Maternal and Child Health Services
Title V Block Grant

Michigan

FY 2017 Application/FY 2015 Annual Report

DRAFT

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I. General Requirements

I.A. Application/Annual Report Executive Summary

Michigan's Title V Maternal and Child Health (MCH) program operates under the vision of the Michigan Department of Health and Human Services (MDHHS) to promote better health outcomes, reduce health risks and support stable and safe families while encouraging self-sufficiency. The Title V program is housed within the Division of Family and Community Health (DFCH) and works collaboratively with the Children's Special Health Care Services (CSHCS) Division. In Michigan, Title V funding is used to support both state and local MCH activities. At the state level, funding is used within DFCH and CSHCS to support a wide range of MCH priorities and needs, as highlighted in this application. At the local level, funding is distributed to local health departments to meet locally-identified needs, particularly those that align with Michigan's national and state performance measures.

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

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

MDHHS developed action plans that align with each priority need and will measure progress via National Performance Measures (NPMs) and State Performance Measures (SPMs). Michigan's priorities, measures, and action plans cover each of the six Title V population domains. A summary is included below, and detailed action plans can be found in Section II.F.1.

Women/Maternal Health: In order to address several identified gaps in women's and maternal health, MCH leadership prioritized the need to "Reduce barriers, improve access, and increase the availability of health services." Michigan selected the NPM "Percent of women with a past year preventive medical visit" as a measure of progress toward addressing this priority need. Michigan has seen an increase in the use of long-acting reversible contraceptives and an increase in the percent of pregnancies that are intended. However, given changing funding for family planning, gaps in provider capacity to offer long-acting reversible contraceptives, and slow uptake in the provider community around discussing reproductive life planning with

clients, MCH staff developed a five-year plan focused on ensuring women have the reproductive and health care services they need to plan for pregnancy. The plan's objectives and strategies include outreach to improve awareness of family planning clinics; increasing the use of highly effective contraceptive methods among family planning clinics; providing tools for providers to support reproductive life planning; intensifying local efforts to support health insurance enrollment; and linking women who receive family planning to primary care providers.

Perinatal/Infant Health: MCH leadership prioritized two needs to improve health outcomes in the perinatal and infant stage of the life course: "Support coordination and linkage across the perinatal to pediatric continuum of care" and "Foster safer homes, schools, and environments with a focus on prevention." Progress will be measured by two NPMs: "Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)" and "A) Percent of infants who are ever breastfed and B) Percent of infant's breastfed exclusively through 6 months." Progress toward fostering safer environments will be measured by a SPM: "A) Percent of infants put to sleep alone in their crib, bassinet or pack and play and B) Percent of infants put to sleep without objects in their crib, bassinet or pack and play."

Although Michigan has had several successes in perinatal and infant health, sufficient progress has not been made toward improving the percent of VLBW infants delivered at appropriate facilities or in its breastfeeding rates. Additionally, while the percent of infants who are put to sleep on their backs has steadily improved, the percent of infants who sleep in safe environments has not. Moreover, inequities in access to birthing facilities, breastfeeding, and safe sleep set the stage for disparate health outcomes across the life course.

To support coordination and linkage across the perinatal to pediatric continuum of care MCH staff developed two five-year action plans. The first plan focuses on piloting community perinatal care systems; expanding the use of the March of Dimes Preterm Labor Assessment Toolkit by birth hospitals; promoting case management for at-risk pregnant women through home visiting; developing surveillance processes to monitor risk appropriate deliveries; and providing medical providers with training in screening/referral for substance abuse. The second plan focuses on developing a state breastfeeding plan; increasing the number of baby-friendly hospitals; improving surveillance systems related to breastfeeding initiation, duration and exclusivity; and increasing the percentage of VLBW babies who receive breast milk.

To foster safer environments, MCH staff developed a five-year plan to promote infant safe sleep, which includes building community capacity to implement safe sleep education and outreach activities; improving connections with non-traditional partners; developing new public awareness strategies for promoting safe sleep; and supporting providers who work with families to have effective conversations about safe sleep.

Child Health: In order to improve child health in Michigan, MCH leadership identified two priority needs: “Invest in prevention and early intervention strategies, such as screening” and “Foster safer homes, schools, and environments with a focus on prevention.” Progress toward investing in prevention and early intervention will be measured by the NPM “Percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool.” Based on parent self-report, the percentage of children who have received a developmental screening has been steadily increasing. However, Michigan does not have a system for consistently measuring developmental screening at the population level aside

from the National Survey of Children's Health, which is not available with sufficient frequency or at the local level. This gap in the state's public health infrastructure makes surveillance of developmental concerns challenging. The state's five-year plan focuses on development of a statewide developmental screening system, including developing screening and referral procedures; procedures for responding to referrals; and strategies to report results to families.

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

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

To address this priority, MCH staff developed a five-year plan which includes improving adolescent preventive visits, focusing on Medicaid eligible youth; increasing the number of providers trained on culturally-competent, adolescent-friendly care; increasing the proportion of adolescents with a documented well child exam in Michigan's Child and Adolescent Health Centers (CAHCs); and developing a social media campaign to promote adolescent well-care and targeted health messages.

Children with Special Health Care Needs (CSHCN): Based on the issues facing CSHCN, MCH leadership prioritized "Increasing family and provider support and education for CSHCN" and "Reducing barriers, improving access, and increasing the availability of health services." In order to measure progress toward increasing family and provider support and education, two NPMs were selected: "Percent of children with and without special health care needs having a medical home" and "Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult care." To measure progress toward reducing barriers, improving access, and increasing services, MCH staff developed a SPM: "Percent of CYSHCN enrolled in CSHCS that receive timely medical care and treatment without difficulty." Although Michigan's system for meeting the needs of CYSHCN has many strengths, especially around family engagement and support, the needs assessment identified opportunities for strengthening the system. Too few CYSHCN have access to a medical home or transition services, and CYSHCN face barriers to accessing the services they need.

Michigan developed three separate state action plans to address the needs of CYSHCN. To increase family and provider support and education and to increase access to a medical home, CSHCS staff developed a plan that includes providing training to medical home providers;

partnering to improve systems of care; developing reimbursement mechanisms that support the functions of a medical home; and increasing families' understanding of the benefits of a medical home. To improve transitions to adult care, Michigan's action plan includes expanding the use of transition planning; increasing youth and family awareness and understanding of the transition process; and increasing provider awareness and understanding of the transition process. Finally, to improve medical services and treatment for CSHCN, the plan includes covering specialty care and treatment costs when insurance is inadequate; supporting healthcare delivery models that focus on care coordination and family partnership; expanding the use of telemedicine; and strengthening care coordination, case management, and support services provided to CYSHCN and their families through local health departments.

Cross-cutting/Life Course: Based on the strategic issues identified in the needs assessment process, MCH leadership selected three cross-cutting or life course priorities. Progress toward the first priority "Increase access to and utilization of evidence-based oral health practices and services" will be measured by the NPM "A) Percent of women who had a dental visit during pregnancy and B) Percent of children who had a preventive dental visit in the past year." Increasing access to oral health services for CSHCN will be part of this priority. Both pregnant women and children lack access to dental care in Michigan. To improve access to and utilization of oral health services, Michigan's five-year plan will expand the SEAL! Michigan program to promote dental sealants through schools; establish a state plan for improving oral care for the MCH population; increase training for medical and dental providers who treat pregnant women and infants; distribute perinatal oral health guidelines and educational materials; and establish a communication plan.

Progress toward the second priority, “Promote social and emotional well-being through the provision of a continuum of behavioral health services,” will be measured by a two-part SPM: “A) Percent of high school students who report feeling sad or hopeless almost every day for two or more weeks in a row, to the extent they stopped doing usual activities during the prior 12 months and B) Percent of women who enrolled in the Maternal Infant Health Program who are screened for depression.” Depression is a serious public health concern across two high-need populations in Michigan: adolescents and postpartum women. MCH staff developed an action plan for improving adolescent mental health; strategies include training school district personnel on concerns related to social and emotional health and promoting telepsychiatry among CAHCs. To address depression in the postnatal period, Michigan’s action plan focuses on expanding participation in the Maternal Infant Health Program, which provides home visits to prenatal and postpartum women, and improving the program’s approach to depression screening and referral.

Finally, progress toward the third priority “Invest in prevention and early intervention strategies, such as screening” will be measured by the SPM “Percent of children 19-36 months of age who have received a completed series of recommended vaccines and B) Percent of adolescents age 13-18 who have received a completed HPV vaccine series.” Immunization rates among some of the state’s populations have not met Healthy People 2020 objectives. In particular, the immunization rate among children 19-35 months is a concern, as is the percent of adolescents who have received the HPV vaccine. To address these priorities, MCH staff developed an action plan that includes generating letters to parents who have children or

adolescents with overdue immunizations and providing immunization data to providers and health departments to support quality improvement efforts.

II. Components of the Application/Annual Report

II.A. Overview of the State

Principal Characteristics of the State

Michigan's Title V Maternal and Child Health (MCH) program operates within the larger context of public health services as articulated by the mission of the Michigan Department of Health and Human Services (MDHHS) to provide opportunities, services, and programs that promote a healthy, safe, and stable environment for residents to be self-sufficient. In 2015, to reshape and align programs and services, the Department of Community Health (which historically housed Title V) and the Department of Human Services merged to form the MDHHS. In 2016, state administration of Title V was moved to the Division of Family and Community Health (DFCH), which is now housed in the newly created Bureau of Epidemiology and Population Health.

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

initiatives of mutual importance and responsibility, which are described throughout this application.

According to the U.S. Census Bureau, Michigan's population is 9,922,576 (July 2015 Current Population Survey). Michigan has seen a steady decrease in birth rates over the past 20 years, including a decline in teen births. The majority of Michigan's population resides in the southern half of the Lower Peninsula, with approximately half of the population residing in Southeast Michigan. Out of the current total population, approximately 22% are age 0-17 and 78% are age 18 and over (Kids Count). According to 2014 U.S. Census Bureau data, Michigan's population is 79.9% White (with 78.9% identifying as White alone, not Hispanic or Latino), 14.2% Black or African American, 2.9% Asian, 2.3% two or more races, and 0.7% American Indian and Alaska Native. Out of the total population, 4.8% identify as Hispanic or Latino.

Michigan's economy has seen significant improvements over the past seven years, with the seasonally adjusted unemployment rate decreasing from 14.9% in June 2009 to 4.8% in April 2016. The median household income in Michigan in 2014 was $49,847 (U.S. Census Bureau). However, the state still faces significant challenges that impact the MCH population. For instance, certain areas of the state continue to experience high unemployment. In March 2016, Detroit's unemployment rate was 11%. According to Kids Count in Michigan (2015), from 2006 to 2013 Michigan improved on eight key indicators of child well-being but regressed on five.

Despite the state's economic recovery, poverty has remained a significant problem—especially for Michigan's children. According to Kids Count, 22.6% of children (ages 0-17) live in poverty. Overall, 16.2% of Michigan's population lives in poverty. Of additional concern are findings from

the 2014 ALICE (Asset Limited, Income Constrained, Employed) report by the Michigan Association of United Ways which found that even in households with earnings *above* the FPL, 40% of households struggle with basic necessities of housing, child care, food, health care and transportation. In addition to households *below* the FPL in Michigan, this equates to more than 1.54 million households struggling to meet basic needs. Certain areas of the state are particularly impacted. For instance, in addition to the 38% of households with income below the FPL in Detroit, an additional 29% are ALICE households.

Family support programs continue to be an important source of assistance. As of May 2016, an estimated 1,492,286 persons participated in Michigan's Food Stamp Program (USDA). Thirty-eight percent of pregnant mothers enroll in WIC during their first trimester and 54% of babies born in Michigan are enrolled in WIC. Out of WIC families, 90.5% live below 150% of the FPL.

Agency Priorities and Title V Program Roles

The Title V program is administered by the Division of Family and Community Health (DFCH). DFCH supports the MDHHS vision to develop and encourage measurable health, safety and self-sufficiency outcomes that reduce and prevent risks, promote equity, foster healthy habits, and transform the health and human services system to improve the lives of Michigan families. DFCH is responsible for over 60 initiatives/programs designed to achieve core MCH outcomes. Activities include needs assessment; policy recommendation; development/promotion of best practices; and evaluation to provide quality, accessible, culturally-competent services within the context of health care reform.

The life course framework is the model for DFCH's organizational structure and its strategic plan, and is central to the Department's goal to protect, preserve and promote health with special attention to the needs of the vulnerable and underserved. The life course perspective recognizes that health outcomes are the product of the complex interplay over time between an individual and his/her environment, and emphasizes that both early experiences and exposures during key periods can have a lasting impact on health and development. Organizationally, DFCH units are based on the life stages: reproductive/interconception; maternal/perinatal; infant; child; and adolescent and family. Oral health spans all stages. While DFCH units concentrate on their respective phase of the life course, they also coordinate, complement and build on adjacent life stages. An important component of this life course perspective is redefining key health outcomes and performance measures to align across the lifespan. DFCH is working toward developing an integrated set of key health outcomes that align with the life course perspective. DFCH also collaborates with CSHCS since the infant, child and adolescent health issues addressed in DFCH also impact Children and Youth with Special Health Care Needs (CYSHCN).

MDHHS is committed to achieving health equity throughout Michigan. In August 2013, the Practices to Reduce Infant Mortality through Equity (PRIME) initiative released the state's first Health Equity Status Report. The report presented data for 14 indicators related to social determinants of health and health disparities (including psychosocial, socioeconomic, basic needs and health care access). The report demonstrated what has been long recognized: persistent racial and ethnic disparities exist across health, education and income that are systemic, avoidable and unjust. The report also made recommendations for reducing health

inequities in MCH. A key strategy focusing on social justice recommended broad-based training for staff within the former Bureau of Family, Maternal and Child Health, as well as in local public health, to support shared goals and collective impact.

A key MDHHS initiative has been to eliminate disparities in infant mortality (IM). Governor Snyder identified the reduction of IM as a top priority, providing gubernatorial leadership on this issue. IM is considered a critical indicator of the health status of the state, the availability and quality of health care services, and exposure to socioeconomic stress. The disparities in Michigan's IM rates suggest not all population groups have the same opportunity to access health services and to reach their health potential. In 2012, Michigan published its IM Reduction Plan which recommended a set of strategies to address the multiple, complex causes of IM, including social determinants of health. The plan emphasized collaboration between government, health care providers, LHDs, universities, professional organizations, businesses and community leaders. In 2015, MDHHS updated the infant mortality reduction plan for 2016-2019 with an increased focus on achieving health equity and eliminating racial and ethnic disparities. Additionally, in 2015 MDHHS released the *Practices to Reduce Infant Mortality through Equity (PRIME): Guide for Public Health Professionals*. The guide was shared with state and national stakeholders and is an informational resource for transforming public health through equity education and action.

Early childhood system building has been central to DFCH's current initiatives related to infancy and childhood. Governor Snyder has defined a set of prenatal to age 8 outcomes and created an Office of Great Start (OGS) within the Michigan Department of Education to lead the

integration of the state's health, development and early learning investments. DFCH collaborates closely with OGS and other partners across state government to support the development of early childhood systems that are integrated and designed around the needs of children and families. One example has been Michigan's federal Early Childhood Comprehensive Systems grant. Through the grant, Michigan has worked across systems to build a trauma-informed approach into programs and services for young children, with a focus on the mitigation of toxic stress. Additionally, Michigan's implementation of the Maternal Infant and Early Childhood Home Visiting (MIECHV) Program involves collaboration across early childhood systems to assure that, as home visiting expands, it is integrated with other early childhood services and offers a continuum of home visiting services that align with what families want and need.

Health Care Reform

Since becoming law in 2013, the Affordable Care Act (ACA) has significantly impacted how health care is accessed and delivered. Health care reform efforts have made broad and profound changes to health care delivery, access and the scope and breadth of services provided—all of which have significantly impacted Michigan's MCH populations. ACA coverage expansions provided Michigan consumers with two new options: the Healthy Michigan Plan (HMP) and the Health Insurance Marketplace (Marketplace). In January 2014, eligible individuals above 133% of the federal poverty level (FPL) could enroll in private health insurance coverage through the Marketplace. In April 2014, Michigan expanded its Medicaid program to cover residents aged 19 to 64 who were at or below 133% of the FPL, and who were

not previously eligible for traditional Medicaid. Between the HMP and the Marketplace, Michigan insured over 700,000 people in less than a year, exceeding initial enrollment expectations.

HMP benefits include preventive/wellness services, chronic disease management, prenatal care, oral health and family planning services. Most HMP beneficiaries are required to pay some level of cost-sharing in the form of monthly contributions and co-pays based on income. Some populations are excluded from cost sharing, such as individuals under 21 years of age, pregnant women, and those who have no income. Enrollees who complete a health risk assessment and agree to maintain or address healthy behaviors, as attested to by their primary care provider, are eligible for cost-sharing reductions or other incentives.

For CYSHCN, ACA consumer protections have greatly improved access to private insurance by eliminating preexisting condition exclusions and discrimination based on health status, the two most frequently encountered enrollment barriers for families. The ACA also expanded access to parent employer coverage for adults 19-26. The HMP covers approximately 700 individuals who are dually enrolled in it and CSHCS. LHDs, Family Resource Centers and designated state staff work with families and community partners to help families understand and access all available private and publicly-funded resources to meet individual needs.

CYSHCN often require and use more health care services than other children. Specialty care and extensive, on-going or long-term treatments and services may be required to maintain or improve health status. Financing these costs can pose significant challenges and burdens for families even with access to private insurance. Family health care costs can include deductibles,

cost sharing and premium payments. In addition, private insurance may not include any covered benefit for a specific, medically necessary service. In other cases, only a limited benefit may be available through insurance. Although ACA eliminated annual and lifetime dollar limits, other annual limits exist and benefits may be exhausted for the current contract year even though needs continue. As such, CSHCS continues to be a significant resource for achieving adequate, appropriate health and specialist care and helps to limit costs to families. Steady CSHCS enrollment following ACA's implementation reflects the value of CSHCS to families even when private insurance is available.

ACA also provided significant resources targeted to MCH services including home visiting programs. Michigan received funding to increase home visiting services through MIECHV which allowed a greater number of families and children to be served in additional communities. Additionally, through community partner collaboration, increased funding was allocated by the state legislature for evidenced-based home visiting programs, furthering access to home-based services. In FY 2015, Michigan's Home Visiting Initiative served 1,169 volunteer families, with 835 pregnant women and 1,344 children among its clients.

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

health care and community resources. During the SIM test design process, stakeholders committed to the aims of better health, better care, and lower costs, and set specific, measurable, attainable, realistic, and timely targets. These initial goals reflect the state's determination to tackle the challenges of better health and better care at a lower cost. While the model is being tested and continues to evolve, these goals and metrics will also evolve to better reflect what is occurring on the ground and other external factors. Milestones reached during the last year include evaluating and selecting the five SIM regions, identifying backbone organizations for the regions, designing an evaluation plan, hosting several statewide webinars to provide additional details on SIM to participants and stakeholders and executing detailed Collaborative Learning Network design and planning.

Finally, ACA provided significant funds through HRSA to expand access to primary care by increasing the number of Community Health Centers in Michigan. In the last two years, the number of Federally Qualified Health Centers (FQHCs) grew as additional centers were funded and look-alike sites were approved. Michigan now has 240 centers providing care to more than 615,000 patients annually. Of those served, 34% are children less than 18 years old and 44% are women ages 15-44.

Factors that Impact Health Services Delivery

While many strengths and opportunities in Michigan are being leveraged to support and expand the MCH infrastructure and delivery system, significant competing factors will also receive attention through 2020. As Michigan emerges from a decade of economic decline, health care spending and costs continue to pull attention away from a public health and

primary prevention focus that is needed to truly improve the health and wellness of all Michigan citizens. Core state infrastructure components such as roads and bridges, public safety services and environmental threats compete for state resources and public support. Rebuilding Michigan's economic climate is critical to resourcing health and wellness, as well as other key areas that can drive people to or from living and working in Michigan.

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

Addressing social determinants of health holds the same challenge. Stakeholders increasingly understand that access to transportation, education, adequate and sustainable income, and social and cultural supports are critical to achieving and maintaining health. However, knowing where and how to improve these factors in high-risk communities is not easy. Furthermore, the

layered funding that communities receive from federal, state, local and private sources can be difficult to align. A lack of stable, ongoing funding coupled with inconsistent funding priorities contributes to an inability to make long-term, sustainable changes that are based on data-driven, community-based needs.

Health care costs also impact health services delivery. Both nationally and in Michigan, health care costs are driven by competing factors such as payment systems, malpractice regulations, chronic disease incidence, nursing care costs, emergency room "super utilizers," population demographics, prevalence of adverse health behaviors and the absence of access to hospitals and physicians within a reasonable geographic distance in rural areas. U.S. Census Bureau data indicate that there are many geographic regions in Michigan facing provider shortages, with the greatest provider shortage occurring among nurse practitioners. Using the U.S. Department of Health and Human Services designation for primary care professional shortage areas, 18.2% of Michigan's population has insufficient access to primary care. The state has 270 geographic primary medical care Health Provider Shortage Areas, with many located within Wayne County and in Detroit.

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

overnight stays. This requires extended time away from work/income, additional child care and other expenses.

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

Challenges for Delivery of Title V Services

After a decade-long recession, Michigan's economy has seen recent improvements, but women and children still face many economic disadvantages. According to Kids Count in Michigan, nearly one in four Michigan children live in poverty, up from 18% in 2006. Half of these children meet the definition of living in extreme poverty, with their families struggling to get by on incomes that are less than half the poverty level. Statewide, the percentage of students eligible for free or reduced price lunches has steadily increased in recent years. In 2013, nearly 70% of students were eligible for free or reduced price lunches.

Michigan's current unemployment rate is 4.8% (Bureau of Labor Statistics, 2016). However, many jobs are considered low-wage and many Michigan residents were unemployed for long periods of time during the recession. Notably, long-term unemployment impacts health and well-being**.** A 2013 study by the Urban Institute found that persons who have been out of work for more than 27 weeks see their incomes decline by as much as 40%. These individuals are likely to have poorer health and their children do worse in school and earn less income over time. Thus, the long-term impact of Michigan's recession is still being felt throughout the state.

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

Socioeconomic determinants of health such as education, unemployment and poverty as they specifically relate to IM were examined by the Health Equity Status Report. For every 1,000 babies born in Michigan, almost seven die by age one. The IM rate for African American and

American Indian babies is more than twice that of Whites. As poverty increases, IM rates also increase. At every level of poverty, the Black IM rate is higher than that of White infants. As the level of maternal education increases, IM decreases; but again, there are disparities between Black and White rates across all education levels. Because IM is an important indicator of the overall health of the population, it is one measure monitored on Michigan's Health and Wellness Dashboard.

Access to all forms of health care is a problem for many Michigan residents, particularly those living in rural areas. In 2011, the ratio of population to primary care providers in Michigan overall was 1268:1. However, in some rural counties the ratio was greater than 6500:1. According to the American Community Survey, the proportion of children aged 0-17 without health insurance in Michigan is 4.0%. However, older children and adolescents aged 6-17 were more than twice as likely to be uninsured compared to children under 6 years of age (6.0% and 2.4% respectively). The greatest *number* of uninsured children resides in large urban counties, while the greatest *proportion* of uninsured children resides in low-income rural counties with relatively high unemployment rates. Lack of providers, health care facilities and lack of transportation all underscore the need for safety net services such as those provided to the MCH population by LHDs and through programs supported by MDHHS.

State Statutes Relevant to Title V

In FY 2016, state funding for MCH and CSHCS programs was appropriated through Public Act 84 of 2015 (Senate Bill 133). CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, in cooperation with the federal government under Title V of the Social Security Act

and the annual MDHHS Appropriations Act. State general fund dollars for MCH programs are itemized in Sec. 119 of Public Act 84 of 2015, whereas CSHCS is addressed in Sec. 121. Prenatal care is addressed in Sec. 1307 – 1308 and 1311. These sections essentially prescribe what funding shall be used for; MDHHS and contractor requirements; and requirements that some appropriated funding be used to implement evidence-based programs to reduce infant mortality. Statutory requirements in the FY 2016 omnibus budget for CSHCS included criteria in Sec. 1360 for MDHHS to provide services; and in Sec. 1361, the authorization that some of the appropriated funding be used to develop and expand telemedicine capabilities.

Current and Emerging Issues

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

Since the fall of 2015, the Flint water crisis has been a driving issue for MCH activities in Michigan. The state's MCH leadership is extensively involved in many aspects of the "Mission Flint" initiative to address the crisis and its potential impacts. MCH staff are leading efforts to increase accessibility and flexibility for case management services; expanding home visiting programs and educating home visiting stakeholders on lead testing and collaboration with case management providers; expanding school nursing and school-based health centers among K-12

public and charter schools; working with WIC clinics to support enhanced nutrition and promote breastfeeding/lactation support, and offer blood lead testing in the WIC clinic; and distributing lead and nutrition information and materials in Flint.

In partnership with our Medicaid Administration, MCH is working with existing and new providers to expand capacity for Medicaid Outreach and enrollment efforts for eligible children and families covered through Michigan's new Medicaid waiver. These activities are tracked via a weekly Mission Flint monitoring and update process. The Governor's office has also developed a dashboard of indicators to measure the impact of MCH and other activities in Flint, including case management, expansion of home visiting, and other activities related to health and nutrition.

To more clearly align programs and deliver population health services in Michigan, MDHHS underwent a reorganization within the Population Health and Community Services Administration in 2016. The Administration housed the former Bureau of Family, Maternal and Child Health (BFMCH) which historically administered Title V. The three divisions previously housed within the BFMCH were moved to three distinct bureaus. The Division of Family and Community Health (DFCH), which now administers Title V, was moved to the newly created Bureau of Epidemiology and Population Health. The Children's Special Health Care Services (CSHCS) Division moved to the Medical Services Administration, where it will continue to be active in Title V leadership and will continue to serve as the Title V CYSHCN Program. The Women, Infants and Children (WIC) Division moved to the Bureau of Health and Wellness. This

reorganization will support effective collaboration between program areas and increased communication within the Bureau of Epidemiology and Population Health.

MDHHS recognizes the need for access to a continuum of services across the life span that aligns with the needs of families. Addressing fragmentation of programs and services and breaking down silos are key components of several major initiatives. There is a particular need to build connections between behavioral health and health care systems for all populations. Data systems have the ability to support such connections, and MDHHS is working toward developing the capacity to connect records across data systems through a master person index. Such linkages would create the ability to follow individuals across systems and over time, creating a person-centered view of individual experiences and outcomes.

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

Per federal guidelines, this section cannot be edited in the five-year application cycle.

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

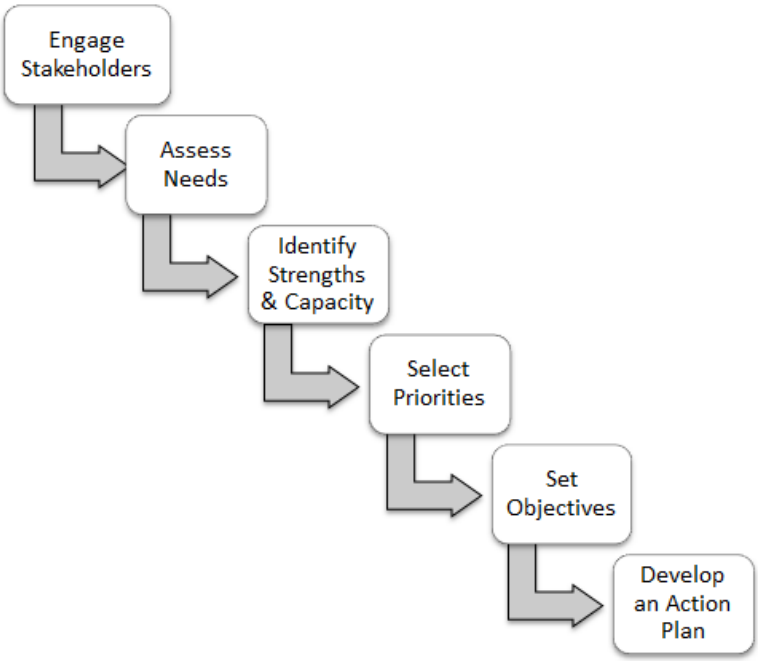
Process

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

- Engage a diverse group of stakeholders to assess both needs and system strengths and capacity;
- Utilize existing data and stakeholder experience and expertise to identify strategic issues or unmet needs, that, if addressed, would improve health in each of the six population health domains; and
- Identify priority unmet needs in each of the population health domains and strategies for addressing those needs.

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

Figure 1. Michigan's Needs Assessment Process



Engage Stakeholders

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

Table 1. Core MDHHS Representation on NAPC
Bureau of Family, Maternal, and Child Health
Division of Family and Community Health
Children's Special Health Care Services Division
Family Center for Children and Youth with Special Health Care Needs
Women and Maternal Health Section

Table 1. Core MDHHS Representation on NAPC
Early Childhood Health Section
Child, Adolescent, and School Health Section
Division of Life Course Epidemiology and Genomics
Maternal and Child Health Epidemiology Section

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

Assess Needs

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

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

Using these measures, the Maternal and Child Health Epidemiology Section within the Bureau of Epidemiology and the Children's Special Health Care Services (CSHCS) Policy and Program Development Section led the compilation and presentation of data. From the prioritized list, epidemiology staff reviewed health status data by race/ethnicity, trends and geography. A variety of different sources were used, such as the Michigan Behavioral Risk Factor Surveillance System (MI BRFSS), the Youth Risk Behavior Surveillance System (YRBSS), Vital Records, the National Immunization Survey (NIS), the American Community Survey (ACS), the National Survey of Children's Health (NSCH), the National Survey of Children with Special Healthcare Needs (NSCSHN) and the Pregnancy Risk Assessment Monitoring System (PRAMS). Epidemiology staff then selected indicators that suggested an unmet need (based on several factors). These indicators were reviewed by program staff, who suggested additional indicators to include.

Additionally, an online survey was developed to gather existing evaluation and consumer feedback information. Members of the NAPC reached out to program staff to complete the survey. Participants were asked to report on any program evaluation findings or consumer

feedback data collected in the past five years that suggested unmet needs related to maternal and child health.

Next, the three stakeholder groups—which included a total of 84 participants—were convened to review these data and participate in a consensus workshop designed to identify strategic issues. Core indicators were presented to the stakeholders and additional metrics and analysis were provided as data sheets. The presentations and data sheets formed the basis of a rich discussion of emerging issues, unmet needs, data gaps and disparities. Stakeholders were engaged throughout the process and provided information from their own perspective and experience. Throughout the presentations, participants were asked to note the unmet needs suggested by the data as well as their own experiences. After discussing the data, participants were asked to write down the 7-10 unmet needs they felt were most critical to improving health for the population group over the next five years. Participants then worked in small groups to build consensus around 6-8 unmet needs. After the small groups reached consensus, the entire workgroup built consensus around a set of strategic issues that reflected the unmet needs. Each of the three workgroups developed between 10 and 15 strategic issues, for a total of 37 strategic issues across the six MCH population domains. Out of these strategic issues, the NAPC selected Michigan's state priorities.

Examine Strengths and Capacity

To inform the process of identifying strategic issues, each stakeholder group also participated in a focused conversation designed to gather information about system strengths and capacity.

Each of the three workgroups was asked to reflect on the ways the MCH system supports each population group by identifying the following:

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

Feedback from each group was captured and summarized.

Select Priorities

The NAPC was responsible for reviewing the strategic issues identified by stakeholder workgroups and selecting strategic priorities. In April 2015, the NAPC selected the strategic priorities that will guide the implementation of the Title V Block Grant. The list of strategic issues was first narrowed by the leadership group by considering the following factors:

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

After narrowing the list, the remaining strategic issues were prioritized using a matrix methodology. Each issue was rated against two scales. The first scale was related to the difficulty of achieving change through a focused programmatic effort and the second was related to the potential to achieve an improved outcome or impact. Members of the leadership

group were asked to focus on the population domain they were most familiar with and rate the issue on each scale. They were asked to consider system strengths and capacity, their organizational structure and relationships, and existing priorities. Based on the matrix rating and their own expertise, the NAPC selected seven strategic priorities.

Select Performance Objectives

The NAPC selected NPMs based on the final priorities and the strategies that might be used to address those priorities. The selection of NPMs was also informed by current performance on the measure. Additionally, the NAPC identified priorities that will require state performance measures (SPMs) starting in FY 2017.

Develop an Action Plan

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

Findings

Michigan's priorities were selected based on identifying MCH population needs, the capacity of Michigan's MCH and CSHCN programs, and partnerships that expand the reach of these

programs. A summary of the findings that supported the selection of priorities is presented here.

MCH Population Needs

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

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

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

days in 2013, a slight but insignificant increase from 2011 (MI BRFSS). The rate of binge drinking among women in Michigan exceeded the U.S. rate of 17.2%.

