Maternal and Child Health Services Title V Block Grant

Michigan

FY 2024 Application/ FY 2022 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

A Letter of Transmittal will be uploaded prior to submission.

I.B. Face Sheet

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

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

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

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

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

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

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

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

State action plans for NPMs and SPMs in Section III.E. include information on objectives and strategies, metrics, program planning and improvement, and family and consumer engagement. A brief summary of each NPM and SPM is presented below.

Women/Maternal Health

The first goal in this domain is to decrease the percent of cesarean deliveries among low-risk first births (NPM 2). Michigan’s percentage of low-risk cesarean deliveries has consistently been higher than the US and has been slower to decrease over time. Michigan has also seen increases in low-risk cesarean deliveries to Black birthing individuals (from 29.6% in 2012 to 32.2% in 2021) while the percentage of low-risk cesarean deliveries to White birthing individuals has decreased (from 29.5% in 2012 to 28.2% in 2021) (MDHHS, Division for Vital Records & Statistics). However, both Black and White individuals saw an increase in low-risk cesarean deliveries from 2020 to 2021 (from 30.9% to 32.2% for Black; from 28.0% to 28.2% for White). The Title V plan focuses on reducing the overall rate of low-risk cesarean deliveries while focusing on disparities among women of color. Strategies include working with Regional Perinatal Quality Collaboratives (RPQCs) to implement the Michigan Alliance for Innovation on Maternal Health (MI-AIM) bundle, providing bias and equity training for providers, and increasing the number of birthing hospitals participating in MI-AIM.

The second goal in this domain is to increase the percent of individuals with a preventive dental visit during pregnancy (NPM 13.1). In 2021, 53.6% of Michigan women had their teeth cleaned during their most recent pregnancy, an increase over the 40.8% who reported doing so in 2020 (MI PRAMS). However, Non-Hispanic Black individuals saw a decrease in preventive dental care during pregnancy during the COVID-19 pandemic, dropping from 41.3% in 2019 to 35.2% in 2020, although these numbers increased to 41.6% in 2021 (MI PRAMS). Strategies to increase dental visits include training for medical and dental providers who treat and refer pregnant people; increasing the number of socioeconomically disadvantaged pregnant people receiving oral health care services; and exploring alternative models of care for service delivery.

The third goal is to increase the percent of individuals who have an intended pregnancy (SPM 5). While Michigan has seen a modest increase in the rates of pregnancy intention from 2012 (52.2%) to 2021 (59.0%), White mothers (68.5%) were 1.7 times as likely as Black mothers (40.2%) to report their most recent pregnancy was intended (2021) (MI PRAMS). The state action plan focuses on increasing access to contraception by making most or moderately effective contraceptive methods readily available and by improving the quality of contraceptive care by assessing client-centeredness and offering equity trainings for reproductive health care providers.

Perinatal/Infant Health

The first perinatal/infant health goal is to increase the percent of infants who are ever breastfed and the percent of infants breastfed exclusively through six months (NPM 4). While breastfeeding rates have increased in Michigan, exclusivity rates still fall short of state goals. In Michigan, 82.5% of infants are ever breastfed (2020) and 25.8% are exclusively breastfed through six months (MDHHS, Division for Vital Records & Statistics; National Immunization Survey 2020 Breastfeeding Report Card). According to PRAMS, initiation rates among Black mothers continue to be 12% lower than White mothers (2020). To increase breastfeeding rates, MDHHS will implement strategies to support and promote access to breastfeeding professionals and peer counseling and increase the number of Baby-

Friendly© hospitals. To address disparities, Michigan will support non-Hispanic Black individuals who initiate breastfeeding through promotion of culturally responsive messages, racially and culturally diverse breastfeeding professionals, and community-based breastfeeding organizations.

The second goal is to increase the percent of infants placed to sleep in safe sleep environments (infants placed to sleep on their backs, in cribs without objects) (NPM 5). In 2019, 149 sleep-related infant deaths occurred in Michigan (Centers for Disease Control and Prevention Sudden Unexpected Infant Death Case Registry, 2010 to 2019, Michigan Public Health Institute, 2021). Sleep-related infant deaths are a leading type of death for infants aged 1-12 months old (2018-2020 Michigan Resident Infant Death File, Division for Vital Records & Health Statistics, MDHHS). Data between 2016 and 2021 reveal state level improvements in infants reported as sleeping with no soft objects and in a separate approved sleep surface, although the last five years have shown a decline in back sleep position among Hispanic respondents (90.3% in 2016 to 72.9% in 2021, Michigan PRAMS). MDHHS strategies focus on increasing safe sleep behaviors by all families, while also addressing the disparity for non-Hispanic Black infants. Strategies include supporting local safe sleep activities; working with providers to ensure safe sleep education and resources for families; developing tools for client/patient centered safe sleep conversations; promoting protective factors; and working with hospitals in areas with high rates of sleep-related infant deaths.

Child Health

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

A second goal is to increase the percent of children less than 72 months of age who receive a venous lead confirmation testing within 30 days of an initial elevated capillary test (SPM 1). Between 1998 and 2021 Michigan made progress reducing lead poisoning, with the percentage of birth to six-year-old children in Michigan with blood lead levels >5 ug/dL decreasing from 44.1% to 2.3%. Yet some communities still experience higher rates of lead poisoning. Confirming elevated capillary results with a venous test is key to facilitating follow up. Progress has been made, with MDHHS data indicating a rise in venous confirmation testing within 30 days of an initial elevated capillary test from 16.1% in 2013 to 45.3% in 2021. Due to the COVID-19 pandemic and recalls in blood lead testing kits, Michigan saw a significant drop in blood lead testing for children under 6 years old. To continue to make progress, Michigan will screen for lead exposure risk factors in children; conduct provider education; and work to increase blood lead testing for all children, especially those who are Medicaid-enrolled.

MDHHS is working to increase the percentage of children ages 19-35 months who are up-to-date with all recommended vaccines (SPM 2). The estimated percentage of children in this age group who received all age-appropriate recommended vaccines was 66.1% in 2022 (Michigan Care Improvement Registry). The COVID-19 pandemic negatively impacted childhood vaccination rates in Michigan. Strategies to increase vaccination rates include targeted outreach to parents of children who are overdue for a vaccine; vaccine outreach to areas with a high social vulnerability index; working with local health departments to reach under-vaccinated populations; and working with stakeholders to promote vaccine confidence among parents of this age group.

Adolescent Health

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

A second goal is to increase the percent of adolescents who have received a completed HPV vaccine series (SPM 3). As of December 2022, 72.8% of adolescents ages 13 through 17 years were current with immunizations, but that percentage dropped to 42.8% when HPV series completion was included (MCIR). However, Michigan has improved the percentage of adolescents receiving at least one dose of the HPV vaccine, and in 2021 64.7% of Michigan adolescents were up to date with the HPV series (NIS-Teen). To boost HPV completion rates and increase protection from HPV-related diseases, MDHHS will update HPV materials to ensure an equitable approach to vaccine hesitancy; increase vaccine confidence among parents and adolescents; and work with local health departments, providers, and health systems to implement quality improvement strategies and measures.

Children with Special Health Care Needs (CSHCN)

A goal is to increase the percent of adolescents with special health care needs who receive services necessary to make transitions to adult health care (NPM 12). In Michigan, 20.0% of CYSHCN reported they received services necessary to transition to adult health care, which is comparable to the US at 20.5% (NSCH 2020-2021). To improve transitions to adult care, efforts will include expanding Health Care Transition (HCT) activities to students through school-based clinics; marketing the revised CSHCS website and the Got Transition health professional course; revising MHP contract language to incorporate additional HCT activities; and expanding the assessment of health care transition activities to include additional partner organizations.

Another goal is to increase the percent of CSHCN enrolled in CSHCS who receive timely medical care and treatment without difficulty (SPM 4). CSHCN often require and use more health care services than other children. Health care costs can pose significant burdens for families, even with private insurance. CSHCS helps to cover the costs of specialist medical care and treatment. In FY 2022, an average of 41,000 individuals were covered by CSHCS each month. Strategies to increase access to high-quality services include covering specialty care and treatment costs for qualifying conditions; expanding access to specialty clinics and the use of telemedicine; improving outreach and advocacy services; and enhancing the CYSHCN system of care.

Cross-Cutting

The needs assessment identified unmet mental health needs in the women/maternal health, adolescent health, and CSHCN domains. A goal across these domains is to support access to developmental, behavioral, and mental health services (SPM 6). In 2021, over 24.3% of Michigan women ages 18-44 years reported more than two weeks of poor mental health during the prior 30 days (Behavioral Risk Factor Surveillance System). Postpartum depression symptoms were reported by 16.1% of mothers in 2020 (MI PRAMS). In 2021, 40.3% of adolescents reported two or more weeks of sad or hopeless feelings and 19.0% considered suicide (YRBS). Among CSHCN with a mental or behavioral health diagnosis, 68.1% received appropriate treatment in 2019-2020 (NSCH). The Title V program will support the work of local health departments in addressing behavioral health needs; support perinatal screenings among RPQCs; increase collaboration between Title V CSHCS and behavioral health partners; and support the Handle with Care initiative for school-aged children and adolescents.

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

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

Title V funding also supports the MCH work of all 45 Local Health Departments (LHDs). Collectively, LHDs are allocated approximately 36% of Michigan's Title V dollars through the Local MCH (LMCH) program which awards annual, noncompetitive grants to each LHD. LHDs serve as Michigan's local public health "arm" through community-based services and systems. Title V funding administered through the LMCH program helps to ensure the delivery of core MCH services while addressing state identified priorities and locally identified needs. These local activities complement the state's public health infrastructure and state-led work in supporting the health of the MCH population. For example, Title V funding at the local level provides the MCH population with increased access to and provision of gap-filling services such as immunizations and childhood lead screening. Title V funding is also used for enabling services such as breastfeeding support and safe sleep training for parents and providers. Public health services and systems are supported through health promotion campaigns, health equity practices, needs assessments, and collaboration with Neonatal Intensive Care Units (NICUs) in relation to CSHCS services. Throughout the COVID-19 pandemic, LHDs have also been able to redirect LMCH funds to support COVID-19 activities related to the MCH population, as needed.

III.A.3. MCH Success Story

Many efforts outlined in the Mother Infant Health & Equity Improvement Plan (MIHEIP) are driven forward through efforts of the Michigan Perinatal Quality Collaborative (MI PQC). The MI PQC is housed within the Division of Maternal and Infant Health (DMIH) and is comprised of nine (9) RPQCs. Each RPQC represents a prosperity region in Michigan with membership consisting of clinical and community partners committed to improving birth outcomes in their respective region. The RPQCs are tasked with authentically engaging families; convening diverse cross-sector stakeholders; improving birth outcomes through data-informed decision making and quality improvement methodology; and actively addressing health inequities and disparate outcomes.

Title V funds are used as gap-filling funds for the RPQCs and, thus, broadly support efforts within the Michigan PQC. As mentioned above, the RPQCs are required to actively address health inequities and disparate outcomes in their region. Many provide trainings or guest speakers on health equity or implicit bias for Collaborative members. While others, like the Southeast Michigan Perinatal Quality Improvement Coalition (SEMPQIC)/Region 10 RPQC, have integrated health equity into their daily efforts. SEMPQIC has established the Detroit Health Equity Education Resource (DHEER), hosted strength-based listening sessions on community supports that exist within the region, and invited Collaborative members to share health equity tools used in their work.

Many of the RPQCs have also focused efforts on perinatal substance use initiatives, such as adding pregnancy-related information to a local substance use recovery website, MI Recovery; implementing rooming-in programs in some regional birthing hospitals; implementing the High Touch, High Tech (HT2) universal electronic screening tools in prenatal care clinics; and establishing the UP MOM program, a community health worker model that provides holistic support and care coordination for pregnant and postpartum people with a history of, or currently experiencing, opioid use disorder.

In FY 2022, the MI PQC received funding from the Centers for Disease Control and Prevention (CDC) to support increased capacity of the MI PQC to conduct perinatal quality improvement initiatives that make measurable improvements in perinatal care and outcomes. It is expected that through these efforts, Michigan will see an increased participation of birthing hospitals in the PQC, as well as increased implementation of patient safety bundles and other quality improvement efforts to reduce disparities in perinatal outcomes. To achieve these goals, the MI PQC is partnering with the Regional Perinatal Quality Collaboratives, the Michigan Alliance for Innovation on Maternal Health (MI AIM) and the Michigan Health and Hospital Association (MHA).

III.B. Overview of the State

Geography, Demographics, and Economy

Michigan is the only state made up of two peninsulas and has the longest freshwater shoreline in the world. Comprised of 83 counties, Michigan is the 10th most populous state and 11th largest state by total square mileage. Approximately 10 million people live in the state (2020 Census). Compared to other states, Michigan had the 32nd lowest rate of population change from 2021 to 2022, and estimated 36th lowest birth rate in 2022. Most of Michigan's population resides in the southern half of the Lower Peninsula, with approximately half of the population residing in Southeast Michigan. The state's largest cities are Detroit, Grand Rapids and Warren. Over 1.8 million people live in rural areas. The median age of the population is 40.2 years. Out of the total population, approximately 22.1% are ages 0-17 and 77.9% are ages 18 and over. Michigan's population is 79.0% White, 14.1% Black or African American, 3.4% Asian, 2.7%, two or more races, and 0.7% American Indian and Alaska Native[1]. Out of the total population, 5.6% identify as Hispanic or Latino.

Michigan's economy saw improvements over the nine years leading up to 2020. While the seasonally adjusted unemployment rate decreased from 14.9% in June 2009 to 4.0% in January 2019, the unemployment rate spiked to 22.7% in April 2020 at the start of the COVID-19 pandemic. The economic impact of COVID-19 was significant, but Michigan's 2022 labor market continued to show improvement with an annual jobless rate only 0.2 percentage points above the 2019 pre-pandemic rate. Michigan's seasonally adjusted unemployment rate was 4.3% in December 2022, compared to 5.1% in December 2021.

However, the economic recovery has been uneven across the state. According to the 2021 ALICE (Asset Limited, Income Constrained, Employed) report, 38% of households in Michigan struggled to afford the basic needs of housing, childcare, food, technology, health care and transportation. The 2020 poverty rate in rural Michigan was 12.1%, compared with 12.8% in urban areas (USDA Economic Research Service). According to the 2022 Kids Count, Michigan ranks 27th in health, 29th in both economic and family wellbeing, and 40th in education for children. The percent of children ages 0-17 who live in poverty is 16.8% and certain areas of the state experience higher levels of poverty. Statewide, 51.1% of students receive free and reduced-price lunch.

Roles and Priorities of the State Health Agency

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

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

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

Michigan's MCH programs align with several of these goals. The 2020-2023 Mother Infant Health & Equity Improvement Plan (MIHEIP) focuses on the mother-infant dyad to achieve the vision of "Zero preventable deaths, Zero health disparities." The MIHEIP provides a framework for expanding partnerships and strategies to enhance local and state efforts in addressing the root causes of adverse outcomes—social determinants of health and systemic racism. A Year Three Update was released in September 2022 to highlight stakeholder achievements and updated indicator data.

The current MIHEIP sunsets in 2023, with a new iteration, Advancing Birth Equity, to be released in September 2023. Much like the current plan, the contents and structure will be developed collaboratively by MDHHS and stakeholders and informed by input garnered from regional town hall meetings, the Mother Infant Health and Equity Collaborative (MIHEC), Regional Perinatal Quality Collaboratives (RPQCs), Michigan families, MCH stakeholders, health care providers, and community leaders. Implementation of the MIHEIP relies on internal alignment of programs within MDHHS; quality improvement efforts of RPQCs; and external implementation through community partners and health care providers.

Improving maternal and infant health outcomes continues to be a priority for Gov. Whitmer. In 2020, Gov. Whitmer released the Healthy Moms, Healthy Babies initiative to address health disparities and ensure all women have access to high-quality health care. Expansion of Healthy Moms, Healthy Babies continues through allocations in the state budget. The FY 2021 and FY 2022 budgets allocated funds to increase access to evidence-based home visiting and continuous postpartum Medicaid coverage for 12 months postpartum. The FY 2023 budget allocated funds to support doula infrastructure and increase investment in Early On. The Governor's FY 2024 budget recommendations include increased funding for Healthy Moms, Healthy Babies and expanded access to family planning services, the Michigan Perinatal Quality Collaborative, Centering Pregnancy, Levels of Maternal Care and the Michigan Alliance for Innovation on Maternal Health.

Additionally, a Home Visiting Advisory is charged with building an integrated home visiting system for families. Michigan's evidence-based home visiting (EBHV) system includes the Maternal Infant Health Program, Nurse-Family Partnership, Healthy Families America, Early Head Start-Home Based, Parents as Teachers, Infant Mental Health, Play and Learning Strategies, and Family Spirit. The Advisory is intended to have an active role in system development through discussions about centralized access, professional development, and equity. Title V leadership participates in the Advisory.

Michigan is expanding EBHV to better support families who have been impacted by child welfare involvement and family separation. The first expansion is to implement EBHV in seven high-risk counties under the Families First Prevention Services Act. The Children's Services and Public Health Administrations are partnering on this initiative.

The second expansion is to support families with infants who have been exposed prenatally to substances in 10 communities with high rates of maternal substance misuse. The project is piloting Peer Navigators within the healthcare system to break down barriers of shame and stigma. Peer navigators will connect families to resources, including EBHV, and will provide support 12 weeks postpartum.

Early childhood partnerships and systems building are also critical to supporting children and their families. The Office of Great Start (OGS) within the Michigan Department of Education (MDE) leads the integration of the state's healthy development and early learning investments for prenatal to age 8. MDHHS collaborates with OGS to support the development of early childhood systems that meet the needs of children and families. The Great Start Operations Team (GSOT) convenes state agencies and partners to provide strategic direction for early childhood integration and coordination. Several MDHHS program areas, including Title V and home visiting, serve on the GSOT. GSOT work is grounded in Michigan's early childhood outcomes which include "children born healthy" and "children healthy, thriving, and developmentally on track from birth to third grade."

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

Advancing equity is a priority within the State of Michigan and MDHHS. At the state level, Gov. Whitmer implemented several initiatives to address implicit bias, racism, and racial disparities. Executive Directive 2019-09 established Equity and Inclusion Officers within each state department. Executive Directive 2020-07 required implicit bias training for licensed health care professionals. Racism was recognized as a public health crisis in August 2020 through Executive Directive 2020-09. As part of that directive, all state employees must complete an implicit bias training. Related goals have included building Diversity, Equity, and Inclusion (DEI) infrastructure and leadership and measuring DEI efforts across state departments.

In response to COVID-19, Gov. Whitmer created the Michigan Coronavirus Task Force on Racial Disparities in April 2020. The Task Force investigated causes of COVID-19 racial disparities and recommended actions to address disparities including transparency in data reporting; reducing medical bias in testing and treatment; and developing systems to support economic recovery and access to physical/mental health care. MDHHS collaborated with the Task Force to establish 22 Neighborhood Testing Sites in 15 communities. A data-driven approach used the CDC's Social Vulnerability Index and mortality data for six comorbid conditions associated with increased risk of adverse COVID-19 outcomes. MDHHS partnered with churches, colleges, community-based organizations, and cultural brokers to establish neighborhood testing sites. Between August 2020 and November 2022, neighborhood testing sites hosted 7,365 testing events, administering at least 364,104 COVID-19 tests (PCR, Antigen). The Taskforce released a final report in February 2023.

At the departmental level, MDHHS is working to assess and change policies and programs to support DEI. The MDHHS DEI Plan, rolled out in 2018, details the Department's "commitment to eliminating systematic inequities and promoting diversity, equity and inclusion." A DEI Council was created to promote and foster a culture that values DEI throughout MDHHS and the diverse communities it serves. In October 2020, the Race, Equity, Diversity, and Inclusion (REDI) Office was created to address racial, health, social and wealth disparities. MDHHS' Equity and Inclusion Officer is the director of the REDI Office. The MDHHS Office of Equity and Minority Health (OEMH) is part of REDI and delivers an annual Health Equity Report to the state legislature. The OEMH also provides training and technical assistance to the MDHHS workforce on implicit bias, systemic racism, cultural and linguistic competency,

health equity, and equitable community engagement.

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

In response to Executive Directive 2020-09, the OEMH was selected to pilot the Equity Impact Assessment (EIA) in coordination with the Governor’s Office and completed the EIA in 2022. The EIA also responds to the Biden-Harris administration’s Executive Order 13985 on Advancing Racial Equity and Support for Underserved Communities. The EIA is intended to “inform decisions and create more equitable solutions by identifying potential unintended impacts of a policy, program or initiative on marginalized populations” (Health Equity Report). MDHHS is currently streamlining and making efficiencies based on the pilot process. An EIA Expansion phase will be rolled out between October 2023 and September 2026 with 8-15 new work areas at MDHHS and other state government agencies.

Lastly, the MDHHS Office of Policy and Planning led development of a collaborative, statewide Social Determinants of Health (SDOH) Strategy. The goal of the SDOH Strategy is to “Improve the health and social outcomes of all Michigan residents while working to achieve health equity by eliminating disparities and barriers to social and economic opportunity.” Phase 1 of the SDOH Strategy included the release of “Michigan’s Roadmap to Healthy Communities.” The initial focus areas are health equity, housing stability, and food security. Phase 2 of the SDOH Strategy launched with a virtual summit in January 2023. Phase 2 explores community health worker expansion, community information exchanges, and bridging food security and housing stability efforts. REDI-OEMH is partnering on this effort.

Equity is also being addressed within MCH programs. In addition to strategies to achieve equity discussed in state action plans, MCH activities include:

- The Medicaid doula reimbursement policy went into effect January 1, 2023. The policy allows for Medicaid recipients to receive doula care under their Medicaid health plan. A Doula Council with statewide representation, including tribal doulas, was created to inform the advancement of doula services in Michigan.
- The Infant Safe Sleep program allocates funds and provides technical assistance in an equitable, data-driven manner. Funding is allocated to five local health departments and the Inter-Tribal Council of Michigan whose geographical areas account for over 50% of sleep-related infant deaths.
- MIHP engaged the Michigan Public Health Institute (MPHI) to promote health equity and inclusion among staff to better understand the needs of diverse MIHP agencies and apply best practices. MPHI also provides DEI training for agencies.
- MIHP holds bi-weekly Health Equity Meetings to ensure program documents and services are created using an equity lens. At the local level, MIHP agency staff are required to take a Health Equity and Systemic Racism course to ensure that staff are equipped to provide equity-based services tailored to family needs. Licensed social workers and registered nurses who provide MIHP case management services are required to pursue education on implicit bias and its effect on service delivery. They also assist in referring families to community supports like healthy food, transportation, and housing.
- The Early Hearing Detection and Intervention DEI plan was designed to decrease the number of children “lost to follow up” after a failed hearing screen by addressing medically underserved geographies/populations. The

plan includes efforts to investigate local data sources, establish local improvement teams, explore barriers to follow up, and develop targeted outreach and education strategies.

- To improve perinatal and birth outcomes, Regional Perinatal Quality Collaboratives (RPQCs) address disparate outcomes in their quality improvement efforts and actively address health inequities and social determinants of health.
- The DMIH DEI Council was formed in September 2022. The council meets monthly to move health equity in the division forward. Short term goals include creating an internal DEI mission statement and creating an equity in hiring framework.
- DCAH participated in the MIECHV Health Equity CoIIN and supported local agencies to test and implement equitable practices. Core knowledge expectations for home visitors were updated to include equity. Technical assistance was provided for local staff regarding equitable recruitment, hiring, and pay. Focus groups were held with home visiting parents regarding SDOH.
- DCAH facilitated discussions with advisory bodies about language that promotes equity and is updating an environmental scan of the division's DEI activities.
- The Bay Area Regional Health Inequities Initiative framework was incorporated into ECCS grant activities.
- Families were engaged to update the cultural competence and diversity training module in the Parents Partnering for Change training.
- DCAH provided DEI training to grantees and expanded use of the Rapid Adolescent Prevention Screening tool + additional SDOH questions within CAHCs to assess need and connect to local resources.
- CSHSC began a project with MPHI in FY 2022 to move equity forward and expand equity in managed care. The goal is to eliminate racial and ethnic disparities in health care and health outcomes by focusing on vulnerable populations in CSHCS. The project team is creating a valid and reliable system to quantify and monitor racial and ethnic disparities to identify gaps in care; reviewing data; and identifying performance standards to address barriers to care. Policy and contracting levers will be established to sustainably address disparities. Throughout the process, transparency and accountability will be promoted to drive improvements in disparities. The project mirrors work underway in the MDHHS Managed Care Plan Division.

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

Strengths and Challenges that Impact the MCH Population

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

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

Since March 2020, the most significant public health challenge has been the COVID-19 pandemic. In 2021 and

2022, Title V conducted assessments to gauge the pandemic's ongoing impact on the MCH population. Findings are included in prior years' Needs Assessment Updates. In 2023, assessment activities have focused on the public health workforce and broadband in Michigan which are discussed in the Needs Assessment Update. The NPM/SPM annual reports and state action plans also include information about the impact of the pandemic on programs and service delivery.

Comprehensive information on the state's COVID-19 response is available on the Coronavirus website. As of March 10, 2023, Michigan reported 3,064,125 confirmed and probable cases and 42,205 confirmed and probable deaths. Cumulative data including trends, demographics, and testing information is available on the COVID-19 Data Dashboard. The pandemic disproportionately affected certain populations in Michigan. Total cases per million are 212,024 for Black/African American in comparison to 185,343 for White. Deaths per million by race are also highest for Black/African American (4,725 per million) and American Indian/Alaska Native (4,455 per million) in comparison to White (3,543 per million). However, the disparity between Black and White death rates was nearly eliminated in 2022. The death rate for Black/African American was 8.6 per 10,000 in 2022 compared to 8.7 deaths per 10,000 for White. According to the Michigan Coronavirus Racial Disparities Task Force Final Progress Report issued in February 2023, "the stark racial disparities in death rates detected during the early COVID-19 waves, and specifically targeted by the Task Force, were virtually eliminated during the omicron and subsequent smaller waves, an outcome that compares favorably with the national experience." Death rates for American Indian/Alaska Native also decreased from 25.4 per 10,000 in 2021 to 10.0 per 10,000 in 2022.

To mitigate and contain the spread of COVID-19 and to prevent overwhelming healthcare systems, especially early in the pandemic, the State of Michigan utilized Executive Orders and MDHHS Orders (e.g., related to mask wearing and social distancing). The Protect Michigan Commission was created by executive order in December 2020 to serve in an advisory capacity to the Governor and MDHHS and to elevate the COVID-19 vaccine. The COVID-19 Vaccination Dashboard indicates that 69.5% of residents have initiated vaccination (i.e., one or more doses of any vaccine) as of March 3, 2023; 59.5% have completed vaccination. In February 2022, MDHHS adopted a new Readiness (pre-surge) – Response (surge) – Recovery (post-surge) cycle to allow the state to respond to surges in COVID-19 and adapt public health recommendations accordingly.

Efforts to address COVID-19 and to support vaccination among the MCH population include the following:

- Michigan's public schools, teachers, and students continued to feel the burden of the pandemic in 2022. Efforts to bring resources to schools included establishing onsite COVID-19 testing and reporting; launching the School Backpack Program to send home tests for families in communities at high-risk; and embedding Health Resource Advocates and School Liaisons to support testing, contact tracing, and other mitigation strategies.
- Child and Adolescent Health Centers (CAHCs) provide school-based or school-linked comprehensive primary and preventive health and mental health services for children and adolescents ages 5-21. CAHCs help students keep vaccination status up to date by providing any needed vaccines. CAHCs directly supported influenza and COVID-19 vaccination efforts during the pandemic. In FY 2022, these sites delivered 11,645 COVID-19 vaccines to youth and are continuing to deliver COVID-19 vaccines as part of routine care.
- The DMIH hired a Nurse Consultant in 2021 within the Maternal Infant Health Program (MIHP) to focus on immunization efforts. The consultant worked with a marketing firm to develop and launch a campaign in 2022 to increase awareness of immunizations. A vaccine education toolkit is under development for MIHP agencies with resources to communicate with families about vaccines during pregnancy and vaccines for infants. A required training module for MIHP agencies is being developed to focus on vaccine communication using motivational interviewing, with anticipated completion in 2023. The consultant also held trainings to

increase knowledge about immunizations and led efforts to develop web-based vaccine resources for families and MIHP agencies. In 2023, the consultant will begin site visits at MIHP agencies to consult on vaccine promotion.

- The CSHCS Vaccine Initiative addresses vaccination gaps in CYSHCN and their families. Funding is provided to LHDs to improve access to COVID-19 vaccines; expand vaccination education, messaging, and partnerships; and improve understanding of barriers to vaccination.

Components of the State's Systems of Care

Health Services Infrastructure and Financing

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

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

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

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

As of January 23, 2023, 1,062,063 beneficiaries are enrolled in HMP (HMP County Enrollment Report) which is an increase from March 23, 2020 (674,853 beneficiaries). The Medicaid program has kept Medicaid eligibility cases open until the end of the COVID-19 Public Health Emergency, which is discussed in the Needs Assessment Update.

The Healthy Michigan Plan (HMP) ensures beneficiary access to quality health care, encourages utilization of high-value services, and promotes adoption of healthy behaviors. HMP benefits include preventive/wellness services, chronic disease management, prenatal care, oral health, and family planning services. Most HMP beneficiaries are required to pay cost-sharing based on income. Some populations are excluded from cost sharing, such as individuals enrolled in CSHCS, under 21 years of age, pregnant people, and those with no income. A Health Risk Assessment gives beneficiaries the opportunity to earn incentives for engaging with the health care system. Enrollees who complete a health risk assessment and agree to maintain or address healthy behaviors, as attested

by their primary care provider, may be eligible for cost-sharing reductions.

ACA consumer protections improved access to private insurance for CSHCN by eliminating preexisting condition exclusions and discrimination based on health status, the two most frequent enrollment barriers. The ACA also expanded access to parent employer coverage for adults 19-26 years of age. The CSHCS/Healthy Michigan Plan enrollment for November 2022 was 1,418 (MDHHS Health Services Data Warehouse, 2/1/2023). LHDs, Family Resource Centers, and designated state staff work with families and community partners to help families understand and access private and publicly funded resources to meet needs.

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

Integration of Services

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

- The Michigan Peer Warmline is a statewide, anonymous line for any Michigander experiencing a mental health or substance use condition. The warmline is staffed by certified peer support specialists and recovery coaches. Additionally, the Michigan Crisis and Access Line (MiCAL) is now available statewide after being piloted in the Upper Peninsula and Oakland County in 2021. MiCAL is staffed 24/7 and provides crisis and warmline services, information, and coordination with local systems of care such as Community Mental Health Services Programs.
- The Expanding, Enhancing Emotional Health (E3) model helps to address the need for mental health services for children and youth. E3 is a designated model through the Child & Adolescent Health Center (CAHC) Program. E3 programs provide on-site comprehensive mental health services from mild to moderate severity of need by a licensed Mental Health Professional. Services include assessments, brief intervention, ongoing therapy, referrals, and follow-up. E3 sites are open year-round and provide telehealth when school is not in session. Services are designed for children and adolescents 5-21 years of age when access to behavioral health resources are limited or inaccessible in a community. Currently, 104 E3 sites operate in 43 counties.
- The CAHC program budget increased by $25 million in FY 2023 and will allow MDHHS to fund approximately 75 new school-based or school-linked health centers. Each of these new sites, in addition to primary health care, will have a full-time master's level mental health worker to provide one-on-one and small group mental health therapy for the K-12 population.
- The CAHC program is also using $4.25 million in MI Kids Now funding to expand mental health services for youth throughout the state via existing CAHCs. These funds will allow for expansion of mental health staffing from 0.5 FTE to 1 FTE per site.

- In 2021, Michigan continued to roll out expanded coverage for nursing and mental health services for general education students through a CMS approved Medicaid waiver. The Caring 4 Students (C4S) expansion allows schools that provide mental health and nursing services to general education students to receive Medicaid reimbursement. All 56 Intermediate School Districts participate in C4S.
- In August 2020, MDHHS was approved for a two-year CMS Certified Community Behavioral Health Clinic (CCBHC) Demonstration. In 2021, the demonstration was extended an additional four years. CCBHC demonstration sites provide nine core behavioral health services, including care coordination with primary care providers, and must meet standards for service provision, staffing, governance, and quality and financial reporting. Currently 13 CCBHCs participate in Michigan's demonstration made up of 10 Community Mental Health Services Programs and three nonprofit Behavioral Health Providers. MDHHS is conducting an evaluation to identify how the model impacts behavioral health service delivery for Michiganders.
- MDHHS was awarded the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) Grant in FY 2019. PIPBHC is a five-year grant to promote integration and collaboration in clinical practice between primary and behavioral health care, and to support improvement of integrated care models for primary and behavioral health care to improve the overall wellness of adults with serious mental illness or children with serious emotional disturbance. Grantees promote integrated care for screening, diagnosis, prevention, and treatment of mental and substance use disorders and co-occurring physical health conditions and chronic diseases.
- The Michigan Child Collaborative Care (MC3) increased access to mental health treatment for underserved children, adolescents, and high-risk perinatal women in all 83 counties. The expansion was significant given the shortage of specialty providers, especially in rural areas. MC3 provides psychiatry support to primary care providers who have patients with behavioral health concerns. Behavioral Health Consultants are linked with or embedded in pediatric primary care practices to assess and link children to mental health services. Patients are linked to evidence-based interventions if specialty services are not available. MC3 also provides behavioral health education for primary care providers, including cultural sensitivity. MC3 is administered collaboratively by MDHHS, the University of Michigan, and Michigan State University.
- MC3 for MOMs was launched in FY 2021 to engage Michigan's perinatal providers and their patients in targeted areas. The initiative is intended to improve perinatal providers' knowledge of and comfort with perinatal behavioral health screening and treatment (e.g., mood and anxiety disorders, substance/opioid use disorders). Universal psychiatric screening is important since up to 25% of perinatal women experience depression and anxiety. Behavioral Health Consultants are being trained in interventions to address behavioral health issues that impact the perinatal period.
- CSHCS continues to work with Behavioral Health partners to identify challenges accessing services experienced by populations served by the mental/behavioral health, intellectual/developmental disabilities, and physical health systems. Work includes cross-sector education, tools to assist families, and addressing systemic access issues.

Title V and Medicaid

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

In January 2023, 2,281,448 Medicaid beneficiaries were enrolled in Medicaid Health Plans (and 1,374,016 beneficiaries were enrolled in fee for service). Medicaid uses a managed care delivery system to maximize the health status of beneficiaries, improve beneficiary experience, and lower cost. Medicaid contracts with nine Medicaid Health Plans (MHPs) to achieve these goals through evidence- and value-based care delivery models; health information technology; strategies to prevent chronic disease; and coordination of care that includes assessing social determinants of health such as transportation, housing, and food access. MDHHS requires MHPs to annually report the Healthcare Effectiveness Data and Information Set (HEDIS) and uses a Pay for Performance Incentive Program with access, process, and outcome metrics for all managed care populations, including women and children. Each MHP governing body must either have a minimum of 1/3 representation of Medicaid enrollees or the plan must establish a consumer advisory council that reports to the governing body.

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

The DMIH and Michigan Medicaid jointly manage several programs for the Medicaid-eligible MCH population. One of the largest collaborations is the Maternal Infant Health Program (MIHP), Michigan's largest population-based home visiting program available to all pregnant people and infants up to age one eligible for Medicaid insurance. MIHP services provided to beneficiaries enrolled in an MHP are administered by the MHPs. In FY 2022, MIHP provided services to 12,127 adults and 15,069 infants.

Another area of coordination is for CSHCN. In January 2023, CSHCS program data indicate that 31,137 CSHCS beneficiaries were dually enrolled in an MHP. MHPs are responsible for the medical care and treatment of CSHCS members while community-based services beyond medical care and treatment are provided through an LHD's CSHCS office. MHPs are responsible for coordinating and collaborating with LHDs and Children's Multidisciplinary Specialty Clinics to provide a range of essential health care and support services to enrollees. MHPs are also responsible for coordination and continuity of care for enrollees who require integration of medical, behavioral health and/or substance abuse services.

Information Systems

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

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

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

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

State Statutes Relevant to Title V (Effective July 20, 2022)

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

In FY 2023, state funding for MCH and CSHCS programs was appropriated through Public Act 166 Enrolled House Bill 5783, Article 6, Health and Human Services of 2022. CSHCS is mandated by the Michigan Public Health Code, Public Act 368 of 1978, in cooperation with the federal government under Title V of the Social Security Act and the annual MDHHS Appropriations Act. State general funds for MCH programs are itemized in Sec. 116, Family Health Services, of Public Act 166 of 2022, and CSHCS is addressed in Sec. 117.

Additional MCH funding requirements and legislative reporting relate to evidence-based programs to reduce infant mortality (Sec. 1308), family planning/pregnancy prevention (Sec. 1301-1305, 1309, 1314, 1320, 1347), healthy moms healthy babies (Sec. 1348), prenatal care outreach and rural home visiting (Sec. 1311), Healthy Start (Sec. 1312), fetal alcohol syndrome services (Sec. 1313), oral health initiatives (Sec. 1315-1317, 1343), Michigan Model for Health™ (Sec. 1321), drinking water declaration of emergency fund support services (Sec. 1306), healthy exercise programs for school-age children (Sec. 1342); and immunization policy, practices and statewide media campaign (Sec. 1322, 1349).

Requirements in the FY 2023 Health and Human Services budget for CSHCS included criteria in Sec. 1360 for MDHHS to provide services; Sec. 1361 authorizes that some funding be used to develop and expand telemedicine capabilities and to support chronic complex care management.

[1] American Indian race is known to be underreported in Michigan due to several reasons, including a hesitancy to identify as American Indian given a history of inequitable treatment by state and local governments.

III.C. Needs Assessment
FY 2024 Application/FY 2022 Annual Report Update

Ongoing and emerging issues that impact the MCH population are discussed in this section, including infant and maternal mortality, COVID-19 and pregnancy, COVID-19 vaccination, routine childhood vaccination trends, the impact of the COVID-10 pandemic on local public health, the unwinding of the Public Health Emergency and Medicaid continuous enrollment, fluoridation, and health concerns specific to children and youth with special health care needs (CYSHCN). Additionally, Title V needs assessment activities in FY 2023 focused on assessing the public health workforce and broadband access for service delivery, which are also discussed in this section.

Ongoing and Emerging Issues that Impact MCH

Infant and Maternal Mortality

MDHHS closely monitors infant and maternal mortality and has seen the following trends and emerging concerns. The infant mortality rate (IMR) in Michigan for 2021 was 6.2 deaths per 1,000 live births, which is another lowest on record IMR. The last lowest on record IMR occurred in 2019. Racial and ethnic disparities remain a major contributor to Michigan's infant mortality rates. The gap between the Black and white infant mortality rate widened in 2021. The Black infant mortality rate was more than three times that of the White infant mortality rate (13.6 versus 4.4 per 1,000 live births in 2021). The pregnancy-related mortality ratio in Michigan for 2019 was 23.2 maternal deaths per 100,000 live births[[1]]. As with infant mortality, disparities between Black and white mothers exist, with the Black pregnancy-related mortality ratio nearly three times that of the white rate (29.8 versus 10.7 per 100,000 live births based on 2015-2019 data). In addition to maternal deaths caused by pregnancy-related issues, addressing pregnancy-associated, not related mortality[[2]] remains important: 37.9% of all pregnancy-associated, not related deaths from 2015-2019 were caused by accidental poisoning/drug overdose. Michigan's maternal mortality committees have focused on developing recommendations to help prevent current and expecting mothers from developing substance use disorders.

COVID-19 and Pregnancy

Michigan continues to participate in the CDC COVID-19 Pregnancy and Neonate Surveillance Project. For the project, women who have received a confirmed diagnosis of COVID-19 during pregnancy are identified through the Michigan Disease Surveillance System (MDSS) which is then linked with birth and death certificates to track pregnancy outcomes. After each pregnancy outcome has taken place, medical records for both mother and infant are requested to obtain details regarding the impacts of COVID-19 on the health of mother and infant.

For the 2020 cohort, 1,378 Michigan women were identified with a confirmed COVID-19 diagnosis during pregnancy. A pregnancy outcome was confirmed for 1,288 (93.5%) with the remaining 90 women (6.5%) lost to follow-up. The 1,288 documented pregnancy outcomes resulted in 1,316 live births and less than five fetal deaths. Black pregnant persons were 3.4 times more likely to have a COVID-19 complication than white pregnant persons. Infants of Black parenting persons that were diagnosed with COVID-19 during pregnancy were 2.5 times more likely to be low birthweight compared to infants of white parenting persons that were diagnosed with COVID-19 during pregnancy. Furthermore, birthing parent races other than white were 1.2 times more likely to be in the COVID-19 cohort than those without a COVID-19 diagnosis during pregnancy. Michigan is currently completing data collection for the 2021 project cohort.

In addition to this surveillance project, the Michigan Pregnancy Risk Assessment Monitoring System (MI PRAMS) added COVID-19 questions to the survey. Results from the 2020 MI PRAMS COVID-19 questions indicate that an

estimated 2.6% of new Michigan mothers reported that a health care worker told them they had COVID-19 during their most recent pregnancy, and it was confirmed through testing. When including mothers who were told by a health care worker that they had COVID-19 during their most recent pregnancy but they weren't tested, this number increases to an estimated 3.7% (which represents 3,589 new mothers in 2020). Black, non-Hispanic mothers were nearly twice as likely to report COVID-19 during their most recent pregnancy when compared to white, non-Hispanic mothers. Michigan is awaiting the final 2021 Michigan PRAMS data file from the CDC. Similar analyses will be conducted on the COVID-19 questions.

COVID-19 Vaccination

Table 1 provides Michigan COVID-19 vaccine coverage percentages by age group as of January 14, 2023. Initiation is defined as the percentage of Michigan residents who have received 1 or more doses of any vaccine; completion is defined as the percentage receiving 2 doses of Pfizer or Moderna or 1 dose of Johnson & Johnson, and up to date is defined as the percentage who have received the Pfizer or Moderna Bivalent Booster. Just over one quarter of Michigan residents aged 5-11 years have either initiated or completed their initial COVID-19 vaccinations, but less than 5% of this group are up to date on their COVID-19 vaccinations (i.e., received Pfizer or Moderna Bivalent Booster). Initiation and completion rates increase to around 50% for those aged 12-29 years and increase to 60% or above for Michigan residents aged 30 years and above. Most of the Michigan population is not up to date with COVID-19 vaccinations.

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

Dose	Initiation			Completion			Up-To-Date		
Age Group	Coverage	Residents Vaccinated	Population	Coverage	Residents Vaccinated	Population	Coverage	Residents Vaccinated	Population
under 5 years	9.22%	52,210	566,442	4.98%	28,227	566,442	2.76%	15,648	566,442
5-11 years	31.04%	256,222	825,575	28.19%	232,734	825,575	4.28%	35,355	825,575
12-15 years	50.18%	249,895	497,986	46.60%	232,086	497,986	6.83%	34,005	497,986
16-19 years	57.10%	295,633	517,722	52.27%	270,601	517,722	5.58%	28,886	517,722
20-29 years	56.23%	775,740	1,379,576	50.29%	693,793	1,379,576	5.73%	79,048	1,379,576
30-39 years	66.34%	804,740	1,213,131	60.49%	733,839	1,213,131	9.73%	117,993	1,213,131
40-49 years	67.89%	800,703	1,179,375	63.13%	744,573	1,179,375	11.81%	139,316	1,179,375
50-64 years	77.07%	1,573,479	2,041,683	72.90%	1,488,367	2,041,683	20.46%	417,684	2,041,683
65-74 years	90.64%	940,415	1,037,580	86.62%	898,744	1,037,580	38.92%	403,811	1,037,580
75+ years	87.37%	635,866	727,821	82.61%	601,269	727,821	34.42%	250,517	727,821

Priority Childhood Vaccinations

Table 2 provides Michigan child vaccination percentages for January through September 2022. When compared to the US average, Michigan reports lower immunization percentages for each of the main childhood vaccinations. Table 3 provides information on child vaccination percentages in Michigan over time. Since the first quarter of 2020 (January-March 2020), Michigan has experienced consistent decreases in each of the priority childhood vaccinations.

Table 2. Michigan Childhood Vaccination Rates in Comparison to US

Child Vaccination (19 through 35 months)		
	Michigan Coverage (%)	US Average (%)
4313314*	67.7	75.4
43133142*	55.4	-
2+ Hepatitis A	57.4	77.4
4+ DTap (Diphtheria/Tetanus/Pertussis)	70.5	87.2
PCV Complete (Pneumococcal)	76.5	86.0

Table 3. Michigan Childhood Vaccination Rates Over Time

	Percentage by end calendar year quarter							
	2020Q1	2020Q2	2020Q3	2021Q3	2021Q4	2022Q1	2022Q2	2022Q3
4313314*	73.1	70.7	70.3	70.4	69.9	68.5	67.5	67.7
43133142*	57.3	53.9	55.8	57.6	56.8	55.4	54.5	55.4
4+ DTap	75.6	73.2	72.9	73.0	72.6	71.1	70.2	70.5
PCV Complete	81.9	80.2	79.3	79.2	79.0	77.6	76.4	76.5

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

Impact of COVID-19 on Local Public Health

In 2022, the MDHHS Division of Local Public Health held site visits with 40 of 45 Local Health Departments (LHDs) to obtain feedback about the impacts of COVID-19. Conversations with LHD staff revealed that both the immediate and longer-term impacts of the pandemic have been significant and far-reaching for staff, families, and communities. LHD staff described trauma in the form of battle fatigue, lost leave, threats to staff and leadership, heartbreak at the community response, and mental and behavioral health challenges. State and local staff turnover was another challenge that resulted in loss of institutional knowledge. LHD staff also noted the need to promote workplace flexibility and to rebuild relationships with the community. They suggested that flexibility in background and experience in hiring may also help to mitigate staff turnover.

Staff also described how LHDs have had to contend with misinformation. Additionally, the ending of the public health emergency impacted Medicaid, WIC, and MIHP eligibility. Essential worker funds have been exempted from LHDs all but one time, significantly impacting morale and retention. Reengagement with LPH services, including clinical services, especially WIC and Immunizations, has become necessary. After Action Reporting has been proposed to capture the response in a useful form for the future. Despite the many challenges, there have been positives, such as the Michigan National Guard (MING) partnership, establishment/strengthening of regional lab systems, volunteers in the community, and CDC Foundation surge staffing.

Unwinding of the Public Health Emergency and Medicaid Continuous Enrollment

During the COVID-19 Public Health Emergency (PHE), state Medicaid agencies were required to continue health care coverage for all medical assistance programs, even if a person's eligibility changed. The end of the PHE on May 11, 2023, triggered the unwinding of the Medicaid continuous enrollment provision which ends on March 31, 2023. Starting in June, Michigan Medicaid beneficiaries will have to renew their coverage as the state resumes eligibility redeterminations. MDHHS has taken many steps to ensure beneficiaries are aware of the redetermination requirements and to help individuals retain Medicaid coverage if eligible. MDHHS communications provide consistent messages about three key steps for Medicaid beneficiaries related to the redetermination process and avoiding gaps in coverage: make sure contact information is up to date; report any changes to a household or income; and complete a renewal packet by the due date, if eligible. A Medicaid Benefit Changes website provides information on the PHE, eligibility renewal timeline, an FAQ document, and resources for Medicaid providers and community partners. A stakeholder toolkit includes a "Get Ready" flyer in English, Spanish, and Arabic; a platform to request redetermination materials in English, Spanish, and Arabic (e.g., wallet cards, posters, and animated files); Medicaid renewal information; and a Beneficiary Renewal Alert Letter example. MDHHS will also launch a multi-media campaign with radio ads, mobile and social media ads, audio streaming, and outdoor ads.

MDHHS issued a press release about the unwinding on February 15, 2023, which included information related to individuals who are no longer eligible for Medicaid:

Michiganders who no longer qualify for Medicaid will receive additional information about other affordable health coverage options available, including on HealthCare.gov. Affected Michiganders will be able to shop for and enroll in comprehensive health insurance as they transition away from Medicaid, and many Michiganders can purchase a plan for less than $10 per month. Renewals for traditional Medicaid and the Healthy Michigan Plan will take place monthly starting in June 2023 and run through May 2024. Monthly renewal notices will be sent three months prior to a beneficiaries' renewal date starting with June renewal dates.

To help ensure that the MCH population continues to receive Medicaid services and, if no longer eligible, avoids gaps in coverage, MCH programs have shared information about the unwinding with partners and program recipients. For example, the Child and Adolescent Health Center (CAHC) Program provided detailed information on the unwinding to school based/linked health centers and School Wellness Program sites. Information included MDHHS information and resources, a link to the MDHHS stakeholder toolkit, and tips for how CAHCs—since they provide Medicaid outreach and enrollment assistance onsite—can help families navigate the redetermination process.

The CSHCS program reached out to Medicaid partners to provide an overview of the unwinding and redetermination process for the CSHCS Advisory Committee. The Advisory Committee is comprised of organizations (providers, disease specific organizations, etc.) and parent/family members with a focus on children with special needs. A discussion about the redetermination process will focus on how CSHCS stakeholders can support clients with redetermination eligibility. Additionally, potential loss of Medicaid coverage due to the end of the PHE could have cost implications for the CSHCS program. CSHCS dual enrollment with Medicaid increased during the PHE. If dual enrollment numbers return to pre-Covid levels, it will lead to an increase in non-Medicaid costs for the CSHCS Title V medical care and treatment program.

Michigan's MCH programs will continue to monitor the unwinding and redetermination processes and identify ways to assist partners and clients, to ensure that everyone who is eligible for Medicaid benefits continues to receive them.

Fluoridation

In 1945, Community Water Fluoridation (CWF) began in Grand Rapids, Michigan. Over the last 78 years, it has been a safe and effective strategy in the prevention of cavities. The US Surgeon General states that CWF is one of the most cost-effective, equitable, and safe measures communities can take to prevent tooth decay and improve oral health. Over the past few years, anti-fluoridation groups have grown more visible. Nationally, municipal water systems that have had an interruption in their supply line for fluoride have come under pressure to stop fluoridating. In a northern Michigan community, the city council recently voted to discontinue community water fluoridation due to the lack of supply and increased costs despite community support of fluoridation. The once robust School Mouth Rinse Program has ended with the last manufacturer discontinuing production. The removal of this fluoride delivery system leaves many children at risk of tooth decay and poorer oral health outcomes.

Children with Special Health Care Needs

There is an emerging focus on Children with Medical Complexity (CMC) who suffer from one or more chronic conditions that affects three or more organ systems or one-life limiting illness or rare pediatric disease. Nationwide, CMC make up less than 4% of the total children's population but are estimated to account for 40% of Medicaid's pediatric spending. To address the complex needs of this population, CSHCS is collaborating with Michigan Medicaid, Michigan Medicine, Michigan-based Children's Hospitals, and stakeholders to explore the establishment

of a CMC benefit in Michigan. The goals of the CMC benefit are to improve patient outcomes, increase patient and family satisfaction, and reduce health care costs by enhancing the systems of care for CMC and, more broadly, CYSHCN.

Application of a health equity lens has contributed to greater awareness of disparities in access to health care experienced by individuals with sickle cell disease (SCD) which disproportionately affects African Americans. An estimated 3,500 to 4,000 Michiganders are living with SCD. Individuals with SCD are prone to higher rates of hospitalization, emergency room utilization, and premature death. In FY 2021, CSHCS partnered with the Lifecourse Epidemiology and Genomics Division (LEGD) to submit a proposal to the Governor's Office to expand CSHCS eligibility to adults with SCD, expand clinical services, and enhance the system of care serving clients with SCD. The proposal was embraced by the Governor and enacted in the FY 2022 budget appropriation. In FY 2022, 421 adults were enrolled with CSHCS. The program continues to implement outreach strategies to reach adults who can benefit from the CSHCS eligibility expansion, while also partnering with colleagues in LEGD to enhance clinical capacity to serve individuals with SCD. In addition, CSHCS is implementing strategies to expand the CMDS clinic model to include adult clinics caring for patients with SCD and developing toolkits for transition programs to improve transition to adulthood.

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

Literature Review

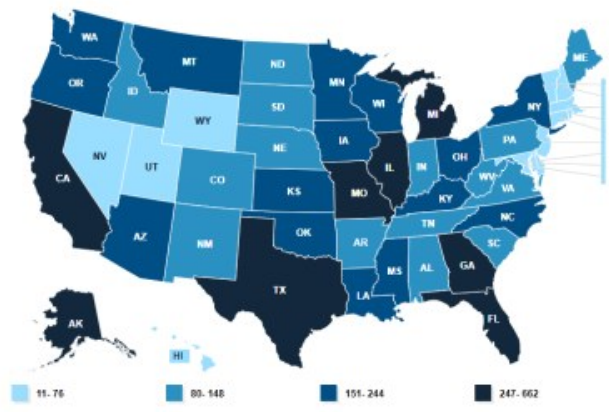
In 2023, a literature review was completed to understand more about the public health workforce and broadband access in Michigan. The full literature review, including citations, is included as a Supporting Document to this application. Highlights are included below.

Public Health Workforce

The public health workforce is essential to protecting and promoting the health and wellbeing of Michigan's population of over 10 million people. The workforce is responsible for a range of essential services, including disease prevention and control, environmental health, emergency preparedness and response, health education, and health policy development. The COVID-19 pandemic exerted significant pressure on the public health system, including the maternal and child health system, and highlighted gaps that were compounded by the lack of investment into the state's public health infrastructure, which has been understaffed and underfunded for many years (Bridge Michigan, 2023).

The strain on Michigan's public health infrastructure is further exacerbated by several other challenges facing the public health workforce. One of the biggest challenges is the shortage of public health professionals in the state. According to a report by the National Public Health Information Coalition (NPHIC), there is a significant nationwide shortage of public health professionals, especially among nurses (NPHIC, 2021). Michigan ranked 5th in the highest number of mental health HPSAs, after California, Texas, Arkansas, and Missouri. The state ranked 6th in the highest number of primary care HPSAs and 7th in the highest number of dental health HPAs (HRSA, 2022).

Figure 1. Primary Care Health Professional Shortage Areas (HPSAs)

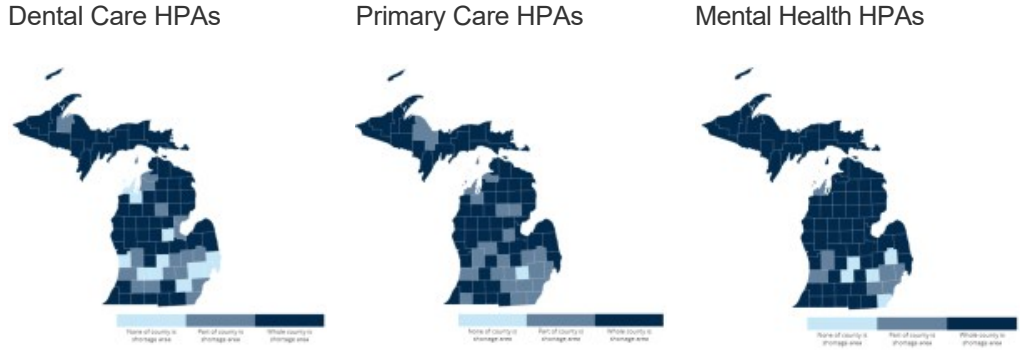


Location	Total Primary Care HPSA Designations
Michigan	285

Source: Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, 2022

According to 2022 data from the Health Resources and Services Administration (HRSA), 55 of 83 counties in Michigan (66%) were considered whole area dental care shortage areas. A higher percentage of counties (71%) were considered whole area primary care shortage areas, while 86% of counties in Michigan were considered whole area mental health shortage areas.

Figure 2. Dental Care, Primary Care, and Mental Health HPAs, by County, 2022 – Michigan



Source: Health Resources and Services Administration (HRSA), U.S. Department of Health & Human Services, 2022

Although these shortages were observed before the pandemic, they were exacerbated by stressors placed on the workforce during the pandemic. Several factors contribute to the shortage of public health workers in Michigan, including:

- Burnout, Stress, and Trauma
- Aging Workforce
- Lack of Funding and Low Pay

The need for additional specialized skills and training is another obstacle facing the public health profession in

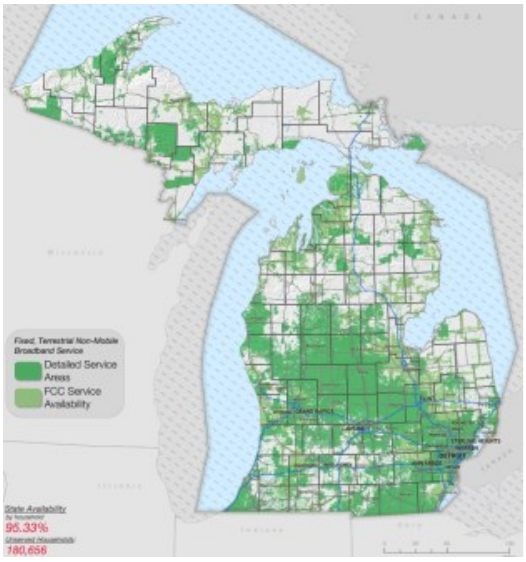
Michigan. Finally, there is a need for a more diverse public health workforce in Michigan. According to the PH WINS, the public health workforce is not representative of the communities it serves, particularly in terms of race and ethnicity. This lack of diversity can limit the effectiveness of public health programs and services in reaching and engaging communities of color.

To address workforce issues in the state, Michigan has implemented several initiatives to support the maternal and child health workforce and increase access to care for these populations. For example, the state has established loan repayment programs and other financial incentives to encourage mental health providers to provide direct service and physicians to practice in underserved areas. Additionally, Michigan has implemented telehealth programs to expand access to care in rural areas. Another potential solution includes increasing the number of healthcare professionals trained to provide maternal and child healthcare services in rural areas.

