, or otherwise.

As of Spring 2024, five RPQCs have implemented prenatal screening at clinics that serve residents within their respective regions. West Michigan's major health system has built their preferred evidence-based screening tool into their electronic medical record. The screening tool is being utilized for both inpatient and outpatient care. Northern Lower Michigan, the Upper Peninsula, Saginaw/Bay area, and the Thumb area are working with clinics to implement an electronic screening tool that is based on evidence-based Screening, Brief Intervention and Referral to Treatment (SBIRT). Initial results have shown success both in patients completing the screening tool (upwards of 80-95% of patients) and in identifying pregnant people with behavioral and/or mental health concerns that might not otherwise have been assessed or addressed. Patients utilizing the screening tool have expressed their overall satisfaction and commented on the ease of use. Expansion of universal screening throughout the state is expected to continue in FY 2025.

Five RPQCs have implemented nonpharmacological care and rooming-in at birthing hospitals within their respective region for treatment of infants born substance-exposed. The programs encourage a family-centered approach where infants remain with their birthing person in a quiet, calming environment in which breastfeeding, skin-to-skin and bonding techniques are encouraged instead of the infant's immediate admission to the Neonatal Intensive Care Unit (NICU) for care and treatment. The RPQCs continuously seek feedback from families that have utilized the program; one RPQC has an advisory team that includes families with infants born substance exposed. These families were vital in the design and implementation of the rooming-in program at the regional hospital. Families are linked to supportive services and resources prior to discharge from the hospital. It is expected that as the hospitals continue implementation and garner patient feedback, they will grow and expand their programs.

Stigma and bias can impede care and treatment for pregnant people with mental and behavioral health concerns, leading to adverse health outcomes. RPQCs will continually be encouraged to provide educational opportunities in bias, equity, and stigma reduction for Collaborative members and perinatal care providers. These opportunities are

intended to be arenas for personal growth to increase awareness and knowledge, while reinforcing the need to be conscious of personal biases which can affect clinical judgement. Ideally, the opportunities will also stimulate the desire to create systemic and cultural change within the provider's facility, creating a safer and more inclusive space for prenatal, postpartum, and infant care.

The final strategy for this objective is to continue collaborative efforts between CSHCS and BCCHPS to process Tax Equity and Fiscal Responsibility Act (TEFRA) applications for families. TEFRA application processing requires a behavioral health assessment, which is completed by BCCHPS, and a nursing level of care assessment which is completed by the CSHCS Division. These completed assessments are then discussed to determine eligibility, while simultaneously reviewing other Michigan waiver program slots to seek appropriate placement, if applicable. This collaborative effort streamlines enrollment processes for TEFRA and the Michigan waiver programs which minimizes waitlists and enhances access to needed specialty services for children who are currently unable to access. This strategy aligns with the "*Blueprint*" Access to Services Area, Principle 3a, "Eligibility criteria and enrollment processes for services and supports are linked and streamlined across programs."

Objective C: Support increased collaboration and engagement between Title V and behavioral health partners.

The first strategy for this objective is to reflect the unique challenges of CYSHCN and their families in decisions related to the behavioral health system of care. This is accomplished through monthly meetings with leadership from the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) and CSHCS. During these meetings, leadership discusses important topics that impact a shared population of children with behavioral health and special physical/medical health care needs. This strategy aligns with the *"Blueprint"* Access to Services, Principle 3 "Service sectors increase the ability of CYSHCN and their families to access services by addressing administrative and other processes that hinder access."

The second strategy is to continue providing CSHCS, Family Center, and CSN Fund educational sessions at the Home and Community-Based Waiver Conference, the Michigan Council for Exceptional Children Conference, and Community Mental Health Association seasonal conference series. These educational sessions provide general information on the CSHCS program, describe how to access services, explain the relationship between CSHCS and the community mental health system of care, and introduce the Family Center. The CSN Fund presentation shares important information on how the CSN Fund helps families and the best way to approach the CSN Fund for support. This strategy aligns with the "*Blueprint"* Family & Child Well-Being and Quality of Life Critical Area, principle 1d, "Service providers and professionals have the tools they need to practice culturally responsive, family-centered, trauma-informed care for CYSHCN and their families." In FY 2025, the Family Center will offer training for families on accessing care and services from physical and behavioral health providers. The training will include a background on the two systems and tips and strategies for effectively navigating both systems to coordinate care for their child with special health care needs.