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

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

Using the consensus process described above, stakeholders used the data presented and their experience and expertise to identify strategic issues that, if addressed, would improve women/maternal health in Michigan over the next five years. Strategic issues are presented in Table 2.

Table 2. Strategic Issues Identified by MCH Stakeholders

Population Domain	Strategic Issues
Women/Maternal Health	i. Support coordination and linkage across the perinatal to pediatric continuum of care ii. Integrate CHWs to improve systems navigation iii. Improve access to and education about reproductive life planning

Table 2. Strategic Issues Identified by MCH Stakeholders	
	iv. Assure quality accountable MIHP services v. Support access to appropriate obstetrical care vi. Access to and integration of improved health services including substance use, IPV, and mental health
Perinatal/Infant Health	i. Support coordination and linkage across the perinatal to pediatric continuum of care ii. Community level support for breastfeeding iii. Take a family-centered approach iv. Engage and support fathers v. Increased parenting support and strategies to facilitate bonding vi. Assure quality accountable MIHP services
Child Health	i. Invest in prevention and early intervention strategies (e.g., screening) ii. Foster safer homes, schools and environments with a focus on prevention iii. Invest in high quality early childhood programs and services (e.g., quality child care) iv. Implement a coordinated approach to health promotion that contributes to development and academic success
Adolescent Health	i. Support evidence-based bullying prevention programs ii. Foster positive adolescent sexual health education and development iii. Implement a coordinated approach to health promotion that contributes to development and academic success iv. Ensure social and emotional well-being through the provision of a continuum of behavioral health services v. Reduce barriers, improve access, and increase availability of health services
Children and Youth with Special Health Care Needs	i. Better utilization of data measuring performance and outcomes ii. Assure that all components of a medical home are put into practice iii. Increase coordination and collaboration in Systems of Care iv. Assure residents in all areas of the state have access to appropriate primary and specialty providers v. Care based on need not funding or program criteria vi. Remove barriers to access to improve health equity vii. Bridge mental, behavioral, developmental, and physical health viii. Lack of early and continuous screening ix. Lack of transition planning over the life course x. Increase family/provider support and education xi. Improve quality of life, healthy development and healthy behaviors across the life course

Table 2. Strategic Issues Identified by MCH Stakeholders	
Cross-cutting/Life Course	i. Provide culturally and linguistically competent services to address disparities and achieve health equity ii. Promote equity in funding, services, and health outcomes iii. Foster safer homes, schools and environments with a focus on prevention (e.g., opportunities for physical activity, lead poisoning prevention, preventing toxic stress & ACEs) iv. Improve quality of life, healthy development, and healthy behaviors across the life course v. Collaborate to improve access to basic needs vi. Early initiation and promotion of health education across the lifespan (e.g., obesity, smoking, parent education) vii. Support families to navigate the system viii. Ensure social and emotional well-being through the provision of a continuum of behavioral health services ix. Increase access to and utilization of evidence-based oral health practices x. Support the emotional health of the frontline workforce xi. Reduce barriers, improve access, and increase availability of health services

Perinatal/Infant Health: A total of 61 perinatal and infant health measures were reviewed. Measures that suggested an unmet need were prioritized and presented to stakeholders. Based on the data and the experience of key stakeholders, areas of unmet need included access to and coordination of care and services; health risks during pregnancy; disparities in infant mortality and safe sleep; and breastfeeding.

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

care in 2012 (MI Resident Live Birth File). (Note: Rates reported as White and Black include only non-Hispanic White and non-Hispanic Black populations.)

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

More White women reported smoking during the last three months of pregnancy than any other racial/ethnic group. In 2011, 16.8% of White women smoked during the last three months of pregnancy compared to 12.6% of Black women (PRAMS). However, the percent of women reporting that smoking was allowed in the home after delivery was much higher for Black women than White women (16.8% vs. 6.3% respectively, PRAMS). Overall, 14.7% reported smoking during the last three months of pregnancy and 8.4% reported that smoking was allowed in the home after delivery. Michigan's rates of smoking during pregnancy and in the home exceed U.S. rates, as reported by 25 states. In 2011, about 10.2% of women in the U.S. reported that they smoked during the last three months of pregnancy and 4.8% of women reported that smoking was allowed in the home after delivery (PRAMS).

Michigan has the 8th highest pregnancy-related mortality rate in the country. The Michigan pregnancy related mortality rate was 22.2 per 100,000 live births compared to the U.S. rate

which was 15.6 per 100,000 live births (NVSS 1999-2010). The Healthy People 2020 target for reducing the rate of maternal mortality is 11.4 per 100,000 live births.

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

In 2013, the sleep-related infant death rate for Black infants (20.6 per 10,000 live births) was twice the rate of all sleep-related infant deaths in Michigan (10.3 per 10,000 live births) and nearly three times the rate of sleep-related infant deaths for White infants (7.6 per 10,000) (MI Resident Infant Mortality File). Although in 2011 78.7% of Michigan infants slept on their back, which exceeded the Healthy People target of 75.9%, the percent of infants who slept in safe sleep environments was only 37.8% (MI PRAMS). Only 29.4% of Black mothers reported their infants sleep in safe sleep environments compared to 39.9% reported by White mothers (MI PRAMS). Furthermore, Black mothers had the lowest reported percent of infants who are put to sleep on their backs (59.5%) compared to Hispanic mothers (79.5%) and White mothers (83.4%) (MI PRAMS).

In 2011, the total percent of infants ever breastfed in Michigan was 79.8% compared to 83.9% of infants in all PRAMS states (PRAMS). Michigan's rate of breastfeeding did not meet the Healthy People target for breastfeeding initiation, which is 81.9% of infants. Black mothers and

mothers with the lowest level of education had the lowest rates of breastfeeding. About 65.1% of Black mothers reported ever breastfeeding their infant compared to 84.0% of White mothers and 88.2% of Hispanic mothers (MI PRAMS). About 60.9% percent of mothers with less than a high school education and 75.6% of mothers with a high school diploma reported ever breastfeeding their infants compared to 92.4% of mothers with college degrees (MI PRAMS). In 2011, the percent of infants breastfed exclusively through six months in Michigan was 16.2% compared to 18.8% in the U.S. (CDC NIS). Michigan's rate of exclusive breastfeeding through six months falls below the Healthy People target of 25.5%.

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

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

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

strengths suggested by measures related to immunization and lead poisoning prevention were also highlighted.

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

In order to understand school performance, the NSCH promoting school success summary measure was reviewed. To meet all criteria in the measure, children had to have positive responses on the following: 1) Usually/always engaged in school; 2) Participate in extracurricular activities; 3) Usually/always feel safe at school. In 2011, 64.3% of parents reported their children are experiencing school success; however, school success was less frequently reported by Black parents (40.9%). The percent of children experiencing school success in the U.S., in 2011, was 61.0%. State data on school performance were reviewed as well. Third grade reading proficiency as measured by a state-based standardized test (the Michigan Education Assessment Program) is one measure on Michigan's dashboard. In 2013-14, 61.3% of children were proficient in reading by the end of third grade. However, in the same year only about 37.3% of Black or African American children were reading proficiently.

According to data reported by Kids Count (datacenter.kidscount.org), in 2008 there were 11 substantiated cases of child maltreatment per 1,000 children aged 0-17, compared to 15 cases

per 1,000 children in 2012. The U.S. rate in 2012 was nine substantiated cases per 1,000 children, while the Healthy People 2020 target is 8.5 maltreatment victims per 1,000 children. In Michigan, in 2012, 42% of victims of child maltreatment were aged 0-4 and 31% were aged 5-10. In 2012, 84% of victims were victims of neglect, 40% were victims of emotional abuse and 25% were victims of physical abuse.

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

Child health stakeholders reported that evaluation, quality improvement, interdepartmental collaboration, and a commitment to evidence-based practice were system strengths for promoting child health. Furthermore, stakeholders identified developmental screenings, evidence-based home visiting programs, school-based services, and maternal child health nutrition programs as services that have the greatest capacity to improve child health.

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

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

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

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

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

Additionally, both motor vehicle and homicide mortality rates have decreased among adolescents aged 15-19. The motor vehicle accident mortality rate decreased from 14.4 per 100,000 individuals aged 15-19 in 2009 to 8.5 per 100,000 in 2013 (MI Resident Death File). According to the MI Resident Death File, in 2009 there were 13.3 homicides per 100,000 individuals aged 15-19, compared with 8.3 homicides per 100,000 in 2013.
Adolescent health stakeholders reported that evaluation and interdepartmental collaboration were system strengths for promoting adolescent health. Stakeholders identified school-based health programs, reproductive health education, and behavioral and mental health programs as services that have the greatest capacity to improve adolescent health.

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

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

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

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

criteria (NSCH). In comparison, 27.7% of U.S. CSHCN with more complex medical needs met all quality of care criteria.

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

In 2010, 41.2% of children in Michigan with special health care needs aged 12-17 received the services needed for transition to adult health care, work and independence compared to 40.0% of CSHCN aged 12-17 receiving services needed for transition in the U.S. (NSCHCN). The Michigan rate, however, does not meet the Healthy People 2020 target which is 45.3%. Furthermore, only 15.1% of Hispanics and 27.7% of Blacks reported receiving necessary services needed for transition (NSCHCN).

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

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

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

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

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

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

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

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

Oral health measures were also reviewed. In 2011, although 57.7% of women reported having their teeth cleaned in the 12 months prior to pregnancy compared to 56.6% of all total reporting states, there were disparities on this measure (PRAMS). Hispanic women least frequently reported having their teeth cleaned (43.2%), followed by Black women (46.9%). 61.9% of White women reported having their teeth cleaned (MI PRAMS). Additionally, in 2008, 44.5% of women in Michigan reported having their teeth cleaned during their most recent pregnancy (MI PRAMS). However, only 24.5% of Black women reported having their teeth cleaned during pregnancy, compared to 50.7% of White women.

The number of children aged 1 to 17 with at least one oral health problem in the past 12 months decreased from 25.4% in 2007 to 15.7% in 2012 despite the fact that the percent of children who had preventive dental visits in the past year decreased from 83.0% to 77.4% during the same period (NCHS). However, 28.1% of Black children had one or more oral health

problem compared to 12.9% of White children (NSCH). Only 71.3% of Black children had a preventive dental visit compared to 81.2% of White children. In comparison, in the U.S., the percent of children with at least one oral health problem was 18.7% and the percent of children with a preventive dental visit was 77.2% (NSCH).

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

Title V Program Capacity

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

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

Agency Capacity: BFMCH has a longstanding history and proven capacity to promote and protect the health of all mothers and children, including CYSHCN. The majority of Title V services and programs are delivered through DFCH, while services focused on children and youth with special needs are administered by CSHCS. Collaboration between CSHCS and DFCH is meant to assure that attention to services for CYSHCN are integrated into all Title V programs, as CYSHCN have similar child and adolescent health issues as their peers.

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

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

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

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

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

The *Health Equity and Perinatal Systems Unit* has two focuses: promote and guide the division-wide effort on achieving health equity and promote a healthy perinatal period with positive pregnancy outcomes. The target populations are pregnant and postpartum women and their newborns through their first year of life. Current efforts work to reduce infant mortality and morbidity; eliminate infant mortality disparity; and implement risk-appropriate community

perinatal care systems. Historically, this unit has also been responsible for conducting MCH Block Grant subrecipient consulting and monitoring to Michigan's local public health system on the appropriate use of these funds.

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

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

The *Infant Health Unit* is responsible for infant health promotion and initiatives to reduce fetal and infant deaths; increase the percentage of infants sleeping in safe environments; promote screening and evidence-based treatment for known chronic conditions in newborns; and increase the proportion of newborns that receive hearing screens, evaluations and services. This unit oversees the Early Hearing Detection and Intervention Program which includes screening, diagnosis and intervention for newborns with congenital hearing loss; the Safe Delivery Program which by state law allows for the anonymous surrender of an infant within 72 hours of birth to an Emergency Service Provider; and the Infant Death Prevention and Bereavement Program. The Michigan Fetal Infant Mortality Review (FIMR) Program aims to

reduce infant mortality by informing target communities about risk factors and issues contributing to poor pregnancy outcome and infant health and safety issues. FIMR brings together multidisciplinary community teams to review confidential, de-identified cases of infant and fetal death for the purpose of making recommendations to improve care, services and resources for women and families.

The *Early Childhood Systems Unit* administers programs and initiatives that improve early child wellness across all domains of development; increase family ability to understand and promote child wellness; support the development of an integrated and comprehensive early childhood system that spans public/private organizations and includes promotion, prevention and intervention activities; and collects and analyzes data to improve systems and service outcomes. Initiatives within the unit include: Childhood Lead Poisoning Prevention, Parent Leadership in State Government initiative, and the Trauma-Informed System ECCS grant. This unit serves as a liaison between Public Health and Part C/Early On and Race to the Top, which are administered by the Michigan Department of Education (MDE). The unit collaborates with internal and external partners on initiatives to improve early childhood systems coordination and seeks to include and empower parents as partners in decision making, community collaboration and communication.

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

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

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

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

The *Child & Adolescent Health Center (CAHC) Unit* oversees Michigan's school-based/school-linked health center program, funding 100 health centers and related programs in medically underserved, high-need communities. CAHCs provide comprehensive primary care and

behavioral health services, health education, Medicaid outreach and enrollment, and screening/case finding to K-12 students and young adults up to age 21. This unit also oversees the state's school nurse program, mental health in schools initiative, adolescent health demonstration grants and a new telehealth pilot. MDHHS and MDE co-manage the CAHC program and have two shared staff members, the State School Nurse Consultant and the State School Mental Health Consultant.

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

CSHCS Division: CSHCS focuses on identifying and addressing the health needs of CYSHCN. CSHCS achieves this aim by partnering with families, community providers and other state agencies to ensure that quality services are accessible to children with special needs and their families. CSHCS creates and administers policies, provides oversight and support to local partners, promotes evidence-based care models, and facilitates positive change through the extensive involvement of family advocates. CSHCS's goal is to help children with special needs achieve optimal health and an improved quality of life.

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

- ***Rashmi Travis**, **MPH, CHES, Director, Bureau of Family, Maternal and Child Health*** has 12 years of local public health experience and currently serves as Bureau Director at the state level. She possesses a dual bachelor's degree in Microbiology and Communications and a Master's of Public Health Degree with a concentration in Behavioral and Community Health Sciences. She is a Certified Health Education Specialist.
- ***Brenda Fink**, **A.C.S.W., Director, DFCH*** has over 35 years of clinical and administrative public sector experience at both local and state levels, directed toward improving the lives of at-risk children, families and adults. Ms. Fink is administratively responsible for managing the majority of Michigan's MCH services and initiatives using a life course approach that seeks to address equity and social determinants of health.
- ***Lonnie Barnett**, **MPH, Director, CSHCS Division*** has over 20 years of state and local public health experience in a variety of areas including community health assessment, planning, policy and primary care systems development. Mr. Barnett has served as the Title V CYSHCN Director since 2011.
- ***Stan Bien**, **MPA, Director, WIC Division*** has over 37 years of state-level experience in public health, administration and nutrition programs. Mr. Bien was appointed by USDA and U.S. Secretary of Agriculture to the National WIC Advisory Council and elected by his peers to

chair the council. He was elected to the Executive Committee of the National WIC Association and recently served as its Treasurer.

- ***Sarah Davis, MPA, Departmental Specialist, Bureau of Family, Maternal & Child Health*** has 15 years of work experience in the public and private sectors, including eight years of state-level experience in the child abuse and neglect prevention field.
- ***Paulette Dunbar-Dobynes***, ***Women and Maternal Health Section Manager*** has over 30 years of state-level experience working in maternal and child health, overseeing a range of programs such as Title X Family Planning, the Maternal & Infant Health Program, Infant Mortality Prevention and Maternal-Infant Death Review.
- ***Nancy Peeler***, ***Early Childhood Section Manager*** has over 30 years of experience working in research impacting early childhood development, and in local and state-level service and early childhood system design and implementation.
- ***Carrie Tarry***, ***MPH, Child, Adolescent & School Health Section Manager*** has over 15 years of state-level experience working in child health, adolescent and school health, and teen pregnancy prevention programs and initiatives.
- ***Patti McKane, MCH Epidemiology Section Manager*** has over five years of state-level experience with epidemiologic analysis and interpretation to inform and guide MCH program leaders and policymakers about the health of MCH populations.

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

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

Several projected shifts are expected to occur over the next five years related to the MCH workforce, including the need to build additional state infrastructure across key areas of maternal and child health such as administration and program coordination, epidemiologic support and data analysis. Key positions that were historically established as full-time

contractual staff may also be moved into civil servant positions. More details on the MCH workforce are included in Section II.F.2.

MDHHS promotes and provides culturally competent services through several mechanisms, many of which are coordinated through the Practices to Reduce Infant Mortality through Equity (PRIME) initiative. PRIME supports MCH staff training to understand equity concepts and to focus programming and policy to consider historic, social, economic and environmental factors that impact MCH outcomes. Additionally, PRIME developed and piloted Health Equity Learning Labs with WIC staff with a goal of incorporating equity thinking, perspectives and action into daily work responsibilities. After participating in a Lab, WIC staff developed a plan to increase outreach to the American Indian community. The plan is currently being piloted.

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

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

first Health Equity Status Report highlighting 14 indicators related to the social context in which women and children live.

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

MDHHS is supporting the provision of culturally competent services through initiatives such as a data inventory and quality improvement project to standardize collection and use of race, ethnicity, sex, language and disability status data. The project has expanded to include six additional measures including a postpartum care measure. Additionally, MDHHS Human Resources includes a question on health equity in hiring, and developed managerial annual performance evaluations that include a measure related to inclusion of equity work or addressing disparities.

MCH programs also implement specific strategies to provide culturally competent services. For example, the Home Visiting Program developed contractual requirements to use specific data analysis (Kitagawa) to develop outreach plans to enroll the most at-risk moms. This method

uses data analysis of infant mortality disparities to identify minority populations with the greatest need and aids in setting recruitment goals.

Partnerships, Collaboration & Coordination

While the needs assessment did not include a formal assessment of partnerships, BFMCH has continuous internal discussions and will consider options for completing a formal assessment of its MCH partnerships in the future. Currently, the ability to meet MCH population needs with a coordinated approach is facilitated by the organizational structure of BFMCH, which allows for collaborative work and sharing of best practices across divisions and programs. In addition to CSHCS, the DFCH manages programs within the scope of reproductive health; perinatal and infant health; and child, adolescent and school health. The BFMCH is located in the Population Health and Community Services administration, as are the Bureau of Local Health and Administration Services (Vital Records and Health Statistics, Chronic Disease and Injury Control which is where the oral health office resides) and the Bureau of Disease Control, Prevention and Epidemiology (Immunizations, Lifecourse Epidemiology and Genomics, Communicable Disease). Other administrations within MDHHS include Health Services and Family Support where the state Medicaid program is housed and the Behavioral Health Services Administration. The Children's Services Agency was also recently created as part of the merger between the Departments of Community Health and Human Services to house child welfare and children's mental health services.

MDHHS has long-standing relationships with numerous public and private organizations and service providers to carry out the scope of work within the MCH Block Grant. MDHHS contracts with LHDs, making Title V MCH Block Grant funds available to address identified MCH needs

within their jurisdictions through local program implementation and direct service delivery. MDE is a close partner in numerous programs supporting early childhood, school health and child and adolescent health at the state, intermediate and local school district levels. MDE and MDHHS have a long history of integrating funding around early childhood, Child and Adolescent Health Centers, and Hearing and Vision school-based screenings. They have created shared state-level positions to address school nursing and social-emotional health support needs in local districts. MDHHS also has strong collaborative partnerships with the Michigan Family to Family Health Information Center and Parent to Parent of Southwest Michigan.

MDHHS also partners with many non-governmental organizations. Advocacy organizations such as the Michigan Association for Local Public Health, Maternal and Child Health Council, Early Childhood Investment Corporation, School-Community Health Alliance of Michigan, Michigan Association of Health Plans, Michigan Health and Hospital Association, Michigan Family Voices, Michigan Alliance for Families and Michigan Primary Care Association provide a voice for policy and funding considerations. Provider organizations such as the Michigan chapters of the American College of Obstetrics and Gynecology, American Academy of Pediatrics and Society of Adolescent Medicine enhance advocacy efforts and offer services (e.g., education and training). Several Michigan universities partner in program evaluation and in pilot projects to expand services, including projects in telemedicine and telepsychiatry. Tribal, youth-serving, faith-based, community-based and other non-profit organizations are often recipients of grant funds for service delivery and create linkages to service recipients, allowing MDHHS to engage the consumer voice through consumer representation on various permanent and ad-hoc advisory boards, councils and task forces.

II.B.2. Five-Year Needs Assessment Summary Update

2016 Activities

In FY 2016, Michigan's Title V needs assessment activities focused on gathering information about local health departments' maternal and child health (MCH) needs and priorities for use of block grant funds. Michigan's 45 local health departments each receive Title V Block grant funds to address locally identified MCH needs. These Local Maternal and Child Health (LMCH) grants play an important role in building local health department infrastructure and supporting the delivery of programs and services. After the five-year needs assessment was completed in 2015, the Title V Steering Committee (which evolved out of the Needs Assessment Planning Committee) determined that it was important to support local health departments in realigning with the state's new priorities and performance measures, and to assure continuity of infrastructure, programs, and services at the local level.

In order to achieve these goals, an internal LMCH workgroup was convened to complete a LMCH needs assessment. This group completed two types of assessment activities. First, it reviewed LMCH-funded activities to identify areas of alignment and variance with the state's revised priorities, NPMs, and SPMs. The workgroup reviewed all 45 LMCH plans and budgets and completed a crosswalk between the activities in these plans and the state's priorities and performance measures. The group also examined the degree to which funding was focused on building infrastructure to deliver the 10 essential services or was focused on delivering direct or enabling programs and services. Second, the LMCH workgroup held discussions with local health departments, both individually and collectively, to share information; gather input

regarding the new priorities and performance measures; and obtain feedback and suggested revisions to the new annual plan format and narrative.

The workgroup found that LMCH plans substantially aligned with the state's priorities and performance measures. However, several local health departments were using LMCH funds to support improving immunization rates within their communities. Although the importance of improving immunization rates was recognized, it was not identified as a priority during the 2015 needs assessment. However, Michigan's immunization rate has been declining among some populations; the state has a high percentage of kindergarten exemptions for vaccines required for school entry; and the state has a low rate of adolescents who have completed the HPV series.

The workgroup also found that LMCH plans emphasized using funding to deliver programs and services, and less on building public health infrastructure. Given high levels of community need, declining public health funding, the lack of flexible funding for local health departments, and the relatively recent expansion of health insurance coverage, it was clear that LMCH funds have served a critical role in assuring MCH services. However, as Title V continues to evolve at the federal and state level, it was also clear that local health departments will need support in assessing changing community needs and in rebuilding their public health infrastructure to meet those needs.

In summary, two main outcomes emerged from FY 2016 needs assessment activities:

1. Based on state data and local priorities, the Title V Steering Committee added a State Performance Measure (SPM) focused on immunizations. Described in detail in its

associated state action plan, the measure will track: A) Percent of children 19 to 36 who have received a completed series of recommended vaccines, and B) Percent of adolescents 13 to 18 years of age who have received a completed series of the HPV vaccine. The decision to focus on these two measures was made in coordination with Title V leadership and Division of Immunization staff.

2. Moving forward, Michigan's Title V program plans to offer one-time "transition" funding to local health departments to assist them in transitioning to the new state priorities and performance measures, as needed. This transition funding will support local capacity building, strengthen the statewide needs assessment, and provide a foundation for thinking beyond direct services to systems-level solutions to community health issues and needs. This proposal is discussed in more detail below.

2017 Plans

In order to assure Michigan's Title V priorities continue to align with the most important needs in our state, the Steering Committee discussed a variety of options for FY 2017 needs assessment activities. The group sought ideas that 1) would generate meaningful and timely information that could be used to refine priorities or action plans, 2) could be carried out efficiently, and 3) would engage a wide variety of stakeholders in the process. The Steering Committee selected three main strategies for ongoing needs assessment that will be initiated in FY 2017:

1. Develop a process for tracking and monitoring performance data on an annual basis;
2. Facilitate transition planning with local health departments; and

3. Increase stakeholder input by developing or strengthening strategies, systems and processes to regularly hear from state and local partners and consumers about needs and strengths of the MCH system.

Performance Monitoring

In FY 2017, the Steering Committee will engage with MDHHS's Life Course Metrics project to identify a core set of measures, which include Michigan's NPMs and SPMs, to track annually. The Life Course Metrics project is led by Michigan's MCH director. The intent of this effort is to identify core measures across the life course and at the population, community, and system level that can be used to inform decision making at the state and local level. Working with the Life Course Metrics team, the Steering Committee will identify a process for monitoring Michigan's current NPMs and SPMs. On an annual basis, the Title V Steering Committee will review performance on these measures. These conversations will focus on identifying emerging issues that could inform Michigan's priorities and opportunities for adjusting Michigan's action plans to improve progress toward outcomes.

Facilitate Transition Planning with Local Health Departments

Michigan's Title V program plans to provide one-time funding to the state's 45 local health departments that receive Title V block grant funding to undergo a local transition process tailored to the health department's needs. For example, the process will support capacity building at the local level; inform the state level needs assessment; and support alignment of LMCH plans with Michigan's Title V priorities, performance measures, and emphasis on system building. In addition to funding, the state Title V program will support the local transition

process by providing instruction via webinar and phone consultation on each step of the process and providing local health departments with key MCH data. Local health departments will also be expected to pull from existing community needs assessment results and any supplemental local data to determine priority needs of their MCH population.

Through a facilitated transition and needs assessment process, Michigan's Title V program expects local health departments will:

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

ii. Develop local MCH plans with measureable objectives and evidence-informed or evidence-based strategies to address Michigan's Title V priorities, NPMs, and SPMs;

iii. Allocate more Title V dollars for capacity building around core public health functions and infrastructure development; and

iv. Ensure funds used for direct and enabling services are gap-filling.

Notably, the transition process was already begun in FY 2016. The internal LMCH workgroup drafted a revised LMCH application, which was shared with a small group of local health department representatives for review and revision before broader distribution occurred. This revised LMCH local plan format and guidance will be fully operationalized with FY 2017 contracts, utilizing measurable objectives and activities to address Michigan's Title V priorities, NPMs, and SPMs (as well as locally-identified MCH needs). DFCH representatives presented the revised local plan at several statewide local health department workgroups that regularly convene throughout the year. The response to the new format was positive. Local health

departments were invited to join a webinar in May 2016 to review the new plan format and guidance.

Strengthen Stakeholder Input

While the Needs Assessment Planning Committee convened a broad group of stakeholders to help identify strengths and needs of the MCH population in the five-year needs assessment, a future goal is to increase consumer feedback in the process. Strategies to address this gap will be developed in FY 2017. Steering Committee members will develop or build on existing strategies, systems, and processes to regularly hear from state and local partners and community members about needs and strengths of the MCH system. The Steering Committee will develop multiple methods for gathering input that work best for each priority area, MCH program, and consumer population, depending on time and resource availability. Methods may include but are not limited to: consumer satisfaction surveys, town hall meetings, focus groups, key informant interviews, and direct observations. Gathering consumer input will help to identify gaps or barriers in the MCH system that prevent women, mothers, and children, including those with special health care needs, from achieving health and wellness. The Steering Committee will use data collected through these methods to identify emerging priorities and improve state action plans.

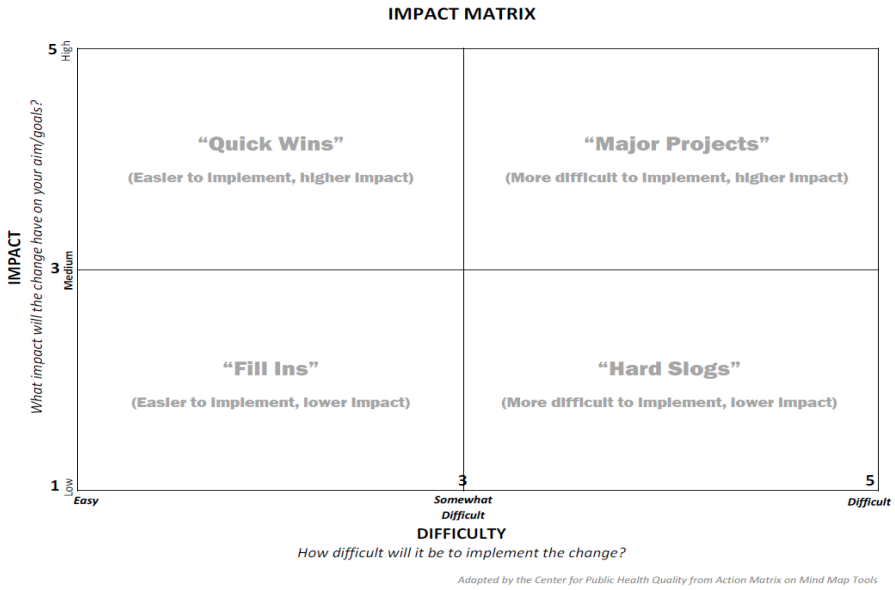
II.C. State-Selected Priorities

In the process of selecting state priorities, the Title V Needs Assessment Planning Committee (NAPC) honored the input of MCH stakeholders by selecting priorities from the strategic issues identified through the needs assessment and also maintaining the language stakeholders used to describe the strategic issues. As a first step in the overall prioritization process, the NAPC recognized that some of the strategic issues were better aligned with efforts outside of the Title V block grant. Therefore, the NAPC reviewed the strategic issues developed by stakeholder groups and identified strategic issues that a) could be addressed without using Title V Block Grant funding, b) were not within the control or influence of the state MCH program or c) were not aligned with programmatic, state and federal priorities. These strategic issues were removed from consideration during the prioritization process.

The NAPC then selected priorities from among the remaining strategic issues based on the results of a prioritization exercise, their knowledge of Title V program capacity, and the potential to leverage Title V funding through partnerships and coordination. Additionally, the NAPC considered the need to sustain activities currently funded by Title V. The prioritization exercise involved placing each strategic issue on an impact matrix (see Figure 2). This exercise is used to help groups identify and prioritize strategic issues that are more difficult to implement but will have a high level of impact (major projects) or that can be implemented with less difficulty and have a high level of impact (quick wins). The exercise also helps groups identify and place less priority on strategic issues that are easy to implement but have little impact (fill ins) or that are difficult to implement but will have little impact (hard slogs). In order to identify where each strategic issue fell on the matrix, members of the NAPC rated each strategic issue,

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

Figure 2. Prioritization Matrix



After completing the exercise, the NAPC considered strategic issues that were placed in the "Quick Wins" quadrant first, followed by strategic issues that were placed in the "Major Projects" quadrant. The NAPC did not consider strategic issues that were placed in the other two quadrants. Most of the priorities selected by the NAPC were considered more difficult to address but highly impactful (i.e., "Major Projects"). The final list of priorities reflected the needs of the population, stakeholder input, and the knowledge and expertise of MCH leadership. The NAPC selected the priorities that appear in Table 3.

Table 3: Michigan's FY 2016-2020 Title V Block Grant Priorities	
FY 2016-2020 Priorities	**Title V Population Domain**
Reduce barriers, improve access, and increase the availability of health services for all populations	Women/Maternal Health Adolescent Health CSHCN
Support coordination and linkage across the perinatal to pediatric continuum of care	Perinatal/Infant Health

Table 3: Michigan's FY 2016-2020 Title V Block Grant Priorities	
Invest in prevention and early intervention strategies, such as screening	Child Health Cross-cutting/Life Course
Increase family and provider support and education for Children with Special Health Care Needs	CSHCN
Increase access to and utilization of evidence-based oral health practices and services	Cross-cutting/Life course
Foster safer homes, schools, and environments with a focus on prevention	Child Health Perinatal/Infant Health
Promote social and emotional well-being through the provision of behavioral health services	Cross-cutting/Life course

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

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

Selected Priorities Compared with the Prior Needs Assessment

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

Table 4: Alignment between FY 2011-2015 Priorities and FY 2016-2020 Priorities	
FY 2011-2015 Priorities	**FY 2016-2020 Priorities**

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

Eight of the previous priorities were essentially retained or enveloped into the new priorities by combining and/or rewording them into broader priority issues. If a new priority in some way aligned with a previous priority, but the wording or scope changed, it was considered a "replaced" priority on Form 9. By increasing access to health services, many specific issues can be addressed, including unintended pregnancies and sexually transmitted diseases. Infant

mortality has been a continued focus across the state and improving coordination of the system was chosen as a priority to address multiple factors related to infant mortality and the pressing disparity. While reducing discrimination in health care services remains a priority in Michigan, providing culturally and linguistically competent services to address disparities and achieve health equity was identified as a priority to continue integrating across Michigan's MCH work and state action plans. Finally, reducing obesity continues to be a high priority in Michigan and within MCH-related programs; however, it is addressed through a variety of other funding streams and initiatives.