Broadband Access

Michigan is a state with diverse geography and population, ranging from urban areas like Detroit and Grand Rapids to rural and remote communities in the Upper Peninsula and Northern Lower Peninsula. Although more communities have access to broadband in recent years than in the past, significant disparities in broadband access remain. According to a report by the Michigan Department of Labor and Economic Opportunity (LEO), which houses the newly established Michigan High-Speed Internet Office (MIHI), an estimated 1.24 million Michigan households (31.5%) do not have a permanent, fixed internet connection at home and an additional 865,000 households face barriers related to cost, adoption, or digital literacy. The lack of access is more severe in rural areas and among low-income families, communities of color, and individuals with disabilities. According to LEO, “Black and Latino Michiganders are nearly half as likely to have a home broadband connection than non-Black or Latino residents” and “nearly 35% of households earning less than $20,000 annually do not have a broadband connection.” These disparities in access have implications for public health, as they can limit access to health information, public health services, telemedicine, and eHealth technologies, particularly for under-resourced communities and populations. The map below shows the availability of broadband service with speeds of at least 25 Mbps download in Michigan.

Figure 3. Broadband Service with Speeds of at Least 25 Mbps Download/3 Mbps Upload – Michigan



Source: Connected Nation Michigan, 2021

The lack of broadband access can have significant public health implications for residents of Michigan. Limited access to telemedicine can limit the ability of residents to receive timely and appropriate medical care. Initial data suggest that employing virtual care to replace some traditional in-person sessions, such as home visiting, may be a positive long-term alternative for some families and some types of services. Telemedicine can be particularly important for individuals living in rural areas or those with mobility challenges.

Strategies to Improve Broadband and Telehealth Access

Strategies have been proposed to address the digital divide and improve public health outcomes in Michigan. These strategies include:

1. Increasing broadband infrastructure in rural areas
2. Providing affordable internet and technology
3. Improving digital literacy and accessibility
4. Partnering with community organizations
5. Leveraging telehealth technology

Michigan has taken several steps to address the digital divide and promote public health broadband access, including the creation of the Michigan Broadband Roadmap, which was developed by the Michigan Department of Labor and Economic Opportunity (LEO) in collaboration with stakeholders from government, industry, and community organizations. The roadmap aims to identify gaps in broadband infrastructure and services, prioritize investment and deployment strategies, and promote public-private partnerships to expand access.

Broadband Funding Opportunities and Initiatives

Another important strategy for promoting public health broadband access in Michigan is the use of federal funding programs, such as the Connect America Fund (CAF) and the Rural Digital Opportunity Fund (RDOF). These programs provide subsidies and grants to broadband providers to expand their networks to unserved and underserved areas, including rural and low-income communities.

Other state-level programs include Connecting Michigan Communities (CMIC). The Michigan Department of Technology, Management, and Budget (DTMB) is offering a grant to extend broadband service to unserved Michigan areas. The grant funds are available for projects that demonstrate collaboration to achieve the area's community investment and economic development objectives. Statewide funding of $20 million was allocated to this grant program for the 2019 application year. The initial round of awards has been announced, and next year, approximately $15 million is anticipated to be allocated to this program.

Conclusion

The public health infrastructure in Michigan plays a critical role in promoting and protecting the health of communities. However, the public health workforce is facing a range of challenges, including an aging workforce, shortages of certain types of professionals, low compensation, stress and trauma, and a need for workforce development and training. By addressing these challenges and seizing these opportunities, Michigan can ensure that it has a robust and effective public health workforce that is well-equipped to meet the needs of its diverse communities.

Technology and access to broadband can be leveraged to further strengthen public health infrastructure and access to services. Improving broadband access for people of childbearing age, pregnant people, infants, children, adolescents, and children and youth with special health care needs in Michigan is critical to improving public health outcomes and reducing health disparities for these populations.

By implementing innovative strategies, Michigan can improve public health outcomes for all residents, including those who are currently unserved and marginalized. By continuing to prioritize the public health workforce and broadband access as essential elements of an effective public health system, Michigan can make progress towards improving health outcomes and reducing health disparities for the MCH and CSHCN populations.

[[1]] Includes maternal deaths while pregnant or within 1 year of the end of a pregnancy from any cause related to or aggravated by the pregnancy or its management. Data source: Maternal Deaths in Michigan, 2014-2018 Data Update. MDHHS. Michigan Maternal Mortality Surveillance Program.

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

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

2023 Application/2021 Annual Report – Needs Assessment Update

2022 Application/2020 Annual Report – Needs Assessment Update

2021 Application/2019 Annual Report – Needs Assessment Summary

III.D. Financial Narrative

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$19,316,300	$18,757,073	$19,415,900	$17,942,890
State Funds	$48,158,300	$45,760,081	$42,008,500	$49,686,928
Local Funds	$0	$0	$0	$0
Other Funds	$500,000	$560,970	$790,000	$574,036
Program Funds	$68,599,500	$54,711,675	$7,868,700	$6,955,280
SubTotal	$136,574,100	$119,789,799	$70,083,100	$75,159,134
Other Federal Funds	$344,942,800	$342,780,969	$315,888,100	$314,180,131
Total	$481,516,900	$462,570,768	$385,971,200	$389,339,265

	2022		2023	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$19,474,600	$17,579,527	$18,917,600	
State Funds	$51,089,300	$47,071,402	$52,970,400	
Local Funds	$0	$0	$0	
Other Funds	$790,000	$726,486	$790,000	
Program Funds	$7,897,800	$5,570,069	$8,363,000	
SubTotal	$79,251,700	$70,947,484	$81,041,000	
Other Federal Funds	$365,627,200	$323,648,146	$340,960,300	
Total	$444,878,900	$394,595,630	$422,001,300	

	2024	
	Budgeted	Expended
Federal Allocation	$19,132,100	
State Funds	$45,125,500	
Local Funds	$0	
Other Funds	$790,000	
Program Funds	$9,237,300	
SubTotal	$74,284,900	
Other Federal Funds	$398,990,439	
Total	$473,275,339	

III.D.1. Expenditures

Financial Narrative Overview

Title V federal funding, in conjunction with non-federal state funding and other federal funds, are budgeted and expended to support Michigan's MCH priority needs and Title V requirements. Over one-third of Title V funding supports medical care and treatment for Children with Special Health Care Needs (CSHCN) and over one-third supports the MCH work of all 45 local health departments across the state. Title V funding also supports other state priorities such as immunizations, childhood lead poisoning prevention, oral health for children, infant safe sleep, breastfeeding, reproductive health, Fetal Alcohol Spectrum Disorders (FASD), Regional Perinatal Quality Collaboratives (RPQCs), health equity initiatives, and surveillance mechanisms such as PRAMS, maternal mortality surveillance, and Fetal Infant Mortality Review (FIMR). State general funds are used for Michigan's required state match. Title V state match funding includes home visiting, rural home visiting, infant safe sleep, infant mortality reduction, RPQCs, adolescent parenting support, and staff support for MCH programs including the Michigan Model for Health™. To ensure alignment with Title V requirements, Title V leadership and the MDHHS Budget liaison meet throughout the year to review Michigan's MCH expenditures. Expenditures for FY 2022 and budget plans for FY 2024 are discussed in Sections III.D.1 and III.D.2, respectively.

Expenditures (FY 2022 Annual Report Year)

In FY 2022, Title V funds were spent on an array of MCH programs and initiatives. The following narrative corresponds with the budget forms in this application and annual report.

Form 2

Form 2, Line 1, FY 2022 Annual Report Expended of $17,579,527 represents Title V funding from the Federal Fiscal Year (FFY) 2022 grant period (i.e., the two-year grant period from October 1, 2021 to September 30, 2023) that was spent down in the state Fiscal Year (FY) 2022 (i.e., October 1, 2021 to September 30, 2022). Per section 503(b) of Title V legislation, states have the authority to spend down Title V funds over a two-year grant period (i.e., to use unspent funds from the first year of the grant award in the second year of the grant award). The FFY 2022 grant was not fully expended in FY 2022 but will be fully expended in FY 2023. Form 2, Line 1, also does not include FFY 2021 dollars expended in FY 2022 (i.e., carryover from the FFY 2021 award). The Annual Report Expended amount of $17,579,527 is lower than the FY 2022 budgeted amount of $19,474,600 because the original budget included carryover dollars.

Michigan has experienced increased Title V carryover the past three years due in large part to the COVID-19 pandemic. Some programs that traditionally deliver in-person health services were unable to do so, especially during the first half of FY 2022, and/or were operating at decreased capacity as staff were reassigned to COVID-19 mitigation activities.

Michigan's Title V state match as reflected on Form 2, line 3, "State MCH Funds" in Annual Report Expended exceeds federal match and Maintenance of Effort requirements. Approximately 80.6% of Michigan's State MCH Funds were comprised of state general funds for CSHCS medical care and treatment and 3.3% were comprised of other CSCHS-related funds (non-emergency medical transportation for CSHCN, CSHCN administration, and bequests for care and services for CSHCN). The remaining 16.1% includes state general funds that support MCH appropriations for family planning local agreements; family, maternal and children's health; pregnancy prevention services; and prenatal care and outreach. Fluctuations in State MCH Funds expended can occur each year based on significant one-time costs for CSHCS medical care and treatment. Form 2, line 5, "Other Funds" in the Annual

Report Expended represents the Children with Special Needs Fund. CSHCS only spends the earnings of the fund, which in FY 2022 was $726,486. Program Income (Form 2, line 6) includes newborn screening follow-up.

As illustrated in Form 2, line 9, “Other Federal Funds,” Michigan’s MCH work was supported by a variety of other federal funds in FY 2022 including: Women, Infants and Children (WIC); State Systems Development Initiative (SSDI); Title XIX (Medicaid); Immunization; Lead Poisoning Prevention; Abstinence Education Grant Program; Personal Responsibility Education Program (PREP); Home Visiting; Early Hearing Detection; Awareness and Access to Care for Children and Youth with Epilepsy; Universal Newborn Hearing Screening; Pregnancy Risk Assessment; and Title X (Family Planning).

30/30/10 Requirement

Michigan tracks expenditures to comply with the Title V 30/30/10 legislative requirements. A minimum of 30% of total funding must be expended for CSHCN; a minimum of 30% of total funding must be expended for preventive and primary care for children ages 1-21; and a maximum of 10% of total funding can be expended for Title V administration. In FY 2022, expenditures were tracked by CSHCN; preventive and primary care for children ages 1-21; pregnant women, mothers, and infants; and others. Expenditures track the required amount, variance, percent of total and percent required to assure legislative compliance. In FY 2022, 33.4% of Title V FFY 2022 expenditures were for preventive and primary care for children; 39.6% of expenditures were for services for CSHCN; and 3.2% of expenditures were for Title V administrative costs. The remaining 23.8% of expenditures were for pregnant women, mothers, infants, and others (including men and non-pregnant women).

To assure the 30/30/10 requirement is documented within the Local MCH (LMCH) program and to record expenditures by the types of individuals served, the LMCH program has specific budget project titles in the Electronic Grants Administration & Management System (EGrAMS) and in the LMCH Year End Report. The LMCH Year End Report has one table to capture the types of individuals served and another table that mirrors the federal reporting of the MCH Types of Services. The FY 2022 budget project titles in EGrAMS were “MCH–Children” and “MCH–All Other.”

For the 30% children requirement, Michigan tracks related expenditures at the state and local level including immunizations for children and adolescents, oral health services for school-age children, family planning and reproductive health for adolescents and young adults, teen pregnancy prevention and parenting support, childhood lead poisoning prevention and case management, bullying prevention, special projects such as services for children with FASD, and other LMCH activities. For the 30% CSHCN requirement, Michigan tracks expenditures paid to providers for medical care and treatment billed through CHAMPS. Also, local health department care coordination expenditures for CSHCN are billed through EGrAMS, which allows for the tracking of various types of care coordination assistance.

In Form 2, Annual Report Expended, the following line items had a variance of 10% or more of the original budgeted amount, for the following reasons:

- Line 1.A, Preventive and Primary Care for Children, FY 22 Annual report Expended does not include carryover dollars whereas the original FY 22 budget included carryover estimates.
- Line 6, Program Income, was lower than budgeted due to Newborn Screening earnings being less than projected when the original budget was set.

Local MCH

Title V funding is allocated to each of the 45 local health departments (LHDs) in Michigan through the LMCH

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

Table 1 summarizes spending by LHDs in FY 2022 by the MCH Pyramid of Services (i.e., direct, enabling, and public health services and systems).

Table 1. LMCH Spending by MCH Pyramid of Services

Types of Services	FY 2022 Expended
1. Direct Services (sum of A, B, & C)	$1,182,878
A. Preventive and primary care services for pregnant women, women, mothers, and infants up to age one	$161,544
B. Preventive and primary care services for children 1-21	$1,019,850
C. Services for CSHCN	$1,485
2. Enabling Services	$3,664,813
3. Public Health Services and Systems (i.e., Infrastructure)	$1,432,358
Total (sum of lines 1, 2, & 3)	$6,280,049

For FY 2022, each LHD was encouraged to select one to two national or state performance measures and/or locally identified measures. Out of 45 LHDs, 44 LHDs chose at least one national performance measure or state performance measure (with the remaining LHD selecting only a local performance measure).

In total, 9 LHDs chose one performance measure; 18 chose two performance measures; 9 chose three performance measures, 3 chose four performance measures; 4 chose five performance measures; and 2 chose six performance measures. Table 2 summarizes the number of LHDs expending funds in each performance measure, the amount expended, and the number of clients served.

Table 2. LMCH Spending by Performance Measure in FY 2022

Performance Measure	Number of LHDs selecting	Amount Expended	Number of Clients Served
NPM 2 (Low-risk Cesarean Delivery)	0	$0	0
NPM 4 (Breastfeeding)	19	$754,024	4,953
NPM 5 (Safe Sleep)	10	$690,933	5,687
NPM 9 (Bullying prevention)	0	$0	0
NPM 12 (Transition)	3	$45,000	208
NPM 13 (Preventive Dental Visit)	5	$165,418	13,663
SPM 1 (Lead Poisoning Prevention)	13	$679,680	10,817
SPM 2 (Children immunizations)	15	$873,098	27,003
SPM 3 (Adolescent immunizations)	12	$466,259	35,098
SPM 4 (Provision of Medical Services and Treatment for CSHCN)	3	$163,317	362
SPM 5 (Intended pregnancy)	4	$249,990	1,021
SPM 6 (Behavioral/mental health)	6	$180,222	3,878
Local Performance Measure defined by Local Health Department (See Table 3 for details)	19	$1,822,881	39,954
COVID-19 response	8	$189,227	336,577
Total		**$6,280,049**	**479,220**

As noted in the table above, 19 LHDs chose a local performance measure. The priority areas for those locally defined measures to meet locally identified needs are highlighted in Table 3.

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

Local Priority	Expenditures
Adolescent well visit | Sexually Transmitted Infections (3 LHDs)	$62,442
Adverse Childhood Experiences	$34,186
Car seat safety	$2,750
Childbirth education car seat incentive	$5,600
Community health needs and assessment (4 LHDs)	$284,157
FIMR (2 LHDs)	$49,393
Health education in schools (physical activity, obesity prevention, maturation, reproductive health topics)	$22,728
Health Equity	$123,208
Healthy Family America (gap-filling support)	$136,745
Hearing and Vision (3 LHDs)	$172,235
Linking families to resources (NICU families, telephone call line) (2 LHDs)	$359,818
Media campaign to improve birth outcomes	$172,674
Obesity and physical activity	$7,612
Peer to Peer pregnancy mentoring program (2 LHDs)	$349,108
Stakeholder education/discussion on MCH topics and collective impact	$5,000
Tobacco treatment services (2 LHDs)	$10,000
Well woman visit (exam, STD, cancer screening, reproductive life plan, referrals)	$25,225
Total	**$1,822,881**

Form 5

Form 5 reflects the number and percent of the MCH population served by the Title V program in Michigan, as defined by both Title V funding and Title V state match. As reflected in Form 5a, the estimated total count of individuals served via direct and enabling services (i.e., the top two levels of the MCH Pyramid of Services) was 504,966. This count includes individuals who received a service funded by Title V federal dollars or non-federal state match dollars as reported on Form 2, line 8. For FY 2022 reporting, data on individuals served were collected from Local MCH, Nurse-Family Partnership (NFP), Rural Home Visiting, 3rd grade sealants program, childhood lead support and education, safe sleep program, Family Planning, FASD, Michigan Adolescent Pregnancy and Parenting Program (MI-APPP), PREP Michigan Organization on Adolescent Sexual Health, breastfeeding support, FIMR family interviews, and CSHCS medical care and treatment. Form 5b provides an estimate on the total percentage of populations who received a Title V supported service in each of the MCH population groups across all three levels of the MCH Pyramid of Services (i.e., direct, enabling, and public health services and systems). This estimate includes all individuals and populations served by the total federal and state match as reported in Form 2, line 8. As reported on Form 5b, the Title V program served 100% of pregnant women, 100% of infants, 100% of children, 100% of CSHCN and 7% of others which includes males and non-pregnant women of childbearing age. For more details, see Form 5 field notes.

Payer of Last Resort

Michigan supports Title V regulations to use Title V funds as the payer of last resort. The comprehensive contract for each local health department includes contractual language which emphasizes this payment structure for programs

that provide direct or enabling services to individuals such as LMCH, lead poisoning prevention, immunizations, oral health, and CSHCS programs. The remaining Title V funds are used for systems-level work in infrastructure or related to the ten essential services, which are non-claims related reimbursement.

III.D.2. Budget

Budget (FY 2024 Application Year)

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

Form 2, Line 1, Federal Allocation, FY 2024 Application Budgeted amount of $19,132,100 is based on the Federal Fiscal Year (FFY) 2022 award amount, which is the most recent fully awarded grant. In FY 2024, Michigan will also spend down any unspent funds (i.e., carryover) from the FFY 2023 federal award as allowable by Section 503(b) of the Title V legislation. Per HRSA instructions, that carryover is not included in Form 2, FY 2024 Application Budgeted.

Based on the estimated federal award and the state's Executive Budget recommendation, Title V funding is projected to be used for the following MCH programs and services in FY 2024:

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

The largest amounts of Title V funding go toward the Local MCH Program (~37% of funding is awarded to Local Health Departments through non-competitive contracts) and Medical Care and Treatment for CSHCN (~36% of funding). The remaining Title V funding (~27%) is used for the programs and services listed above which impact all five Title V population domains.

As previously discussed, Michigan's 2020 Title V needs assessment identified a new set of state priority needs and performance measures. Through state level work and/or local health department activities, it is anticipated that Title V appropriations will support activities related to federally defined National Performance Measures (NPMs) in FY 2024:

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

- NPM 13 (Preventive Dental Visit)

The annual LMCH Plans for FY 2024 are not available at the writing of this application. In FY 2023, Local Health Departments (LHDs) selected NPMs 4, 5, 12 and 13. Due to the COVID-19 pandemic, many LHDs have not had the opportunity to consider realigning work in their LMCH plan to address NPM 2 and NPM 9, which were added to Michigan's NPMs based on the 2020 needs assessment. In FY 2021, the format of the LMCH plan and workplan changed to better align with federal Title V requirements. Technical assistance through webinars, learning labs and sample workplans was offered to all LHDs to provide ideas and examples on how LHDs might operationalize activities to address these measures in the future. The 30/30/10 requirement was emphasized because LHDs, who collectively receive over one-third of Title V funding, contribute to meeting the 30% children 1-21 requirement.

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

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

At the state level, all SPM program areas have allocations in the FY 2024 Title V budget. The programs and activities that will support work on the above NPMs and SPMs in FY 2024 are detailed in the Title V state action plans. Although FY 2024 LMCH plans are not yet available, it is anticipated that local health departments will also implement work across all SPMs, based on FY 2023 LMCH plans. LHDs use a Community Health Needs Assessment to inform the creation of FY 2024 LMCH plans, including a focus on the state's identified NPMs and SPMs as well as locally identified priorities and needs.

30/30/10 Requirement

Michigan's commitment to adhere to the 30/30/10 Title V legislative requirement was discussed in the preceding Expenditures section. For FY 2024, this commitment is again reflected in Form 2 (Lines 1A, 1B, and 1C) in the Application Budgeted. For FY 2024, 32.5% of the total Title V budget is designated for preventive and primary care for children; 36.5% is designated for Children with Special Health Care Needs; and 3% is designated for administrative costs. Title V leadership will hold discussions throughout the fiscal year (in coordination with the MDHHS Budget liaison) to assure that the budget and spending are on track, and to address any new or unplanned MCH needs.

Form 2

MDHHS meets and monitors the required Title V state match which is a $3 match in non-federal funds for every $4 of federal Title V funds expended. Michigan exceeds the required match in expenditures and budgeting. Michigan's "State MCH Funds" (Form 2, line 3) of $45,125,500 which is considered the state's applied Maintenance of Effort for Title V, is composed of state general funds for the following appropriations: medical care and treatment for CSHCN; Family Planning local agreements; prenatal care and outreach; pregnancy prevention services; CSHCS and Family, Maternal and Child Health administration; non-emergency medical transportation; and bequests for care and services. Approximately 81.7% of the "State MCH Funds" are related to medical care and treatment for CSHCN and other CSHCS-related funds. Along with other federal funds, these state MCH dollars provide a critical component of Michigan's MCH infrastructure. In Form 2, line 5, "Other Funds" reflects income from the Children with Special Needs

(CSN) Fund. CSHCS limits expenditures from the CSN Fund to 3% of the funds value each year. The investment mix for the CSN fund is expected to generate a 5% return; therefore, overtime the value of the fund will grow. Michigan's "Program Income" (Form 2, line 6) includes Newborn Screening follow-up. Other federal funds anticipated in FY 2024 are indicated in Form 2, line 9.

Form 3a and 3b

Each year, Michigan's Title V administrative staff also completes an assessment of "Types of Individuals Served" and "Types of Services" provided by Title V funding at the state and local level, as reflected in Form 3a and 3b, respectively.

For example, Title V funding supports the Local Maternal Child Health Program. The LMCH Plan was transformed in 2021 to align more closely with Title V reporting. The LMCH 'Count and Allocation' table was further revised for FY 2024 by adding a population measure to track expenditures intended to impact the health and wellness of children 1-21. In alignment with Form 3a, LHDs are required to report types of individuals served and amount expended by population classifications. Additionally, LHDs are required to report expenditures as identified in the Title V MCH Pyramid of Services (i.e., direct services, enabling services, and public health services and systems) in a "Types of Services" table. The table mirrors Form 3b. Beginning in FY 2021, budget categories in EGrAMS were reduced to two projects to create clearer alignment with the Title V 30-30-10 rule. The two projects use population classifications instead of pyramid of services. The latter is captured through the new Types of Services reporting table.

At the state level, Title V funding is budgeted across MCH population groups and is in alignment with the 30-30-10 rule as reflected in Form 3b. For example, Title V allocations for NPM 9 (Bullying), NPM 13.2 (Oral Health-Children), SPM 1 (childhood lead poisoning prevention), SPM 2 (Immunizations-Children), SPM 3 (Immunizations-Adolescents) contribute to the 30% requirement for primary and preventative services for children 1-21. SPM 4 (medical care and treatment for CSHCN) supports the 30% requirement for CSHCN. For state level activities that align with Form 3b, Title V allocations are assessed to determine where activities fall in the MCH Pyramid of Services (i.e., direct services, enabling services, and public health services and systems).

Form 5

The total Federal-State partnership funding is evaluated when completing Form 5. MCH programs that receive Title V federal and/or state match funds are asked to provide counts of individuals served. These counts of individuals in Form 5 relate to the total expenditures provided by population serviced on Form 3. Form 5 demonstrates the reach of Title V funds and state match across MCH population groups.

III.E. Five-Year State Action Plan

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

State: Michigan

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

State Action Plan Table - Entry View

State Action Plan Table - Legal Size Paper View

III.E.2. State Action Plan Narrative Overview

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

Partnership and Leadership Roles

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

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

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

MCH program areas within MDHHS also coordinate and/or partner with the Michigan Alliance for Innovation in Maternal Health, Maternal Infant Health Summit, Michigan Oral Health Coalition, Safe Sleep Advisory Council, Michigan Home Visiting Advisory, Michigan Home Visiting Annual Conference, Michigan Breastfeeding Network, Child & Adolescent Health Advisory, Michigan Model for Health Steering Committee, and many other program-specific initiatives. The DMIH also funds and coordinates the Michigan Perinatal Quality Collaborative comprised of Regional Perinatal Quality Collaboratives. The Division of Child and Adolescent Health provides funding and oversight to the state's Child and Adolescent Health Centers and oversees comprehensive school health education through its regional School Health Network.

CSHCS provides leadership and coordination for the CSHCS Advisory Committee (CAC). The CAC is comprised of professionals and family members involved in the care of children with special needs. The CAC makes policy recommendations and promotes public awareness of CSHCS. The Family Center is housed within the CSHCS

Division and provides a family-centered and parent-driven approach to informing Michigan's CSHCN work. The Family Center contributes to CSHCS programs and policies; supports the statewide Parent-to-Parent Network; maintains the statewide Family Leadership Network; and administers the Family Phone Line, which provides support and information to families of children with special health care needs.

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

In addition to these initiatives, the Title V program works with a broad range of partners including community health service systems, such as local public health; Federally Qualified Health Centers; the private sector; managed care plans; community-based organizations; MCH advocates; faith-based organizations; schools; and universities. Within MDHHS, program and policy activities are coordinated with Medicaid, behavioral health and substance use, chronic disease, communicable disease, injury prevention, child welfare, public health preparedness and others. Title V is also part of the interdepartmental Great Start Operations Team (GSOT) to address early childhood services integration and coordination. The GSOT convenes MDHHS, the Department of Education, the Early Childhood Investment Corporation, and other partners to provide strategic direction and systems-building expertise for programs that serve Michigan's young children and their families.

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

Title V Framework

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

1. Build capacity to *achieve equitable health outcomes* by understanding and addressing the role of implicit bias and macro-level forces such as racism, gender discrimination, and environmental degradation, on the health of women, infants, children, adolescents, and children with special health care needs.
2. Intentionally and routinely find opportunities to *seek the knowledge and expertise of communities and families* in all levels of decision-making to build trust and create policies and programs that align with family and community needs.

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

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

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

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

Foundation for Family and Community Health

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

The public health functions of assessment, policy development, and assurance are shared between MDHHS and local health departments. Legal and legislative requirements support quality services through codification (the Michigan Public Health Code) and MCH fiscal obligations are supported through the annual budget process. The Title V program supports coordinated, comprehensive systems of care at the state and local levels, as described in the Health Care Delivery System section. The creation of MDHHS in 2015, which resulted from a merger of the

Departments of Community Health and Human Services, reflects the state's commitment to effective, customer-focused systems that support physical and behavioral health and safety.

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

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

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

A strong workforce is the backbone of public health. To best serve the MCH population, the Title V and public health workforce must include personnel with MCH subject expertise and strong program leadership. Michigan's MCH programs include a range of personnel, including public health consultants, epidemiologists, departmental specialists, program managers, and division directors who carry out the state's MCH work. Assessment of workforce trends and the evolving MCH landscape help to identify areas of need, as discussed in the Needs Assessment Update. Throughout the COVID-19 pandemic, state and local MCH staff rapidly adapted to a remote work environment and identified ways to effectively coordinate and deliver MCH services. Additional information related to the MCH workforce is included in the 2020 Five-Year Needs Assessment.

Title V and MCH Staff

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

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

Four of these positions are currently supported by Title V funding to provide administrative support to the Title V

block grant. The MCH nurse consultant position is the only administrative position fully funded by Title V. The block grant coordinator, public health consultant, and CASH epidemiologist are supported through blended funding (e.g., Title V, state general funds, other federal funds) as the positions have responsibilities in addition to Title V.

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

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

MDHHS Hiring Practices

To recruit and retain qualified staff, MCH programs work with MDHHS Human Resources to post positions through the State of Michigan job postings website and Indeed.com, in addition to sending out job postings through MCH listservs. To help the workforce deliver services that are informed by equity-related knowledge and practices, MDHHS developed the Diversity, Equity, and Inclusion (DEI) Plan recognizing that a "diverse workforce will be an essential asset for developing and providing health and human services that are culturally proficient to address existing and emerging health and social issues." The DEI plan is being implemented in the areas of Leadership, Culture and Climate, Recruiting and Hiring, Training and Professional Development, and Service Delivery. Beyond but inclusive of MCH, MDHHS launched mandatory "Introduction to Health Equity" and "Systemic Racism" online trainings in 2019 for all staff. The Office of Race Equity, Diversity and Inclusion (REDI) was created in 2020 "to address racial, health, social and wealth disparities, that impact both internal and external partners". In 2021, MDHHS implemented a new requirement that all MDHHS position postings include a Valuing Diversity and Inclusion competency in the posting questions as well as a standard set of DEI interview questions.

Beginning in 2019, Diversity Hiring Team (DHT) trainings were rolled out to individuals in two cohorts with the goal of applying a Diversity, Equity, and Inclusion (DEI) lens to various phases of the hiring process. Cohort members participated in a series of DHT trainings. The goal was for DHT alumni to assist hiring managers with the process of screening, interviewing, scoring, and selecting job candidates in an equitable way to ultimately have a workforce that is more reflective of the diversity of the state. The Office of Human Resources provides assistance to MDHHS program areas that are aligning hiring protocols with the DHT approach.

In April of 2019, MDHHS Office of Workforce Development and Training (OWDT) partnered with Children's Services Administration (CSA) to create an Anti-Racism Transformation Team (ARTT). This process began with a Planning and Design Task Force (PDTF) which organized the team and its training. Training was provided to equip the CSA ARTT with the knowledge and skills needed to create a structural intervention that includes strategies to break down barriers and create anti-racist and anti-oppressive structures, policies, practices, and procedures within the child welfare system. Since the creation of the first ARTT at MDHHS, three additional ARTTs have gone through the same process. The Michigan Child Support ARTT began the PDTF process in October 2021, followed by the Jackson County ARTT and Kent County ARTT in January 2022.

In 2022, the MDHHS Diversity, Equity, and Inclusion (DEI) Council's Recruitment, Hiring and Retention Action team introduced the MDHHS Toolkit for Managers: *Recruiting, Hiring, and Retaining a Diverse and Inclusive Workforce*.

The toolkit provides practical information, tips, and resources for integrating DEI into hiring and retention processes. The toolkit is available for all managerial levels and work areas.

Training and Professional Development for MCH Staff

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

The Guiding NEAR training was designed for emerging leaders to work with stakeholders to design programs and services that interrupt the trajectory of adversity for Michigan residents. The current NEAR Collaborative is coordinated by MDHHS and focuses on addressing policies, practices, and norms within hiring and program recruitment, implementation, and evaluation. The NEAR Collaborative also designed a Trauma-Informed Road Map for State Systems which is included in the 2021 report. In the fall of 2022, MDHHS hosted the first Trauma Informed Home Visiting training series.

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

- Training and consultation to internal staff and partner networks on equity principles and strategies.
- Clinician training throughout the state on implicit bias with a focus on the use of best practices to enhance the patient-provider relationship (e.g., Medicaid Health Plan partners and health systems).
- Training and consultation to the MCH workforce in local communities through Regional Perinatal Quality Collaboratives (RPQCs). RPQCs are required to address health inequities, the social determinants of health and disparate outcomes.
- On-demand trainings and resources are available on the DMIH webpage for use by anyone visiting the website (e.g., internal staff, partner networks, community members).
- Discussions and opportunities for peer sharing occur through quarterly Mother Infant Health and Equity Collaborative meetings.
- Maternal Infant Health and Equity Updates are shared on a regular basis (at least twice monthly) via a listserv that is distributed to over 11,407 primary contacts and an additional 2,000 individuals through secondary sharing by MDHHS programs and professional organizations. The listserv reaches a broad array of state and local partners, including practitioners and parents.
- In August 2022, MDHHS hosted a Public Health Nursing 101 Conference, with 72 registrants from 22 Local Health Departments, representing nine of Michigan's 10 Prosperity Regions. Participants attended seven sessions, including The History of Public Health Nursing, MI Public Health Law, Practice & Policy, a Public Health Nursing Leaders Panel Discussion, and The Importance of Self Care. The conference was well received, and two additional Public Health Nursing 101 Conferences were held in April 2023.

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

Rights and Justice, Integrated Infant Mental Health, Birth Justice, the Role of Doula and Midwifery Care, and Using Your Power and Privilege. Over 600 attendees participated in both the 2021 and 2022 Summits. Attendees indicated that their areas of interest were health equity, disparities in birth outcomes, structural racism, and implicit bias. Attendees in 2021 indicated a greater interest in inclusivity especially when discussing family make-up, LGBTQ+ families, and male engagement, all of which received increased focus at the 2022 event. The 2023 Summit will offer an array of learning opportunities for the MCH workforce that center health equity and justice. The Summit will be held in-person in June 2023, with the theme "Taking Action Today for an Equitable Tomorrow." The planning team is building on the momentum of the past two years, with a focus on moving attendees from learning into meaningful action. Additionally, to support access to doula services statewide and in support of Michigan Medicaid's new coverage of doula services, DMIH will provide doula related education and training content at the 2023 Summit. Resources will also be available through DMIH to support individuals statewide to obtain MDHHS approved doula trainings to further expand Michigan's doula workforce.

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

In FY 2022, CSHCS also participated in Boston University's Care Coordination Academy which provided an opportunity for CSHCS professional development. Through participation in this national, HRSA-funded program, CSHCS learned about care coordination best practices including tiering for complexity and social determinants of health assessments, and the use of evidence to measure system improvements. The CSHCS team included CSHCS and Medicaid staff as well as family, LHD, and university partners. The focus of the project is children with medical complexities.

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

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

- The DCAH convenes an internal Health Equity and Social Justice (HESJ) Workgroup composed of 26 members who are focused on individual growth and consciousness around race and equity issues, with the intention that as MCH professionals grow and are more aware of equity and social justice, their work will be authentically impacted. Agendas focus on topics such as implicit bias and structural racism in healthcare.
- The DCAH provides technical assistance and program support to all 45 local health departments through the Local MCH (LMCH) program. Support ranges from administrative aide in implementing the LMCH program to identification of best practices for specific MCH program areas or performance measures.
- School-based mental health services and staffing for Child and Adolescent Health Centers (CAHCs) expanded through an annual $4 million investment from MI Kids Now funding. This funding will allow each CAHC to fund a full-time mental health provider and increase availability of mental health services for youth throughout the state.
- The FY 2023 state budget included an additional $25 million to start up to 100 school based/linked health centers (Child & Adolescent Health Centers) in new and existing counties in Michigan. These additional

dollars will support primary care, nursing and mental health services in new schools and community locations. DCAH provides support and technical assistance to these centers across the state.

- In January 2023, the Michigan Home Visiting Initiative announced training opportunities that include individual trainings on NEAR, HOPE (Healthy Outcomes from Positive Experiences), and Strengthening Families. Those training sessions are planned for February, May, and August 2023.

MCH staff also participate in a wide range of conferences and professional development opportunities. For example, MDHHS hosts conferences attended by MCH staff and statewide partners, including the Child, Adolescent, School Health (CASH) Conference, Michigan Home Visiting Conference, MIH Summit, and Teen Parent Summit. MCH staff participate in the Mother Infant Health and Equity Collaborative (MIHEC). An MCH team from Michigan (including a family leader) participates in the annual AMCHP conference. The Family Center hosts an annual meeting for the Family Leadership Network (FLN). Each year, the CSHCS Division also invites a parent to attend a CSHCS Division meeting to share their family's story with staff, which is a powerful way for staff to see the impact of their work. CSHCS provides regular workforce development opportunities for LHDs through annual meetings, regular technical assistance, monthly calls and the CSHCS LHD Advisory Council. In response to significant turnover in local health department CSHCS staff, due in part to the COVID-19 pandemic, CSHCS developed and is implementing a series of peer-led training sessions for new local staff to learn from more experienced local staff on various program implementation topics.

Staffing Structures and Workforce Financing

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

The Family Center for Children and Youth with Special Health Care Needs (Family Center) also utilizes an innovative staffing structure. The Family Center requires that all staff hired within the Family Center are parents of children with special health care needs. In addition, the Family Center has a paid Youth Consultant which improves the Family Center's ability to provide a family and youth perspective to CSHCS programming. In FY 2022, CSHCS had one Family Center staff member participating in the MCH Leadership Lab Family Leaders Cohort. The Leadership Lab provides an opportunity for state staff to accelerate their professional development in a way that is framed by MCH Leadership Competencies and guided by adult learning principles.

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

Assessment.

MPHI has also worked with the Maternal Infant Health Program (MIHP) within the Division of Maternal and Infant health to develop intervention-based strategies for supporting families who may have experienced Adverse Childhood Experiences (ACEs). This CDC-funded initiative focused on prevention through public education campaigns and incorporating ACEs into plans of care developed for families as well as training on ACEs and trauma-informed care for home visiting staff. Through continuous funding and support from the Michigan Health Endowment Fund, MPHI will continue to offer support for the expansion of this project within the MIHP statewide network.

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

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

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

- The Michigan Early Hearing Detection & Intervention (EHDI) Program's goals are to provide better outcomes for Michigan newborns and young children with hearing loss and their families. EHDI utilizes the Michigan Hands and Voices (MHV) Guide By Your Side™ (GBYS) program to foster family-to-family supports after a child has been identified with hearing loss. Families are connected with parents of a child who is Deaf or Hard of Hearing (D/HH). They may also choose to speak with an adult who is D/HH, through a mentor program. Families are involved when updating EHDI materials, which are available in Spanish and Arabic. EHDI supported the creation of videos outlining family support services and is currently redesigning the website to improve access to information. EHDI is partnering with MHV to host a Family Matters 2023 conference aimed at families with children who are deaf or hard of hearing. EHDI also sponsors an annual scholarship for parents to attend the national EHDI conference.
- MDHHS provides funding to local health departments (LHDs) and the Inter-Tribal Council (ITC) of Michigan to develop and implement community-based infant safe sleep activities. FY 2023 contracts for LHDs and the ITC require that activities include input from families at highest risk for sleep-related infant death. Grantees are also required to participate in or coordinate a local/regional advisory team (that includes community members) to oversee their safe sleep efforts. Parents are often involved as parent educators and speakers. Additionally, MDHHS convened Action Committees aligned with the priorities of the Mother Infant Health and Equity Improvement Plan. MDHHS regularly partners with two parents with an infant loss who are part of the Infant Safe Sleep Action Team.
- The Parent Leadership in State Government (PLISG) initiative is an interagency effort to recruit, train, and empower parents to be change agents who help shape programs and policies at the state and local level. When parents are engaged as partners and leaders, programs and services better meet family needs, make services more effective, increase fiscal responsiveness and lead to more equitable outcomes. Since 2007, several state agencies (including MDHHS) have collaboratively funded the PLISG, which includes Title V funding. The PLISG Advisory Board includes representatives from funding agencies plus at least 51 percent parents of children ages birth-18 who have been or are eligible to utilize specialized public services. A primary role of the PLISG is to deliver the “Parents Partnering for Change” (PPC) leadership training. Training topics include leadership skills; how to use your voice to tell your story; effective meetings; and handling conflict. Since 2008, 1,492 parents have participated in the training. In 2022, PPC participants reported utilization of the following MCH-related services: WIC (53.9%); food assistance (34.2%); Healthy

Kids (7.9%); Healthy Kids Dental (27.6%); MI Child (23.7%); and home visiting (10.5%). Due to the COVID-19 pandemic, updates were made to the training to ensure that the curriculum could be delivered via an online platform. This delivery mode has continued to be the primary way to access the trainings throughout the pandemic. PLISG training evaluations are completed immediately after each training and three months post-training. A longitudinal evaluation of the PLISG initiative is currently being conducted to better assess the impact of the training and how participants have utilized the training.

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

Children's Special Health Care Services (CSHCS) uses a multifaceted approach to ensure services reflect the needs of the CYSHCN population. A critical component of administering services is the intentional involvement of families of CYSHCN in decision making. To achieve this goal, CSHCS works closely with the CSHCS Advisory Committee (CAC) and the Family Center for Children and Youth with Special Health Care Needs (Family Center). The CAC is comprised of professionals and family members who are involved in the care for children with special needs, with approximately 50% of CAC members being parents or family members of CYSHCN. The CAC makes policy and program recommendations to the CSHCS Division and promotes awareness to ensure that services reflect the voices of CYSHCN and their families. The primary responsibilities of the CAC are to support and maintain clarity of the mission, philosophy, and service goals of CSHCS; promote public awareness of the CSHCS program; and identify strengths and gaps in services. The Family Center assists in recruiting family members to serve on the CAC, the Children with Special Needs Fund (CSN Fund) Advisory Committee, and other committees within the CSHCS Division as needed. The Family Center also compensates family members who serve on these advisory committees.

The Family Center, in addition to serving as a resource and liaison to children with special health care needs and their families, serves functionally as a sounding board for all CSHCS programming and administration. Being organizationally housed in the CSHCS Division, the Family Center provides a tangible reminder to program staff of the importance of its mission and goals resulting in the family perspective being integrated at all levels of the program. Sharing and promoting leadership opportunities within Michigan is an important role of the Family Center. The Family Center has supported family members from the CAC and the CSN Fund Advisory Committee to attend AMCHP's annual conference. The Family Center also recognizes the importance of providing Family Center staff with leadership opportunities. The Family Center Director, a Parent Consultant, a Youth Consultant, and the CSHCS Division Director will also attend AMCHP's annual conference. The Division Director (also the Title V CSHCN Director) previously served as an active member on the AMCHP Family Leadership, Education, and Development (Family LEAD) Committee. The Family Center's Director was accepted to serve on this committee and remains an active participant.

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

In addition to the Parent-to-Parent Support Network, the Family Center provides emotional support and information to families of children with special needs through a variety of other programs. Families can access support through the Family Phone Line, which is a service provided to any family that has a child with special needs. Parent Consultants within the Family Center offer immediate help to families navigating systems of care which includes identifying needs; referral to resources; and connecting parents to educational and emotional supports. The Family Center's statewide Family Leadership Network also provides a diverse community-based perspective on programs and policies as well as a platform for the development of new family leaders. The Family Leadership Network functions on a regional level to inform families of resources and services. The Family Center has recently implemented "Lunches with Leaders." In years past, Parent Mentors expressed the desire to connect to other Parent Mentors within Michigan. Lunches with Leaders are bi-monthly virtual meetings where Parent Mentors throughout Michigan can join to share resources, experiences, and creative solutions with each other. Learning opportunities on topics such as leadership, transition, Life Course, etc. are also included.

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

The Family Center creates significant impact through several projects:

- The Family Center Director and a Parent Consultant serve on the quality improvement efforts within the CSHCS Division related to program evaluation and care coordination. The Family Center is currently in the process of finalizing a Family Guide, which is a family resource packet providing links and information relevant to family support and services. The Family Center is currently exploring use of the Pediatric Integrated Care Survey, created by Boston Children's Hospital, to help the Family Center with internal planning and addressing gaps in the state.
- Based on the most recent Title V Needs Assessment, and the selection of the Title V National Performance Measure to address Bullying, the Family Center and CSHCS have continued to implement a small grant opportunity to local school districts to support a bullying prevention initiative to support CYSHCN and their peers.
- CSHCS offices within local health departments have established in-person and/or virtual parent support groups. The Family Center supports these efforts by providing annual small grant opportunities for local health departments to hire parents to facilitate these support groups. The groups connect parents and family

members of CYSHCN to resources and support from other families.

- The Family Center offers Sibshop Grants to support siblings of children with special health care needs using the evidence based Sibshop model. The goal of the grant is to provide statewide opportunities for brothers and sisters of children with special health and developmental needs to obtain peer support and education within a recreational context with a certified Sibshop.

In response to the COVID-19 pandemic, the Family Center began offering trainings virtually. Virtual options are available for both the Parent Mentor Trainings and Bereaved Parent Mentor Trainings. In response to family feedback during the pandemic, the Family Center offers opportunities twice a month for parents to connect: Parent Connect Calls and Professional Connect Calls. These calls feature speakers from several different areas including disability, education, and other state initiatives. Families that participate in the meetings provide input and assist the Family Center on decisions regarding topics, frequency, and other factors for the meetings.

Lastly, Michigan's Leadership Education in Neurodevelopmental and Related Disabilities (MI-LEND) program is an interdisciplinary leadership training program, funded under the Autism Collaboration, Accountability, Research, Education and Support (CARES) Act. MI-LEND is coordinated by the Michigan Developmental Disabilities Institute (MI-DDI) in partnership with the Family Center and eight Michigan universities. Since its start in 2016, MI-LEND has trained 5,667 graduate and/or professional students, family members, and self-advocates in interdisciplinary leadership and culturally competent, family-centered care. Training includes information about health care transition and the role pediatric health care providers have in supporting youth and families as they transition to adult systems of care.

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

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

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

Maternal and Child Health Epidemiology Section Manager (1.0 FTE)

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

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

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

Infant Health Epidemiologist (1.0 FTE)

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

Newborn Screening Epidemiologist (1.0 FTE)

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

Home Visiting and ECHO Epidemiologist (1.0 FTE)

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

Pediatric Genomics and Early Hearing Epidemiologist (1.0 FTE)

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

Birth Defects and Family Planning Epidemiologist (1.0 FTE)

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

PRAMS Data Analyst (0.75 FTE)

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

Adverse Childhood Experiences Epidemiologist (0.3 FTE)

Kim Hekman, MPH, started as the Adverse Childhood Experiences (ACEs) Epidemiologist in January 2021. Kim

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

Preventable Mortality Epidemiologist (1.0 FTE)

Heidi Neumayer, MPH, started as the Preventable Mortality Epidemiologist in March 2019. Heidi received her Master of Public Health degree from Grand Valley State University in 2016. As the Preventable Mortality Epidemiologist, Heidi is responsible for monitoring and analyzing severe maternal morbidity, maternal mortality, and sleep-related infant deaths. Infants safely sleeping and healthy girls, women and mothers are two priorities in the MIHEIP. Statistics related to these priorities are also utilized within Title V work plans. This position is funded by Title V and other federal funding sources.

The remaining positions within the MCH Epi Section focus on PRAMS operations, maternal mortality surveillance, and COVID-19 activities. PRAMS operations and maternal mortality surveillance are partially supported through Title V. Title V funding is used within PRAMS to help support web, mail, and phone data collection activities. For maternal mortality surveillance, Title V also supports the maternal mortality project coordinator and case abstractor positions that are responsible for requesting/collecting case records, abstracting information from case records, developing summaries of cases for review, and guiding cases through the review committee process. Although not funded by Title V or SSDI, the COVID-19 mortality review team (one project coordinator and one case abstractor) conduct a similar committee review process for a sample of COVID-19 deaths that have occurred in Michigan. Furthermore, the MCH Epi Section employs a public health consultant to perform activities associated with the CDC COVID-19 Pregnancy and Neonate Surveillance project.

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

Vaccine Preventable Disease (VPD) Epidemiologist (1.0 FTE)

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

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

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

Oral Health Epidemiologist (0.5 FTE)

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

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

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

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

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

WIC Epidemiologist (1.0 FTE)

Madhur Chandra, PhD, started as the WIC Epidemiologist in October 2021. Madhur received her PhD in Epidemiology from Michigan State University in 2020. As the WIC Epidemiologist, Madhur is responsible for providing epidemiological knowledge and guidance to the WIC Division for the MCH population it serves. The position creates, manages, and links multiple datasets related to Pediatrics and Pregnancy Surveillance Systems (PNSS & PedNSS) and USDA Participant Characteristics. Data calculated by the WIC Epidemiologist are integrated into WIC-related activities that intersect with other MCH programs (e.g., breastfeeding). This position is fully funded by WIC.

Birth Outcomes Epidemiologist (1.0 FTE)

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

Ongoing MCH Epidemiology Workforce Activities

A few MCH Epi staff within MDHHS are still involved in COVID-19 response projects. The MCH Epi Section is responsible for the Michigan COVID-19 Mortality Review and Michigan’s participation in the CDC COVID-19 Pregnancy and Neonate Surveillance Project. Details of these projects are included in the “Other MCH Data Capacity Efforts” section.

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

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

Michigan's SSDI activities are primarily aimed at strengthening our capacity to collect, analyze, and use reliable data to inform Title V MCH Block data-driven programming. The MCH Epidemiology Section Manager and the Child, Adolescent and School Health (CASH) Epidemiologist meet with core Title V staff to ensure that epidemiologic needs are met for Title V activities. Epidemiologists within the MCH Epidemiology Section work closely with Title V staff to provide epidemiologic support to ongoing Title V needs assessment activities and regularly review and update performance measures and annual objectives.

In addition to ongoing needs assessment activities, the MCH Epidemiology Section continues to provide the Bureau of Health and Wellness with routine statistics in support of Michigan's Title V activities. The MCH Epidemiology Section has placed a focus on expanding the depth and breadth of the infant and maternal health statistics provided to the Title V program. These expanded statistics are also presented to each of the state's regional perinatal quality collaboratives on a routine basis. The CASH Epidemiologist has also presented data related to specific national performance measures to local health department staff as a way of promoting the integration of performance measures into local Title V plans. The MCH Epidemiology Section also continues to assist in the evaluation of selected performance measures and will provide recommendations to the Title V program regarding if or how these measures should be modified.

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

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

The Michigan SSDI Project remains focused on enhancing the development, integration, and tracking of health equity and social determinants of health (SDoH) metrics to inform Title V programming. MCH Epi Section staff continuously examine existing datasets and modify data collection instruments to maximize the collection of health equity and SDoH metrices for MCH populations. Furthermore, MCH Epi Section staff are in discussions with the Division for Vital Records and Health Statistics to develop a more accurate method for collecting race and ethnicity information on birth and death certificates.

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

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

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

In addition to the epidemiologic activities described above, the MCH Epidemiology Section is also responsible for managing Michigan's maternal mortality surveillance program and various COVID-19 activities, including Michigan mortality review committee process and Michigan's participation in the CDC COVID-19 Pregnancy and Neonate Surveillance Project. SSDI supports the MCH Epidemiology Section Manager's role in managing the data component of the Michigan Maternal Mortality Surveillance (MMMS) project, while Title V supports a portion of the MMMS Project Coordinator and Case Abstractor in their maternal death case identification, case summary development, committee review, and recommendation development and implementation activities.

As the COVID-19 pandemic continues to impact Michigan and the nation, several MCH Epidemiology staff are still involved in various COVID-19 activities. The MCH Epidemiology Section is responsible for the COVID-19 Mortality Review and the COVID-19 Pregnancy and Neonate Surveillance Project. SSDI funds continue to partially support the MCH Epidemiology Section Manager's supervisorial activities related to these two projects, while Epidemiology and Laboratory Capacity (ELC) funding from the Centers for Disease Control and Prevention supports the COVID-19 Project Coordinator and Case Abstractor in their death identification, sampling, case abstraction, case summary development, review committee coordination, and recommendation development activities.

For the COVID-19 Mortality Review, medical records are requested, and next-of-kin interviews are conducted for a sample of COVID-19 deaths that occurred in Michigan. This information is then reviewed by a panel of subject matter experts to identify contributing factors, assess COVID relatedness and preventability of the death, and develop recommendations that may help prevent future deaths due to COVID-19. This review committee has completed their review of a sample of deaths from the initial peak and Delta surge and is currently reviewing a sample of deaths from the first Omicron surge. The preventability recommendations from the reviewed cases have been compiled and provided to upper administration to development implementation strategies.

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

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

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

Due to several inquiries regarding the accuracy of infant health statistics that we calculate for Michigan's American Indian population, the MCH Epidemiology Section has had conversations with the Division for Vital Records and Health Statistics regarding potential misclassification of this population. Through these conversations, we have discovered that the parental worksheet that is currently utilized in Michigan to identify race/ethnicity still uses open-ended race and ethnicity variables. These open-ended responses are then translated by birth clerks into the "check all that apply" OMB standard race and ethnicity categories. Due to the potential for misclassification with the current process, the Division for Vital Records will be taking action to update the parental worksheet so that parents are able to directly fill in the "check all that apply" race and ethnicity questions. Once implemented, these changes have the potential to improve the accuracy of maternal and paternal race and ethnicity reporting on the birth certificate for all racial/ethnic populations within Michigan.

Ongoing MCH Epidemiology Workforce Activities

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

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

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

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

The EOP and the Michigan Emergency Management Plan (MEMP) describe planning consideration and outreach for "populations with functional needs" which includes young children, pregnant people, and individuals with disabilities. Staff from the MDHHS Bureau of Health and Wellness (BHW) have been actively involved in both the planning and response to emergencies and disasters. The WIC director is part of MDHHS Executive Leadership Team that reviews the EOP when it is updated. Additionally, WIC is involved with local MDHHS offices that provide human services to community members (which may include recipients of Title V services or other MCH services, such as safe sleep or breastfeeding support, immunizations, lead screening, or CSHCS). The BHW also falls within the Incident Command Structure (ICS) as a key team member of the Community Health Emergency Coordination Center (CHECC). The CHECC structure is in accordance with the National Incident Management System (NIMS).

Following the response to any incident resulting in the participation of subject matter experts (SMEs), which includes the Bureau of Health and Wellness, an After-Action Report (AAR) is developed, along with an Improvement Plan (IP) that is based on lessons learned. These AARs and IPs are reviewed on a regular basis to ensure that processes are amended to improve efficacy and efficiency of programs' response activities during an emergency or disaster. Improvement action items are then integrated into training and exercises to enable MDHHS to better respond to future incidents. Additionally, the MDHHS Preparedness Program is collecting information on community engagement initiatives at the local health department level to inform community engagement and inclusion efforts in the next budget period beginning in July 2023. This preparedness activity was delayed due to COVID-19 response activities.

The Title V role in emergency preparedness and response was evident in the response to the COVID-19 pandemic. Title V leadership and MCH staff participated in departmental COVID-19 response efforts including staffing provider hotlines; contact tracing; standing up alternative care sites; convening and participating on COVID-19 workgroups and committees; and other projects as needed. Staff from the Division of Immunization has led the COVID-19 vaccine distribution effort and the Director of the Bureau of Health and Wellness has led the Department's efforts with local health departments, which included testing, contact tracing, and vaccine distribution and promotion.

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

More recently, the Infant Safe Sleep program formed a collaboration with the MDHHS Emergency Medical Services (EMS) and Systems of Care Division to train first responders in promoting safe sleep practices and provide other

supports. Since July 2022, nine fire departments and EMS agencies have been Infant Safe Sleep Certified and nine additional agencies are currently in the process of becoming certified.

Early in the pandemic, CSHCS worked within the Medical Services Administration on the formulation of policies and procedures that ensured access to care and continuity of services for CSHCS program enrollees. Policy and procedure adjustments were designed to remove barriers to program participation (i.e., enrollment and renewals), protect clients from unnecessary viral exposure by eliminating face-to-face requirements, and increase utilization of telemedicine. Adjustments were also made to ensure access to medications and durable medical supplies (by adjusting prior authorization requirements and modifying requirements related to obtaining durable medical equipment and medications) and to ensure compliance with Centers of Medicare/Medicaid Services and with the Governor's executive orders. CSHCS maintained ongoing communication with local health departments (LHDs), providing guidance and information when relevant to the CSHCS program. In 2021, CSHCS helped to amplify and elevate the voices of parents of children with special needs to revise the state's vaccine priority groups to move family caregivers of CYSHCN into a higher priority category.

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

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

In addition to the information noted above, MCH program areas partnered with local and regional stakeholders during the COVID-19 pandemic to continue to provide critical MCH services, including but not limited to linking families with pediatric audiologists; assuring accessibility for virtual clinical visits and home visits; addressing barriers related to utilizing WIC benefits; and helping families obtain concrete support and needed items (e.g., breast pumps and supplies, diapers, pack and plays, and groceries).

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

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

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

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

Partnerships with external entities that support and complement MCH are described throughout this application and include health care systems, provider organizations, universities, community-based organizations, advocacy organizations, and local health departments (LHDs). These partnerships support program delivery, evaluation, pilot projects, community engagement, and training. The Local Maternal Child Health (LMCH) program is supported by Title V and provides funding to all 45 LHDs to address national and state priorities as well as locally identified needs.

Strengthening Integration of Health Care Delivery

Michigan's MCH programs continually seek strategies to strengthen and integrate services through new or enhanced partnerships. Several are highlighted here by population domain.

Maternal and Infant Health

- High Touch, High Tech (HT2) provides an electronic screening tool based on evidence-based Screening, Brief Intervention and Referral to Treatment (SBIRT) in prenatal care clinics. The tool is used for universal behavioral health screening prior to obstetric intake appointments, with subsequent linkage to services and treatment. HT2 is supported by Regional Perinatal Quality Collaboratives, Michigan State University, Michigan-based vendors for tele-behavioral/mental health, and MDHHS Statewide Opioid Settlement funds.
- The Michigan Alliance for Innovation on Maternal Health (MI AIM) is part of the national quality improvement initiative to prevent maternal morbidity and mortality through evidence-based patient safety bundles. Over half of Michigan birthing hospitals are engaged in MI AIM to implement the obstetric hemorrhage, severe hypertension in pregnancy, and sepsis safety bundles.
- DMIH is partnering with the MDHHS Office of Recovery Oriented Systems of Care to provide funding to three health systems to implement 'rooming in' programs in the hospitals' birthing units. The family-centered model encourages parent-infant bonding and uses non-pharmacological care of infants born substance-exposed, ensuring they remain with their parent or caregiver in a private hospital room. Hospital staff provide support for breastfeeding, skin-to-skin contact, calming techniques, and referrals to services. Statewide Opioid Settlement funds are being used to expand efforts.
- MDHHS partners with the Michigan Breastfeeding Network (MIBFN) to support Great Lakes Breastfeeding Webinars, a free monthly series grounded in racial equity and designed for peer counselors, maternity care nurses, and home visitors.

- DMIH received funding from the Michigan Health Endowment Fund to implement the Maternal & Infant Vitality project in Wayne, Oakland, and Macomb counties. The initiative uses an asset-based approach to identify and build upon regional strengths and a mixed-methods analysis to assess efforts to reduce infant mortality plus. DMIH partnered with three community-based organizations and four local health departments.
- DMIH received funding for “Grief & Bereavement Infrastructure: Maternal & Infant Health Response” to address the need for family and community support immediately following the death of a mother or infant. This is a partnership with 2-1-1, hospitals, and grief providers.
- DMIH partnered with WIC and the Infant Safe Sleep program to create a breastfeeding online course for MCH professionals that will present breastfeeding rates and disparities and the systemic causes behind them; identify health benefits; and share best practices and resources to promote breastfeeding.
- The Early Hearing Detection and Intervention program is collaborating with the University of Michigan to pilot a telehealth project that will test the effect of remote EHDI diagnostic services on EHDI’s loss to follow-up rates.
- DMIH provides funding and partnership to support 12 local health departments and the Inter-Tribal Council of Michigan to conduct Fetal Infant Mortality Review (FIMR) programs across Michigan to identify and analyze factors that contribute to fetal and infant death.
- MDHHS partners with the Michigan Organization on Adolescent Sexual Health (MOASH) which mobilizes youth, engages community partners, and informs decision makers. Youth engaged in MOASH Youth Advisory Councils help to identify ways to improve access to sexual and reproductive health care and inform Family Planning website content to be more youth friendly.