The final strategy for this objective is to continue collaborative efforts between divisions to process Tax Equity and Fiscal Responsibility Act (TEFRA) applications for families. TEFRA application processing requires a behavioral health assessment, which is completed by BCCHPS, and a nursing level of care assessment which is completed by the CSHCS Division. These completed assessments are then collaboratively discussed by both divisions to determine eligibility, while simultaneously reviewing other Michigan waiver program slots to seek appropriate placement, if applicable. This collaborative effort streamlines enrollment processes for TEFRA and the Michigan waiver program which minimizes waitlists and enhances access to needed specialty services for children who are currently unable to access. This strategy aligns with the "*Blueprint*" Access to Services Area, Principle 3a, "Eligibility criteria and enrollment processes for services and supports are linked and streamlined across programs."

Objective D: Support students' mental health and wellness through implementation of Handle with Care.

Handle with Care (HWC) is an initiative designed to promote communication between local law enforcement and schools. When law enforcement is on the scene of an incident that was experienced or witnessed by a school-aged child, they determine what school the child attends and a "Handle with Care" notice is sent to the child's school before the bell rings the next day. School staff are encouraged to handle that child with care and look for possible signs that the trauma the child experienced is affecting his or her behavior in school.

The goal of HWC is to help students succeed in school. Regardless of the source of trauma, the common thread for effective intervention is the school. Research shows that trauma can undermine children's abilities to learn, form relationships, and function appropriately in the classroom. A national survey of the incidence and prevalence of children's exposure to violence and trauma revealed that 60% of American children have been exposed to violence, crime, or abuse; 38% were direct victims of two or more violent acts[6]. Prolonged exposure to violence and trauma can impact a child's ability to focus, behave appropriately, and learn in school. In turn, this can lead to school failure, truancy, suspension or expulsion, dropping out, or involvement in the juvenile justice system.

HWC promotes school-community partnerships so that children who are exposed to trauma in their home, school, or community receive appropriate interventions to help them achieve academically despite experiences of trauma. HWC is a partnership between law enforcement, schools, and mental health providers, and connects students and families to mental health services. Schools that participate in HWC are encouraged to implement individual, classroom, and whole school trauma sensitive strategies so that traumatized children are "Handled with Care." If a child needs more intervention, on-site trauma-focused mental healthcare is available at the school, or a referral is made to a community provider.

Title V block grant dollars are being used to fund the expansion, maintenance, and enhancement costs associated with the online notification system. All objectives will be continued and expanded upon in FY 2025.

The first strategy for this objective is to enhance and expand the current online system to track HWC notices. In FY 2022, Title V funding was used to create a centralized online notification system that streamlines and automates HWC notices from law enforcement to the appropriate school liaisons. The HWC state team holds monthly office hours for two user groups (law enforcement and schools) to gather feedback on the app and troubleshoot concerns. A "wish list" of improvements is kept by the state team and as funding is available, enhancements are made to improve useability and efficiency. In FY 2025, further enhancements to the online notification system are anticipated to improve the user experience.

The second strategy for this objective is to monitor HWC notices among counties participating in the online notification system. Prior to development of the online notification system, each site was tasked with manually creating, tracking, and responding to notifications. Local HWC partners expressed a need for a centralized system for submitting and tracking notices. This need led to the development of the online notification system. In FY 2022, two counties piloted the newly developed system, submitting 108 notices from law enforcement to schools during the pilot process. Initial feedback from those initial implementing counties indicated that the notification system was simple to use, efficient and streamlined communication for law enforcement to submit a HWC notice and for the local school entity to receive the information. The system also stores data about notices sent for law enforcement and schools to access at any time and to provide reports and data to community partners.