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

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

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

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

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

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

Women/Maternal Health

In order to measure progress toward "Reducing barriers, improving access, and increasing the availability of health services," Michigan will report progress on the "Percent of women with a past year preventive medical visit" (NPM 1). Although 67.0% of women in 2013 received a preventive medical visit in Michigan (MI BRFSS), there were significant disparities on this measure, with only 47.3% of women who were uninsured receiving a preventive medical visit. As insurance options for women expand, MDHHS wants to maintain and build on the state's success in connecting women with preventive care by helping women access insurance and connecting them with primary care providers. The ESM for this NPM will be to increase the percentage of women aged 18-44 who have ever discussed reproductive life planning during a visit with a doctor, nurse, or other health professional.

Perinatal/Infant Health

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

success of this effort. The ESM for NPM 3 will measure the percent of Centering Healthcare Institute approved Centering sites in Michigan.

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

Child Health

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

Adolescent Health

In the area of adolescent health, the priority "Reduce barriers, improve access, and increase the availability of health services for all populations" will be measured by the "Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year" (NPM 10). Although according to the NSCH, 85.6% of adolescents had a preventive medical visit in the past year in Michigan, in-state data suggest there are wide disparities in this measure. As the insurance landscape continues to change the health care system, MDHHS wants to maintain and build on the state's success in connecting adolescents with preventive care in appropriate settings and using practices that are sensitive to the needs of this age group. The ESM for NPM 10 will measure the percent of health care providers who complete both the Motivational Interviewing web course and the Motivational Interviewing professional development training who report an increase in skills in effectively counseling youth on changing risky behaviors.

Children with Special Health Care Needs

Progress toward the priority "Increase family and provider support and education for Children with Special Health Care Needs" will be measured using two NPMs. Michigan will measure progress on the "Percent of children with and without special health care needs having a medical home" (NPM 11). Only 47.5% of CSHCN in Michigan had a medical home in 2011, and even fewer CSHCN with more complex needs had a medical home (NSCH). Stakeholders identified the need to support and educate providers and families on the components of a medical home and how they relate to the unique needs of the CSHCN population. This NPM has an associated ESM that will measure the percent of families that indicate care coordination and family partnership are working well within their primary or specialty care provider setting.

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

Cross-cutting/Life Course

Michigan will measure progress toward "Increasing access to and utilization of evidence-based oral health practices and services" by reporting progress on the "A) Percent of women who had a dental visit during pregnancy and B) percent of children, ages 1 through 17, who had a preventive dental visit in the past year" (NPM 13). The needs assessment found that only 44.5% of women had their teeth cleaned during their most recent pregnancy, and that there were disparities in this measure (MI PRAMS). There were also disparities in the percent of children who had a preventive dental visit in the past year, and fewer children had preventive dental visits in 2012 as compared with 2007 (NSCH). Stakeholders recognized the need to build on Michigan's efforts to improve access to oral health care across population groups. The oral health ESM will track the number of students who have received a preventive dental screening through the SEAL! Michigan program.

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

The Title V federal guidance requires states to develop three to five State Performance Measures (SPMs) to further address state priorities based on the results of the needs assessment. Per federal requirements, these SPMs were finalized in FY 2016 and will be implemented in FY 2017. Michigan identified five SPMs related to lead prevention, safe sleep, depression across the life course, provision of medical services and treatment for children with special health care needs, and immunizations.

Lead Prevention

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

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

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

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

Safe Sleep

The second SPM to address the priority area of **"Foster safer homes, schools and environments with a focus on prevention"** was developed to promote infant safe sleep environments: A) the percent of infants put to sleep alone in their crib, bassinet or pack and play and B) the percent of infants put to sleep without objects in their crib, bassinet or pack and play. According to the Centers for Disease Control (CDC), approximately 3,500 infants die suddenly and unexpectedly in the U.S. each year. In 2014, MDHHS Vital Records reported that 125 infants died from Sudden Unexpected Infant Deaths (SUIDs) in Michigan, accounting for almost 15% of all infant deaths. For the last several years, SUID has been the third leading cause of death for infants

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

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

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

Data from the Pregnancy Risk Assessment Monitoring Survey (PRAMS) confirm that unsafe sleep behaviors continue to put infants at risk. PRAMS results from 2012 show that 20% of all infants usually sleep on their side, stomach or a combination; 22% of babies usually bed share

with another person; and 12% do not usually sleep in a crib or portable crib. Furthermore, almost half of all babies regularly sleep in an environment with at least one item such as a pillow, blanket or stuffed toy. These behaviors have been shown to increase the risk for a sleep-related infant death. According to the SUID Case Registry Project, three out of four sleep-related infant deaths in Michigan occurred in an unsafe sleep location. In addition, approximately 60% of sleep-related infant deaths occurred among infants who shared a sleep surface such as with an adult or sibling. Michigan has elevated safe sleep to a priority due to the persistently high number of sleep-related infant deaths that occur each year. Parental and caregiver behavior is a modifiable factor which can be addressed through culturally appropriate, relevant education and counseling. Although difficult to accomplish, changing parental and caregiver behavior is key to reducing and ultimately eliminating these preventable infant deaths.

Depression across the Life Course

To address the priority area of **"Promoting social and emotional well-being through the provision of behavioral health services,"** MDHHS developed a two-part SPM related to reducing depression across the life course, focusing on adolescents and pregnant and postpartum women. The SPM includes: A) Percent of high school students who report feeling sad or hopeless almost every day for two or more weeks in a row, to the extent they stopped doing some usual activities during the prior 12 months; and B) Percent of women enrolled in Michigan's Maternal Infant Health Program (MIHP) who are screened for maternal depression.

Depression is increasingly common in adolescence. According to the 2015 Michigan Youth Risk Behavior Survey (YRBS), 31.7% of the state's high school students felt sad or hopeless almost

every day for two or more weeks in a row, to the extent they stopped doing some usual activities during the 12 months prior to the survey. This represents nearly a 5% increase from 2013 data (27%). Symptoms of depression among this age group are often related to the stresses and challenges of transitioning from childhood to adulthood. Depression can impact every aspect of life, from academic success to physical health, and is sometimes associated with increased risk for suicide. Early identification of depression is crucial in reducing prevalence of depression and for implementing timely and effective interventions to manage symptoms and reduce negative outcomes.

Untreated depression among pregnant and postpartum women is of concern due to its adverse effects on the health of the mother, infant and the mother-infant relationship. Between 10% to 20% of all women experience depression during the perinatal period, with prevalence in low-income and Black women estimated at almost double that of White women. Analysis of depression rates across six home visiting programs found that the percentage of women exceeding clinical cutoff for depression at enrollment ranged from 28.5% to 61%. The Maternal Infant Health Program (MIHP) is Michigan's largest home visiting program, serving pregnant and postpartum women with Medicaid. MIHP data are collected based on the beneficiary's response to the stress/depression risk questions asked on the maternal risk-identifier screen. FY 2014 data (utilizing the Edinburgh Postnatal Depression Scale) showed that 19,529 (100%) of enrolled women were screened for maternal depression. Of those screened, 7,736 (40%) scored moderate or high risk for depression.

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

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

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

To address the priority area of **"Reducing barriers, improving access, and increasing the availability of health services for all populations,"** MDHHS developed a SPM for Children and Youth with Special Health Care Needs (CYSHCN): Percent of CYSHCN enrolled in CSHCS that receive timely medical care and treatment without difficulty. While access to public and private health insurance coverage has improved as a result of the ACA, CYSHCN require and use more health care services than other children. Specialty care and extensive, on-going, or long-term treatments and services may be required to maintain or improve health status. Financing these costs can pose significant challenges and burdens for families even if a family has access to private insurance. Family health care costs can include deductibles, cost sharing and premium payments. In addition, private insurance may not include any covered benefit for a specific, medically necessary service. In other cases, only a limited benefit may be available through insurance. Transportation costs may also pose challenges to families who may need to travel long distances to appropriate specialty medical care. Although the ACA eliminated annual and lifetime dollar limits, other annual limits exist, and benefits may be exhausted for the current contract year even though the need continues. For each of these financing and resource challenges, CSHCS continues to be a significant resource for achieving adequate, appropriate health and specialist care and also provides a way to contain substantial costs to families.

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

Immunizations

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

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

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

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

II.F. Five-Year State Action Plan

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

This section presents Michigan's five-year (2016-2020) state action plan tables and FY 2017 narrative plans as well as FY 2015 reports, by population domain. National Performance Measures (NPMs) and State Performance Measures (SPMs) from the previous reporting cycle are organized by population domain, as required by federal guidelines.

Women/Maternal Health Domain

NPM 1 – Well-woman Visit

State Priority Need	**Objectives**	**Strategies**	**National Outcome Measures (NOM)** (prepopulated by HRSA)	**National Performance Measure** (NPM) (prepopulated by HRSA)
Reduce barriers, improve access, and increase the availability of health services for all populations	A) By 2020, increase by 5% the proportion of Michigan pregnancies that are intended	A1) Each year, assess contraceptive needs and service gaps for Michigan women of childbearing age A2) Each year, assess reproductive health needs and service gaps for publicly-funded family providers A3) Develop and implement a statewide outreach plan to increase awareness and access to family	- Severe maternal morbidity per 10,000 delivery hospitalizations - Maternal mortality rate per 100,000 live births - Low birth weight rate (%) - Very low birth weight rate (%) - Moderately low birth weight rate (%) - Preterm birth rate (%) - Early preterm birth rate (%) - Late preterm birth rate (%) - Early term birth rate (%) - Infant mortality per 1,000 live births	Percent of women with a past year preventive medical visit

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
		planning services and clinics A4) Increase the number of women of childbearing age using highly effective contraceptive methods	- Perinatal mortality per 1,000 live births plus fetal deaths - Neonatal mortality per 1,000 live births - Postneonatal mortality rate per 1,000 live births Preterm-related mortality per 1,000 live births	
	B) By 2020, increase by 5% the proportion of Michigan women who report ever having discussed reproductive life planning during a visit with a doctor, nurse, or other health professional	B1) Identify existing evidence-based reproductive life planning toolkits through an environmental scan B2) Solicit state and local level partner and stakeholder feedback regarding toolkit content, provider approach, and patient experience B3) Select and promote a reproductive life planning toolkit within publicly-funded family planning provider networks B4) Explore the feasibility of supporting inter-conception care		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
		projects in 3 to 5 communities with infant mortality rates *above* the state rate		
	C) By 2020, increase the capacity of 50 Michigan reproductive health providers to offer highly effective contraceptive services	C1) Develop a three-part contraceptive counseling module series to educate providers on patient-centered counseling, contraceptive counseling, and method billing and coding C2) Disseminate the contraceptive counseling module series with publicly-funded family planning providers and other health care professionals, offering continuing education credits as resources allow C3) Reduce reproductive health provider barriers for long-acting reversible contraceptives through assessment and strategy development		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
	D) By 2020, increase by 5% the proportion of Michigan women who report having a routine check-up within the past year	D1) Promote enrollment in Medicaid expansion and other insurance products to increase number of women with primary care coverage D2) Promote referrals to primary care providers with family planning clinic network		

Well-woman Visit Narrative

Through the five-year needs assessment process, the state priority issue of "Reduce barriers, improve access, and increase the availability of health services for all populations" was selected for the Women/Maternal Health domain. The percent of adult women with a preventive medical visit in the past year (NPM 1) was selected to address this priority need. According to the Michigan Behavioral Risk Factor Survey (MiBRFS) report for 2014, 76.6% of women over 18 years of age received a preventive medical visit in the year preceding the survey. While this is a high proportion of adult women who accessed preventive medicine, just under 25% of Michigan women did not, leaving them susceptible to increased health care costs over their life course, exacerbated symptoms or onset of chronic disease, limited access to screening for cancer and sexually transmitted infections, and unintended or mistimed pregnancy.

To work toward 100% of adult women receiving a preventive medical visit each year, the MDHHS will work toward increasing the number of women who have ever discussed reproductive life planning during a visit with a doctor, nurse, or other health professional. Given that the majority of females of reproductive age want to prevent pregnancy or achieve it, preventive health for women is largely concentrated on reproductive health issues, making strategies to increase preconception and reproductive health services a smart investment.

Objective A: By 2020, increase by 5% the proportion of Michigan pregnancies that are intended. From 2006-2011, approximately 50% of pregnancies in Michigan have been unintended. While half of Michigan's pregnancies are unintended, increased access to family planning services through insurance expansion programs such as Michigan's Medicaid expansion program (i.e., Healthy Michigan Plan) and the increased use of highly-effective, long-acting reversible contraceptives among women of childbearing age provides our state with the foundation to work toward increasing the proportion of Michigan pregnancies that are intended.

The first strategy to increase the proportion of intended pregnancies is to assess the contraceptive needs and service gaps for Michigan women of childbearing age, annually, by identifying and analyzing secondary data sources such as the Guttmacher Institute's *Contraceptive Needs and Services Update,* which highlights the number of women in need of publicly-funded contraceptive services and supplies at national, state, and county levels. This annual assessment will help to ensure state and local level outreach activities are data-driven, targeted, and reaching women with the highest need.

A second strategy is to assess the reproductive health needs and service gaps for publicly-funded family planning providers on an annual basis, by identifying and analyzing secondary data sources such as family planning agency project documentation (i.e., Annual Plan) and utilizing the Family Planning Mappist tool. The Mappist tool has the capability to locate Title X clinics as points and then counties are color-coded according to the estimated number of women in need of Title X services, which will allow agencies the ability to target local outreach efforts, identify new target populations, and assess potential clinic locations. This type of annual assessment will help ensure local level outreach activities are data-driven, targeted, and making the best use of limited family planning resources.

A third strategy for this objective is to develop and implement a statewide outreach plan to increase awareness and access to family planning services and clinics. Michigan's Title X Family Planning client numbers have declined over the past several years, with the steepest decline occurring between calendar year 2013 and 2014, a 12% decrease in client volume. Further exploration is needed, as women of reproductive age are still in need of publicly-funded family planning services. Family planning researchers and professionals presume the decrease in client volume is a culmination of the following: decreased funding available for services; increased insurance coverage for clients who then choose other providers for reproductive health care; a decreased need for frequent family planning visits with Pap smear protocol changes; and increased use of long-acting reversible contraceptives such as IUDs. State Title X providers report that clients with new insurance plans think they can no longer visit their trusted, publicly-funded family planning providers. In fact, Title X providers can bill most insurance plans. The outreach plan would target Michiganders in need of family planning services

statewide. The plan is expected to include media spots, social media, and use of local resources to help area providers conduct outreach in their communities.

A final strategy is to increase the number of women using highly effective methods of contraception. These methods are categorized as having a high effectiveness rate and include implants, intrauterine devices (IUDs), sterilizations and injectables. These methods are highly effective once correctly administered and rely less on correct and consistent use. The high up-front cost for many of the most effective methods (e.g., IUDs and implants) poses a barrier despite proven cost-effectiveness over time. The Affordable Care Act (ACA) is drastically expanding the availability of effective contraceptive methods as both public and commercial insurance plans are required to cover them without cost sharing. The Food and Drug Administration's approval of a low-cost IUD will help publicly-funded providers stock a previously high-cost option. Michigan will monitor state Medicaid data and contraceptive performance data from Title X family planning clinics to measure whether or not the use of highly effective contraceptive methods is increasing.

Objective B: By 2020, increase by 5% the proportion of Michigan women who reported ever having discussed reproductive life planning during a visit with a doctor, nurse, or other health professional. While initiatives are under way to improve access to family planning services and encourage preventive health care for women and girls prior to pregnancy, 32.1% of new mothers who participated in the 2010 Michigan Pregnancy Risk Assessment Monitoring Survey reported having received advice about how to improve their health before pregnancy in the year prior to conception. To address this gap in preconception care, the MDHHS will promote

reproductive life planning as a routine part of health care for women of reproductive age. Given that more women have access to health care coverage, there is opportunity to expand the number of women who receive this type of care; however, this is not without challenges. Challenges to integrating reproductive life planning into routine care include lack of provider awareness, lack of comfort and confidence in raising reproductive health issues, and a lack of tools to facilitate these discussions.

MDHHS's first strategy is to identify existing evidence-based reproductive life planning toolkits through an environmental scan. A second strategy is to solicit state and local level partner and stakeholder feedback regarding toolkit content, provider approach, and patient experience. State and local level partners and stakeholders are comprised of provider groups such as the family planning provider network, Health Plans and Federally Qualified Health Centers, the Michigan Quality Improvement Consortium, local health departments, and key maternal and child health leaders and experts.

The third strategy will involve the selection and promotion of the reproductive life planning toolkit within publicly-funded family planning provider networks. Adaptations and tailoring will be pursued if partner and stakeholder feedback indicates it is necessary prior to toolkit dissemination within Michigan's network of publicly-funded providers. The family planning network is ideal for adapting and tailoring the selected toolkit since preconception health and reproductive life planning are concepts of care that have been integrated into practice for a number of years. In addition, the 2014 Office of Population Affairs (OPA) and Centers for Disease Control (CDC) recommendations on Providing Quality Family Planning Services re-

emphasized these concepts. OPA and CDC are supporting efforts to train staff on reproductive life planning and providing guidance that will support toolkit evaluation efforts and refinement. MDHHS will also utilize state and local level partners and stakeholders to explore ways to promote the use of the selected reproductive life planning toolkit among publicly-funded family planning provider networks. MDHHS and family planning providers have strong collaborative relationships with this network, as well as home visiting programs serving at-risk women and families. MDHHS will work with the state Medicaid office to determine the feasibility of convening a group of Medicaid Health Plans to share and promote the reproductive life plan toolkit.

As a final strategy, MDHHS will work with statewide partners and stakeholders to explore the feasibility of supporting inter-conception care projects in three to five communities with infant mortality rates above the state rate. This project provides an innovative practice model, built off of existing evidence-based inter-conception models implemented in other states. This project's target population would be Michigan women who have experienced an adverse pregnancy outcome. Project participants would receive comprehensive inter-conception care to reduce the risk of poor birth outcomes in subsequent pregnancies. Comprehensive inter-conception care focuses on providing supportive services that are designed to assist project participants in achieving optimal health prior to a subsequent pregnancy, in addition to reproductive life planning where participants discuss pregnancy planning and learn about the health benefits associated with optimal birth spacing.

Objective C: By 2020, increase the capacity of 50 Michigan reproductive health providers to offer highly effective contraceptives. Women who use highly effective contraceptive methods are less likely to experience an unintended or mistimed pregnancy. In an effort to ensure Michigan women of reproductive age are educated and have access to highly effective contraceptives, capacity building efforts need to be undertaken with publicly-funded family planning providers to ensure clients are receiving contraceptive counseling that mirrors national standards of care and provider barriers to highly effective contraceptive methods are reduced.

The first strategy to increase the capacity of Michigan reproductive health providers is to develop a three-part contraceptive counseling module series to educate providers on patient-centered counseling, contraceptive counseling, and method billing and coding. MDHHS will contract with the Michigan Public Health Institute to produce the three-part module series, and will contract with experts from the family planning field to develop the module content. State level family planning staff will coordinate these efforts and will develop any Michigan specific content, as needed.

A second strategy will be to disseminate the contraceptive counseling module series with publicly-funded family planning providers and other health care professionals, offering continuing education credits, as resources allow. MDHHS will rely on state and local level partners and stakeholders to promote the contraceptive module series within their networks, such as family planning providers, Medicaid providers, and federally qualified health center

providers. Additionally, when family planning providers experience turnover, this module series will be accessible to the network for staff training purposes.

A final strategy to building provider capacity to deliver highly effective contraceptives is reducing the reproductive health provider barriers to long-acting reversible contraceptives through assessment and strategy development. MDHHS plans to survey the Title X family planning provider network to assess the barriers that providers face in providing clients with highly effective contraceptive methods. Providers can face a number of barriers including a lack of training, method costs, and provider myths about contraceptive methods. Additionally, MDHHS will work with Medicaid to gather information from providers outside publicly-funded family planning networks to assess whether these providers are facing the same barriers and the strategies used to overcome barriers, if any. Once more information has been gathered on provider barriers to long-acting reversible contraceptives, MDHHS will work with state and local partners and stakeholders to develop a plan to reduce barriers within publicly-funded family planning networks.

Objective D: By 2020, increase by 10%, the proportion of Michigan women who reported having a routine checkup within the past year. In 2014, 76.6% of adult women aged 18-64 who participated in the MiBRFS reported having a routine medical visit within the past year, while 15.0% reported not seeing a doctor within the past year due to cost, and 11.1% reported not having a personal health care provider. In 2014, 11.3% of women aged 18-64 reported having no health care coverage. Over the next five years, MDHHS anticipates the proportion of women aged 18-64 who report having no or limited health care coverage will be reduced, given the

expanded access to health care coverage under the Affordable Care Act and Medicaid expansion in Michigan. MDHHS will continue to collaborate with state and local partners and stakeholders to encourage enrollment and health care coverage to increase the number women who have access to health care and participate in preventive health care.

The first strategy to promote Medicaid and other health insurance plan enrollment activities includes intensifying efforts to encourage enrollment into the Healthy Michigan Plan and other insurance plans in partnership with the family planning provider network, local health departments, and other community-based partners. The family planning network has developed expertise in enrollment activities since 2006, when Michigan began its Medicaid Family Planning Expansion Program, Plan First. Given that the Healthy Michigan Plan has expanded coverage, Michigan is in the process of phasing out Plan First. Despite Plan First being phased out, the family planning network has had continued involvement in outreach and enrollment activities. A second strategy to increase routine primary care visits among women is the promotion of referrals to primary care providers within the family planning clinic network. State guidelines and national standards of care among family planning clinics include asking each client about access to primary care services and making primary care referrals, as needed.

Women/Maternal Health Annual Report

The following performance measures and the related data trends, program summaries, successes, and challenges address the **Women/Maternal Health** population domain for FY 2015 reporting.

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

Data Trends: The trend in percent of infants born to pregnant women receiving prenatal care beginning in the first trimester has remained relatively unchanged over the past five years, from 73.5% in 2009 to 72.7% (provisional) in 2014. The 2014 indicator remains below the Healthy People 2020 target of 77.9%.

FY 2015 Program Summary: Michigan's Medicaid expansion program, the Healthy Michigan Plan (HMP) was launched in 2014. As of June 1, 2015, the HMP included more than 290,000 women, 85% of which are of childbearing age. One of the primary goals of the HMP program is to include adequate prenatal and postpartum care to improve the health of the mother and baby. Other key features that support healthy mothers and health babies include: 1) incentives for healthy behaviors to encourage personal responsibility; 2) encouraging use of high-value services; and 3) promoting overall health and well-being. The Comprehensive Health Care Program (CHCP) for Michigan Medicaid beneficiaries, released in 2015, describes opportunities and requirements for Michigan's Managed Care health plans starting January 1, 2016. It is designed to improve the health of individuals receiving coverage through a population health management framework. CHCP has an overarching emphasis on health promotion and disease prevention, incorporates community-based health and wellness strategies with a strong focus on addressing social determinants of health. Once women are in care, there are a number of home visitation programs in place to provide services that complement prenatal care (i.e., Maternal & Infant Health Program and Nurse-Family Partnership). Additionally, MDHHS worked

with the Michigan Primary Care Association to bring Centering Pregnancy/Parenting (a multi-component group care model that integrates health assessment, education and support into a unified program) to three Federally Qualified Health Centers. A regional statewide perinatal quality improvement work began in 2015. There are three regions in the state selecting their own perinatal quality improvement priorities based on locally defined data.

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

SPM 1: Percent of pregnancies that are intended

Data Trends: Provisional data indicates that the percent of pregnancies that are intended gradually decreased by 6% (from 58.2% in 2012 to 52.2% in 2013) and has remained constant at 52.2% in 2014 and 2015. At the same time, it is important to note that the percentage of unintended pregnancies has also decreased by almost twice as much (11%). A change in data collection for pregnancy intention now allows women a greater range of response options,

including “I wasn’t sure what I wanted,” which accounts for 17% of all responses, and impacts the overall percentage of women categorizing their pregnancies as either strictly intentional or unintentional.

FY 2015 Program Summary: The Michigan Title X Family Planning Program served 72,312 clients in 2015 through a network of 32 local providers operating 97 clinics. Twenty percent of clients were teens. Seventy-eight percent of clients were 150% of the federal poverty level and below.

Program Successes: The percent of female clients using highly effective long-acting reversible contraceptives is increasing; from 5% in 2013 to almost 8% in 2015. According to a cost savings methodology by The Guttmacher Institute, Michigan’s Family Planning Program helped avert an estimated 19,340 unintended pregnancies in 2014.

Program Challenges: The program has faced challenges through funding reductions, cost increases and revenue decreases with the end of Plan First (Michigan’s Family Planning Section 1115 Waiver). Family planning agencies have been instrumental in enrolling clients in Michigan’s Medicaid expansion program which has led to the most recent challenge, declining program numbers as clients are enrolled with primary care providers. The program works to sustain a robust clinic network for clients who are uninsured, in need of confidential services, and/or who choose to remain with Title X providers for high quality contraceptive services. Despite program caseload reductions, Family Planning programs remain a trusted primary source of health care for many clients. Moving forward, the Family Planning Program plans to

emphasize reproductive life planning and utilizing highly effective contraceptives with clients, as well as emphasizing program sustainability with providers.

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

Data Trends: Provisional data show 27.7% of mothers with a pre-pregnancy BMI >29.0, which remains below both national and overall state adult obesity rates, but does not meet the performance objective of 22%. Per the Michigan Behavioral Risk Factor Survey, the prevalence estimate for the percentage of obese female residents decreased from 31.9% in 2013 to 30.6% in 2014.

FY 2015 Programmatic Activities and Accomplishments: Title X Family Planning clinics assessed BMI and provided education for all clients. The Maternal & Infant Health Program (MIHP) and Nurse-Family Partnership Program assessed BMIs of all mothers served and provided healthy eating and exercise education. WIC clinics provided nutrition education for pregnant and postpartum clients, promoting healthy prenatal and postpartum weight with an emphasis on breastfeeding. WIC local agencies statewide developed annual Nutrition Services Plans based on predominant client risks, with 22% specifically targeting maternal obesity and overweight. A state-level Breastfeeding Consultant position was created to further increase breastfeeding rates and assist with coordination of breastfeeding efforts across state programs. Michigan intensified efforts to provide education on the importance of planned pregnancies to achieve optimal health prior to conception, which includes a healthy BMI.

Program Challenges: The underlying challenges remain that complex physical and behavioral changes are necessary to reduce obesity rates and, therefore, require consistent public health efforts. The successes detailed above will continue to be the foundation necessary to see

improvement. Michigan WIC will continue to offer client learning opportunities and expand quality training opportunities for staff around the topics of breastfeeding, obesity prevention and intervention, and client-centered nutrition counseling.

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

Data Trends: Final data from 2013 and provisional data estimates from the 2014 and 2015 Michigan PRAMS show the percent of women physically abused during the 12 months prior to pregnancy has decreased from 4.4% to 3.1%. Maternal Infant Health Program (MIHP) FY 2015 data from the Michigan Department of Health and Human Services (MDHHS) Data Warehouse show that 19,358 pregnant Medicaid beneficiaries completed a risk screener. Of those women, 40% (7,713 women) scored moderate or high risk for domestic violence. Of the women who completed a risk screener, 6.6% (1,275 women), answered yes to the question, "Within the last year, have you been hit, kicked, slapped or otherwise physically hurt by someone?"

FY 2015 Program Summary: MIHP is a population-based home visiting model. Every Medicaid-insured pregnant woman is eligible for comprehensive risk screening, care coordination and services based on risk. Data are collected based on the beneficiary's response to the domestic violence risk questions asked on the validated, maternal risk-identifier screen and stored in the MDHHS Data Warehouse. MIHP provides universal screening and education for domestic violence at entry into the program and again at time of delivery. An evidence-based plan of care is developed for women who screen at-risk for domestic violence, including a required intervention to develop a safety plan. Women may receive up to nine additional visits throughout pregnancy and post-partum by a registered nurse and licensed social worker, and

when applicable, registered dietician (with a physician order) and an infant mental health specialist. Each MIHP agency receives periodic certification reviews by a contracted MIHP review nurse to assure agencies are providing services with fidelity to the model. A sample of beneficiary charts are reviewed during the certification review and this includes checking that safety plans are in place and that women scoring at high risk in any domain, including domestic violence, have had the domain addressed by the home visiting professional within the first three visits. Staff training on domestic violence is provided using an adaptation of the "Futures without Violence" curriculum. Continuing education credits are available for MIHP nurses and social workers upon completion.

Program Successes and Challenges: Data availability has both impeded and contributed to the success for this indicator. The MIHP risk screeners and discharge summaries are electronic, allowing for accurate data extraction; but other forms with pertinent data, such as progress notes and care plans, are not electronic at this time. There are future plans to add the additional MIHP forms to the electronic database. The MIHP certification review tool has been revised and indicators have been enhanced to assure and improve the quality of services provided to MIHP beneficiaries. Future plans include revising the risk identifiers and discharge summary to align with recent evidence for not only the domestic violence risk, but all risk domains.

Perinatal/Infant Health Domain

NPM 3 – Perinatal Regionalization

State Priority Need	**Objectives**	**Strategies**	**National Outcome Measures (NOM)** (prepopulated by HRSA)	**National Performance Measure** (NPM) (prepopulated by HRSA)
Support coordination and linkage across the perinatal to pediatric continuum of care	A) By 2020, support the implementation and evaluation of Regional Perinatal Care Systems in five pilot communities or regions	A1) Disseminate guidance documents for the development of Regional Perinatal Care Systems (RPCS) A2) Provide staff and financial support in the initiation of three Regional Perinatal Care Systems (RPCS) in one rural and two urban areas A3) Assess for expansion of RPCS in other regions of Michigan	- Infant mortality per 1,000 live births - Perinatal mortality per 1,000 live births plus fetal deaths - Neonatal mortality per 1,000 live births - Preterm-related mortality per 100,000 live births	Percent of very low birth weight (VLBW) infants born in a hospital with a Level III+ Neonatal Intensive Care Unit (NICU)
	B) By 2020, increase Risk Appropriate Care for mothers and infants from baseline data indicators by 20%: • Percent Very Low Birth Weight (VLBW) • Percent Low Birth Weight (LBW) • Percent live births 32-33 weeks	B1) Participate in the MCHB Infant Mortality CoIIN and Risk Appropriate Care Network B2) Promote the March of Dimes Preterm Labor Assessment Toolkit to Michigan birth hospitals B3) Promote case management/care coordination for at-risk pregnant women in Michigan through evidence-based programs such as		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
	gestation (preterm) • Reduction of VLBW, LBW, preterm disparity	CenteringPregnancy®, CenteringParenting® and Maternal, infant and early childhood home visiting (MIECHV) B4) Participate in the Maternal and Child Health Bureau's Alliance for Innovation of Maternal Health (AIM) B5) Identify education materials, messaging and social marketing strategies regarding risk appropriate care for mothers and their babies		
	C) By 2020, expand quality improvement efforts related to substance use disorders (i.e. opioids, alcohol, tobacco) for the prevention of maternal mortality and improved birth outcomes	C1) Promote screening for substance use, as part of pre- and inter-conception care, and prenatal periods, according to nationally established standards C2) Implement training for women's health care providers regarding the screening for all forms of substance use and providing treatment referrals when necessary		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
		C3) Continue quality improvement efforts regarding Neonatal Abstinence Syndrome through the Michigan Quality Collaborative Initiative		

Perinatal Regionalization Narrative

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

Infants born prematurely and of VLBW or low birth weight (LBW) are at greater risk of hospitalization, long-term health and developmental problems, and death in comparison to babies that are full-term and of healthy weight. Families in poverty have higher rates of low birth weight babies and subsequent health and developmental problems. African American, Native American, Middle Eastern and Hispanic babies are seriously impacted by health inequities. For example, Black babies experience twice the rate of prematurity and LBW in comparison to White babies. The percent of Black VLBW infants (3.2%) was nearly triple that of White VLBW infants (1.2%) in 2013. In Michigan, the percentage of preterm births increased from 9.8% in 2009 to 12.0% in 2013, which exceeds the Healthy People 2020 target of 11.4%. In

addition, the percent of LBW and VLBW infants in the state has remained stagnant and above the Healthy People 2020 target of 7.8% for LBW and 1.4% for VLBW (LBW was 8.4% in 2009 and 8.3% in 2013; VLBW was 1.7% in 2009 and 1.6% in 2013).

Addressing the existing health inequities and disparities that exist in Michigan will result in the reduction of the overall Michigan LBW, VLBW and preterm birth rates. At the same time, increasing the number of very preterm and VLBW infants born in a risk appropriate care hospital has reduced the risk of neonatal death.