Child and Adolescent Health

- MIECHV and state-funded home visiting programs are expanding partnerships with the child welfare system to ensure families whose children are at risk of entering foster care are provided voluntary referrals to home visiting. Plans to build a more connected system for families who are experiencing substance use or who have an infant born substance exposed are also underway to ensure that health care systems are aware of home visiting and warm handoffs are available for families. Service navigator positions have been embedded in birthing hospitals and high-need OB clinics to help connect families to home visiting.
- A partnership between law enforcement, schools, human services, and local mental health is leveraged through Michigan’s Handle with Care Initiative which provides trauma-informed support within schools to students who have had an experience in which law enforcement was involved.
- The Child & Adolescent Health Center program is expanding in new communities in 2023 through an annual $25 million investment from the state budget. This will expand primary care, nursing, and mental health services to underserved children and adolescents throughout the state. This program is a partnership between healthcare, education, and behavioral health networks and in over 240 schools in Michigan.

CSHCN

- In partnership with Michigan Medicine, Michigan Medicaid, and other Michigan-based children’s hospitals, CSHCS is exploring a Children with Medical Complexity benefit to improve health outcomes, increase patient and family satisfaction, and decrease costs associated with care.
- CSHCS partnered with MDHHS Public Health Genomics and the Sickle Cell Disease Association of America (SCDAA-MI) to investigate health inequities related to Sickle Cell Disease (SCD). As a result, a proposal was submitted to the Governor’s Office to support a CSHCS adult benefit expansion, long-term services provided by SCDAA-MI, and expanded clinical services. The collaboration will create a list of

providers who treat SCD; catalog state activities to ensure collaboration and efficiency; and address inequities related to provision of transition services for adolescents with SCD. The proposal was embraced by the Governor and enacted in the FY 2022 Michigan budget appropriation.

- In FY 2021, CSHCS and the Family Center launched a bullying prevention initiative aimed at decreasing bullying in the CYSHCN population. The effort is a collaboration between CSHCS, the Family Center, Adolescent and School Health, MDE, and the CSHCS Advisory Committee. Activities included a focus group with parents of CYSHCN, a small grants program for schools, and participation in a HRSA Region IV/V collaborative.
- The Family Center's Parent-to-Parent program is Michigan's statewide Parent to Parent Support Network. The Family Center is also an alliance member of Parent-to-Parent USA which allows Michigan to connect with other states and have a broader reach when seeking mentor matches for parents in Michigan. The Family Center's network consists of Parent Mentors who have been trained to support other caregivers of children with the same or similar diagnosis as their own child's. These Parent-to-Parent connections provide emotional and informational support to Michigan parents.

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

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

The Title V/Medicaid agreement is contained in the Medicaid State Plan (Sections E and F). Discussions between Title V leadership and MDHHS legal counsel determined that the existing document broadly outlines the relationship between the two entities which are both housed in MDHHS.

One of the largest partnerships is between Medicaid and CSHCS. In January 2023, 82.8% of CSHCS enrollees were dually enrolled in Medicaid and approximately 85% of those dual enrollees were served through an MHP. In relation to Section E of the Medicaid State Plan, CSHCS determines programmatic eligibility for CSHCS; provides case management in coordination with LHDs and Children's Multidisciplinary Specialty (CMDS) clinics; authorizes providers; and utilizes the same payment mechanism as Medicaid (CHAMPS). BPHASA determines eligibility for Medicaid; conducts CSHCS medical reviews for prior authorizations and medical eligibility; pays CSHCS providers; and provides IT support. Medicaid is responsible for the medical care and treatment of Medicaid enrollees dually enrolled in CSHCS. Assistance with community-based services beyond medical care and treatment is provided by the LHD CSHCS office. MHPs are responsible for coordinating with LHDs and CMDS clinics to provide essential health care and support services for enrollees. MHPs are also responsible for the coordination and continuity of care for enrollees who require integrated medical, behavioral health and/or substance abuse services. CSHCS has been integrated into the MHP contract compliance review process. In 2022, CSHCS participated in MHP site visits with Managed Care Plan Division (MCPD) staff. These reviews focused on sickle cell disease, children with medical complexity, health equity, and case management.

In relation to Section F, several programs and initiatives support maternal and infant care, dental health, and children and youth health through cooperative program planning and monitoring; referrals; program standards and guidelines; and certification processes between MCH and Medicaid. The MCPD in BPHASA requires all MHPs to ensure home visiting for pregnant people and families with infants enrolled in managed care. The Maternal Infant Health Program (MIHP), Michigan's largest evidence-based home visiting program, is available to all pregnant people and infants up to age one who are eligible for Medicaid insurance. In FY 2022, MIHP provided services to 12,127 pregnant people and 15,069 infants. The goal of MIHP is to promote healthy pregnancies, positive birth outcomes and healthy infant growth and development with the long-term goal of reducing infant mortality and morbidity. MIHP is jointly managed by the Division of Maternal and Infant Health (DMIH), the MCPD, and the Medicaid Program Policy Division (MPPD). DMIH develops MIHP procedures, monitors the fidelity of the program (e.g., compliance to the model and quality services through certification) and provides technical assistance to MIHP providers. MPPD promulgates Medicaid policies. MCPD helps providers implement Medicaid policies, monitors MHP contracts and makes payments to Medicaid providers. MIHP has shown favorable effects on prenatal care, birth outcomes (e.g., prematurity, low birth weight), postpartum care, and well-child visits.

The Healthy Kids Dental (HKD) program is available for children enrolled in Medicaid and CHIP. HKD provides dental coverage to approximately 1 million qualifying individuals including infants, children, and pregnant people under the age of 21. Eligible beneficiaries are offered two HKD dental health plans. Since 2018, non-Healthy Michigan Plan Medicaid eligible pregnant women receive dental care through managed dental plans due to a

Comprehensive Health Care Program 1915(b) waiver amendment. This benefit provides greater access to dental services and comprehensive prenatal care. MCH and BPHASA coordinate oral health outreach and engagement via multiple avenues including MIHP and other home visiting networks. Infants and children receive preventive services through the Varnish Michigan and SEAL! Michigan programs targeted to the Medicaid population. Healthy Michigan Plan beneficiaries receive dental benefits through MHP managed dental networks.

MCH programs and Medicaid also collaborate on quality improvement initiatives for women, pregnant women, infants, children, and CSHCN such as:

- *Medicaid Eligibility:* To better address maternal and infant health disparities, MDHHS extended Medicaid eligibility for postpartum women to 12 months beginning April 1, 2022, and began covering doula services as of January 1, 2023. An initial cohort of doulas are currently enrolled as Medicaid providers, and MDHHS is focused on expanding the provider base to improve service accessibility.
- *EPSDT or Well Child Services:* Medicaid Managed Care is an important payor for preventive health care services for children and youth. The Division of Child and Adolescent Health works to improve well care rates for adolescents with Medicaid through Child & Adolescent Health Centers. The work is especially important as states focus on preventive care and immunizations that declined during the COVID-19 pandemic.
- *Lead Poisoning Prevention Projects:* Medicaid and CLPPP partner on data quality projects to decrease inconsistencies between data sets; improve reporting, testing, and interventions; and improve data availability for LHDs, Medicaid Health Plans, and foster care health liaison officers. They also partner on education to health care providers and MHPs about elevated blood lead outreach, testing recommendations and requirements, and implementation of point-of-care testing.
- *Caring for Students:* Michigan continued to roll out its expanded coverage for nursing and mental health services for general education students through a CMS approved Medicaid waiver that expanded the existing school-based services program. This expanded coverage, called Caring 4 Students (C4S), enables schools that provide mental health and nursing services to general education students to receive Medicaid reimbursement. All 56 Intermediate School Districts participate in C4S, and 800,000 students are eligible to receive services.
- *MI Kids Now:* MI Kids Now is a statewide effort to improve behavioral health services for children and youth with Medicaid coverage and/or in the foster care system by ensuring access to behavioral health services and support when needed. CSHCS continues to participate and provide a voice for children with special health care needs and their families. CSHCS is also working behavioral health colleagues to develop tools for families, provide education, and create system navigation resources for LHDs and community mental health staff.
- *Quality Monitoring:* In 2023, MDHHS will begin using Performance Monitoring Reports to track Medicaid health plan performance on several measures related to maternal and infant heath, including:
    - Prenatal Immunization Status
    - Prenatal Depression Screening and Follow-Up
    - Postpartum Depression Screening and Follow-Up
    - Prenatal and Postpartum Care: Postpartum Care (PPC)
    - Contraceptive Care–Postpartum Women (CCP)
    - Pregnancy Management
    - Tobacco Use: Screening and Cessation Intervention
- *Medicaid Comprehensive Quality Strategy (CQS):* The CQS provides the framework to design and implement a coordinated and comprehensive system to proactively drive quality across all Michigan Medicaid managed care programs, including the CSHCS managed care program. CSHCS participates in this effort to

assess and improve the quality of care and services provided to CSHCS clients.

Title V and MCH leadership and program staff routinely meet with BPHASA regarding collaboration on these and other initiatives. For example, MIH leadership meets with BPHASA regarding doula coverage, maternal and infant health disparities, and the Healthy Moms Healthy Babies initiative.

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

State Action Plan Introduction

The following state action plans provide comprehensive information including objectives, strategies, and performance metrics regarding Michigan's Title V MCH priority areas. Per Title V requirements, the state action plans are organized within five population domains: women/maternal health; perinatal/infant health; child health; adolescent health; and children with special health care needs (CSHCN). Michigan also created one measure within the optional cross-cutting/systems building domain. The NPM/SPM/priority needs linkages table, included in the Supporting Documents, provides a snapshot of Michigan's performance measures and priority areas across the population domains. The state action plans for FY 2024 focus on the following National Performance Measures (NPMs) and State Performance Measures (SPMs):

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

These NPMs and SPMs were chosen based on Michigan's five-year needs assessment completed in 2020 for the FY 2021-2025 cycle. This is also the second year of reporting for the current five-year cycle. Therefore, FY 2022 annual reports are provided for the NPMs and SPMs listed above. The NPM/SPM annual reports include a discussion of activities and outcomes; family and community engagement strategies; health equity strategies; and impacts of the COVID-19 pandemic.

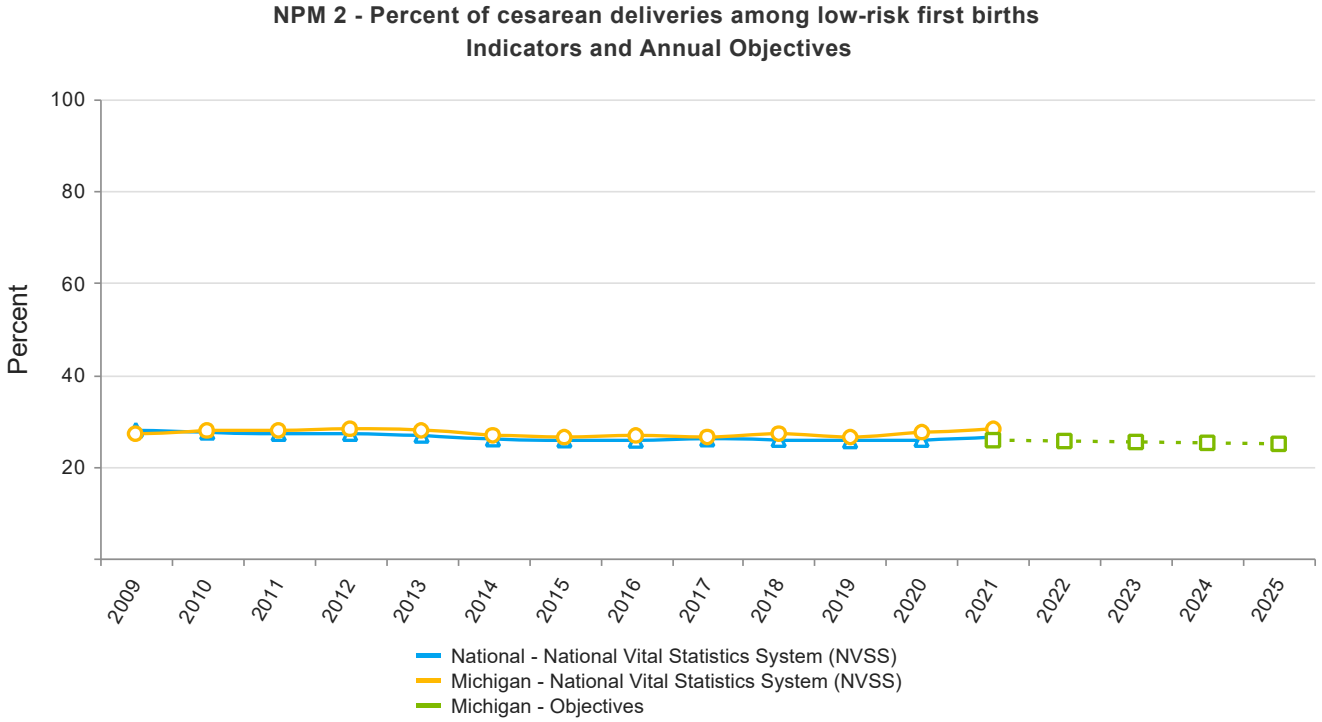
Each domain includes a brief overview of key MDHHS activities and leadership within the domain as well as information on how local health departments (LHDs) utilized Title V funding in FY 2022 to address national, state, and local performance measures. Local health departments complete an annual Local Maternal Child Health (LMCH) plan that describes the jurisdiction's priority maternal and child health needs; the action steps that will be used to address the needs; and the service categories from the MCH pyramid of services.

Local MCH needs and priorities vary across the state. Therefore, communities may have locally identified needs that they address via Title V funding which are not captured by the state priorities or performance measures. In addition to Michigan's identified NPMs and SPMs, 19 LHDs selected a Local Performance Measure (LPM) which collectively accounted for 29% of total LMCH expenditures in FY 2022. A summary of local priorities (addressed through an LPM) and related expenditures is included in the "Expenditures" section of this application.

Additionally, LHDs continued to divert or postpone some planned activities in FY 2022 as they responded to the COVID-19 pandemic. COVID-19 mitigation strategies included reporting, outbreak mitigation/support, and vaccination activities. Agencies also reported a high frequency of staff vacancies. In total, eight LHDs redirected funding in the amount of nearly $190,000 from planned LMCH activities to COVID-19 mitigation in FY 2022.

Women/Maternal Health

National Performance Measures



Federally Available Data				
Data Source: National Vital Statistics System (NVSS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			25.6	25.6
Annual Indicator	27.3	26.5	28.1	28.1
Numerator	9,510	9,054	9,273	9,273
Denominator	34,845	34,117	33,009	33,009
Data Source	NVSS	NVSS	NVSS	NVSS
Data Source Year	2018	2019	2021	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	25.4	25.2	25.0

Evidence-Based or –Informed Strategy Measures

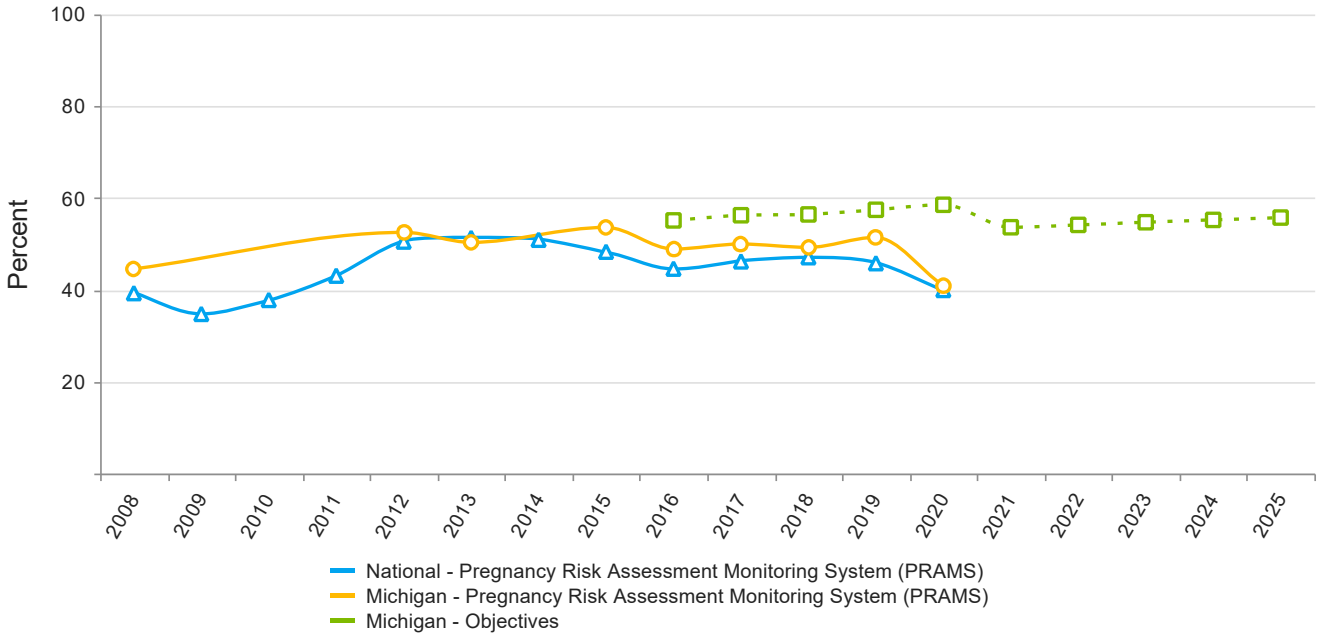
ESM 2.1 - Number of birthing hospitals participating in Michigan AIM

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	73.0	74.0	75.0

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy
Indicators and Annual Objectives



Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	56.4	57.4	58.5	54.1	54.1
Annual Indicator	49.8	49.2	51.3	40.8	40.8
Numerator	53,356	51,874	53,228	40,909	40,909
Denominator	107,079	105,470	103,825	100,195	100,195
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2020

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	54.7	55.2	55.7

Evidence-Based or –Informed Strategy Measures

ESM 13.1.1 - Number of medical and dental professionals who receive perinatal oral health education through MDHHS

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		390	410	430	450
Annual Indicator	648	401	423	439	253
Numerator					
Denominator					
Data Source	FY2018 MDHHS Tracking Database	FY2019 MDHHS Tracking Database	FY2020 MDHHS Tracking Database	FY2021 MDHHS Tracking Database	FY 2022 MDHHS tracking database
Data Source Year	FY2018	FY2019	FY2020	FY2021	FY2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	470.0	490.0	510.0

ESM 13.1.2 - Percent of pregnant people who receive at least one oral health service through Medicaid during the perinatal period

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

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	42.0	43.0	44.0

State Performance Measures

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

Measure Status:	Active

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

Annual Objectives			
	2023	2024	2025
Annual Objective	61.9	63.0	64.0

State Action Plan Table

State Action Plan Table (Michigan) - Women/Maternal Health - Entry 1	
Priority Need	
Develop a proactive and responsive health system that equitably meets the needs of all populations, eliminating barriers related to race, culture, language, sexual orientation, age and gender identity	
NPM	
NPM 2 - Percent of cesarean deliveries among low-risk first births	
Objectives	
A) By 2025, reduce the percentage of cesarean deliveries among all Michigan low-risk births to 27%	
B) By 2025, reduce the percentage of low-risk cesarean births in African American, American Indian and Asian/Pacific Islander pregnant people to 28%, 29.3% and 28.4% respectively	
Strategies	
A1) Educate the Regional Perinatal Quality Collaboratives (RPQCs) regarding low-risk Cesarean data A2) Regional representatives will share ongoing information with RPQCs regarding the Obstetrics Initiative (OBI) and Alliance for Innovation on Maternal Health (AIM) bundle on safe reduction of primary cesarean birth A3) Continue partnering with the American College of Obstetricians and Gynecologists (ACOG) Alliance for Innovation on Maternal Health (AIM) and work through MI-AIM to increase the number of birthing hospitals participating in MI-AIM	
B1) Include bias and equity training as part of the MI-AIM hospital designation criteria B2) Encourage and support ongoing bias and equity training of MI-AIM Steering and Operations Committee members B3) Support ongoing education and training regarding bias and equity for the Michigan Maternal Mortality Surveillance Review Committee members	
ESMs	**Status**
ESM 2.1 - Number of birthing hospitals participating in Michigan AIM	Active
NOMs	
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	
NOM 3 - Maternal mortality rate per 100,000 live births	

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

Priority Need

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

NPM

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Objectives

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

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

Strategies

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

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

ESMs	Status
ESM 13.1.1 - Number of medical and dental professionals who receive perinatal oral health education through MDHHS	Active
ESM 13.1.2 - Percent of pregnant people who receive at least one oral health service through Medicaid during the perinatal period	Active

NOMs

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

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

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

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

Priority Need

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

SPM

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

Objectives

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

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

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

Strategies

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

B1) Support at least 8,000 individuals' access to publicly funded contraception B2) Translate regional listening session findings into action for youth and young adults B3) Translate youth input into action on the Family Planning website

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

Women/Maternal Health Overview

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

Title V funding also supports the Local Maternal Child Health (LMCH) program which provides funding to all 45 Local Health Departments (LHDs). In FY 2022, Title V funds via the LMCH program were expended on NPM 13.1 (oral health-women), SPM 5 (intended pregnancy), SPM 6 (behavioral/mental health), and Local Performance Measures (LPMs) in the women/maternal health domain. Two LHDs worked on engaging women regarding oral health (NPM 13.1) through education, referrals, and community outreach. Four LHDs supported intended pregnancy (SPM 5) and an LPM for well-women activities through gap-filling reproductive health services, reproductive education and counseling, data analysis of postpartum visits, a postpartum toolkit, and media campaigns with preconception and reproductive life plan topics. Staff training and participation in county/regional meetings also occurred. Three LHDs expended funds on SPM 6 (behavioral/mental health) including gap-filling depression screening and treatment referrals for women and pregnant women, staff development, and participation in coalition meetings.

Ten LHDs chose LPMs in the women/maternal health domain with activities that included gap-filling immunizations for childbearing women, childbirth education classes, a peer mentor initiative for pregnant people, gap-filling Healthy Families America support, support for MCH telephone information/referrals, a postpartum visit media campaign, tobacco cessation services, and stakeholder education on MCH issues. LMCH funds were diverted for COVID-19 mitigation strategies in this domain including COVID-19 vaccinations for women and a media campaign. Some planned activities and outreach could not be completed due to the pandemic, but agencies noted improvements over previous years. Many meetings and educational events remained virtual until mid-year when restrictions were lifted, and some in-person events occurred. LHDs reported that COVID-19 impacted referral rates as well as the acceptance of services.

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

Low-risk Cesarean Delivery (FY 2022 Annual Report)

Recent data trends suggest that low-risk cesarean deliveries among all Michigan births have increased in calendar years 2020 and 2021. Continued partnerships and collaborations with key internal and external partners are vital to reversing this trend. Examples of partnerships include Michigan families, the Michigan Perinatal Quality Collaborative (MI PQC)/Regional Perinatal Quality Collaboratives (RPQCs); Michigan Alliance for Innovation on

Maternal Health (MI AIM); Obstetric Initiative (OBI); Michigan Department of Health and Human Services (MDHHS) Maternal and Child Health (MCH) Epidemiology; Michigan Maternal Mortality Surveillance program; Michigan birthing hospitals; and Michigan Public Health Institute (MPHI).

The impacts of the COVID-19 pandemic continued to be felt across maternal and child health programs in FY 2022. Hospitals continued to face staffing shortages and thus had limited bandwidth to take on additional tasks, meetings, or trainings. However, toward the end of FY 2022, some agencies began offering hybrid meetings with the option for individuals to attend in-person or virtually. Staff have continued to recognize the importance, and strive toward the incorporation, of quality improvement within maternal and infant health. Two Regional Perinatal Quality Collaboratives with historically low MI AIM participation continued to encourage engagement of additional birthing hospitals in their respective regions. Health equity remained at the forefront of all efforts, including those of the Regional Perinatal Quality Collaboratives, MI AIM, and the Michigan Maternal Mortality Review Committee. Implicit bias education of providers was supported through multiple maternal health entities.

Objective A: By 2025, reduce the number of cesarean deliveries among all Michigan low-risk births to 26%.

Collaboration between the Regional Perinatal Quality Collaboratives (RPQCs), MI AIM and the Obstetric Initiative continue to be important in Michigan's efforts to reduce the overall percentage of low-risk cesarean deliveries. Updated state data show that low-risk cesarean deliveries have increased from 28.2% in 2019 to 28.7% in 2020, and then to 29.1% in 2021[1]. RPQCs are continually encouraged to create better alignment with MI AIM to strengthen relationships between community and clinical efforts to address maternal, infant, and family health. In FY 2022, MDHHS was awarded a grant from the Centers for Disease Control and Prevention to expand and enhance participation of birthing hospitals with MI AIM and the RPQCs, as well as support quality improvement efforts of birthing hospitals. RPQCs also receive financial support from MDHHS, a portion of which is Title V federal funding, as well as staff support in the form of a direct consultant and a Michigan PQC Coordinator.

Michigan families are the most important partner in MDHHS efforts. Therefore, RPQCs are expected to authentically engage families and community members from their respective regions in their ongoing efforts. Hosting regional townhalls is one example of how RPQCs have engaged community members. For the past three years, the townhall meetings have been paused due to the COVID-19 pandemic. The end of FY 2022 offered some reprieve from the pandemic and thus, planning began for townhall meetings which will be held in quarters two and three of FY 2023. In past townhall meetings, community members and families came together to provide feedback and give direction to efforts of the RPQC and MDHHS. Individuals shared powerful personal birthing experiences, including those who were forced to have a cesarean delivery out of convenience for the provider or due to the decision of the provider to utilize higher-cost birthing interventions. Progress hinges on provider and community understanding of the importance of reducing rates of low-risk cesarean deliveries. Garnering feedback and stories from those with lived experience will enhance that knowledge and stimulate discussions within each RPQC on efforts that can be implemented. Pairing stories of lived experience with data can make a greater impact and therefore, in FY 2023, data on low-risk cesarean deliveries will be included in the annual RPQC data meetings.

The RPQCs received region-specific maternal morbidity and mortality data as part of the FY 2022 data meetings. The data were not directly attributed to cesarean deliveries; however, low-risk cesarean deliveries can lead to outcomes such as hemorrhage, infection, uterine rupture, cardiac arrest, and anesthesia complications – all of which are included in morbidity and mortality data. Additionally, as the Michigan Maternal Mortality Review Committee (MMRC) reviews maternal mortality cases, policy recommendations aimed to prevent future deaths are drafted and shared through various avenues, one of which is the Regional Perinatal Quality Collaboratives. Recent MMRC recommendations include implementation of the Safe Reduction of Primary Cesarean Birth Safety Bundle. This

bundle is currently being implemented in 75 of 80 Michigan birthing hospitals through the Obstetrics Initiative, but the identification of it as an MMRC priority recommendation speaks to the importance of it as a continued area of focus.

Each of Michigan's 10 prosperity regions are represented by an RPQC and have an assigned MI AIM representative. As part of the ongoing alignment between the RPQCs and MI AIM, the MI AIM regional representatives are required to provide bi-annual MI AIM and OBI updates to their respective RPQC membership. In FY 2022, most RPQCs received at least two updates from their MI AIM representative. Updates include the status of regional birthing hospitals on implementation of the Obstetric Hemorrhage, Severe Hypertension in Pregnancy and Maternal Sepsis safety bundles, as well as OBI performance indicators. General MI AIM updates are also provided. Participation in the RPQC and OBI activities is further encouraged through MI AIM designation criteria. In FY 2022, criteria included points associated with birthing hospital participation in their respective RPQC, as well as points for an OBI metric.

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

The COVID-19 pandemic impacted the participation of birthing hospitals with MI AIM. Staffing turnover and limited staffing impacted the ability of some hospitals to fully engage in bundle implementation and/or data abstraction. Two Michigan RPQCs continued to work with birthing hospitals in their respective regions to engage them in MI AIM. These regions historically had low participation with MI AIM. In FY 2022, Region 10 (southeast Michigan) was able to obtain commitment from 19 birthing hospitals to participate in MI AIM. In previous years, only 12 hospitals had been actively participating. Additionally, in Region 1 (Upper Peninsula) all eight birthing hospitals committed to participate in MI AIM, whereas previously, only three hospitals actively participated. The most recent data available for this ESM is from 2021. In 2021, 65 out of 80 birthing hospitals actively participated in MI AIM.

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

The data trend for this objective appears to follow the trend seen in the previous objective; percentages of low-risk cesarean deliveries has increased from 2020 to 2021. This is also the trend seen in overall US data. From 2020 to 2021 low-risk cesarean deliveries in Michigan increased in African American pregnant people (from 30.9% to 32.2%) and in Asian/Pacific Islander pregnant people (from 31.3% to 32.6%). In the same year, low-risk cesarean deliveries decreased (from 32.1% to 31.0%) in American Indian pregnant people[2]. Despite this decrease in the data for American Indian pregnant people, the data for each population is still illustrative of a persistent disparity. One approach that Michigan is taking to reduce the racial disparity in low-risk cesarean deliveries is to support ongoing bias and equity training and education in birthing hospital staff and providers, MI AIM members and leaders, and the Michigan Maternal Mortality Review Committee members.

Every year Michigan birthing hospitals are assessed for their level of participation and commitment to implementing

AIM safety bundles. The safety bundles are standardized approaches for condition specific, evidence-based practices, which when delivered in a consistent manner, result in improved patient outcomes. To assess individual birthing hospitals, MI AIM uses a set of 'designation criteria' in which points are assigned to various criteria yielding a final tally and corresponding score. Bias and equity trainings were included as a priority in the 2022 designation criteria.

Home visitors also have a role in helping to reduce low-risk cesarean deliveries as they meet with clients prenatally. They provide education to clients on the risks of non-medically indicated cesarean births and how to advocate for themselves. All Maternal Infant Health Program (MIHP) home visiting agency staff are required to take a Health Equity and Systemic Racism course to ensure that office staff, coordinators, and home visitors are equipped to provide equity-based services tailored for the needs of the family with dignity and respect. In addition, Licensed Social Workers and Registered Nurses who provide MIHP case management services are required to pursue education on implicit bias and its effect on service delivery.

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

The Health Equity Action Committee is one of five Mother Infant Health Action Committees that were launched by MDHHS in FY 2021. Over the course of FY 2022, the Health Equity Action Committee met to discuss next steps. Leadership of the Health Equity Action Committee felt that membership's time would be best spent by integrating health equity into the goals and objectives of other Action Committees to further strengthen those priorities. Several members of the Health Equity Action Committee joined one of the four other Action Committees.

In FY 2022, Michigan's Maternal Mortality Review Committee piloted the Discrimination, Assessment and Social Determinants of Health Tool (DASH tool), which was developed by the Texas Maternal Mortality and Morbidity's Subcommittee on Maternal Health Disparities, to better address and identify the role of bias and discrimination in maternal mortality. This tool provides a standard process to guide discussion on determining the extent discrimination on individual, system, and community levels contributed to the person's death. The tool aides in completion of the Maternal Mortality Review Information Application (MMRIA) Committee Decisions Form, a standardized tool used to document committee decisions on pregnancy relatedness, cause of death, preventability, critical contributing factors to the death and recommendations for prevention and intervention. MMRC members also received information on trainings that address health equity, implicit bias, stigma, and antiracism, as well as met the MDHHS Bureau of Licensing and Regulatory Affairs requirements for license renewal.

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

In FY 2022, the Michigan Maternal Mortality Surveillance (MMMS) program also convened an advisory group, MMMS Recommendations Workgroup. The advisory group is tasked with acting on the prevention recommendations developed by the MMRC. The MMMS Recommendations Workgroup's diverse members represent various specialties, facilities, and systems that interact with and impact maternal health.

Oral Health – Women/Maternal Health (FY 2022 Annual Report)

In FY 2022, The Michigan Oral Health Program (OHP) worked diligently amongst many challenges to improve oral health awareness and to create an oral health delivery system that provides access through multiple avenues. Although the COVID-19 pandemic has entered a new phase, and a new normal has emerged, clinics continue to suffer from staffing shortages and capacity limitations, which has caused considerable strain on Michigan's oral health safety net. Resources remain limited and wait times for care may be measured by months. Despite these challenges, the OHP has worked to provide comprehensive programming and technical assistance to its partners across the state and has maintained a successful perinatal oral health initiative. FY 2022 saw an influx of new, diverse partnerships and continued opportunities for education and system transformation through data driven strategies. In combination with other funding, Title V supports an Oral Health epidemiologist who analyzes PRAMS data and Medicaid utilization data within NPM 13.1. The epidemiologist also assists in survey development, needs assessments, dashboard creation, and other data needs as required by the perinatal oral health program.

NPM 13.1 continued to play a vital role in multiple state and national partnerships, specifically with the Association of State and Territorial Dental Directors (ASTDD), the Michigan Initiative for Maternal and Infant Oral Health (MIMIOH), and the Network for Oral Health Integration (NOHI). The OHP worked with these programs to improve oral health for pregnant women and children through technical support and assistance. The OHP maintained working relationships with WIC, Head Start, advisory committees, local coalitions, and refugee organizations to further promote and advise on issues within perinatal oral health. New partnerships were also developed with Regional Perinatal Quality Collaboratives and the Office of Great Start. In partnership with stakeholders and program such as these, the OHP continued to see success in FY 2022 in educating professionals (with over 250 trained); developing a first-of-its-kind data methodology that is now serving as a national model; piloting a refugee dental day; continuing to utilize educational modules for clients; and launching new projects which have helped to educate and inform new partners serving some of Michigan's most vulnerable populations.

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

In FY 2022, the MDHHS Oral Health Program continued to expand efforts to train and educate the medical and dental communities on the importance of perinatal oral health, as well as methodologies and best practices to integrate perinatal oral health into practice. The evidence-based or informed strategy measure (ESM), which is the number of medical and dental professionals who receive perinatal oral health education through MDHHS within a 12-month period, is part of this objective. FY 2022 focused on maintaining current relationships with the University of Michigan College of Nursing as well as expanding into new partnerships. Of particular significance were extensive work with Michigan's refugee populations, the Office of Great Start with the Michigan Department of Education, and the development of a plan to partner with Regional Perinatal Quality Collaboratives. By participating in webinars with organizations such as the Early Childhood Support Network and home visiting groups, the Perinatal Oral Health Initiative was able to speak not only to public health professionals but also engage directly with parents and community members. During FY 2022, 253 health professionals were trained on culturally competent, practical perinatal oral health practices. This is a decrease from previous years due to an extended maternity leave for the MDHHS Perinatal Oral Health Consultant. Although there was a decrease in the number of providers trained in FY 2022, a notable addition to increase the quality of education was launched—a first-of-its-kind, interactive Medicaid utilization dashboard for dental care during pregnancy. Michigan is the first state to have developed a methodology for obtaining accurate data from the data warehouse and our efforts are being used as a model for other states with the Dental Quality Alliance. By being able to show specific utilization rates and health inequalities within Michigan's different regions, the Perinatal Oral Health Initiative has been able to engage with organizations and provide applicable, real-life information regarding the populations they serve. The interactive dashboard is also published on

the MDHHS website for public use. This dashboard and Medicaid utilization measure informs an ESM for this strategy, which is the number of pregnant people on Medicaid who have at least one dental encounter during the perinatal period. The goal for FY 2022 was 41% and in FY 2022 the utilization rate was 20%. For comparison, pre-COVID statewide rates hovered around 24% which is typical of overall Medicaid utilization rates in Michigan for adult dental. The FY 2022 (using FY 2021 data) numbers show the continued impacts of COVID on dental utilization even into later years.

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

In FY 2022, the OHP analyzed PRAMS and Medicaid utilization data to assess differences in dental care amongst different races and ethnicities. Although our capacity to delineate between many races and ethnicities is limited, we have been able to show disparities between people who are Black, White, and Hispanic. In our last available reporting data, white, non-Hispanic individuals were more likely to have received dental care (21%) during their pregnancy than those who were Hispanic (17%). Geographic data indicates that the Detroit area has some of the lowest dental utilization during pregnancy with only 14% percent of pregnant people having any type of dental care. In comparison, Southwestern Michigan has utilization rates of nearly 30%. These data have offered tremendous insight into geographic disparities. FY 2022 focused on targeting specific areas through education as well as identifying barriers and opportunities that may have influenced differences in rates across the state.

In FY 2022 the Oral Health Program worked closely with Michigan's refugee community to help educate staff and families as well as help link incoming Afghan nationals to dental care. The OHP collaborated with refugee resettlement agencies, Delta Dental, the Michigan Primary Care Association, the US public health service, mobile dental providers, dental schools, and other volunteer dentists to help coordinate dental care to hundreds of Afghan nationals (including pregnant people) staying in a large hotel. This complex effort helped to triage families, identify needs, and work with partners to obtain follow-up care. This was the first time the OHP has worked in this capacity with refugee agencies and plans to continue to provide education and logistical support in the future.

Michigan expanded access to Medicaid through a dental pregnancy benefit that expanded dental coverage to one-year post-partum in FY 2022. This benefit allows pregnant people to be placed in a health plan resulting in an increased network of accepting providers and allows coverage to be maintained for one year post delivery date. This expansion is critical for allowing the completion of care considering dental staffing shortages, current wait times, the socioeconomic barriers pregnant people may face that result in delayed care, and time to allow the completion of complex treatment plans. In FY 2022, education surrounding this benefit was integrated into trainings from the perinatal oral health program and was well received by agencies and families served—many of which did not have prior knowledge of this expansion. As this and other Medicaid enhancements become established, the oral health program will report on their impact on the number of pregnant people who utilize care.

In FY 2022, the Michigan Initiative for Maternal and Infant Oral Health (MIMIOH) worked to maintain participating sites and share results from its comprehensive evaluation. Its continued goal is to improve the oral health of mothers and children in the state of Michigan, with particular focus on patients within Federally Qualified Health Centers. Evaluation results indicated that pregnant people who received pregnancy care at a participating site had a 20% increase in receiving needed care, with more than half of pregnant people having a dental encounter as compared to non-participating sites. Further refinement of the model continues, and sustainability has been achieved in sites with a large enough patient population to create fiscal sustainability. Nationally, Michigan continues to serve as a model on interprofessional practice and other entities are in the process of replicating adding dental hygienists into the medical team.

Lastly, in FY 2022 the MDHHS Oral Health Program continued to provide education to women via the Perinatal Oral

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

Intended Pregnancy (FY 2022 Annual Report)

In FY 2022, MDHHS focused on strategies to maintain access to reproductive health services, including long-acting reversible contraceptives (LARC); family planning services across the state; enhanced providers' skills to recognize and address bias and provide high-quality, client-centered care; translated youth and young adult input on reproductive and sexual health (RSH) service needs into action; and improved MDHHS-related reproductive health care policy, practice, and programming. Title V funding helped to support access to reproductive health and contraception through local agencies with a focus on serving young adults. Michigan's Family Planning network continued to use telehealth to expand and enhance access to contraception while limiting exposure to COVID-19 for staff and clients and other emergent public health threats. While innovation has been utilized to maintain and expand access, COVID-19 has adversely impacted Michigan's Family Planning Program. MDHHS relies heavily on its local public health system to deliver affordable reproductive health care services. Local public health was integral to the COVID-19 vaccine rollout across the state and ongoing mitigation strategies, thus affecting service delivery capacity (e.g., staffing shortages, appointment scheduling/spacing) for other programs including family planning.

While MDHHS was able to translate some virtual input gathered from young adult Michiganders on their reproductive and sexual health (RSH) needs, COVID-19 impacted MDHHS's ability to develop meaningful relationships with strained community-based agencies to fully implement its planned regional listening sessions. MDHHS continued to promote its "youth-informed" media campaign, which highlights affordable and confidential RSH services offered by Family Planning providers. The Family Planning Program also engages consumers by soliciting feedback through state and local client satisfaction surveys and participation on state and local Advisory Boards. Youth voice is incorporated into policies, programs, and practices by collaborating with Michigan Youth Voice, a statewide youth council coordinated by the Michigan Organization on Adolescent Sexual Health. The quality of reproductive health care is assessed by monitoring local agency quality assurance mechanisms (i.e., abnormal pap follow-up) and improvement efforts (i.e., PDSA cycles).

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

The first strategy to achieve this objective is to support the provision of contraception to low-income and un/underinsured individuals who can get pregnant in the Family Planning Program. Having access to client-centered counseling and a broad range of effective contraceptive methods allows each person who can get pregnant the opportunity to choose the method that is right for them to successfully delay or prevent pregnancy. In 2022, 72.5% of female (i.e., assigned at birth) Family Planning clients aged 15 to 44 years old chose a most (i.e., sterilization, vasectomy, or LARC) or moderately effective (e.g., pills, patch, ring, cervical cap, or diaphragm) method, with 19.0% choosing LARC. The integration of approximately half of Family Planning and Sexually Transmitted Infection (STI) clinics has resulted in more comprehensive services for clients, while concurrently increasing the number of females (i.e., assigned at birth) aged 15 to 44 who report external condoms as their primary method of contraception. In FY 2022, MDHHS worked to maintain access to a broad range of contraception, while balancing individuals' contraceptive needs and preferences. Preserving access to a broad range of contraception, particularly for low-

income and un/underinsured individuals who often face multiple barriers (e.g., financial, transportation, paid leave, etc.) to contraceptive care (which was exacerbated by COVID-19) is critical to making informed decisions about reproductive health. In FY 2022, MDHHS's Family Planning Program served 31,437 female (i.e., assigned at birth) clients, along with 45% low-income (≤100% federal poverty level (FPL)) clients and 40% uninsured clients.

A second planned strategy was to facilitate long-acting reversible contraceptive (LARC) training opportunities for Title X and other health care providers to support on-site access to provider-dependent FDA-approved contraceptive methods during the public health emergency (PHE). To bolster provider proficiency and client access, MDHHS's Family Planning Program provided three LARC clinical practicums in FY 2022. On May 25, 2022, MDHHS's Family Planning Program sponsored an all-day clinical practicum in Lansing, Michigan on the insertion and removal of Mirena, Kyleena, Skyla, and Paragard intrauterine devices (IUD). Eighteen mid-level clinicians attended this practicum. In conjunction with the MDHHS's annual Family Planning Conference at the Delta Hotels Kalamazoo Conference Center, evening clinical practicums were offered each night, with the Liletta IUD being the first and Nexplanon (implant) offered the second night. Nine mid-level clinicians attended the Liletta practicum and 11 attended the Nexplanon practicum. Practicum evaluations for each training event indicated respondents gained new skills, abilities, or knowledge; liked the hands-on component the best; and found practicum trainers to be knowledgeable and effective. The Family Planning Program surveys its network of providers annually to assess clinical practicum needs and guide future training offerings.

Expanding and enhancing the integration of telehealth as a service delivery tool across Family Planning's provider network was a third strategy to support this objective. Telehealth visits are delivered directly to clients by telephone, video, or messaging technologies. In 2022, approximately 6% of all family planning encounters were virtual. To bolster access to telehealth, Family Planning providers interested in enhancing their telehealth capabilities were able to use FY 2022 Title X supplemental funds (i.e., $19,000) to support these efforts. Additionally, MDHHS in partnership with eight local Family Planning agencies was awarded approximately $700,000 in Title X telehealth enhancement and expansion funds in FY 2022. This funding provides participating agencies the opportunity to build upon their lessons learned from the PHE by streamlining workflow processes, increasing clinician time for service delivery, greater scheduling flexibility, and removing barriers clients experience (e.g., Wi-Fi access, transportation, interpreter services) when accessing services via telehealth. To disseminate telehealth innovations and best practices, MDHHS hosted a telehealth panel, *Tackling Telehealth, a Win for Clients & Providers*, at its 2022 annual Family Planning Update conference with five of the agencies that partnered on the Title X telehealth enhancement and expansion grant. This breakout session had approximately 30 attendees and 94% of conference evaluations indicated panelists were knowledgeable, with several attendees noting the session had "great discussion" and was "very informative."

In 2021, MDHHS had planned to facilitate regional learning sessions with people of reproductive age across the state to learn more about their reproductive and sexual health needs. While MDHHS was able to pilot a learning session with a Family Planning provider, developing meaningful relationships with community-based agencies outside of traditional partnerships proved challenging given the COVID-19 pandemic. MDHHS worked to recruit community-based organizations for listening sessions with state/local partners and large collaborative listservs and garnered few responses. Building authentic relationships takes time and given local agencies were juggling staffing shortages, program adaptations, and retaining participants for routine service delivery, the timing was not right. Additionally, conducting virtual listening sessions was a barrier for some community-based agencies and their participants. MDHHS plans to move forward with regional listening sessions in FY 2023 and is in the planning stages for protocol development and recruitment of participants with state/local partners.

A fifth strategy was to convene at least one training for 50 health care professionals on systemic racism and reproductive health. To achieve equitable reproductive health outcomes, providers must understand the role systemic

racism plays in creating and sustaining inequities in clinical settings and systems. To increase providers' competency, MDHHS utilized its 2022 Family Planning Update conference, which was attended by 111 health care professionals. The breakout session, *Implicit Bias in Healthcare*, was delivered by Mariah Martin from MDHHS's Office of Equity & Minority Health with approximately 40 attendees. The closing keynote, *Reproductive Justice in a Time of Injustice,* was delivered by Dr. Brent Davidson, MDHHS's Family Planning Medical Director with approximately 100 attendees. Conference evaluations indicated both speakers were knowledgeable and effective with their teaching methods.

Objective B: Increase the percent of females aged 15 to 19 who use a most or moderately effective contraceptive method from 84% to 89% by 2025.

The first strategy to achieve this objective was to support at least 10,000 individuals' (i.e., 18 to 21 years old) access to publicly funded contraception. In Michigan, sexually active adolescents encounter multiple barriers to accessing affordable contraception. An estimated 171,780 sexually active women <20 years old need publicly supported contraception (Guttmacher Institute, 2014). In 2019, 65% of sexually active high schoolers did not use a most effective reversible method (i.e., IUD or implant) or moderately effective method (i.e., shot, pills, patch, or ring) and 14% reported not using any methods to prevent pregnancy at last intercourse (Michigan YRBS, 2019). To support progress toward this objective, 20% (7,012) of Family Planning clients were ages 15 to 19 years old in 2022, with 83.9% of female clients (i.e., assigned at birth) aged 15 to 19 years old choosing a most or moderately effective method and 20.1% choosing LARC. The best contraceptive option is one that will be used consistently and correctly. Approximately 11% of female clients (i.e., assigned at birth) aged 15 to 19 years old chose an external condom as their primary method, the only method that provides dual protection against pregnancy and STIs.

A second strategy was to translate the virtual listening sessions held with youth and young adults into action. Achieving equitable health outcomes for young people begins with incorporating their knowledge and expertise into programs designed to support them. Shame, stigma, and intimidation were themes that arose when young people described their experiences of wanting, needing, or seeking sexual/reproductive health care, particularly for LGBTQ+ youth or youth with a disability. To combat shame, stigma, and intimidation, MDHHS offered breakout sessions on *Providing Gender-Affirming Care in Your Clinic* by Dr. Anita Hernandez and *Foundational Cultural Competence in Populations with Disabilities* by Candice Lee at its 2022 Family Planning Update conference. In FY 2022, a Family Planning staff member participated in MDHHS's Disability Health Program Advisory Council, which meets quarterly and is comprised of internal and external stakeholders and partners. Additionally, Family Planning promoted online disability cultural competency trainings, *Responsive Practice: Providing Health Care* and *Screening to Individuals with Disabilities* and *Response Practice: Accessible & Adaptive Communication*, with its provider network and other health care partners.

The third strategy to support this objective was to obtain input on Family Planning website content to make it more youth-friendly and visually appealing. In FY 2022, MDHHS migrated all programs to a new website platform (e.g., Sitecore) and due to platform roll-out delays and training requirements for website content authors, Family Planning was unable to complete the evaluation of its website content with Michigan Organization on Adolescent Sexual Health's (MOASH) youth advisory councils (YACs). MDHHS will move forward with reviewing its website content with MOASH YACs in FY 2023 and is in the initial planning stages of protocol development for website content evaluation and identifying YAC availability for calendar year 2023.

Objective C: Increase the percent of women who report ever having discussed reproductive life planning during a visit with a doctor, nurse, or other health professional from 58% to 63% by 2025.

Family Planning providers and other health care professionals recommend women and men of reproductive age who

want to achieve or prevent a pregnancy consider making a reproductive life plan. Reproductive life plans help individuals think about when and under what conditions they would like to become pregnant or, conversely, think about how pregnancy will be prevented, with the primary focus on increasing the overall health and well-being of the individual regardless of reproductive intentions. According to the 2020 Michigan BRFSS, 63% of Michigan women (i.e., assigned at birth) aged 18 to 44 reported ever having discussed reproductive life planning during a visit with a doctor, nurse, or other health professional. To support progress toward this objective, MDHHS's Family Planning Program discussed reproductive life planning with 35,670 pregnant capable persons, exceeding its FY 2022 service delivery target of at least 25,000, with the reentry of Planned Parenthood of Michigan into MDHHS's Title X network, its largest provider.

A second strategy was to support the Maternal Infant Health (MIH) Action Committee's implementation of short-term action priorities aimed at optimal birth spacing and healthy weight babies. The priorities spanned the reproductive health continuum of before, between, and beyond pregnancy, recognizing that before means never for some individuals and families. In FY 2022, MDHHS staff supported the Committee assessment of short-term progress across key policy and practice recommendations made to MDHHS leadership and state/local partners and assisted with identifying action opportunities for Committee members to undertake to further support policy and practice change. Engaging private third-party payers and private providers, who are outside of MDHHS's jurisdictional authority, on issues related to maternal health and sexual/reproductive health care were key challenges for the Committee in moving this work forward across the state. Additionally, MDHHS staff assisted Committee co-chairs with meeting convening, conducting topical research, and identifying content experts and guest speakers.

The third strategy was to apply a reproductive justice framework within Family Planning and related maternal/infant health projects. To begin incorporating reproductive justice elements into Family Planning, its FY 2022 local request for proposal (RFP) to ensure statewide access to high-quality, client-centered reproductive health care services was utilized. Local RFP applicants addressed the following: 1) health inequities present in community systems within proposed service areas; 2) reproductive, sexual, and preventive health disparities experienced by populations to be served; 3) how marginalized and underserved populations will be recruited for services; 4) organizational supports and/or actions that foster diversity, equity, and inclusion; 5) how services will be delivered in a diverse, equitable, and inclusive manner without negatively impacting priority population attributes; and 6) mechanisms used to gather consumer input to meaningfully inform program development and evaluation. Additionally, local RFP applicants were required to include at least one health equity, health disparities, or social determinants of health objective within their project work plans. Progress toward achieving this objective and associated activities will be reported on a quarterly basis to MDHHS in FY 2023 and will be evaluated utilizing program monitoring/oversight mechanisms (i.e., comprehensive site reviews). MDHHS awarded Family Planning funds to 34 local agencies that comprise 94 clinic locations across the state for FY 2023.

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

Women/Maternal Health - Application Year

Low-risk Cesarean Delivery (FY 2024 Application)

Percent of cesarean deliveries among low-risk births (NPM 2) was selected as a measure for the Women/Maternal Health domain to address the state priority need of developing a proactive and responsive health system that equitably meets the needs of all populations and eliminating barriers. For some medical indications, cesarean births can be a life-saving measure. However, for some low-risk pregnancies, a cesarean delivery can lead to preventable risks of maternal mortality and morbidity outcomes. Such outcomes include mortality due to hemorrhage or morbidities, such as infection, uterine rupture, cardiac arrest, and anesthesia complications. In Michigan from 2015-2019, 14.3% of pregnancy-related deaths were due to hemorrhage and 13% were due to infection or sepsis. Overall, 63.6% of pregnancy-related deaths in Michigan from 2015-2019 were deemed preventable[1]. In 2021, 29.1% of all live births[1] in Michigan were low-risk cesarean deliveries. The 2021 percentage of low-risk cesarean deliveries (29.1%) is above both the Healthy People 2030 goal of 23.6% and the 2021 average for the United States (US) which was 26.3%[2]. From 2020 to 2021, the percentage of low-risk cesarean deliveries has increased in Michigan and in the U.S., further validating that efforts must continue.

As with other birth outcomes, racial disparities are evident in low-risk cesarean births. In 2021, of all live births, 32.2% of black pregnant people had low-risk cesarean deliveries, as did 31% of American Indian pregnant people and 32.6% Asian/Pacific Islander pregnant people, compared to 28.2% of white pregnant people[1,][3]. In addition to the data portraying disparities in low-risk cesarean deliveries, anecdotal qualitative data suggest that black and brown pregnant people may feel coerced into delivering via cesarean section. Research has documented the negative feelings and self-perception that can be experienced when birth plans go awry. This can further contribute to experiences of post-traumatic stress disorder, postpartum depression, and anxiety. The Michigan Maternal Mortality Surveillance Review Committee identified common themes across maternal deaths and drafted recommendations which included increasing access to education for providers and systems related to culturally competent care; reducing stigma, bias, and barriers; and integrating a health equity framework to address systemic inequities. The strategies for this NPM will continue to focus on reducing the number of low-risk cesarean deliveries, as well as the racial disparity that exists in this delivery method.

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

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

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

27%.

Michigan Vital Records data will be used to track the number of low-risk cesarean deliveries and three strategies will be used to address this objective. The first strategy is to provide information and data related to this NPM to the RPQCs. Increasing the knowledge of the RPQCs related to rates of low-risk cesarean delivery and associated poor outcomes will create broad, baseline understanding across many different agencies, organizations, and health systems. Voices of families, especially those with lived experience, will enrich the understanding and stimulate discussion on efforts and interventions, including nonpharmacological, that can be implemented to address the growing trend of utilizing cesarean delivery for low-risk births. Regional Town Hall meetings, hosted by the RPQCs and MDHHS, provide an opportunity for families and birthing people to share their experience with cesarean delivery.

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

Continued partnership with Michigan AIM (MI AIM) and the Obstetrics Initiative (OBI) is the third strategy in reducing the number of primary low-risk cesarean deliveries. Partnering with stakeholders and professional organizations has allowed Michigan to work toward improved maternal morbidity and mortality outcomes, as well as reduction in disparities of adverse maternal outcomes. Several staff members from the Michigan Department of Health and Human Services (MDHHS) are working with MI AIM, including the Michigan Title V Director who actively participates on the MI AIM Executive and Steering Teams. In 2021, 65 birthing hospitals in Michigan received a designation status award (i.e., bronze, silver, etc.), which corresponds to a certain level of participation in MI AIM. MDHHS will continue to work with AIM members to support and encourage all birthing hospitals to participate in MI AIM and OBI. The number of birthing hospitals participating in Michigan AIM is the ESM for this measure.

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

As discussed above, Michigan has disparities in the number of low-risk cesarean deliveries by race. To achieve parity while reducing low-risk cesarean births across all racial/ethnic groups, Michigan's goal is to achieve by 2025 a 10% relative decline in low-risk cesarean rates for African American, American Indian and Asian/Pacific Islander pregnant people, which equates to 28%, 29.3% and 28.4%, respectively. Three strategies will be used to address the disparities that exist in this birth outcome measure. The first strategy is to include bias and equity training as an annual criterion for MI AIM hospital designation. While each hospital is responsible for providing the training to their respective staff, the MDHHS Division of Maternal & Infant Health webpage houses numerous resources and trainings that hospitals can utilize. Every year Michigan birthing hospitals are assessed for their level of participation and commitment to implementing the AIM safety bundles and thus, improving maternal birth outcomes. Including bias and equity training in the criteria ensures it becomes and remains a priority area of focus for birthing hospital staff, eventually creating sustained change in policies and care for pregnant people of all races and ethnicities.

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

The third strategy focuses on supporting ongoing education and training for Michigan Maternal Mortality Review Committee (MMRC) members. This committee is comprised of providers, epidemiologists, other content experts and most importantly family and community members, who review annual maternal deaths in Michigan. The MMRC was recently restructured to assure diverse membership and equitable, regional member distribution. The team reviews the circumstances surrounding each death, categorizes the death as either 'pregnancy-related' or 'pregnancy-associated, not related', and determines if the death was preventable. The MMRC also releases recommendations specific to the broad categories of maternal deaths. The intention is that if these recommendations are followed, and changes are made by providers and health systems, more maternal deaths will be prevented. Recommendations are reviewed quarterly, with revisions and additions based on findings of each quarter's case reviews. To ensure unconscious bias and health equity remain at the forefront of this committee when reviewing cases and creating recommendations, committee members are required to complete annual bias training for continued participation.

Oral Health – Women (FY 2024 Application)

The Title V needs assessment identified need among Michigan's MCH population related to gaps in dental services for certain populations including young children and pregnant people. Focus group respondents identified a need for more standardized care practices for dental professionals to offer treatment options in an equitable manner as well as an overall shortage of dental providers that will accept Medicaid. As a result, a state priority need was established to "improve oral health awareness and create an oral health delivery system that provides access through multiple systems."

Leadership for Michigan's MCH oral health programs and initiatives is located within the Oral Health Unit. The Oral Health Unit and Perinatal Oral Health Initiative are housed in the Child and Adolescent Health Division within the Bureau of Health and Wellness in the Population Health Administration, allowing for significant collaboration, particularly on issues related to women's oral health. The Perinatal Oral Health Initiative partners not only with state programs such as the Maternal Infant Health Program and WIC, but also with Michigan medical and dental schools, nurse practitioner programs, community organizations and local health departments. These partnerships focus on serving populations with the highest level of need and promoting health equity. The Perinatal Oral Health Initiative also continues to partner with Medicaid in the enhanced dental benefit for pregnant people, which now includes coverage for services for one year postpartum. In FY 2024 the adult dental Medicaid benefit is undergoing significant changes which will increase not only the reimbursement rate but also expand the number of covered services with the goal to attract additional providers to the oral health workforce. The promotion and outreach regarding these changes will play a large role in programmatic activities in FY 2024.