Over the past two years, further expansion has occurred with nine counties currently utilizing the system. To date, notices impacting over 600 students have been submitted through the HWC app. In FY 2025, it is anticipated that an additional five counties will onboard and begin utilizing the system. Communities receive a $2,000 stipend to help

offset any costs associated with the onboarding process. The overarching goal is to have all 83 counties in Michigan implement HWC and utilize the online system in the future.

The third strategy for this objective is to provide training and onboarding support to new schools and counties to assist in expanding HWC. Monthly office hours convened by the HWC state team serve as a means for system users to receive technical assistance and troubleshoot any program related issues. Comprehensive training videos and user guides are made available for each of the key roles utilizing the HWC notification system including Law Enforcement Administrators, Law Enforcement Officers, and School Administrators. The HWC state team continues to streamline the onboarding process so that HWC counties are well positioned to utilize the online notification system, make changes locally and provide follow-up as needed. In addition, the HWC state team regularly works with local HWC programs that are not utilizing the system but need technical assistance and support related to creating trauma-informed school communities. Lastly, the state team makes themselves available to any youth-serving entity to provide introductory presentations and trainings on HWC or trauma-informed systems. All training and onboarding related activities will continue in FY 2025 with the state team finding ways to improve efficiencies. It is anticipated that a new HWC Coordinator will be hired in FY 2025 to support all HWC project activities; this position is dependent upon securing additional funding.

Current plans are for the online notification system to be available in FY 2025 to all interested counties and to have the necessary supports to onboard and provide seamless support. Early use of the online notification system has shown that it can streamline communication and create efficiencies when starting a new HWC program locally. Additionally, it supports improved communication for existing local HWC programs and aids in clearly defining roles/responsibilities and ensuring all users are implementing the program with fidelity. It is anticipated that the online notification system will continue to be an incentive for additional counties to adopt the HWC program and allow for more widespread trauma-informed supports in Michigan's schools.

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[1] Children's Hospital of Philadelphia. Perinatal or Postpartum Mood and Anxiety Disorders. Perinatal or Postpartum Mood and Anxiety Disorders | Children's Hospital of Philadelphia (chop.edu)
[2] 2021 Birth Year: Michigan PRAMS Maternal and Infant Health Summary Tables. 2023-07-17---2021-MI-PRAMS-Annual-Tables.pdf (michigan.gov)
[3] Centers for Disease Control and Prevention. 2011-2021 Youth Risk Behavior Survey Data Summary & Trends Report CDC releases the Youth Risk Behavior Survey Data Summary & Trends Report: 2011-2021 | 2023 | Dear Colleague Letters | NCHHSTP | CDC
[4] Michigan State Health Assessment 2022 Addendum. Michigan State Health Assessment Report Addendum 2022 (govdelivery.com)
[4] Source: Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services
[5] 2020 Birth Year: Michigan PRAMS Maternal and Infant Health Summary Tables
[6] Finkelhor D, Turner H, Ormrod R, Hamby SL. Violence, abuse, and crime exposure in a national sample of children and youth. Pediatrics. 2009 Nov;124(5):1411-23. doi: 10.1542/peds.2009-0467. Epub 2009 Oct 5. PMID: 19805459.

III.F. Public Input

A draft of the narrative components of the Title V FY 2025 application/FY 2023 annual report will be posted on the Michigan Department of Health and Human Services (MDHHS) website for public review and comment. Public input will also be invited through notification to over 50 MCH and CSHCN advisory groups, community-based partners, nonprofit partners, advocacy groups, and other state programs. Notice will be sent to all 45 local health departments via the Local MCH program. Additionally, individuals who participated in the 2020 Needs Assessment Stakeholder Group and Population Domain Workgroups will receive notification of the posting. This year's public posting will specifically encourage feedback on the Title V state action plans, which reflect most Title V activities and investments, to help make the review process more manageable and accessible for the public. After the public posting period closes, public comments will then be presented to the Title V steering committee and relevant MCH program staff for review and consideration prior to submission of the final grant application.