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

In FY 2016, the Michigan Department of Health and Human Services (MDHHS) developed Regional Perinatal Care System (RPCS) Quality Improvement (QI) guidelines utilizing the life course perspective. RPCSs will be piloted in three areas of Michigan with varied demographic compositions, including rural and urban communities. Key stakeholders at the community level include: birth hospitals, local health departments (LHDs), professional organizations, medical providers, health systems, Federally Qualified Health Centers (FQHCs), home visitation programs, community agencies and families. Community-identified key stakeholders will make up the leadership team for each identified community charged with the development of a RPCS.

Currently, one rural community in northern Lower Michigan has begun the process for RPCS QI. A leadership team is working collaboratively with stakeholders to examine local data. Two QI projects have been identified which include 1) improving access and implementation of evidence-based services for the identification and referral of pregnant women engaged in high risk substance use; and 2) the creation of a sustainable system of family support visits in the home for pregnant/postpartum women and their infants. An urban community in southeast Michigan has engaged community champions, who have convened regional and community stakeholders. This community is gathering maternal and infant health and social data as a method of comprehensive assessment. The southeast Michigan RPCS QI efforts include the impending use of the CDC Level of Care Assessment Tool (LOCATE) including added social determinants of health related assessment questions. A third RPCS is in the stage of convening stakeholders to begin the assessment and planning process. The department will assess for expansion of RPCS in other regions of the state.

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

The second strategy is to promote the March of Dimes Preterm Labor Assessment Toolkit to birth hospitals in Michigan. This toolkit supports hospital clinicians in understanding the importance of standardizing preterm labor assessment and the steps to take to drive change in assessing patients presenting with signs and symptoms of preterm labor.

The third strategy is to promote case management and care coordination for pregnant women in Michigan through evidence-based programs. The department is working with the Michigan Primary Care Association to expand CenteringPregnancy® and CenteringParenting® to Federally Qualified Health Centers (FQHCs) that provide prenatal care in Michigan. Three FQHCs have begun implementation of CenteringPregnancy® with two additional FQHCs to implement in FY 2017. One FQHC has implemented CenteringParenting® and at least two others are exploring the model for use in their centers. MDHHS also promotes case management and coordination for women though evidence-based home visitation programs. Evidence-based home visitation programs promote health care utilization and reduced risk for adverse birth outcomes such as VLBW, LBW and premature birth.

The fourth strategy for this objective is to participate in the Maternal and Child Health Bureau's Alliance for Innovation of Maternal Health (AIM). In partnership with stakeholders and professional organizations, Michigan is collaboratively working toward improved maternal morbidity and mortality outcomes. Finally, MDHHS will identify educational materials, messaging and social marketing strategies for Michigan residents regarding risk appropriate levels of care.

Objective C: **By 2020, expand quality improvement efforts related to substance use disorders (i.e. opioids, alcohol, tobacco) for the prevention of maternal mortality and improved birth outcomes.** Substance use during pregnancy (including smoking, alcohol and illicit drug use) is a risk factor for adverse birth outcomes such as preterm birth and LBW. Opiate use/abuse has become an epidemic in Michigan. The number of infants affected by Neonatal Abstinence Syndrome (NAS) and treated pharmacologically has increased at an alarming rate from 84.8 per 100,000 births in 2003 to a staggering 658.6 per 100,000 live births in 2013. According to PRAMS 2011 data, 6.2% of mothers reported having alcoholic drinks during the last three months of pregnancy and 14.9% of mothers reported smoking cigarettes. In Michigan in 2013, 21.9% of women of childbearing age (18-44 years) reported smoking compared to 20.5% of women nationally. Many rural areas of the state have higher substance use rates in comparison to urban areas.

The Michigan Prescription Drug and Opioid Abuse Task Force released a "Report of Findings and Recommendations for Action" in October 2015. The Task Force recommendations, in conjunction with emerging scientific research, are the basis for determining best practice standards or identifying and caring for mothers and infants impacted by substance use. Thus, the first strategy for this objective is to promote screening for substance use, as part of pre- and inter-conception care, and prenatal periods, according to nationally established standards. Activities for this strategy include 1) Title X Family Planning clinics in Michigan will assess for tobacco use and refer clients to tobacco quit services, when appropriate; 2) the northern lower Michigan RPCS will host a Perinatal Substance Use Summit in July 2016, as a means of developing and aligning perinatal substance use services; and 3) a pilot, based on a Texas

model, will be implemented on a Pre-Paid Inpatient Health Plan (PIHP) regional level using health navigator/case managers who work with pregnant women with an opioid dependency.

The second strategy is to increase education to providers statewide who come into contact with women of childbearing age as a mechanism for increasing overall provider knowledge of the need to assess and provide resource referrals when substance use is identified. Activities will include 1) provider networks (including, but not limited to, the Michigan State Medical Society, Michigan State Osteopathic Association, and Michigan Hospital Association) will be engaged to promote delivery of this education; 2) Michigan Area Health Education Centers will work with the department to develop a tool and database which looks at gaps in curriculum related to perinatal substance use, health literacy, health equity and perinatal oral health; and 3) a webinar on what providers need to know as a mandated reporter, planned by the Office of Recovery-Oriented Systems of Care.

As a final strategy, MDHHS will continue quality improvement efforts regarding NAS through the Michigan Collaborative Quality Initiative (MICQI) which includes the Vermont Oxford Network (VON) participation. This is a tertiary prevention strategy that works with infants and families affected by NAS to help infants have a safe withdrawal from opiate or other drugs and to support on-target growth and development. MICQI will provide several regional workshops to share information on identification, care and treatment of neonates born with NAS. MICQI is expanding QI efforts related to a statewide standardized NAS screening and treatment protocol.

Perinatal/Infant Health Domain

NPM 4 – Breastfeeding

State Priority Need	**Objectives**	**Strategies**	**National Outcome Measures (NOM)** (prepopulated by HRSA)	**National Performance Measure** (NPM) (prepopulated by HRSA)
Support coordination and linkage across the perinatal to pediatric continuum of care	A) By 2018, develop and promote a state plan to improve and support breastfeeding with a focus on duration, initiation and reducing disparities	A1) Create the state breastfeeding plan utilizing key stakeholder input A2) Promote the state breastfeeding plan statewide A3) Develop a system for statewide plan implementation and to measure progress A4) Develop a website to support state breastfeeding efforts, including promotion of state breastfeeding plan	- Infant mortality per 1,000 live births - Postneonatal mortality rate per 1,000 live births - Sleep-related SUID per 100,000 live births	A) Percent of infants who are ever breastfed and B) Percent of infants breastfed exclusively through 6 months
	B) By 2020, increase Baby-Friendly hospitals to 20% across Michigan	B1) Begin a statewide assessment of hospital maternity care practices supporting breastfeeding B2) Award a minimum of four mini-grants to assist hospitals in Baby-Friendly Hospital Initiative implementation		
	C) By 2020, study and determine method(s) to accurately measure breastfeeding initiation,	C1) Develop a workgroup to obtain input on determining a baseline for breastfeeding data collection in Michigan C2) Determine the feasibility of collecting		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
	duration, and exclusivity rates and measure racial and ethnic differences	standardized breastfeeding data from community partners including hospitals and pediatricians		
	D) By 2020, increase breast milk at discharge by ≥ 10% (over baseline) for VLBW (under 1500 grams at birth) infants	D1) Support the Michigan Quality Collaborative Initiative and staff D2) Support the use of RedCap for breast milk use in VLBW infants in NICUs D3) Analyze data in RedCap for the purpose of identifying quality improvement opportunities for Michigan NICUs related to VLBW infants and breast milk use		

Breastfeeding Narrative

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

The State of Michigan encourages breastfeeding with support from the Healthy People 2020 objectives. The Healthy People 2020 objective targets are 81.9% of infants ever breastfed and 25.5% of infants exclusively breastfed through six months. The National Immunization Survey 2012 reported that 76% of Michigan's infants are ever breastfed with a decline to 17%

exclusively breastfed through six months. According to Michigan's Women, Infants, and Children (WIC) data from October 2015, 63.3% of women breastfed initially. WIC data generated in April 2016 reveal that just 9.9% exclusively breastfed through six months.

The American Academy of Pediatrics (AAP) reaffirms its recommendation of exclusive breastfeeding for the first six months of a baby's life. This recommendation is supported by positive health outcomes, as well as social and economic advantages for mothers and children, making it a public health issue and not only a lifestyle choice. Families require an enabling environment to achieve optimal breastfeeding. By addressing this need, MDHHS will move closer to achieving breastfeeding initiation, duration and exclusivity goals while reducing any disparities in breastfeeding.

Objective A: By 2018, develop and promote a state plan to improve and support breastfeeding with a focus on initiation, duration and reducing disparities. While hospitals, coalitions and other support systems have long tried to increase breastfeeding initiation, duration and exclusivity, the importance of comprehensive breastfeeding support is still under-recognized. As a result, breastfeeding promotion and support efforts have been fragmented. As a part of the first strategy, MDHHS has reinstated an internal breastfeeding workgroup. This workgroup has been charged with providing an assessment of 1) the breastfeeding efforts occurring throughout the state and 2) ways to collaborate with partners to reach breastfeeding goals. In 2016, MDHHS and the workgroup planned two state breastfeeding forums to obtain key stakeholder input on how to remove barriers to breastfeeding, build on successful interventions, and build a culture in Michigan that supports breastfeeding families. Key stakeholders included employers, educational institutions, health care professionals, health

care systems, public health professionals, community organizations and community members. From the results of the forums, Michigan will create a State Breastfeeding Plan. The plan will describe the approach and milestones to be achieved for the next three to five years with an added focus on reducing breastfeeding disparity. It will be a living document that identifies strategies that can be used by programs and partners across sectors. It is expected that a preliminary plan will be developed by December 2016. Once created, MDHHS will work on promoting the plan throughout the state and developing an implementation system (for example, focused workgroups or communities of practice).

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

Objective B: By 2020, increase Baby-Friendly hospitals to 20% across Michigan. Recognizing the important role that hospitals and birthing facilities play in supporting and encouraging mothers' efforts to breastfeed, the Baby-Friendly Hospital Initiative (BFHI) was launched by WHO and UNICEF in 1991. The "Ten Steps to Successful Breastfeeding" are a central part of the BFHI and are evidence-based practices that support breastfeeding behaviors and influence outcomes. Having the BFHI helps hospitals give mothers the information, confidence and skills they need to successfully initiate and continue breastfeeding. As of April 2016, 12 out of 83 Michigan hospitals (14%) have independently achieved the prestige of Baby-Friendly status to

help initiate breastfeeding at birth. The AAP states that several studies have demonstrated that implementation of Baby-Friendly maternity care practices is associated with increased rates of exclusive breastfeeding. All health care facilities should aim to adhere to BFHI practices which are known to increase initiation, duration and exclusivity of breastfeeding.

A first strategy for this objective is to begin a statewide assessment of hospital maternity care practices supporting breastfeeding. During state-conducted site visits, MDHHS will observe hospital maternity care policies and advise on ways to improve and support breastfeeding practices. MDHHS will also offer guidance and technical assistance to hospitals that plan to complete the Baby-Friendly process, as well as to hospitals that don't plan to complete the process but are interested in improving their breastfeeding supportive practices.

The second strategy will make modest mini-grants of up to $10,000 available to four hospitals to assist them in accomplishing one of the ten Baby-Friendly Initiative Steps. MDHHS plans to award these funds in 2017. MDHSS will also promote the availability of other funding opportunities, training and technical assistance, and additional supports as identified to help hospitals sustain continuation of these activities beyond the term of any funding. It is anticipated that long-term impacts of this project will increase breastfeeding rates by encouraging successful breastfeeding-friendly practices in health facilities.

Objective C: By 2020, study and determine method(s) to accurately measure breastfeeding initiation, duration and exclusivity rates and measure racial and ethnic differences. Tracking breastfeeding rates in Michigan is crucial to evaluating and improving infant health programs. While WIC is a critical source of breastfeeding duration and exclusivity data, it is important to

identify other sustainable resources to support data collection. Other sources (mostly national) provide initiation, duration and exclusivity rates, but definitions and findings often vary.

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

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

Objective D: By 2020, increase breast milk at discharge by ≥ 10% (over baseline) for VLBW (under 1500 grams at birth) infants. Substantial research supports the benefits of breast milk being provided to very low birth weight (VLBW) infants within Neonatal Intensive Care Units

(NICU). The first strategy for this objective is to support the Michigan Quality Collaborative Initiative (MICQI) and its staff. The MICQI is a voluntary collaboration of NICUs that have been working to increase human milk use within the NICU, and to decrease necrotizing enterocolitis infections in VLBW infants. Currently, all 20 NICU hospitals throughout Michigan participate in some way with this collaborative.

The second strategy is to support the use of Research Electronic Data Capture (RedCap) for breast milk use in NICUs. MICQI uses the RedCap system to collect data with the support of the MICQI nurse. The final strategy is to analyze data collected through RedCap for the purposes of identifying quality improvement opportunities for Michigan NICUs related to VLBW infants and breast milk use. The data will be analyzed for strengths; areas to improve receipt of human milk in NICU; increased breast milk at discharge; and factors that affect mothers' ability to sustain milk production. Analyzing the data will provide further insights on how to best provide support of using breast milk for the nutrition of preterm infants.

Perinatal/Infant Health Domain

SPM 2 – Safe Sleep Environments

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
Foster safer homes, schools, and environments with a focus on prevention	A) By 2020, increase the percent of infants put to sleep alone in their crib, bassinet or pack and play by 4% B) By 2020, increase the percent of infants put to sleep without objects in their crib, bassinet or pack and play by 4%	A1, B1) Provide funding to a subset of local health departments and the Inter-Tribal Council of Michigan to support the implementation of community-based infant safe sleep activities A2, B2) Facilitate new collaborations with non-traditional partners to carry out programming that promotes infants being placed to sleep alone in their crib, bassinet or pack and play A3, B3) Develop new public awareness mediums that focus on scenarios that support infant safe sleep A4, B4) Provide education and tools for providers who work with pregnant and parenting families (in programs such as home visiting, WIC, child care, prenatal care, etc.) to have effective conversations about infant safe sleep A5, B5) Produce an annual safe sleep report A6, B6) Reduce the racial disparity related to unsafe sleep practices	A) Percent of infants put to sleep alone in their crib, bassinet or pack and play and B) Percent of infants put to sleep without objects in their crib, bassinet or pack and play

Safe Sleep Environments Narrative

Through the needs assessment process, the state priority issue of "Foster safer homes, schools, and environments with a focus on prevention" was selected for the Perinatal/Infant Health domain. The SPM created to address this priority need is: 1) the percent of infants put to sleep alone in their crib, bassinet or pack and play and 2) the percent of infants put to sleep without objects in their crib, bassinet or pack and play. These two behaviors are critical in the prevention of sleep-related infant deaths which are the third leading cause of death for infants

overall in Michigan and the leading cause of death for infants 28 days to 1 year old. Of the leading causes of infant death, sleep-related infant deaths are considered the most preventable.

In 2014, MDHHS Vital Records reported 125 infants died in Michigan from Sudden Unexpected Infant Death (SUID). Historically, the number of infant deaths classified as SUID is an under reporting of the actual number of infant deaths that occur from sleep-related causes. Michigan is fortunate to be one of 18 jurisdictions/states that participate in the Centers for Disease Control and Prevention (CDC) SUID Case Registry Project which is a population-based, multistate surveillance system designed to identify SUID trends and risk factors. Through the SUID Case Registry Project, infant deaths are examined in detail to determine if sleep-related causes were involved. Additional sources are reviewed including death scene investigations, autopsies, and medical records. Frequently, this thorough review results in additional deaths being attributed to sleep-related causes. Thus, in 2014, Michigan's SUID Case Registry Project reported 152 sleep-related infant deaths. Although the *rate* of sleep-related deaths (deaths per 1,000 live births) remained constant from 2013 to 2014, the *number* of deaths increased (from 142 deaths in 2013).

In addition to the persistently high numbers, significant and unacceptable racial disparities exist among sleep-related infant deaths. Statewide, according to MDHHS Vital Records for the birth cohort 2009-2013, Black infants were disproportionately represented with 4.6 times more SUIDs among Black infants than White infants, even after accounting for the fact that more White infants were born. The SUID Case Registry Project confirms the racial disparity, showing

that Black infants in Michigan die at a rate more than three times greater than White infants, and American Indian infants die at more than twice the rate of White infants. These rates are likely an underreporting of the actual racial disparity as they do not include infants whose parents are of different races.

The data on sleep-related infant deaths reveal that parents are continuing to practice infant sleep behaviors that put infants at risk. Data from the Pregnancy Risk Assessment Monitoring Survey (PRAMS) confirm this trend. PRAMS results from 2012 show that 20% of all infants usually sleep on their side, stomach or a combination; 22% of babies usually bed share with another person; and 12% do not usually sleep in a crib or portable crib. Furthermore, almost half of all babies regularly sleep in an environment with at least one item such as a pillow, blanket or stuffed toy. These behaviors have been shown to increase the risk for a sleep-related infant death. In 2012, 78.65% of Michigan infants were usually sleeping on their back. Nationally, according to the National Infant Sleep Position study which was conducted from 1992-2010, 74% of infants are usually placed to sleep on their back. Thus, Michigan is faring better than the national average on this behavior.

PRAMS also provides data by race/ethnicity. From PRAMS results for 2009-2011, 43.6% of non-Hispanic Black mothers reported that their baby usually slept on their side, stomach or a combination compared to 20.3 % of non-Hispanic White mothers. Similar differences are found in the other two behaviors with 24% of non-Hispanic Black mothers reporting that their baby usually slept with another person (compared to 11.1% of non-Hispanic White mothers) and

23.1% of non-Hispanic Black mothers reporting that their baby does not usually sleep in a crib or portable crib (compared to 8.9% of non-Hispanic White mothers).

Infant deaths in the sleep environment continue to occur due in large part to the risky behaviors discussed above. According to the SUID Case Registry Project, three in four sleep-related infant deaths in Michigan occurred in an unsafe sleep location—with 50% of infants who died being placed in an adult bed for sleep; 20% placed on a couch, chair, or the floor; and 10% placed in other unsafe sleep locations. In addition, approximately 60% of sleep-related infant deaths occurred among infants who shared a sleep surface such as with an adult or sibling. Two in three infants found unresponsive are not on their backs with approximately 50% found on their stomach and 15% on their side. Although these data look at the position when the infant was found unresponsive, it is unclear whether infants were placed to sleep in the found position or if they moved to that position during sleep.

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

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

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

The first strategy is to increase the capacity of communities to implement infant safe sleep education, awareness and outreach activities to promote infants being placed to sleep alone in their cribs, bassinets or pack and plays with no objects. This strategy will be accomplished through the provision of mini-grants to communities identified as having high numbers of SUIDs. Since 2013, these mini-grants have been provided to local health departments (LHDs) and the Inter-Tribal Council of Michigan. Currently, 14 LHDs and the Inter-Tribal Council of Michigan receive such grants. Each community uses a local advisory council to guide activities, and all efforts must adhere to the current American Academy of Pediatrics guidelines for infant sleep safety and SIDS risk reduction.

This strategy has the potential to impact racial disparity, as most of the identified communities have a significantly higher rate of deaths among Black and American Indian infants than among White infants. A benefit of increasing local capacity is that communities are able to tailor their activities based on their needs and are not confined to a generic approach. The creativity and innovation that has developed around these strategies in the past three years is encouraging and affirms this approach. Since the mini-grants have been offered, communities have either initiated or strengthened their existing local advisory council (by increasing diversity of membership, for example). A wide range of activities has occurred, including safe sleep training for health professionals and others, translation of materials to meet local needs, home visits to provide safe sleep education, social media, advertising campaigns, and numerous safe sleep

educational events at faith-based organizations, shelters, schools, stores, WIC clinics, and mental health treatment programs. Mini-grantees are extending their reach as their relationships in the community have developed, and they are gaining the trust and acceptance needed to reach out further to non-traditional partners. An additional strength of this approach is that people from the community will more likely be seen as trusted messengers and accepted by others in the community. They are often able to connect better with individuals and families and may have a greater impact on parenting behavior and practices. An ongoing challenge with this strategy is the availability of funds and the ability of the mini-grantees to retain experienced and knowledgeable staff who can work effectively with families.

The second strategy to increase the percent of infants put to sleep safely is to facilitate new collaborations with non-traditional partners so the message spreads in communities that may not have been reached in previous campaigns. Substance abuse treatment centers have been identified as one potential partner as the SUID Case Registry Project reported that more than half of sleep-related infant deaths are associated with a parent or caregiver who has a history of substance abuse. Most treatment programs have a didactic component where safe sleep education could be incorporated. Faith-based organizations have also been identified as a potential partner, as they are an important part of many families' lives and often have a strong influence on parenting behavior. Additionally, faith-based organizations appear open to spreading this message as it aligns with their commitment to strengthening families. Outreach and linkages with non-traditional partners will occur at both the local and state levels. Challenges that may arise include the possibility that these non-traditional partners do not see this topic area as a priority and/or that they are already incorporating multiple health messages

in their work and are unable to include safe sleep. Increasing collaborations with non-traditional partners could potentially impact racial disparity if the partners work with groups that have high numbers of sleep-related infant deaths. For example, the initial work with faith-based organizations in Detroit have a majority of congregants who are African American.

A third strategy is to develop new public awareness mediums that focus on scenarios that support infant safe sleep. These mediums could include publications, PSAs for radio and/or television, and social media components. The state currently offers a wide array of publications (including brochures, posters, window clings and DVDs) free of charge through a statewide Clearinghouse. The brochures are available in Spanish and Arabic and the poster is available in Spanish. Over 330,000 educational items are distributed statewide annually. Additionally, the state has produced a DVD combining safe sleep education with family stories that is distributed through the Clearinghouse and is posted on the state's safe sleep website. A safe sleep television PSA was produced in 2013 featuring an African American mother who is also a local sports figure. The PSA is currently shown in communities with high numbers of sleep-related infant deaths, including Detroit. An additional television PSA, focusing on the reasons to not bed share with an infant, is being shown statewide. Social media, including Facebook and Twitter, is used to keep safe sleep messages in the public eye. In FY 2015, our media branched out into new territory and used mobile advertising and Google Adword searches. Both techniques greatly extended our reach, especially among the targeted population of young African American mothers. Radio advertising will be conducted and will include new avenues such as Pandora. This advertising will be targeted to high-need areas of the state including Detroit, Flint and Grand Rapids.

Plans are underway to evaluate both the *message* that is currently used at the state-level for public awareness and the *methods* used for conveying the message. In the second half of FY 2016, a series of focus groups will be held with providers and parents to gain a better understanding of how the message is being received and if there are more effective ways to communicate the message both in terms of language and methodology. Additionally, a phone survey is being developed that will focus on parents' experience with the safe sleep message, how it was received and if it was implemented in the home and why or why not. The survey will target parents in Detroit as that is where the majority of sleep-related infant deaths occur. By targeting African American parents in Detroit, we will also gain valuable feedback on how the African American community is receiving this message and how to improve it. The phone survey is currently in development and is projected to be complete by the end of FY2016. The results from both the focus groups and the phone survey will be used to determine if the message needs to be changed and if so, how. We will also use the results to determine what mediums would be most effective in reaching the target populations.

As a fourth strategy, we will continue to provide safe sleep education to providers who work with pregnant and parenting families in programs that reach those populations including home visiting, WIC, child care, and prenatal care. Currently, staff at both the state and local levels provide training to a number of these provider groups at both statewide and local events. Additionally, an online safe sleep training for health care providers was recently updated and is available free of charge, offering continuing education credits for social workers, nurses and certified health educators. A second online safe sleep training specific to child care providers was launched in 2014. Since its inception, over 10,000 individuals have completed the course.

A new focus will be on providing tools for providers to have more effective conversations with parents/caregivers about infant safe sleep. Thus, the education will go beyond simply teaching them how parents should practice infant safe sleep, but explore how to have conversations with parents about their barriers to practicing safe sleep and how to help parents meet and overcome those challenges. The results of the previously discussed focus groups will provide additional input into what specific education and tools could be helpful to providers.

Currently, we have many existing relationships with these providers at both the state and local levels which will prove helpful in advancing this work. Policy changes are currently being pursued with some of these provider groups, including one with the Maternal Infant Health Program (MIHP) that would require providers to complete an online safe sleep training. Collaboration with MIHP has also led to safe sleep content for providers and families being posted on their website and a training on safe sleep scheduled in an upcoming webinar for MIHP Coordinators. At the state level, many of these provider groups are represented on the Michigan Infant Safe Sleep State Advisory Committee. At the local level, many of the health departments that receive infant safe sleep mini-grants are either providers of services to pregnant and parenting families (such as WIC, home visiting, etc.) or are partners with agencies that provide services.

One challenge with this strategy is that many of these providers are overwhelmed with information/education that must be provided to clients in addition to substantial data collection requirements. Adding “one more thing” for providers to cover during visits could be difficult, and there is the possibility that material would not be presented thoroughly or

effectively. To meet these challenges, we will again look to the results of the focus groups to see what can be done to make this information easier for providers to convey.

The next strategy is to produce an annual infant safe sleep report. In Michigan, we are fortunate to have many sources of data that can help us learn more about sleep-related infant deaths and point to potential strategies for prevention. In addition to MDHHS Vital Records data, we have data from the CDC SUID Case Registry Project and PRAMS, including a Native American PRAMS. A detailed report that compiles and analyzes data from all of these sources, including providing recommendations based on the data, would be valuable in guiding programming and targeting resources. The report would be disseminated widely so that both providers, partners and the general public could gain a better understanding of the problem and what can be done.

Challenges to the production of a report include obtaining data that are recent and therefore reflective of the current situation. Much data related to infant mortality and sleep-related deaths in particular report the numbers at least two years prior. For example, the most recent PRAMS results are from 2012. This lag time makes it difficult to accurately portray the current situation and what, if any, impact our activities are having.

The final strategy focuses on the need to reduce the unacceptable racial disparity that exists in sleep-related infant deaths. This is addressed in each strategy, however, as a priority strategy for Michigan, it is also individually highlighted. As noted in the narrative above, each strategy integrates the need to address racial disparity. How this is done varies according to the activity, but may involve allocating more resources to areas that experience greater racial disparity and

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

Perinatal/Infant Health Annual Report

The following performance measures and the related data trends, program summaries, successes, and challenges address the **Perinatal/Infant Health** population domain for FY 2015 reporting.

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

Data Trends: The Michigan WIC breastfeeding duration rate has remained relatively stable since FY 2009. The 6-month breastfeeding duration rate for FY 2015 is 18.4%, consistent with 2014 and is just slightly below the annual performance objective.

FY 2015 Program Summary and Successes: Staff education is critical to supporting WIC moms. This past year, approximately 200 staff attended WIC conference sessions focused on supporting breastfeeding moms. For the fifth consecutive year, WIC offered *Building Bridges to Breastfeeding Duration* in partnership with local WIC agencies and birthing hospitals. Additionally, WIC piloted a mentoring project with local agency WIC staff, recognizing that breastfeeding duration depends on multiple factors. Staff watched a Lactation Consultant counsel moms, then provided counseling themselves; as they helped to identify challenges of mother and baby, and how to successfully resolve identified issues in order to increase duration.

Strong support for initiation prior to birth, at birth, and for overcoming challenges is necessary to achieve six-month breastfeeding duration. Twelve Michigan hospitals have achieved a Baby-

Friendly status as they provide strong support to breastfeeding initiation at birth. Michigan is involved in the *Coffective* breastfeeding initiative, aligned with the Baby-Friendly Hospital Initiative, working with community partners to further breastfeeding objectives. Home visiting programs provide new mothers with extra support for breastfeeding duration. The Maternal Infant Health Program (MIHP) provides prenatal and postpartum breastfeeding interventions.

Program Challenges: Based on the success of the pilot, Michigan WIC received USDA Infrastructure Grant Funding to host regional one-day trainings filled with hands-on, interactive breastfeeding counseling and practical skill building to current lactation counselors, educators, and/or specialists. These statewide trainings are planned for spring/summer of 2016. The overall goal of this project is that staff success will be marked by improved duration rates. Additionally, Michigan WIC will host approximately 40 local agency staff at a Certified Lactation Specialist Course in 2016.

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

Data Trends: The Early Hearing Detection and Intervention (EHDI) Program continues to have 100% birthing hospitals participating in infant hearing screening. Last year, over 97% of infants completed the hearing screening by one month of age. Of infants diagnosed with permanent hearing loss, 58.9% (n=102 of 173) were diagnosed by three months of age. All 173 infants were referred for early intervention services, final enrollment data for 2014 is not yet available.

FY 2015 Program Summary and Successes: EHDI uses the quality improvement framework, Plan-Do-Study-Act (PDSA) with collaborative strategies via a statewide network. These

strategies to reduce loss to follow-up include implementation of 1) two regional audiology consultants who provided site visits to 27 designated hearing screening hospitals to facilitate best practices and quality improvement strategies; 2) Wayne Children's Health Access Program partnership assisted 208 families with follow-up appointments; 3) Michigan Midwives partnership to provide hearing screenings: a total of 344 (32%) homebirth babies had completed hearing screens in 2014, which is an increase from the 19% screened in 2013. To date in 2015, 357 home birth babies had hearing screens; 4) Henry Ford Hospital collaborative to utilize new hearing screening equipment to decrease screening referral rates. Program quality improvements focus on provider and parent education of the EHDI process. The EHDI Guide by Your Side (GBYS) program continues to offer resources to families with infants who are deaf or hard of hearing and 65 families had guide visits in 2015.

In 2015, EHDI completed revisions to the Family Resource notebook given to parents in the GBYS program. In 2015, planning was conducted for both parent and professional conferences to be held in 2016. EHDI will continue to conduct statewide advisory and learning collaborative meetings with input from providers and parents for program improvement. The EHDI program achieves parent representation on committees and work teams through referral from program partner agencies, such as Michigan Hands & Voices and recruitment of parent guides in the GBYS program. Parents' feedback and unique perspectives are utilized to improve program activities, including: family support conference planning; sharing experiences in newsletters and at advisory committee meetings to increase awareness and promote best practices among professionals; participation in quality improvement projects; attendance at national conferences; evaluation of websites; and development of written materials for

families. Typically one to three parents participate at any given time. The EHDI program also uses surveys to assess parents' experiences with the hearing screening process, barriers to timely diagnosis and entry into intervention services, and satisfaction with parent support services after diagnosis.

EHDI will maintain efforts to improve data collection methodology via system upgrades, with a proposed electronic HL7 data messaging system to be piloted in 2016. The program will continue to provide quarterly reports to hospitals to improve screening efforts.

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

Data Trends: The trend in the percent of low birthweight infants delivered at facilities for high-risk deliveries has remained relatively stable over the past five years, ranging from 85.2% to 86.8%. Provisional data for 2014 indicate 87.3% of low birthweight infants were delivered at these facilities, which exceeds the Healthy People 2020 target of 83.7%.

FY 2015 Program Summary: Key strategies to assure VLBW infants are delivered at facilities equipped to care for them are to implement a perinatal care system, and to have a surveillance system in place to monitor this trend. Implementation of a regional perinatal system of care is one of the state's infant mortality reduction strategies.

Michigan participates in the Infant Mortality Collaborative Improvement & Innovation Network (CoIIN). Michigan also participates in perinatal regionalization (or risk appropriate care). In 2015, a CoIIN Risk Appropriate Care pilot quality improvement project was initiated which looked at low birth weight deliveries in northern Lower Michigan to determine gaps in the delivery of risk

appropriate care. The results of the quality improvement project may assist in programmatic and/or perinatal care systems changes that may improve the health outcomes of Michigan mothers and infants in northern Lower Michigan.

Certificate of Need Standards for Neonatal Intensive Care Services/Beds and Special Newborn Nursing Services beds standards became effective in March 2014. The addition of Special Care Nursery services for the first time marks a new era of quality and safety for newborn care in the state.

Program Successes: MDHHS is strengthening a data-driven approach to interventions. Perinatal Periods of Risk Data (PPOR) has been completed on each prosperity region in the state, which gives a better understanding of risk analysis and guides evidence-based or best practice strategies to improve outcomes.

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

Data Trends: The trend in percent of low birthweight (LBW) births among live births has remained relatively unchanged over the last five years (8.4% in 2009 to 8.3%), which does not yet meet the Healthy People 2020 target of 7.8%. The three-year analysis of average infant mortality rate by cause for 2005 to 2013 shows a slow decline in LBW births.

FY 2015 Program Summary and Successes: A key strategy to address LBW infants is to assure they are delivered at facilities equipped to care for them within a perinatal care system. In FY 2015, Michigan participated in Infant Mortality Collaborative Improvement & Innovation

Network (CoIIN) for Risk Appropriate Care, with a quality improvement pilot project in northern lower Michigan to determine gaps in delivery of risk appropriate care.