In FY 2024, the Perinatal Oral Health Initiative will continue to maintain educational efforts for the health community and expecting mothers while also continuing to explore additional data to help implement new programs that further address oral health disparities and access to care issues. Current Medicaid data indicate that disparities exist and were further exacerbated by the COVID-19 related dental shutdown in 2020. Currently, less than 1 in 5 pregnant people on Medicaid in Michigan received any dental care during their pregnancy. Less than 5% of pregnant people statewide had any restorative care. In addition, significant racial inequalities persist. African American or Latino

pregnant people continue to be less likely to have a dental visit than white pregnant people. Existing strategies that educate providers as well as new strategies that focus on alternative practice models and recent Medicaid enhancements will continue to be harnessed to address disparities. Mapping from the University of Michigan that shows racial and ethnic disparities by prosperity region will continue to be shared with stakeholders in local communities and utilized for targeted interventions. The data will also be used to bring awareness to the current state of Medicaid utilization in Michigan, workforce shortages, as well as how to create a path forward to address the oral health needs of pregnant people in Michigan.

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

In FY 2024, the MDHHS Oral Health Program (OHP) will continue to expand efforts to train and educate the medical and dental communities on the importance of perinatal oral health, as well as methodologies and best practices to integrate perinatal oral health into practice. Due to COVID-19, some of these trainings may occur virtually, but the program has adapted to this modality and has systems in place to accommodate virtual trainings. Data collected from a statewide provider survey indicates that many medical providers (82%) acknowledged that perinatal oral health was an important consideration for optimal obstetric management; however, only one-fifth (22%) of providers stated that they routinely examined the patient's oral cavity during pregnancy. Routine oral health assessments by a dentist were also infrequently recommended (28%). These data indicate a need to promote the practices of oral health screening and referral for preventive and restorative dental services among perinatal care providers. Current educational efforts are being evaluated at a 99% approval rating, with professional students indicating that this is the first time they have had comprehensive education surrounding perinatal oral health. In FY 2022, new educational efforts began at a new public health program (Central Michigan University) with a commitment to continue these perinatal oral health lectures into 2024. PRAMS and Medicaid data indicate that continued education efforts must also occur in the dental community surrounding pregnancy, as utilization rates remain low among pregnant women. FY 2024 will see a concerted effort with private practice dentists and Dental Associations to further target these providers, utilizing the new, enhanced Medicaid benefit as a tool to engage the dental community. Data driven efforts will continue to focus on health disparities and equity in specific Michigan regions.

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

Another strategy is dissemination of perinatal promotional and educational materials. Together with a variety of medical and dental professionals and other stakeholders, MDHHS developed Perinatal Oral Health Guidelines to create a unifying voice that emphasizes the importance of perinatal oral health to perinatal care and dental providers. The guidelines provide state-specific resources and tools; provide a summary of the issues surrounding perinatal oral health; and promote the consistent delivery of medical and dental service. In FY 2024, the Perinatal Oral health Initiative will utilize resources in partnership with new perinatal materials such as a Michigan Initiative for Maternal and Infant Oral Health Tool Kit that is under development. This tool kit will be developed in partnership with the Michigan Primary Care Association and a state dental school and will serve as a guide for implementing interprofessional education initiatives within clinical settings. Other materials will focus on health equity, best practices, specific health disparities by region, and proposed recommendations to address health inequities and

access to care issues with providers. MDHHS will continue to utilize nationally recognized American Academy of Pediatrics (AAP) materials that are co-branded with both agency logos. MDHHS will continue to develop and distribute promotional and education materials that promote dental visits during pregnancy and infant oral health to health entities across the state as well as directly to pregnant people. These materials will continue to be developed in partnership with community stakeholders and distributed to local health departments, Federally Qualified Health Centers (FQHCs), WIC clinics, dental offices, the Office of Great Start, home visiting, medical offices (including obstetric providers) and other entities. Material promotion has been a successful strategy and will continue in FY 2024. Efforts may focus on virtual methods of dissemination where applicable. Any new materials created will be reviewed with a health equity lens.

The final strategy will include the continuation of communication efforts for dental health providers surrounding changes in Medicaid benefits for pregnant people as well as the entire adult Medicaid benefit. MDHHS allotted funds to increase the adult dental Medicaid benefit for pregnant people within the state in FY 2022 and in FY 2023 increased reimbursement and expanded allowable services. This increase in benefits is addressing a critical need in access to care and increasing the number of pregnant people with a dental visit. The number of pregnant people on Medicaid who have at least one dental encounter during the perinatal period is a second ESM. Through a data use agreement and IRB with Child Health Evaluation and Research (CHEAR) Center at the University of Michigan, the oral health program will be able to obtain data as needed. CHEAR has access to the data warehouse and the technical ability to analyze the data. Medicaid utilization data that became available in FY 2022 will be crucial to measure the impact of the benefit and guide further educational efforts in FY 2024. This strategy aligns with other statewide efforts by focusing on data-driven solutions, addressing the need for comprehensive care, and reducing poor health outcomes.

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

In FY 2024, the OHP will continue to analyze PRAMS data and new Medicaid data to assess disparities in healthcare access by race and ethnicity. Data will be examined by geographic area which will help to determine targeted interventions and a new data dashboard will be continually updated to reflect perinatal oral health trends geographically. The targeted interventions will be viewed through a health equity lens and will be adjusted according to the population and groups they address. Efforts will continue to be made to integrate community voice as data efforts move forward and focus on engaging with specific communities across the state through local oral health coalitions. These coalitions are comprised of local professionals and community members representing the populations served. This strategy aligns with the statewide focus on data integration and population identification components.

In FY 2024, the Michigan Initiative for Maternal and Infant Oral Health (MIMIOH) will work to maintain participating sites and share results from its comprehensive evaluation. Its continued goal is to improve the oral health of mothers and children in underserved areas and to examine alternative models of care. The MDHHS grant-funded effort began as a one-year project at six sites in partnership with the University of Detroit Mercy School of Dentistry and the Michigan Primary Care Association, with the aim to examine the feasibility and impact of placing a registered dental hygienist in an OBGYN medical clinic. This collaborative model of care also allows for feedback and engagement not only from providers but from the patients served. The feedback obtained from patients via conversations with the dental hygienist will continue to provide an important opportunity to create more culturally and linguistically appropriate educational materials and outreach strategies. FY 2024 will look to promote best practices developed from this initiative and further promote efforts to integrate medical and dental professionals. New partnerships with refugee entities are part of the 2024 strategy to facilitate models of care to improve oral health service acquisition, with the OHP playing an active role in not only engaging refugee services agencies but also helping to plan

alternative models of care for large numbers of Afghan nationals and develop a proactive plan to assist large numbers of arrivals, including pregnant people.

In FY 2024, the OHP will also continue to provide education to pregnant people and engage directly with the local communities via partnerships with different agencies and groups in the state. SisterFriends Detroit is a volunteer effort to support healthier women and babies that helps women who are pregnant gain access to services and resources in Detroit. They aim to improve birth outcomes and infant mortality rates in Detroit by connecting mentors to women who are pregnant. The OHP started holding oral health educational sessions in FY 2022, with more scheduled in FY 2023 and the intention to continue into 2024. The feedback from pregnant people and their mentors has been positive and this practical presentation helps to not only answer common questions and address concerns, but also provides a chance to hear the consumer voice and engage authentically with Michiganders. For example, feedback from pregnant people has helped to shape the presentation and add more relevant content. In addition, in FY 2024 the OHP hopes to continue its collaboration with the Office of Great Start within the Michigan Department of Education to share relevant information with different parent and community advisor groups, as a continuation of FY 2023 efforts. This collaboration allows the OHP to receive even more community feedback and develop connections and partnerships that help pregnant people receive the care they need.

Intended Pregnancy (FY 2024 Application)

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

For most people who can get pregnant, their first encounter with the health care system is driven by reproductive health needs, with nearly three decades spent avoiding an unintended pregnancy (Sonfield, Hasstedt, & Gold, 2014). Equipping individuals who can get pregnant and their partners, regardless of life circumstances or ability to pay, with knowledge and access to reproductive health services can improve health outcomes and reduce health care costs over the life course when delivered equitably. Title V needs assessment results indicated Michiganders’ health outcomes are negatively affected by systemic racism, poverty, and trauma. Transportation impeded access to health care systems and services (e.g., routine, follow-up) particularly for low-income and rural individuals. Quality of care was found to be influenced by health care providers’ implicit or explicit bias of clients’ race, class, insurance status/type, and sexual orientation. Maternal and child health service systems were found to assume need rather than intentionally seek input from the entire community to inform programs, policies, and practices. Stakeholders also indicated that women’s health policy is oftentimes contentious and routinely restricts or removes access to needed health education and services.

FY 2024 objectives are concentrated on improving 1) contraceptive access and 2) quality of contraceptive care. Strategies seek to address the Title V needs assessment findings noted above and Michigan’s Title V pillars: 1) equitable health outcomes, 2) seeking the knowledge and expertise of communities and families, and 3) delivering culturally, linguistically, and age-appropriate health education. Strategies that can drive improved performance include translating regional listening sessions, integrating telehealth best practices, supporting access to publicly funded contraception, measuring the person-centeredness of contraceptive care, using client input to improve service delivery, and promoting contraceptive counseling best practices. Additionally, this state action plan directly supports related priorities in MDHHS’s Mother Infant Health & Equity Improvement Plan and Maternal Infant Health Strategy Plan, as well as the Governor’s “Healthy Moms Healthy Babies” plan. MDHHS supports contraceptive

access at local agencies through a variety of funding sources, including Title X Family Planning. Title V funding helps to support contraceptive access through local clinics with a focus on serving individuals 15 to 21 years of age at no or low cost.

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

Contraception is a highly effective clinical preventive service that assists people who can get pregnant in achieving their reproductive health goals, such as preventing unintended pregnancy and achieving healthy spacing of births. While there is no single method of contraception that is right for everyone, the type of contraceptive method used by a person who can get pregnant is strongly associated with their risk of unintended pregnancy. Having access to a full range of effective contraceptive methods allows each person the opportunity to choose the method that is right for them to successfully delay or prevent pregnancy. In 2022, 72.5% of female (i.e., assigned at birth) Family Planning clients aged 15 to 44 years old chose a most (i.e., sterilization, vasectomy, or LARC) or moderately (i.e., pills, patch, ring, cervical cap, or diaphragm) effective method, with 17.0% choosing LARC.

The first strategy—support the provision of contraception to low-income, uninsured, and underinsured people who can get pregnant in the Family Planning Program—will focus on providing client-centered counseling and a broad range of FDA-approved contraceptive methods to reproductive aged people who can get pregnant at no-cost or low-cost. A focus will be working to ensure that Michigan's Family Planning network of 34 local agencies and 94 clinical sites offer contraceptive services in accordance with *Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Populations Affairs*. Family Planning providers are required to have a broad range of contraceptives available, including LARCs. In FY 2024, MDHHS will monitor local agency provision of contraception through semi-annual Family Planning Annual Report (FPAR) submissions.

The second strategy is to facilitate long-acting reversible contraceptive (LARC) training opportunities for Family Planning and other health care providers. This strategy will focus on supporting on-site access to provider-dependent FDA-approved contraceptive methods. Stocking all methods, including LARC, is necessary to ensuring full access to care. Clients who receive their method of choice are more likely to use it consistently and correctly, be more satisfied, and continue with it. In FY 2024, MDHHS's Family Planning Program will offer at least one clinical practicum, promoting it with local Family Planning providers and other safety-net providers (e.g., Medicaid Health Plan, Federally Qualified Health Centers). Additionally, MDHHS's Family Planning Program can assist local providers by connecting them with pharmaceutical company representatives for individual clinic and/or regional trainings.

The third strategy is to support the integration of telehealth best practices across Family Planning's provider network. This strategy will focus on continuing to scale up telehealth practices across Michigan's Family Planning providers, while working to mitigate the unique challenges telehealth presents for ensuring equitable access to care. In FY 2024, MDHHS will focus on incorporating telehealth best practices and promoting project successes from the cohort of eight local Family Planning agencies that received one-time funding to expand and enhance access to telehealth. MDHHS will utilize its program newsletter, annual events, and other standing meetings throughout the year to disseminate best practices and project successes. MDHHS will provide targeted technical assistance to local Family Planning agencies, as requested.

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

them. In FY 2024, MDHHS will develop short- and long-term strategies to guide program decision-making, continuous quality improvement, and collaborative efforts with state and local partners and stakeholders, as appropriate.

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

In Michigan, sexually active adolescents encounter multiple barriers to accessing affordable contraception. Contraception is critical because it protects against disease transmission and unintended pregnancy and also enhances future reproductive health. An estimated 147,450 sexually active females (i.e., assigned at birth) <20 years old likely need publicly supported contraception (Guttmacher Institute, 2016). In 2019, 65% of sexually active high schoolers did not use a most effective reversible method (i.e., IUD or implant) or moderately effective method (i.e., shot, pills, patch, or ring) and 14% reported not using any methods to prevent pregnancy at last intercourse (Michigan YRBS, 2019). The teen birth rate for 15- to 19-year-old females (i.e., assigned at birth) was 12.2 per 1,000 in 2021, which is a historic low. Despite improvements in Michigan's teen birth rate, teens and young adults (i.e., 18 to 21) have unmet reproductive and related preventive health needs. During 2022, 20% or 7,012 of Family Planning clients were teens (i.e., <15 to 19 years old), with 83.9% of female (i.e., assigned at birth) clients aged 15 to 19 years old choosing a most or moderately effective method and 20.1% choosing LARC. The best contraceptive option is one that will be used consistently and correctly. Approximately 11% of female clients (i.e., assigned at birth) aged 15 to 19 years old chose an external condom as their primary method in 2022, the only method that provides dual protection against pregnancy and sexually transmitted infections (STIs).

The first strategy to achieve this objective, to support at least 8,000 individuals' access to publicly funded contraception, will focus on providing client-centered counseling and a broad range of FDA-approved contraceptive methods to sexually active adolescents (i.e., ≤15 to 21 years old) at no-cost or low-cost. Removing financial barriers to contraception assists young people in deciding if, when, and under what circumstances to get pregnant. In FY 2024, MDHHS will monitor local Family Planning providers' provision of contraception semi-annual clinical service delivery data submissions. Service delivery is routinely informed by youth voice for continuous quality improvement.

The second strategy, to translate regional listening session findings into action for youth and young adults, will focus on creating actionable strategies to meet identified needs and remove barriers that impede access to sexual and reproductive health care across Michigan. Achieving equitable health outcomes for young people begins with incorporating their knowledge and expertise into the programs designed to support them. In FY 2024, MDHHS will develop short- and long-term strategies to guide program decision-making, continuous quality improvement, and collaborative efforts with state and local partners and stakeholders, as appropriate.

The third strategy is to translate youth input into action on the Family Planning website to be more youth-friendly in content and visual appeal. Adolescents deserve to know their rights regarding access to sexual and reproductive health services in Michigan, medically accurate information about contraceptive and barrier methods, and what to expect at a Family Planning clinic visit. In FY 2024, MDHHS will utilize youth input to identify 'youth-friendly' website enhancements (e.g., content, visual appeal), develop short- and long-term enhancement priorities, and promote completed website enhancements with local Family Planning network, public health partners, and youth serving professionals.

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

Research in Family Planning has demonstrated that contraceptive counseling has an influence on a client's family

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

The first strategy is to include the person-centered contraceptive counseling (PCCC) measure on Family Planning's annual statewide consumer survey. This strategy will focus on measuring the quality of contraceptive care Family Planning clients receive from their provider such as interpersonal connection, adequate information, and decision support. Following a visit at which contraceptive counseling was received, clients will be asked to complete the survey before leaving the clinic. MDHHS collects Family Planning client input annually through a statewide consumer survey administered at each clinic site. Local Family Planning agencies routinely collect consumer input for continuous quality improvement. In FY 2024, MDHHS's Family Planning clinics will document the patient-centeredness of contraceptive care with new clients (20 adult and 10 teen) using the PCCC on its annual statewide consumer survey. Local Family Planning agencies will aggregate survey results and submit to MDHHS for analysis and dissemination.

The second strategy—analyze the PCCC measure, share key findings with Family Planning network, and promote data-driven decision-making—will focus on evaluating the client-centeredness of contraceptive counseling within MDHHS's Family Planning network and supporting continuous quality improvement of the client experience, as needed. In FY 2024, MDHHS will analyze the PCCC measure to assess contraceptive counseling strengths and disparities at the program and local agency levels. Key findings and implications for practice will be shared with the Family Planning network and partners via the program's Advisory Council meeting and other standing meetings. At a minimum, MDHHS will utilize key findings to inform its annual training plan to support client-centered contraceptive counseling across the Family Planning provider network. MDHHS will offer technical assistance to local Family Planning agencies on utilizing quality improvement techniques to address disparities in quality of contraceptive care and improve the client experience, as needed.

The third strategy is to promote MDHHS's updated Contraceptive Counseling Modules with Family Planning network, other healthcare providers, and related public health programs (e.g., home visitors). This strategy will focus on reaching a broad audience of healthcare providers and public health professionals to encourage the utilization of contraceptive counseling best practices. Client-centered contraceptive counseling techniques assist clients with identifying a method that best fits their needs and preferences, free from coercion. Contraceptive methods that meet client preferences are more likely to be used correctly and consistently. In FY 2024, MDHHS will utilize program (e.g., newsletter) and partner (e.g., listserv) communication mechanisms to promote its updated Contraceptive Counseling Modules with its Family Planning network, other healthcare providers, and staff in related public health programs. Continuing education credits will be offered to incentivize participation. MDHHS will monitor module completion rates and participant satisfaction on a quarterly basis.

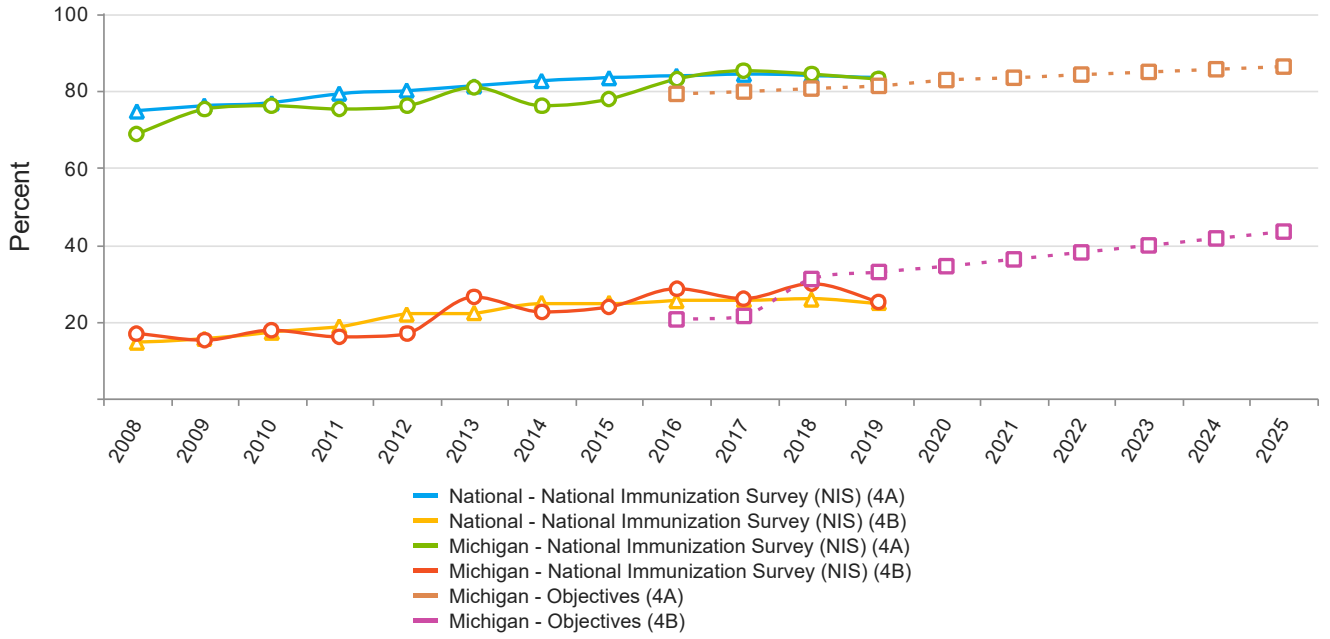
[1] Michigan Resident Live Birth Files; MDHHS Division of Vital Records and Health Statistics. Maternal and Infant Health program staff use

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

Perinatal/Infant Health

National Performance Measures

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



NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80.5	81.2	82.7	84.1	84.1
Annual Indicator	77.7	83.0	85.3	83.1	83.1
Numerator	88,168	86,380	88,053	75,064	75,064
Denominator	113,401	104,098	103,283	90,308	90,308
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2019	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	84.8	85.5	86.2

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	31.1	32.9	34.4	38	38
Annual Indicator	23.9	28.4	25.8	25.1	25.1
Numerator	25,921	28,764	25,629	22,387	22,387
Denominator	108,464	101,206	99,495	89,287	89,287
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2019	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	39.8	41.6	43.4

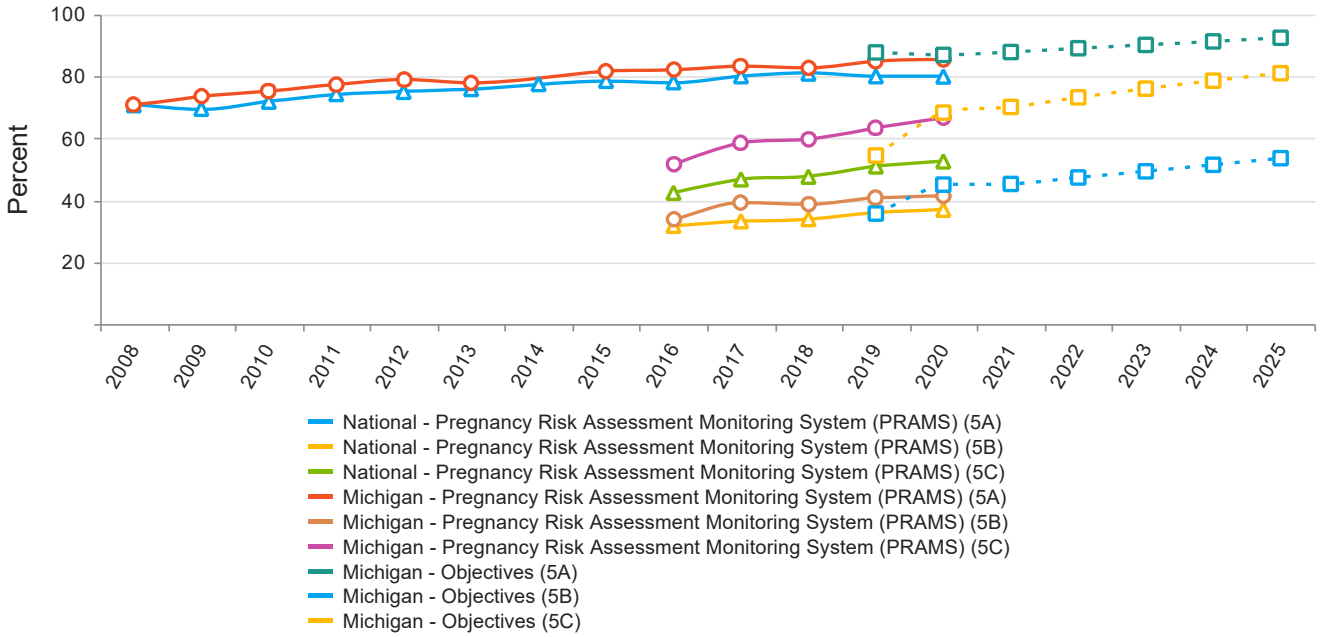
Evidence-Based or –Informed Strategy Measures

ESM 4.1 - Percent of Baby-Friendly designated birthing hospitals in Michigan

Measure Status:	Active				
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	20	23	26	29	18
Annual Indicator	19.5	18.8	18.8	16.3	16.5
Numerator	16	15	15	13	13
Denominator	82	80	80	80	79
Data Source	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	19.0	20.0	21.0

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		87.6	86.8	88.9	88.9
Annual Indicator	83.3	82.5	84.9	85.4	85.4
Numerator	87,247	85,511	85,912	83,784	83,784
Denominator	104,718	103,596	101,194	98,121	98,121
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2020

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		87.6	86.8	87.7	88.9
Annual Indicator	83.5	82.5	84.9		
Numerator	87,247	85,511	85,912		
Denominator	104,517	103,596	101,194		
Data Source	PRAMS	PRAMS	PRAMS		
Data Source Year	2017	2018	2019		
Provisional or Final ?	Final	Final	Final		

Annual Objectives			
	2023	2024	2025
Annual Objective	90.0	91.1	92.3

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		35.7	45	47.3	47.3
Annual Indicator	39.2	38.9	40.6	41.5	41.5
Numerator	39,142	38,781	39,451	38,620	38,620
Denominator	99,861	99,669	97,218	92,994	92,994
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2020

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		35.7	45	45.2	47.3
Annual Indicator	34	39.2	38.9		
Numerator	34,751	39,142	38,781		
Denominator	102,182	99,861	99,669		
Data Source	PRAMS	PRAMS	PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	49.3	51.4	53.5

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		54.4	68.2	73.1	73.1
Annual Indicator	58.3	59.8	63.1	66.7	66.7
Numerator	58,277	59,314	61,216	62,663	62,663
Denominator	99,994	99,167	96,949	93,957	93,957
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2020

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		54.4	68.2	70	73.1
Annual Indicator	51.8	58.3	59.8		
Numerator	52,803	58,277	59,314		
Denominator	101,994	99,994	99,167		
Data Source	PRAMS	PRAMS	PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	75.9	78.5	80.9

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Increase the number of Maternal Infant Health Program agencies that have staff trained to use the concepts of motivational interviewing with safe sleep

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		85	84	83	73
Annual Indicator		83	83	78	72
Numerator					
Denominator					
Data Source		Maternal Infant Health Program (MIHP) staff	Maternal Infant Health Program (MIHP) staff	Maternal Infant Health Program (MIHP) staff	Maternal Infant Health Program (MIHP) staff
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	72.0	72.0	72.0

ESM 5.2 - Increase the number of agencies that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	20
Annual Indicator			1	5
Numerator				
Denominator				
Data Source			Infant Safe Sleep Program	Infant Safe Sleep Program
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	10.0	15.0	20.0

ESM 5.3 - Increase the number of hospitals that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			2	4
Annual Indicator			2	3
Numerator				
Denominator				
Data Source			Infant Safe Sleep Program	Infant Safe Sleep Program
Data Source Year			FY2021	FY2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	6.0	8.0	10.0

State Action Plan Table

State Action Plan Table (Michigan) - Perinatal/Infant Health - Entry 1	
Priority Need	
Create and enhance support systems that empower families, protect and strengthen family relationships, promote care for self and children, and connect families to their communities	
NPM	
NPM 4 - A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months	
Objectives	
A) Increase the percent of infants who are breastfed exclusively until 6 months to 41.1% by 2025	
B) To impact breastfeeding disparity, increase percent of non-Hispanic black women who initiate breastfeeding from 74.4% to 78.4% by 2025	
Strategies	
A1) Require breastfeeding education of MDHHS Maternal Infant Health staff which includes recognizing systemic racism as a root cause of breastfeeding inequities A2) Support and promote increased access to breastfeeding support professionals and peer counseling services in programs serving families A3) Increase the percent of Baby Friendly Hospitals in Michigan from 16% to 18%	
B1) Increase training opportunities to improve the number, availability, opportunities for professional advancement, and racial and cultural diversity of breastfeeding professionals B2) Normalize and promote culturally congruent and responsive breastfeeding messages for MDHHS and breastfeeding supporter use B3) Promote resources, created by BIPOC-led community organizations, that address the most common breastfeeding barriers	
ESMs	**Status**
ESM 4.1 - Percent of Baby-Friendly designated birthing hospitals in Michigan	Active
NOMs	
NOM 9.1 - Infant mortality rate per 1,000 live births	
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	

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

Priority Need

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

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

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

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

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

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

Strategies

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

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

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

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

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

ESMs	Status
ESM 5.1 - Increase the number of Maternal Infant Health Program agencies that have staff trained to use the concepts of motivational interviewing with safe sleep	Active
ESM 5.2 - Increase the number of agencies that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol	Active
ESM 5.3 - Increase the number of hospitals that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol	Active

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

Perinatal/Infant Health Overview

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

Title V funding also supports the Local Maternal Child Health (LMCH) program which provides funding to all 45 Local Health Departments (LHDs). In FY 2022, Title V funds via the LMCH program were expended on NPM 4 (breastfeeding), NPM 5 (infant safe sleep), and Local Performance Measures (LPMs) in the perinatal/infant health domain. Nineteen LHDs implemented breastfeeding (NPM 4) activities including breastfeeding support in a variety of settings for pregnant people and women to provide infants with human milk. Other activities included staff development and lactation training; participation in virtual community breastfeeding coalition meetings, promoting breastfeeding friendly businesses; social media posts; and community outreach events. Ten LHDs addressed infant safe sleep (NPM 5) through education in a variety of creative, socially distanced ways such as prenatal/postnatal classes, home visits, social media posts, and community events. Infant safe sleep education was provided to childcare, faith-based entities, emergency management, and nursing students. Sleep sacks, pack-n-plays, and books were distributed to families with an assessed need.

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

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

Breastfeeding (FY2022 Annual Report)

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

post-partum hemorrhage, lower the risk of type 2 diabetes, and may decrease the likelihood of developing breast, uterine, and ovarian cancers. Human milk remains the optimal source of nutrition for the first months of life.

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

According to the National Immunization Survey (NIS), in 2019 Michigan's initiation rate was 83.1% (CI 77.3-87.7). This meets the annual objective set of 81.2%. Michigan's breastfeeding exclusivity rate through six months was 25.1%, and Michigan's goal is to reach 41.1% by 2025.

PRAMS data 2020 tell a more complicated story with an initiation rate of 85.9%, which is above Healthy People 2020 goals. PRAMS has shown that Michigan's initiation rate has increased steadily from 2009 to 2014. However, from 2014 to 2020, a leveling in breastfeeding initiation occurred, with no significant change seen. Disparities in breastfeeding initiation persist among non-Hispanic white women and non-Hispanic black women. According to PRAMS, while from 2009-2014 initiation rates grew among black women at a comparable or even faster rate than white women, from 2014 to 2017, initiation rates among black women remained unchanged (77.3% to 77.2%) compared to increases among white mothers (86.3% to 90.1%). Alarmingly, initiation rates among black women were lower in 2020 (75.1%) compared to 2017 (77.2%). Initiation rates among black mothers are now about 12% lower than white mothers. This 12% gap in initiation has grown from a prior gap of 10% in 2014-2016 [86.3% NHW - 73.8% NHB]. Data from MDHHS Office of Vital Statistics also show slightly lower initiation rates among Hispanic and Native American women when compared to white women. MDHHS will continue to intentionally gather data as it relates to Native American breastfeeding rates.

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

MDHHS receives and shares parent and community input on breastfeeding-related issues through several means, including collaboration with the Michigan Breastfeeding Network and their CORE Cohort workgroup members. MDHHS recruits and encourages local breastfeeding clinicians and advocates to speak at maternal child health conferences. In addition, MDHHS team members attend state and local breastfeeding conferences in order to support breastfeeding networks.

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

Since its public release in February 2021, the *Michigan Breastfeeding Plan* has continued to set a common agenda necessary for a collaborative approach to support breastfeeding in Michigan. A key staff positions tasked with overseeing the activities in the *Michigan Breastfeeding Plan* was vacant from January 2022 through September 2022. However, as of October 2022, a staff member has been hired to support breastfeeding promotion activities and programs. Despite the vacancy, MDHHS convened a course development team to create a breastfeeding training course for professionals working with families in Michigan. Content in the breastfeeding training course will cover breastfeeding disparities in Michigan, the root causes of inequities and how to address them, information to support consistent messaging about breastfeeding, and community-based, culturally responsive breastfeeding resources to support families and professionals. The breastfeeding training course is in the final stages of development and will be available to professionals across the state. In accordance with the vision of the Plan, MDHHS will promote the training course widely and continue to work toward improving the knowledge of breastfeeding support among staff working in maternal and infant health programs.

A key activity to train home visitors and other maternal and infant health staff is the Great Lakes Breastfeeding Webinar Series, a project of the Michigan Breastfeeding Network. These webinars have continued to be offered every month at no cost to participants and are available on demand for up to one year after their initial release dates. Participation in the webinars varies, but most webinars have over 1,000 attendees nationally. During FY 2022, over 400 participants from Michigan viewed the webinars, with a combined total of over 3,500 unique webinar participants during FY 2022. Statistics show that among webinar participants from Michigan, 14% are home visitors and over 50% work for a state or local health department.

Evidence shows that access to professional and peer support can increase breastfeeding duration. MDHHS directly supported this activity through mini-grants, awarded in partnership with the Michigan Breastfeeding Network, to Black and Indigenous-led breastfeeding organizations that provide breastfeeding support to families. The goal was to give local organizations the flexibility to use the funds to respond to the unique needs of their communities. The mini grants were supported with Title V funds. Projects focused on developing educational resources addressing latch, milk supply, and pain, which were identified through PRAMS data as top reasons for why Michigan mothers stop breastfeeding. As part of the project, a resource guide was created, which linked to all of the resources created by the 10 organizations. Over 30 resources were created, which included videos, infographics, and informational documents that can be used to inform and support breastfeeding families. In addition, access to local breastfeeding and peer support has been placed on the MDHHS website and distributed to local partners and families. The WIC Division also leads efforts to increase access to breastfeeding support by funding peer counselors and a warmline.

MDHHS continues to work with Michigan Birthing hospitals to encourage, support, and acknowledge hospitals achieving Baby-Friendly status. This is Michigan's ESM for this NPM. MDHHS staff promote the implementation of breastfeeding-friendly maternity care practices through trainings and encouraging hospitals to review and complete the CDC Maternity Practices in Infant Nutrition and Care (mPINC) survey. MDHHS has also remained engaged with partners that support Baby-Friendly efforts across the state. In 2022, MDHHS submitted a support letter as part of a community partner's Baby-Friendly grant application and has continued to identify new ways to promote these efforts. The Great Lakes Breastfeeding Webinar series is promoted with hospital staff, and it is estimated that around 10% of participants identify maternity care nurse as their primary job function. Unfortunately, one birthing unit in Michigan closed as of June 1, 2022, bringing the total number of birthing hospitals from 80 to 79. The number of Baby-Friendly Hospitals in Michigan has remained at 13, with the percent of Baby-Friendly designated birthing hospitals also staying the same at about 16%. Responding to the COVID-19 pandemic has placed incredible strain on Michigan's hospitals in recent years and has impacted their ability to meet and/or maintain the Baby Friendly USA

standards.

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

According to PRAMS data, breastfeeding initiation among Michigan's non-Hispanic Black women was 75.1% in 2020. Non-Hispanic white women breastfeeding initiation rates were 87.3% in 2020, which has remained relatively consistent since 2017. When asked about 10 different possible barriers to initiating breastfeeding, fewer non-Hispanic Black women report that they had multiple reasons for not initiating breastfeeding (37.1% vs. 46.2%) compared to non-Hispanic white mothers. This reflects persistent challenges in reducing the disparity in breastfeeding and a need for MDHHS to continue intentionally gathering data related to reasons for not initiating. While PRAMS data often illustrate individual reasons for not breastfeeding, systems level reasons—including historical and present-day racism—must be examined. Still, about half of non-Hispanic Black mothers who did not initiate, stated that there was just one barrier to initiate breastfeeding. As we investigate systems-level barriers and other complex problems, we will seek to support those whose single stated barriers may be more readily addressed.

To reduce disparity gaps, MDHHS continues to partner and support the Great Lakes Breastfeeding webinar series, a project of the Michigan Breastfeeding Network, which offers breastfeeding-specific information every month at no cost to participants. Over the last year, the Michigan Breastfeeding Network has expanded the types of continuing education offered through the webinars and now provides contact hours for nurses, social workers, lactation consultants, community health workers, certified health education specialists, physicians, and dietitians. This free, easy-to-access education allows all providers the ability to receive advanced training, which diversifies and strengthens Michigan's lactation workforce. Topics have a strong focus on health equity and supporting community-driven work in BIPOC communities. The webinars have been viewed by participants in 24 countries; in the U.S., there have been participants from all 50 states and the District of Columbia. Webinar participants report a variety of job functions including peer counselors, maternity care nurses, home visitors, other breastfeeding services, nutrition, social work, physicians, and nurse practitioners.

In August 2022, the State of Michigan issued a proclamation recognizing August 2022 as Breastfeeding Month in Michigan. Proclamations were also issued recognizing Black Breastfeeding Week and Indigenous Milk Medicine Week in the State of Michigan. The WIC Division hosted a webcast to celebrate Black Breastfeeding Week, which was viewed by 81 participants.

In FY 2022, MDHHS funded a social media campaign, which targeted the areas within Michigan that experience the largest breastfeeding disparities. The goal of the campaign was to normalize breastfeeding among young parents and promote the ways in which breastfeeding has been shown to reduce the risk of sleep-related infant deaths. Social media content was created with a goal of reaching parents and pregnant people who are 21 and under, extended family networks and friends of BIPOC parents and pregnant people of any age, and those with household incomes of $33k or less. Content from the campaign was viewed or heard over 20 million times, and nearly 50,000 clicks to the MDHHS website were generated from the campaign. MDHHS continues to identify new and innovative methods, including via social media, to promote breastfeeding within the communities most affected by breastfeeding-related disparities.

The MDHHS Communications team has continued to prioritize creating and posting breastfeeding promotional messages on the department's social media accounts. MDHHS has over 147,000 Facebook followers, over 34,000 Twitter followers, and over 12,000 followers on Instagram. As part of breastfeeding awareness commemorations during August, MDHHS created and shared 18 posts promoting breastfeeding across all MDHHS social media pages. Social media posts were created to recognize specific groups and celebrations throughout the month of

August, including Indigenous Milk Medicine providers, Asian American, Native Hawaiian and Pacific Islander Breastfeeding Week, and Black Breastfeeding Week.

Rather than facilitating community efforts in one community to impact low breastfeeding rates among women of color, a more complete approach was used by funding 10 BIPOC-led breastfeeding organizations as described above. Organizations were based throughout the state in Detroit, Grand Rapids, Saginaw, Benton Harbor, Battle Creek, Pontiac, the Upper Peninsula, and Flint. In addition, MDHHS continues to work with the Genesee County Health Department to increase breastfeeding rates within Genesee County and the City of Flint. Activities were impacted by the COVID-19 pandemic, but breastfeeding promotion progress has resumed.

Safe Sleep (FY 2022 Annual Report)

Michigan's safe sleep strategies and activities promote three key messages to parents and caregivers: infants should sleep 1) alone, 2) on the back, and 3) in a crib, bassinet or pack and play. These behaviors are critical to the prevention of sleep-related infant death. Of the leading causes of infant death, sleep-related causes are considered the most preventable. In FY 2022, Title V federal funding was used for activities that support Michigan's safe sleep work, including PRAMS, infant mortality communication, Fetal Infant Mortality Reviews, breastfeeding support, and funding to local health departments to support community-based safe sleep prevention efforts.

When comparing birth year 2019 to birth year 2020, there were improvements in the weighted percentage of mothers placing infant to sleep on the back, in separate approved sleep surface, and with no soft objects or loose bedding. However, none of the measures reached a statistically significant improvement. In 2020, 85.4% of Michigan mothers placed their infants to sleep on their back, compared to 84.9% in 2019. The proportion of infants sleeping with **no** soft objects (i.e., pillows, bumpers, blankets, toys) has increased from 63.1% in 2019 to 66.7% in 2020. Infants placed to sleep on a separate approved sleep surface increased from 40.6% in 2019 to 41.5% in 2020. Starting in 2016, this measure has been based on the combination of five different sleep risk factors, including whether infants sleep in a car seat or swing. That risk factor has an especially large impact on this measure.

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

Objective A: Increase the percent of infants put to sleep on their backs from 84.9% in 2020 to 92.3% by 2025.

Objective B: Increase the percent of infants put to sleep on a separate approved sleep surface from 40.6% in 2020 to 53.5% by 2025.

Objective C: Increase the percent of infants placed to sleep without soft objects or loose bedding to from 63.1% in 2020 to 80.9% by 2025.

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

In FY 2022, activities occurred within six strategies:

1. Support safe sleep activities of local health departments and the Inter-Tribal Council of Michigan.

2. Support providers to implement safe sleep policies/protocols/programming to ensure families receive infant safe sleep education and access to resources.
3. Explore legislative/regulatory change to increase the number of babies that are safely sleeping.
4. Develop and share tools with providers, families, and workers regarding having client/patient centered conversations regarding safe sleep.
5. Promote protective factors (i.e., smoking cessation, breastfeeding, immunizations) and evidence-based programs (i.e., home visiting) to enhance the overall health and well-being of moms and babies.
6. Engage hospitals in areas with a high rate of sleep-related infant deaths and disparities to explore needed policies and resources to ensure families of NICU infants are practicing safe sleep behaviors after discharge.

The first strategy is to support the safe sleep activities of local health departments (LHDs) and the Inter-Tribal Council of Michigan (ITC) to increase the capacity of communities to implement infant safe sleep education, awareness, and outreach activities. In FY 2022, the Detroit Health Department received $125,000 in funding, four other LHDs received $70,000 in funding, and the ITC received $45,000 in funding. These five LHDs account for 51% of sleep-related infant deaths in the state and experience significant racial disparities among the deaths. Grantees are required to participate in or coordinate a local/regional advisory team to oversee their safe sleep efforts. The teams are required to include community members. The grants allowed communities to develop programming that targeted the highest-risk areas and that were informed by the community. Activities ranged from providing safe sleep education sessions; purchasing billboards; providing group classes; conducting community awareness events; creating public service announcements; engaging families; and promoting protective factors such as breastfeeding and smoking cessation. A portion of the grant funds were used to purchase pack and plays, sheets, and/or sleep sacks.

In FY 2022, the COVID-19 pandemic continued to have an impact on grantees with many offices and related services only operating virtually. Grantees have moved to a hybrid approach to be flexible on whether events are in-person or virtual. Several LHDs planned to implement the Society for Public Health Education (SOPHE) SCRIPT® (Smoking Cessation and Reduction in Pregnancy Treatment) Program but were unable to due to only seeing families virtually. Despite challenges, grantees were able to provide infant safe sleep education to nearly 12,000 individuals (parents, caregivers, professionals, and community members) through virtual and in-person classes and community events. LHDs continued to be creative in ways to reach families, hosting virtual house parties and gender reveal parties, as well as virtual bingo. Some LHDs were exhibited at untraditional places such as farmers' markets.

Social Determinants of Health (SDOH) are drivers in the disparity of sleep-related infant deaths. In addition to community members, the local/regional advisory teams are required to include partners that can address SDOH. This includes partners that can meet resource needs of families, as well as partners that work further upstream to address systemic policies and practices that drive disparities.

A second strategy was to support providers in implementing and updating existing safe sleep policies or protocols to ensure families receive infant safe sleep education and access to resources. An evidence-based or -informed strategy measure (ESM) was established to increase the number of agencies that have a safe sleep policy/protocol. Agencies faced a multitude of constraints (staff turnover, the pandemic, etc.) that limited their ability to update or implement a policy/protocol. Therefore, this ESM was updated to focus on the number of agencies that received technical assistance on updating or implementing a policy. Four agencies received technical assistance and support with implementing and/or updating a safe sleep policy. One local health department implemented the policy with their home visiting program, with plans of rolling it out to other programs. Another program already had a policy but made some updates. In addition, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program was provided technical assistance on a policy guidance document for their funded programs. All MIECHV programs will be required to implement a safe sleep policy by the end of FY 2023.

As part of the third strategy, in FY 2021, the MDHHS Infant Safe Sleep (ISS) program met with MDHHS Legislative Affairs to discuss how to increase awareness among the legislature about maternal child health and infant safe sleep. A presentation on infant safe sleep was made to the Senate Families, Seniors, and Veterans Committee and a Lunch and Learn for Legislative staff was held in October 2021. This strategy also included identifying possible legislative or regulatory changes that would increase the number of babies safely sleeping. A scan of regulations was completed in FY 2020 and a proposed policy/regulation change document was developed. Updates were made in FY 2021. This document was shared with the Maternal Infant Health (MIH) Policy and Legislation Action Committee in late FY 2021. The committee planned to determine any actions in FY 2022, but they didn't pursue any items because of other priorities.

A continued strategy was to develop and share tools with providers and family support workers on how to have client/patient centered conversations regarding safe sleep. This strategy included continuing to promote the *Helping Families Practice Infant Safe Sleep (Safe Sleep 201)* training and incorporating the core tenets of this training into other educational venues: how to have more effective conversations with families by starting where the family is at, educating on safe sleep guidelines and helping the family evaluate their current risk and explore strategies for risk reduction. A continued ESM is to increase the number of Maternal Infant Health Program (MIHP) agencies that have staff trained to use motivational interviewing with safe sleep. In FY 2022, all 72 MIHP agencies have staff trained to use the concepts of motivational interviewing with safe sleep by requiring the *Safe Sleep 201* training for all staff.

To reach professionals who work with pregnant and parenting families, the MDHHS ISS Program continued to build upon connections with existing partners, such as the Women, Infants and Children (WIC) Program, home visiting programs (MIECV and MIHP), child welfare, the Regional Perinatal Quality Collaboratives, MDHHS Tobacco, and MDHHS Emergency Medical Services and Trauma (EMS). These continued collaborations led to training on the safe sleep basics, how to support families, and access to resources for a variety of professionals. In FY 2022, nearly 1,000 individuals attended a virtual or in-person safe sleep training and over half of those individuals received training on how to support families. In addition, over 10,000 individuals completed one of the three online infant safe sleep trainings, just over 140 hospital nurses and other staff took the online training *Infant Safe Sleep: The Basics and Beyond*, and over 275 participants attended one of four safe sleep webinars. Providers were also supported with access to free educational materials; over 215,000 educational items were distributed by MDHHS in FY 2022. By the end of FY 2022, over 5,700 professionals were subscribed to the infant safe sleep email listserv, an 80% increase over FY 2021.

As an additional tool to integrate safe sleep education into prenatal visits, the High Touch, High Tech (HT2) e-screening tool, which delivers a brief motivational intervention and helps connect families to additional supports, was expanded to include screening for safe sleep knowledge and behaviors. The safe sleep education modules were rolled out in May 2022. To date, over 600 patients participated in the prenatal safe sleep intervention.

Another strategy is to promote protective factors (i.e., smoking cessation, breastfeeding, immunizations) and evidence-based programs (i.e., home visiting) to enhance the overall health and well-being of moms and babies. As noted above, outreach to and coordination with other MDHHS programs continued. In conjunction with MDHHS Tobacco Section, the MDHHS ISS Program continued to host a quarterly call to support local health departments implementing SOPHE SCRIPT and other smoking cessation activities.

In FY 2021, University of Michigan students completed a Capstone project on how MDHHS can better address the needs of younger parents—including teen parents and those 20-24 years old—through more effective programming and messaging for these cohorts. The Capstone project helped launch several projects, supported by Title V funds, directed at youth and young parents. These included a media campaign on breastfeeding and infant safe sleep. The media campaign was developed by first having the Michigan Organization on Adolescent Sexual Health (MOASH)

complete education sessions and focus groups on safe sleep and breastfeeding with a diverse group of youth ages 13-21. The themes that emerged in the focus groups were used to develop media (social media posts and audio streaming app ads) that ran in the first quarter of FY 2022. The campaign ran statewide, but targeted parents and pregnant people 21 and under, as well as the LGBTQ+ community. Through audio streaming, almost 700,000 impressions were delivered; through Facebook, over 500,000 impressions were delivered with over 7,000 post engagements; and through Instagram, over 66,000 impressions were delivered with over 2,500 post engagements.

MDHHS ISS Program continued to explore other ways to engage families directly in the work, including support of the MIH Infant Safe Sleep Action team which included two parent members. In FY 2022, the parent members were active at meetings and helped plan Infant Safe Sleep Awareness month activities for October 2022.

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

An ESM was utilized to track the number of hospitals that have implemented or revised/updated a safe sleep policy/protocol. However, hospitals faced a multitude of constraints (staff turnover, the pandemic, etc.) that limited their ability to update or implement a policy/protocol. Therefore, this ESM was updated to focus on the number of hospitals that received technical assistance and support on updating or implementing a policy. Technical assistance was provided to one hospital and their updated policy will be rolled out in FY 2023. One hospital that worked to revise a policy in FY 2021 was going to roll it out in FY 2022 but experienced several delays. Due to limited response from the contact, it is unknown if it was rolled out in FY 2022. However, that hospital did recruit Safe Sleep Champions for their pediatric, NICU and Mother Baby Units. In that role, they conduct regular crib audits.

In FY 2022, the MDHHS Infant Safe Sleep program was connected to a hospital that felt more attention needed to be paid to social determinants of health and other factors. Several meetings were held to discuss this concern, and technical assistance was provided to help better connect their patients with services in the community.

The Infant Safe Sleep program worked with one hospital to get the online training for hospital nurses and staff, *Infant Safe Sleep: The Basics and Beyond*, integrated into their staff education system. In FY 2023, that hospital plans to make the training mandatory for staff.

Finally, the program continues to host quarterly meetings for hospitals. The informal meetings are intended to be an avenue for hospitals to learn what other hospitals are doing to support safe sleep, learn about MDHHS activities, serve as a venue to problem solve, and be an avenue to obtain resources and have questions answered.

Perinatal/Infant Health - Application Year

Breastfeeding (FY 2024 Application)

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

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

According to the National Immunization Survey (NIS), in 2019 Michigan's initiation rate was 83.1% (CI 77.3-87.7). This meets the annual objective set of 81.2%. Michigan's breastfeeding exclusivity rate through six months was 25.1%, and Michigan's goal is to reach 41.1% by 2025.

PRAMS data 2020 tells a more complicated story with an initiation rate of 85.9%, which is above Healthy People 2020 goals. PRAMS has shown that Michigan's initiation rate increased steadily from 2009 to 2014. However, from 2014 to 2020, a leveling in breastfeeding initiation occurred, with no significant change being seen. We celebrate the commitment by Michigan mothers, year after year, that this level of initiation represents, while also aiming to support future increases to initiation.

Disparities in breastfeeding initiation persist among non-Hispanic white women and non-Hispanic black women as well. According to PRAMS, while from 2009-2014 initiation rates grew among black women at a comparable or even faster rate than white women, from 2014 to 2017, initiation rates among black women remained unchanged (77.3% to 77.2%) compared to increases among white mothers (86.3% to 90.1%). Alarmingly, initiation rates among black women were lower in 2020 (75.1%) compared to 2017 (77.2%). Initiation rates among black mothers are now about 12 percentage points lower than white mothers [86.3% NHW - 73.8% NHB]. This 12% gap in initiation has grown from what used to be a gap of 10% in 2014-2016. Data from MDHHS Office of Vital Statistics also show slightly lower initiation rates among Hispanic and Native American women when compared to white women. MDHHS will continue to intentionally gather data as it relates to Native American breastfeeding rates.

Based on the above disparity data, the Title V state action plan continues to focus on reducing disparities in breastfeeding rates among women of color. In alignment with the plan, MDHHS has continued to prioritize using culturally responsive, evidence-based images and messages within public health campaigns to support the normalization of breastfeeding. Action plan strategies focus on increasing breastfeeding knowledge among maternal

and infant health professionals who work with pregnant or postpartum women; offering breastfeeding educational opportunities statewide through a webinar series and forthcoming online breastfeeding training course; supporting and promoting access to breastfeeding support resources; normalizing breastfeeding in culturally responsive ways; and promoting community-driven resources that address common breastfeeding barriers. The evidence continues to support that babies born in Baby-Friendly designated hospitals are more likely to be breastfed. Therefore, increasing the percent of Baby-Friendly hospitals in Michigan remains the Evidence-based Strategy Measure (ESM) for this NPM. Title V funding supports breastfeeding promotion efforts, including social media activities.

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

The first strategy is to provide MDHHS Maternal Infant Health (MIH) staff with an appropriate level of breastfeeding education. This includes increasing MIH staff knowledge on the health benefits of breastfeeding to parents and infants, common barriers to breastfeeding, root causes of breastfeeding disparities among racial and ethnic groups, information to support consistent messaging about breastfeeding, and community-based, culturally responsive breastfeeding resources to support both Michigan families and professionals. The training will also include how to have honest and non-judgmental conversations about risk reduction strategies for safe sleep. This strategy, in tandem with the next two strategies, will help to achieve the state priority need by enhancing support systems that empower families, promote care for self and child, and connect families to resources in their communities. It also supports the strategy of promoting breastfeeding across programs within MDHHS. In 2022, MDHHS convened a development team to create the breastfeeding training course, and it is expected that the course will be available in 2023. In 2024, this breastfeeding course will continue to be promoted to MCH professionals and partner agencies across the state. Going forward, the breastfeeding training course will be updated as needed to reflect current guidance and recommendations.

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

The third strategy, increase the percent of Baby-Friendly Hospitals in Michigan from 16% to 18%, is Michigan's ESM for this NPM. Activities will focus on continuing to leverage and develop partnerships with organizations that promote and support hospitals' ability to achieve and maintain Baby-Friendly designation. MDHHS will continue to encourage the benefits of Baby-Friendly designation and maintaining Baby-Friendly standards beyond designation through routine data collection, monitoring of practices, and quality improvement activities, which can support breastfeeding duration. Breastfeeding content will be included at the 2024 Maternal Infant Health Summit, which is broadly attended by MIH stakeholders, including hospital and clinic staff. Additionally, MDHHS will recognize hospitals that adopt breastfeeding-supportive maternity care and infant feeding as best practices. Michigan hospitals' response to the COVID-19 pandemic has placed incredible strain on hospital resources in recent years and has impacted their ability to meet and/or maintain the Baby Friendly USA standards.

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

Disparities in breastfeeding initiation persist among non-Hispanic white women and non-Hispanic Black women. This objective seeks to achieve more equitable health outcomes by addressing this disparity. PRAMS data will be used to measure and track the objective. The first strategy is to support training opportunities that improve the racial

and cultural diversity of breastfeeding professionals. One example is the Great Lakes Breastfeeding Webinar Series hosted by the Michigan Breastfeeding Network. This webinar series provides monthly on-demand online training opportunities for professionals who serve families, at no cost to participants. The Michigan Breastfeeding Network has expanded the types of continuing education offered through the webinars and now provides contact hours for nurses, social workers, lactation consultants, community health workers, certified health education specialists, physicians, and dietitians. Not only do the webinars remove barriers such as travel and cost, but webinar topics have an intentional health equity focus.

The second strategy is to promote breastfeeding promotion campaigns to normalize breastfeeding in culturally responsive ways. At a minimum, in FY 2024 social media messages promoting breastfeeding will be identified and used on MDHHS social media channels. These social media messages will aim to integrate community voice by reflecting the input and preferences shared by community-based organizations. MDHHS will also work with partners to recognize observances such as, but not limited to, Breastfeeding Awareness Month, Indigenous Milk Medicine Week, Black Breastfeeding Week, and Asian American, Native Hawaiian and Pacific Islander Breastfeeding Week. MDHHS will also continue to work with the Genesee County Health Department to increase breastfeeding rates within the City of Flint and Genesee County. Past work with Genesee County has supported efforts to develop breastfeeding education animated “shorts” and print materials using evidence-informed curriculum to provide tailored breastfeeding education via social media and local advertising.

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

Safe Sleep (FY 2024 Application)

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

In Michigan, sleep-related infant deaths are a leading type of death for infants 1-12 months old (2018-2020 Michigan Resident Infant Death File, Division for Vital Records & Health Statistics, MDHHS), with suffocation being the most common cause. Statewide 1.3 sleep-related infant deaths occur per 1,000 live births [Centers for Disease Control and Prevention (CDC) Sudden Unexpected Infant Death (SUID) Case Registry – 2010 to 2019, Michigan Public Health Institute (MPHI), 2021] and there is no clear trend showing either an increase or a decrease in the state rate. Rates across the state vary widely, with some jurisdictions experiencing rates as high as 3.2 and some as low as 0.6 (CDC SUID Case Registry – 2010 to 2019, MPHI, 2021).

Significant racial disparities exist among sleep-related infant deaths. In Michigan, non-Hispanic Black (NHB) infants are 3.8 times more likely to die of sleep-related causes than non-Hispanic White (NHW) infants. Compared to NHW infants, infants whose race was categorized as being part of an Additional Group (including American Indian, Asian,

Pacific Islander, and multi-racial infants) are nearly 3.5 times more likely to die of sleep-related causes (CDC SUID Case Registry – 2010 to 2019, MPHI, 2021).

Additionally, data show infants born pre-term and low birth weight are also at increased risk for sleep-related infant deaths. Pre-term infants experience a sleep-related infant death rate 2.5 times higher than infants born at 37 weeks or greater gestation. Moreover, infants born with low birth weight have a 2.9 times greater risk of dying due to sleep-related causes as compared to infants with a birth weight of 2,500 grams or higher (CDC SUID Case Registry – 2010 to 2019, MPHI, 2021).

Most sleep-related infant deaths are preventable with safe sleep practices. Data from the Michigan Pregnancy Risk Assessment Monitoring Survey (PRAMS) often take several years to reach statistically significant change. Significant progress for placed to sleep on back has been slow, but infants placed to sleep with no soft objects or loose bedding and infants placed to sleep on a separate approved sleep surface has had more sizeable improvements. In birth year 2021, PRAMS data show 86.5% of Michigan mothers placed their infants to sleep on their backs, 41.3% of infants were placed to sleep on a separate approved sleep surface, and 64.1% of infants were reported as sleeping with no soft objects (pillows, bumpers, blankets, toys). These are all improvements from birth year 2019, although these improvements did not reach statistical significance. When looking at data between 2016 and 2021, state level significant improvements have occurred in infants reported as sleeping with no soft objects and significant improvement in separate approved sleep surface.

Data show that the behaviors described above do impact deaths. One example is when looking at sleep location. According to the CDC SUID Case Registry, three in four sleep-related infant deaths in Michigan occurred in an unsafe sleep location, including adult beds (48%) and couches or chairs (15%). Only 22% of infants who died of sleep-related causes were placed to sleep in a crib, bassinet, or portable crib. Of the infants who die of sleep-related causes in Michigan, 58% of deaths occur while an infant is sharing a sleep surface with an adult(s), another child(ren), and/or an animal(s) (CDC SUID Case Registry – 2010 to 2019, MPHI, 2021).