After the application has been submitted, MDHHS will continue to work with entities representing advocates, advisory bodies, providers, families, and consumers to receive input on Michigan's Title V work and other MCH efforts. For example, the Children's Special Health Care Services (CSHCS) Division routinely works with Michigan Family Voices (MIFV), the Family Leadership Network, and the CSHCS Advisory Committee (CAC). Quarterly meetings with MIFV and the ARC Michigan provide an opportunity for information sharing and feedback on CSHCS initiatives and activities. The Family Leadership Network provides a diverse community-based perspective on programs and policies as well as a platform for the development of new family leaders. 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.

Families and consumers are also represented in strategic planning initiatives aimed at advancing maternal, infant, and child health outcomes. For example, to implement the state's *Advancing Healthy Births: An Equity Plan for Michigan Families & Communities (2024 – 2028)*, MDHHS leads the Mother Infant Health and Equity Collaborative, which consists of representatives from hospitals and local health departments, parents and community members, and partners from research institutions, professional associations, community organizations, state programs and nonprofit organizations. In 2023, 12 in-person town hall meetings were held in each region of the state to obtain input from local communities and families on their experiences and priorities related to maternal and infant health. Regional Perinatal Quality Collaboratives hosted the town halls in collaboration with the Division of Maternal and Infant Health. The feedback obtained via the town halls informed the *Advancing Healthy Births* plan and will also inform the 2025 Title V needs assessment. Additional town halls are planned in 2024 as part of a continuing listening and feedback loop with partners and communities.

Families and consumers also serve on advisory committees for home visiting, oral health, infant safe sleep, Family Planning, Early Hearing Detection and Intervention, Teen Pregnancy Prevention Program local coalitions, Parent Leadership in State Government, Fetal Alcohol Spectrum Disorder, and more. An assessment of family and community engagement within Title V programs is also being developed for the 2025 needs assessment.

III.G. Technical Assistance

With the release of the new three-year Title V Guidance in January 2024 by the Health Resources and Services Administration (HRSA), Michigan's Title V program may seek out additional information and assistance on the contents and requirements of the new Guidance. In particular, the Guidance outlines expectations and requirements for the next five-year needs assessment, including new universally required National Performance Measures. Michigan anticipates that technical assistance will be utilized through the MCH Evidence Center and other TA partners specifically related to the new Postpartum Visit NPM (in the Women/Maternal Health domain) and Medical Home NPM (in the Child Health and CYSHCN domains), particularly in relation to the development of evidence-based and informed strategy measures and the creation of state action plans for the FY 2026–FY 2030 cycle. Having additional information on states' approaches to these new measures (including what states have found to be effective) will also be helpful. Michigan may also seek TA related to implementation of the *Blueprint for Change: A National Framework for a System of Services for Children and Youth with Special Health Care Needs*. For example, TA may be sought related to tools to translate and implement the *Blueprint,* either in relation to the needs assessment or the CSHCN state action plans. Other technical assistance needs may include information and assistance with new forms, such as Form 7 – Title V Program Workforce, as well as evidence-based/informed strategies related to new Title V NPMs.

Additionally, as Michigan's Title V program continues to implement its FY 2025 state action plan in the current five-year period, it will identify any areas of needed technical assistance. Based on Michigan's current priorities, these areas may include integration and implementation of health equity and family engagement strategies in Title V state action plans, as determined by MCH program areas; ongoing learning opportunities and technical assistance related to evidence-based or informed strategy measures; or sharing of best practices and other peer learning opportunities (e.g., between states or within regions).

In addition to these potential areas of technical assistance, many training needs are met by professional development opportunities provided by HRSA and AMCHP throughout the year. These include the AMCHP Conference, HRSA learning labs, and regional meetings. For example, staff from the Division of Maternal and Infant Health have been participating in the Region V CityMatCH Alignment for Action Learning Collaborative "Culture of Equity" assessment. Training or technical assistance provided by HRSA and AMCHP, especially in relation to performance measures, the Title V Information System, and other Title V priorities or requirements, is shared with relevant MCH programs and staff throughout the year.