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

Program Successes: MDHHS has utilized a new and informative perspective of analyzing information, geo-spatial analyses of cause-specific (i.e. LBW) infant mortality rates and causes using maps, along with epidemiological analysis. This is useful to identify geographical areas with populations of greater need, where resources should be focused.

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

Data Trends: The trend in percent of preterm births among live births does not meet the Healthy People 2020 target of 11.4%, having increased from 9.8% in 2009 to 12.3% in 2014 (provisional data). The three-year analysis of average infant mortality rate by cause for 2005-2013 shows a slow decline in premature births. Prematurity and low birth weights remain the leading causes of infant death in Michigan. There continues to be a racial disparity among premature infant deaths with Black infants experiencing significantly higher death rates compared to Hispanic and White infants.

FY 2015 Program Summary: MDHHS supported three Michigan centers through start-up funding for participation in the CenteringPregnancy® model, which has been shown to reduce the risk of premature birth and reduction in racial disparities in preterm birth. Population strategies to improve birth outcomes continue, such as the avoidance of alcohol, tobacco cessation and avoidance of other substances among pregnant women. MDHHS supported Vermont Oxford Newtork training for 24 birth hospital providers on improving outcomes for infants and families affected by Neonatal Abstinence Syndrome. MDHHS also implemented a Fetal Alcohol Spectrum Disorder Alcohol Prevention/Health Promotion and Education Campaign for underserved pregnant moms. All Medicaid health plans provide coverage of both 17 hydroxy progestrone and intravaginal progestrone for approved indications of history of preterm birth and short cervix. Screening for short cervix using ultrasound examination between 18-24 weeks pregnant is included into the evidence-based *Routine Prenatal and Postnatal Care Guidelines* by the Michigan Quality Improvement Consortium. Evidence-based home visitation programs (i.e., Maternal Infant Health Program and Nurse Family Partnership) are encouraged for pregnant women. Targeted strategies to reduce disparities remain a priority.

Program Challenges: Preterm birth is a complex problem. The department has a health equity focus to assist in working on reducing disparity in birth outcomes.

Program Successes: The CenteringPregnancy® model expanded to include two more centers in the current fiscal year.

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

Data Trends: Between 2010 and 2012, the National Survey of Children's Health (NSCH) showed a 7.1% increase in the percentage of Michigan children receiving standardized developmental screening. This upward trend is supported by other data sources. From 2014-2015, Medicaid claims for billing codes 96110 and 96111 (developmental screenings) increased from 47,771 to 59,865 for 0 to 3 year olds. Similarly, during 2015, evidence-based home visiting programs reported that 76% of children received developmental screens their first 12 months of enrollment. New NSCH data will not be available until 2017; at that time MDHHS will be able to review trends from that data source and confirm new targets.

FY 2015 Program Summary and Successes: In 2015, a number of special activities contributed to increases in developmental screening. All evidence-based home visiting programs are conducting screening, and one MIECHV funded site is focusing on developmental screening and surveillance in the second phase of the HV CoIIN project. Michigan began to refine its plan for its Race to the Top-Early Learning Challenge grant, which will educate both families and child care providers about the importance of developmental screening. Many of the state's Great Start Collaboratives (early childhood advisories in each county in Michigan) have continued to focus on developmental screening as a key early childhood activity. Michigan has also strengthened developmental screening activities in Southeast Michigan with the Help Me Grow affiliate operating in Oakland, Wayne, and Macomb Counties; and in West Michigan with the Connections program.

Program Challenges: A significant challenge is that without a statewide data system to capture screening activities across agencies and funding streams, services may be duplicative and inefficient. This has been recommended for policy discussion within the cross-agency Great Start Steering Team**.** Title V Block Grant funds may be used to support development of a strategic plan to implement a statewide system.

Child Health Domain

NPM 6 – Developmental Screening

State Priority Need	**Objectives**	**Strategies**	**National Outcome Measures (NOM)** (prepopulated by HRSA)	**National Performance Measure** (NPM) (prepopulated by HRSA)
Invest in prevention and early intervention strategies, such as screening	A) By 2018, identify initial implementation steps of a statewide developmental screening system	A1) Create a strategic plan for a statewide developmental screening system A2) Ask Great Start Steering Team to adopt this objective as a focus item for the Great Start early childhood system	- Percent of children in excellent or very good health - Percent of children meeting the criteria developed for school readiness	Percent of children, ages 10-71 months, receiving a developmental screening using a parent-completed screening tool
	B) By 2020, adopt consistent screening and referral procedures across the system C) By 2020, adopt consistent procedures for responding to referrals, receipt and disposition D) By 2020, adopt procedures/strategies for reporting results to parents	B1, C1, D1) Conduct analysis and compile current policy/funding streams		

Developmental Screening Narrative

Through the five-year needs assessment process, the state priority issue of "Invest in prevention and early intervention strategies, such as screening" was selected for the child

population domain. The percent of children, ages 10 through 71 months, receiving a developmental screening using a parent-completed screening tool (NPM 6) was selected to address this priority need.

According to the 2011-2012 National Survey of Children's Health, 25.3% of Michigan children aged 10 months to 5 years received a standardized screening for developmental or behavioral problems. Notably, according to U.S. Census estimates, in Michigan in 2013 approximately 51% of children (351,326 children) aged 0-5 years were enrolled in Medicaid or MIChild and should have received standardized developmental screening as part of EPSDT. According to the Michigan Medicaid 2015 HEDIS Results, 65% of children aged 15 months were up-to-date on their well-child visits, while 76% of children aged 3-6 had an annual visit. This would seem to indicate that a fairly high percentage of children aged 0-5 enrolled in Medicaid are up-to-date on well-child visits, but this does represent a slight decrease from 2014. Standardized developmental screening is a key part of ensuring children at risk of developmental disability or delay are identified and referred for further evaluation as soon as possible; thereby enrolling in services at an earlier age and improving developmental outcomes for each child and their family. MDHHS will address the need to improve developmental screening policies and coordination across the state. Our proposed approach will primarily focus on addressing state level coordination, policy and procedures.

Objective A: By 2018, identify initial implementation steps of a statewide developmental screening system. Although it is important for Michigan to build off other state initiatives such as Michigan's Medicaid State Innovation Model (SIM), in FY 2017, MDHHS will focus on our

Evidence-based Strategy Measure (ESM): Create a strategic plan for a statewide developmental screening system to begin to focus on addressing state level coordination, policy, and procedures. Michigan currently lacks a coordinated, comprehensive developmental screening state system—one that identifies and tracks children who are receiving screens, increases efficiency by reducing duplication, and identifies potential groups of children who are not being screened. Michigan plans to convene a range of early childhood and other stakeholders, including parents of young children, to write a strategic plan to develop a statewide developmental screening system. The plan will:

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

The Early Childhood Systems Section has a long history of including parents as partners in state level work, and has established procedures to identify and support parents. To ensure appropriate parent representation, established procedures to recruit and support parents' involvement in the stakeholder workgroup and activities at all levels will be used. The plan will address how policy and implementation strategies regarding developmental screening could be incorporated with efforts at the community level, thereby addressing the needs of all children and families, not just those enrolled in Medicaid. Given the high number of entities within the early childhood system currently conducting developmental screening (e.g., physicians, home visitors, Head Start) and also talking about incorporating screening into their care efforts (i.e.,

child care), there is a possibility that children could be screened so often that parents will become desensitized to the importance of quality standardized screening. Therefore, there is a need to convene a number of statewide stakeholders and partners to develop a plan that could help to increase screening rates but reduce duplicative screening.

MDHHS is part of Michigan's Early Childhood System, using an interdepartmental team approach to address early childhood services integration and coordination. Working with the Great Start Steering Team (GSST) and the Great Start Operational Team (GSOT), MDHHS, the Department of Education and the Early Childhood Investment Corporation provide strategic direction and system-building expertise for programs focused on Michigan's young children and their families. This approach ensures that efforts are efficient and not duplicated, and that meaningful connections are made within our agencies as well as with the local communities they serve. The strategic plan will lay out the steps to ensure that by 2020, Michigan is successful in meeting our additional objectives (see below).

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

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

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

The Early Childhood Health Section has a long history of providing successful implementation of a variety of initiatives (e.g., Project Launch, MIECHV, and ECCS grants). While the desire to move this project forward is strong, current capacity of staff to facilitate the work group that

will develop the strategic plan may be a challenge. A solution to our capacity issue may be to hire a facilitator to lead the work on the strategic plan. MDHHS will continue to consider available funding sources that may be used to fund a skilled facilitator. The initial strategy to address the objectives is for MDHHS staff, who serve on the GSST, to bring the issue of developmental screening to the GSST and ask for it to be adopted as an item of state-level focus in the upcoming year. If the GSST adopts this item, it will create a broader framework of cooperation and system development upon which to build.

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

identify ways to change or align these policies/procedures in order to produce a more efficient and non-duplicative system; one that provides equity in funding and services.

The strategic plan will be the culmination of the activities listed above. Future steps for this stakeholder group include recommending metrics that could measure successful implementation of the recommendations, and also serve as a platform for a continuous quality improvement process (such as Plan-Do-Study-Act) to ensure that any implementation could be comprehensive and achieve quality. As part of future implementation of the strategic plan, consistent statewide screening procedures will be identified (e.g., quality tools to use, when to refer, community resources, screening junctions). Short cycles of public comment and testing will be identified to determine if the procedures can be implemented at a statewide level, are clear and consistent, and do not cause undue burden on the early childhood system. Plan modifications will be made based on these results.

An important part of the process to create a developmental screening state plan will be to make sure that procedures to assure sharing of screening results with parents are included and highlighted. A communication strategy will be developed to ensure that parents are receiving the appropriate messaging about the importance of developmental screening, what it is, what to expect, and what should happen based on screening results. Lessons learned through the Assuring Better Child Development project (National Academy for State Health Policy) support the role of parents in enhancing a developmental screening system within a state. The more parents know about and understand developmental screening, the more responsive providers are to their requests, leading to a high-quality system of screening for all children.

Child Health Population Domain

SPM 1 – Lead Prevention

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
Foster safer homes, schools, and environments with a focus on prevention	A) By 2018, increase by 33% the percent of young children enrolled in Medicaid Health Plans who receive a venous confirmation test	A1) Identify and implement strategies within Medicaid Health Plans to 'flag' the capillary results that need venous confirmation testing for primary care providers and Medicaid Health Plans A2) Convene a workgroup to develop educational materials focused on Medicaid Health Plans that support understanding of the need for venous confirmation testing	Percent of children less than 72 months of age who receive a venous confirmation testing within 30 days of an initial positive capillary test
	B) By 2020, increase by 53% the percent of all young children who receive a venous confirmation test	B1) Identify and implement additional strategies (beyond Medicaid Health Plans) to 'flag' the capillary results that need venous confirmation testing for primary care providers and private insurance carriers B2) Convene a workgroup to spread the use of previously developed educational materials (beyond Medicaid Health Plans) that support understanding of the need for venous confirmation testing	
	C) By 2018, increase the focus on venous confirmation testing	C1) By 2018, include additional analyses focused on venous	

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
	through enhanced analysis of data	confirmation testing in the state's annual lead reports	

Lead Prevention Narrative

Blood lead testing rates in Michigan have been decreasing since 2010. One strategy being used to increase testing is adoption of point-of-care capillary testing machines in many primary care provider offices and WIC clinics. These desktop analyzers provide parents with immediate results, and in many instances are easier on the child and the parent than a trip to a laboratory for a venous draw. However, elevated capillary results still need to be confirmed with a venous test. Capillary blood lead tests are considered to be screening tests, and are prone to false positives. It is important to obtain a confirmatory venous test before interventions are initiated. In 2014, approximately 2,300 children aged birth to six had elevated capillary tests and never received the appropriate follow-up venous testing. This negatively impacts their access to appropriate clinical follow-up, as well as in-home supports and follow-up such as case management and environmental investigations, both of which are typically triggered by an elevated venous result.

Objective A: By 2018, increase by 33% the percent of young children enrolled in Medicaid Health Plans who receive a venous confirmation test. In order to address the issue of unconfirmed capillary tests, a step-wise process is proposed, first working with the Medicaid Health Plans (Objective A), followed by a broader, statewide focus (Objective B). We are initially focusing on Medicaid Health Plans because the majority of children enrolled in Medicaid are served through these Health Plans.

The first strategy is to identify and implement a means to 'flag' capillary results for children who need a venous confirmation test. Calling specific attention to these results will support Medicaid Health Plan case managers and primary care providers to take specific steps to follow-up with families to order tests, help arrange transportation as needed, and address any other barriers to obtaining the venous test. Medicaid currently sends a weekly data extract to Medicaid Health Plans, and we propose to work with Medicaid staff to modify that weekly data extract to assure that all children with unconfirmed capillary results are included in that weekly extract, and are flagged as needing the follow up venous test. In addition, Medicaid uses a case management data system called 'CareConnect 360', which is being expanded to include a lead module. We also propose to work with Medicaid to assure that CareConnect 360 can be programmed to include a 'flag' for unconfirmed capillary tests for children that need a venous confirmation test.

A second strategy is to convene a workgroup across MDHHS staff (Early Childhood Health Section, Environmental Health, Medical Services Administration, Communications Office, etc.) to develop educational materials that support understanding of the need for venous confirmation testing. The initial focus will again be on Medicaid Health Plans, due to the large number of children they serve. One proposed product is a 'Top Ten' list that Medicaid Health Plans could utilize and sort their weekly data extracts to help support their lead case management activities. Another product would be a brochure or 'prescription' that can be readily available for primary care providers using point-of-care lead testing machines to share when they discuss the capillary test results, which identifies the need for the follow-up venous test. The Childhood Lead Program has a draft 'prescription' developed with a primary care

provider workgroup that could be modified for this purpose. Medicaid has a similar product that was developed for use in Flint related to sharing capillary test results with the primary care provider. Either of these existing documents can serve as a model, or be modified to incorporate this new purpose.

Objective B: By 2020, increase by 53% the percent of all young children who receive a venous confirmation test. Objective B seeks to learn from the strategies and activities developed and implemented with Medicaid Health Plans and expand to impact other children enrolled in Medicaid Fee for Service, children served by private insurance carriers, or children with no insurance coverage. In order to 'flag' the unconfirmed capillary test results, MDHHS proposes to work with the Michigan Care Improvement Registry (MCIR) and/or our agency colleagues that work with the Health Information Exchange (HIE). These systems contain data for all children, not limited to Medicaid Health Plans. MCIR already displays lead testing data results for primary care providers and offices and 'flags' children that have not yet had a lead test. We propose to build capacity to also flag the unconfirmed capillary results, so a primary care provider can determine whether to order a venous test. In addition, we propose to meet with our agency colleagues that work on the HIE and HL7 messaging, to learn what opportunities may exist to promote venous confirmation testing in alignment with their work.

The second strategy will involve spreading the use of the previously developed educational materials/'prescription' more broadly, beyond Medicaid Health Plans. This would involve spreading to WIC clinics, where many capillary tests are conducted.

Objective C: By 2018, increase the focus on venous confirmation testing through enhanced analysis of data. A third objective concentrates on enhanced analyses of the state's lead surveillance data to focus on the issue of unconfirmed capillary tests, and the need for venous confirmation testing. An immediate step is to convene a meeting between MCH and surveillance staff to request that they include enhanced analysis about this issue in the upcoming childhood lead annual report (reporting on 2015 surveillance data, due to be released the summer of 2016), and that similar analyses be conducted and highlighted in each subsequent annual report. Initial conversations about this request have already taken place. Additionally, MCH will work with surveillance staff to implement analyses that will disaggregate the lead data by Medicaid Health Plan and by local health department, and develop specific data reports to share with these entities to highlight data at those levels.

Challenges to the proposed activities include availability of staff to participate in or implement the proposed activities, especially given that many MCH and Medicaid staff are currently focusing attention on the water crisis in Flint, and promoting the health and safety of those children and families. Another potential challenge, and opportunity, is that we remain under an emergency declaration, thus all educational materials related to lead must be reviewed by a Joint Information Committee (JIC) that is part of the emergency response structure. A third potential challenge is whether the data systems we propose to modify can actually be modified to achieve the identified purposes.

Our opportunities lie in the elevated awareness, due to the Flint water crisis, of the importance of assuring that children are receiving appropriate lead testing and follow-up services; thus, the

proposed activities may be seen as a high priority. With the support of the Title V block grant, we are also expanding staff capacity in the areas of childhood lead surveillance and education, case management, and nursing technical assistance. This additional staffing will be critical for carrying out the proposed activities and addressing the proposed State Performance Measure.

Child Health Annual Report

The following performance measures and the related data trends, program summaries, successes, and challenges address the **Child Health** population domain for FY 2015 reporting.

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

Data Trends: Coverage level trends for vaccination of 19-35 month olds against measles, mumps, rubella, polio, diphtheria, and tetanus have decreased from 82% in 2008 to 74.2% in 2015. The change in rates is partially due to new vaccines that were added to the vaccine series. Since 2013, Michigan Care Improvement Registry (MCIR) data has been used to assess coverage levels; therefore, coverage prior to this time (2012 and earlier) is not a meaningful comparison as National Immunization Survey (NIS) estimates were used previously. Health care provider reporting to MCIR is mandatory for individuals less than 20 years of age, and doses documented in the registry are provider-verified (correct intervals and timing), so MCIR estimates are the gold standard for vaccination assessment in Michigan. NIS estimates use a small sample size of less than 400 individuals with large confidence intervals, while MCIR rates are population-based and are an underestimate of true vaccination coverage levels. Coverage levels for other

routinely recommended vaccines not listed here (including flu and Hepatitis A) are also low among children 19-35 months of age.

FY 2015 Program Summary and Successes: County level report cards are distributed quarterly and posted online. These report cards rank counties according to coverage levels for children, adolescents, and adults, as well as waiver rates for childcare and school entry. County coverage levels are compared to state and national coverage estimates, as well as Healthy People 2020 targets. MCIR quarterly workbooks include 19-35 month-old coverage level by race. These are updated semi-annually and posted under resources for local health departments. The Vaccines for Children (VFC) program has over 1,300 enrolled providers for administration of nearly $90 million worth of vaccines in Michigan.

Program Challenges: The Immunization Program in Michigan has identified fourth dose DTaP coverage as an area where improvements need to be made, as many children are not receiving the recommended fourth dose at 15 through 18 months of age. Research shows that children who delay or forgo needed vaccines as infants are not as likely to ever catch up and become up-to-date as children and adults; therefore timely infant immunization is a top priority. Hepatitis A coverage is also low and has become a priority. Challenges in coverage levels are being addressed through provider education and training during in-office and grand rounds settings and during the fall regional immunization conferences that are hosted each year in eight different regions of the state. AFIX feedback sessions (quality improvement meetings at provider offices) focus on strategies, behaviors, and office systems/policies that help or inhibit timely vaccination. In January 2015, administrative rules were implemented which require

education of parents (at the local health department) who waive vaccines in a school or child care setting. Michigan has already experienced a 39% decrease in the number of waivers submitted for schools. In 2016, the Immunization Program will begin a routine notification system using the MCIR to send notices to all children between the age of six to 19 months.

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

Data Trends: Deaths to children aged 0 to 14 caused by motor vehicle crashes remain low. The motor vehicle death rate per 100,000 children in this age range fell from 3.0 in 2008, to 1.2 in 2014, and has remained relatively stable over the past four years. For children under age 5, occupant injuries are more prevalent while, for older children, pedestrian-related injuries are more prevalent.

FY 2015 Program Summary: MDHHS does not have specifically-funded motor vehicle safety programs (e.g., Child Passenger Safety, pedestrian safety, bicycle safety) but supports local Safe Kids Coalition initiatives to reduce motor vehicle crash related deaths of children, and serves on the Governor's Traffic Safety Advisory Commission's Action Teams. In 2015, the MDHHS Injury & Violence Prevention Section assisted local Child Passenger Safety (CPS) programs and 13 community-based Safe Kids Coalition child safety seat program efforts. Funding, marketing and outreach efforts for CPS-certified technician classes were provided through the Office of Highway Safety Planning and local partners.

Program Successes and Challenges: More than 6,500 car seats were delivered to CPS technicians in 60 counties. Instructors certified 76 new CPS technicians through the delivery of

five grant-funded classes; another 163 technicians worked toward recertification through participation in grant-funded continuing education classes; and 24 former technicians were recertified. While the goal to retain 63% of certified technicians was not met, steps were taken with instructors to keep current technicians engaged and involved. Spanish-language materials were obtained for use by instructors and technicians, and five bilingual technicians were trained.

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

Data Trends: The percentage of children, aged 2 to 5 years, receiving WIC services with a BMI at or above the 85th percentile has remained relatively stable since 2008. Last year, there was a decrease in the rate from 30.9% to 29.9%. This indicates progress toward reaching the performance objective of 27%.

FY 2015 Program Summary and Successes: Individual counseling, group education, and internet education opportunities on healthy eating (including breastfeeding) and physical activity continued to be offered to all WIC families as obesity prevention measures. WIC clients were supported in nutrition and lifestyle change through access to 22 online, interactive nutrition education modules in English and Spanish. WIC continued to assess and monitor the weight of all WIC children; and those aged 2 to 5 years with a BMI $\geq 95^{th}$ percentile were referred to registered dietitians for high-risk nutrition counseling. Childhood obesity was addressed at the 2015 Michigan WIC Conference, attended by approximately 750 individuals including local agency WIC staff. WIC local agencies developed annual Nutrition Services Plans

based on predominant client risks, with 9 of 49 agencies (18%) specifically targeting childhood obesity.

Program Challenges: Childhood overweight and obesity prevention and intervention are complex, multifactorial issues. The changes necessary to reduce obesity rates require consistent, ongoing, and collaborative public health efforts. Michigan WIC will continue to support breastfeeding initiation and breastfeeding exclusivity to prevent obesity; offer client learning opportunities; and expand quality training opportunities for staff around the topics of breastfeeding, obesity prevention and intervention, and client-centered nutrition counseling. In 2015, WIC local agency staff were offered the opportunity for increased training around client-centered services. This style of communication increases engagement and rapport with clients to address issues of concern to them and work toward improved lifestyle changes, including sensitive topics like childhood obesity and overweight. Continued focus on the client-centered approach to counseling is underway; as well as creating a new mentoring network for local agency leaders to provide support to all staff in building competencies around communication and counseling that addresses sensitive and difficult conversations.

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

Data Trends: After a slight increase the previous year, there was nearly a 10% decrease in the number of children under age 6 years with confirmed elevated blood lead levels of ≥ 10 ug/dL (EBLL) from FY 2014 to FY 2015 (from 676 children to 615). And while the number of Black children with EBLLs and the number of White children with EBLLs both decreased, the ratio of

Black to White children with EBLLs went up slightly, to 2.7, thereby not meeting the Annual Performance Objective of 2.4.

FY 2015 Program Summary and Successes: Title V funds were provided to local health departments to deliver lead education to professionals who work with young children. During FY 2015, more than 200 trainings were delivered. Funds were also used to provide support and technical assistance to medical professionals, parents, and public health professionals regarding the care of children with EBLL (around 1,900 calls annually). A total of 150,111 BLL results for children under age 6 years were processed. Results were made available to primary care providers via the Michigan Care Improvement Registry, and to local health departments and Medicaid Health Plans via weekly data files. The Childhood Lead Poisoning Prevention Program has been very involved in the response to the Flint water crisis. Lessons from this crisis will inform and impact future statewide program activities, including surveillance, nursing technical assistance, and education and outreach activities.

Adolescent Health Population Domain

NPM 10 – Adolescent Well-visit

State Priority Need	**Objectives**	**Strategies**	**National Outcome Measures (NOM)** (prepopulated by HRSA)	**National Performance Measure** (NPM) (prepopulated by HRSA)
Reduce barriers, improve access, and increase the availability of health services for all populations	A) Develop a state plan for improving adolescent well-care, focusing on Medicaid eligible youth	A1) Convene a state-level workgroup to promote comprehensive adolescent well-care A2) Review and update relevant MQIC adolescent clinical practice guidelines A3) Work with Health Plans to expand strategies to incentivize well-child exams	- Percent of children in excellent or very good health. - Percent of children ages 6 months through 17 years who are vaccinated annually against seasonal influenza. - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year
	B) By 2020, increase by 625 the number of providers trained on culturally-competent, adolescent-friendly preventive care	B1) Promote Michigan's adolescent web courses (e.g. Motivational Interviewing, Positive Youth Development) among health plans and provider groups B2) Provide training and professional development in		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
		partnership with health plans and provider networks		
	C) By 2020, increase by 10% the proportion of adolescents with a documented well-child exam among 25 Child & Adolescent Health Centers	C1) Implement annual CQI initiative among CAHCs C2) Provide technical assistance as needed to CAHCs seeking NCQA PCCC (PCMH) status		
	D) Develop a social media campaign to promote adolescent well-care and targeted health messages	D1) Work with MDHHS Communications to develop a coordinated social media campaign D2) Identify and disseminate best practice guidelines for the use of social media to promote services and appointment reminders		

Adolescent Well-visit Narrative

Through the five-year needs assessment process, the state priority issue of "Reduce barriers, improve access and increase the availability of health services for all populations" was selected for the adolescent population domain. The percent of adolescents, aged 12-17, with a preventive medical visit in the past year (NPM 10) was selected to address this priority need. While reported bullying on school property slightly increased between 2011 and 2013, the Michigan Department of Education coordinates efforts to address this issue and has launched

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

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

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

local health departments (LHDs), health systems and Federally Qualified Health Centers (FQHCs) to examine gaps in existing efforts and to identify opportunities for coordinating efforts to promote comprehensive adolescent well-care.

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

As a final strategy for this objective, MDHHS will work with the state Medicaid office to convene a sub-group of Medicaid Health Plans to share and expand strategies to incentivize well-child exams among their provider networks. Ideally, this will include initiatives already underway, such as linking payments to achievement of well-child exam goals and adolescent-friendly performance requirements including care satisfaction, privacy and confidentiality. Additionally, the MDHHS Child and Adolescent Health Center (CAHC) program will share its “Proactive Reminders” publication to foster successful, proactive approaches to well-child exam appointment-making and reduction of no-show rates. These approaches were successful when

used by Michigan's CAHCs, which report annually on proactive steps taken to increase well-child exams as part of their contract requirements.

It is expected that a preliminary plan will be developed within the first eighteen months of this 5-year block grant cycle. This plan will include specific strategies involving LHDs in leading local efforts to promote and improve adolescent well-child exams in their jurisdictions. In years two through five, LHDs will be expected to report on progress in contributing to an improvement in adolescent well-care rates in their jurisdiction. It is expected that level of participation and progress will vary among LHDs based not only on varying need, but also on varying levels of local funding and staff capacity.

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

Objective B: By 2020, increase by 625 the number of providers trained on culturally-competent adolescent-friendly preventive care. A key component of quality adolescent care is the extent to which services are delivered in a developmentally-appropriate, adolescent-friendly and confidential manner. Positively impacting adolescent care requires significant

system changes aimed at addressing known barriers to quality care: health professional lack of training; lack of effective communication skills; and low self-efficacy in providing adolescent preventive services. In real-world practice, the quality and delivery of preventive health care for adolescents varies widely and is highly dependent on the experience of the individual healthcare provider or professional; his or her knowledge of clinical guidelines; communication skills and training; subconscious biases; and personal comfort level.

For the past two years, MDHHS Child, Adolescent and School Health Services (CASHS) staff have partnered with the Michigan Public Health Institute to design two web-based Adolescent Health Courses, grounded in research and best practice, to improve provider competencies in Motivational Interviewing (MI) and Positive Youth Development/Resiliency. A third course on Adolescent Growth Development and Brain Development is slated for a 2016 release. These courses will be promoted and offered at no charge to public and private providers throughout the state. As incentive for participation, continuing medical education credits will be offered for course completion. The objective is to reach 250 providers over five years with these foundational adolescent health courses. To supplement the MI course, in-person training will be offered each year to providers who have completed the web-based course. This in-person training (Improving Adolescent Health by Motivating Change for Primary Care Providers) has been approved for 4.5 American Medical Association Physician Recognition Award Category I Credits. Additional professional development and training opportunities focused on culturally-competent, adolescent-friendly preventive care will be offered, with a goal of reaching 375 providers over the five-year period.

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

Objective C: By 2020, increase by 10% the proportion of adolescents with a documented well-child exam among 25 Child and Adolescent Health Centers (CAHCs). With 81 state-funded clinical school-based/school-linked health centers, Michigan has one of the nation's largest programs of its kind. To demonstrate quality across its program, each CAHC is required to participate in a multi-faceted approach to quality improvement which has led to dramatic improvements in core performance measures, including a 27% increase over four years in the percentage of adolescents up-to-date with a documented comprehensive physical exam. (In FY 2015, more than half of the state's CAHCs report 66% or more of their clients were up-to-date with annual well-care exams.) To continue this momentum, MDDHS will engage five CAHCs each year in Continuous Quality Improvement (CQI) initiatives to increase well-child exam rates.

The CAHC Quality & Evaluation Support Team (QuEST) will coordinate the months-long, tailored initiatives using the Plan-Do-Study-Act cycle of change, partnered with regular coaching calls,

meetings and/or site visits with all participating CAHC staff. To initiate each project, QuEST will conduct conference calls/meetings with each CAHC to review the following: current available data; data needed to set goals; current processes for consent and well-child exam administration; challenges and facilitating factors for implementing the initiative; and next steps. A second conference call/meeting and a series of email, telephone and/or in-person communications will follow to review data; develop goals and action steps; and determine resources and support needed for success. QuEST will provide ongoing support tailored to each health center which will include guidance and support for policy/procedure and process review, revision and development. Access to current and relevant journal articles, tip sheets, training and educational materials will also be provided as relevant.

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

In a second strategy to increase the proportion of adolescents with documented well-care exams in CAHCs, MDHHS will provide technical assistance as needed to health centers in

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

State staff will be available to provide technical assistance to CAHCs pursuing PCCC status; acting as a liaison to foster understanding and interpretation of requirements; and advising CAHCs in making necessary changes to meet standards for recognition. A crosswalk of CAHC and PCCC standards will be created to readily identify areas of both alignment and discrepancy; and to determine how CAHCs can best meet PCCC standards that are not fully aligned with current CAHC standards. Due to limited CAHC staff time and capacity, just two CAHCs in the state have achieved any type of PCMH status on their own; therefore, this support is critical to foster the attainment of PCCC recognition among state-funded health centers. MDHHS staff will monitor progress of PCCC recognition status in order to determine specific resources needed to facilitate PCCC recognition beyond its current capacity.

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

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

Adolescent Health Annual Report

The following performance measures and the related data trends, program summaries, successes, and challenges address the **Adolescent Health** population domain for FY 2015 reporting.

NPM 8: Rate of birth per 1,000 females aged 15 through 17 years

Data Trends: Since 1990, the teen birth rate in Michigan among females aged 15-17 years has steadily declined to a historic low. The birth rate decreased 75% since that year and the rate among both Black and White females has decreased 48% since 2005. Michigan continues to exceed its performance objective for this measure (target for 2014: 10.3; actual: 8.9).

FY 2015 Program Summary: MDHHS provides funding to agencies to implement teen pregnancy prevention and parenting programs through schools, after-school programs, community-based organizations, faith-based organizations and LHDs. In FY 2015, Michigan's three teen pregnancy prevention and parenting programs provided programs and services to both youth and parents. The Michigan Abstinence Program (MAP), which promotes sexual risk avoidance among youth aged 10-15 by incorporating a model of positive youth development, served over 3,000 youth and 200 parents. The Taking Pride in Prevention Program (TPIP) utilizes

evidence-based curricula to educate adolescents aged 12-19 on both abstinence and contraception, as well as three adulthood preparation topics: healthy relationships, adolescent development and parent-child communication. TPIP served 4,288 youth and 701 parents in high-need geographical areas (high number of teen births). The Michigan Adolescent Pregnancy and Parenting Program (MI-APPP) works to create an integrated system of care and linkages to support services for pregnant and parenting adolescents aged 15-19, young fathers, and their families. This system of care includes strength-based case management and linkages to support services. MI-APPP aims to serve 300 pregnant and parenting teens and their families each year. MAP funds nine agencies, TPIP ten, and MI-APPP six, for a total of 25 teen pregnancy prevention and parenting grantees providing direct services in their communities.

Program Successes: Successes include a solid evaluation plan and participant data tracking system at the state level; statewide pregnancy prevention media campaign and public awareness materials; using creative, non-traditional methods to increase youth and parent participation, particularly for adolescent fathers; and leveraging funds to expand programming especially for MI-APPP, which allows an additional 100 teens and families to be served. Each grantee specifically addresses needs and barriers through supplemental services and individual case management, which leverages the resources in each community.