The disparity gap in back sleeping was relatively constant through 2014. Starting in 2014, a seven-year period was observed in which placing infants to sleep on their backs remained statistically unchanged among Black mothers. In combination with modest improvements among White mothers, this has resulted in a widening disparity gap for back sleep. According to 2021 PRAMS data, there is a disparity gap of 19.8% for the behavior of infants usually being placed to sleep on their backs between NHW and NHB, 91.3% and 71.5%, respectively. There is also a growing disparity in some safe-sleep performance measures that has only just become clear upon examination of the most recent 2020 PRAMS data and continues into 2021. In 2016, the proportions of NHW and NHB mothers sleeping their infants on separate approved surfaces and in spaces without loose objects or bedding were equivalent. A single digit disparity gap opened in 2017-2018 and grew to double digits for each measure by 2021. There is now a 16.1% disparity gap of infants being put to sleep without soft objects or loose bedding (68.8% for NHW as compared to 52.7% for NHB). NHW mothers also reported a higher proportion of infants sleeping on a separate approved sleep surface (44.0% for NHW compared to 38.7% for NHB for a disparity gap of 5.3%; smaller than the disparity gap of 14.2% seen in 2020). Many of these disparities are large enough to reach statistical significance.

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

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

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

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

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

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

The first strategy is to support safe sleep activities of Local Health departments (LHDs) and the Inter-Tribal Council of Michigan (ITC) by offering grants to increase the capacity of those communities to implement infant safe sleep education, awareness, and outreach activities, with a focus on populations within their jurisdiction that experience high rates of sleep-related infant death and disparity. In FY 2024, five LHDs and ITC will be offered grants. The jurisdictions served by the five LHDs account for 51% of the sleep-related infant deaths in Michigan and all experience significant racial disparities among the deaths. Racial disparities in infant deaths also exist for American Indian babies in Michigan with American Indian infants being 2.5 times more likely to die of sleep-related causes than white infants (CDC SUID Case Registry – 2010 to 2019, MPHI, 2022). Grantees, as experts in their own communities, are given the latitude to design, direct and conduct their work.

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

Since 2020, COVID-19 has impacted the ability of LHDs and ITC to conduct safe sleep activities due to factors including staffing challenges and some programs remaining virtual; their partners faced the same challenges, limiting opportunities for collaboration. However, LHDs and ITC have been creative in overcoming these challenges and many of their solutions have remained a permanent part of their programming, such as continuing to offer virtual options for events. They will be encouraged to continue to be creative in their efforts to meet program objectives.

The second strategy is to continue to support agencies in implementing and/or updating existing safe sleep policies or protocols to ensure that families interacting with those agencies receive up-to-date infant safe sleep education; have access to tangible resources for safe sleep; and are given referrals to supportive programs such as home visiting, WIC and lactation support. The support to agencies will continue to be customized to fit their needs and will include access to recommendations that outline how agencies serving families can support infant safe sleep. Success at connecting with agencies in the last several years has been challenging, particularly due to staff shortages and other competing program needs. However, the ISS Program will continue to recruit agencies, including non-traditional partners such as substance use treatment centers, domestic violence service providers and agencies serving the homeless population as well as other historically marginalized and underserved populations. ISS Program staff will continue to provide support to other federal and state programs including the Maternal Infant Health Program (MIHP), the Maternal, Infant, and Early Childhood Home Visiting program (MIECHV), and WIC to

support and enhance infant safe sleep education and awareness with staff and clients. The ESM tied to this strategy will continue to count the number of agencies supported.

The third strategy is to provide education and share tools with providers on how to have client/patient centered conversations regarding safe sleep. This includes trainings (i.e., virtual, online and in-person) for providers who work with pregnant and parenting families in programs such as home visiting, WIC, childcare, child welfare, CPS, emergency medical services and prenatal care. In FY 2024, motivational interviewing concepts and risk reduction techniques will continue to be included in trainings conducted with professionals who work with families. The trainings help professionals better understand the challenges a family may face in following the guidelines by having honest and open conversations; equip professionals to help the family evaluate their current risk and explore strategies for risk reduction; and identify needed supports. The ESM to require all new MIHP staff to take the online *Helping Families Practice Infant Safe Sleep* training will continue in FY 2024. In FY 2022, MIHP agencies served approximately 12,000 pregnant moms and 15,000 infants on Medicaid. Targeting MIHP providers allows mothers and families at higher risk to be reached.

As part of the Child Safety Learning Collaborative, in FY 2023 the ISS program established a partnership with MDHHS Bureau of Emergency Preparedness, EMS and Systems of Care to implement an Infant Safe Sleep Certification Program for EMS Agencies and Fire Departments. The program requires the fire departments and EMS agencies to train providers as well as connect with local safe sleep contacts to access supportive services for families. This program will continue in FY 2024. The High Touch, High Tech (HT2) e-screening tool delivers a brief motivational intervention, notifies the healthcare provider, and helps connect families to additional supports. Its expansion to include screening for safe sleep knowledge and behaviors continues to be available. Opportunities to expand and enhance this project will continue to be explored in FY 2024.

Support for professionals will also be continued through the email listserv and webinars. Resources for infant safe sleep and infant care will continue to be available through the Infant Safe Sleep website and the MDHHS Clearinghouse. Images used in educational materials will continue to reflect the diversity of families in Michigan and most materials are offered in Spanish and Arabic as well as English. The basic safe sleep brochure is also available in eight different languages common in Michigan, including Bengali, Burmese, Dari, French, Kinyarwanda, Nepali, Pashto, and Swahili. Other languages will be added as necessary.

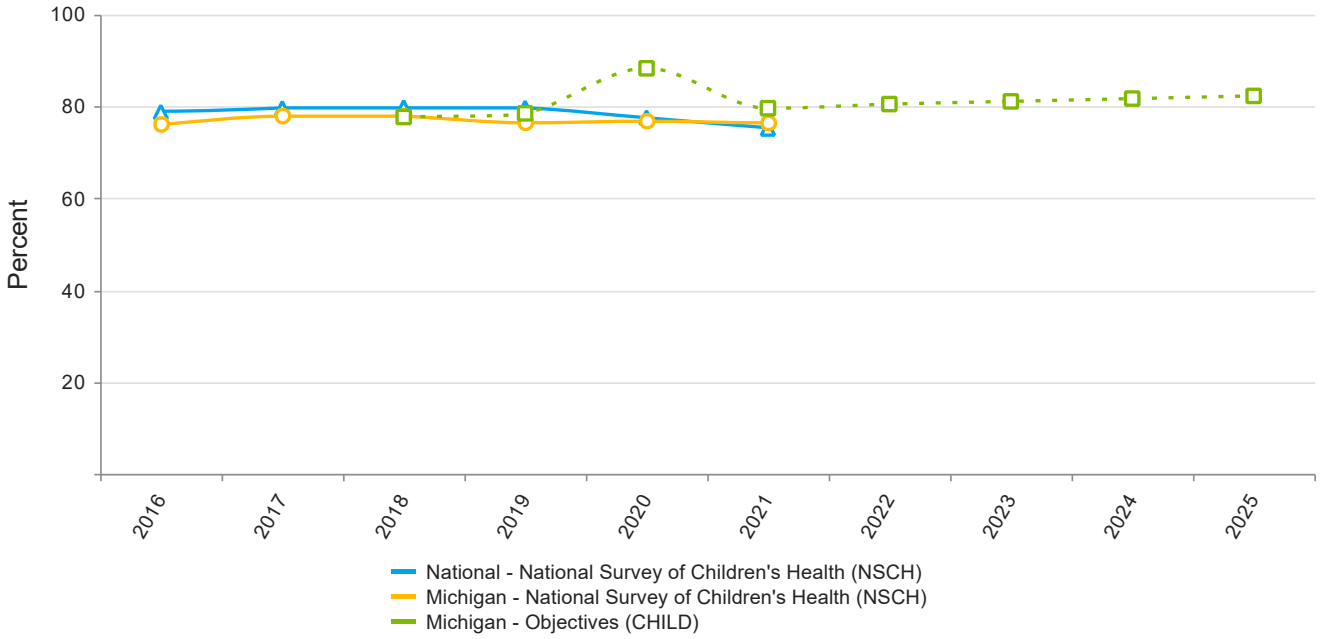
Another strategy is to provide professionals and families with guidance on protective factors (i.e., smoking cessation, breastfeeding, immunizations) and evidence-based programs (i.e., community-based doula support, home visiting) to enhance the overall health and well-being of moms and babies. Information on protective factors is incorporated into safe sleep messaging and educational materials when possible. In FY 2024, the Infant Safe Sleep and Breastfeeding Programs will continue to integrate their work more closely. Quarterly calls with MDHHS programs such as Immunizations, WIC, Tobacco, and Home Visiting will maintain collaborations that work to infuse infant safe sleep into all aspects of work with families.

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

Child Health

National Performance Measures

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year
Indicators and Annual Objectives



NPM 13.2 - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	77.6	78.4	88.2	80.4	80.4
Annual Indicator	77.9	77.7	76.5	76.2	76.2
Numerator	1,629,730	1,618,664	1,574,401	1,540,558	1,540,558
Denominator	2,092,116	2,083,849	2,058,613	2,020,499	2,020,499
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	81.0	81.6	82.2

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Number of students who have received a preventive dental screening through the SEAL! Michigan program

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	6,127	6,327	6,527	6,727	6,927
Annual Indicator	6,964	6,897	6,168	3,639	9,396
Numerator					
Denominator					
Data Source	SEAL MI 2018 All Grantees Data Report	SEAL MI 2019 All Grantees Data	SEAL MI 2020 All Grantees Data Report	SEAL MI 2021 All Grantees Data Report	SEAL MI 2022 All Grantees Data Report
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	6,927.0	7,127.0	7,327.0

State Performance Measures

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

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	24.6	27.1	29.6	50	52.5
Annual Indicator	43.4	45.8	48.1	45.3	49.2
Numerator	1,308	1,671	994	718	636
Denominator	3,017	3,646	2,068	1,586	1,293
Data Source	MDHHS Data Warehouse	MDHHS Data Warehouse	MDHHS Data Warehouse	MDHHS Data Warehouse	MDHHS Data Warehouse
Data Source Year	2018	2019	2020	FY2021	FY2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	55.0	57.5	60.0

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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	77	75	76	77	78
Annual Indicator	74.1	74.1	70.7	69.4	66.1
Numerator	123,596	121,707	119,786	113,259	107,075
Denominator	166,746	164,167	169,474	163,218	162,076
Data Source	Michigan Care Improvement Registry	Michigan Care Improvement Registry	Michigan Care Improvement Registry	Michigan Care Improvement Registry	Michigan Care Improvement Registry
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	79.0	80.0	80.0

State Action Plan Table

State Action Plan Table (Michigan) - Child Health - Entry 1	
Priority Need	
Improve oral health awareness and create an oral health delivery system that provides access through multiple systems	
NPM	
NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	
Objectives	
A) Increase the number of students who have received a preventive dental screening within a school-based dental sealant program	
B) Increase dental sealant placement on children enrolled in Detroit Public Schools Community District (DPSCD)	
Strategies	
A1) Utilize the 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 annual SEAL! Michigan all grantee reports to monitor for annual growth of students receiving a preventive dental screening A4) Examine ongoing trends to identify geographic areas experiencing a high burden of disease and identify populations that will benefit from an increase in dental sealant placement in proportion to disease and population	
B1) Increase access to dental consent forms for students' caretakers B2) Provide oral health education to the Physical Health Department (e.g., counselors) and continue training of newly contracted nurses by DPSCD B3) Increase the number of dental providers at DPSCD to allow more access to care and increase sealant placement	
ESMs	**Status**
ESM 13.2.1 - Number of students who have received a preventive dental screening through the SEAL! Michigan program	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	

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

Priority Need

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

SPM

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

Objectives

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

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

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

Strategies

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

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

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

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

Priority Need

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

SPM

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

Objectives

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

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

Strategies

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

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

Child Health Overview

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

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

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

Title V funding also supports the Local Maternal Child Health (LMCH) program which provides funding to all 45 Local Health Departments (LHDs). In FY 2022, Title V funds via the LMCH program were expended on NPM 13.2 (oral health-children), SPM 1 (childhood lead poisoning prevention), SPM 2 (childhood immunizations), SPM 6 (behavioral/mental health), and Local Performance Measures (LPMs) in the child health domain. Three LHDs supported oral health for children (NPM 13.2) by providing gap-filling dental services, fluoride varnish, and education through outreach events and social media posts. Childhood lead poisoning prevention (SPM 1) was selected by 13 LHDs. Activities included gap-filling lead screening and case management, venous confirmation follow-up, lead packet distribution in high-risk zip codes, and community/provider education. Changes in the blood lead reference value for clinical lead management created some challenges in FY 2022. Additionally, much lead screening is traditionally conducted in WIC clinics. WIC in-person services were limited due to the pandemic, and the infant formula shortage also required significant WIC time and attention. Thirteen LHDs selected SPM 2 (childhood immunizations). Agencies facilitated gap-filling immunization services, recall notifications, waiver education, social media education, and a PSA campaign. LHDs reported an increase in vaccine hesitancy and mistrust in government related to the pandemic. Vaccine waivers also increased. One agency worked on SPM 6 (behavioral/mental health)

by providing presentations on mental health to elementary school age children. The same agency worked on an LPM related to obesity/nutrition.

Three LHDs worked on an LPM for gap-filling hearing and vision screening. One agency planned to implement an LPM for car seat safety training but due to loss of staff, this service was not provided. Two health departments diverted funds for COVID-19 vaccinations for children 19-35 months and testing at childcare facilities. LHDs reported staff vacancies that also impacted the ability to complete planned activities.

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

Oral Health – Children (FY 2022 Annual Report)

The MDHHS Oral Health Program (OHP) provides population-based oral health prevention efforts and effective utilization of the dental workforce in implementing and improving oral health access. With increased awareness of the impact of oral health on overall health, the OHP has increased collaborations with community partners to improve oral health through prevention activities and direct access programs. The activities of NPM 13.2 in FY 2022, as discussed below, illustrate these strengthened partnerships. Title V funding was used to support the activities of the SEAL! Michigan program through local school-based dental sealant programs. In combination with other funding, Title V also supports an oral health epidemiologist who analyzes SEAL! Michigan program data and prepares reports for SEAL! Michigan grantees and partners.

Following a year of difficulty in FY 2021 reaching remote learning students due to the COVID-19 pandemic, FY 2022 was an overall positive return to schools. Many SEAL! Michigan programs experienced a positive response to school-based dental services. Anecdotally, parents have reported issues accessing dental services linked to a variety of access to care issues. Some parents lost their employee-sponsored dental benefit and some reported issues accessing a dental office, as the dental workforce continues to experience challenges across the state. Wait times can be significant in private practice offices and some dentists have moved to accepting only out-of-pocket payment. School-based programs have seen a strong return in parent consent forms and SEAL! Michigan programs report that need often exceeds capacity.

Costs continued to rise which impacted SEAL! Michigan providers. Due to the workforce shortage of hygienists, many hygienists needed a pay increase to stay with the program (private practices are offering significant pay to recruit and retain hygienists); fuel prices impacted mobile programs; and costs for Personal Protective Equipment (i.e., masks, gloves, respirators, disposable gowns, etc.) were significantly higher than before the pandemic.

SEAL! Michigan programs continued to see a wide variety of school grades in FY 2022, as the need was great in schools for students who could not otherwise access dental services. SEAL! Michigan programs also continued to seal primary teeth as dental decay is on the rise possibly due to students being home and often without access to a dental office and/or community water fluoridation and healthy foods, which they may have received in school prior to the pandemic.

To support coordination between schools and dental programs for children, the annual SEAL! Michigan Workshop was held as a preconference session in conjunction with the MDHHS Child and Adolescent School Health (CASH) conference in September 2022. The six-hour SEAL! Michigan session addressed tobacco/vape use in schools, oral health education in schools, proper protocol on follow-up with students in urgent/emergent oral heath situations, and SEAL! Michigan updates. By jointly holding the two events, most SEAL! Michigan preconference participants also attended the CASH conference which supported interprofessional collaboration across school health programs. Two SEAL! Michigan providers presented on school oral health programs at the conference. MDHHS partnered with a

SEAL! Michigan program, Smiles on Wheels, to sponsor an oral health exhibit and raffled educational oral health items to school health attendees, resulting in a strong oral health presence at the CASH conference. Feedback was overwhelmingly positive, supported collaboration across disciplines and allowed more networking time with SEAL! Michigan programs.

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

The first strategy to achieve this objective was to utilize the SEAL! Michigan database to track the number of students annually receiving a preventive dental screening. The number of students receiving a preventive dental screening through SEAL! Michigan is also the ESM for this NPM. The SEAL! Michigan data forms continued to be utilized in FY 2022. To ensure the forms continued to work well for MDHHS staff and funded partners, a workgroup was established to identify changes needed to the forms. They were then reviewed by SEAL! Michigan staff for additional feedback and tested by MDHHS epidemiologists. The data forms were modified to include a variety of locations (community sites, daycare centers, shelters, etc.) and to include data collection of primary teeth sealed. These additions were made to ensure all activities could be seamlessly documented. The annual SEAL! Michigan all grantee reports continued to be used to monitor the number of students receiving a preventive dental screening. Data forms were collected at the end of the fiscal year; data was cleaned; and the grantee reports were developed and submitted for publication.

In FY 2022, nine SEAL! Michigan programs were directly funded. Across all SEAL! Michigan programs 9,406 students were screened. The majority of students screened were in kindergarten and 2nd grade. The average age of students was 7.9 years old, with the range of students screened between 4 and 23 years of age. The older students screened were in alternative education locations, such as youth centers and special education locations, and were eligible for the program due to the exceptions put in place to accommodate the pandemic.

The racial and ethnic backgrounds of students served included Arab American, Hispanic, and Black. Over 65% of the students were white, 8.9% were Black, and 13.2% were multiracial. These rates are in proportion to where programs provided services during the reporting period. Rural areas in the state, such as the Upper Peninsula, have a higher population of white families and were more likely to have schools open for operation during the pandemic, whereas more urban areas (Detroit, Oakland County, Ingham County) which have more diverse populations, were in virtual learning the majority of—if not the entire—school year.

Approximately one-quarter of students served had special health care needs which included those needing more medical care and those receiving special therapy, counseling, or treatment. Over half of the students were enrolled in the Healthy Kids Dental Insurance program, 20.7% had private insurance, and 16.4% had no dental insurance.

The second strategy was to promote dental sealant programs through school health professionals which built on work established the prior year. In 2021, the MDHHS School Health Consultant worked with the MDHHS Detroit Public Schools Community District (DPSCD) Oral Health Coordinator and the district School Nurse to provide a series of six webinars on oral health to DPSCD school nurses. The trainings were recorded to ensure DPSCD school nurses have ongoing access to them and are available for new school nurse staff. The webinars covered a variety of oral health topics specific to both children and adults such as access to care; current data extracted from the Basic Screening Survey specific to children in Detroit; dental first aid; how poor oral health affects overall health; dental decay; periodontal disease; nutrition; and the role of school oral health programs and SEAL! Michigan in preventing disease. Feedback from the webinars was positive with school nurses reporting learning related to their own oral health as well as concerns to watch for in students. The videos continued to educate new DPSCD school nurses on-demand.

The final strategy was to examine ongoing trends to identify geographic areas experiencing a high burden of disease and identify populations that will benefit from an increase in dental sealant placement in proportion to disease and population. In FY 2022, two surveys were completed, one on students in Head Start and one on students in third grade. The surveys are completed every five years and provide data and benchmarks on oral health data trends in certain regions of the state. The data projects were conducted in FY 2022 and reports are expected to be published by March 2023. Once published, the data can be used to help place sealant programs and to help monitor existing programs for health change and an increase in sealant placement.

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

Michigan's 2016 Count Your Smiles (CYS) report collected data from open-mouth screenings of third grade children across Michigan. According to the report, the City of Detroit data indicated that approximately 82% of third grade children had active dental disease and only 28.3% of children had at least one dental sealant, which is the lowest percentage by region in Michigan. Given these disparities in oral health outcomes, establishing stronger oral health programs and follow-up care coordination in the Detroit Public Schools Community District (DPSCD) was identified as a key strategy to achieve health equity and positive oral health outcomes for Michigan's children. The DPSCD system is the largest school district in the state and provides educational services to approximately 50,000 students. According to a report by the Michigan Department of Education, the majority of children (approximately 82%) attending DPSCD are African American.

The first strategy to achieve this objective was to hire an Oral Health Coordinator to oversee oral health related work in DPSCD. The 0.5 FTE Oral Health Coordinator (OHC) is supported by Title V funding and was fully onboarded by October 1, 2020. The OHC position continues to be a unique partnership between MDHHS and DPSCD. The employee is a Michigan Public Health Institute affiliate employee, is located within the MDHHS Oral Health Program, and is physically housed in Detroit with other DPSCD school health employees. The OHC oversees all DPSCD dental services partners and completes site visits to oversee school dental clinics, infection control, and safety. The OHC also works to ensure all students assigned to school nurses on a regular basis report to the DPSCD pediatrician; and has workplan goals related to family engagement and student focus groups. The OHC orders oral heath supplies for students; tracks the distribution of those supplies; and works with staff to order education supplies for all school nurses. In FY 2022, the OHC provided Oral Health Education to the school district's Parent Outreach Coordinators to help increase enrollment in oral care. A dental day that provided services at no cost to 200+ students at a DPSCD school was staffed by oral health professionals who volunteered their time. In addition, an online seminar in partnership with the Dairy Council presented a three-part nutrition class on oral health to students' caregivers.

A current challenge of the OHC position is that only 0.5 FTE is available in funding. Due to COVID-19, many schools had fewer students attending in-person. This allowed the OHC to become established within the school district, to work closely with school nurses and dental partners, and to focus on establishing the roles of this new position. In FY 2022 students returned to schools and dental services resumed, which provided the first full half-year of overseeing dental providers within DPSCD and assisting with care coordination in addition to other ongoing projects from the prior year.

A second planned strategy to support this objective was to organize parent and student focus groups in DPSCD. Implementation of this strategy was delayed due to COVID-19. Many students were learning from home in FY 2021 and given other ongoing COVID-19 challenges, including parents' challenges managing remote learning, there were not opportunities to organize parent and student focus groups as originally planned. However, during the summer of 2021, the OHC started planning ways for parents to learn about oral health in this new and remote environment. A

logic model was created, and community partners committed to the project. The project allowed parents of DPSCD to increase their knowledge of what good oral health looks like and how to create a healthy breakfast that supports oral health. The parent and student focus group then started in the fall of 2022. During the summer, the OHC also established a relationship with dentists, Delta Dental Foundation, and Dental Quest to ensure they are part of the team of oral health education activists. One of their objectives was to attend PTA meetings and provide educational oral health information, which began in the fall of 2022.

The third strategy was to enhance reporting requirements from all DPSCD oral health providers. Comprehensive reporting requirements were not previously in place for dental services at DPSCD, so the MDHHS OHP worked with an internal epidemiologist to modify the existing SEAL! Michigan data forms to reflect both the comprehensive and preventive dental services being provided in DPSCD. The revised data forms were piloted and distributed to the DPSCD dental providers. The official data sheets are collected annually on October 1; however, informal data was collected quarterly to allow the OHC to review services that were completed and address any compliance concerns. The official data sheets were developed into individual final reports for each dental provider and used to help manage each dental program. Collective program data was also combined into one report and presented to DPSCD leadership and other dental providers.

In FY 2022, the DPSCD dental providers collectively screened 3,631 students at 67 sites in Detroit. The majority of students screened were in kindergarten, 2nd grade, and 3rd grade. The average age of students was 8.8 years old, with an age range between 1 and 26 years of age. Almost half of students (43.6%) screened had a reported race of Black/African American; however, race information was absent for 48.3% of students. As stated above in Objective A, the rates are proportionate to the locations where programs provided services. Schools in Detroit, which have more diverse populations, were virtual for part of the school year, returning to in person classes in January 2022.

Only 5.5% of students screened in Detroit had special health care needs which included needing more medical care or receiving special therapy, counseling, or treatment. Over three-quarters of students were enrolled in Healthy Kids Dental insurance program, while 4.1% of students had private insurance and 7.8% of students did not have dental insurance.

It is important to note the data reported here for the DPSCD dental providers are not reflected in Objective A. The providers in Objective A received funding to support the provision of services whereas providers in Objective B are contracted through DPSCD. The funding for Objective B supports the DPSCD OHC position as terms of the Memorandum of Agreement between MDHHS and DPSCD.

In FY 2022, the Memorandum of Understanding (MOU) between DPSCD, the State of Michigan, and the dental providers was reviewed and updated. The MOU included the expected service, reporting requirements, and the number of consent forms needed before starting service with DPSCD. When school started in the fall of FY 2022, the dental providers' MOUs were revised and signed, and all 107 schools had a dental provider assignment. The MOUs are reviewed at the end of each school year to ensure that they accurately reflect the partnership, and school assignments were modified for the following school year to best meet the needs of the dental providers and each individual DPSCD school building.

Childhood Lead Poisoning Prevention (FY 2022 Annual Report)

The Michigan Childhood Lead Poisoning Prevention Program (CLPPP) has carried out mandated blood lead surveillance and lead poisoning prevention activities since 1998. Childhood lead poisoning has steadily declined in Michigan, but elimination has not yet been attained. During FY 2022, the Michigan Department of Health and Human Services (MDHHS) updated its definition of an elevated blood lead level for children from 5 µg/dL to 3.5 µg/dL, following the Centers for Disease Control and Prevention updating their blood lead reference value (BLRV). At a

level of 3.5 µg/dL or greater, lead education, nursing case management, environmental investigations, and additional medical monitoring should be established to lower the blood lead level.

This report describes CLPPP activities undertaken in FY 2022 to improve screening for risk factors and increase blood lead testing, specifically confirmatory venous testing. In 1998 (the first complete year of required reporting) for children under the age of six tested for lead, 44.0% of children had EBLLs (29,165 of 66,204 children tested). In 2022, for children under the age of six who had a blood lead test, 2.0% (1,769 of 89,206) had elevated blood lead levels using a blood lead reference value of 5 µg/dL. There was no significant change from 2.0% (2,035 of 102,926) in 2021. The rate of confirmatory venous testing of EBLL capillary test results in 2022 was 49.2% (636 of 1,293 EBLL capillary tests), which was an increase from 45.1% (552 of 1,158 EBLL capillary tests) in 2021.

Blood lead testing rates remain low in Michigan. Since the start of the COVID-19 pandemic, deferred care and increased use of telemedicine has negatively impacted blood lead testing. The pandemic also resulted in children spending more time at home, which increases the risk of exposure for children living in homes with lead contamination. MDHHS continued to follow a response plan to address the decrease in testing rates, with strategies around education, outreach, and data surveillance. A mass media campaign was launched in FY 2022 to remind parents and caretakers that lead is an invisible threat and to encourage them to talk to their health care providers about blood lead testing for their children.

In response to the decreased testing rates, CLPPP identified three local health departments to participate in a blood lead testing pilot project during FY 2022. Those communities received funding to implement innovative strategies to increase testing rates in their areas. Additionally, in FY 2022 13 local health departments were awarded grants to focus on provider education, parent education, and outreach to at-risk populations, with the goal of increasing testing rates and addressing the three objectives outlined in this state action plan. These grants are supported by Title V funding. Activities funded by the grants included:

- Developing and implementing a protocol to increase confirmatory testing rates by outreach and education to families of children with capillary elevated blood lead levels. This includes coordination with the child's primary care provider, Medicaid Health Plan, and family to ensure that barriers to getting the confirmatory test are addressed.
- Distributing materials, providing education, and presenting at community events, many of which remained virtual due to the COVID-19 pandemic.
- Developing messages to distribute to their community via social media, media campaigns, local radio/TV shows, and mailings.
- Supporting lead testing at WIC clinics and local health departments. This was a particular challenge given the barriers of closed WIC clinics and recalled Lead Care testing kits. Local health departments adjusted by switching to other testing methods like microtainers and filter paper.
- Convening lead poisoning prevention partners to coordinate efforts and messaging.
- Education to health care providers about lead testing recommendations for children and pregnant persons.
- Education to students in health care programs.
- Nursing Case Management services for home visits not covered under Medicaid.

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

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

The first strategy to achieve this objective was to flag children in the Michigan Care Improvement Registry (MCIR)

who need to be screened for blood lead risk factors. MCIR displays blood lead test results for children when providers access their patients' immunization records which allows providers to see if a child needs to be tested. When a child has an EBLL, MCIR flags the results and provides the recommended follow up for medical management. Provider offices can use this information during visits with patients and order necessary testing. During FY 2022, CLPPP began to research whether blood lead test results can be populated directly into provider EHR systems. This will be an additional strategy to assist providers in determining whether a child has been tested or received proper follow-up for an elevated lead level.

A second strategy was to provide education activities to encourage providers to screen all children less than 72 months of age for lead exposure risk factors. Provider education was ramped up in FY 2022 through the hiring of an additional physician public health detailer, making a team of two detailers and a physician to focus on increasing education to providers. The physician education team presented to 24 health care provider offices/clinics throughout Michigan.

Additionally, an important partnership with the Michigan Chapter of the American Academy of Pediatrics (MIAAP) was enhanced. CLPPP partnered with MIAAP to develop a provider health care provider education packet, which was finalized in FY 2022. Approximately 10,200 clinicians received the provider packet via mailings, presentations, and at conferences.

An online module for health care providers went live in August 2020 and was updated in FY 2022 to reflect the changes to the blood lead reference value. During FY 2022, 215 health care providers completed the course, including pediatricians, social workers, nurses, and students. The module covers the sources of lead exposure, recommendations for screening and testing for children, and medical management of children identified as having an elevated blood lead level.

To achieve equitable health outcomes, a third strategy was to partner with agencies to provide culturally appropriate lead education to at-risk populations. In FY 2022, CLPPP continued a contract with a community advocate to provide education and outreach to the Arab American community in Southeast Michigan, specifically newly resettled refugee families. According to the CDC refugee toolkit, newly resettled refugee children have a higher prevalence of EBLLs compared to US born children. Through this project, the consultant provides trainings to health care providers and resettlement agencies in Wayne, Macomb, and Oakland counties about the CDC recommendation for lead testing for all refugee and immigrant children within 90 days of arriving to the USA, and within 3 to 6 months of finding a permanent residence. The consultant also partners with faith-based and community-based partners to provide educational materials like handouts, calendars, and posters in both English and Arabic.

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

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

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

also encouraged providers to provide blood lead tests to Medicaid-enrolled children at the recommended times.

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

In FY 2022, the local health department quarterly report bundle was finalized and posted to the CLPPP data sharing application for health departments. The reports include both annual and monthly data at the state, local health department, county, target city, and zip code levels. Presentations and training were also provided to local health departments on how to access and use the reports.

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

During FY 2022, CLPPP was invited to participate with Medicaid staff on intensive focus studies with Medicaid Health Plans (MHPs) across the state. This partnership enabled an opportunity to provide technical assistance to MHPs on innovative strategies to support their families that have children with an elevated blood lead level. It has also been an important tool for CLPPP to identify the activities MHPs provide to enrollees that can be shared with local health departments. This collaboration has been instrumental in helping CLPPP to connect MHP staff with local health department staff to partner on encouraging families to pursue confirmatory blood lead testing for an elevated capillary test.

In addition to the MHP focus studies, CLPPP staff have been invited to participate in quarterly meetings with MHP Care Directors to share updates and answer questions regarding blood lead screening. In FY 2022, CLPPP staff presented on the changes to the blood lead reference value and how it may impact their enrollees.

Immunizations – Children (FY 2022 Annual Report)

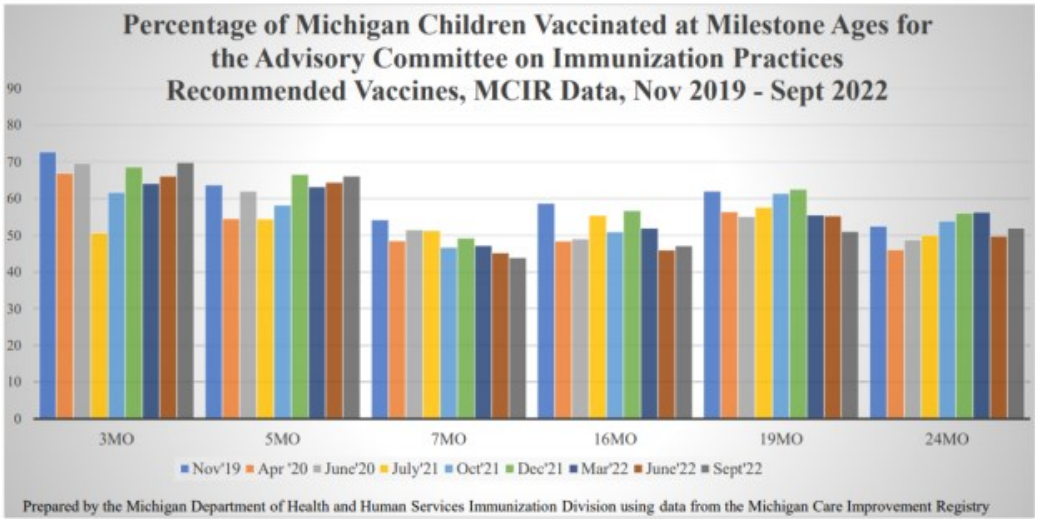
The MDHHS Division of Immunization is focused on improving the uptake of all Advisory Committee on Immunization Practices (ACIP) recommended vaccines among Michigan children 19-35 months of age. Specifically, the Immunization Program closely monitors the pediatric series vaccination rate which includes 4 doses of DTaP, 3 polio, 1 MMR, 3 Hib, 3 Hepatitis B, 1 varicella, and 4 pneumococcal conjugate (4313314 series) for Michigan children 19-35 months of age. The COVID-19 pandemic has presented numerous challenges to both healthcare and public health and has led to an overall increase in vaccine hesitancy. Michigan immunization rates for the pediatric series declined once again from 69.4% in FY 2021 to 66% in FY 2022. Prior to the COVID-19 pandemic, in FY 2019, the vaccine coverage rate for the 4313314 series was 74%.

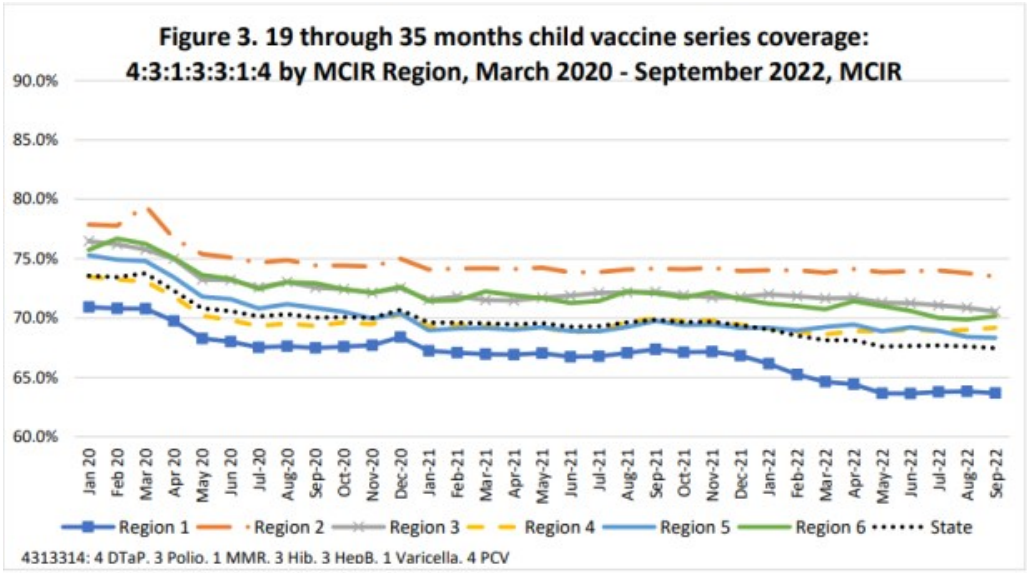
As a result of the COVID-19 pandemic, the Immunization Program disseminates a report to monitor the impact of the pandemic on non-COVID non-Influenza immunization administration and reporting patterns to the Michigan Care Improvement Registry (MCIR) and the resulting effect on immunization coverage estimates.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

As of September 30, 2022, MCIR data show that the vaccination coverage for children under 2 years at milestone ages has increased for 3, 5, 16, and 24-month age groups since June 2022 (Figure 1 from the MCIR report). However, there is a decrease in coverage from the last quarter for 7- and 19-month-old kids. Furthermore, the vaccination coverage levels for all the age groups remained below their pre-pandemic levels except for the 5- month

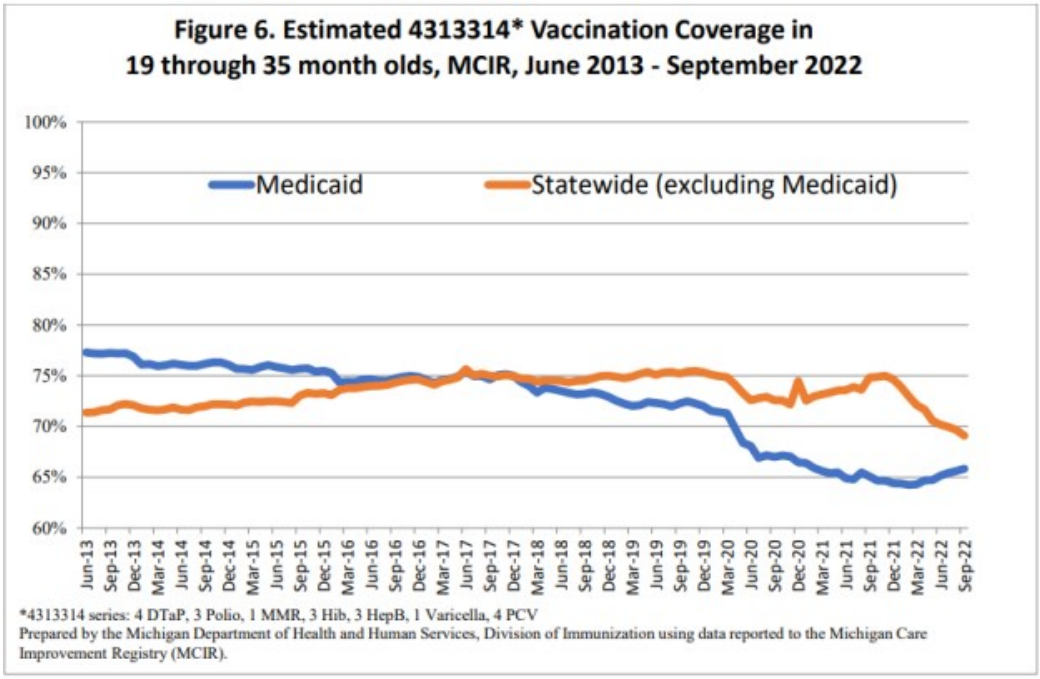
age group where it increased by 2.4 percentage points. Statewide coverage for children 19-35 months with the 4313314 series (Figure 3 from the MCIR report) decreased approximately 6 percentage points from the pre-pandemic level of 73.6% in January 2020 to 67.5% in September 2022. Parents' hesitancy for COVID-19 vaccine in children may have a spillover effect to other routine immunizations leading to continued decreased coverage levels for most age groups.

1. **Child Coverage by Milestone Vaccination Ages**





The pandemic has exacerbated an existing disparity in 4313314 series coverage between children aged 19-35 months enrolled in Medicaid and their peers who are not enrolled in Medicaid (Figure 6 from the MCIR report). Medicaid enrollees have experienced an 8.8 percentage point loss in coverage, which equates to 65.8% in June 2022 compared to 74.6% in March 2017. Coverage rates for children not enrolled in Medicaid had rebounded compared to pre-pandemic rate of 75.1% (January 2020) but recently decreased by 3 percentage points in September 2022 (69.1%) from 72.1% in March 2022.



The pandemic brought many challenges for pediatric providers, and vaccine hesitancy among parents has also been in the spotlight. In the early days of the pandemic, millions of children in the United States missed routine pediatric appointments at which they would have received vaccinations against diseases such as measles, polio, and pertussis. An MMWR published in April 2022, Vaccination Coverage with Selected Vaccines and Exemption Rates Among Children in Kindergarten — United States, 2020–21 School Year, shows that while most of those children have since gotten their shots, the national childhood vaccination rate among kindergarteners declined by 1%, from 95% in 2019 to 94% in 2021. A decrease by “only” 1% would include millions of doses nationwide that kindergartners did not receive. Overall, vaccine hesitancy has continued to increase, perhaps in relation to increased media attention on vaccines and changing vaccine recommendations. To combat the decline of pediatric vaccination rates, the Immunization Program is working diligently with providers, health care associations, and local public health to catch children back up on vaccines they may have missed due to the COVID-19 pandemic. In FY 2022, Title V funding continued to support childhood vaccination efforts.

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

In FY 2022, largely due to the COVID-19 pandemic, Michigan continued to experience a decrease in the percentage of children 19-36 months of age who received ACIP-recommended vaccines. According to data from MCIR, the vaccination coverage rate for the pediatric series (4 doses of DTaP, 3 polio, I MMR, 3 Hib, 3 Hepatitis B, 1 varicella, and 4 pneumococcal conjugate) decreased from 69.4% in FY 2021 to 66% in FY 2022.This continued downward trend is very concerning. The Immunization Program continues to use MCIR to monitor children 6-24 months of age who are overdue for vaccines and share this information, as appropriate, with partners, which is a key strategy to support progress on this objective. Using the data, the Immunization Program works to highlight the importance of pediatric vaccines through educating providers and the public and continues its partnership with public and private stakeholders to combat vaccine hesitancy and in turn promote vaccine confidence.

A second strategy was to generate letters to parents of children who were overdue for a vaccine. Due to competing priorities, including the COVID-19 pandemic and staffing shortages among the Immunization Program’s epidemiologists and MCIR team, pediatric recall letters were not generated for children 6-24 months of age who

were overdue for a vaccine. The Immunization Program is planning to generate recall letters for this population in FY 2023.

A third strategy was to partner with the City of Detroit Health Department to assist with increasing 19-36 months of age vaccination rates in Detroit. The Immunization Program is working closely with Detroit Health Department (DHD) and Detroit Public School Community District (DPSCD) to implement the Vaccines for Children (VFC) Program to increase access to vaccines. Further, they are holding school-located vaccine clinics to better reach this community. DPSCD enrolled as a VFC provider during the 2021-2022 school year to increase vaccination rates among their student population. Now operating in its second school year, DPSCD reported that they have facilitated over 100 clinics across the district and given an excess of 1500 VFC vaccines. The DHD continues to support the school district to facilitate school-located flu vaccine clinics. While there have been some barriers to this process, including staff turnover at DHD and DPSCD, the Immunization Program is continuing to meet with DHD and DPSCD to identify and implement strategies to increase vaccine update. Further, the Immunization Program is determined to continue this work to increase vaccine equity and improve vaccination rates within the city.

In addition to the strategies listed above, the Immunization Program used Title V funds to improve the functionality of MCIR to improve the overall public health infrastructure of the state's immunization information system. These functionality updates included enhancements to person deduplication, LHD school waivers, institution health monitoring, VFC/Outbreak enrollment, adoption record process, outbreak modules, forecasting and school/childcare online enrollment. Improvements to the state's public health infrastructure, specifically MCIR, is crucial to efficiently assess for vaccines, monitor vaccine uptake, and improve public health response.

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

The first strategy to support this objective was to produce a quarterly report card for each county showing vaccination rates and rankings compared to other counties across the state for multiple age groups, including children. In FY 2017, County Immunization Report Cards were first generated and posted on the MDHHS website on a quarterly basis. The report cards were generated to reflect the immunization rates of each county in Michigan and the rankings by county. The report cards have been modified several times to better meet the needs of local health departments. The goals of the report card data are to 1) provide each county with an understanding of vaccination rates in their respective communities and 2) identify areas for improvement. County report cards have been published every quarter and highlighted during several conferences.

The county report cards highlight vaccination coverage rates for pediatric, adolescent, and adult residents within each county and highlight their overall rank among all counties in Michigan. In addition, the report cards highlight both school and childcare waiver rates for each county and indicate their rank on this measure. The Immunization Program uses this rate and rank system to foster awareness among local health departments with the goal of improving vaccination uptake across the state.

The second strategy was to produce reports showing vaccination levels of infants from birth to 24 months of age showing vaccination drop-off by series and vaccine. This is illustrated above in Figure 1 of this report and is being shared with stakeholders as part of the MCIR COVID Impact Report.

Finally, the third strategy was to produce county coverage levels by race for children 19-36 months of age and make them available to local health departments. This strategy is currently in progress as program enhancements are being made to MCIR to ensure accurate race data. The Immunization Program aims to have these MCIR enhancements available in FY 2023.

Objective C: Implement the I Vaccinate Campaign.

Vaccine hesitancy continued to be a notable concern in FY 2022. The Michigan Immunization Program continues to support the statewide media campaign, I Vaccinate, which began in March of 2017. Specifically, the Immunization Program provides subject matter expertise on the website and messaging for social media and broadcasts as identified by the second strategy. The I Vaccinate Campaign continues with funding to run through 2023 to provide vaccine information to parents. The campaign promotes vaccination of children in Michigan using multiple media methods, including TV ads, radio ads, social media posts on several social media sites, immunization provider materials, and parent-focused social media influencers promoting vaccines and vaccine safety. More information is available at the I Vaccinate website.

The I Vaccinate Campaign has worked closely with MDHHS to promote COVID-19 vaccination among all Michigan residents, especially among eligible Michigan children. I Vaccinate utilizes family and community involvement via focus groups and various social media influencers to identify the needs and concerns of the community to better relate overall. Addressing the needs and concerns of the community is crucial in combatting vaccine hesitancy. Furthermore, I Vaccinate continues to create commercials “normalizing vaccination.” One example is the “My Why” videos which emphasize why people are choosing to get vaccinated with the COVID-19 vaccine. An example is available on the MDHHS social media page here. The Immunization Program continues to provide subject matter expertise and feedback to the I Vaccinate Campaign to craft information and messages.

Child Health - Application Year

Oral Health – Children (FY 2024 Application)

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

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

In Michigan, 58 of the state’s 83 counties have a full, partial or facility Health Provider Shortage Area (HPSA) designation, with 11 counties having less than five dentists. Only 38% of Medicaid-eligible children in Michigan receive dental services. Children under the age of five are the least likely to have visited a dentist. The Michigan Medicaid Program has been addressing access to oral health care by implementing the Healthy Kids Dental program throughout the state. The Healthy Kids Dental program began as a demonstration program through a contract with Delta Dental Plan of Michigan in 22 counties in May 2000. By October 2015, the program had expanded into all 83 counties. The Healthy Kids Dental Plan now utilizes Delta Dental, Blue Cross Blue Shield and DentaQuest network of dentists and provides a higher reimbursement rate to dentists, thereby allowing greater access to dental care for Medicaid-enrolled children. The utilization of dental care within this program has increased to over 50% of enrollees. This program assists children and adolescents, ages 0-21, with access to dental care.

The Healthy People 2030 target goal is to have 42.5% of children ages 3 to 19 with one or more dental sealants in place. Between 2005 and 2016 there was an increase in the percent of third grade students in Michigan with one dental sealant or more. In 2005, 23.3% of third grade students had one or more dental sealants; in 2010 it was 26.6%; and in 2016 it was 37.6%. This increase is attributed in part to the MDHHS SEAL! Michigan school-based dental sealant program which piloted in 2007 and has expanded within the state over the last several years. Until the fall of 2018, SEAL! Michigan was funded through Title V, CDC Cooperative Agreements, HRSA grants (as available), and annual gifts received from the Delta Dental Foundation of Michigan. Beginning in the fall of 2018, the SEAL! Michigan program experienced a loss of federal grants, and is now primarily funded through a Medicaid match, Title V, and annual gifts from the Delta Dental Foundation. This blended funding supports direct services delivered in schools across Michigan, a School Oral Health Consultant to manage SEAL! Michigan at the state level, and a 0.5 FTE Oral Health Coordinator at Detroit Public School Community District (DPSCD). Although less funding is currently available for sealant programs, the loss of federal grant funding did result in the state Medicaid program supporting the Oral Health Consultant position which adds significant sustainability to the program overall.

Historically the SEAL! Michigan program was entirely school-based and/or school-linked, focusing only on permanent molars; additionally, students served were in the first, second, sixth, or seventh grade for all of lower Michigan, minus Wayne County, and all students (K-12) were served in Wayne County and the Upper Peninsula. During the pandemic, SEAL! Michigan programs have been school-based and school-linked when possible, and when not possible, have been allowed to provide services in alternative locations (i.e., daycare centers, WIC, head

start centers, YMCA, churches, Boys & Girls Club, sporting arenas, youth homes, group foster homes, community centers, township halls, city halls, food pantries) and can set up external service areas in retail and health center parking lots. Students served are between the ages of 1-21 and it is now allowable to seal both primary and permanent teeth. These changes are in response to so many students in Michigan not having access to preventive dentistry in a dental home or lacking dental services in a school environment. SEAL! Michigan programs have been given the flexibility to think 'outside the box' on how, where, and when to provide dental screenings, sealants, and other preventive treatments.

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

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

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

Dental decay is the leading chronic childhood disease and nationally leads to more than 51 million missed school hours per year. Dental sealants are an evidence-based strategy to prevent dental decay. SEAL! Michigan is a school-based dental sealant program that provides dental screening and places dental sealants for students at no cost to families. In addition to dental sealants, students receive a dental screening, oral health education and (over 90% of the time) fluoride varnish. Although this strategy does not include comprehensive dental services, dental screenings are an effective point of entry to connect to a dental provider, which is increasingly more accessible with the expansion of Healthy Kids Dental.

SEAL! Michigan began in 2007 with a single pilot program serving a handful of schools. Through increased awareness and advocacy, the program has seen consistent growth by adding more programs and schools annually. Currently the program has nine grantees across the state, plus programs operating in DPSCD (which will be determined by DPSCD but ideally will be no less than four programs at a time). Although the SEAL! Michigan program provided service to 193 schools in FY 2020 (before the state shutdown in mid-March 2020), most schools in Michigan do not offer a dental sealant program to students. Dental sealants ultimately decrease dental disease in youth as they are nearly 100% effective in preventing dental decay when they are retained on the tooth. Reaching children through school-based services is efficacious and is a recognized best practice approach by the CDC and the Association of State and Territorial Dental Directors.

Program management and growth significantly rely on data collection. SEAL! Michigan has made ongoing improvement modifications to its data collection efforts. Data are collected annually and entered into software to be cleaned and analyzed by the oral health epidemiologist. Annual reports are written and released for each local program as well as aggregated into a statewide report. Data illustrates program success through annual increases in number of schools and students served and through number of sealants placed. The data will be captured by the

Michigan Basic Screening Survey of third grade students (completed every five years), Count Your Smiles Report, to demonstrate the rates of dental sealant placement and dental decay in children across the state. In FY 2020, the SEAL! Michigan team in the Oral Health Unit created a year-end infographic which will be updated by each individual program annually. The infographic highlights data from each individual program for the fiscal year and can be used to share accomplishments with stakeholders, school administrators, and additional funders. The infographic was also created for the OHP to highlight the cumulative outcomes of SEAL! Michigan.

The SEAL! Michigan program attempts to reach the target population through family and consumer outreach and engagement. As stated previously, programs focus on schools with a high number of children enrolled in the FRLP. The program relies on parent and guardian awareness of the program; thus, parents' consent for their children to receive the preventive oral health services is a key component of the program. To reach families and consumers, staff from the funded programs attend back-to-school nights and Parent Teacher Organization (PTO) meetings. A satisfactory rate of parental consent is achieved among currently established SEAL! Michigan programs. New programs will assess parent engagement strategies, as discussed in Objective B. All student consent forms are delivered home with an informational brochure on the SEAL! Michigan program and the benefits of dental sealants. The brochure was initially developed by professional health literacy specialists and was written at a third grade reading level to accommodate varying literacy levels. The brochure was updated in the summer of 2020 by the MDHHS Communications Office and will continue to be used in FY 2024. The brochure strives to deliver linguistically and age-appropriate health information.

The first strategy under this objective is to utilize the SEAL! Michigan database to track the number of students receiving an annual preventive dental screening. This strategy reflects the measure's ESM, which is the number of students who have received a preventive dental screening through the SEAL! Michigan program. Continual updating of the database allows for tracking the number of unique students who receive one or more dental sealants through the program.

The second strategy is to promote dental sealant programs through school health professionals. The growth of the program relies on continual expansion into new schools. The MDHHS School Oral Health Consultant will continue to a) promote dental sealant programs through school nurses and other school health professionals and b) encourage participation with SEAL! Michigan or other school-based dental sealant programs. This strategy will be accomplished through collaboration with internal MDHHS partners, as well as embracing external partnership opportunities via professional organizations, conferences, and educational venues. Ninety percent of the nurses are contracted and will require training on oral health yearly. A plan to provide oral health education will occur during monthly meetings to ensure newly hired nurses are provided oral health education information.

The third strategy is to monitor evaluations to determine best practices in school sealant programs in schools with high participation. Ongoing evaluation of sealant programs is imperative to overall growth. Learning from all partners involved (students and parents, school administrators, teachers, school nurses, health professionals, social workers etc.) through evaluation will assist in directing the SEAL! Michigan program towards continued success. In FY 2017, a full SEAL! Michigan program evaluation was conducted by the Michigan Public Health Institute, and the final evaluation provided program improvement strategies. Recommendations continue to be implemented by individual programs to the extent possible.

A fourth strategy is to examine ongoing health trends to identify geographic areas experiencing a high burden of disease, and then use the information to identify populations that will benefit from an increase in dental sealant placement in proportion to disease and population. This strategy will help assess whether oral health programs are funded in areas of high need and to maximize access and preventive potential to the populations with the highest need. This strategy will help build the OHP's capacity to achieve equitable health outcomes. In addition, MDHHS will

partner with data and evaluation entities to build systems to measure the impact of increased sealant coverage in the state of Michigan.

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

Detroit Public Schools has incorporated BLUEPRINT 2020 into their system to help “rebuild Detroit Public Schools.” Oral health is included in the plan and falls under the Whole Child Commitment, as students receiving dental care will have less toothaches and will be more likely to achieve their full potential. The DPSCD system is the largest school district in the state and provides educational services to approximately 50,000 students. According to a report by the Michigan Department of Education, the majority of children (approximately 82%) attending DPSCD are African American.

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

During the COVID-19 pandemic, dental care was not provided in DPSCD school buildings due to school closings. In March 2022, dental service returned full time. Administrators took the opportunity to pause and create an oral health plan that provides more clarity on which providers serve the schools. The new plan involves contracting with four different providers (three restorative and one preventive) and assignment of one to each school. This improvement enables DPSCD to have more oversight over which programs are coming in and out of each school building. Historically, DPSCD did not have a designated position to oversee all oral health activities and lacked the oversight to ensure that students receive preventive and restorative care as well as urgent follow up care. Thus, the MDHHS OHP worked with DPSCD to create and fund a half-time Oral Health Coordinator (OHC) position to oversee work relating to oral health in all DPSCD buildings. This OHC was hired in August 2020 and will continue to be funded in FY 2024 to provide oversight of the dental programs and to help the students in DPSCD receive both preventive and restorative care.

One strategy is for the OHC to provide multiple ways to access a dental consent form. The dental consent form is given to the student to take home for the caretaker to complete and return to the school. However, this delivery method sometimes requires consent to be sent home several times. In FY 2024, the OCH will work with school administration staff, parents, and students to identify alternative methods to help increase receipt of positive consent forms. Delivery methods might include having forms available online and at PTA meetings and/or having dental packages available during 106 open enrollments and open houses.

The second strategy is to have all staff from the Physical Health Department understand oral health prevention and how pain in oral health can limit student participation in school activities and overall academic performance. In FY 2024, the OHC will train Behavioral Health Counselors in oral health education at each school to help provide a better understanding of how children’s behavior can be affected by pain. In addition, the plan will include a DPSCD school specializing in students with developmental disabilities. Research shows that children with developmental

disabilities can experience more pain than children without disabilities. Pain can affect not only the physical status of students but also their mental health.

The third strategy is to increase the number of dental providers in DPSCD. At the time of this writing, DPSCD has approximately 46,000 students enrolled. In FY 2024, the OHP will work to increase the number of dental providers by two. The OHP recognizes that it is essential for students to have a positive relationship with healthcare providers. If there are more dental providers whom students can trust and build a positive relationship with, it will offer rewards in the future. A student will experience seeing a dental professional every six months and will learn about quality dental care. In addition, this will increase the number of sealant placements and other dental services. As the number of positive dental consent forms increases, assessing service data will help determine how many additional providers are needed in the future.

Childhood Lead Poisoning Prevention (FY 2024 Application)

Lead poisoning prevention and intervention continues to be a critical need in Michigan. Michigan has made significant progress over time in reducing the percentage of children who have elevated blood lead levels. However, several of Michigan's cities (including Highland Park, Detroit, Hamtramck, Grand Rapids, and Muskegon) have significantly higher rates of elevated blood lead levels. Additionally, the COVID-19 pandemic has negatively impacted blood lead testing rates due to deferred care and increased use of telemedicine. Children spending more time at home increased the risk of exposure for those living in homes with lead contamination. In addition, blood lead testing rates decreased even more in 2021 due to a recall of LeadCare II capillary test kits. LeadCare II capillary testing is the main method used for majority of capillary testing in Michigan. With that testing method unavailable, testing rates decreased throughout the state. Although the LeadCare II test kits concerns have been resolved, in FY 2024 those tests will continue to be monitored for accuracy and education will be provided to providers concerned about the recall.

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

Leadership for Michigan's lead prevention activities, as they relate to the MCH population, is housed within the Childhood Lead Poisoning Prevention Program (CLPPP). CLPPP resides in the Division of Environmental Health-Lead Services Section to better strengthen the health/housing partnership at the state and local levels. Title V funding supports the childhood lead programs administered by CLPPP. CLPPP staff work collaboratively with MCH staff and Medicaid, particularly on issues related to case management and blood lead testing. In FY 2024, CLPPP will continue to focus on implementing innovative strategies to increase blood lead testing across the state. Strategies will include new partnerships with the Medicaid Health Plans (MHPs) and Federally Qualified Health Centers (FQHCs) as well as continued support of long-standing partnerships with the Women, Infant & Children's (WIC) program and local health departments (LHDs).

Three focus areas of CLPPP include data surveillance, nursing assistance, and community education and engagement. Title V funding directly supports nursing assistance and community education. Data surveillance allows for CLPPP to better target areas for needed nursing assistance and community education. CLPPP provides statewide community outreach to parents, health care providers, childcare providers, public schools, homeowners, and tenants on the prevention of lead exposure and the importance of blood lead testing. CLPPP also provides technical nursing assistance for LHDs and health care providers to support the management and coordination of

services for children with elevated blood lead levels (EBLL).

An EBLL is defined as a blood lead level (BLL) equal to or greater than 3.5 micrograms per deciliter of blood (µg/dL). Children with an EBLL should have interventions such as 1) in-home nursing case management, 2) environmental investigations to mitigate health effects of lead exposure and identify and remove sources of lead in their environments, and 3) referrals to health and human services and appropriate resources.

During FY 2022, the Michigan Department of Health and Human Services updated its definition of an elevated blood lead level for children from 5 µg/dL to 3.5 µg/dL, following the Centers for Disease Control and Prevention updating their blood lead reference value (BLRV). At a level of 3.5 µg/dL or greater, lead education, nursing case management, environmental investigations, and additional medical monitoring should be established to lower the blood lead level.

With a lowered BLRV, we are identifying additional children as having an EBLL, both through capillary and venous testing. Title V funding and support for MDHHS and state local health departments is critical to ensure that resources are available for outreach and services to families that will be identified as having children with EBLLs. Additionally, outreach is needed to health care providers, laboratories, and partners to share the information on the new BLRV and that capillary results at a level of 3.5 µg/dL should be followed up as an EBLL and a venous test is needed.

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

Blood lead testing of children at risk of exposure to lead in homes or from other sources is critical for targeting interventions to prevent adverse health effects of lead. All children covered by Medicaid are considered at high risk for blood lead poisoning. In Michigan, all Medicaid children are required to receive blood lead testing at 12 and 24 months of age, or between 36 and 72 months of age if not previously tested. MDHHS also recommends targeted testing for other children who are especially at risk of lead exposure. This risk is determined by screening the child using the Michigan blood lead risk assessment tool. Assessment questions include:

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

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

The blood lead risk assessment is a verbal questionnaire that is conducted with family members when they are in a health care provider’s office. Currently, there is not a consistent way to document completion of the risk assessment, which creates a barrier to accurately determining the number of providers conducting the risk assessment with patients.

A strategy to increase blood lead screening is to improve notification to health care providers of patients’ blood lead levels and the need for blood lead testing. Activities include work with the Michigan Care Improvement Registry (MCIR) team. MCIR is the state immunization registry, accessed by local health departments, health care providers, Medicaid health plans, and schools throughout the state. In FY 2022, CLPPP worked with MCIR to determine the

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

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

- Expanded outreach to health care providers in Michigan to ensure awareness of the new BLRV and that levels of 3.5 µg/dL are considered elevated.
- Continued connection between the MDHHS physician consultant and public health detailer with health care provider offices across the state to provide education about blood lead testing recommendations, discuss testing options for offices (including point of care testing), and build partnerships.
- Partner with the Michigan Chapter of the American Academy of Pediatricians (MI-AAP) to present to pediatricians at annual conferences and during a webinar series.
- Follow up with health care providers who received a mailing of a resource packet in February 2022.
- Continued dissemination of an online training module for health care providers, in partnership with the Michigan Public Health Institute. Continuing education credits are available for social workers, nurses, physicians, and pediatricians. The goal of the course is to increase knowledge, understanding, and behaviors to reduce the health impacts of lead exposure in children under the age of six. Training content focuses on understanding how children are exposed to lead, the health impacts of lead, blood lead testing requirements and the risk assessment questions, the importance of working with local health departments and other resources.
- Provide grants to local health departments to connect with and build partnerships with local health care providers within their jurisdiction. The coordination of care between local health departments and health care providers is critical when a child has been identified as having an EBLL. It is important that these partnerships are developed ahead of time and both parties recognize the other’s services and resources.

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

- CLPPP will continue to provide educational materials to daycare providers throughout the state.
- A project by the Genesee Health Coalition Community Health Access Program to partner with area health care providers, specifically OBGYNs, to recommend testing for pregnant women identified as being at risk for lead exposure and refer them to health and human services and resources.
- CLPPP has partnered with a consultant in Southeast Michigan to provide trainings and equip staff with tools and materials to conduct environmental assessments, screenings, and education in Arabic for immigrant and refugee clients. This work will be based on the CDC’s Lead Poisoning Prevention in Newly Arrived Refugee Children toolkit.
- CLPPP plans to continue to have lead poisoning prevention materials available in commonly used languages including Spanish, Arabic, and Bengali. CLPPP will work with the Culturally Appropriate Services for All

(CASA) group in the Division of Environmental Health (DEH). CASA is a group of DEH employees who come from various cultural background and speak different languages. The group reviews materials to ensure that they are both linguistically and culturally appropriate. In FY 2024, CLPPP will work to have additional languages available, both electronically and for mailing.

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

As mentioned above, all Medicaid-enrolled children are considered at high risk for blood lead poisoning. Specifically focusing on Medicaid-enrolled children can help to increase equitable health outcomes across the population. Medicaid policy requires blood lead testing at 12 and 24 months of age, or between 36 and 72 months of age if not previously tested. This population is a priority target for CLPPP to increase testing rates overall.

The first strategy for this objective is to provide local health departments with a monthly report that includes all Medicaid-enrolled children within that local health department's jurisdiction. The report includes all children less than 72 months of age and their blood lead testing status. Local health departments can use this report as a tool to identify children who need follow up to encourage blood lead testing.

The second strategy to achieve Objective B in FY 2024 will be health care provider education and outreach, as discussed under Objective A. The same activities and efforts will be used here, specific to encouraging blood lead testing to Medicaid-enrolled children.

A third strategy to achieve Objective B in FY 2024 is to expand partnerships with other programs serving Medicaid enrolled children. In FY 2023, CLPPP began meetings with the Michigan Primary Care Association to partner on a Lead Testing Initiative to support increased blood lead testing efforts at Federally Qualified Health Centers across the state. Another important partnership with Medicaid has resulted in CLPPP's participation in the Medicaid Health Plan focus studies. These focus studies will take place during the summer of FY 2024. A goal of CLPPP's involvement in the focus studies has been to increase blood lead testing rates and increase education to their provider network. This important partnership has resulted in additional support for local health departments by increasing communication with MHPs about services they provide to families we are both serving. These partnerships will continue and expand in FY 2024.

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

Two sample types are used in blood lead testing: a capillary draw and a venous draw. Any blood lead test that is done on a capillary drawn sample must be confirmed by a venous drawn sample. This is because oftentimes a capillary blood lead test can be falsely elevated, and a venous test is needed to confirm that the blood lead level is truly elevated. Additionally, a child who has an elevated blood lead level confirmed with a venous test qualifies for services like nursing case management, the Lead Safe Home Program, and Early On. This objective will use MDHHS data warehouse data to track progress through 2025.

The first strategy for Objective C is to continue to send local health departments quarterly spreadsheets for each county within their jurisdiction. The spreadsheet will include a venous follow-up testing status for all capillary EBLLs, deduplicated by month, as well as a line list of children with a capillary EBLL no venous follow-up. Local health departments will be able to use these quarterly reports to conduct phone calls, mailings, and home visits to encourage the venous confirmatory test.

A second strategy CLPPP plans to implement in FY 2024 is working with the families of those that have received

nursing case management, to get feedback and ideas for improving the case management process. Once nursing case management is completed, the child's BLL has declined, and the family is connected with resources, CLPPP is planning to work with the family to understand how and if nursing case management is helping, whether the service met families' expectations, and whether the desired outcomes are being achieved.

The third strategy to achieve Objective C is health care provider education and outreach, as discussed under Objective A. The same activities and efforts will be used, specific to encouraging that all elevated blood lead test results from a capillary test are followed up with a venous confirmation test.

An additional strategy to achieve Objective C is a result of our increased partnership with the MHPs as mentioned in Objective B. In FY 2024, CLPPP, Molina and the Detroit Health Department (DHD) will continue monthly meetings to identify how to coordinate case management, education, and outreach efforts among shared clients. A Plan-Do-Study-Act (PDSA) cycle will be implemented to increase the number of children receiving a venous confirmatory test. The DHD is partnering with Molina's outreach and case management team to reinforce and more closely monitor how many children receive a venous confirmatory test. The DHD will identify current zip codes with the highest rate of elevated blood lead levels. Once the zip code is identified, both the health department and Molina will develop an engagement strategy and decide on the best method to track and share data to measure how many children received a venous confirmatory using the decided upon strategy. CLPPP will assess the progress of this initiative and expand statewide during FY 2024 with other LHDs and additional MHPs.

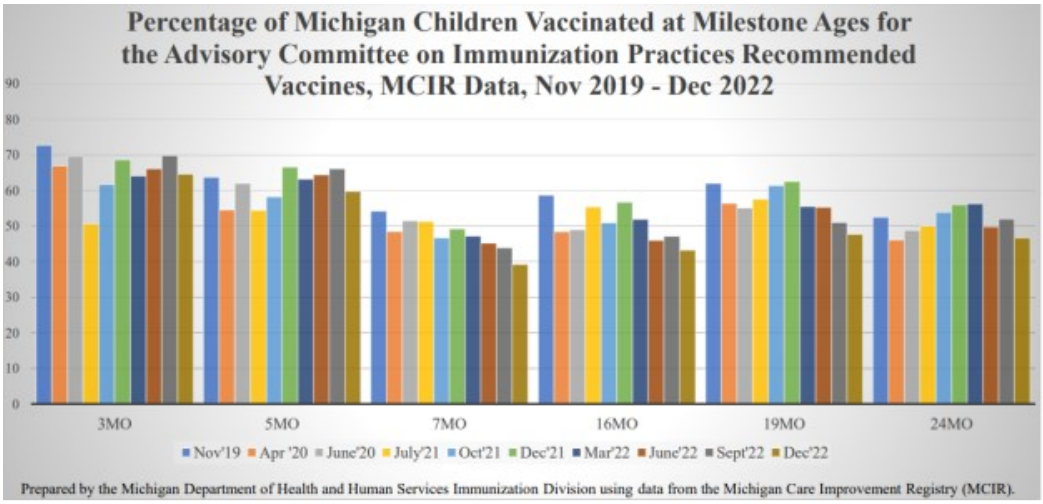
Immunizations – Children (FY 2024 Application)

Based on the Title V needs assessment, the state performance measure (SPM) created in 2015 was retained in 2020, which is the "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)." The 4:3:1:3:3:1:4 series represents 4 doses of DTaP, 3 doses of Polio, 1 dose of MMR, 3 doses of Hib, 3 doses of HepB, 1 dose of Varicella, and 4 doses of PCV vaccines. In the 2020 needs assessment Provider Survey, when asked "Which of the following healthcare-related needs are most often unmet among the families you serve?" 37.8% of respondents across population domains identified immunizations as an unmet need. The need was identified as highest among respondents who serve CSHCN (46%) and children and adolescents (40.6%). The forces of change assessment also identified an increasing focus on individual choice (including vaccine refusal) versus community benefits as a factor that impacts population health. Notably, those needs assessment findings were obtained prior to the COVID-19 pandemic.

Michigan continues to experience significant impacts on immunization rates. In May 2020, the CDC published "Decline in Child Vaccination Coverage During the COVID-19 Pandemic —Michigan Care Improvement Registry, May 2016–May 2020" in its *Morbidity and Mortality Weekly Report*. Data from the Michigan Care Improvement Registry (MCIR) showed vaccine coverage declines among most children at milestone ages in May 2020 compared to previous May estimates. For example, from January through April 2020, the number of non-influenza vaccine doses given to children aged ≤18 years decreased 21.5% compared to the average for the same period in 2018 and 2019. Up-to-date vaccinations have also declined to <50% among most children ≤2 years.

In addition to the vaccine coverage challenges typically experienced in Michigan, the impact of the COVID-19 pandemic has created new, unique challenges. Image 1 indicates falling vaccination rates at several milestone ages over time.

Image 1. Percentage of Michigan Children Vaccinated at Milestone Ages



Michigan has experienced declining immunizations rates and has not met the Healthy People 2030 goal of 80% for child immunizations. As of December 2022, according to the MCIR, the percent of children ages 19-35 months who received a full schedule of age-appropriate immunizations (Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B) is at an alarming 66.1%, 7.5 percentage points lower than the pre-pandemic level of 73.6% in January 2020. The COVID-19 pandemic and vaccine hesitancy have contributed to falling vaccination rates.

Parent vaccine hesitancy has greatly increased even though many published scientific articles show that vaccines are safe and effective. Michigan continues to have some of the highest vaccine exemption rates for kindergarten children compared to other states. Michigan has worked hard to educate providers on the importance of immunizations as a standard of care and the importance of talking with parents about any questions or concerns they may have. Michigan has also partnered with a non-profit organization called the Franny Strong Foundation to provide information for parents through the I Vaccinate campaign to learn facts about immunizations and the risks of not vaccinating. MDHHS will continue to work with internal and external partners to provide educational messages to the public to promote timely vaccinations.

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

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

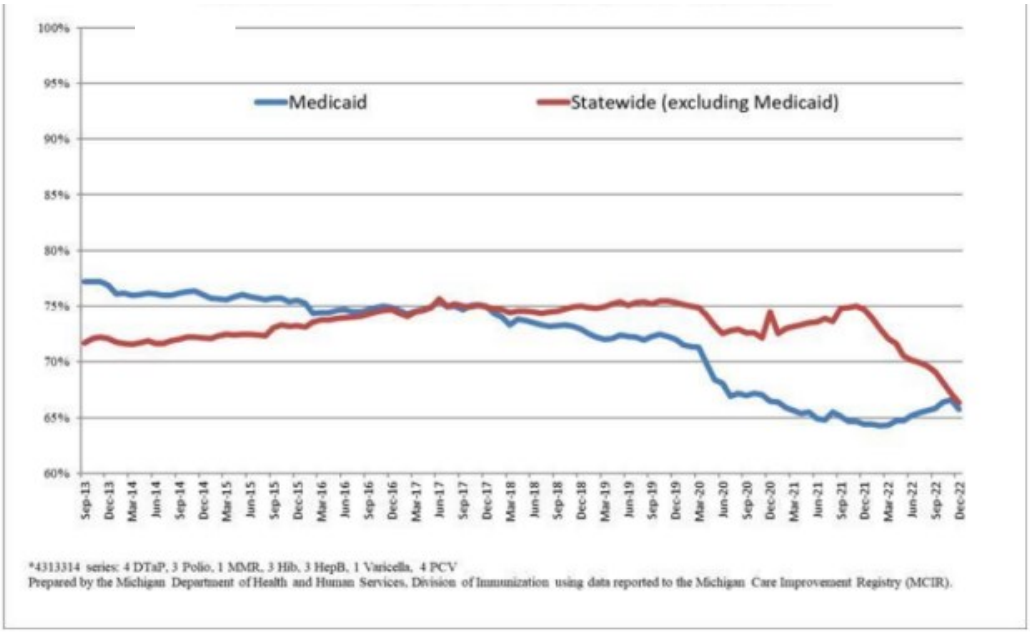
The vision of the Division of Immunization is to implement effective strategies and to strengthen partnerships with our stakeholders to eliminate vaccine preventable diseases in Michigan.

The Michigan Division of Immunization operates the Michigan Care Improvement Registry (MCIR). The MCIR is a statewide immunization registry that contains over 192 million provider doses administered to 13 million persons in Michigan. MDHHS continues to subcontract with six MCIR regions to enroll and support every immunization provider

in the state. MCIR is used routinely by nearly 7,700 users to access and determine the immunization records of children and adults. In 2019, MCIR generated over 203,187 recall letters notifying responsible parties whose children had missed shots and encouraged them to visit their immunization provider to receive needed vaccines.

MCIR can forecast needed doses of vaccine for all children who are contained in the system. All children should have completed the recommended pediatric vaccines by the time the child reaches 19 months of age. Data from MCIR indicate that between 45.5% and 55.4% of children who reside in Michigan have received the routinely recommended 4313314 series by the time they reach 24 months of age. MCIR rates have experienced gradual decreases in compliance rates for children enrolled in Medicaid as illustrated in Image 2.

Image 2. Estimated Pediatric Vaccine Series Coverage, Children 19 through 35 months, Medicaid and Statewide, September 2013 – December 2022



The Immunization Program intends to use Title V funds in FY 2024 to support program work in addressing declining immunization rates and increasing vaccine confidence among providers and parents. The funds will be used to target areas with low vaccination rates, while working collaboratively with internal and external partners to increase vaccination rates through communication campaigns, targeted outreach, and sending vaccine recall letters using the MCIR for those overdue for any vaccine.

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

Data obtained from MCIR show that children are not receiving vaccines on-schedule, and many of these children never catch up on all needed vaccines, as illustrated in Image 1. This puts children at risk, with nearly half of children susceptible to these serious diseases. From birth to 2 years of age, children are recommended up to 25 vaccinations to prevent 14 infectious diseases. The vaccination schedule is designed to protect children when they are most vulnerable. Recommendations based on ages of vaccines are shown to be safe and effective. There are no known benefits to delaying vaccinations.

MCIR can also assess existing immunization data for children and forecast needed doses. This functionality greatly

assists clinicians in determining any needed doses of vaccine during a clinical encounter. This same forecasting functionality can be used at a population level to determine any children who need vaccines. To increase vaccination rates, in FY 2024 the Division of Immunization will notify parents of all children 24 months of age who are overdue for one or more vaccines. In the past, efforts have been targeted at children who are 2 to 3 years of age, but this effort will attempt to impact parents of children less than 2 years of age who are not staying on schedule. Data from MCIR show that children who stay on schedule are twice as likely to complete all needed vaccines as those who fall behind early in life. A central strategy to address this objective is to generate notices to parents of children who are overdue for vaccines. These notices are not intended to replace other efforts that may be underway in provider offices or at local health departments but are meant to enhance existing efforts to remind parents of the importance of immunizations.

In Michigan, disparities exist in immunization rates. The Division aims to use MCIR data to conduct a root cause analysis and identify high social vulnerability index (SVI) areas within the state and conduct targeted vaccine outreach in those areas. It is of the utmost importance that vaccine access is equitable to all Michigan children. Identifying high SVI areas within the state and conducting targeted vaccine outreach in those areas will assist in addressing the disparities in vaccination coverage.

Furthermore, the COVID-19 pandemic has contributed to an increase in vaccine hesitancy for all vaccines. In FY 2024, the Division of Immunization will work with national partners, including Centers for Disease Control and Prevention, as well as internal and external partners to promote vaccine confidence among parents of this age group through resources, media, and presentations. While most parents choose to vaccinate their children according to the recommended schedule, some parents may still have questions about vaccines and getting answers they trust may be hard. It is vital that the Division works with these partners to address any questions or concerns Michigan parents may have with childhood vaccinations and promote vaccine confidence among this group.

Finally, the Division aims to work more directly with the Alliance for Immunization in Michigan Coalition (AIM) to better engage families and communities through education and improvements to the aimtoolkit.org website. AIM is a partnership of public and private sector organizations formed in 1994 to focus on a broad spectrum of immunization issues in Michigan. AIM's mission is to promote immunizations across the lifespan through a coalition of health care professionals and agencies. The AIM coalition continues its focus on improving all facets of immunization services in Michigan.

As a result of the COVID-19 pandemic, the AIM coalition was essentially put on hold. As immunization rates continue to drop statewide, it is more important than ever to re-ignite this coalition and work collaboratively with private and public stakeholders to address vaccine hesitancy and improve vaccine uptake. AIM's website, aimtoolkit.org, provides education and promotes vaccination for both healthcare professionals and individuals and families. Harnessing the Division's partnership with the AIM coalition will better connect the Division's resources directly with consumers.

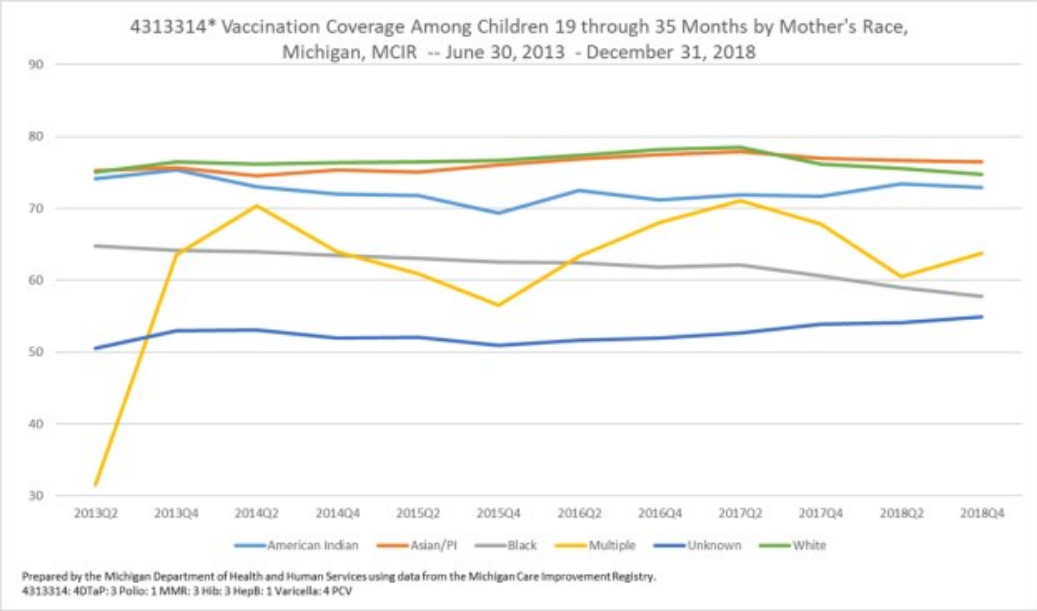
Objective B: Assist local health department immunization staff with targeting outreach to under-served populations in their jurisdiction.

The Michigan Immunization Program will continue to distribute population-based county "report cards" for local health departments to better understand immunization barriers and opportunities for improvement in their communities. The MCIR epidemiologist will generate county report cards on a quarterly basis, which will be posted on the MDHHS Immunization website (www.michigan.gov/immunize). The immunization report card will contain coverage level information in several key areas including pediatric, adolescent, and adult coverage levels. Report cards rank each county in the state, so a county can also compare its progress to other counties.

Another key report which will be made available to local health departments is the COVID-19 Impact Report. This report shows how COVID-19 has impacted childhood and adolescent immunization rates, while encouraging providers to catch Michigan children up on recommended vaccines. The Michigan Immunization Program will continue to make the data available to local health departments so they can be better informed on areas for improvement as they work with immunization providers in their jurisdiction. Due to the COVID-19 pandemic, there have been decreases in the coverage levels of childhood vaccines, and much work needs to be done to keep children on schedule. These reports not only identify immunization rates by age but also show immunization rates by age broken down by vaccine types. Local health departments can identify immunization levels by vaccine type to determine areas where immunization providers may not be offering all recommended vaccines.

Michigan has large disparities in immunization coverage rates based on race. Using the same assessment logic being used by the CDC for the National Immunization Surveys, the statewide immunization rate is 66.1% for the 4313314 series, as of December 2022. Image 3 illustrates vaccination coverage among children ages 19-35 months by mother's race. Black children record the lowest immunization rates (57.71%) as compared to the highest rates of Asian/Pacific Islanders (76.49%).

Image 3. Vaccination Coverage by Mother's Race

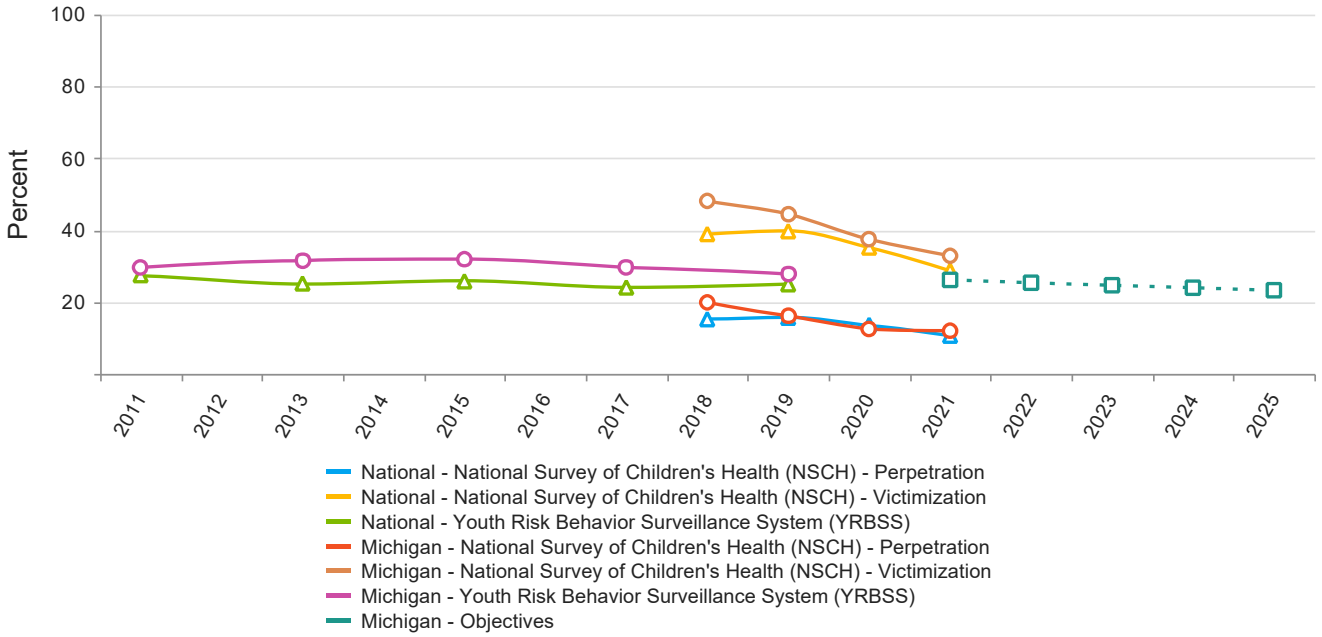


The Michigan Immunization Program will create reports showing immunization rates by race for each local health jurisdiction. These data are being made available to local health departments to bring more focus to issues of health equity and health disparities as a key strategy to achieving equitable health outcomes related to vaccine coverage. As a result of the COVID-19 pandemic, the MCIR now contains the race of each person. The immunization rates for race had previously been created using the mother's race information.

Adolescent Health

National Performance Measures

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others
Indicators and Annual Objectives



Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			25.4	25.4
Annual Indicator	29.8	28.0	28.0	28.0
Numerator	127,314	117,383	117,383	117,383
Denominator	426,596	418,810	418,810	418,810
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2019	2019	2019

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2019	**2020**	**2021**	**2022**
Annual Objective			25.4	25.4
Annual Indicator	20.0	16.1	11.9	11.9
Numerator	145,381	116,534	88,231	88,231
Denominator	727,587	723,002	741,127	741,127
Data Source	NSCHP	NSCHP	NSCHP	NSCHP
Data Source Year	2018	2018_2019	2020_2021	2020_2021

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Victimization				
	2019	**2020**	**2021**	**2022**
Annual Objective			25.4	25.4
Annual Indicator	48.0	44.5	32.8	32.8
Numerator	349,295	321,323	242,215	242,215
Denominator	727,587	721,708	738,767	738,767
Data Source	NSCHV	NSCHV	NSCHV	NSCHV
Data Source Year	2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	24.7	24.0	23.3

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - Number of secondary schools implementing the Michigan Model for Health™ Social and Emotional Health Module with 80% fidelity

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			5	11
Annual Indicator			5	5
Numerator				
Denominator				
Data Source			Classroom Implementation Logs	Classroom Implementation Logs
Data Source Year			2020-2021	2021-2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	16.0	22.0	28.0

State Performance Measures

SPM 3 - Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus vaccine

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		44	54	56	58
Annual Indicator	41.9	52.4	44.1	42.8	44.2
Numerator	313,144	334,188	331,995	326,193	334,398
Denominator	746,563	637,751	752,019	762,977	756,464
Data Source	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	60.0	62.0	64.0

State Action Plan Table

State Action Plan Table (Michigan) - Adolescent Health - Entry 1	
Priority Need	
Create safe and healthy schools and communities that promote human thriving, including physical and mental health supports that address the needs of the whole person	
NPM	
NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others	
Objectives	
A) By October 2025, 30 secondary schools will implement schoolwide bullying prevention initiatives emphasizing social emotional health (SEH) education and creating safe schools for LGBTQ+ students	
B) By October 2025, provide 1,050 schools with guidance on state laws and model policies on bullying prevention with protections for LGBTQ+ youth	
C) Explore bullying prevention campaigns for CSHCS and determine goals for bullying prevention initiatives in Michigan	
Strategies	
A1) Six secondary schools per year will implement the Michigan Model for Health™ SEH module in all health education classrooms A2) Provide intensive training and technical assistance to six secondary schools per year on creating safe schools for LGBTQ+ students	
B1) Facilitate professional development for schools and school health coordinators on PA 241 and State Board of Ed Model Anti-Bullying policy B2) Provide technical assistance to school health coordinators working directly with schools B3) Support and promote professional development for schools on the creation and sustainability of Gender and Sexuality Alliances (GSAs)	
C1) Repeat the focus group with the Family Center's Family Leadership Network C2) Implement the CSHCS Bullying Prevention small grants program C3) Serve on the HRSA Region IV/V workgroup	
ESMs	**Status**
ESM 9.1 - Number of secondary schools implementing the Michigan Model for Health™ Social and Emotional Health Module with 80% fidelity	Active
NOMs	
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	

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

Priority Need

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

SPM

SPM 3 - Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus vaccine

Objectives

A) By 2025, increase the percentage of adolescents who have completed the HPV series to 64%

B) Emphasize routine assessment of all recommended vaccines for adolescents to increase influenza and meningococcal vaccine rates by 3%, by 2025, among this age group

Strategies

A1) Update current HPV materials to reflect up-to-date vaccine changes and effective communication strategies to promote vaccination and make materials available for providers A2) Provide updated translations of HPV materials to ensure a more equitable approach in addressing HPV vaccine hesitancy A3) Work with internal and external partners, including the Michigan HPV Alliance, to promote timely HPV vaccination A4) Work with the Alliance for Immunization in Michigan Coalition to better engage families and communities through education and improvements to the aimtoolkit.org website

B1) Work with internal and external stakeholders on a statewide influenza campaign to improve influenza vaccination coverage among all ages, including adolescents B2) Generate and distribute a letter to Michigan healthcare providers highlighting the importance of catching children and adolescents back up on routine vaccines that they may have missed due to the COVID-19 pandemic B3) Offer quality improvement visits (virtual or in-person) to provide a comprehensive assessment of immunization rates and offer strategies for practice improvements B4) Work with external stakeholders to conduct targeted outreach to improve meningitis B vaccination rates for adolescents 16 through 18 years of age

Adolescent Health Overview

The needs of adolescents are addressed at the state and local level in Michigan through a diffuse network of governmental and non-governmental organizations. Within MDHHS, the Division of Child and Adolescent Health (DCAH) plays a central role in meeting the health needs of Michigan's adolescents. DCAH includes programs designed to build healthy relationship skills among adolescents, prevent unintended pregnancy, and address bullying. It houses programs designed to meet adolescents' physical health needs in school settings through Child and Adolescent Health Centers and school nursing. The Division of Immunization includes sections focused on adolescent outreach and education, as well as assessment and local support. The Children's Special Health Care Services (CSHCS) Division administers programs that impact adolescents and young adults with special health care needs, especially as they relate to transition.

Title V funding supports a variety of programs and services for adolescents through state and local organizations—including immunization, reproductive health services and prevention of unintended pregnancy, and bullying prevention—as well as services for adolescents who have special health care needs. Other federal MCH funds that impact adolescents include the State Abstinence Education Program (Administration for Children and Families), the State Personal Responsibility Education Program (Administration for Children and Families), and an Epilepsy grant (HRSA). In addition, critical partnerships in the state that impact adolescent health include those with school-based health centers, the Michigan Department of Education, the Youth Risk Behavior Survey and its state-based counterpoint (the Michigan Profile for Healthy Youth), the Michigan Organization on Adolescent Sexual Health, the Michigan Council for Maternal and Child Health, and the School-Community Health Alliance of Michigan.

Title V funding also supports the Local Maternal Child Health (LMCH) program which provides funding to all 45 local health departments (LHDs). In FY 2022, Title V funds via the LMCH program were expended on NPM 13.2 (oral health), SPM 3 (adolescent vaccinations), SPM 5 (intended pregnancy and reproductive health), SPM 6 (behavioral/mental health), and Local Performance Measures (LPMs) in the adolescent health domain. Two LHDs worked on oral health for adolescents (NPM 13.2) by providing gap-filling mobile dentistry services and oral health education at community outreach events. Twelve LHDs completed activities related to adolescent immunization (SPM 3) which included media campaigns, provision of gap-filling adolescent vaccinations, waiver education, recalls and reminders, and provider surveys. Vaccine hesitancy was noted in relation to the pandemic. One agency worked on SPM 5 related to adolescent reproductive health services. Four LHDs selected SPM 6 (behavioral/mental health) and activities included suicide prevention, gap-filling depression screening, provision of mental health education to middle/high school youth, trainings to community schools and other organizations, and social media posts about behavioral/mental health.

Four LHDs worked on LPMs related to adolescent health with gap-filling activities such as well-visit physical exams, health education, hearing/vision screening for adolescents, family planning services, links to community services, and Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infection (STI) counseling, testing and Expedited Partner Therapy. Three LHDs diverted LMCH funds to COVID-19 vaccinations for adolescents. Agencies noted competing demands on staff time with response to COVID-19 and mpox plus loss of staff.

Michigan's approach to adolescent health through Title V focuses on increasing wellness through bullying prevention; suicide prevention; promotion of HPV vaccination; and access to reproductive health services, including contraception.

Bullying Prevention (FY 2022 Annual Report)

To address the state priority need to create safe and healthy schools for Michigan students, NPM 9 was selected and ESM 9.1 was developed. In FY 2022, activities undertaken to address NPM 9 included intensive intervention within five secondary schools that provided access to content experts for direct consultation as well as the implementation of health education curriculum designed to teach the skills necessary to curb bullying and create a safe and healthy school environment. In addition to this focused intervention, a series of professional development opportunities were made available to all schools throughout the state with the goal of preparing more schools to jumpstart their bullying prevention efforts or grow what is already in place. These opportunities were virtual and well attended. The statewide efforts were extended to include focused support for schools on creating and sustaining a Gender and Sexuality Alliance. Combining this focused and broad approach garners momentum for the work and meets schools where they are while also pushing for progress.

Title V funding supported the work of a project consultant who provided one-on-one consultation with five secondary schools striving to address the needs of LGBTQ+ students within their schools, particularly around creating safe and supportive environments. Funding also provided each of these schools with $5,000 to implement the strategies identified in consultation with the project consultant. Schools received resources relevant to their bullying prevention efforts. Funding also supported a portion of the salary of a project consultant working to help schools throughout the state create and sustain Gender and Sexuality Alliances.

Focusing on the LGBTQ+ student population addresses health inequities while also recognizing that improved school environments for this population mean improved environments for ALL students. Partners interested in bullying prevention, especially as it relates to the experiences of the LGBTQ+ student population, found common ground in the objectives and strategies for NPM 9. Partnering with the Michigan Department of Education (MDE) LGBTQ+ Students Project was essential as the goals of the two projects aligned and the work of the project consultants was shared between the two programs. These consultants have extensive expertise and a proven track record helping schools achieve positive outcomes and create safe and supportive environments for LGBTQ+ students. The goal of the LGBTQ+ Students Project is to build the capacity of Michigan schools to impact the health, well-being, and educational outcomes of LGBTQ+ students.

Partnering with the Michigan Organization on Adolescent Sexual Health (MOASH) was also essential given the alignment of its mission to our project goals. MOASH staff bring extensive expertise in centering youth voices, especially LGBTQ+ youth voices, and are leaders within Michigan on the formation and sustaining of impactful Youth Advisory Councils. Their expertise facilitating youth councils, Gender and Sexuality Alliances (GSA), and training school personnel provided a partnership to ensure that youth voice and youth engagement would be an integral component of the project. The involvement of the Michigan School Health Coordinator's Association (MISHCA) was key due to their work with schools across the state training teachers and supporting implementation of the *Michigan Model for Health™,* along with other school health initiatives. They are the local representatives for school health education in Michigan.

While COVID-19 created some barriers to full implementation, a greater challenge to the project was political pushback toward inclusionary policies and practices directed toward programs that address the needs of LGBTQ+ youth. As a result, some school leaders are becoming wary of implementing this work. This backlash against affirming policies and practices harms students and plays a role in creating a stressful environment in which teaching and learning are compromised.

A barrier for one school involved administrative staff turnover. The school did not receive approval to spend their school stipend on project activities until after FY 2022 ended. That school will work with MDHHS during the 2022/2023 school year as their current administrator is supportive of their involvement in the project.

Objective A: By October 2025, 30 secondary schools will implement schoolwide bullying prevention initiatives emphasizing social emotional health (SEH) education and creating safe schools for LGBTQ students within a schoolwide SEL process.

The first strategy involves participating secondary schools fully implementing (defined in ESM 9.1 as 80% of lessons taught) the *Michigan Model for Health*™ SEH modules/lessons in their health education classrooms. In FY 2022, five participating secondary schools provided a solid foundation for bullying prevention efforts in their buildings. Students practiced and learned skills foundational to treating one another with respect and care. MMH SEH curriculum modules were purchased for participating schools (through another funding source) and implementation logs completed to ensure fidelity. MISHCA partners provided curriculum training and support for teachers.

For the second strategy, training and TA was provided to secondary schools to help create safe schools for LGBTQ+ students. Title V funding supported intensive technical assistance (TA) with a project consultant who worked with school teams (team members were designated at the beginning of the project year) to provide hands on support, professional development, and TA to create change within their schools. School teams developed visions, goals and strategies around schoolwide bullying prevention that focused on safe schools for LGBTQ+ students. Feedback received indicated that educators found this consultation extremely beneficial.

Each school team used their stipend ($5,000 per school) to support planning expenses, program implementation costs, substitute teacher coverage or staff stipends to attend curriculum trainings, workshops and/or meetings, and other relevant bullying prevention activities, such as attendance at bullying prevention conferences.

The partnership with the MDE LGBTQ+ Students Project enabled participating schools to take full advantage of the suite of learning opportunities offered. Providing relevant and impactful professional development was a shared goal of both projects.

Objective B: By October 2025, provide 1,050 schools with guidance on state laws and model policies on bullying prevention with protections for LGBTQ youth.

Through the partnership with MDE, MOASH, MISHCA and the Child, Adolescent and School Health (CASH) conference, schools across Michigan are learning about state laws and model policies along with a variety of other issues surrounding safe and supportive schools for ALL students. Youth panels and Youth Advisory Councils are providing learning opportunities as well as informing the overall work of the projects making up this partnership. The MDE LGBTQ+ Students Project alone provided 28 workshops in FY 2022 for schools across the state.

To support this objective, one strategy was to conduct training for schools and MISHCA members on relevant guidance on PA 241 and the State Board of Education Model Anti-Bullying policy. MDE staff led a session at the CASH conference walking school teams through the model policy and the law and working with them to develop a plan for becoming compliant with both, while also sharing data and making the case for supporting LGBTQ+ (and therefore ALL) students. Technical assistance was provided to MISHCA members through a variety of avenues: MDHHS and MDE attend quarterly meetings with MISHCA; monthly Lunch and Learns; and providing TA through calls and emails. MOASH staff members work closely with MISHCA members seeking TA in addition to the trainings they provide. Coordinators who are well versed in bullying prevention laws and policies is an especially important strategy now as more schools face resistance to LGBTQ+ supportive policies.

Another strategy addresses professional development opportunities for schools on supporting the LGBTQ+ student population in general and Gender and Sexuality Alliances specifically. The CASH conference met in hybrid format in October 2021 and included several sessions directly or indirectly relevant for educators supporting the LGBTQ+ student population, including “Changing the Narrative in a World Ripe for Bullying” and “Beyond Bathrooms:

Understanding and Supporting Transgender, Nonbinary and Gender Expansive Young People" with the MDE LGBTQ+ Students Project lead consultant. Both the keynote and plenary sessions also included relevant content. A total of 365 participants joined the conference.

The lead consultant also partnered with a parent engagement expert to host a workshop for parents titled, "LGBTQ+, Sexual Orientation, Gender Identity and Gender Expansive: What Does It All Mean?" in May of 2022. In June of 2022 a second statewide school health conference hosted by MISHCA partners, "Connecting with Kids Through School Health," included a session facilitated by the consultant on "Making the Case for Creating LGBTQ+ Inclusive and Equitable Schools." Another session facilitated by MOASH partners was titled, "Gender and Sexuality Alliances (GSAs) in School: What You're Missing Without One."

MOASH partners led the effort on GSA activities in FY 2022. They provided TA to school staff, parents, students, and other key stakeholders. Contacts often involved requests for resources, strategies, and guidance, both generally and regarding school/district specific scenarios. As a part of broader TA efforts, the project is developing a TA manual that will include example responses and resources to send for commonly asked questions regarding GSAs. The project is also working to develop a GSA assessment tool to aid in the evaluation of a GSA. Two GSA Advisor Network meetings allowed advisors across the state to connect and share ideas and resources. Also, the 9th annual Building a Movement for Michigan (BAMM) Pride Youth Summit was held in March 2022 and reached 375 LGBTQ+ youth and supportive adults.

It is difficult to determine duplicate schools given the cross section of partners providing learning opportunities and varying levels of tracking attendance, but it is estimated that more than 400 schools were reached through these activities in FY 2022.

Objective C: Explore anti-bullying campaigns for CSHCS and determine goals for anti-bullying initiatives in Michigan.

For the first strategy, CSHCS utilized the Family Center's Family Leadership Network (FLN) Annual Meeting to hold a focus group regarding the bullying experience for youth with special health care needs. FLN is a statewide network of family leaders building community connections to resources and services for families of children with physical, developmental, behavioral, or emotional conditions. The bullying prevention focus group included 16 participants who were parents or caregivers of CYSHCN. The group discussed how bullying is different for CYSHCN than the general student population. For example, some CYSHCN may not realize they are being bullied but the situation is recognized as bullying by other observers. As a result, parents may not know that bullying is occurring unless it is reported by other students or school staff. This is especially relevant for students who are unable to speak for themselves. The biggest concerns for these parents regarding bullying is that the long-term impact of bullying is unknown for children with special health care needs; there is inconsistency in the response across schools and districts; and parents expressed that schools are already behind on cyberbullying. Parents also shared that bathrooms have replaced school buses as the place where their child is bullied most often. The FLN focus group identified the following items as potential solutions: creating teams within schools to address bullying concerns, including bullying as a topic in the IEP process; having bathroom monitors in schools; creating a toolkit to help parents navigate bullying issues; and providing additional training for teachers, students, and parents. The highest priority item for parents was for schools to address cyberbullying.

In addition to the Family Leadership Network focus group, CSHCS implemented a focus group with the Bullying Prevention Initiative Grantees from FY 2021 at the annual meeting. Eleven of the 13 grantees were represented at the annual meeting which hosted approximately 35 attendees. Grantees participated in robust discussion regarding positive outcomes, challenges, and specific solutions they had identified throughout their program year. Grantees reported positive outcomes such as growing participation, increasing student confidence, increasing inclusion,

growing support from teachers, witnessing positive cultural shifts, improving leadership capacity of participants, and increasing buy-in from parents. Schools faced challenges with unpredictable and varying COVID restrictions, limited time and resources, peer retention, creating a friendship model versus a helping model, challenging group dynamics, and creating consistency between buildings and grade levels.

The second strategy was to analyze the status of bullying policies within Michigan and from other states. In FY 2022, CSHCS focused on understanding bullying policies within Michigan. In Michigan, schools are required to have a bullying policy on file with the state, and it is required that policies are reviewed and approved by the school board. Many schools utilize a template bullying policy. CSHCS will advocate for CYSHCN-specific language to be included in the template the next time language is reviewed and updated.

For the third strategy, CSHCS partnered with the Family Center to administer a second year of small grants to address bullying for children and youth with special health care needs. Title V funding was allocated to school districts and buildings for grants up to $10,000 to create or expand Peer to Peer (P2P) support programs in their schools. The objectives of the grant program are:

1. Contribute to safe cultures within school communities for CYSHCN.
2. Provide or enhance the school environment for peer support for CYSHCN.
3. Increase social and emotional support for CYSCHN.
4. Expand bullying prevention efforts for CYSHCN.

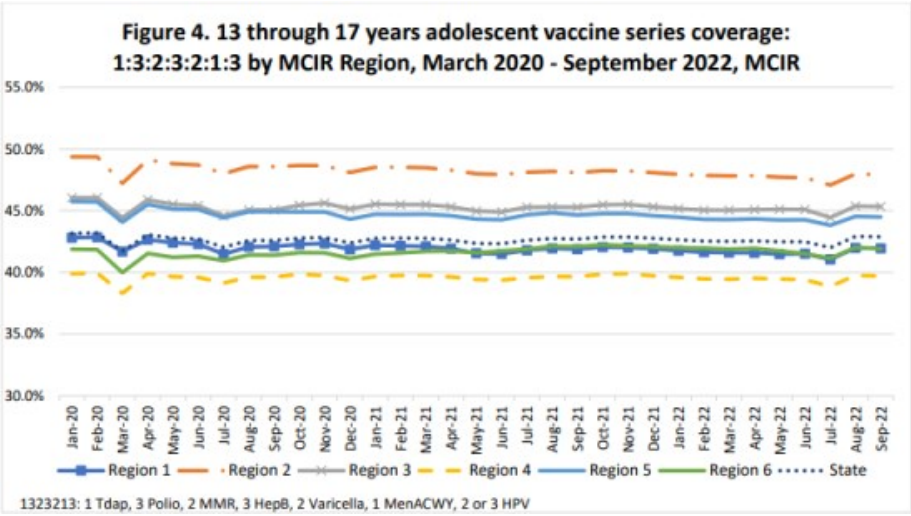
In FY 2022, 35 grant applications were received and 15 organizations were granted a total of $121,164. CSHCS has formed a partnership with Grand Valley State University's START (Statewide Autism Resources & Training) Program to provide support to grantees. START has provided the following webinars for grantees: Programming at the Elementary Level "Empower One, Empower All"; Mediums of Exchange; Playbook Implementation; Survey Implementation; and Participating versus Helping.

Immunizations – Adolescents (FY 2022 Annual Report)

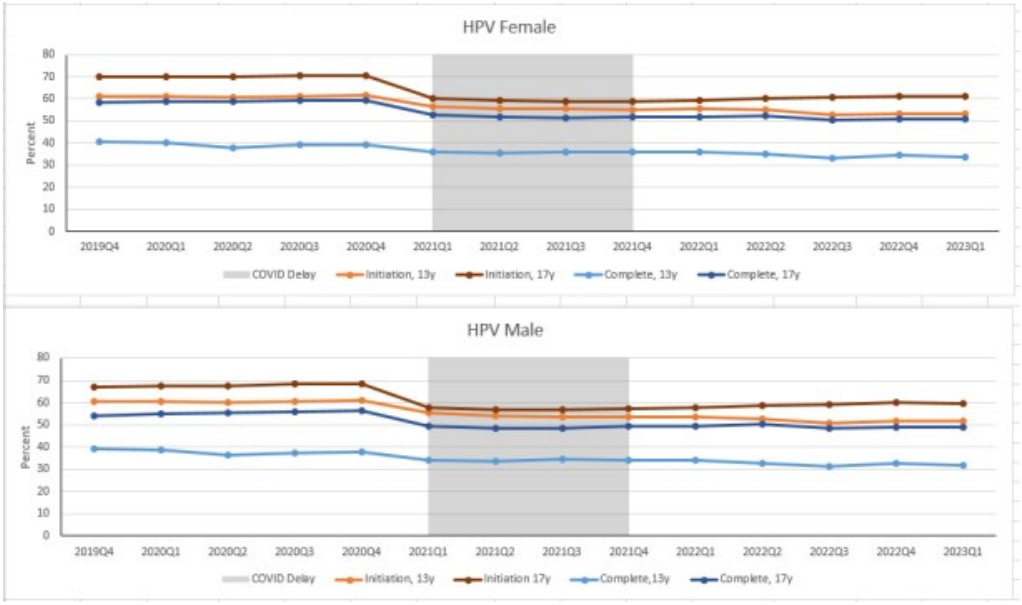
The MDHHS Division of Immunization is focused on improving the uptake of all Advisory Committee on Immunization Practices (ACIP) recommended vaccines among Michigan adolescents 13 to 18 years of age. Specifically, the Immunization Program closely monitors the percent of adolescents in this age group who have completed the Human Papillomavirus (HPV) vaccine series. Michigan saw a decline in HPV vaccination rates from 44.1% in FY 2020 to 42.8% in FY 2021; however, in FY 2022 the HPV completion rate at 17 years of age increased to 44.2%. While this number is still below pre-pandemic levels of 52.4% HPV completion rate in FY 2019, this trend upward is a good sign that coverage is steadily improving. The Immunization Program has been greatly impacted by the COVID-19 pandemic, resulting in competing priorities and staff turnover. However, towards the end of FY 2022, the Immunization Program was able to begin re-focusing on other non-COVID-19 vaccines, specifically HPV. While several planned activities in this state action plan were not able to be completed in FY 2022 due to the COVID-19 pandemic and response, the Immunization Program is actively working to conduct these activities in FY 2023 as the Program moves towards a "new normal."

As a result of the COVID-19 pandemic, the Immunization Program disseminates a report to monitor the impact of the pandemic on non-COVID non-Influenza immunization administration and reporting patterns to the Michigan Care Improvement Registry (MCIR) and the resulting effect on immunization coverage estimates. This report is created by the MDHHS Division of Immunization, in collaboration with the University of Michigan Child Health Evaluation and Research Center (CHEAR) team. To better illustrate the impact of the COVID-19 pandemic on adolescent immunization rates, Figure 4 from that report is shared below.

Statewide coverage for adolescents 13 through 17 years of age for the 1323213 series (1 Tdap, 3 Polio, 2 MMR, 3 HepB, 2 Varicella, 1 MenACWY, 2 or 3 HPV; Figure 4) fell by less than 1 percentage point from 43.2% in January 2020 to 42.9% in September 2022. Coverage for the same series without HPV fell more than 4 percentage points from 77% in January 2020 to 73% in September 2022.



While other adolescent vaccination coverage has continued on a downward trend, HPV initiation and completion rates have begun to gradually increase. As stated above, from FY 2020 to FY 2021, Michigan saw a decline in HPV vaccination rates from 44.1% to 42.8%. In FY 2022, the HPV completion rate at 17 years of age has increased to 44.2%, as seen in the trends below. While this number is still below pre-pandemic levels of 52.4% HPV completion rate in FY 2019, this trend upward is an initial sign that coverage is improving.



Unfortunately, the Immunization Program was greatly impacted by the COVID-19 pandemic. Due to competing priorities resulting from the COVID-19 pandemic, especially among Division of Immunization staff, as well as staff turnover and vacancies, some activities specific to HPV vaccination for adolescents were not completed as planned. The Quality Improvement Coordinator position has not been filled for over a year and many of these tasks were spearheaded by this position. The Adult and Adolescent Coordinator, however, continued to work with stakeholders

within the Michigan HPV Cancer Prevention Alliance in an effort to resume HPV activities statewide. The HPV Alliance was formed by the American Cancer Society and engaged several public and private partners—including health systems, providers, pharmacy associations, cancer organizations and local public health—to focus on improving HPV vaccination rates among Michigan adolescents. The Immunization Program, in collaboration with the HPV Alliance, is currently planning for a virtual HPV Summit to occur in Spring 2023. This summit will include provider and healthcare community engagement to promote timely HPV vaccination.

Objective A: By 2025, increase the percentage of adolescents who have completed the HPV series to 64%.

The first strategy to support this objective included generating and mailing a letter using MCIR data to parents of adolescents who have initiated but not yet completed the HPV vaccine series. Due to competing priorities as a result of the COVID-19 pandemic and staffing shortages among the Immunization Program's epidemiologists and MCIR team, HPV vaccine recall letters were not generated for adolescents in FY 2022. The Immunization Program continues to monitor HPV initiation and completion rates and shares this information at the county level with partners, as appropriate, and is planning to generate recall letters for this population in FY 2023.

The second strategy to support this objective includes partnering with the MDHHS Cancer Program and American Cancer Society to strengthen the Michigan HPV Cancer Prevention Alliance to promote timely HPV vaccination as cancer prevention. The Immunization Program continued to collaborate with the American Cancer Society and other public and private stakeholders, including local public health, the MDHHS Cancer Program, Karmanos Cancer Institute, Michigan Medicine, MSU and other health systems, as well as the Michigan Pharmacists Association to promote HPV vaccination as part of the MI HPV Cancer Prevention Alliance. As stated above, the HPV Alliance is currently active and planning a virtual HPV summit for Spring 2023. The audience for this summit will include providers, and anyone in the healthcare or dental community who is interested in learning about and promoting timely HPV vaccination.

Finally, the third strategy to support this objective is to partner with Michigan health systems to develop and implement strategies to increase timely HPV administration for their members. Due to vacancies within the Immunization Program, targeted outreach with health systems did not occur in FY 2022. However, local public health and Immunization Program Field Representatives have continued to conduct quality improvement visits with providers and always encourage timely HPV vaccination. The Immunization Program has started discussion with our Federally Qualified Health Centers (FQHC) dental clinics to promote HPV vaccine education among dental professionals. Often, dentists are the first medical professional to diagnosis an HPV related oral cancer; therefore, it is imperative that the dental community discusses the importance of HPV vaccination with their patients.

In addition to the strategies listed above, the Immunization Program used Title V funds to improve the functionality of MCIR to improve the overall public health infrastructure of the state's immunization information system. These functionality updates included enhancements to person deduplication, LHD school waivers, institution health monitoring, VFC/Outbreak enrollment, adoption record process, outbreak modules, forecasting and school/childcare online enrollment. Improvements to the state's public health infrastructure, specifically MCIR, is crucial to efficiently assess for vaccines, monitor vaccine uptake, and improve public health response.

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

The first strategy to support this objective included using MCIR data to generate a list of adolescent providers and their MCIR HPV completion rate at various ages. Although this did not occur at the provider level in FY 2022 due to staff shortages and competing priorities as a result of the COVID-19 pandemic, the Immunization Program did generate and disseminate HPV coverage rates by county and statewide as part of the County Immunization Report

Cards. Specifically, these report cards identify HPV completion rates for both females and males at 13 to 18 years of age. The report cards are generated to reflect the immunization rates of each county in Michigan and the rankings by county. The report cards have been modified several times to better meet the needs of local health departments. The overall goals of the report card data are to 1) provide each county with an understanding of vaccination rates in their respective communities and 2) identify areas for improvement. County report cards have been published every quarter and highlighted during several conferences. The goal of targeted outreach to adolescent immunization providers with low immunization rates remains a priority for the Immunization Program and the Immunization Program plans to focus on this in FY 2023.

The second strategy to support this objective included prioritizing provider outreach to practices with large adolescent populations and the lowest HPV immunization rates. Unfortunately, targeted provider outreach did not occur in FY 2022 due to staff vacancies within the Division of Immunization and competing priorities in the field. Michigan continued to conduct both Vaccines for Children (VFC) site visits and Quality Improvement (QI) visits but additional HPV-focused QI visits did not take place due to the challenges listed above.

The third strategy to support this objective included offering quality improvement (QI) visits (virtual or in-person) to provide a comprehensive assessment of immunization rates and offer strategies for practice improvements. Due to staff shortages within the Immunization Program and the vacancy of the Quality Improvement Director, state-directed QI visits were not conducted. However, local public health continued to conduct QI visits with their providers during FY 2022. A total of 474 QI visits were conducted by local public health and reviewed by Immunization Program Field Representatives. During these visits, site visitors provided a comprehensive assessment of immunization rates and recommendations for overall clinical flow and practice improvements to increase these rates. Information was also shared on the importance of emphasizing on-time vaccination of adolescents during 11-12-year-old visits.

Finally, the fourth strategy to support this objective emphasized “on-time” HPV vaccination of adolescents during the 11-12-year-old visits using Quality Improvement reports in the MCIR system. During the 474 QI visits conducted by local public health in FY 2022, QI reports and vaccination coverage estimates (including HPV completion by 13 years) were discussed and shared with provider offices. Local public health nurses strongly encouraged providers to promote and emphasize the importance of timely HPV vaccination as it relates to cancer prevention.

Although the COVID-19 pandemic is not over, the Immunization Program, in partnership with local public health and providers, continues to focus on all adolescent vaccines in FY 2023. Since COVID-19 vaccines are available to adolescent patients, the Immunization Program continues to educate providers on promoting all Advisory Committee on Immunization Practices (ACIP) recommended vaccines to adolescents, while also emphasizing the importance of HPV vaccine as cancer prevention.

Bullying (FY 2024 Application)

The percent of adolescents, ages 12-17, who are bullied or who bully others (NPM 9) was selected to address Michigan's priority need to "Create safe and healthy schools and communities that promote human thriving, including physical and mental health supports that address the needs of the whole person."

A variety of data sources point to why NPM 9, with a focus on the health of LGBTQ+ students, is a good fit for the current five-year cycle. Michigan saw a decline in overall bullying rates of high school students who reported in-school or online bullying from 27.7% in 2019 to 24.2% in 2021 (YRBS). However, LGBT students remain at significantly higher risk of being bullied than their non-LGBT counterparts (40.8% vs 21.3%).

Bullying is strongly associated with adverse mental health outcomes. Michigan students who reported any bullying in the previous year were significantly more likely than students who did not experience bullying to report: feeling sad/hopeless for 2+ weeks in the past month (1.9x as likely); considering suicide in the past year (2.7x as likely); attempting suicide in the past year (2.5x as likely); a suicide attempt requiring medical attention in the past year (3.1x as likely); and engaging in self-harming behaviors (2.4x as likely).