Program Challenges: Challenges include a lack of funding to expand teen pregnancy prevention and parent programs into additional high-need communities or to serve more youth; access to in-school programming in some locations despite evidence that participant retention increases when programming is delivered during the school day; and no legislative mandate for evaluation of sexual risk avoidance at the federal level to substantiate effectiveness. For MI-

APPP, the multi-faceted and complex needs of families served (particularly fatherhood engagement and navigating the many available services) pose additional challenges.

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

Data Trends: The suicide death rate per 100,000 population for youth aged 15-19 increased between 2008 and 2014 from 7.3 to 10.0. Provisional 2015 data indicate the rate fell to 8.1 last year, which is below the annual performance indicator of 9.5.

FY 2015 Program Summary: MDHHS was awarded a federal State/Tribal Youth Suicide Prevention and Early Intervention grant in the fall of 2014. Technical assistance, as well as professional and community gatekeeper training support, continues to be provided to Community Mental Health agencies, local human services collaborative bodies and suicide prevention coalitions. The Michigan Model for Health continues to be used in Michigan's public, charter and private schools. The curriculum promotes life skills for children and youth in grades K-12 in areas such as problem solving, decision making, resolving conflict, anger management and listening skills.

During FY 2015, work continued around addressing the need for suicide prevention among youth. MDHHS has relationships with several entities that provide suicide prevention training and resources. LivingWorks, Michigan Public Health Institute, and University of Michigan's Depression Center house certified trainers who are available to schools and service agencies to conduct trainings and/or presentations to address this issue. Through these partnerships, SafeTALK and ASIST trainings as well as other suicide prevention workshops have been provided to local community agency representatives and residents. Michigan Association for Suicide

Prevention members meet regularly to discuss needs in the state around suicide prevention for youth and adults.

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

Program Successes: The Michigan Department of Education, in partnership with MDHHS, received Project Aware grant funding from the Governor's office for three intermediate school districts to provide Youth Mental Health First Aid (YMHFA) trainings to school representatives. YMHFA gives attendees the knowledge, skills and tools to talk with young people who are contemplating suicide in an effort to keep them safe until additional support is available. Efforts continue to train thousands of people in YMHFA.

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

Data Trends: Michigan saw consistent increases in chlamydia rates among teens through 2009, followed by a plateau until 2011. There were considerable annual declines between 2011 and 2014. In 2015, due in part to the ACA and Medicaid expansion, more young women than ever had healthcare coverage that included increased access to screening services. Michigan saw a slight increase in the rate of chlamydia from 2014 to 2015 (from 2,017 to 2,071 per 100,000 population). We believe this is likely due to increased screening and not a true increase in disease burden. It is estimated that approximately 90% of chlamydia cases in young females are asymptomatic, however increased screening typically uncovers those infections.

FY 2015 Program Summary: The Child and Adolescent Health Center (CAHC) program specifically supported a total of 5,026 chlamydia tests, identifying 582 positive youth (11.6% positivity). Almost every CAHC (school-based, school-linked health center) treated 100% of these cases onsite.

Program Successes: Michigan is building upon its success in numerous ways. First, CAHCs are working to increase medical access to at-risk teens throughout the state. They have implemented a number of new service models and send a consistent message to providers to screen for chlamydia regardless of symptoms. Staff from the STD Section annually partner with medical personnel to take testing to the highest risk populations via school-wide screening events. In 2015, this service was implemented in select schools in Wayne, Kalamazoo and Macomb Counties. These events decrease the stigma of testing and cull disease out of communities, decreasing future transmissions. MDHHS will continue to support testing for adolescents aged 15 to 19 in school-based and school-linked CAHCs as well as through school-

wide screening events. These venues ensure access to confidential STD services for this population.

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

Data Trends: According to the YRBS, the percentage of high school youth who experienced dating violence dropped from 11.9% in 2013 to 8.2% in 2015. This measure exceeds the performance objective of 10.0 for the year 2015.

FY 2015 Program Summary: Efforts to prevent dating violence among high school students focused on coalition building, training, changing policy and norms, and distributing informational materials. In 2015, the five Michigan Sexual Violence Prevention (MSVP) grantees collectively trained over 544 youth-supporting professionals; provided high school focused educational seminars to 5,283 participants; worked with nine schools and 10 businesses on policy change; and added 13 new members to local SVP teams comprising a range of community professionals as well as youth. Also, grantees hosted 32 community events, distributed 70,301 units of informational materials and posted 713 social media messages. All five grantees targeted individual level change through youth primary prevention programming. On pre/post-test assessments, nearly all youth respondents in MSVP programs disagreed with the statement 'Dating violence is personal and family, friends and others should not get involved,' with demonstrated improvements after program participation.

Dating violence prevention efforts are not exclusive to MSVP. Early prevention lessons are delivered in K-12 classrooms using the evidence-based Michigan Model for Health™ curriculum. At the elementary level, the social and emotional health lessons are embedded within the grade-level-specific comprehensive health education curriculum module. Additionally, the "Safe

and Sound for Life: Social and Emotional Health and Safety" module (released in 2014) targets middle school students in an effort to establish social skills and healthy relationship dynamics before students reach high school and young adulthood. Similarly, the "Healthy and Responsible Relationships" module (updated in 2014) addresses dating violence prevention along with pregnancy and STI prevention at the high school level.

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

CSHCN Population Domain

NPM 11 – Medical Home

State Priority Need	**Objectives**	**Strategies**	**National Outcome Measures (NOM)** (prepopulated by HRSA)	**National Performance Measure** (NPM) (prepopulated by HRSA)
Increase family and provider support and education for Children with Special Health Care Needs	A) By 2020, increase the number of CSHCN served in a medical home by 4.7%	A1) Support practices with training or technical assistance to develop or improve policies on care coordination, transition planning, and family partnership A2) Work with partners across the state to improve the system of care coordination by providing education, leadership, and support A3) Encourage primary care practices to adopt medical home practices by developing reimbursement mechanisms that support the additional functions of a medical home	- Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system - Percent of children in excellent or very good health - Percent of children ages 19 through 35 months, who have received the 4:3:1:3(4):3:1:4 series of routine vaccinations - Percent of children 6 months through 17 years who are vaccinated annually against seasonal influenza - Percent of adolescents, ages 13	Percent of children with and without special health care needs having a medical home

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
			through 17, who have received at least one dose of the HPV vaccine - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine - Percent of adolescents, ages 13 through 17, dose of the meningococcal conjugate vaccine	
	B) Increase families' understanding of the benefits of the medical home model, and help connect families to medical homes in their region	B1) Develop and disseminate educational materials to CYSHCN enrolled in CSHCS about additional services provided by medical homes B2) Conduct outreach to families about availability and benefits of the medical home		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
	C) Improve the delivery of care within a medical home	C1) Survey families on the strengths and weaknesses of care coordination and family partnership in the provider setting C2) Support practices to build partnerships with families (e.g., family advisory groups, focus groups, family-centered processes)		

Medical Home Narrative

Through the five-year needs assessment process, the state priority issue of "Increase family and provider support and education for Children with Special Health Care Needs" was selected for the CSHCN population domain. Percent of children with and without special health care needs having a medical home (NPM 11) was selected to address this priority need.

Objective A: By 2020, increase the number of CSHCN served in a medical home by 4.7%. The Healthy People 2020 objective for the percent of all children having a medical home (63.3%) is 4.7% higher than the state measurement as indicated on the 2011/2012 National Survey of Children's Health (NSCH). The current trend in Michigan shows an average annual decrease of 0.8% in all children having a medical home. In order to meet the Healthy People 2020 objective, this indicator would need to increase by an average of 0.6% annually. To achieve this goal,

CSHCS will assist medical homes in providing more effective and efficient care to children with special needs, and assist primary care practices in becoming medical homes.

One of the challenges preventing children with special needs from receiving care in a medical home is the capacity and efficiency of pediatric medical homes. Children with special needs often require more complex care, which involves many providers beyond a primary care physician. Coordination among all of the necessary partners involved in a child's care is time intensive and limits the medical homes' capacity to serve more children. Additionally, children with special needs may require additional support and resources to make a successful transition into adulthood. CSHCS will assist medical homes in administering more effective and efficient care to CSHCN by providing training to six select medical homes beginning in late FY 2016, and continued in FY 2017. These trainings will be evaluated and refined to better meet the needs of medical homes and families, and will be used as a model to be implemented statewide.

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

CSHCS will also continue its partnership with the Michigan Chapter of the American Academy of Pediatrics (MIAAP), Children's Healthcare Access Program (CHAP), local health departments, and others to provide training and support to practices to improve their medical home capacities. Through partnership with the Family Center, parents of CYSHCN will be involved in planning the trainings and in leading components of the training.

Objective B: Increase families' understanding of the benefits of the medical home model, and help connect families to medical homes in their region. CSHCS recognizes the value in empowering families to be their own advocates and to seek the necessary services that provide optimal care for their child. CSHCS and the Family Center will develop and disseminate educational materials to CYSHCN who are enrolled in CSHCS, which will inform families about the additional services offered by medical homes. This activity will occur in coordination with local health departments. In addition, CSHCS and the Family Center will work with multiple partners including the Medicaid Health Plans, Michigan Primary Care Transformation Project, the MIAAP, CHAP, and the Michigan Primary Care Association to connect parents to a medical home within their available provider network. In comparison to the previous five-year planning cycle, the capacity of the Family Center has increased and now has the infrastructure and staffing to work with CSHCS and families to receive information on benefits and how to connect to a medical home. Families that receive information on the value of the medical home model will then be able to more readily identify and access services within a medical home.

Objective C: Improve the delivery of care within a medical home. One of the strongest components of the Medical Home model is assisting families with coordinating health care

among the various providers involved in caring for a child with special needs. Effective care coordination first requires a thorough understanding of the barriers and challenges families encounter when trying to access care for their child with special needs. Recent national and statewide changes in the health care landscape, such as the Affordable Care Act and transition from Medicaid Fee-For-Service to managed care plans, require CSHCS to reassess where barriers and gaps in health care access exist. To do this, CSHCS and the Family Center will conduct a needs assessment that will begin with surveying families on the strengths and weaknesses of care coordination and family partnership in a provider setting.

In addition to surveying families, CSHCS and the Family Center will also work with LHDs to gather additional information on how families try to navigate the systems of care for CYSHCN. This process will entail conducting phone interviews of families that call the Family Phone Line, as well as assessing the communication strategies employed by each LHD across the state.

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

CSHCS and the Family Center will also support practices in forging their own partnerships with families by encouraging and providing technical assistance regarding the formation of practice-

based family advisory groups, focus groups, and family-centered processes. Through the years, CSHCS and the Family Center have gained valuable expertise in effective ways to engage families. CSHCS and the Family Center will work with medical practices to identify the types of support that practices need to implement family partnership strategies, and provide resources to address those needs.

CSHCN Domain

NPM 12 – Transition

State Priority Need	**Objectives**	**Strategies**	**National Outcome Measures (NOM)** (prepopulated by HRSA)	**National Performance Measure** (NPM) (prepopulated by HRSA)
Increase family and provider support and education for Children with Special Health Care Needs	A) By 2020, increase the number of youth who have a plan of care that includes transition planning beginning at age 14 by 4.1%	A1) Hire staff to address transition needs of clients A2) Increase the number of local health departments that develop and implement a transition policy A3) Develop electronic solutions to help identify clients with greater need for transition services	- Percent of children with special health care needs (CSHCN) receiving care in a well-functioning system - Percent of children in excellent or very good health	Percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care
	B) Increase youth and family awareness and understanding of the transition to adulthood process	B1) Facilitate discussions with youth and their families on how to better address needs relating to transitioning to adulthood B2) Identify new, effective ways to		

State Priority Need	Objectives	Strategies	National Outcome Measures (NOM) (prepopulated by HRSA)	National Performance Measure (NPM) (prepopulated by HRSA)
		provide transition services and resources that are more accessible to today's youth		
	C) Increase provider awareness and understanding of the transition to adulthood process	C1) Partner with AAP, AFP, ACP, and AANP to disseminate evidence-informed transition resources to primary care practices and local health departments.		

Transition Narrative

Through the five-year needs assessment process, the state priority issue to "Increase family and provider support and education for Children with Special Health Care Needs" was also linked to NPM 12, the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

Objective A: By 2020, increase the number of youth who have a plan of care that includes transition planning beginning at age 14 by 4.1%. Achieving this objective would bring Michigan into alignment with the Healthy People 2020 goal. A key strategy for this objective is to hire a transition analyst to lead the work. As of spring 2016, the position is in the process of being posted and filled. The revised transition analyst position, once filled, will be responsible for leveraging technology to better reach and assist youth with special needs who are entering adulthood. Through the use of online tools, including the CSHCS website and social media, the

transition analyst will develop and implement strategies that enable CSHCS to better engage youth with special needs.

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

Youth with special needs require varying levels of assistance to successfully transition into adulthood. In collaboration with families and key stakeholders, a third strategy is to develop database tools and conduct data analysis to help CSHCS identify youth with the greatest need of transition services. This effort will be the first step toward exploring additional strategies on how CSHCS can develop a statewide approach to transition planning in a way that best meets the needs of each individual.

Objective B: Increase youth and family awareness and understanding of the transition to adulthood process. Youth with special needs and their families often have additional

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

Beginning in FY 2017, CSHCS, the Family Center and LHDs will partner in facilitating discussions with youth and their families to understand what they identify as their greatest transition needs. CSHCS will revise its transition materials based on the input received and will follow-up with families to ensure that the new materials meet their needs.

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

Once transition materials have been developed with youth and family input, these materials will be made available online on the CSHCS website, as well as publicized using social media and correspondence mailed to families. Each marketing strategy will be monitored and evaluated to optimize the reach and value, and will be continually revised to have maximum impact. LHDs will also develop ways to increase awareness of transition services that are specific to their local communities.

Objective C: Increase provider awareness and understanding of the transition to adulthood process. A key aspect to successful transition planning is a competent public health workforce

that has the knowledge and training to provide comprehensive transition services. CSHCS will partner with the Michigan chapters of the American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, and American Academy of Nurse Practitioners to disseminate evidence-informed transition resources to primary care providers throughout Michigan. Additionally, CSHCS will develop a webinar series that will be delivered to LHDs and interested provider practices on the transition process. These webinars will be evaluated and refined based on LHDs and provider practices' identified needs. CSHCS anticipates providing a series of webinars that will include content related to consent, supported decision making, alternatives to guardianship, educational needs and workforce development.

CSHCN Domain

SPM 4 – Provision of Medical Services and Treatment for CSHCN

State Priority Need	**Objectives**	**Strategies**	**State Performance Measure (SPM)**
Reduce barriers, improve access, and increase the availability of health services for all populations	A) Reduce barriers to medical care and treatment by minimizing financial barriers from the increased medical services associated with the child's special need	A1) Cover specialty care and treatment related to a qualifying condition when insurance is not existent or inadequate for children that require the recurring care from a pediatric sub-specialist	Percent of CYSHCN enrolled in CSHCS that receive timely medical care and treatment without difficulty

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
	B) Improve access to medical care and treatment by improving the systems of care for CSHCN	B1) Support models of care delivery, such as Medical Homes and Children's Multi-disciplinary Specialty Clinics, which focus on increased care coordination and family partnership	
	C) Increase the availability of health services, particularly in underserved regions, through the utilization of telemedicine and community based services	C1) Expand, promote, and support the use of telemedicine/telehealth in rural and underserved communities C2) Support and assist local health departments in providing care coordination, case management, and support services for CSHCN and their families	

Provision of Medical Services and Treatment for CSHCN Narrative

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

Objective A: Reduce barriers to medical care and treatment by minimizing financial barriers from the increased medical services associated with the child's special need. A core strategy is to cover specialty care and treatment related to a qualifying condition when insurance is not existent or inadequate for children who require the recurring care from a pediatric sub-

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

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

Objective B: Improve access to medical care and treatment by improving the systems of care for CSHCN. To achieve this objective, CSHCS will support models of care delivery, such as Medical Homes and Children's Multi-disciplinary Specialty Clinics, which focus on increased care coordination and family partnership. CSHCS will continue to provide enhanced reimbursement for Children's Multi-Disciplinary Specialty (CMDS) clinics: a model of care delivery that provides greater care coordination and family participation than typical specialty care models deliver. In FY 2016, CSHCS migrated the enhanced reimbursement from a contract/grant based model, to providing additional reimbursement through the Community Health Automated Medicaid

Processing System (CHAMPS). This reimbursement mechanism provides a greater level of monitoring and control of services provided, helps ensure appropriate reimbursement, and provides increased access to data through Michigan's Data Warehouse. Additionally, this mechanism is familiar to CMDS Clinics, as it is the system used to seek reimbursement through Medicaid.

Patient Centered Medical Homes (PCMH) are another model of care delivery supported by CSHCS. While CSHCS does not provide reimbursement for primary care, it still supports primary care practices in attaining and maintaining PCMH certification. CSHCS has partnered with the Michigan Public Health Institute to begin assisting primary care practices in pursuing PCMH certification. This work will continue in FY 2017, and will continually be developed and improved as CSHCS gains expertise in PCMH certification and best practices.

Objective C: Increase the availability of health services, particularly in underserved regions, through the utilization of telemedicine and community based services. The first strategy is to expand, promote, and support the use of telemedicine/telehealth in rural and underserved communities. CSHCS has been engaged in telemedicine/telehealth activities through its work associated with a HRSA grant. Through this grant, CSHCS and its affiliates have established several new rural telemedicine sites throughout underserved regions of the state. Beginning in FY 2017, CSHCS will continue its efforts to support and expand telemedicine, but will begin incorporating more of these efforts into CSHCS activities outside of those supported through the grant. This includes creating or revising existing telemedicine policies, hiring staff to support

telemedicine/telehealth activities, and identifying sustainable payment mechanisms to encourage the use of telemedicine/telehealth.

A second strategy is to support and assist local health departments in providing care coordination, case management, and support services for CSHCN and their families. CSHCS utilizes the statewide network of local health departments (LHDs) as the local arm of the program. Each LHD has at least one CSHCS coordinator, CSHCS representative, and CSHCS nurse to assist CSHCS clients within their community. A significant part of their roles is to provide care coordination and case management. In order to ensure consistent and effective care coordination/case management throughout the state, CSHCS will develop and implement training curriculum beginning in FY 2016 and continuing into FY 2017.

In order to support the LHD efforts to provide care coordination and case management services, CSHCS has developed an automated system for all LHDs to use. Children's Healthcare Automated Support Services (CHASS) was developed, with input from LHDs and CSHCS staff, to monitor the delivery of care coordination and case management services for every CSHCS client. CHASS provides a greater ability to ensure financial controls and program integrity, while providing a mechanism to identify best practices through data-supported evidence.

CSHCN Annual Report

The following performance measures and the related data trends, program summaries, successes, and challenges address the **CSHCN** population domain for FY 2015 reporting.

NPM 1: Percent of screen positive newborns who received timely follow-up to definitive diagnosis and clinical management for conditions mandated by their State-sponsored newborn screening programs

Data Trends: During 2015, 111,718 newborns were screened and to date 237 were diagnosed with one of 54 disorders (hearing and critical congenital heart disease not included in this total). All newborns who screened positive received timely follow-up to definitive diagnosis and clinical management, a measure Michigan has met since 2009. The program continues to use quality improvement techniques to improve timeliness of specimens transport, testing and response using hospital and disorder specific measures. The NBS Quality Assurance Advisory Committee approved the addition of Mucopolysaccharidosis I (MPS I) and X-linked adrenoleukodystrophy when appropriate laboratory methods become available and follow-up/medical management infrastructure are in place.

Pompe disease was added to the NBS panel with an effective date of October 1, 2014; however, screening has not yet begun due to limitations in availability of laboratory method. The state laboratory has selected a platform for screening and is waiting for FDA approval of that method before screening can commence. The advisory committee comprised of clinical, follow-up, and laboratory staff continue to meet to prepare for screening initiation.

FY 2015 Program Summary: The addition of consent language to the NBS Saves Lives Act required a revision to the BioTrust for Health consent form. The elements of consent language was added to the consent form. From March 15, 2015 through depletion of the 2015 consent forms, study-specific consent will be required. Once the 2016 consent forms are in circulation, broad-based consent will be re-initiated.

Program Successes: The NBS Program celebrated 50 years of screening in 2015. To celebrate the 50th anniversary of this important public health program, the Michigan Department of Health and Human Services (MDHHS) planned a year-long campaign in 2015 designed to educate the general public, expectant parents, clinicians, and legislators. Multiple approaches were used to increase NBS awareness. To maintain consistency throughout the campaign, a new program logo was developed. The NBS program identified a list of existing events for relevant target audiences including health fairs, baby fairs, and professional meetings, and assigned staff to attend as many as possible. While resources were limited, simple items (crayons and NBS coloring sheets developed by staff) were distributed at events geared for expectant parents and young families. Brochures and educational materials were distributed at professional events. Throughout the year, a variety of social media content, press releases and newsletter articles were shared with the MDHHS Communications office for dissemination both internally through the department and to external audiences. A governor's proclamation was obtained and a day-long educational event was organized during September to coincide with NBS Awareness month. The event included a tour of the NBS lab, recognition of hospitals that excelled in NBS bloodspot collection or hearing screening, and a symposium with a variety of speakers including clinicians at medical management centers and families. To promote awareness among policy makers, individualized reports were created for each state legislator. These reports listed the number of babies screened and number identified with disease over 50 years of screening in Michigan, as well as the numbers screened and identified from birthing facilities in his/her district in the last five years. Individualized reports were also created for birth hospitals listing the number of screens submitted and number of babies identified with

disorders in the last five years from that facility. An informational booklet reviewing the beginnings of Michigan's program and special milestones throughout the past 50 years was developed.

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

Data Trends: Data for this performance measure are collected from the National Survey of Children and Youth with Special Health Care Needs which has historically been completed every four years. The last survey was completed in 2009/2010 and more recent data are not currently available. Therefore, no new data trends are identified in this section.

FY 2015 Program Summary: The Family Center for Children and Youth with Special Health Care Needs (Family Center) is the parent-directed section of the Children's Special Health Care Services (CSHCS) division. The Family Center is an integral part of the division. The Family Center provides services to families statewide and serves as the collective voice for families. Information the Family Center receives from families is used to provide consultation to Michigan Title V programs regarding policy and program development. The Family Center also partners with and receives information from the Family to Family Health Information Center, Parent to Parent of Southwest Michigan, Michigan Family Voices, Developmental Disabilities Council and others. All written materials intended for families created by CSHCS, as well as CSHCS policy and procedure, are reviewed by the Family Center for recommendations or revisions. The Family Center also provides review of the federal MCH Block Grant application.

An important service the Family Center continues to provide is the toll-free Family Phone Line. The Family Phone Line is available to families who have children with special needs throughout Michigan, whether they are enrolled in CSHCS or not, meeting the broader definition of special health care needs as outlined by the HRSA MCH Bureau. The Family Phone Line is used to assist families in accessing providers and obtaining information on the CSHCS program, as well as general information and referral to resources for families of children with special needs. In 2015, the phone line handled 10,661 calls. In an effort to be culturally competent and accessible to all families, the Family Phone Line uses a Language Line to increase access for individuals who do not speak English. In 2015, eight calls used the language line, primarily for Spanish and Arabic translation.

The Family Center developed a statewide database that is used to help make parent matches, outreach to parents with children with special needs, and provide information on parent and professional resources. This database also serves as a case management system for Family Center staff, which ensures that quality, timely services are delivered to families that request them.

The Family Center also continues to provide parent support through its statewide Parent to Parent Support Network of Michigan. This network matches parent volunteers with other parents in similar situations in need of support. In 2015, the Parent to Parent Support Network held nine trainings, which trained 65 new Parent Mentors. Additionally, the Parent to Parent Support Network made 36 parent matches, which provided peer support and resources to parents across the state. The Family Center also provided conference scholarships for youth

and parents to attend conferences around the United States that pertain to the youth or child's diagnosis.

In addition to the Parent to Parent Support Network trainings, the Family Center also trained 51 Sibshop Facilitators across the State of Michigan. Sibshop facilitators are trained to attend and facilitate sibling workshops, which focus on support and developing friendships among siblings of children with special needs. Finally, the Family Center held a conference on family-professional partnerships; 51 parents and professionals attended the conference.

Program successes: The Family Center had many successes, most notably the development of a statewide database, the creation of new parent consultant and secretary positions, and the development of new policies and procedures. The Family Center continues to build and expand its support services, youth and family input, and consultation to local health departments. Partnership is also occurring on two HRSA grants with other program areas.

Program challenges: The Family Center continues in its efforts to revitalize programming and build capacity. A significant amount of focus has been placed on rebuilding the statewide Parent to Parent Support Network, as well as expanding awareness and utilization of the parent/youth Conference Scholarship Fund. In May of 2015, we trained 51 facilitators across the State of Michigan to implement Sibshop Workshops at the local level. We are continuing to develop new partnerships and strengthen existing ones through collaborations and ongoing communications.

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

Data Trends: Data for this performance measure are collected from the National Survey of Children and Youth with Special Health Care Needs which has historically been completed every four years. The last survey was completed in 2009/2010 and more recent data are not currently available. Therefore, no new data trends are identified in this section.

FY 2015 Program Summary: In late FY 2014, CSHCS was awarded a HRSA grant to improve services for young children with autism spectrum disorders and other developmental disabilities (ASD/DD). As part of the ASD/DD grant, CSHCS and the Michigan Chapter of the American Academy of Pediatrics trained 13 primary care practices throughout FY 2015. This training focused on helping physicians and their front and back office staff 1) implement developmental screening tools; 2) more effectively managing populations with ASD/DD; and 3) provide better care coordination services for all children with special needs. The ASD/DD grant also provided an opportunity to increase collaboration with the Behavioral Health and Developmental Disabilities Administration (BHDDA) at both the state and local levels.

During FY 2015, CSHCS was also in its third year of administering a HRSA grant focused on the Awareness and Access to Care for Children and Youth with epilepsy. Part of this grant involves working with Federally Qualified Health Centers (FQHCs) in rural areas to strengthen their capacity to provide services to CYSHCN through the use of telemedicine. These FQHCs received training on topics including care coordination, transition planning, and incorporating telemedicine capabilities within their practice. Increasing the use of telemedicine provides the opportunity for families in rural settings to get comprehensive, specialty care provided by a multi-disciplinary team that would otherwise be unavailable in their region.

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

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

CSHCS medical consultants and Family Center staff provide support for the pediatric care managers of MiPCT (approximately 50 pediatric practices and some family medicine practices) by offering conferences and a series of webinars. Principles and practices of Family-Centered Care and effective parent-professional partnerships have been addressed as core learning objectives at conferences for pediatric care managers. The Family Center has participated in planning all three conferences. Parents of CYSHCN have presented to the large group of care managers (approximately 60 at each conference) and co-facilitate small group discussions along with pediatric professionals. Parents were recruited to speak and co-facilitate at the summit in 2015. Webinars have addressed a variety of topics including the CSHCS program, developmental and autism screening, coordinating care across multiple domains, recognizing

and addressing mental health needs in primary care, working with children with ASD/DD, transition of youth to adult services and supporting self-determination and others.

Children's Multi-Disciplinary Specialty (CMDS) Clinics are specialty pediatric health care providers throughout Michigan that provide comprehensive specialty care to children with particular diagnoses. This model of care is largely derived from the medical home model, but pertains to specific conditions that are often at the center of the child's health needs. In 2014, CSHCS embarked in efforts to significantly strengthen its partnership with CMDS clinics, which included establishing a workgroup consisting of CMDS clinic staff at each of the approved CMDS clinic organizations throughout the state. Throughout 2015, this workgroup set out on the task of learning from each other to identify best practices and to devise solutions to shared problems in administering care to CYSHCN. One of the barriers identified by this workgroup was the billing and reimbursement mechanism for the CMDS Clinic "Facility Fee" – a fee that supports comprehensive and well-coordinated care. The existing billing and reimbursement mechanism was predominantly a manual process, which limited CSHCS and the clinics from appropriately monitoring and evaluating the care provided to CYSHCN. In 2015, CSHCS worked with the clinics to migrate to the CHAMPS billing and reimbursement system, which is currently used by Michigan Medicaid FFS. This electronic billing and reimbursement solution took advantage of an existing mechanism and process, and provides an enhanced ability to monitor the care being delivered through the CMDS clinic model.

Additionally, CSHCS worked closely with the Family Center and CMDS clinics to develop an electronic survey to evaluate the ease of accessing care for CYSHCN, as well as CMDS clinic

performance. This pilot survey is being administered at CMDS clinics, and is completed by patients or their parents/caregiver on an iPad. The data is submitted electronically to the MDHHS data warehouse, allowing for robust analytical review.

Program successes: A major success in 2015 was strengthening the partnership between CSHCS and the Behavioral Health and Developmental Disabilities Administration (BHDDA) through the ASD/DD grant. CSHCS and BHDDA staff now meet regularly to discuss not only the grant activity but also Children's Mental Health access to care and Medicaid waiver issues. This partnership is leading us toward a more integrated approach to caring for children and youth with special needs. Another critical success was the partnership with MiPCT in developing medical homes in pediatric and family practices across the state. MiPCT has provided opportunities to work with the largest health care providers throughout the state on identifying and promoting evidence-based best practices.

Program challenges: One of the greatest challenges, despite the progress that has been made, remains the poorly integrated systems of care for CYSHCN. Forming new partnerships and strengthening existing ones requires time and resources that are often limited. Another major challenge is the varying information technology capacity and incompatible EMR systems, which contribute to difficulties in sharing information and assuring care coordination in the context of a medical home.

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

Data Trends: Data for this performance measure are collected from the National Survey of Children and Youth with Special Health Care Needs which has historically been completed every four years. The last survey was completed in 2009/2010 and more recent data are not currently available. Therefore, no new data trends are identified in this section.

FY 2015 Program Summary: CSHCS provides coverage for medical care and treatment regarding over 2,700 different diagnoses. In 2015, the program provided services to 41,259 children and some adults. CSHCS also has the Insurance Premium Payment Benefit, whereby the state pays the private health insurance premium for the eligible client. This benefit allows CSHCS clients to maintain their private health insurance coverage that they may otherwise not be able to afford. This enables the state to prevent the cost of medical services from shifting from the private health insurance company to CSHCS funding.

Children's Special Health Care Services may pay the beneficiary's portion of health insurance premiums through employer based insurance, Health Insurance Marketplace, COBRA, Medicare Part B, and Medicare Part D. Cost effectiveness and financial hardship must be proven in order for CSHCS to pay premiums. In 2015, the Insurance Premium Payment Benefit assisted 173 beneficiaries with insurance premiums, saving the program over $4.5 million.

In 2015, new CSHCS policy clearly defined what is considered financial hardship. A financial hardship can be determined when the family has a payment agreement that falls within the two lowest payment agreement categories. If the family has a payment agreement that is above the two lowest categories, the family must describe the reason for lack of resources that is impacting the ability to pay for the insurance.

Once a beneficiary is determined eligible for the Insurance Premium Payment benefit, the benefit can last up through the beneficiary's next enrollment with CSHCS. After the re-enrollment, the beneficiary must re-apply for the Insurance Premium Payment benefit, using the CSHCS Application for Payment of Health Insurance Premiums. It is at that time that the cost effectiveness and financial hardship are re-determined, and the beneficiary is re-enrolled in the benefit if eligible.

CSHCS continued its policy that requires applicants who—based on financial information provided—may be eligible for MIChild (Michigan's SCHIP program) or Medicaid to apply for the programs. As CSHCS only provides payment for medical care and treatment relating to the approved diagnoses, this change also increased access to primary care and other services for many of our clients.

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

To further ensure that CSHCS clients had adequate private and/or public insurance, CSHCS developed tools and partnered with external organizations to help eligible CSHCS clients enroll in the Healthy Michigan Plan (Medicaid Expansion) or any of the available plans through the Health Insurance Marketplace (HIM). CSHCS also refined its electronic work queue that allowed our local health department (LHD) affiliates to more readily identify CSHCS clients who may be eligible for an insurance plan provided through the HIM. This tool was used by our LHD partners to provide outreach and education about the HIM, as well as direct CSHCS clients to a Certified Application Counselor or Navigator.

Program successes: CSHCS continued to improve upon its existing initiatives and practices to help ensure that CYSHCN receive comprehensive care by assisting them in receiving adequate health insurance coverage. CSHCS also participated in discussions regarding the implementation of the statewide Healthy Michigan Plan (Medicaid Expansion) that has benefitted some of our adult clients.

Program challenges: Health insurance related to special health care needs remains a complex process for families to navigate, and makes it difficult to direct families to seek the appropriate insurance coverage. Additionally, mental and physical health continue to be provided in largely independent systems that don't always treat the individual as a whole.

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

Data Trends: Data for this performance measure are collected from the National Survey of Children and Youth with Special Health Care Needs which has historically been completed every

four years. The last survey was completed in 2009/2010 and more recent data are not currently available. Therefore, no new data trends are identified in this section.

FY 2015 Program Summary: Michigan relies heavily on our LHD partners to be the community-based arm of the CSHCS program. CSHCS works with the LHDs to assist families in locating additional resources within their community. Because CSHCS relies so heavily on the LHDs, it is crucial that the division provide them with the most current information and a streamlined process to handle clients' needs. The CSHCS database, implemented in 2011, continued to undergo enhancements that allowed for improved client management. This same database is also used by all CSHCS central office staff, which removes many barriers to a more effective partnership. CSHCS's internal staff and LHDs use this database to handle issues relating to the enrollment and renewal process for all CSHCS clients and their families.

CSHCS continued the process of the Michigan Local Public Health Accreditation Program for local CSHCS offices. In 2015, the first year in a three-year accreditation cycle was completed. LHDs were required to meet the following six minimum program requirements during the FY2015 accreditation cycle:

• Minimum Program Requirement 1: The local health department CSHCS program shall assure that adequate, trained personnel are available to provide outreach, enrollment and support services for CYSHCN and their families.

• Minimum Program Requirement 2: In accordance with the security and privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA), the local health department

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

• Minimum Program Requirement 3: The local health department CSHCS program shall have family-centered policies, procedures and reporting in place.

• Minimum Program Requirement 4: The local health department CSHCS program shall provide outreach, case-finding, program representation and referral services to CYSHCN/families in a family-centered manner and to community providers.

• Minimum Program Requirement 5: The local health department CSHCS program shall assist families in the CSHCS application and renewal process as well as the application processes for other relevant programs.

• Minimum Program Requirement 6: The local health department CSHCS program shall provide information and support services to CSHCS enrollees and their families. The division also worked closely with the Family Center for CYSHCN to provide outreach and information to 13 organizations regarding the CSHCS program, its benefits, and how to access services including the pediatric medical home model.

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

Program successes: In 2015, CSHCS completed its first year of the second cycle of accrediting LHDs. This process provided a better understanding of the strengths and needs of each LHD, and revealed ways that CSHCS could provide better assistance to our local partners. The accreditation process also strengthened the relationship between LHDs and CSHCS, and improved the communication among and between LHDs and CSHCS.

Program challenges: Perhaps the biggest challenge in providing easily accessible community-based services remains the fragmentation of systems of care serving CYSHCN such as medical, behavioral, developmental and educational systems. This fragmentation contributes to challenges in providing family-centered and local care coordination and systems navigation assistance.

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

Data Trends: Data for this performance measure are collected from the National Survey of Children and Youth with Special Health Care Needs which has historically been completed every four years. The last survey was completed in 2009/2010 and more recent data are not currently available. Therefore, no new data trends are identified in this section.

FY 2015 Program Summary: The CSHCS division continued to distribute transition anticipatory guidance letters. Each month in 2015, the Medicaid payment system (CHAMPS) identified clients based on their birthdates to create five client/family specific letters for ages 16, 17, 18, and 21. Additionally, all CSHCS authorized providers with a client turning 16, 18, and 21

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

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

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

CSHCS also administered a HRSA grant throughout FY 2015 that focused on building telemedicine capacity for children with epilepsy. The grant work included a significant emphasis on the development of the transition process for children and youth with epilepsy. In FY 2014, nine epilepsy telemedicine sites were surveyed to assess the transition policies within the organizations. These nine sites included five rural FQHCs and four private pediatric practices. The results of these surveys showed varying levels of transition policies in place among the providers, but all sites indicated that their policies would benefit from a review and comparison

to current national guidelines. Families within these practices were also surveyed, which revealed that children and youth with epilepsy and their families were unaware of a transition policy at their local primary care provider. These findings led to significant efforts to engage providers and patients in developing transition plans, which have been ongoing.

Additionally, CSHCS participated in improving the transition process for young adults receiving private duty nursing who are approaching 21 years old. Once a young adult turns 21, Medicaid will no longer cover private duty nursing in Michigan. These young adults must transition to a Medicaid Waiver option in order to continue receiving private duty nursing in their communities. Young adults that require being transitioned to a Medicaid waiver are now assisted by a team of local and state representatives, including the individuals responsible for making the medical eligibility determination for the Medicaid Waiver options. This process ensures that all necessary parties are involved in the transition from the beginning, and are able to develop relationships with the young adults and their families.

Program successes: Throughout FY 2015, CSHCS continued its major overhaul of transition planning strategies, including: assessing transition planning in pediatric practices, revising the transition specialist position description, and developing a training model that can be used within various provider entities across the state. Another major success remains the involvement of parents, youth, and multiple state agencies in the planning and development process.

Program challenges: Transition needs vary greatly among the CYSHCN population, making it difficult to ensure the right person gets the right services. Additionally, transitioning to

adulthood requires a cross-sector approach that includes educational and vocational training, continuing medical care, and at times legal matters such as supportive decision making and alternatives to guardianship. Providing comprehensive transition services requires specific knowledge and training that much of the public health workforce does not have, which makes it difficult to assist families in accessing the needed services.

Cross Cutting/Life Course Domain

NPM 13 – Oral Health

State Priority Need	**Objectives**	**Strategies**	**National Outcome Measures (NOM)** (prepopulated by HRSA)	**National Performance Measure** (NPM) (prepopulated by HRSA)
Increase access to and utilization of evidence-based oral health practices and services	A) Increase the number of students who have received a preventive dental screening within a school-based dental sealant program	A1) Utilize the SEAL! Michigan 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 SEAL! Michigan annual all grantee reports to monitor for annual growth of students receiving a preventive dental screening.	- Percent of children in excellent or very good health - Percent of children ages 1 through 17 who have decayed teeth or cavities in the past 12 months	A) Percent of women who had a dental visit during pregnancy, and B) Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
	B) By 2020, develop and implement a state plan for improving oral health care focusing on pregnant women, infants, children and youth	B1) Develop and disseminate a survey to stakeholders to prioritize proposed goals B2) Publish and disseminate a plan for specific populations of pregnant women and children		
	C) By 2020, increase by 100 the number of medical and dental providers trained to treat, screen and	C1) Plan and develop standardized training modules and courses for medical and dental professionals		

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

Oral Health Narrative

Through the five-year needs assessment process, the state priority need "Increase access to and utilization of evidence-based oral health practices and services" was selected for the cross cutting/life course domain. NPM 13 was selected to address this priority need: A) Percent of women who had a dental visit during pregnancy and B) Percent of children, ages 1-17, who had a preventive dental visit in the past year. In Michigan, 68 counties (out of 83 counties in total) have a full, partial or facility Health Provider Shortage Area (HPSA) designation, with 12 out of 83 counties having less than five dentists. In addition, just 42% of pregnant women reported

seeing a dentist during their pregnancy, with 27% reporting a need for immediate care. Children in Michigan face a similar struggle with only 37% of Medicaid-eligible children receiving dental services. Children under age 5 are the least likely to have visited a dentist.

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

Objective A: **Increase the number of students who have received a preventive dental screening within a school-based dental sealant program.** Dental decay is the leading chronic childhood disease and nationally leads to more than 51 million missed school hours per year. Dental sealants are an evidence-based strategy to prevent dental decay. SEAL! Michigan is a school-based dental sealant program that focuses on providing dental screening and placing dental sealants on students at no charge to families. In addition to dental sealants, students

receive a dental screening, oral health education and fluoride varnish. Dental sealants ultimately decrease dental disease in youth as they are 100% effective in preventing dental decay when they are retained by the tooth.

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

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

The first strategy under this objective is to utilize the SEAL! Michigan database to track the number of students receiving annual preventive dental screening. Continual updating of the

database will allow for tracking the number of unique students who receive one or more dental sealants through the program.

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

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

Objective B: **In fiscal year 2017, implement a state plan for improving oral health with a focus on pregnant women, infants, children and youth, including CYSHCN.** Michigan published the first State Oral Health Plan (SOHP) in 2006. It discussed a plan of action to improve the oral health status of the state's population around four broad topic areas and ten goals. In 2010, the SOHP was re-evaluated and updated based on the progress review and consideration of more recent data about prevalence of oral disease in Michigan. In FY 2016, the State Oral Health Plan (SOHP) was developed and combined with the Perinatal Oral Health Action Plan, the Michigan

Oral Health Coalition Policy Priorities and the Director Dental Report into one cohesive document. Stakeholders were surveyed in order to prioritize goals and objectives based on feasibility and need and priorities identified by the Michigan Oral Health Coalition included preventive strategies for infants and children along with increasing school-based dental sealant programs.

The SOHP has been published and disseminated to stakeholders such as the Michigan Oral Health Coalition, LHDs, FQHCs, WIC programs, dental programs and non-profit organizations and advocacy groups. Fiscal year 2017 will focus on implementing this plan and contributing to increased access and utilization of evidence-based oral health practices and services.

Objective C: **During FY 2017 increase by 20 the number the number of medical and dental providers trained to treat, screen and refer pregnant women and infants to oral health care services.** The Perinatal Oral Health Action Plan—a broad and multifaceted statewide initiative intended to inspire stakeholders to engage in the dynamic process of changing the oral health care delivery system—was created to address the call to support better health status for women and girls.

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

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

In FY 2016 the Perinatal Oral Health Program trained 390 health professionals in the medical and dental fields through lectures, webinars, conference calls and other training events. This number is calculated through records from each training event. These events will continue through FY 2017 and are tracked using a simple database. As a result of these trainings, the Perinatal Oral Health Program is collaborating with the Division of Family and Community Health, Women and Maternal Health Section, on the development and implementation of a curriculum evaluation project in Michigan OBGYN Residency programs as well as Dental and Nursing Schools. This project enacts an upstream approach towards assessing and enhancing the education of Michigan health care providers surrounding the topics of Perinatal Oral health, Substance Use Assessment, Health Literacy, and Health Equity. Considerable time and effort are committed to the continuing education of established Michigan healthcare professionals, but this pilot project focuses on improving the education of future health professionals while they are still in their respective educational programs. Currently, the project is investigating a partnership with the Wayne State University Area Health Education Center (AHEC) and other AHECs across the state to assist in the implementation of this project. The Perinatal Oral Health Consultant will a) partner with maternal and child health staff, Medical and dental institutions, AHECs, and other parties to develop an evaluator mechanism, b) work to identify and evaluate gaps in curriculum, and c) partner with educational institutions to enact curriculum change if indicated.

Objective D: In 2017 increase by 2% the number of pregnant women and infants receiving oral health care services. Together with a variety of medical and dental professionals and other stakeholders, MDHHS developed Perinatal Oral Health Guidelines as the first strategy to increase the number of pregnant women and infants receiving oral health care. These guidelines 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 services. During FY 2017, the perinatal oral health program will continue to promote the guidelines through partnerships with statewide public health, medical, and dental entities.

In the second strategy, MDHHS will develop and distribute promotional and education materials that promote dental visits both during pregnancy and infant oral health to health entities across the state. These materials are developed in partnership with stakeholders and distributed to LHDs, FQHCs, WIC clinics, dental offices, medical offices (including obstetric providers) and other important entities. The development of a specific Perinatal Oral Health module in partnership with WIC is beginning with expected completion in FY 2017. This module (delivered through wichealth.org) will serve as a training mechanism to mothers across the state of Michigan as well as on a national level. Wichealth.org provides stage-based, client-centered, WIC nutrition education and an anticipatory guidance model where WIC clients can successfully complete educational lessons in English and Spanish, with women completing lessons to receive their WIC benefits.

For the final strategy, MDHHS has already developed and begun implementing a multifaceted communications plan, using a core message document to standardize communication efforts across the state. Communication began in 2014, when MDHHS began broad-scale messaging of a trial perinatal oral health public service announcement that informs mothers about caries transmission and encourages them to see a dentist. MDHHS will continue to expand communication efforts to reach pregnant women across Michigan through the use of large-scale messaging as well as educational materials created in partnership with maternal and child health entities during this year. The Perinatal Oral Health Program is partnering with the Michigan State University College of Communication Arts and Sciences in the development of innovative perinatal oral health messaging and materials. Under the guidance of the Oral Health program and MSU teaching staff, senior design students will develop culturally appropriate and creative posters, brochures, and other health literature for unrestricted use by the Perinatal Oral Health program. After completion in FY 2017, these materials will be disseminated for use by LHDs, FQHCs, WIC clinics, dental offices, medical offices (including obstetric providers) and other important entities.

Life Course/Cross-cutting Health Domain

SPM 3 – Depression across the Life Course

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
Promote social and emotional well-being through the provision of behavioral health services	A) Participants of Eliminating Barriers for Learning training will demonstrate a 45% increase in ability to identify symptoms of mental	A1) Provide Eliminating Barriers for Learning training to school district personnel	A) Percent of high school students who report feeling sad or hopeless almost every day for two or more weeks in a row, to the extent they stopped doing some

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
	health disorders including depression; and a 30% increase in ability to identify ways mental health affects learning and classroom environment		usual activities during the prior 12 months, and B) Percent of women enrolled in MIHP who are screened for maternal depression
	B) Increase by 920 per year the number of school personnel who are trained on the impact of social and emotional health on learning	B1) Provide Eliminating Barriers for Learning training to school district personnel B2) Provide Eliminating Barriers for Learning Training of Trainers	
	C) 60 adolescents per year will access child psychiatry case consultation services through the provision of telepsychiatry services at Child and Adolescent Health Centers (CAHCs)	C1) Provide MC3 telepsychiatry services to patients of Child and Adolescent Health Centers (CAHCs)	
	D) Increase by 5% the enrollment of Medicaid-eligible pregnant women into the MIHP	D1) Incorporate transition of changes in Benefit Administration of Maternal Infant Health Program Services for Individuals Enrolled in a Medicaid Health Plan	
	E) Ensure appropriate coordination of care for MIHP enrolled women identified at risk for maternal depression	E1) Enhance data collection process to improve maternal depression referrals and follow up to care	

Depression across the Life Course Narrative

To address the priority area of **"Promoting social and emotional well-being through the provision of behavioral health services,"** MDHHS has developed a two-part State Performance

Measure relative to **reducing depression across the life course,** focusing on two high need populations: adolescents and pregnant and postpartum women. The SPM includes A) Percent of the Michigan's high school students who report having felt sad or hopeless almost every day for two or more weeks in a row, to the extent they stopped doing some usual activities during the prior 12 months, and B) Percent of women enrolled in Michigan's Maternal Infant Health Program (MIHP) who are screened for maternal depression.

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

To address depression among pregnant and postpartum women, MDHHS will focus on MIHP for pregnant and postpartum women with Medicaid. MIHP is the largest evidence-based home visiting program in Michigan. This population-based program serves pregnant mothers and their infants and provides professional services from a registered nurse and licensed social worker, and when applicable, registered dietician (with a physician order), and an infant mental health specialist. Strategies for this population are implemented through this program and consist of standardized depression screening through a validated risk screener, required behavioral health and stress/depression education for MIHP health professionals, increasing behavioral health referrals, and improving access through increasing the number of endorsed Infant Mental Health Specialists in MIHP.

Part A: Adolescent Health

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

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

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

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

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

disorders, and a 30% increase in identifying ways mental health affects learning and classroom environment.

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

Objective C: 60 adolescents per year will access child psychiatry services through the provision of telepsychiatry case consultation services at Child and Adolescent Health Centers (CAHCs). As a final strategy, the MDHHS Child and Adolescent Health Center Program (CAHC) will incorporate the use of telehealth technology to increase and improve the care and treatment of adolescents with depression. Administered and coordinated by the University of Michigan, MDHHS will provide funding support for CAHC participation in the MC3 Program. MC3 provides psychiatry support to primary care providers in CAHCs who are managing patients with mild to moderate behavioral health concerns including depression, which complements social work services (individual and group therapy) provided at the centers. Psychiatrists offer case consultation on diagnoses, medications and psychotherapy interventions so that primary care providers can better manage patients in their practices. This integration of care is welcome by primary care providers who may not want to independently

prescribe psychotropic medications, but who want more integrated physical and mental health care for their patients with mental health needs. Additionally, psychiatric support is provided through phone consultations with providers and by remote psychiatric evaluation to patients and families through video telepsychiatry. This access may be the only access to child psychiatrists that many providers and patients have. It is expected that a minimum of 60 patients will be reached each year at select CAHCs across the state.

Part B: Women/Maternal Health

Clinical depression is a leading cause of disability. Depression affects twice as many women as men, regardless of racial and ethnic background and income; and one in four women will experience severe depression at some point in life. Untreated depression among pregnant and postpartum women is of concern due to its adverse effects on the health of the mother, infant, and the mother-infant relationship. Between 10% and 20% of all women experience depression during the perinatal period, with prevalence in low-income and Black women estimated at almost double that of White women. Analysis of depression rates across Michigan's six home visiting programs found that the percentage of women exceeding clinical cutoff for depression at enrollment ranged from 28.5% to 61%. The largest home visiting program in Michigan, the Maternal Infant Health Program (MIHP) stores data in the MDHHS Data Warehouse, allowing for further analysis. MIHP data are collected based on the beneficiary's response to the stress/depression risk questions asked on the validated, maternal risk-identifier screen and stored in the MDHHS Data Warehouse. FY 2014 data from the MIHP screener for maternal depression (utilizing the Edinburgh Postnatal Depression Scale) showed that 19,529 (100%) of

enrolled women were screened for maternal depression. Of those screened, 7,736 (40%) scored moderate or high risk for depression.

Every Medicaid-insured pregnant woman is eligible for MIHP which includes a comprehensive risk screening, care coordination and up to nine additional visits based on risk. A validated standardized risk screener is administered for all participants at entry to the MIHP which encompasses many domains, including a stress/depression domain utilizing an embedded Edinburgh Postnatal Depression Scale. If a participant screens "at risk" for stress/depression, an evidence-based plan of care is implemented. This plan of care includes education, coping strategies, referral offerings as needed, discussion of treatment options, preparation of a postpartum support plan, and development of a safety plan.

To support the SPM related to maternal depression, general strategies will include required training for MIHP professionals (implementation of MIHP Depression Interventions; Infant Mental Health; Reaching the Most Difficult to Reach Families: An Attachment perspective; and Motivational Interviewing); continuation of the MDHHS MIHP Mental Health Workgroup which meets monthly to assure that the most beneficial and current interventions are included in the program; and the inclusion of MDHHS MIHP staff as liaisons for various Michigan organizations and projects (Community Mental Health, Michigan Association of Infant Mental Health, and the Michigan Statewide Perinatal Mood Disorder Coalition).

Objective D: Increase by 5% the enrollment of Medicaid-eligible pregnant women into the Maternal Infant Health Program (MIHP). A core strategy toward meeting this objective is through a new MIHP enrollment partnership with the Medicaid Health Plans. An increase in

MIHP enrollment is anticipated beginning October 1, 2016, as MIHP services provided to individuals enrolled in a Medicaid Health Plan (MHP) will be administered by the MHP. As a result of this change, all MIHP services provided to MHP enrollees on and after October 1, 2016, will be coordinated and reimbursed by the MHPs. Increased screening for maternal depression among Medicaid eligible pregnant women is expected as MIHP enrollment increases, since MHPs are required to assign all MIHP-eligible women and infant enrollees to an MIHP provider for MIHP outreach, screening and care coordination within one month of the effective date of MIHP eligibility.

Objective E: Ensure appropriate coordination of care for MIHP enrolled women identified at risk for maternal depression. A strategy to meet this objective is to enhance data collection processes to improve maternal depression referrals and follow up to care. This includes standardized referral data capture processes among all MIHP agencies in order to better capture data from the referral portion of those at risk for maternal depression. The first activity will bring stakeholders together to share best practices, data collection, reporting and evaluation processes to improve monitoring and data capture for MIHP maternal depression referrals. The second activity to standardize data is to perform special analyses to build knowledge of effective maternal depression interventions and communicate the value of referral offerings currently in place.

Cross-cutting/Life Course Population Domain

SPM 5 – Immunizations

State Priority Need	Objectives	Strategies	State Performance Measure (SPM)
Invest in prevention and early intervention strategies, such as screening	A) Increase the percentage of children 19-36 months of age who receive recommended vaccines	A1) Use data in the Michigan Care Improvement Registry (MCIR) to identify all children 6-18 months of age who are overdue for a vaccine A2) Generate quarterly letters to parents of children 6-18 months of age who are overdue for a vaccine A3) Track the number of children who have responded to the notices	A) Percent of children 19 to 36 months of age who have received a completed series of recommended vaccines (4:3:1:3:3:1:4 series) and B) Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus (HPV) vaccine
	B) Make quality improvement reports (AFIX reports) available to immunization providers using the MCIR	B1) Identify requirements needed to make AFIX reports available to immunization providers B2) Provide requirements to MCIR technical staff for programming into the MCIR B3) Train providers on the use of AFIX reports B4) Outreach to providers who see the largest number of pediatric patients and have the lowest immunization levels and offer AFIX visits in their practice	
	C) Enable local health departments to better track successes or shortfalls for their health jurisdiction	C1) Using MCIR data, generate county report cards that rank all counties based on pediatric, adolescent, and adult immunization rates	

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

Immunizations Narrative

To address the priority area of **"Invest in prevention and early intervention strategies, such as screening,"** MDHHS developed a SPM related to **Immunizations**. This SPM includes two

measures: A) Percent of children 19 to 36 months of age who have received a completed series of recommended vaccines (4:3:1:3:3:1:4 series) and B) Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus (HPV) vaccine. Within some populations, Michigan has experienced declining immunizations rates and has not met the Healthy People 2020 goal for child immunizations. For example, the percent of 19 to 35 month olds who received a full schedule of age appropriate immunizations (Measles, Mumps, Rubella, Polio, Diptheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B) fell from 82% to 74.8% between 2008 and 2014.

Additionally, the state has the fourth highest percentage of kindergarten exemptions for one or more vaccines required for school entry, with some counties experiencing rates as high as 20%. Sixty-seven percent of Michigan's 13-18 year olds are complete with immunizations, but that percentage drops to 20% when HPV series completion is considered. Establishing an immunization SPM aligns with work at both the state and local level. For example, several local health departments use MCH funding for both direct services and enabling services, particularly to support childhood immunization efforts. Additionally, several of the National Outcome Measures (NOMs) focus on immunizations. Thus, immunizations was determined to be a timely and important SPM.

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

- Promote high immunization levels for children and adults

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

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

The National Immunization Surveys (NIS) are a group of telephone surveys sponsored and conducted by CDC's National Center for Immunization and Respiratory Diseases (NCIRD). In 1994, the NIS began to monitor child immunization coverage in all 50 states and select local areas. The NIS is the only standardized sampling method that can show differences and disparities from one state to another. The NIS uses random-digit-dialing to identify households with children aged 19 through 35 months. A parents or guardian is interviewed on child immunization status and vaccination providers are mailed a survey to verify immunizations. NIS currently measures: 4 DTaP, 3 Polio, 1 MMR, 3 Hib, 3 HepB, 1 Varicella, 4 PCV (4313314). The most recent NIS data from 2014 shows that the point estimate for Michigan is 65% for the 4313314 series. This is a 5% decline from the prior year and ranks Michigan 47th in the country.

The Division of Immunization operates the Michigan Care Improvement Registry (MCIR). The MCIR is a regionally based, statewide immunization registry that contains over 115 million shot records administered to 8.6 million individuals residing in Michigan. MDHHS is currently working through subcontracts with six MCIR regions to enroll and support every immunization provider in the state. Current enrollments include: 6,171 health care providers and pharmacies; 4,199 schools; and 3,811 licensed childcare programs. The MCIR system is used routinely by over 30,000 users to access and determine the immunization records of both children and adults. In 2015, the MCIR generated over 493,000 recall letters notifying responsible parties whose children had missed shots and encouraged them to visit their immunization providers to receive needed vaccines. In addition, over 3 million reports were generated by users of the MCIR system in 2015.

The MCIR has the ability to forecast for needed doses of vaccine for all children who are contained in the system. All children should have completed the recommended pediatric vaccines by the time the child reaches 19 months of age. Data from the MCIR show that 74% of children who reside in Michigan have received the routinely recommend 4313314 series by the time they reach 36 months of age. MCIR rates have not increased for the past three years; in fact, gradual decreases have occurred in the compliance rates for children enrolled in Medicaid and in WIC. Although the 74% vaccination level is higher than the rate reported by the National Immunization Survey, the Healthy People 2020 goal is 80%.

Adolescent immunization rates for most diseases are similar to national numbers and in some cases Michigan meets the Healthy People 2020 objectives. However, Michigan needs to make significant improvements in HPV vaccination rates. The HPV vaccine has the potential to save

thousands of lives every year, yet our adolescent completion rates are far below national goals. Over the past two years, Michigan has increased the completion rate for adolescents 13 through 18 years of age from 18% to 27%. This was primarily accomplished using the MCIR to generate letters to parents of all adolescents who had not yet completed the HPV series. Funding for this project was through a special grant from the CDC that focused on increasing HPV rates. MDHHS will be seeking funding to continue this successful effort.

Objective A: Increase the percentage of children 19-36 months of age who receive recommended vaccines. Data obtained from the MCIR show that children are not receiving vaccines on schedule, and many of these children never catch up on all needed vaccines. By 7 months of age, only 51% of children in MCIR are current with all recommend vaccines (see Figure 3). This puts our population at risk, with nearly 50% of the children susceptible to these serious diseases.

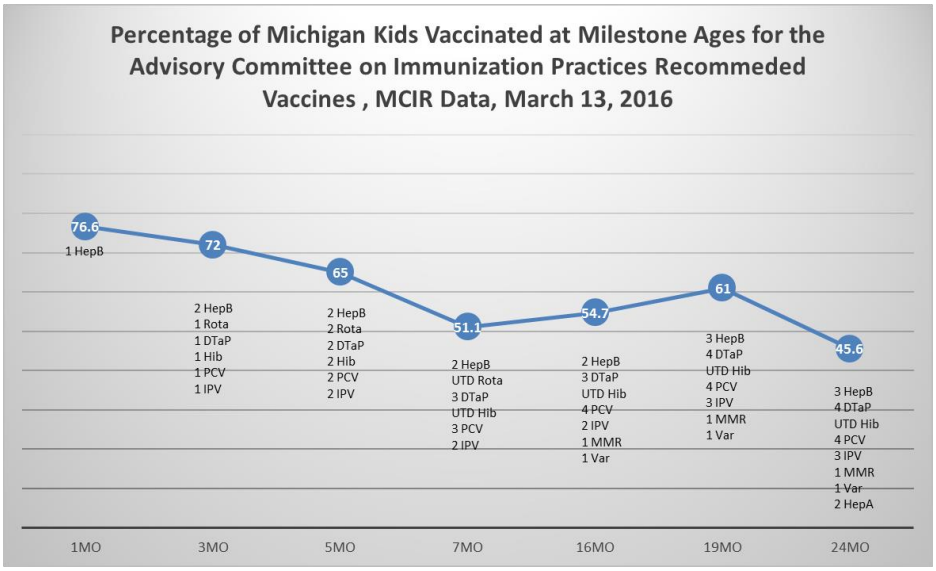


Figure 3. Percentage of Michigan Kids Vaccinated at Milestone Ages

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

Objective B: Make quality improvement reports (AFIX reports) available to immunization providers using the MCIR. The MCIR system has grown to be a robust source of data and can be a useful tool to assure children are vaccinated. For a number of years, MCIR has made AFIX reports available for local health department staff to generate for vaccination providers in their jurisdiction. This new enhancement to the MCIR allows a provider to generate their own AFIX reports. The AFIX report includes information such as a listing of children who are incomplete for one or more doses of vaccine; a listing of individuals who could be complete with one more visit or one more dose of vaccine; and a listing of individuals who had a missed opportunity to

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

By making the reports available directly to the provider, the intention is for staff to take ownership of the vaccine program, empower the practice, and encourage development of a plan to improve immunization rates. MDHHS staff in the Immunization Program are available to work with any practices that need assistance. To support these efforts, the Immunization Program is in the process of training provider office staff on the functionality and use of the data on the AFIX reports.

Objective C: Enable local health departments to better track successes or shortfalls for their health jurisdiction. The Immunization Program recently began distributing population-based county "report cards" for local health departments to better understand immunization issues within their communities. On a quarterly basis, the MCIR epidemiologist will generate county report cards and post them on the website. The report card will contain coverage level information in several key areas including pediatric, adolescent, and adult coverage levels. Report cards rank each county in the state, so a county can also compare its progress to other counties. The report assists the county in understanding areas for improvement and increased attention.

Objective D: Increase the percentage of adolescents who have completed the HPV series. In 2014, the Immunization Program received grant funding to increase HPV immunization rates for adolescents in Michigan. At the beginning of the grant period, the HPV coverage rate was 18% for all adolescents (male and female) 13 to 18 years of age. The Division of Immunization used

the majority of funding to send out notifications to parents of adolescents 11-18 years of age who were overdue for one or more doses of HPV vaccine. The first round of notices went to adolescents who had received two doses of HPV vaccine but had not yet received their third dose. In that round, 34,890 notifications were distributed and 4,496 adolescents (12.89%) were vaccinated with HPV within two months of receiving the notice. The second round of notices was sent to adolescents who had received one dose of HPV vaccine but had not yet received their second dose. For this round, 60,745 notifications were distributed and 8,826 adolescents (14.53%) were vaccinated with HPV within two months. The third round of notices was sent to adolescents who had never received any HPV vaccine. For this round, 400,139 notifications were distributed and 13,195 adolescents (3.30%) were vaccinated with HPV within two months. Through this grant, 26,517 adolescents were vaccinated with HPV vaccine. We have seen our adolescent rates move up to 27%. The immunization program will continue to seek funding for and use this strategy as a way to increase adolescent HPV immunization rates.

As another strategy, the Adult and Adolescent Coordinator in the Division of Immunization will continue to partner with the cancer programs working toward a common goal of increasing HPV coverage rates and decreasing the incidence of cancers caused by Human Papillomavirus. The Division of Immunization has partnered with these programs to promote the message about cancer prevention using social media and public advertising. The Immunization Program will also conduct outreach to colleges and universities to discuss the importance of student vaccination. This outreach will not be exclusively for HPV vaccine, but will also include the importance of other vaccines such as Tdap, meningococcal, and influenza vaccines.

Michigan does not have vaccination requirements for colleges and universities. Some colleges and universities have immunization requirements in place for some or all students, but it is not universal. The Immunization Program will reach out to these institutions to determine their current requirements and to encourage their administration to promote immunizations to all students and faculty.

Objective E: Increase outreach to adolescent immunization providers with low immunization rates. Each month the Division of Immunization epidemiologist will generate a list of all immunization providers submitting data to MCIR who are vaccinating adolescents. The list will show how many adolescents are being seen by the practice and how many of the adolescents are receiving all needed vaccines. Staff will review this list and identify the largest providers with the lowest immunization rates and reach out to those providers. Immunization staff will follow up with the practice and provide a comprehensive AFIX report. Staff will also work with the practice to develop a plan to increase immunization rates. Through direct outreach to the provider practice, we will have the opportunity to customize a practical quality improvement plan to help improve not only immunization rates but also the quality of care as it relates to immunizations.

Cross-Cutting/Life Course Annual Report

The following performance measures and the related data trends, program summaries, successes, and challenges address the **Cross-cutting/Life Course** population domain for FY 2015 reporting.

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

Data Trends: Last year, just over 30% of third grade children (33,766 of 111,588 children) received protective sealants on at least one permanent molar tooth according to provisional data. For the third consecutive year, the annual performance objective (30% for FY 2015) for this NPM was met.

FY 2015 Program Summary: The SEAL! Michigan program continues to see a steady increase in the number of local programs as well as the number of children seen for a preventive dental visit. The program began in 2007, under a pilot with one funded program. The program continues to expand and now has eleven funded programs and two self-sustaining programs that deliver services in 33 Michigan counties. In FY 2015, SEAL! Michigan was delivered in 211 schools and screened 4,889 unduplicated students. The program requires a positive parental consent for students to receive oral health education, dental screening, dental sealants and fluoride varnish, which is a preventive service to decrease dental decay.

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

sealant program in their schools. In addition, two SEAL! Michigan programs use dental hygiene students within the program to provide experience in dental public health programs.

Program Challenges: In FY 2015, Michigan implemented a mobile dental facility law. There has been a proliferation of mobile dental providers throughout Michigan and there has been competition between dental providers regarding schools. The mobile dental facility law requires mobile providers to apply for a permit and meet certain criteria. In addition, school districts have been inundated with calls from mobile dental providers and are confused about which mobile dental providers to select. The Oral Health Program has developed materials to help school districts make informed choices about dental sealant programs.