Students who identify as LGBTQ+ disproportionately and inequitably experience the harmful consequences of bullying. Compared with other students who report being bullied, who themselves report higher levels of adverse mental health outcomes, LGBT students are even more likely to report considering and attempting suicide. The 2021 Michigan YRBS found that LGBT students are more likely to report suicidal thoughts (3.5x more likely to consider suicide) and behaviors (4.0x more likely to attempt suicide) than their high school peers.

Multiple data sources point to school often being an unsafe place for LGBTQ+ youth in Michigan. According to the Gay, Lesbian and Straight Education Network's (GLSEN) 2021 Michigan State Snapshot, 64% LGBTQ+ students experienced at least one form of anti-LGBTQ+ victimization (verbal, online, physical) at school. The State Snapshot also found that only 33% of LGBTQ+ youth had access to a Gender and Sexuality Alliance, or GSA. Only 8% of LGBTQ+ students attend a school with a comprehensive anti-bullying policy. Especially concerning is the finding that 55% of LGBTQ+ students heard school staff make homophobic remarks and 70% heard negative remarks from school staff about someone's gender expression. Furthermore, when LGBTQ+ survey respondents reported victimization at school only 22% reported that it resulted in effective staff intervention.

The CDC's 2021 Adolescent Behaviors and Experiences Survey (ABES) illuminates the ways in which COVID-19 impacted young people and especially LGB young people. The survey found that more than 25% of LGB students, as compared to 5% of heterosexual students, attempted suicide in the past year. Being confined to home during the pandemic proved more dangerous for LGB students as 20% reported physical abuse perpetrated by a parent or other adult in their home, compared to 10% of heterosexual students.

While COVID-19 created barriers for LGBTQ+ students to feel safe and supported in school, an additional threat involves the state and nationwide trend of exclusionary legislation and policies. Some school leaders are also becoming wary of implementing LGBTQ+ supportive policies due to political pressure against the work. This backlash against affirming policies and practices harms students and plays a role in creating a stressful environment in which teaching and learning are compromised.

Michigan's CYSHCN population also experienced bullying at a higher rate, with 57.0% of CYSHCN being bullied compared to 23.8% of general population students in Michigan (2020-2021 National Survey of Children's Health). During focus groups and listening sessions for the 2020 Title V Needs Assessment, youth and their parents

described a need for activities and support groups to address a sense of social segregation and stigma within the community for CYSHCN. In response to the data and feedback, CSHCS utilized $150,000 of Title V funding to implement a bullying prevention initiative within the CYSHCN population to promote peer support and inclusion.

Objective A: By October 2025, 30 secondary schools will implement schoolwide bullying prevention initiatives emphasizing social emotional health (SEH) education and creating safe schools for LGBTQ+ students.

Focus group participants indicated that more progressive policies and innovative strategies for health education are needed to teach children healthy habits and the risks of dangerous health behaviors. Robust health education programs, in which social emotional health (SEH) is foundational, enhances the skills needed to prevent bullying behavior and helps to achieve equitable health outcomes. Addressing this need, efforts will center around bullying prevention through health education in the classroom with added supports for LGBTQ+ students. In FY 2024, Michigan will again select six schools to implement an approach to bullying prevention that includes teaching health education and creating safe schools for all students. All grade levels within selected schools will implement the social and emotional health skills module of the *Michigan Model for Health*™(MMH) curriculum. School teams will receive extensive training and customized support on creating safe schools for LGBTQ+ students. Schools will also receive training and support for the establishment, growth, and sustainability of Gender and Sexuality Alliance (or Gay-Straight Alliance) student clubs. This whole school approach will help move the needle on all students feeling safe and supported at school. Title V funding, via $5,000 stipends to each school, will fund curriculum implementation; cover costs associated with participation in workshops (sub costs, staff stipends, etc.); and costs to implement strategies related to creating safe and supportive schools for LGBTQ+ youth, including GSA support. Funds will also be used to support the consultants, employed by the Michigan Organization for Adolescent Sexual Health (MOASH), working directly with the school teams, facilitating workshops, and providing customized technical assistance.

The ESM for this NPM will be all classrooms in six selected schools implementing the *MMH*™ social and emotional health unit/module with at least 80% fidelity. Both the middle and high school modules focus on the development of social skills, including lessons that directly address bullying and cyber-bullying. Additional lessons addressing anti-bullying skills will be added from other curriculum units. Health teachers will complete fidelity lesson logs documenting the implementation of lessons.

The *MMH*™ is a K-12 comprehensive school health education curriculum that is evidence-based and culturally, linguistically, and age-appropriate. It is recognized by the Collaborative for Academic, Social and Emotional Learning (CASEL). Michigan's 22 regional School Health Coordinators provide training and technical assistance for the *MMH*™ and other school health initiatives. They partner with schools on creating safe schools for all students, addressing the needs of LGBTQ+ students, and addressing the role of adults in an inclusive learning environment.

The second strategy involves intensive training and customized technical assistance for a team of staff members from each school focusing on creating safe schools for LGBTQ+ students and implementing schoolwide strategies to improve the school climate. This includes the establishment, growth, and sustainability of a GSA. A series of workshops, along with individualized technical assistance and networking with other schools, builds the skills of educators so they can lead the effort to improve the school climate for all youth, especially those who identify as LGBTQ+. The trainings/workshops, as well as the customized support, are facilitated by skilled consultants who have worked with schools and LGBTQ+ youth in a variety of settings. These consultants, employed by MOASH, work with the Michigan Department of Education (MDE) on the MDE LGBTQ+ Students Project.

The workshop series, offered by the MDE LGBTQ+ Students Project, includes sessions devoted to understanding the identities and experiences of LGBTQ+ students; recognizing and addressing barriers to supporting LGBTQ+

students and families; legal and policy issues; LGBTQ+ youth panels; the power of GSAs; safe, supportive and inclusive classrooms; practical strategies for affirming LGBTQ+ students; school-wide policies and best practices; and accurately reflecting student gender identities in student information systems. Two new sessions address supporting this population in athletics and physical education along with partnering with parents, caregivers, and families. The workshops include youth panels, and the training content is developed with input from youth through youth advisory councils facilitated by MOASH. Drop-in technical assistance sessions are regularly scheduled and open to all interested schools in Michigan.

Research indicates that school policies supportive of LGBTQ+ youth combined with the presence of a GSA help create school environments where not only LGBTQ+ youth experience peer and teacher support, but the entire student body experiences less bullying and a more supportive school environment. Project consultants affiliated with MOASH will provide school teams with training and support specifically related to GSA establishment, growth, and sustainability. MOASH has been helping to build the capacity of GSA clubs in schools across Michigan for years. MOASH has significant expertise in this area and working with youth via youth advisory councils. MOASH will partner with schools to lend expertise in moving through the five stages of GSA development and functioning: Initiation and Organizing, Establishment, Implementation, Recruitment and Participation, and Sustainability. The MOASH annual statewide summit for LGBTQ+ youth is well attended (375 participants, primarily youth, attended in 2022). GSA participants from these schools will be encouraged (and financially supported) to attend.

Partnering with MDE, MOASH, and School Health Coordinators will ensure that schools receive the training and technical assistance needed for schoolwide *MMH*™ curriculum implementation; that youth voice will be centered; and that school teams will be provided with the training and support needed to create systemic change. The comprehensive and in-depth nature of these strategies, combined with the demonstrated expertise of our partners and the foundation of youth input ensures that schools will advance the goal of creating safe and supportive environments for LGBTQ+ students.

Objective B: By October 2025, provide 1,050 schools with guidance on state laws and model policies on bullying prevention with protections for LGBTQ+ youth.

School districts benefit from guidance on Michigan's laws and policies to better equip staff to appropriately address bullying. Most school staff members understand that it is imperative to intervene when bullying occurs, but surveys show that many feel ill-equipped to do so, resulting in unhelpful or even harmful staff response. Michigan's Public Act 241 mandates that schools develop a district anti-bullying policy. The law includes multiple components, based on best practices, required to be included in the policy. However, many school districts neither fully understand the law nor fully implement it. Michigan's State Board of Education (SBE) has a model anti-bullying policy in place to help school districts meet the law. The policy also has components that render it more comprehensive. While Michigan is a local control state—meaning the SBE Model Policy is a recommendation for schools rather than a requirement—the policy helps schools understand what should be included in a comprehensive bullying prevention policy.

For legislation to be effective as a means of decreasing bullying and cyberbullying, it is necessary for schools to adopt (and fully implement) policies. School Health Coordinators will work with their local schools to provide guidance on Michigan law and anti-bullying policies. Project partners will support their work to create awareness and understanding in the education community by facilitating professional development opportunities on the laws in Michigan and why adopting, and fully implementing, the SBE Model Anti-Bullying Policy is an essential component of bullying prevention efforts.

An additional strategy for promoting safe and supportive school environments for ALL students involves extending the learning opportunities on GSAs to school teams and staff members outside of the six project schools. Increasing

the number of GSAs will help create school environments where not only LGBTQ+ youth experience peer and teacher support but the entire student body experiences a safe, supportive, and inclusive climate where all students can thrive. Project consultants will provide learning opportunities in a variety of formats: webinars, lunch and learns, workshops, and one-on-one technical assistance on the establishment, growth, and sustainability of GSAs.

Objective C: Explore bullying prevention campaigns for CSHCS and determine goals for bullying prevention initiatives in Michigan.

The Family Leadership Network (FLN), staffed by the CSHCS Family Center and the F2F, is comprised of parents of CYSHCN representing each of Michigan's 10 Prosperity Regions. CSHCS utilizes feedback and participation from the FLN to keep family voices at the center of program decisions. The first strategy for this objective is to replicate a focus group with the FLN to document changes in the perception and occurrence of bullying for CYSHCN. The focus group is held at the annual meeting for FLN. Focus group results will inform changes in CSHCS bullying prevention activities.

The second strategy for this objective is to continue implementing the CSHCS Bullying Prevention small grants program. During focus groups with the FLN, parents of CYSHCN identified peer-to-peer support groups as one of the most helpful strategies to improve bullying for their children. In response to this finding, CSHCS launched the Bullying Prevention small grants opportunity in FY 2020. The Family Center co-coordinates this activity. Grants of up to $10,000 are available to schools and school districts to create or expand a peer-to-peer support program within their school. Peer-to-peer programs are evidenced-based and result in decreased anxiety, increased sense of belonging and confidence, increased level of engagement in the school community, and friendships that extend beyond the school building. CSHCS will continue to partner with the Statewide Autism Resources and Training (START) project to provide resources and support to grantees through monthly webinars and an annual in-person meeting. In FY 2024, CSHCS will evaluate the first three years of the grant program to identify additional areas to outreach with information about the grant, adapt the application to meet the needs of grantees, and identify data metrics to measure the success of the initiative. This information will be shared with the CSHCS Advisory Committee and other stakeholders.

In May 2021, some states from HHS Region IV (AL, FL, GA, NC, TN) and Region V (IN, MI, MN, OH, WI) expressed interest in creating a workgroup to share strategies for bullying prevention among CYSHCN. The Maternal Child Health Bureau facilitated quarterly meetings to discuss topics such as data capacity, youth advisory councils, and policies. The third strategy for this objective is for CSHCS to continue serving on the Region IV/V workgroup.

Immunizations – Adolescents (FY 2024 Application)

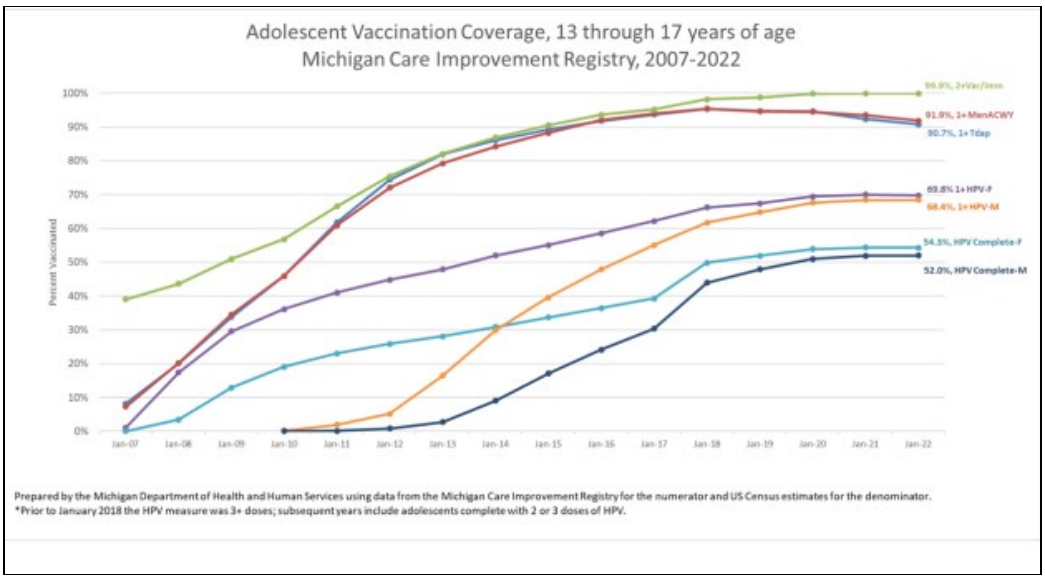
Based on the 2020 Title V five-year needs assessment, the state performance measure (SPM) created in 2015 was retained, which is the "Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus (HPV) vaccine." The HPV vaccine has the potential to save thousands of lives from HPV-related cancers. While Michigan has made progress increasing the timely uptake of HPV vaccination for adolescents, more progress is needed. Further, the COVID-19 pandemic has significantly limited efforts to focus on improving HPV vaccination coverage, due to competing priorities within provider offices.

Data from the Michigan Care Improvement Registry (MCIR), as of December 2022, show that the HPV vaccine completion rate for 13-17-year-old females is 45.3% while the rate for 13-17-year-old males is 43.2%. One goal of the MDHHS Immunization Program is to encourage HPV vaccination at 11-12 years of age when it is routinely recommended, although it can be administered as young as 9 years of age. Further, data from the MCIR as of January 2023 show that only 32.7% of adolescents have received a completed HPV series by 13 years of age. This

is short of the desired immunization level since it is routinely recommended at this younger age.

As seen in Image 1, HPV vaccination remains the lowest among all adolescent series vaccines, however, the disparity between males and females has decreased.

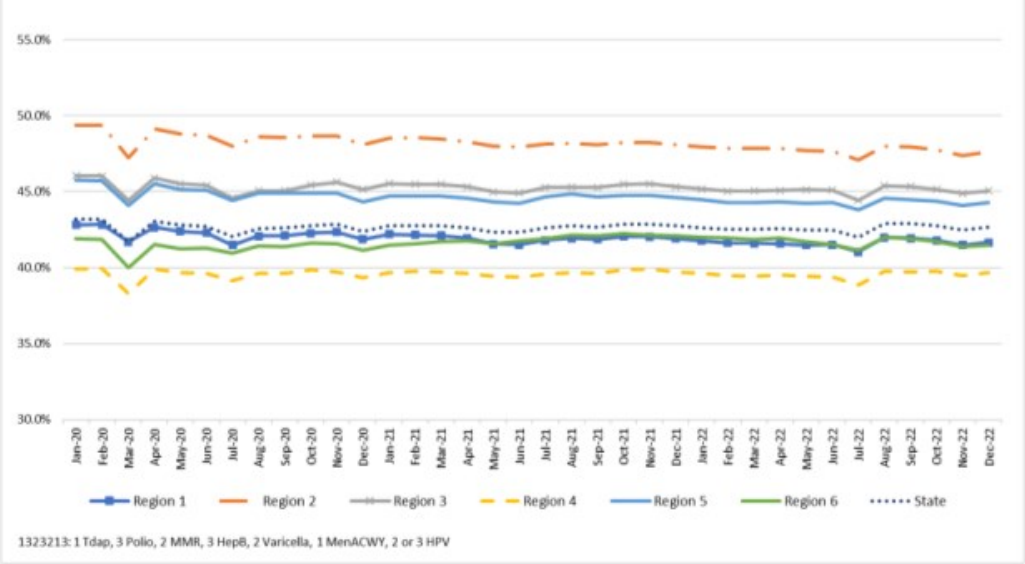
Image 1: Adolescent Vaccination Coverage, by Vaccine, 13-17 Years



Due to the impact of COVID-19 on all adolescent vaccinations, the Immunization Program plans to target all recommended vaccines for adolescents in FY 2024, with a focus on HPV vaccine. The pandemic has illustrated how diseases can severely impact the health of communities. Vaccines are developed to protect the health and well-being of individuals and minimize community spread. On-time vaccination of all recommended vaccines will lead to healthier Michigan adolescents.

As discussed in the SPM 2 Children's Immunization narrative, the Division of Immunization operates the MCIR information system. MCIR data as of December 2022 show that 72.8% of adolescents 13-18 years of age who reside in Michigan have received the recommended 1:3:2:3:2:1 adolescent vaccine series. The 1:3:2:3:2:1 vaccine series represents 1 dose of Tdap vaccine, 3 polio doses vaccine, 2 doses of MMR vaccine, 3 doses of hepatitis B vaccine, 2 doses of varicella vaccine, and 1 dose of meningococcal vaccine. When a complete series of HPV vaccine is added to the same series, the rate drops to 42.8%. Image 2 indicates that the adolescent vaccine series 1:3:2:3:2:1:3 falls below the desired protection for all recommended adolescent vaccines.

Image 2: 13 through 17 years adolescent vaccine series coverage: 1:3:2:3:2:1:3 by MCIR Region, March 2020 – December 2022, MCIR



Specifically, two other adolescent-focused vaccines are concerning to the Immunization Program: influenza and meningitis B (MenB) vaccine. As illustrated by the COVID-19 pandemic, respiratory illnesses such as influenza are highly communicable and can be deadly. Every year Michigan's vaccination rates for influenza are sub-optimal and leave the community susceptible to disease. According to MCIR, and data made available at www.michigan.gov/FLU, for the 2021-2022 influenza season the vaccination coverage for all Michigan residents was 30.48%. Current season estimates for the 2022-2023 influenza season indicate a statewide vaccination coverage of 28.79%. In addition, as of December 2022, adolescent vaccination coverage for 1+ MenB for adolescents 16-18 years was 25.9% (www.michigan.gov/immunize). It is critical to assess for all recommended vaccines and to collectively improve all adolescent vaccination rates.

The Immunization Program plans to use Title V funds to support program work in improving HPV vaccination uptake and working with internal and external partners to improve influenza and meningitis B vaccination rates as illustrated in the activities below. Receiving all recommended vaccines, on-time, protects the health and well-being of Michigan adolescents and their communities.

Objective A: By 2025, increase the percentage of adolescents who have completed the HPV series to 64%.

The Forces of Change assessment in the 2020 needs assessment revealed that for some racial and ethnic groups, cultural barriers (such as historical trauma, language, or norms) may impact accessing mainstream health care. The System Capacity assessment also indicated that the MCH system has an opportunity for improvement in working with providers to establish trust with patients, especially with families in minority populations. It is important to address these concerns related to health equity and access to care, including vaccinations. The Michigan Immunization Program will assess possible strategies for engaging families and communities in the vaccine dialogue. Seeking expertise from families and consumers can help MCH systems and providers identify barriers to vaccine uptake and create vaccination messages that are culturally sensitive and linguistically appropriate, which may include different messages targeted to different population groups or geographical regions.

Using this information, the Immunization Program will update current HPV materials to reflect up-to-date vaccine changes and effective communication strategies to promote vaccination and make the materials available for providers. The Program will work with the MDHHS Vaccine Equity Strategy Group to ensure materials are culturally

and linguistically inclusive. The Program will also provide updated translations of HPV materials to ensure a more equitable approach in addressing HPV vaccine hesitancy. Providers and the public will be able to review these materials on the MDHHS Immunization website, www.michigan.gov/Immunize, and order materials for free at the MDHHS Clearinghouse, www.healthymichigan.com.

The COVID-19 pandemic has contributed to an increase in vaccine hesitancy for all vaccines. The Program will work with national partners, including Centers for Disease Control and Prevention, as well as internal and external local partners to promote vaccine confidence among parents of this age group and adolescents themselves through resources, media, and presentations. MDHHS continues to be an active member in the Michigan HPV Alliance which includes partners from health systems, American Cancer Society, Karmanos Cancer Institute, local public health, and universities. The goal of this alliance to work collaboratively among the public and private sector to promote timely HPV vaccination, with the plan of hosting annual HPV Summits to provide education on HPV vaccine and HPV disease. While many parents choose to vaccinate their adolescents according to the recommended schedule, some parents may have questions about vaccines and getting answers they can trust may be hard. It is vital that the Program works with partners to address any questions or concerns parents, or adolescents may have about vaccinations and to promote vaccine confidence among this group.

Further, the Program has made it routine to provide data and information to local health department clinic staff on coverage levels for patients in their immunization clinics and coverage levels at the county population level with the Michigan Immunization Report Cards. The Immunization Report Cards are posted on the MDHHS website at www.michigan.gov/Immunize and provide population-based immunization coverage levels for each county with rankings compared to other counties in Michigan.

The Michigan Immunization Program will analyze the MCIR data to identify disparities between the adolescent vaccines and to monitor the uptake of HPV vaccine and the adolescent vaccine series. The Program will emphasize that providers who see adolescents for vaccine visits need to assure they are strongly recommending all recommended vaccines and not missing an opportunity to administer the HPV vaccine.

Finally, the Division plans to work more directly with the Alliance for Immunization in Michigan (AIM) Coalition to better engage families and communities through education and improvements to the aimtoolkit.org website. AIM is a partnership of public and private sector organizations which was formed in 1994 to focus on a broad spectrum of immunization issues in Michigan. AIM's mission is to promote immunizations across the lifespan through a coalition of health care professionals and agencies. The AIM coalition continues its focus on improving all facets of immunization services in Michigan.

As a result of the COVID-19 pandemic, the AIM coalition was essentially put on hold. As immunization rates continue to drop statewide, it is more important than ever to re-ignite this coalition and work collaboratively with private and public stakeholders to address vaccine hesitancy and improve vaccine uptake. AIM's website, aimtoolkit.org, provides education and promotes vaccination for both healthcare professionals and individuals and families. Utilizing the Division's partnership with the AIM coalition will better connect the Division's resources directly with consumers.

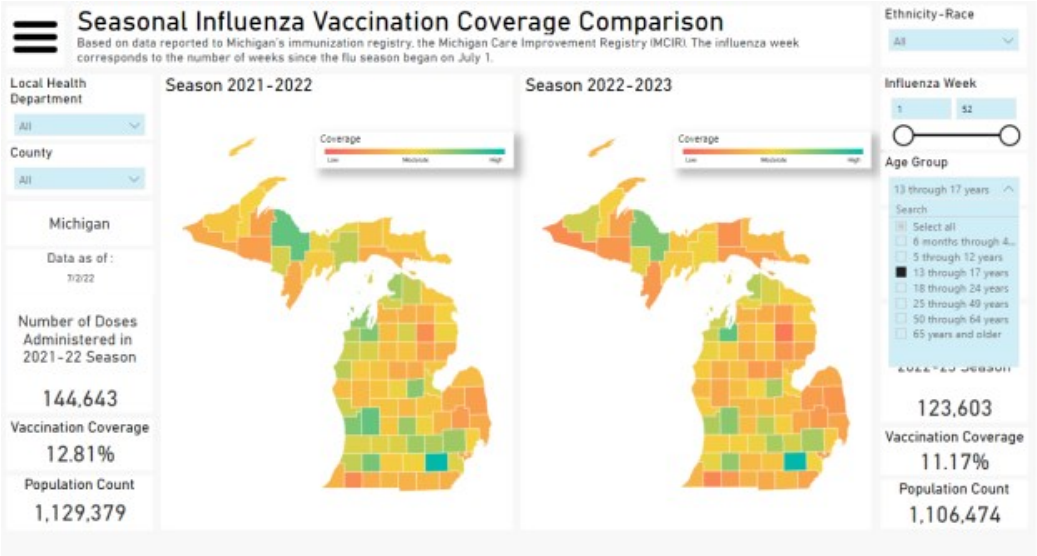
Objective B: Emphasize routine assessment of all recommended vaccines for adolescents to increase influenza and meningococcal vaccine rates by 5% among this age group.

As discussed above, due to the impact of COVID-19 on all adolescent vaccinations, the Immunization Program plans to target all recommended vaccines for adolescents, in addition to HPV vaccine. The pandemic has illustrated how diseases, especially respiratory illnesses, can be deadly and wreak havoc on the health of communities. Vaccines are developed to protect the health and well-being of individuals and to minimize community spread. On-

time vaccination of all recommended vaccines will lead to healthier Michigan adolescents.

In FY 2024, the Immunization Program will work with internal and external stakeholders on a statewide influenza campaign to improve influenza vaccination coverage among all ages, including adolescents. Every year Michigan's vaccination rates for influenza are sub-optimal and leave the community susceptible to disease. According to MCIR, and data made available at www.michigan.gov/FLU, for the 2021-2022 influenza season the vaccination coverage for all Michigan adolescents, 13-17 years of age, was 12.81%, below the statewide average of 30.48%. Current season estimates for the 2022-2023 influenza season indicate a statewide vaccination coverage of 11.17% among this age group, as illustrated in Image 3. This is extremely concerning to the Immunization Program and emphasizes that now is the time to target influenza vaccine, in addition to offering the COVID-19 vaccine, among this age group.

Image 3: Influenza Dashboard, Seasonal Influenza Vaccination Coverage, 13-17 Years



The COVID-19 pandemic has significantly impacted immunization rates at every age. The Immunization Program will produce a COVID-19 Impact Report to illustrate the impact the pandemic has had on childhood and adolescent immunization rates, while encouraging providers to catch Michigan children back up on recommended vaccines. The Immunization Program will continue to make the data available to local health departments so they can be better informed on areas for improvement as they work with immunization providers in their jurisdiction.

Using the data from this report, the Program will generate and distribute a letter to Michigan healthcare providers highlighting the importance of catching children and adolescents back up on routine vaccines that they may have missed due to the COVID-19 pandemic. The Program will work collaboratively with organizations such as Michigan Chapter of the American Academy of Pediatrics, and the Michigan Academy of Family Physicians to generate, distribute and promote this letter among healthcare personnel in the state.

Various studies and Michigan's experience indicate that clinical staff tend to overestimate the immunization rates for their practice. Offering vaccination coverage feedback during annual quality improvement visits, based on MCIR data, is insightful to provider offices and enables staff to consider recommendations to improve how vaccines are promoted and administered. Simple changes could be ensuring that vaccines are assessed and offered at every visit. The Immunization Program will work with local public health to offer quality improvement visits to providers, emphasizing on-time HPV vaccination, and provide a comprehensive assessment of immunization rates and recommendations for practice improvements.

Finally, the Program will work with external stakeholders to conduct targeted outreach to improve meningitis B vaccination rates for adolescents 16 through 18 years of age. Although it is uncommon, meningitis B (MenB) is a serious infection caused by the bacterium Neisseria meningitidis group B, which can cause an infection of the membrane that surrounds the brain and spinal cord. It can also cause septicemia, a serious infection of the bloodstream. Although most people recover, even with appropriate treatment, up to 1 in 10 patients will die, sometimes within 24 hours after the onset of symptoms. Further, up to 1 in 5 survivors of meningitis will experience long-term consequences including hearing loss, skin scarring, neurological problems, or limb loss.

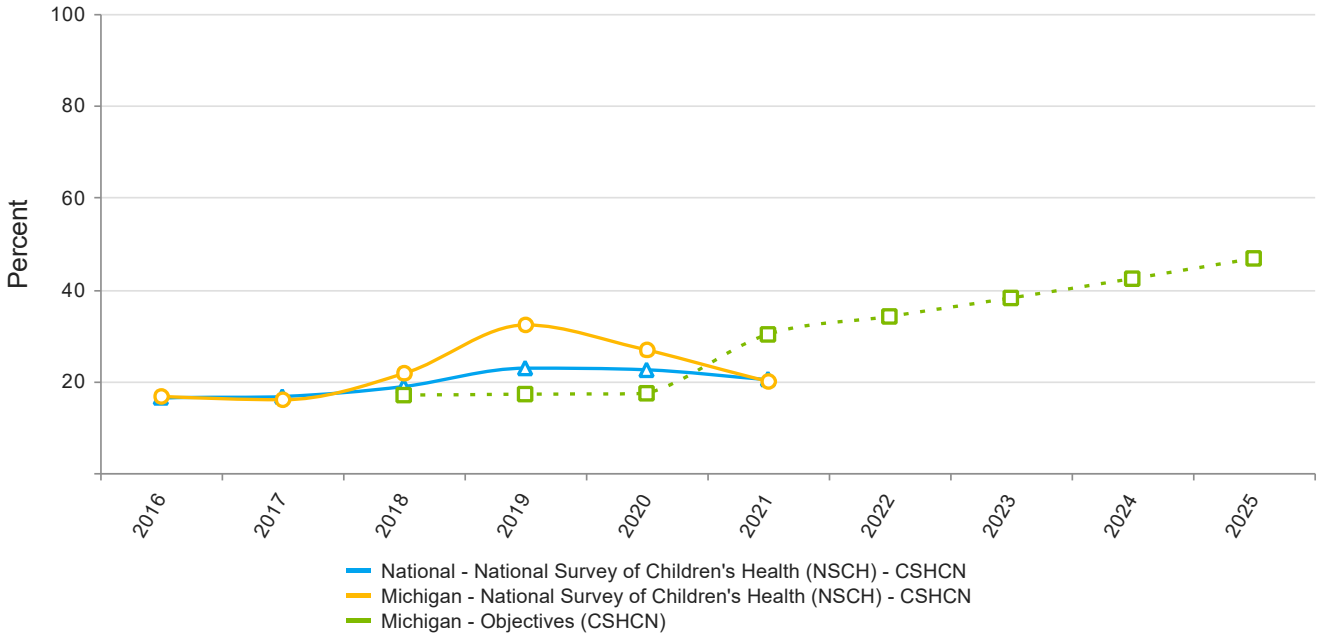
While most people are familiar with MenACWY vaccine, many are unaware that there are two meningitis vaccines needed to protect adolescents from all serotypes of meningitis. The Emily Stillman Foundation was founded by a Michigan mother who lost her daughter from meningitis B in 2013, 36 hours after being admitted to the hospital. The Emily Stillman Foundation has combined forces with the Meningitis B Action Project to raise awareness for meningitis B vaccine. The Immunization Program plans to work with these organizations to conduct targeted outreach to Michigan adolescents and their parents to improve meningitis B vaccination rates. As of December 2022, adolescent vaccination coverage for 1+ meningitis B for adolescents 16-18 years was only 25.9% (www.michigan.gov/immunize). In comparison, the vaccination rate for 1+ MenACWY for adolescents 13-17 years of age was 76.7%.

It is important to assess for all recommended vaccines and to collectively improve all adolescent vaccination rates. Michigan plans to use statewide quarterly immunization report cards to monitor vaccination uptake for HPV vaccine, adolescent series (1:3:2:3:2:1:3) vaccination coverage, 1+MenB and 1+ Flu (6 months – 17 years) to assess the impact of these strategies.

Children with Special Health Care Needs

National Performance Measures

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care
Indicators and Annual Objectives



NPM 12 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	17	17.2	17.4	34.1	34.1
Annual Indicator	16.0	21.6	32.3	20.0	20.0
Numerator	34,325	48,634	69,326	40,729	40,729
Denominator	215,008	225,148	214,341	204,129	204,129
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	38.1	42.3	46.7

Evidence-Based or –Informed Strategy Measures

ESM 12.1 - Percent of CSHCS clients age 18 to 21 years in selected diagnosis groups that have transferred care from a pediatric to an adult provider

Measure Status:	Inactive - Replaced				
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	43	46	49	49.2	49.4
Annual Indicator	49.9	46.7	46.5	45.3	42.8
Numerator	1,725	1,787	1,995	1,923	1,869
Denominator	3,459	3,828	4,289	4,245	4,366
Data Source	CSHCS database, Medicaid Claims, UM Provider Datab	CSHCS database, Medicaid Claims, UM Provider Datab	CSHCS database, Medicaid Claims, UM Provider Datab	CSHCS database, Medicaid Claims, UM Provider Datab	CSHCS data, CHAMPS, UM provider database
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

ESM 12.2 - Percentage of CSHCS partner organizations whose total score increased on the Assessment of Health Care Transition Activities.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	**2025**
Annual Objective	30.0	40.0

State Performance Measures

SPM 4 - Percent of children with special health care needs enrolled in CSHCS that receive timely medical care and treatment without difficulty

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	90.9	91.9	92.9	89.5	90
Annual Indicator	88.9	88	88	88.6	88.4
Numerator	14,678,590	10,365,782	7,297,774	4,977,264	5,731,114
Denominator	16,507,392	11,783,520	8,289,380	5,616,000	6,481,200
Data Source	CAHPS	CAHPS	CAHPS	CAHPS	CAHPS
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	90.5	91.0	91.5

State Action Plan Table

State Action Plan Table (Michigan) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Ensure children with special health care needs have access to continuous health coverage, all benefits they are eligible to receive, and relevant care where they learn and live	
NPM	
NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care	
Objectives	
A) By 2025, increase the percent of CYSHCN ages 12 and older receiving services necessary to transition from pediatric to adult health care from 21.6% to 25%	
B) By 2025, increase by 10% the number of health care professionals who have received training on transition from pediatric to adult health care	
C) By 2025, increase by 10% the number of partner organizations that reach the next level on the Got Transition “Current Assessment of Health Care Transition Activities”	
Strategies	
A1) Expand the school wellness center learning collaborative to promote Health Care Transition (HCT) to students, grades 9-12, through school-based clinics A2) Continue working with MITT to ensure HCT is included in the Michigan Model for Secondary Transition A3) Promote the revised CSHCS website with HCT resources A4) Continue to contract with U of M CHEAR to monitor transition data A5) Utilize the MHP contract, site review, and compliance review processes to improve HCT for CYSHCN enrolled in MHPs	
B1) Implement a marketing plan to promote Got Transition’s health professional courses to providers across the state B2) Engage with the clinic partners for the HRSA-funded CYE initiative to provide HCT education to providers B3) Leverage the CSHCS eligibility expansion to adults with sickle cell disease to improve HCT for these individuals	
C1) Annually implement the “Assessment of Health Care Transition Activities” with CSHCS partner organizations C2) Develop and track an Evidence-informed Strategy Measure (ESM) for the “Assessment of Health Care Activities”	
ESMs	**Status**
ESM 12.1 - Percent of CSHCS clients age 18 to 21 years in selected diagnosis groups that have transferred care from a pediatric to an adult provider	Inactive
ESM 12.2 - Percentage of CSHCS partner organizations whose total score increased on the Assessment of Health Care Transition Activities.	Active

NOMs

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

State Action Plan Table (Michigan) - Children with Special Health Care Needs - Entry 2

Priority Need

Ensure children with special health care needs have access to continuous health coverage, all benefits they are eligible to receive, and relevant care where they learn and live

SPM

SPM 4 - Percent of children with special health care needs enrolled in CSHCS that receive timely medical care and treatment without difficulty

Objectives

A) By 2025, increase the percentage of CSHCS CAHPS' respondents who rate their health care with a top box score of 9 or 10 from 71.9% (2019) to 75%

B) By 2025, increase by 10% the number of meaningfully engaged community partners (families, youth, LHDs, CAC members, contractors, clinic sites, health care providers, other professionals, etc.) to improve knowledge of the CSHCS program

C) By 2025, improve the percentage of CSHCN who report receiving care in a well-functioning system from 17.8% to 20.3%

Strategies

A1) Continue implementing special programs to reduce financial burdens for CSHCS-eligible families A2) Expand the capacity of specialty clinics to ensure delivery of patient-centered, family-friendly, equitable care through Children's multidisciplinary specialty (CMDS) clinics A3) Continue expansion of telemedicine through the HRSA-funded Children and Youth with Epilepsy (CYE) grant

B1) Continue building a coordinated and systematic approach to family engagement B2) Continue implementation of a multi-staged approach to improve provider engagement B3) Maintain a competent workforce that is knowledgeable about CSHCS and able to assist families accessing the system of care

C1) Continue to explore, develop, and implement a statewide benefit to improve care for children with medical complexities (CMC) C2) Complete a comprehensive evaluation plan to assess and then improve CSHCS's capacity and ability to provide effective, efficient, and high-quality services to clients C3) Continue to ensure CSHCS families are receiving care coordination in a high-quality, family-centered, and well-functioning system C4) Improve the system of care by identifying and responding to health inequities

CSHCN Overview

Children with special health care needs (CSHCN) include children with a wide variety of physical, emotional, and behavioral conditions, some of which qualify to receive support through the Children's Special Health Care Services (CSHCS) program within MDHHS. CSHCS annual program enrollment has grown to approximately 50,000 beneficiaries. The CSHCS Division is housed in the Bureau of Medicaid Care Management and Customer Service. The CSHCS Division includes the Family Center for Children and Youth with Special Health Care Needs (Family Center), which is parent-directed and designed to support and connect families with the care they need using a family-centered approach. CSHCS also includes sections focused on customer support, policy and program development, quality and program services, and the special needs fund.

For the CSHCN population, Title V funds are primarily used to support medical care and treatment for CSHCN. This could also include dental services when related to a qualifying diagnosis for which CSHCS covers dental care. Title V funds are also used to support bullying prevention activities specific to CSHCN. Other federal funds that support CSHCS include a HRSA Epilepsy grant and Medicaid. Key partners include Medicaid, Medicaid Health Plans, local health departments (LHDs), service providers, CSHCN and their families, the CSHCS Advisory Committee, the Family Leadership Network, Michigan Family to Family Health Information Center, and Michigan Family Voices.

In addition to direct CSHCS funding, LHDs can elect to expend additional Local MCH (LMCH) dollars for CSHCN. In FY 2022, three LHDs selected NPM 12 (transition) to identify enrollees of transition age and provide education and plans of care for gap-filling transition services. Additionally, two LHDs used LMCH funds to address SPM 4 (medical care and treatment for CSHCN) by providing gap-filling case management services, assistance with CSHCS enrollment, outreach, and monthly newsletters. One agency worked with two local hospitals' Neonatal and Pediatric ICUs to support consistent discharge processes and referrals to CSHCS. Most agencies were able to complete these activities at reduced capacity or through telephone contact instead of face-to-face visits due to COVID-19. Agencies report staff burnout and loss of program staff during the year which also impacted services. One agency planned to provide mental health services (SPM 6) for CSHCN but was unable to fill the Medical Social Worker position, and so services were not rendered.

Michigan's approach to improving the health and well-being of CSHCN through Title V focuses on access to continuous health coverage and benefits. Services offered are patient-centered/family friendly, culturally appropriate and coordinated. These attributes are reflected in all CSHCS services, including those specific to health care transition. In the current five-year cycle, the CSHCS program also began to work on bullying prevention for CSHCN which is included in the NPM 9 (Bullying) state action plan.

Transition (FY 2022 Annual Report)

The Title V Maternal & Child Health Needs Assessment Report completed in 2020 identified opportunities related to transition to adult health care for CYSHCN in Michigan. According to the 2019-2020 National Survey of Child Health (NSCH), only 22.5% of CYSHCN in Michigan had the support needed to transition to adult care. Focus studies and encounter surveys noted silos in communication across providers and provider turnover as challenges that contribute to difficulties with transition to adult health care. In response to these results, Michigan continued the commitment to NPM 12 (Percent of adolescents with and without special health care needs who received services necessary to make transition to adult healthcare) as a priority focus.

To address this NPM, CSHCS created and implemented a comprehensive strategic plan to improve health care transition across the state. Accomplishments in FY 2022 included the launch of a revised CSHCS transition website

that includes expansive resources, the successful pilot of an automated transition letter for 14-year-old enrollees that aligns with the recommendations from Got Transition, and the implementation of a revised Current Assessment of Health Care Transition Activities in Care Coordination Programs with Local Health Departments (LHDs). CSHCS also continued collaboration efforts with the Michigan Interagency Transition Taskforce to integrate health care transition into the Michigan Secondary Transition Model.

Key collaborations and partnerships include the Michigan Interagency Transition Taskforce (MITT), Medicaid Health Plans (MHPs), LHDs, MDHHS Child and Adolescent Health Centers (CAHC), The Family Center for Children and Youth with Special Health Care Needs (Family Center), Children and Youth with Epilepsy (CYE) grant recipients and Got Transition. Title V funds support the partnership with LHDs through care coordination and case management services, which include health care transition activities. Transition is also included as a Minimum Program Requirement during the LHD accreditation process.

The COVID-19 pandemic continued to create challenges in moving health care transition work forward. LHD staff resources were redirected to the pandemic response, limiting their availability to work with youth on health care transition services. In response, CSHCS focused on streamlining transition resources that are available in the virtual environment and adjusting strategies to allow flexibility for partners. Another challenge during the reporting year was a staffing vacancy for the Transition Specialist position at MDHHS for approximately five months of this reporting cycle. Initiatives moved more slowly due to this vacancy.

Objective A: By 2025, increase the percent of CYSHCN ages 12 and older receiving services necessary to transition from pediatric to adult health care from 21.6% to 25%.

The first strategy was to expand the school wellness center learning collaborative through school-based health clinics. CSHCS continued collaboration with Got Transition and the School-Based Health Alliance to finalize their School-Based Health Center Playbook on Health Care Transition which was released during this grant cycle. MDHHS' school wellness center transition pilot project was selected as one of the two programs that were included in the 'Examples from the Field' section of the playbook. Expansion of the pilot is planned for FY 2023.

The second strategy for this objective was to systematically review the CSHCS transition to adulthood website, update resources with current guidance from Got Transition, and launch a revised website. CSHCS formed a committee in FY 2021 that included youth, family, and stakeholder representation to provide diverse input into the website format and content updates. The new homepage was simplified and included links to access the following four categories: Youth and Young Adults; Parents, Caregivers and Family; Health Care Teams (Providers, LHDs, and MHPs); and Resources. Content for health care transition was updated to be consistent with Got Transitions Six Core Elements of Transition 3.0 and an expansion of non-health care transition resources were added. The revised CSHCS transition to adulthood website went live in FY 2022 with plans to review website content annually.

The CSHCS Transition to Adult Services online module was also updated in this grant cycle and is marketed within the revised CSHCS Transition to Adulthood website. In FY 2022, 62 individuals completed the entire Transition to Adult Services online module. Of the individuals who completed the training, 9% were age 21-25 and 91% were 26 and older. Fifty-seven percent (57%) of completing individuals reported the course would have an impact on their transition to adult services and 76% rated the course four or five out of five stars (with five being the best rating). Participants responded that the resource page at the end of the module had "good information" and that it was a great course for youth.

The third strategy was to continue the partnership with the University of Michigan Child Health Evaluation and Research (UM-CHEAR) unit to provide ongoing analyses of the transition ESM. The measure is based upon selected groups that include cardiology, endocrinology, gastroenterology, hematology-oncology, nephrology,

neurology, pulmonology, and rheumatology. The measure combines data from three sources: 1) CSHCS database; 2) CHAMPS (Medicaid claims); and 3) UM-CHEAR provider database which includes providers statewide. In FY 2022, UM-CHEAR reported 42.8% of targeted clients had encounters with only adult providers indicating those clients had a successful transition to the adult model of care.

The current ESM data collection has shown incremental decreases in successful transitions, which currently aligns with the results on the National Survey of Children's Health NPM on Transition for Michigan. The National Survey of Children's Health indicated significant improvement for Michigan in CYSHCN receiving services necessary for transition to adult health care from 16.0% in 2016-2017 to 26.7% in 2019-2020. However, in 2020-2021 that percentage decreased to 20.0%. The COVID-19 pandemic was likely a significant contributing factor to these decreases. The decrease in this ESM data corresponds with a change in the transition transfer of care policy at Michigan Medicine. In 2019, Michigan Medicine moved the target transition age from age 18 to age 21. Since the ESM specifically targets transfer of care by age 21, this policy directly impacts the ESM outcomes. In 2022, CSHCS and members of CHEAR convened to evaluate and strengthen this ESM. Finalized changes to the ESM are planned for FY 2023.

The final strategy for this outcome was to finalize and pilot an automated transition letter for 14-year-old enrollees to align with the recommendations from Got Transition. The automated letter was piloted in the CSHCS database system and was successful. To improve consistency and enable the creation of transition reports for LHDs, the next phase of this project included changing the generation of the existing automated transition letters (for ages 16, 17, 18 and 21) from the Community Health Automated Medicaid Processing System (CHAMPS) database to the CSHCS database system. This phase is currently on hold due to anticipated database changes and funding limitations. Transition reports will continue to be manually created for LHDs to guide their health care transition activities.

Objective B: By 2025, increase by 10% the number of health care professionals who have received training on transition from pediatric to adult health care.

The first strategy for this objective was to implement a marketing plan to promote Got Transition's health professional courses to providers across the state. CSHCS convened with key team members from Got Transition in FY 2022. Got Transition is in the process of updating the professional course and obtaining an updated Continuing Education Unit (CEU) certification. Plans to move forward with this strategy will commence once the courses are updated.

The second strategy was to continue to support the HRSA CYE grant partners to improve transition for children and youth with epilepsy in rural communities. In FY 2022, one-on-one calls were scheduled with each CYE clinic partner to discuss and support the systematic integration of administering health care transition readiness assessments within their clinic. While assessments were completed with a varying level of consistency, providers expressed a genuine interest in putting health care transition strategies, including assessments, into practice. The cross-site provider survey indicated a considerable increase in the number of completed transition readiness assessments by more than 300% from FY 2020 to FY 2021. Both pediatric and adult providers continue to face challenges with the integration of the health care transition assessment due to competing priorities and assessments.

The third strategy for this objective was to identify opportunities to improve transition to adult health care for patients with sickle cell disease. In October 2021, CSHCS expanded enrollment eligibility to include individuals aged 21 and over with sickle cell disease. This expansion resulted in the CSHCS enrollment of 406 adults with sickle cell disease during FY 2022. The transition specialist and Special Projects Coordinator in the Hemoglobinopathy Quality Improvement Program have continued work towards completion of a sickle cell disease clinic toolkit. The goal of the

toolkit is to provide health care transition guidance and sickle cell disease specific resources. Work will continue in FY 2023 and FY 2024 to finalize the clinic toolkit and commence a pilot project for implementation of the toolkit with sickle cell clinics.

The final strategy for this objective was to ensure health care transition was included in the Michigan Model for Secondary Transition. During this grant cycle, the transition specialist served as a member of the Michigan Interagency Transition Taskforce (MITT). This taskforce is a collaboration with representation from the Department of Education, Disability Rights Michigan, Developmental Disabilities Council, Department of Labor and Economic Opportunity, the Arc Michigan, Michigan Alliance for Families, Statewide Independent Living Council, Wayne State University Developmental Disabilities Institute, Statewide Autism Resources and Training (START), Michigan Transition Services Association, and Michigan Disability Rights Coalition. The taskforce continues to collaborate with the National Technical Assistance Center on Transition on the completion of the Michigan State Model for Secondary Transition. In FY 2022, the taskforce finalized objectives, a system flow of services, and fidelity checklist that included a section on health care transition. The transition specialist was also an integral part of creating a Youth Engagement Subcommittee to embed youth voice into the Michigan Model for Secondary Transition. Subcommittee members include representation from the Developmental Disabilities Council, Statewide Independent Living Council, and the Family Center youth consultant. Plans for FY 2023 include integrating youth voice into the Michigan State Model for Secondary Education and implementation of a pilot program.

Objective C: By 2025, increase by 10% the number of partner organizations that reach the next level on the *Got Transition* "Current Assessment of Health Care Transition Activities."

To improve the ability to measure improvements in transition related activities, CSHCS' first strategy was to devise a plan to adopt and implement the Current Assessment of Health Care Transition Activities with CSHCS partners. With the guidance and approval of Got Transition, the health care transition assessment was revised to accurately depict transition activities within the LHDs. CSHCS further collaborated with Michigan State University-Institute for Health Policy (MSU-IHP) to create an electronic version of the assessment survey in Qualtrics, distribute the assessment to LHDs and analyze the results. In FY 2022 the electronic survey was created and sent to all 45 LHDs. It generated 100% participation. Activities in FY 2023 will include analysis of the baseline data and providing an individualized report to each LHD.

The Current Assessment of Health Care Transition Activities was also implemented with clinical partners at the annual CYE meeting. CSHCS continues to support the HRSA CYE grant partners in this second strategy. Each year, the CYE grant partners host a meeting to discuss upcoming components of the grant, hear from an epilepsy panel which includes adolescents with epilepsy and their parents, and share best practices identified in their individual projects. Each year partners complete the annual assessment and progress is monitored. Analysis of the data reflected a 53% increase in the number of level three and four (with four being the highest rating) scores that were obtained from the annual transition assessment from FY 2020 to FY 2022.

Medical Care and Treatment for CSHCN (FY 2022 Annual Report)

Michigan's SPM for the CYSHCN population measures the percentage of CYSHCN enrolled in Children's Special Health Care Services (CSHCS) that receive timely medical care and treatment without difficulty. The measure addresses Michigan's 2021-2025 state priority need to "Ensure children with special health care needs have access to continuous health coverage, all benefits they are eligible to receive, and relevant care where they live and learn." CSHCS utilizes two survey questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) to measure the "Percent of CYSHCN enrolled in CSHCS that receive timely medical care and treatment

without difficulty" (SPM 4). In FY 2022, the result was 88.4%.

The mission of CSHCS is to find, diagnose, and treat children who have chronic illnesses or disabling conditions, enabling them to achieve improved health outcomes and enhanced quality of life. CSHCS accomplishes this mission by reducing barriers to medical care and treatment and minimizing financial burden for families. CSHCS covered an average of 41,000 individuals each month in FY 2022. Enrollees had at least one of the more than 2,500 qualifying diagnoses with 34.6% of enrollees having more than one severe, chronic health condition. Accomplishments in FY 2022 included the successful expansion of CSHCS eligibility to adults with sickle cell disease, the Expanding Equity in CSHCS Project that included data analysis for health disparities, expansion of Children's Multi-Disciplinary Specialty (CMDS) clinics, continued work towards the respite program redesign, and progress establishing a Children with Medical Complexity (CMC) benefit.

Key CSHCS partners include the National Care Coordination Academy, Family Voices, the MDHHS Lifecourse Epidemiology and Genomics Division (LEGD), Bureau of Children's Coordinated Health Policy and Services (BCCHPS), Michigan State University-Institute for Health Policy (MSU-IHP), Medicaid Health Plans (MHPs) and Local Health Departments (LHDs). Approximately 39% of Michigan's Title V FFY 2022 expenditures in FY 2022 were for direct medical care and treatment.

Ongoing response to the COVID-19 pandemic continued to be a challenge for CSHCS. LHD partners have diverted program staff and other resources to operate vaccination clinics and complete contact tracing, resulting in fewer staff members dedicated to CSHCS families. This ongoing response coupled with pressure on LHDs within local communities has resulted in a high staff turnover within LHDs.

Objective A: By 2025, increase the percentage of CSHCS CAHPS' respondents who rate their health care with a top box score of 9 or 10 from 71.9% (2019) to 75%.

The first strategy was to continue enrollment of CYSHCN into the CSHCS medical care and treatment benefit. CSHCS ensures access to specialty care for a client's qualifying condition and reduces financial burden for families. Clients that are medically eligible for CSHCS and have active Medicaid are automatically enrolled. Enrollment into CSHCS benefits clients with Medicaid by increasing access to care coordination and case management services. To further assist with enrollment, CSHCS partners with LHDs, hospitals, specialists, and MHPs to submit medical reports for CSHCS review. CSHCS and Medicaid also implemented policies to ensure continued eligibility for enrollees in their respective programs during the COVID-19 pandemic.

In addition to the medical care and treatment benefit offered by CSHCS, the Insurance Premium Payment Benefit (IPPB) and Non-Emergency Medical Transportation (NEMT) programs further reduce the financial burden for CSHCS families. IPPB can assist the client in maintaining comprehensive private health insurance coverage by paying the client's portion of the insurance premium. Determination is based on financial need and cost effectiveness for the CSHCS program. In FY 2022, CSHCS provided $293,175 in health insurance premium payments for 147 families.

NEMT assisted clients in accessing specialty care by covering qualifying travel expenses. The 2022 CAHPS survey indicated 7.6% of respondents requested transportation assistance from CSHCS. When asked to rate if the assistance met the needs of their family, 86.3% of respondents shared that the assistance "Usually" or "Always" met their needs. In FY 2022, CSHCS processed $130,000 in claims to commercial vendors and $1,078,932 to clients/families.

The second strategy was to expand the capacity of specialty clinics to ensure the delivery of patient-centered, family-centered care through CMDS clinics. These clinics offer a highly coordinated, interdisciplinary approach to the

management of specified complex medical diagnoses, which include teams consisting of a specialist/pediatrician, nurse, social worker, and dietician. CSHCS supports over 30 CMDS clinics in seven tertiary care and teaching hospitals. In FY21, CMDS clinics reported 3,681 client encounters with more than $436,000 of enhanced reimbursement provided to clinics. In FY 2022, five additional CMDS clinics were added to the CSHCS network.

In October 2021, Michigan expanded CSHCS eligibility to include adults with sickle cell disease (SCD) with the goal of improving health outcomes and reducing health disparities for this population. In FY 2022, this expansion resulted in the CSHCS enrollment of 406 adults. Through a partnership with the Michigan Sickle Cell Data Collection (MiSCDC) program at Michigan Medicine and MDHHS LEGD, CSHCS is working to identify additional individuals eligible for CSHCS. The MiSCDC program uses multiple population-level data sources to identify people with SCD in Michigan. In FY 2023, CSHCS will work with MiSCDC to analyze the data and outreach to potential eligible individuals.

The third strategy for this objective was to expand and support the use of telemedicine to improve access to specialty care in rural and underserved areas. This is accomplished through the HRSA Children and Youth with Epilepsy (CYE) grant which utilizes telehealth strategies to increase access to care for youth with epilepsy. The CYE leadership team discussed each of the project focus areas with clinic teams including an assessment of equitable access to telehealth for three patient populations: those not enrolled in a patient portal, those with a language barrier, and those with missed appointments. Discussions about equitable telehealth access for these populations prompted rich discussion with clinic teams about logistics, preferences, and resources. Plans for FY 2023 include providing continued support for clinics in developing telehealth criteria and facilitating clinic improvements related to equity of telehealth options.

Objective B: By 2025, increase by 10% the number of meaningfully engaged community partners (families, youth, LHDs, CAC members, contractors, clinic sites, health care providers, other professionals, etc.) to improve knowledge of the CSHCS program.

The first strategy was to continue building a coordinated and systematic approach to family engagement which is accomplished through the work of the Family Center. The Family Center is a statewide, parent-directed center within CSHCS that offers emotional support, information, and connections to community resources for families of CYSHCN. In FY 2022, the Family Center fielded 8,443 Family Phone Line calls and parent consultants assisted 638 individuals.

In addition to the parent consultant staff, the Family Center team also includes a youth consultant who helps to embed youth voice into the CSHCS program and assist with outreach efforts. The youth consultant serves on a variety of committees including the CYE advisory committee, the Michigan Interagency Transition Team Youth subcommittee, and the Youth Engagement Program planning committee. The youth consultant also co-presented on health care transition at the Adolescent Health Initiative Conference in FY 2022.

The Family Center continued to facilitate quarterly meetings with the Family Leadership Network (FLN) in collaboration with the MI Family to Family Health Information Center to obtain diverse perspectives from families of CYSHCN. The FLN is composed of up to two FLN members from each of Michigan's 10 Prosperity Regions to provide caregiver input on programs and special projects.

The Family Center also offered Parent Connect Calls and trainings in a virtual environment during this grant cycle. The Parent Mentor training was completed by 90 parents, and 39 parents were matched with mentors. Parent Connect Calls provided caregivers of CYSHCN with resources, support, and an opportunity to discuss the most pressing issues for caregivers of CYSHCN. In FY 2022, The Family Center provided 12 Parent Connect Calls which reached 91 caregivers.

To promote education and advocacy, the Family Center continued to offer scholarships for camp and conferences to CYSHCN families and grant opportunities to LHDs. Conference scholarships were available for parents/youth to attend a conference related to the CYSHCN's diagnosis. In FY 2022, 16 conference scholarships were granted. Summer camp scholarships provide up to $250 for CYSHCN to attend a Michigan licensed summer camp. In FY 2022, 69 camp scholarships were awarded, which is a 57% increase compared to FY 2021. The Family Center also provided a grant opportunity for LHDs to increase family support, knowledge, and advocacy skills through implementation of a family-centered support activity for families of CYSHCN. In FY 2022, four LHDs were awarded a total of $17,500.

The second strategy was to implement a comprehensive outreach plan to improve awareness of CSHCS among providers, partners, and families. The Family Center continued to host Professional Connect Calls to share important information, facilitate discussions among providers, and brainstorm opportunities for partnership to support families of CYSHCN. In FY 2022, the Family Center hosted eight Professional Connect Calls reaching 144 professionals. CSHCS also launched a revised, more user-friendly website with expanded and updated content. Additionally, an Outreach and Engagement Analyst position was created and filled to assist with CSHCS outreach, employee engagement, and staff development. Movement on this strategy will continue in FY 2023.

The final strategy was to maintain a competent workforce to assist families in accessing care. In FY 2022, the CSHCS annual training for LHDS and MHPs focused on sickle cell disease. This virtual training had a robust agenda that included specialist providers detailing the treatment guidelines and sickle cell disease process across the lifespan; a nurse practitioner who shared motivational interviewing techniques for use in the process of transitioning care; and a family panel which provided both a parent and teen perspective on living with sickle cell disease. Post meeting surveys indicated 99% of survey respondents agreed or strongly agreed that the training improved their knowledge of the complexities of caring for individuals with sickle cell disease. CSHCS collaborates with MSU-IHP for this training.

CSHCS continued to facilitate regularly scheduled meetings with LHDs and MHPs to discuss program updates, provide education, and offer opportunities for input into the CSHCS program. Two collaborative calls between MHPs and LHDs were hosted by CSHCS during this grant cycle.

Objective C: By 2025, improve the percentage of CSHCN who report receiving care in a well-functioning system from 17.8% to 20.3%.