NPM 13: Percent of children without health insurance

Data Trends: The proportion of children aged 0-17 without health insurance in Michigan during 2014 was 3.8%, a decline of two-tenths of one percent from the prior year. The relatively steady decline in the proportion of uninsured children represents a significant decrease of 0.8% from 2009. Older children and adolescents aged 6-17 were more likely to be uninsured compared to children under 6 years of age (3.9% and 3.4% respectively). According to the 2014 American Community Survey (ACS) 5-year estimates, the greatest *number* of uninsured children reside in the large urban counties of Wayne, Oakland, Macomb, and Kent. However, the greatest *proportion* of uninsured children reside in low-income rural counties with relatively high unemployment rates including Oscoda, Gladwin, Hillsdale, and Mackinac (20.7%, 17.2%, 12.6%, 10.0% uninsured, respectively).

Among Michigan children with health insurance, 52.9% rely exclusively on employer-based coverage. Medicaid and other means-tested coverage represented the next largest single source of insurance for children (35.4%), followed by direct-purchase insurance (3.9%), TRICARE/military health coverage (0.5%), Medicare (0.2%), and VA health care (<0.1%). An additional 7.2% of insured children reported more than one type of health care coverage.

In 2014, the highest uninsured rates among children 0-17 years of age were among American Indian/Alaska Native (7.5%) and Hispanic (4.7%) youth. Comparatively, the percent of non-Hispanic white children without insurance was 3.6% and among black children, the rate was 3.5%. Currently, children under the age of 18 account for 9.9% of all uninsured individuals in Michigan.

FY 2015 Program Summary and Successes: In a larger context, enrollment in the Healthy Michigan Plan (HMP), Michigan's Medicaid expansion plan for adults, and the Health Insurance Marketplace (Marketplace) greatly influences the proportion of uninsured, making the percentage of uninsured a moving target. The HMP is available to those at or below 133% of federal poverty level, and the Marketplace to those above 133%. Initial projections indicated that within five years of Affordable Care Act implementation, the percent of uninsured would drop by more than half. Between the HMP and the Marketplace, Michigan insured over 700,000 people in less than a year; and currently, there are more than 600,000 beneficiaries enrolled in the HMP alone. Fifty-three percent of Michiganders who enrolled in a Marketplace plan in 2015 were new consumers, demonstrating its continued impact on health insurance coverage for the state's residents. Children under 18 may qualify for MI-Child (the Michigan

Children's Health Insurance Program for children whose parents lack insurance) or for Healthy Kids (which provides health care coverage for qualifying pregnant women, babies and children under age 19).

Local health departments (LHDs) and other entities (e.g., FQHCs, school-based/school-linked health centers, "free" clinics and Health Plans) continued to conduct outreach and enrollment activities across the state. Multiple public and private initiatives exist to expand the number of Navigators and Certified Application Counselors (CAC) available to assist in identification of and enrollment in an appropriate health insurance plan. The promotion of MI-Bridges (one-stop online enrollment portal) training for CACs has facilitated the rise in beneficiaries covered under the HMP, Medicaid and MI-Child.

Program Challenges: Despite expanded coverage options and increased access points for enrollment assistance, many families opt not to pursue coverage citing high premium, deductible and co-pay costs (e.g., the perspective is that it is less expensive to be uninsured). For others, maintaining enrollment is challenging as they may be unable to, or forget to, re-enroll annually as required. High transience in the Medicaid-covered population, coupled with a high rate of disconnected or changed phone numbers, also makes it difficult to send reminders and assist beneficiaries in re-enrollment.

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

Data Trends: The percentage of women who smoked in the last three months of pregnancy has been slowly declining over the past seven years. Preliminary 2015 data suggest 11.4% of

pregnant women smoked during the last trimester according to PRAMs estimate. This is a 4% decrease since 2013 and exceeds the annual performance objective.

FY 2015 Program Summary: Michigan addresses prenatal smoking cessation as part of perinatal health and overall population smoking cessation efforts. The Smoke Free for Baby and Me (SFBM) online course is a provider training program on assessment and counseling of prenatal smokers, and is required for all Maternal Infant Health Program providers statewide. SFBM addresses the risk of smoking tobacco in pregnant women and mothers of infants in order to decrease the percentage of women who smoke during and after pregnancy, and exposure of tobacco smoke to their infants and other children in their homes. In FY 2015, 819 individuals viewed the program, and 596 were awarded a certificate of completion.

In 2015, SFBM online course was updated and continuing medical education credits can now be awarded to physicians, nurses and social workers who complete the course. Twenty-six social workers and 28 nurses took the online course and were awarded continuing education credits. Previous smoking cessation efforts will continue in the coming year.

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

Data Trends: The ratio of the percent of the minority population eligible for publicly-funded health programs to the percent of White, non-Hispanic population eligible for publicly-funded health programs increased from 2.4 in 2014 to 3.1 in 2015. The percentage of eligible minorities increased (by 6.4%, from 39.9% to 46.3%) whereas the percentage of eligible White, non-

Hispanics decreased slightly (by .7 %, from 15.8% to 15.1%). This movement in an undesirable direction represents a disparity between the proportion of minorities and Whites needing Medicaid. As reported in the prior year, it is likely that there were greater economic improvements for Whites versus minority populations. In 2014, Michigan's unemployment rate was 7.2%. The unemployment rate for Asians, Whites, Hispanics, and Blacks was 4.8%, 5.8%, 8.8% and 15.9 % respectively. Between October to December 2014, Michigan had the highest Black unemployment rate in the US at 16.3%.

In December 2014, the Healthy Michigan Plan surpassed its original two-year and total eligibility projection by reaching more than 477,000 enrollees. Michigan did very well with encouraging residents to apply for the Healthy Michigan Plan. This may explain why there was an increase in the number of African Americans enrolled in Medicaid. It is plausible that many African Americans may have been eligible for Medicaid in the past but did not complete the enrollment process. Additionally, Medicaid expanded to 133% of the Federal Poverty Level, allowing many more adults to be eligible for coverage.

Of infants less than one year of age with Medicaid, 43% we non-migrant Whites and 24% were non-migrant Blacks. Eighty percent of the non-migrant White infants had at least one initial or periodic visit to the doctor and 83% of non-migrant Black infants did the same. A slightly higher percentage of non-migrant Black infants less than one year of age had a visit to the doctor. For children ages 1-21 with Medicaid, 53% were non-migrant Whites and 28% were non-migrant Blacks. Eighty-six percent of non-migrant White children had at least one service visit to the

doctor whereas only 78% of non-migrant Black children did the same. A higher percentage of non-migrant White children aged 1-21 visited the doctor versus non-migrant Black children.

FY 2015 Program Summary: The Bureau of Family and Maternal Child Health continued to engage staff in the Practices to Reduce Infant Mortality through Equity (PRIME) initiative. In PRIME staff have received training to review and alter policy, procedures and practices to eliminate racial and ethnic disparities in infant mortality. In February 2015, Bureau of Family, Maternal and Child Health (BFMCH) staff engaged in a 3-day Health Equity Social Justice Workshop. In September 2014, the Division of Family and Maternal and Child Health staff began to engage in Health Equity Learning Labs. In the Health Equity Learning Labs staff develop work plans focused on improving health equity in the populations that they serve. In 2013 and 2014 WIC and CSHCS staff engaged in the Health Equity Learning Labs and they develop equity work plans. Between May 2015 and January 2016, WIC and CSHCS staff engaged in a quality improvement project to ascertain why some of the equity plan were not fully implemented. In July 2015, MDHHS released the *Practices to Reduce Infant Mortality through Equity (PRIME): Guide for Public Health Professionals*. The guide was shared with state and national stakeholders and is an informational resource for transforming public health through equity education and action.

Program Success/Challenges: In the summer of 2016, all three divisions formerly housed in BFMCH will have completed the Health Equity Learning Lab training and will be implementing health equity work plans aimed at reducing racial and ethnic disparities in infant mortality and other health outcomes. In 2016, staff will also engage in follow-up technical assistance sessions

at 3, 6 and 12 months after developing their equity work plans. The purpose of the follow-up session is to measure if staff are meeting their indicators for success and assist with overcoming any obstacles.

MDHHS updated its infant mortality reduction plan for 2016-2019. The new plan continues and strengthens efforts to address the social, emotional and environmental factors that affect health and health equity. In the 2012 plan, weaving the social determinants of health into all targeted strategies to promote reduction of racial and ethnic disparities in infant mortality was included as the eighth strategy. In the updated plan, there is an increased focus on achieving health equity and eliminating racial and ethnic disparities by addressing the social determinants of health in all infant mortality reduction goals and strategies; it is also the first goal listed in the plan.

II.F.2. MCH Workforce Development and Capacity

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

During year one, 2.0 full-time positions were established within the Division of Family and Community Health (DFCH) to provide strategic guidance and technical support for the MCH Block Grant across the women, perinatal/infant, child, adolescent and cross-cutting/life course population domains. The first position, housed within the Child and Adolescent Health Systems Unit located in the Child, Adolescent and School Health Section, was filled in May 2016. This advanced Nursing Consultant position is administratively responsible for the oversight and coordination of MCH services funded through LHDs and in alignment with priorities in the MCH Block Grant. This position will provide leadership and strategic guidance in meeting programmatic and fiduciary responsibilities of this grant. The position will also be responsible

for implementing a continuous quality improvement framework, monitoring key outcomes and impacts on state MCH priorities and objectives.

A second departmental specialist position was established to work with the Division's administrative team to coordinate special projects associated with MCH activities and initiatives supported by Title V. This position will also help streamline reporting, assist in data collection efforts, assure that staff orientation and ongoing training is inclusive of knowledge and skills needed to support MCH goals and outcomes and support the Division Director in community capacity and infrastructure development as needed to support Title V requirements and outcomes. It is anticipated that this position will be filled within the next year. In the first year, MDHHS also supported .40 FTE of an epidemiologist position to assist with data collection and analysis and the creation of additional performance measures.

In year two, MDHHS will build upon this increased capacity, and will add the following 2.0 full-time positions: Safe Sleep Program Coordinator and Lead Prevention Program Coordinator. The **Safe Sleep Program Coordinator** will be responsible for development, coordination and promotion of a statewide, consistent, comprehensive strategy to inform families, caregivers and professionals about sleep practices to prevent infant sleep-related deaths. These goals will be accomplished by developing and providing leadership for the MDHHS strategic plan; a state-level advisory committee; funding support and coordination of state and local efforts; promotion of best practices statewide; and monitoring of available data to evaluate progress and impact of local and state efforts. Reducing the racial and ethnic disparities that exist in Michigan's sleep-related infant deaths will be a particular focus of this position.

Michigan will also create a **Lead Prevention Program Coordinator** position within the Childhood Lead Poisoning Prevention Program (CLPPP). The coordinator will oversee planning, implementation and evaluation of CLPPP objectives and activities, in compliance with the purpose of the program as defined in Michigan's Public Health Code. The coordinator will work closely with the CLPPP Nurse Consultant, Program Analyst, and the Early Childhood Health Section Manager to support and monitor community grants; update program policies and procedures; improve use of program educational materials; improve blood lead testing (initial and follow-up testing, including venous confirmation testing); and support statewide implementation of a new case management structure to better address the needs of children with elevated blood lead levels and their families.

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

II.F.3. Family/Consumer Partnerships

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

Examples of the roles of service recipients in programs funded or impacted by Title V are plentiful. Families and consumers are represented in strategic planning initiatives for the reduction of infant mortality and fetal alcohol disorders. They are instrumental in the development of material and guidelines for Oral Health, Family Planning and other programs. As members of advisory committees for Oral Health, Family Planning, Child and Adolescent Health Centers, and maternal and child home visiting programs, they provide valuable insight into the needs and priorities of their respective population groups. Program development is enhanced with specific insight into the various populations affected when consumers and families play an expanded role in the direction and development of services and policies.

An example of family and consumer partnerships is found within the Early Hearing Detection and Intervention (EHDI) program through use of Michigan Hands and Voices Guide By Your Side™ (GBYS) program. GBYS gives families who recently learned of their child's hearing loss an

opportunity to meet with another parent of a child who is deaf or hard of hearing. In 2015, 65 families were provided guide visits. In 2015, the EHDI program supported five parents to attend the National Hands & Voices and National EHDI meetings to engage with other parents and professionals. Families are involved in updating EHDI materials, which are available in Spanish and Arabic. In an effort to assure cultural and linguistic competence, the EHDI program formed a partnership with Wayne Children's Healthcare Access Program to establish an EHDI Program Specialist position to provide assistance to families with babies who do not pass an initial hearing screen. The EHDI Specialist, who speaks Arabic, works extensively with families in the Detroit/Wayne County area, which has a significant Arabic population. Efforts to promote health equity through the EHDI program include diverse parent representation on advisory committees and a family-focused conference for families of children who are deaf or hard of hearing.

Another example that demonstrates parent and caregiver involvement is the Michigan Infant Safe Sleep State Advisory Committee. Currently, three parents are involved. Parents and caregivers are also involved in advocacy projects including sharing their stories by speaking at public events and creating videos for use in trainings so that professionals, parents and caregivers can understand the importance of this issue from the perspective of those who have lost infants. The program currently funds 14 local health departments (LHDs) and the Inter-Tribal Council to develop and implement community-based infant safe sleep education, awareness and outreach activities. The LHDs were chosen based on their location in counties with high numbers of Sudden Unexpected Infant Deaths (SUID). Overall, these counties also experience significant racial disparity in the number of deaths among Black infants compared to

the number of deaths among White infants. The Inter-Tribal Council of Michigan is funded to address the historically high SUID rate among American Indian babies.

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

The MDHHS (Division of Family and Community Health, Early Childhood Health Section) coordinates and is the fiduciary for the Parent Leadership in State Government (PLISG) initiative. PLISG is an interagency, multidisciplinary effort designed to recruit, train and support parents so their voices can help shape programs and policy at the local, state and federal level. Since 2007, several state agencies have collaboratively funded the PLISG which is directed by the Parent Leadership Advisory Board. The Board includes representatives from each of the public state agencies providing funding support, the Early Childhood Investment Corporation and parent representatives who have received services from the funding agencies and/or are in leadership positions within those agencies. At least 51 percent of board members must be parents of children aged 0-18 who have been or are eligible to utilize specialized public services (health, disability, social services, special education, early childhood intervention, mental health, etc.).

A primary role of the PLISG is to provide the “Parents Partnering for Change” (PPC) leadership training which targets any family whose child is using specialized services. The parent training is

based on the following competencies: participants will have an understanding of their own leadership direction; participants will have the ability to be an effective partner and exhibit leadership when working alongside professionals; and participants will understand and have the ability to advance cultural competence. To date, over 830 parents from across the state have participated in the training. Approximately 45% of participants reported utilization of or involvement in an MCH program or service. The PPC training is funded across multiple agencies and systems, so parents who attend the training are involved in an array of programs and initiatives (not just MCH) and apply their leadership skills across many disciplines and local and state initiatives.

While this training is still ongoing, the Board is developing a new shared leadership curriculum, based on training provided by Paul Schmitz, CEO of Leading Inside Out, LLC. Learning objectives of the new training will include understanding shared or collaborative leadership, barriers to collective leadership, understanding of the importance of and focus on health equity, empowering others, and asset-based community development. The curriculum is anticipated by fall 2016. This training will be provided to professionals to help them recognize the importance of sharing leadership with parents and doing 'with' parents rather than doing 'to' parents.

Michigan's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants have also integrated parent and caregiver involvement. MIECHV patterned its approach to parent involvement on previous state-level collaboration with parents for Part C, local Great Start Parent Coalitions, and Project LAUNCH, integrating policy and procedures around parent involvement into the home visiting work. MIECHV communities receive funding to convene a

home visiting Local Leadership Group (LLG), which is connected to their existing local Great Start early childhood collaborative. The LLGs are comprised of representatives from across Head Start, Substance Abuse, Child Abuse and Neglect Councils, Public Health, Mental Health, Education (including Part C), Great Start staff, and parents whose children have participated in evidence-based home visiting programs. Parents are included to assure that the consumer voice is part of local program decision-making and policy development. All of the parents on the LLGs are graduates of the Parent Leadership in State Government training.

In 2016, the LLG Learning Collaborative focused on supporting home visiting programs with increased attention to outreach, enrollment and retention. Parents are once again critical members of the local CQI teams. Parents who participate on the LLGs are also invited to a quarterly parent-specific learning community, which provides an opportunity for mutual support, sharing of information and ideas and skill development. Participants from the parent learning community presented a highly-regarded keynote for the Home Visiting 2015 conference and were asked to present again at the winter 2016 meeting of the National Home Visiting Collaborative Improvement and Innovation Network (CoIIN).

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

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

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

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

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

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

This five-year cycle will see more focus on inclusion of consumers and families who are the service recipients, as these engaged individuals have a vital role in improving the quality of care and services that MDHHS provides or oversees. Partnerships and collaborative efforts relative to family/consumer engagement and leadership with state and local MCH are crucial, and improving access to quality services for CYSHCN in all MCH programs should involve families and consumers from across the state. The Family Center provides a focal point for Title V programs to assure family and consumer engagement. The Family Center works with many key partners, including the Michigan Family to Family Health Information Center, Parent to Parent of Southwest Michigan, Michigan Family Voices, and others to assure family leaders from diverse communities are involved in initiatives that can build and strengthen family and consumer partnerships for all MCH programs.

II.F.4. Health Reform

Supporting Health Reform Efforts: MDHHS, as the agency that oversees Michigan's Title V Maternal and Child Health Block Grant, actively supports health care reform efforts. Affordable Care Act (ACA) coverage expansions provided Michigan consumers with two new options: the Healthy Michigan Plan (HMP) and the Health Insurance Marketplace (Marketplace). In January 2014, eligible individuals who were above 133% of the federal poverty level (FPL) could enroll in private health insurance coverage through the Marketplace. In April 2014, Michigan expanded its Medicaid program to cover residents aged 19-64 who were at or below 133% of the FPL, and who were not previously eligible for traditional Medicaid. Between the HMP and the Marketplace, Michigan insured over 700,000 people in less than a year, far exceeding initial enrollment expectations. Outreach and enrollment assistance efforts were implemented by Children's Special Health Care Services (CSHCS), local health departments (LHDs) and others including Child and Adolescent Health Centers (CAHCs) and Federally Qualified Health Centers.

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

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

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

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

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

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

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

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

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

II.F.5. Emerging Issues

MDHHS Reorganization

As noted in the Overview of the State, the Michigan Department of Health and Human Services (MDHHS) underwent a reorganization within the Population Health and Community Services Administration in April 2016. As part of this reorganization, the Children's Special Health Care Services (CSHCS) Division was moved into the Medical Services Administration, which is the State Medicaid Agency. The Children's Special Health Care Services Program provides a medical care and treatment benefit to over 40,000 eligible clients each year. Two-thirds of these clients are dually enrolled in Medicaid. Organizationally aligning CSHCS with Medicaid should support more effective and efficient service delivery in the areas of prior authorization, pharmacy, managed care, customer service, quality assurance, program policy, and program development.

The Bureau of Epidemiology and Population Health was also newly created as part of the reorganization. The Division of Family and Community Health (DFCH) was placed in this new bureau and continues to provide maternal and child health (MCH) leadership in Michigan, including the Division Director serving as the state's MCH Director. The new Bureau also houses the Divisions of Epidemiology and Genomics, Environmental Health, and Communicable Diseases. Aligning these divisions within the Bureau is intended to strengthen the life course approach to population health, in recognition of the critical role maternal, infant, child, and adolescent health play in impacting the overall health trajectory of individuals into adulthood. MCH in Michigan has developed a comprehensive life course metrics framework that integrates the impact of social determinants of health, and focuses on the relationship of health outcomes

to resourced communities and effective systems infrastructure. In recent years, the MCH and Epidemiology program areas within MDHHS have worked closely to connect these areas, with the goal of strengthening the use of evidence-based practices and integration of health equity across all program areas. Bringing these areas into one administrative entity is already proving to be effective. That said, the need for multi-faceted and cross-department, cross-systems collaborative planning and coordination of services remains deeply embedded across MCH responsibilities. Understanding the need for this "horizontal" and cross-systems coordination is now growing at both state and local levels.

Flint Water Crisis

The Flint water crisis is a driving issue for MCH activities in Michigan. MCH leaders at MDHHS are collaborating with federal, state and local partners to help address the crisis. MCH has and continues to lead activities related to blood lead testing services, case management services, and enhanced education about nutrition and safety.

MCH staff are collaborating with WIC and MSA to support access to blood lead testing in Flint. This includes testing children at ages one and two in accordance with Medicaid policy and AAP Bright Futures recommendations, as well as venous confirmation of capillary tests and appropriate follow-up testing for a child or adult who has an elevated blood lead level. In particular, MCH is focused on the Flint and statewide issue of confirming capillary tests, related to our State Performance Measure (SPM).

Case management services to support children and families is another critical piece of the response in Flint. In October 2015, Michigan's Legislature appropriated new state funding for

case management for children with elevated blood lead (EBL) levels. Nurses and social workers collaborate with families to identify potential sources of lead exposure, and mitigate that exposure. Specific activities include assessing children's health, nutrition, and development; developing and implementing a plan of care to address any issues or concerns for the family, including housing, transportation, access to food, water and filters; facilitating additional blood lead testing to monitor the child's status; and supporting access to in-depth Environmental Investigations and support to abate or fix identified hazards.

Because long-term support and monitoring will be critical in Flint, the EBL Case Management will be augmented by Targeted Case Management (TCM) under a Waiver approved by the Centers for Medicare and Medicaid Services (CMS), through the MDHHS Medical Services Administration (MSA). TCM will chronologically follow EBL Case Management for children with documented EBLs, but is also available to a broader population of children and pregnant women exposed to Flint water (e.g., not dependent upon the results of a blood lead test). MCH staff are coordinating efforts with MSA to assure that the EBL Case Management and TCM will be aligned and coordinated, in order to support long-term success of children and families in Flint. Additionally, MCH staff are working with the Adult Blood Lead Epidemiology and Surveillance (ABLES) program at Michigan State University to support implementation of case management services for adults in Flint with elevated blood lead levels.

MCH has also worked collaboratively with the Michigan Department of Education to expand school nursing, behavioral health and school-based health center capacity in the City of Flint's K-12 public and charter schools. Three additional school-based health center programs will be

fully operational by September 2016, providing comprehensive primary care and behavioral health services to students in their jurisdiction. Additionally, nine full-time school nurses were hired and placed in all Flint public school buildings in spring 2016 to provide nursing support, chronic disease case management and acute care for students. All of these sites will provide onsite Medicaid outreach and enrollment to students and families.

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

Furthermore, MCH has focused on activities to educate and enhance safety and nutrition. This includes working with the Flint emergency response structure to develop and distribute educational materials about lead for families and the health care community, including specific materials about breastfeeding, online modules about nutrition to mitigate the impact of lead exposure; exploring the expansion of WIC; and promoting access to fresh produce and access to summer food programs for breakfast, lunch and weekend meals.

Looking ahead, MCH will work with partners in Medicaid and Children's Special Health Care Services to learn from activities implemented in Flint and modify how EBL case management services are offered statewide, with an enhanced case rate; enhanced training and support; improved monitoring; and enhanced collaboration between case management providers, Medicaid Health Plans, and primary care providers. Any new educational materials developed for Flint regarding blood lead testing, nutrition, and safety will also be modified for statewide use and integrated into the improved case management process and other statewide education and outreach efforts.

Zika

Michigan maintains a vigilant response to the Zika virus regarding the current and potential impacts to the maternal and child health populations of the state. Michigan has a multi-prong approach that includes active surveillance and monitoring, testing capacity, and education and information dissemination. In May 2016, the MDHHS state laboratory began conducting diagnostic testing for Zika, dengue and chikungunya (all mosquito-borne viruses). Michigan also participates in the Centers for Disease Control and Prevention Zika Pregnancy Registry.

Multiple communication efforts are underway to disseminate information to the maternal and child populations throughout the state. To date, communication efforts have included the following:

- Communication with local health departments and other maternal and child health stakeholders via email, Michigan Health Alert Network (MIHAN), and memorandums.

- A webinar held by the Michigan Medical Director regarding the Michigan Zika Response with Health Centers (i.e., Federally Qualified Health Centers) throughout the state that serve more than 600,000 residents annually, including approximately 97,000 migrant farm families.
- The Michigan Home Visiting Initiative, serving pregnant women and their infants, has shared Zika virus information through direct email communication and also distributes information to approximately 700 stakeholders, who receive bi-monthly newsletters.
- The MDHHS Title X Family Planning program, serving primarily low-income, uninsured, underinsured, and underserved women and men of reproductive age, has regularly forwarded information about the emerging Zika threat to its providers since January 2016 and has sent memorandums providing guidance to providers regarding screening clients for travel risks and providing education, counseling, and appropriate referrals.

Michigan will continue to monitor and respond to the Zika virus in FY 2017.

Adolescent Health

An emerging adolescent risk-taking behavior on the rise that needs attention is e-cigarette use. In April 2015, the CDC reported that e-cigarette use now exceeds use of every other tobacco product. Current e-cigarette use among middle and high school students tripled in one year (2013 to 2014). While e-cigarette use was reported as the most common tobacco product used by high school students (13.4%), it was closely followed by hookah (9.4%), regular cigarettes (9.2%) and cigars (8.2%). Nearly half of students in both age groups reported using multiple tobacco products. Risk-reduction/cessation counseling by a provider trained in Motivational

Interviewing, provided within the framework of a comprehensive preventive visit, complements macro-strategies designed to reduce tobacco use among youth including product and marketing regulations, enforcement strategies (e.g., smoke free laws and policies), and increased pricing/taxes and media campaigns.

Children with Special Health Care Needs

Michigan currently screens newborns for more than 50 disorders, with all newborn screening (NBS) disorders medically eligible for CSHCS enrollment. Given new testing and treatment, Michigan's NBS panel will continue to expand, significantly impacting the Children's Special Health Care Services (CSHCS) program. The addition of critical congenital heart disease in 2014 added 12 serious heart conditions needing treatment, typically surgery, and often multiple-staged surgeries in the first year of life. Michigan recently added Pompe disease (glycogen storage disease type 2) to the panel which may identify two babies with early onset disease and seven with late onset disease each year. Treatment requires enzyme replacement therapy (ERT) every two weeks for the rest of an affected individual's life, with a number of specialists involved in their care.

Mucopolysaccharidosis type I and X-linked adrenoleukodystrophy (X-ALD) have been added to the panel in 2016. One to two newborns a year with MPS I are expected to be identified, typically requiring treatment with ERT and hematopoietic stem cell transplant (HSCT). Screening for X-ALD is expected to identify about seven children annually who will need HSCT in addition to other services. These screens also identify individuals with later onset or milder forms of disease who will need long-term diagnostic monitoring to ensure medical intervention at the

appropriate time. This may include, for example, aggressive monitoring for early CNS signs through frequent MRI. Implementation of screening for Pompe, MPS I and X-ALD is currently pending availability of Food and Drug Administration (FDA) approved laboratory test kits, but is expected to begin by the end of 2016 or early 2017.

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

Cross-Cutting

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

The roles of LHDs as facilitators of access to MCH services and as navigators within this new health care environment are growing. LHDs will need to expand on their current activities of referrals for, and assisting in, obtaining coverage or services to focus on the essential public health functions for their communities—as well as on the infrastructure changes required to fulfill these roles. The state will support LHDs in their changing and broadening roles as the

impact from health care reform continues, whether it is with expanded health care eligibility and access or through participation in the State Innovation Model.

II.F.6. Public Input

The Michigan Department of Health and Human Services (MDHHS) engaged an array of stakeholders, including parents and consumers, prior to and during the Title V application process. In 2014-2015, MDHHS completed a statewide five-year needs assessment to identify strategic issues and priority needs to drive creation of the 2016-2020 state action plan. When determining the process to be used, the Needs Assessment Planning Committee prioritized the need to engage a diverse group of stakeholders to assess both needs and system strengths and capacity. As a result, the needs assessment workgroups (which reflected the six population health domains) included state and local MCH staff, state and local MCH system partners, parent consultants, consumers, and partners with expertise in health equity. Their input and experience directly shaped the issues and priority needs considered and included in Michigan's five-year application.

In 2016, once the Title V FY 2017 application/FY 2015 annual report was drafted, it was posted on the MDHHS website for public review and comment. Public input was invited through direct notification via email to advisory groups, local health departments, nonprofit partners, advocacy groups and other state programs. Stakeholders (including parents and consumers) who participated in the 2015 needs assessment workgroups received direct notification of the posting. Public input will be shared with the Title V steering committee for review and consideration prior to the July 2016 submission date. The number and nature of public comments received, and how they were addressed, will be included in the final grant submission.

After the application has been submitted, MDHHS will continue to work with entities representing advocates, advisory bodies, providers and consumers to receive input on the programs, policies, reports and plans included in the Title V application. For example, the Children's Special Health Care Services (CSHCS) division works routinely with parent consultants through the Family Center for Children and Youth with Special Needs (Family Center) and the CSHCS Advisory Committee (CAC). The Family Center provides information and support to families and input on CSHCS program operations. The CAC is comprised of professionals and family members who are involved in the care for children with special needs. The CAC makes recommendations to the CSHCS Division on policy and promotes awareness to assure that services reflect the voices of individuals with special health care needs and their families.

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

II.F.7. Technical Assistance

Throughout FY 2016 and during completion of the grant application, the Title V core team discussed potential areas of training and/or technical assistance that may be needed in the future. The following areas were identified:

- Sharing of best practices and other peer learning opportunities (e.g., between states or within regions) for National Performance Measures (NPMs)
- Ongoing learning opportunities and technical assistance related to identification, refinement, and assessment of evidence-based and evidence-informed strategy measures (ESMs)
- Best practices and tools related to ongoing needs assessment activities, including data monitoring and MCH infrastructure
- Tools and training on how to most effectively engage MCH consumers, parents, and other stakeholders
- Connection to other states and best practices related to supporting local health partners in implementing new requirements and priorities as they relate to Title V

Michigan appreciates the training and technical assistance HRSA has provided over the past year, especially in relation to ESMs, NPMs, and TVIS via Webinars and Learning Labs. Similar and timely support in the future—especially for new Title V requirements or high priority components—would continue to be helpful.

III. Budget Narrative

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

For the 2015 fiscal year for the Local Maternal and Child Health (LMCH) appropriation, the state accounting system tracked expenditures by Preventive and Primary Care Services for all Pregnant Women, Mothers and Infants up to the age of one; Preventive and Primary Care Services for Children; and Services for Children with Special Health Care Needs to assure the 30% match was properly documented. In FY 2016, the State of Michigan established coding in the LMCH appropriation for Direct Services for Preventive and Primary Care Services for all Pregnant Women, Mothers and Infants up to Age One, Preventive and Primary Care Services for Children, Direct Services for Children with Special Health Care Needs, Enabling Services and Public Health Services and Systems to properly record expenditures related to categories designated in the Title V block grant application.

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

budget Form 2 for additional details related to the Title V budget and expenditures that support Maternal and Child Health Programs and services.

Please refer to the draft budget Form 2 for details related to the Title V budget and expenditures.

Form 2

MCH Budget/Expenditure Details

State: Michigan

	FY17 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 19,025,100	
A. Preventive and Primary Care for Children	$ 6,024,900	(31.7%
B. Children with Special Health Care Needs	$ 7,108,800	(37.4%
C. Title V Administrative Costs	$ 599,000	(3.1%
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 77,234,300	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,013,200	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 68,027,100	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 146,274,600	
A. Your State s FY 1989 Maintenance of Effort Amount $ 13,507,900		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424	$ 165,299,700	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	$ 317,334,268	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 482,633,968	

OTHER FEDERAL FUNDS	FY17 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Abstinence Education Grant Program	$ 1,574,727
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,635,544
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Birth Defects and Developmental Disabilities	$ 210,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 175,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 191,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State and Local Healthy Homes and Childhood Lead Poisoning Prevention Programs (CLPPPs)	$ 327,353
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > State Oral Disease Prevention Program	$ 741,121
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	$ 7,493,705
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Medicare Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 104,644,000
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 1,500,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 95,374
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Ryan White	$ 1,057,813
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 7,275,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 190,163,631

	FY15 Application Budgeted		FY15 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 18,682,500		$ 18,033,339	
A. Preventive and Primary Care for Children	$ 6,012,500	(32.2%	$ 5,401,415	(30%
B. Children with Special Health Care Needs	$ 7,250,600	(38.8%	$ 7,074,731	(39.2%
C. Title V Administrative Costs	$ 332,500	(1.8%	$ 447,849	(2.5%
2. UNOBLIGATED BALANCE (Item 18b of SF-424)	$ 0		$ 0	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 41,309,700		$ 44,147,168	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 1,009,300		$ 469,940	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 67,522,400		$ 63,984,361	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 109,841,400		$ 108,601,469	
A. Your State s FY 1989 Maintenance of Effort Amount $ 13,507,900				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Same as item 18g of SF-424)	$ 128,523,900		$ 126,634,808	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	$ 316,990,885		$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 445,514,785		$ 126,634,808	