The CSHCS team continued to develop a model of care for Michigan's CMC with a goal of improving health outcomes and quality of life while minimizing hospitalizations and reducing health care costs. CSHCS worked with the Division of Vital Records and Health Statistics to apply the Pediatric Complex Chronic Conditions Classification System Version 2 (CCCv2) algorithm to Michigan's encounter data to quantify the number of potential eligible beneficiaries for the CMC benefit. The data are being utilized to determine cost impacts and potential saving opportunities. CSHCS consulted with Centers for Medicare and Medicaid (CMS) to better understand the newly released requirements associated with the ACE Kids Act Health Home and how these differed from the ACA Sec. 2703 health home requirements. CSHCS presented planning documents to leadership and engaged with both Medicaid Policy and Medicaid Actuarial to better understand processes and information needed to proceed with benefit development.

In FY 2022, CSHCS completed its participation in the National Care Coordination Academy. CSHCS was also invited to participate in Project ACCELERATE (Advancing Care Coordination *through* Evidence; Leveraging Existing Relationships Around Transforming PracticE). This project brings together stakeholders including Medicaid

Medical Directors, MCH-Title V Directors, and patient advocates to review the latest PCORI-supported findings for enhanced care coordination for CYSHCN.

The second strategy included gathering feedback from provider stakeholders and developing a comprehensive program evaluation plan. In 2019, a CSHCS collaborative workgroup comprised of representatives from the CSHCS Advisory Committee (CAC) was established to provide guidance on the development, process, sampling, and methodology for a CSHCS provider survey. Feedback was obtained utilizing a multi-staged approach that included interviews with executives and an electronic provider survey. The survey was completed in 2020 and findings were compiled and analyzed in 2021. In FY 2022, CSHCS identified findings that will support future MHP contract changes. For example, the provider survey revealed that when a respondent rated prior authorizations for CSHCS services/benefits as “not at all easy,” 81% of those respondents indicated it was related to MHPs. As a result of the survey findings, CSHCS is examining how to utilize the MHP contract to improve how services are provided to clients and to improve the experience of CSHCS providers in working with MHPs. In response to individual provider survey responses, OMA physicians directly followed-up with providers to address concerns and answer questions.

Building on work from previous years, CSHCS continued the development of a comprehensive evaluation plan. The goal of the plan is to measure CSHCS’s capacity and ability to provide effective, efficient, and high-quality services to clients. In FY 2022, CSHCS identified metrics that aligned with established evaluation questions. Additional data analysis will occur in FY 2023.

The third strategy was to ensure CSHCS families are receiving high-quality, family-centered care coordination in a well-functioning system This strategy is accomplished through site visits with CMDS Clinics and MHPs, and accreditation visits for LHDs. CSHCS conducted five virtual CMDS clinic site visits in FY 2022. Site visits confirmed that CMDS clinics excelled in expanding the staffing structure of the provider specialty network to meet families’ needs and providing patient/family education. The most frequent recommendations to the clinics were related to transition to adult providers, documentation, and recruitment of specialty staff, such as dieticians. CSHCS participated in MHP site visits with Managed Care Plan division staff, OMA, and other program areas across MDHHS. In FY 2022, CSHCS visited with nine MHPs with a focus on case management and care coordination received by CSHCS enrollees. LHD accreditation visits continued to be paused through FY 2022 due to the COVID-19 pandemic and are anticipated to resume in FY 2023.

The final strategy for this objective is to ensure CSHCS families are receiving equitable care by applying a health equity lens to all activities within the CSHCS Division. The CSHCS management team makes a concerted effort to apply a health equity lens in all efforts to review program operations. For instance, a review of challenges experienced by young adults transitioning to adult care with a health equity lens led to the development of a proposal to expand CSHCS program eligibility to young adults up to age 26. Challenges with transition to adult care are more acutely experienced by young adults from lower income families and from historically underserved populations, and this proposal to expand eligibility is in response to this identified inequity. In addition, the CSHCS Health Equity, Diversity, and Inclusion workgroup seeks opportunities to educate and engage CSHCS staff and stakeholders to identify health inequities, remove institutional barriers, and advance equitable policies and practices to ensure the reduction in health disparities for CYSHCN. The Workforce Development subcommittee creates monthly Health & Cultural Awareness bulletins that highlight rare diseases and provide education on diversity and inclusion topics. These emails are shared with the Division and LHDs. In FY 2022, the workgroup oversaw the revision of two Division brochures to ensure ADA compliance. This work will continue in FY 2023.

Transition (FY 2024 Application)

Through the Title V five-year needs assessment process, the state priority need to “Ensure CYSHCN have access to continuous health coverage, all benefits they are eligible to receive, and relevant care where they live and learn” was linked to NPM 12, the percent of adolescents with and without special health care needs who received services necessary to make transitions to adult health care.

In Michigan, 20.0% of CYSHCN reported they received services to transition to adult health care (NSCH, 2020-2021). While Michigan’s performance mirrors the national percentage, the data indicates that more than three-fourths of Michigan’s CYSHCN are not receiving necessary Health Care Transition (HCT) services, making them vulnerable to worsening chronic health conditions, behavioral health issues, and underutilization of needed health care services.

Based on the needs assessment and NSCH data, three objectives were developed to address the state priority need, while focusing on promoting awareness, developing skills, and creating capacity for measuring improvement. These objectives align with the Michigan Title V needs assessment pillars of improving capacity to achieve equitable health outcomes; engaging families and communities; and delivering culturally, linguistically, and age-appropriate health education. With the ending of the Public Health Emergency, CSHCS is moving forward with strategies that were on hold during the pandemic. Plans for FY 2024 include marketing the revised CSHCS website and the Got Transitions health professional course; expanding the assessment of health care transition activities to include additional partner organizations; revising the MHP contract language to incorporate additional HCT activities for CYSHCN; evaluating additional ancillary HCT data sources and collection efforts; and expanding HCT activities within school-based health clinics.

Through strong partnerships, CSHCS ensured stakeholder input was integrated in objectives and strategies. Key collaborations and partnerships include local health departments (LHDs), Medicaid Health Plans (MHPs), Michigan State University-Institute for Health Policy (MSU-IHP), Michigan Family Voices, MDHHS Child and Adolescent Health Centers (CAHCs), The Family Center for Children and Youth with Special Health Care Needs (Family Center), and Got Transition. Title V funding is used to provide care coordination services through contracts with local health departments, which includes HCT services. HCT is also integrated in the LHD accreditation process as a Minimum Program Requirement.

Objective A: By 2025, increase the percentage of CYSHCN ages 12 and older receiving services necessary to transition from pediatric to adult health care from 21.6% to 25%.

With the support of a replication grant from the Association for Maternal and Child Health Programs (AMCHP), CSHCS completed a pilot program to develop a process and toolkit for integrating HCT programming into Child and Adolescent Health Center (CAHC) school wellness centers. The pilot project replicated Got Transition’s “Incorporating the Six Core Elements of Health Care Transition into a Medicaid Managed Care Plan: Lessons Learned from a Pilot Project” with a rural school-based health center. Activities included completing a pre-assessment of clinic HCT activities, customization of Core Elements of Transition, implementation of the core elements, data collection, a post-assessment of clinic HCT activities, and sharing results with stakeholders. After demonstrating success in the pilot project, CSHCS planned to expand the pilot and further refine the toolkit. Due to COVID-19 and the varied impact it had on school-based health centers, these plans were delayed in 2020 and 2021.

In FY 2022, Got Transition and the School-Based Health Alliance invited CSHCS to participate as an advisory

committee member in the creation and launch of their School-Based Health Center Playbook on Health Care Transition. The first strategy for this objective is to expand the Michigan's school wellness center learning collaborative to promote HCT in school-based clinics. In FY 2024, CSHCS will lay the groundwork for this expansion by working with MDHHS CAHC to establish a leadership committee. The committee will review the documents utilized during the pilot project, integrate the Playbook on Health Care Transition, and ensure the processes continue to meet the Quality Improvement requirements for school-based clinics, school-linked clinics, and school wellness programs. Three to five clinics will be identified that represent diverse populations and have the capacity to implement the pilot. Implementation of customized documents, processes, and data collection will begin in August 2024 and continue throughout the 2024/2025 school year.

To provide further HCT resources to schools, CSHCS will continue working with the Michigan Interagency Transition Taskforce (MITT) to ensure HCT is represented in the finalized transition model. MITT was formed to align transition services across state agencies, reduce duplication of services, promote common understanding of secondary transition, and improve student outcomes. In FY 2024, the transition specialist will continue to ensure HCT is included as a tenant in the Michigan State Model for Secondary Transition and a recognized step on a pathway towards independence. The transition specialist will utilize Got Transition resources to help guide educational staff in assisting adolescents in navigating their transition to adult providers.

The third strategy for this objective is to promote the revised CSHCS Transition to Adulthood website. Content for health care transition was updated to be consistent with Got Transitions Six Core Elements of Transition 3.0 and expansion of non-health care transition resources were added. Youth, family, and stakeholder representation provided diverse input into the website format and content updates. In FY 2024, CSHCS, through the work of the Family Center and the CSHCS Transition Specialist, will promote the website to LHDs, MHPs, clients, families, and providers.

As a fourth strategy, MDHHS will continue to contract with the University of Michigan Child Health Evaluation and Research (CHEAR) Unit for an amount not to exceed $50,000 to provide ongoing analyses and support related to the CSHCS program. CSHCS and CHEAR will continue to evaluate HCT data criteria and collection efforts to identify opportunities for improvement and implement program changes in response to the data. Consideration for employing an additional ESM will be a topic of discussion for this collaboration in FY 2024.

The final strategy for this objective is to utilize the MHP contract, site review, and compliance review processes to improve HCT for CYSHCN enrolled in MHPs. In FY 2023, following the guidance provided by Got Transition's "Medicaid Managed Care Contract Language to Expand the Availability of Pediatric-to-Adult Transitional Care," CSHCS implemented MHP contract revisions on HCT. These revisions included a definition of HCT, the utilization of consistent HCT language throughout the contract, inclusion of HCT information in the MHP member handbook, and providing an age requirement for the initiation of HCT processes that align with the requirements of other CSHCS partners. In FY 2024, CSHCS will recommend additional MHP contract changes to further strengthen HCT efforts. Topics being explored include the utilization of HCT readiness assessments, how HCT education is provided to CYSHCN, and the network capacity for adult providers to service adults with pediatric conditions. In addition, CSHCS will ensure that MHPs report HCT outcomes during the compliance review process. CSHCS will attend site visits to engage with MHPs, provide additional resources if necessary, and provide technical assistance.

Objective B: By 2025, increase by 10% the number of health care professionals who have received training on transition from pediatric to adult health care.

The first strategy for this objective is to create and implement a marketing plan to promote courses on HCT to providers across Michigan. In partnership with Health Services for Children with Special Needs, Inc., Got Transition

created an online continuing education course designed for pediatric and adult physicians, nurses, and social workers. The course offers a brief review of the updated clinical recommendations on HCT and the quality improvement approach of the Six Core Elements of Health Care Transition. The transition specialist will work with Got Transition staff to establish baseline data for the providers in Michigan who have completed the course. A detailed marketing plan for provider outreach will be developed and implemented to promote the completion of the HCT training course. Data will be monitored annually to determine effectiveness of the marketing strategy.

The second strategy is to engage with the clinic partners for the HRSA-funded CYE initiative to provide HCT education to providers. Michigan's CYE team has a goal of increasing the number of completed transition readiness assessments of youth (ages 14-22) with epilepsy by 75%. To achieve this goal the project will support follow-up on HCT topics through in-person and technology enhanced options. In previous years, the project team obtained input from youth with epilepsy on technology-enhanced tools to support self-management. This input was shared with participating clinics. Project leadership compiled in-person training and online modules for different transition topics. In FY 2024, the project team, which includes the Epilepsy Foundation of Michigan and the CSHCS Family Center, will offer training to community partners to promote HCT strategies and resources. In addition, the project will conduct targeted HCT trainings, such as Teen Transition Workshops for children with epilepsy and their families.

Through a partnership between CSHCS and the Public Health Administration (PHA), the FY 2022 state appropriation included an expansion of CSHCS eligibility to include adults (ages 21 and over) with qualifying sickle cell disease diagnoses. The third strategy for this objective is to leverage the CSHCS eligibility expansion to improve HCT for individuals with sickle cell disease (SCD). To accomplish this, CSHCS will focus on expanding the CMDS model to clinics providing care to children and adults with sickle cell disease. The CSHCS transition specialist will work with the PHA and MSU-IHP to create a HCT toolkit for the SCD clinics. The toolkit will be reviewed by Office of Medical affairs providers and families of children with special health care needs. In FY 2024, two clinics, one pediatric and one adult, will be identified to pilot the toolkit.

Objective C: By 2025, increase by 10% the number of partner organizations who reach the next level on the Got Transition "Assessment of Health Care Transition Activities."

The first strategy for this objective is to implement Got Transition's "Assessment of Health Care Transition Activities" with CSHCS partner organizations. In FY 2022 and FY 2023, CSHCS collaborated with MSU-IHP to create an electronic version of the assessment in Qualtrics, distribute the assessment to LHDs, and analyze the results. Baseline data was documented, and the results were utilized to determine HCT training topics and program development for local health departments. The HCT survey will continue to be implemented annually to LHDs to document trends and provide valuable feedback into the CSHCS program. In FY 2024, CSHCS will replicate this HCT assessment process with other partners such as MHPs and school-based health clinics.

CSHCS will also continue to support the HRSA CYE grant partners in implementing the "Assessment of Health Care Transition Activities" annually. Each year, the CYE grant partners host an in-person meeting to discuss upcoming components of the grant period, hear from an epilepsy panel which includes adolescents with epilepsy and their parents, and share best practices identified in their individual projects. Each year, CYE grant enrolled clinics complete the "Assessment of Health Care Transition Activities" to meet a requirement of the cross-site evaluation for the grant. In FY 2024, CYE grant partners will continue to have enrolled clinics complete the annual assessment, continue to monitor the progress of clinic sites, and determine plans for improving HCT activities.

In FY 2024, CSHCS will implement and track a new ESM to monitor HCT activities within CSHCS partner organizations. The new ESM will reflect the percentage of CSHCS partners whose total score increased on Got Transition's "Assessment of Health Care Transition Activities" annual survey. CSHCS will utilize a Quality

Improvement (QI) approach by implementing the assessment survey to gauge the programs' current HCT activities, provide education and technical assistance for the respective program based on the feedback and scores received, and replicate the assessment process annually. The goal of this ESM is to 1) assist CSHCS partners with implementing additional activities that utilize Got Transitions Six Core Elements of HCT, 2) increase CSHCS partner organizations' scores on the HCT assessment survey, and 3) increase the percentage of CYSHCN in Michigan who receive services necessary to transition to adult health care. CSHCS will continue collaborative efforts with MSU-IHP to annually execute the electronic HCT assessment and analyze results.

Medical Care and Treatment for CSHCN (FY 2024 Application)

Children's Special Health Care Services (CSHCS) was created to find, diagnose, and treat children who have chronic medical conditions. The Family Center for Children and Youth with Special Health Care Needs (Family Center) is housed within the CSHCS Division and provides ongoing support, education, and resources to families of CSHCN. All families of CSHCN can utilize Family Center services, regardless of CSHCS enrollment status. In FY 2024, Title V funding will be used for direct medical care and treatment for Children and Youth with Special Health Care Needs (CYSHCN).

The CSHCS benefit, while not intended to cover all the care a child needs, helps to ensure that necessary specialty care for a child's qualifying diagnosis will not create undue financial burden for families. CSHCS is the payer of last resort and requires families to follow their primary and secondary insurance. If a family's income indicates that they may be eligible for Medicaid, they are required to apply. Most CSHCN who qualify for Medicaid and the CSHCS benefit continue to receive care through Medicaid Health Plans (MHP). Children who are already receiving Medicaid, and are determined to be medically eligible for CSHCS, are automatically enrolled. Automatic enrollment into CSHCS increases family access to care coordination and case management services. CSHCS works with local health departments (LHD), hospital systems, and MHPs to ensure continued enrollment.

The 2020 Title V needs assessment indicated CSHCS beneficiaries experience barriers, including transportation, that impact access to timely health care services. Respite care was identified as a significant need to reduce stress for families of CSHCN. Language and cultural barriers, as well as lack of specialty providers and insurance challenges, were also identified. The health status assessment revealed almost a third of CSHCN with complex health needs did not receive needed care coordination, and CSHCN are more than twice as likely as non-CSHCN to report that they did not receive care coordination (National Survey of Child's Health, 2016- 2017). The encounter survey (a component of the community themes and strengths assessment) highlighted financial burdens for families created by a complex health care system.

Based on the needs assessment and NSCH data, the state performance measure "percent of CSHCN enrolled in CSHCS that receive timely medical care and treatment without difficulty" was chosen to align with the identified priority needs. Some strategies to address this SPM include continued work to develop a benefit for children with medical complexity (CMC), implementation of a Peer Leadership Network to embed youth perspective in CSHCS, and completion of the "Expanding Equity in CSHCS" project to identify health care disparities.

CSHCS key partners include CSHCN and their families, Medicaid, Medicaid Health Plans, local health departments (LHDs), service providers, the CSHCS Advisory Committee, the Family Leadership Network, Michigan Family to Family Health Information Center, and Michigan Family Voices.

Objective A: By 2025, increase the percentage of CSHCS CAHPS' respondents who rate their health care with a top box score of 9 or 10 from 71.9% (2019) to 75%.

The first strategy for this objective is to continue offering special programs to reduce financial burdens for CSHCS-

eligible families. Through the Insurance Premium Payment Benefit program, CSHCS can pay for all or part of the beneficiary's private health insurance premiums when families demonstrate financial need, and it is cost effective for CSHCS.

Transportation continues to be a challenge for families and creates barriers to accessing care. CSHCS will continue to provide the transportation benefit, which provides reimbursement for mileage, lodging, and vendor provided transportation. The treatment requiring transportation must be related to the qualifying medical condition and be provided by a CSHCS-approved provider. In FY 2024, CSHCS will implement a monitoring program to assist in auditing the transportation benefit and improve CSHCS's ability to identify expenditures that require verification.

The Children with Special Needs Fund (CSN Fund) is a privately funded program within CSHCS. The CSN Fund was created to help CSHCN when other funding sources are not available. CSHCS promotes the CSN Fund through LHDs, Family Center networks, and other stakeholders. The CSN Fund can assist children across Michigan in obtaining necessary equipment and home modifications that they need but could not otherwise afford.

The second strategy is to expand the capacity of specialty clinics to ensure delivery of medical care through Children's Multi-Disciplinary Specialty (CMDS) clinics. Efforts in FY 2024 will continue to focus on recruiting additional clinics in the specialties of pulmonology (asthma) and hematology/oncology (sickle cell disease). In FY 2024 CSHCS will work with Medicaid colleagues to explore the addition of CMDS services into the Michigan Medicaid State Plan, thereby allowing the cost of these Title V services to be shared with Medicaid. This process will include a review of reimbursement levels to ensure they are adequate to incentivize multi-disciplinary care for CYSHCN.

The third strategy is to continue expansion of telemedicine through the HRSA-funded Children and Youth with Epilepsy (CYE) grant. The CYE project aims to increase access to care for CYE by 25%. Progress will be measured by the number of clinics conducting, billing, and receiving reimbursement for telemedicine visits. Additionally, the project will document the number of clinic sites suggesting telehealth tools and the number of CYE or their parents who utilize telehealth tools. The project will support expansion of telemedicine visits offered through participating clinic sites and adoption of telehealth strategies for patient education and clinic support. The Family Center Youth Consultant will review material, provide presentations when appropriate, and guide adolescent outreach to improve effectiveness.

Objective B: By 2025, increase by 10% the number of meaningfully engaged community partners (families, youth, LHDs, CAC members, contractors, clinic sites, health care providers, other professionals, etc.) who improve knowledge of the CSHCS program.

The first strategy is to continue building a coordinated and systematic approach to family engagement. This will be accomplished through the work of the Family Center. The Family Center Youth Consultant will also help to maximize outreach to adolescents and provide a valuable youth perspective. In FY 2024, the Family Center will continue to provide the following programs to support, inform, and engage youth and families:

- Family Phone Line: This hotline provides a place for parents to call for assistance navigating their child's health care.
- Family Leadership Network: Collaboration with Michigan Family to Family Information Center to obtain diverse perspectives from families.
- Professional and Parent Connect calls: Virtual opportunities for professionals and parents to discuss important topics regarding healthcare and CYSHCN.
- Parent Mentor program: A program to connect parents with other parents of children with a similar condition

or diagnosis as their child.

- Camp and Conference Scholarships: Scholarships that alleviate the financial burden for CYSHCN attending summer camps or CYSHCN and their families attending conferences to gain information and learn to advocate for themselves.
- LHD Grants to implement family-centered support/educational groups for families of CSHCN: This is a small grant program of up to $5,000 per LHD to increase family support, knowledge, and advocacy skills through implementation of family-centered support or educational groups.
- Free online training courses: On-demand webinars cover topics such as Introduction to CSHCS, Transition to Adult Health Care, and Parent Mentor Training.
- Sibshop grants and facilitator trainings: These grants provide opportunities for siblings of CYSHCN to obtain peer support and education. The Family Center also offers trainings for Sibshop facilitators.

In FY 2024, The Family Center will launch a new initiative to establish a Peer Leadership Network. The goal of the Peer Leadership Network will be to bring together young adults ages 18 to 26 to advise on activities, programs, policies, and resources impacting the health, wellness, and transition of youth across Michigan. In FY 2024, the Family Center will begin recruiting with the goal of identifying two representatives from each of the ten Michigan prosperity regions. Representatives will have personal experience with a disability or diagnosis. The Peer Leadership Network will provide leadership opportunities for youth, create a community for connection among youth, and infuse youth perspective into the CSHCS program.

The second strategy for this objective is to continue implementation of a multi-staged approach to improve provider engagement. During implementation, CSHCS and the Michigan State University Institute for Health Policy (MSU-IHP) facilitated key informant meetings with executive leadership at three children's hospitals and implemented an electronic satisfaction survey. This information was gathered and analyzed. In response to findings, CSHCS Pediatric Medical Consultants followed up with specific providers to responde to their feedback. CSHCS issued information briefs on identified areas of interest and reached out to schedule trainings with requesting provider organizations. In FY 2024, leadership will adjust the process based on lessons learned and determine a cycle for repeating these activities to ensure continued, consistent feedback from and engagement with providers.

The final strategy is to maintain a competent workforce that is knowledgeable about CSHCS and able to assist families accessing services. MDHHS will continue to contract with MSU-IHP for an amount not to exceed $25,000 to design and offer regional training opportunities to LHDs and MHPs. In FY 2024, a mix of statewide and regional trainings will be provided to meet the needs of LHDs and MHPs. CSHCS leadership regularly attends various MHP meetings to share updates on CSHCS initiatives such as eligibility expansion to include adults with sickle cell disease and transition to adult health care.

Objective C: By 2025, improve the percentage of CSHCN who report receiving care in a well-functioning system from 17.8% to 20.3%.

The first strategy is to continue to explore, develop, and implement a statewide benefit to improve care for children with medical complexities (CMC). CSHCS has been assessing the current system of care for CMC and identifying opportunities to improve this system through a targeted case management approach. In FY 2024, CSHCS will partner with MSU-IHP to engage health system stakeholders in the process of developing a CMC benefit. Activities will focus on key areas of the CMC program including enrollment, quality improvement strategies, provider readiness and capacity, and reimbursement methodology. In addition to stakeholder engagement, several key decision areas such as payment methodology; payment rates; provider and beneficiary enrollment; and the roles of CMDS clinics, MHPs, and primary care providers will be explored in FY 2024.

In the Title V Needs Assessment, families of CYSHCN reported challenges accessing respite care. The current CSHCS respite benefit provides a maximum of 180 hours of respite care services per year for families caring for beneficiaries with complex health care needs that require skilled nursing services. Statewide provider shortages are compounded by challenges in identifying providers to work for limited hours. In FY 2024, CSHCS will continue exploring a policy change to support non-licensed providers, including family members or individuals trained by the family, to provide CSHCS respite. CSHCS will also explore increasing the number of available hours to 300 hours per year.

The second strategy is to complete a comprehensive evaluation plan to assess and then improve CSHCS's capacity and ability to provide effective, efficient, and high-quality services to clients. Utilizing the CDC's framework for program evaluation, CSHCS has engaged stakeholders, utilized logic models and causal loop diagrams to create a comprehensive program description, and developed evaluation questions. In FY 2024, the team will collect credible evidence and draw conclusions which will be cross referenced with stakeholder feedback. Benchmarks will be established, and a program dashboard will be created. The program evaluation will be shared with stakeholders and continually reviewed, updated, and implemented.

The third strategy is to continue to ensure CSHCS families are receiving care coordination in a high-quality, family-centered, and well-functioning system. This is accomplished through site reviews with CMDS clinics, focus studies and compliance reviews with MHPs, and accreditation of LHDs. CMDS clinics are visited on a four-year cycle and evaluated on staffing structure, documentation, multi-disciplinary approach, and family centeredness. CSHCS participates in annual focus studies with each MHP to assess the system of care for CYSHCN. Accreditation of LHDs occurs on a three-year cycle, with a team that consists of a parent/caregiver from the Family Center and CSHCS Division staff that evaluate the LHDs performance on a set of six minimum program requirements. The LHD requirements and associated indicators are reviewed and updated every three years.

The final strategy for this objective is to improve the system of care by identifying and responding to health inequities. In response to identified disparities in the population impacted by sickle cell disease, the Michigan legislature authorized an expansion of CSHCS eligibility to adults with sickle cell disease beginning in FY 2022. To reduce barriers to enrollment, CSHCS allowed for modified requirements for this population. CSHCS will consider medical reports from primary care, urgent care, and emergency room providers for an initial two-year CSHCS enrollment. The expectation is that individuals will establish treatment with a specialist for ongoing monitoring of their sickle cell disease during this two-year enrollment period. In FY 2024, CSHCS will continue outreach to adults with sickle cell disease in Michigan. In addition, CSHCS will establish metrics to monitor compliance of individuals establishing care with a specialist provider. Other metrics will also be utilized to monitor the effectiveness of the eligibility expansion including a comparison of hospitalization expenses, emergency room utilization, and hospitalization encounters.

As part of this final strategy, CSHCS will continue the "Expanding Equity in CSHCS" project that was launched in FY 2022. The goal of this project is to support MDHHS in eliminating racial and ethnic disparities in healthcare. The project will create a valid/reliable system to quantify and monitor racial/ethnic disparities and identify gaps in care experienced by CSHCS clients, initially focusing on clients in MHPs. In partnership with the Medicaid Managed Care Plan Division and MHPs, health plan financial performance incentives will be utilized to incentivize MHP behavior to address the disparities identified through the project. In addition, enhanced MHP contract expectations will be developed to address these disparities.

Cross-Cutting/Systems Building

State Performance Measures

SPM 6 - Support access to developmental, behavioral, and mental health services through Title V activities and funding

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			Yes	Yes
Annual Indicator			Yes	Yes
Numerator				
Denominator				
Data Source			State Title V and MCH Programs	State Title V and MCH Programs
Data Source Year			FY2021	FY2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	Yes	Yes	Yes

State Action Plan Table

State Action Plan Table (Michigan) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems
SPM
SPM 6 - Support access to developmental, behavioral, and mental health services through Title V activities and funding
Objectives
A) Support the work of local health departments in addressing developmental, behavioral, and mental health needs in their jurisdictions through 2025
B) Support the work of Regional Perinatal Quality Collaboratives in addressing behavioral and mental health in their respective Prosperity Region through 2025
C) Support increased collaboration and engagement between Title V and behavioral health partners
D) Support students' mental health and wellness through implementation of Handle with Care (HWC)
Strategies
A1) Provide Title V funding to local health departments to address developmental, behavioral, and mental health needs
B1) Provide resources to Regional Perinatal Quality Collaboratives to implement and expand use of universal perinatal screening at prenatal care clinics within their respective regions B2) Provide resources and support to Regional Perinatal Quality Collaboratives to address behavioral and mental health needs
C1) Ensure the challenges of CYSHCN and their families are reflected in the discussions and decisions related to the MDHHS behavioral health restructuring C2) Continue providing CSHCS, Family Center and CSN Fund educational sessions at conferences for the community mental health workforce C3) Evaluate opportunities for integrated care models in CSHCS
D1) Enhance and expand an online system to track HWC notices D2) Monitor HWC notices among counties participating in the initiative D3) Provide training and onboarding support to new schools and counties to assist in expanding HWC

Cross-Cutting Overview

Public health can play a key role in mental health promotion and providing linkages to systems of intervention and treatment. Recognizing that physical and mental health are closely related at the individual and population levels, Michigan is working toward integration of these systems. An issue brief from the Kellogg Family Foundation (February 2021) entitled "The Implications of COVID-19 for Mental Health and Substance Use" indicated that the mental health of women with children and people of color were disproportionately impacted during the pandemic. The COVID-19 pandemic has impacted mental health across population domains and has underscored the need to create mental and behavioral health systems that are accessible and meet the needs of all Michiganders.

In March 2022, MDHHS announced a restructuring to ensure that services are supported across community-based, residential, and school locations. The changes make addressing the needs of children and families a priority, while benefitting people of all ages. As part of the restructuring, the MDHHS Health and Aging Services Administration was renamed to the Behavioral and Physical Health and Aging Services Administration (BPHASA). This administration, in addition to current responsibilities administering Medicaid and services for aging adults, now oversees community-based services for adults with intellectual and developmental disabilities, serious mental illness, and substance use disorders. The Substance Use, Gambling and Epidemiology Section within the Bureau of Specialty Behavioral Health Services in BPHASA is responsible for clinical services within the Substance Use Disorder Treatment System. Services include those specifically for women, adolescents, and young adults.

The restructuring also created the Bureau of Children's Coordinated Health Policy and Supports to improve and build upon the coordination and oversight of children's behavioral health services and policies. The Bureau of Children's Coordinated Health Policy and Supports will manage the implementation of the Infant Mental Health program, a home visiting model that is a needs-driven, relationship-focused intervention for perinatal women, infants, and toddlers and coordinates with public health home visiting programs. MDHHS and the Michigan Department of Education have partnerships related to early childhood mental health, adolescent/school mental health, and Infant and Early Childhood Mental Health Consultation (IECMHC) in childcare.

Intensive Crisis Stabilization Services (ICSS) for Children is a current Medicaid service in the Medicaid Provider Manual. MDHHS identified ICSS for Children as a key service in the MI Kids Now Service Array, and MDHHS will work towards expanding and ensuring access to this service on a statewide basis. MDHHS established a new grant program to provide funds to each Community Mental Health Service Program (CMHSP) to expand ICSS for Children to address crisis situations for young people. MDHHS awarded grants to 18 CMHSPs and will provide ongoing funding opportunities in FY 2024 and FY 2025. MDHHS also established a learning community to support grantees in implementation and to encourage peer-to-peer sharing of best practices. This program will allow CMHSPs to test different models (e.g., rural service delivery, 24/7 coverage, collaboration with other child-serving systems, etc.) using state general funds, and the "lessons learned" will be integrated into Medicaid policy as permissible under federal law and regulations.

In addition, MDHHS is supporting the development of Certified Community Behavioral Health Clinics (CCBHCs) in several locations. The CCBHCs will provide integrated services with an array of mental health services across ages (adults and children) regardless of ability to pay or type of insurance. These changes are intended to streamline and coordinate resources and improve policies and processes.

As described above, the MDHHS infrastructure and core funding mechanisms for behavioral health are primarily located outside of the Title V program. However, many Title V and MCH program areas coordinate and intersect with behavioral health initiatives. Additionally, the Title V 2020 needs assessment identified gaps in behavioral health

services across MCH population domains. To be responsive to the findings and the needs of the MCH population, a new cross-cutting state performance measure (SPM 6) was created in 2020. The role of Title V in addressing behavioral health needs across population domains is discussed in the SPM 6 state action plan. The Title V plan focuses on providing local health departments with funding to implement a range of behavioral health supports for women, children, and adolescents in their jurisdictions; supporting the work of Regional Perinatal Quality Collaboratives in addressing behavioral and mental health in their respective Prosperity Region; strengthening collaboration and engagement between Title V and behavioral health partners for children with special health care needs; and supporting children's health through the trauma-informed Handle with Care initiative.

Behavioral/Mental Health (FY 2022 Annual Report)

Through the 2020 Title V needs assessment, a new state priority need was identified to "Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems." To align with this priority need, a new SPM was created for the 2021-2025 cycle to "Support access to developmental, behavioral, and mental health services through Title V activities and funding." The annual objective in this state action plan signifies the ongoing commitment to mental and behavioral health initiatives within Title V systems work and community-based work that is funded by Title V. The annual yes/no objective was chosen to capture and reflect, in one state action plan, the array of work across Title V programs, population domains, and local initiatives. This approach (i.e., the use of a yes/no objective) is an option in the Title V Information System (TVIS) and is used by other states for cross-domain or systems-focused SPMs.

In FY 2022, this SPM and the objectives in the state action plan focused on work across population domains that was directly supported or funded by Title V: the work of local health departments (LHDs) in addressing behavioral and mental health needs in their communities; the efforts of Regional Perinatal Quality Collaboratives (RPQCs) in addressing behavioral and mental health; and increased engagement between Children's Special Health Care Services (CSHCS) and behavioral health partners. A new objective for Handle with Care was added in FY 2022.

The COVID-19 pandemic continued to impact this SPM in FY 2022. For example, LHDs were still involved in COVID-19 response and vaccination efforts, which impacted their capacity for other work including MCH. Despite the continued pandemic challenges, efforts to expand behavioral and mental health services in Michigan achieved some progress and success. For example, RPQCs continued to support expansion of the universal screening tool and Pregnancy Checkup app in prenatal clinics throughout the state. The High Touch, High Tech (HT2) team at Michigan State University (MSU) made enhancements to the app, including a new narrating avatar and a public-facing feature to make the app accessible to more individuals. Strong partnerships and commitment to the work, as discussed below, continue to be key drivers in these efforts.

Objective A: Support the work of local health departments in addressing developmental, behavioral, and mental health needs in their jurisdictions through 2025.

This objective helps to illustrate how behavioral/mental health is being addressed at the local level with the support of Title V funding. Of the 45 local health departments (LHDs) in Michigan, six LHDs addressed some aspect of mental health as a performance measure in their FY 2022 annual plans through the Local Maternal Child Health (LMCH) Program. Every LHD completes an annual LMCH plan which gives an overview of the jurisdiction; an MCH Needs Assessment update; description of the involvement of families, consumers and stakeholders in ongoing needs assessment activities; and a work plan detailing objectives, activities and deliverables for each selected performance measure. Of the six LHDs in FY 2022 selecting the behavioral/mental health performance measure, work plan activities completed and reported in the agencies' LMCH Year-End Report included: mental health

education to school youth through virtual and face-to-face presentations and to women, pregnant women and adolescents during home visits; staff attendance at suicide prevention, perinatal mood disorder and mental health workgroups, mental health trainings for staff and the community; gap-filling depression screening/referrals; and suicide risk assessment. Agencies provided community educational resources through social media on behavioral/mental health. In total, these LHDs served 3,878 individuals (women, pregnant women, children 1-21 and others) and expended $180,222 in LMCH funds. Notably, since Title V funding is often used as a gap-filling funding source by LHDs, if an LHD does not choose a behavioral health measure for their Title V work plan it does not mean they are not doing meaningful work on this issue in their community.

The COVID-19 pandemic impacted LHDs' ability to deliver services in FY 2022. Progress toward anticipated goals was halted as staff were needed for pandemic response activities; some clinics were closed for all or part of FY 2022. For school-based activities, educational presentations were delivered virtually until COVID conditions improved and an in-person format could be resumed at the end of the school year. Within LHDs, secondary trauma and staff burnout have impacted mental health. Staff turnover has been high, including among LHD leadership, with at least 16 new Health Officers appointed since March 2020. Hiring new staff has also been challenging and has halted or delayed planned activities. An unanticipated consequence of the pandemic was the increase in youth mental health needs.

In FY 2022, the LMCH program planned to provide support, guidance, and technical assistance to health departments. As part of this plan, LMCH created an "Evidence-Based Strategies by Performance Measures for Local MCH" document to provide guidance and technical assistance to LHDs as they created their action plans. The LMCH action plan contains a column to identify evidence-base/informed strategies. The document provides some potential evidence-based/informed or promising practice strategies that may be used in action plans, including SPM 6. As discussed, the pandemic stretched resources at local health departments, and agencies were overwhelmed with COVID-19 response activities. The MDHHS LMCH team provided support when able and avoided inundating agencies with requests that may have further overburdened LHDs during the pandemic. As planned, the LMCH program tracked count/expenditures for Title V spending on behavioral and mental health activities.

Objective B: Support the work of Regional Perinatal Quality Collaboratives in addressing behavioral and mental health in their respective Prosperity Region through 2025.

Behavioral and mental health outcomes continue to impact Michigan's maternal and infant populations. In 2021, 10.6% of birthing individuals in Michigan with a live birth indicated they smoked while pregnant; in 2020, the most recent year available, the Neonatal Abstinence Syndrome (NAS) rate in Michigan was 624.1 per 100,000 live births with individual regions ranging from 2,691.8 per 100,000 live births to 292.8 per 100,000 live births; and in the years 2014-2018, 36.1% of pregnancy-associated, not related deaths were attributed to accidental poisoning/drug overdose and 4.5% were attributed to suicide.[1]

Michigan supports the Regional Perinatal Quality Collaboratives (RPQCs) through direct consultation; overall leadership of the Michigan Perinatal Quality Collaborative by a designated coordinator; and financial support through Title V federal funds, which serve as gap-filling funds for the RPQCs. In FY 2022, three RPQCs and the High Touch High Tech (HT2) team supported the expansion and ongoing implementation of a universal electronic behavioral and mental health screening tool and app in 13 prenatal care clinics and three family planning sites. Overall management is through Michigan State University (MSU) and supported through State Opioid Response funds. The app, called the Pregnancy Checkup app (previously known as the Mom's Checkup app), utilizes evidence-based Screening, Brief Intervention and Referral to Treatment (SBIRT), as well as evidence-based screening tools for depression and trauma. Specific screening tools are based on clinic preference. The app offers patients the opportunity to share their screening results with their provider. If the patient agrees, results are sent via encrypted email to the clinic. This

allows providers/clinics to make further referrals to treatment and resources. If patients decide not to share their screening results, they still can receive a brief intervention, which is consistent with best practice recommendations. Approximately 90% of patients agree to share their screening results.

Access to the Pregnancy Checkup app through personal devices continues to be an efficient option for clinics, especially as some clinics have adapted to shorter times spent in waiting rooms. The link and QR access code were created in response to restrictions put in place during the COVID-19 pandemic in which patients were waiting in their vehicles prior to their appointment. Clinics continue to utilize the QR code and link to the app as an option for patients as they streamline the check-in process upon arrival for appointments. At the conclusion of every screening session, patients are asked to complete an evaluation, providing an opportunity for feedback on the screening tool and app. Patients consistently rate the app 'easy to use' and are satisfied with the methodology used.

Continued funding allowed the MSU team to expand implementation of the Pregnancy Checkup app and universal screening tool, provide continued support to clinics after initial implementation, and build enhancements to the app. At the end of FY 2022, 16 clinics were utilizing the Pregnancy Checkup app, with additional clinics having expressed interest. Implementation of these additional clinics will be pursued in FY 2023. Based on feedback received in FY 2022, the team worked to create an avatar for the app that would resonate with a broad audience. While the previous avatar, a parrot, was appealing, individuals shared they would like the option for a human avatar to lead them through the app. The new avatar was created so that individuals of any race, ethnicity or gender could associate with it. The team also worked to create a chat feature in the app that could be staffed by a community health worker, social worker, etc. who would link patients to resources in real-time. Planning also began for a public facing feature of the app. This feature would make the app accessible to patients not currently linked to a prenatal care clinic or for patients of a clinic that is not currently utilizing the Pregnancy Checkup app. The intention is that these patients could complete the screening tool, receive a brief intervention, and be linked to resources. As mentioned, this is still in the planning stages and will be more fully developed in FY 2023.

Prenatal clinics from a large health system in a fourth RPQC region have also implemented universal behavioral and mental health screening but are utilizing a different evidence-based screening tool. The HT2 team has met with representatives from this health system and is hopeful that as the use of the Pregnancy Checkup app expands into this region, the health system utilizing the previously mentioned screening tool will transition to the electronic universal screening program on the app.

In collaboration with the implementation of the Pregnancy Checkup app universal screening tool, one RPQC contracted with an outside vendor to provide tele-behavioral and mental health services to patients who are unable to utilize local resources, or who live in areas without resources nearby. Other prenatal care clinics utilizing the Pregnancy Checkup app continue to evaluate the resources available in their respective regions and will connect patients to telehealth services as available and appropriate.

The Michigan Child Collaborative Care (MC3) is a virtually based program that provides psychiatry support to primary and prenatal care providers in Michigan who are managing patients with behavioral and mental health concerns. Through the Governor's Healthy Moms, Healthy Babies initiative, MC3 has expanded engagement of perinatal providers in the program, as well as offers short-term remote consultation and care coordination between patients and remote behavioral health consultants. In FY 2022, 213 perinatal providers enrolled in the program, and since late FY 2021, 262 patients have been referred for consultation, of which 90% became in engaged in the program and 73% enrolled. MDHHS and the RPQCs support MC3 through sharing program information, hosting program presentations and promoting informational MC3 webinar opportunities.

As a result of the COVID-19 pandemic, many in-person childbirth education and breastfeeding classes were canceled. Many pregnant and postpartum people were left without options for education and support. The Region 8

PQC (Southwest Michigan) recognized this need and began offering virtual childbirth and breastfeeding education and support classes for pregnant and postpartum individuals and families in this region. The feedback received was positive and many individuals indicated that these classes were either their only option for education based on their geographic location, or the classes were convenient since they didn't have to arrange for transportation or childcare. The Region 8 PQC has continued to offer and support these courses in FY 2022 based on the feedback received from the community. In FY 2022, 10 childbirth series (three classes per series) and 22 breastfeeding education and support sessions were held. These courses provide opportunities for participants to review pregnancy and childbirth education, ask questions of the course instructor, and connect with other pregnant and postpartum people in their cohort.

Objective C: Support increased collaboration and engagement between Title V and behavioral health partners.

In FY 2022, MDHHS restructured how behavioral health services are delivered across community-based, residential, and school locations, as well as other settings. This included the creation of the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) to improve the coordination and oversight of children's behavioral health services and policies. BCCHPS will emphasize the critical importance of including families in addressing the health needs of children. In addition, the Bureau will work with other MDHHS administrations to address children's behavioral health crises and expand dedicated partnerships. CSHCS and BCCHPS leadership meet monthly to discuss barriers to behavioral health care for CYSHCN and best practices for collaboration.

CSHCS continues to facilitate the Children's Special Health Care Services, Behavioral Health and Intellectual and Developmental Disabilities Collaborative. The goal of the collaborative is to identify opportunities and implement activities to better support families with children who are receiving services through both CSHCS and the community mental health system. Due to COVID-19 and the behavioral health redesign, activities of the collaborative were on hold for FY 2022.

CSHCS and the Michigan Developmental Disabilities Council continued their strong partnership in FY 2022. CSHCS Division Director continues to serve by gubernatorial appointment on the Michigan Developmental Disabilities Council (DD Council), representing Title V. This provides an opportunity for the CYSHCN Director to ensure the DD Council focus includes children and adults with special health care needs. In addition, the CYSHCN Director can establish and maintain relationships with many organizations, as well as family and self-advocates who support Michigan residents with a developmental and/or intellectual disability. The CSHCS Policy Specialist continues to represent CYSHCN on the DD Council Policy workgroup. In FY 2022, CSHCS partnered with the DD Council and BCCHPS to create plans for a video series to help families of CYSHCN navigate systems more effectively and provide education to local behavioral and developmental service providers. Work will continue for this strategy in FY 2023.

Objective D: Support students' mental health and wellness through implementation of Handle with Care (HWC).

Handle With Care (HWC) programs promote safe and supportive homes, schools and communities that protect children, and help traumatized children heal and thrive. HWC first came to Michigan in 2014 with the establishment of a HWC program in Jackson County, Michigan. Since that time, 49 communities have taken on this work at the local level with more expressing interest each year. Due to this rapid program expansion, MDHHS was approached by local HWC implementors seeking statewide infrastructure and staffing support for this initiative. The Division of Child and Adolescent Health (DCAH) took on this role in 2019 using existing staff support. Since that time, a state-level advisory committee was formed, a state website created, and a formal implementors guide and training approach

developed. Through feedback on the HWC Advisory, a need was expressed by local communities for a statewide online application that would streamline the submission of HWC notices from Law Enforcement Agencies and the receipt of notices from designated HWC school personnel. Thanks to the support of the Title V MCH Block Grant, funding was designated for the development of this online portal in 2021 and 2022.

Planning for this process began in the Spring of 2021 with assistance and support from colleagues at the Department of Technology, Management and Budget (DTMB) who solicited bids from AI design firms. After reviewing the bids, the HWC state team opted to use Blue Vector Consulting to design and build the HWC portal. This began an ongoing weekly meeting with Blue Vector, DTMB and HWC state staff for a 9-month period in which the system was designed, built, and tested. The online portal also had to undergo a lengthy internal testing process to validate its use and compatibility with the state's overall system and security standards. The HWC online application received final approval to "go live" in the Spring of 2022 which led to the final stage of development, a pilot process. Two HWC communities agreed to be trained on the new online system and pilot it over a 3-month period. Due to timing of the school calendar, the official pilot did not begin until September 2022. Since that time, 114 HWC notices have been submitted by Law Enforcement Agencies to schools in both Jackson and Eaton Counties which involved a total of 185 students. A total of 125 schools and 11 law enforcement agencies are currently utilizing the system. Bi-monthly calls with the pilot communities have also been convened during the pilot process to receive real time feedback on the application. In FY 2022-2023, the team will move from the pilot to broader onboarding of additional communities.

[1] Source: Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services

Cross-Cutting/Systems Building - Application Year

Behavioral/Mental Health (FY 2024 Application)

The findings from the Title V needs assessment led to a new state priority need in 2020 to "Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems." While work that aligns with this priority is evident within other state action plans, a new SPM was also created for the 2021-2025 cycle to "Support access to developmental, behavioral, and mental health services through Title V activities and funding."

Creation of this new SPM was intended to better capture existing and new work across population domains related to behavioral and mental health and to identify opportunities for expanded work in the future. For the state action plan, the Title V program initially focused on three specific areas that are either directly supported or funded by Title V: 1) the work of local health departments in addressing developmental, behavioral, and mental health needs through Title V funding; 2) the work of Regional Perinatal Quality Collaboratives in addressing behavioral and mental health; and 3) increased engagement between the Title V CSHCN program and behavioral health partners. In FY 2022, a fourth objective was added for the Handle with Care (HWC) initiative. HWC focuses on students' mental health and well-being and is supported by Title V funding.

The annual objective in this state action plan signifies the ongoing commitment to mental and behavioral health initiatives within Title V systems work and community-based work that is funded by Title V. The annual yes/no objective was chosen to capture and reflect, in one state action plan, the array of work across Title V programs, population domains, and local initiatives. This approach (i.e., the use of a yes/no objective) is an option in the Title V Information System (TVIS) and is used by other states that created cross-domain or systems-focused SPMs (e.g., utilization of an MCH database, development of a social marketing/awareness campaign, advancing racial equity in the MCH workforce). Michigan's SPM 6 state action plan is not an exhaustive reflection of efforts to better integrate or expand mental and behavioral health access or services. Other MCH initiatives and partnerships are underway but are not discussed in this state action plan, as the intent is to capture cross-domain work related to Title V activities and/or funding.

Objective A: Support the work of local health departments in addressing developmental, behavioral, and mental health needs in their jurisdictions through 2025.

Mental health was a strategic priority identified by approximately one-third (12) of Michigan's local health departments (LHDs) in the 2017 Local Maternal Child Health (LMCH) needs assessment. Mental health challenges continue to impact women, children and families across the lifespan. One in seven women will experience a Perinatal Mood and Anxiety Disorder[1].Twenty percent of Michigan women experience depression before pregnancy, 18.9% of women experience depression during pregnancy, and 16.1% experience depression following pregnancy[2]. The COVID-19 pandemic exacerbated stressors that many women and families faced prior to the pandemic. It also led to new stressors such as social isolation, job loss, housing insecurity, and poverty. Therefore, supporting behavioral health work within local health departments remains critical in FY 2024.

The CDC Youth Risk Behavior Survey Data Summary & Trends Report[3] includes the first data collected since the start of the COVID-19 pandemic. As seen in the decade before the COVID-19 pandemic, mental health among students overall continues to worsen. Findings indicate that more than 40% of high school youth felt so sad or hopeless that they could not engage in their regular activities for at least two weeks during the previous year.

There were significant increases in the percentage of youth who considered suicide, made a suicide plan, and attempted suicide. The data also reflect stark disparities in outcomes for female and LGBTQ+ students. Some

providers are noting dramatic increases in depression and anxiety among patients, including at younger ages. Additionally, mental health service needs in Michigan outweigh the number of providers available, especially in rural areas, leading to long wait times for treatment.

Simultaneously, the LHD workforce is experiencing high levels of stress as many public health employees have faced harassment and pushback regarding pandemic mitigation efforts such as masking, social distancing, and vaccination. LHDs have noted an unprecedented rate of staff turnover and multiple staff vacancies.

The objective in this FY 2024 state action plan helps to illustrate how behavioral/mental health needs are being addressed through the Local Maternal Child Health (LMCH) program which provides Title V funding to all 45 of Michigan's local health departments. Each health department has the flexibility to use Title V funds to align with their local MCH strategic priorities. Some LHDs work on mental/behavioral health with Title V funds; other LHDs may work on mental/behavioral health with other funds or in broader MCH program areas and therefore their activities may not be captured in their Title V LMCH workplans.

Many LHDs report having a long and rich history of being active partners with established community groups, advisory boards, collaboratives, and coalitions such as Community Mental Health, Child Abuse and Neglect Prevention Councils, child advocacy, school nurses, county courts, and law enforcement. LHDs describe receiving family feedback on services through paper and telephone surveys. LHDs value and elevate parent and adolescent voices by recruiting and promoting consumer involvement in decision making on collaboratives, councils, and advisory boards.

Seven LHDs are addressing some aspect of mental health as a performance measure in their current annual LMCH plans such as depression, adverse childhood experiences and suicide prevention within the women/maternal health and adolescent health domains. For example, SPM 6 was utilized in the women/maternal health domain by two LHDs that used LMCH funds to provide gap-filling universal stress/depression screening for pregnant and postpartum home visiting clients using the Edinburgh Postpartum Depression Scale and abbreviated Perceived Stress Scale. The LHDs educated pregnant/postpartum clients on stress, depression prevention and management, and created treatment goals with clients during case management. Women who scored as high risk for depression were referred for mental health treatment. The COVID-19 pandemic continued to impact access due to closures and fear related to meeting in person. Within the LMCH plans, outcome measurements include the number of women screened for depression, the number of women receiving case management for depression, and the number of referrals for treatment.

An example of SPM 6 in the adolescent health domain is a LHD that provides education to middle and high school students on mental health topics such as stress management, depression, body image, and substance use during health education classes. Another LHD teaches suicide prevention gatekeeping training to students. One LHD describes having high school students and a teacher on their reproductive health advisory board, and the health educator uses age-appropriate health education strategies. This LHD measures the number of adolescents who receive the education and knowledge gained through pre/post-test evaluations. Other LHDs conduct gap-filling depression and suicide risk assessments for adolescents.

State strategies to support LHD work on this measure in FY 2024 will include provision of guidance and technical assistance from the MDHHS LMCH consultant. To support the Title V pillars, LHDs will be encouraged to use a health equity lens in the formation of workplans and to involve families and clients as partners in their work. Sample LMCH workplans and webinars will be provided to LHDs to demonstrate inclusion, equity, and family engagement strategies. A specific workplan that integrates SPM 6 was created as part of a FY 2024 sample LMCH Plan.

The LMCH program will continue to track Title V spending on behavioral and mental health activities in FY 2024.

LMCH data gathered from this performance measure will provide a local perspective, which will be important for informing future Title V behavioral/mental health strategies and activities.

Objective B: Support the work of Regional Perinatal Quality Collaboratives in addressing behavioral and mental health in their respective Prosperity Region through 2025.

Behavioral and mental health has a significant impact on maternal and infant morbidity and mortality. Poor behavioral and mental health outcomes in Michigan, especially in pregnant people, are illustrated through several indicators. For example, in 2021, 10.6% of individuals in Michigan with a live birth indicated that they smoked while pregnant; in 2020, the Neonatal Abstinence Syndrome (NAS) rate for Michigan was 624.1 per 100,000 live births; and from 2015-2019, 37.9% of pregnancy associated injury deaths were attributed to accidental poisoning/drug overdose and 4.5% were attributed to suicide[4]. Furthermore, 68.5% of individuals with a live birth in 2020 stated they had experienced one or more life stressors (i.e., homelessness, close family member sick or died, loss of job, etc.) in the 12 months prior to delivery and 18% stated they had one or more unmet basic needs (i.e., skipped meals because there was not enough money for food; did not have safe housing; could not keep basic utilities on; etc.) during pregnancy.[5]

Michigan is working to address behavioral and mental health concerns through the work of the Regional Perinatal Quality Collaboratives (RPQCs). The aim of the RPQCs is to develop innovative strategies to regionally address the drivers of adverse birth outcomes. Several RPQCs have begun addressing perinatal substance use through implementation of universal prenatal screening, increasing treatment capacity in their respective region, supporting nonpharmacological treatment of infants born substance-exposed, and offering educational opportunities in unconscious bias and stigma reduction. Depending on the availability (or lack) of other funding sources, Title V funding is used as a gap-filling funding source for RPQCs. Title V MCH leadership is also closely involved in the work of RPQCs.

Strategies to achieve Objective B focus on providing resource supports to the RPQCs to implement and expand universal screening, as well as other services and resources to improve care and treatment of mental and behavioral health in pregnant people and their infants. Previous surveys of prenatal care clinics illustrated a lack of consistent or universal screening of patients for perinatal substance use and/or mental health conditions such as depression and anxiety. Universal screening of all pregnant people is the first step in addressing behavioral and mental health in this population, as well as the related stigma that surrounds these conditions in general. Subsequent linkage to behavioral and mental health professionals, treatment, and other supportive services is the essential next step for those identified through universal screening, or otherwise.

As of Spring 2023, five RPQCs have implemented prenatal screening at clinics that serve residents within their respective regions. West Michigan's major health system has built their preferred evidence-based screening tool into their electronic medical record. The screening tool is being utilized for both inpatient and outpatient care. Northern Lower Michigan, the Upper Peninsula, Saginaw/Bay area, and the Thumb area are working with clinics to implement an electronic screening tool that is based on evidence-based Screening, Brief Intervention and Referral to Treatment (SBIRT). Initial results have shown success in both patients completing the screening tool (upwards of 80-95% of patients) and in identifying pregnant people with behavioral and/or mental health concerns that might not otherwise have been assessed or addressed. Patients utilizing the screening tool have expressed their overall satisfaction and commented on the ease of use. Expansion of universal screening throughout the state is expected to continue in FY 2024.

Three RPQCs have implemented nonpharmacological care and rooming-in at birthing hospitals within their respective region for treatment of infants born substance-exposed. The programs encourage a family-centered

approach where infants remain with their birthing person in a quiet, calming environment in which breastfeeding, skin-to-skin and bonding techniques are encouraged instead of the infant immediately being admitted to the Neonatal Intensive Care Unit (NICU). The RPQCs continuously seek feedback from families that have utilized the program; one RPQC has an advisory team that includes families with infants born substance exposed. These families were vital in the design and implementation of the rooming-in program at the regional hospital. Families are linked to supportive services and resources prior to discharge from the hospital. It is expected that as the hospitals continue implementation and garner patient feedback, they will grow and expand their programs.

Stigma and bias can impede care and treatment for pregnant people with mental and behavioral health concerns, leading to adverse health outcomes. RPQCs will be encouraged to continue providing educational opportunities in bias, equity, and stigma reduction for Collaborative members, as well as prenatal care providers. These opportunities are intended to be arenas for personal growth to increase awareness and knowledge, while reinforcing the need to be conscious of personal biases to prevent them from affecting clinical judgement. Ideally, the opportunities will also stimulate the desire to create systemic and cultural change within the provider's facility, creating a safer and more inclusive space for prenatal, postpartum, and infant care.

Objective C: Support increased collaboration and engagement between Title V and behavioral health partners.

In FY 2022, MDHHS launched a behavioral health restructuring process to ensure services are provided across community-based, resident and school locations as well as other settings. Changes to this system of care will benefit people of all ages, with addressing the needs of children and their families as a top priority. These changes will streamline and coordinate resources and improve policies and processes to make them more effective.

The first strategy for this objective is to ensure the unique challenges of CYSHCN and their families are reflected in the decisions related to the behavioral health restructuring. This is accomplished through CSHCS participation on various workgroups and consistent meetings with leadership from the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS). The CSHCS Advisory Committee (CAC) receives regular updates on the restructuring project and has opportunities to provide feedback to the MDHHS behavioral health leadership team. The CSHCS leadership team meets monthly with BCCHP to discuss important topics that impact a shared population of children with behavioral health and special health care needs. In addition, CSHCS will re-envision a collaborative committee with key stakeholders, BCCHP, and community mental health providers. The committee will identify and explore solutions for challenges in accessing services by populations served by mental/behavioral health, intellectual and developmental disabilities (I/DD), and physical health systems.

The second strategy is to continue providing CSHCS, Family Center, and CSN Fund educational sessions at the Home and Community-Based Waiver Conference, the Michigan Council for Exceptional Children Conference, and Community Mental Health Association seasonal conference series. These educational sessions provide general information on the CSHCS program, describe how to access services, explain the relationship between CSHCS and the community mental health system of care, and introduce the Family Center. The CSN Fund presentation shares important information on how the CSN Fund helps families and the best way to approach the CSN Fund for support.

The final strategy for this objective is for CSHCS to evaluate opportunities to better address the needs of CSHCS clients who are at higher risk for developmental delays due to their CSHCS-qualifying medical condition. The CSHCS program is intended to cover acute/specialty care that is directly related to the CSHCS qualifying diagnosis. Since the program's inception, CSHCS has not covered mental health related care. Historically, neurodevelopmental testing and neuropsychiatric testing has been considered mental health related. In FY 2024, CSHCS will continue the

process of evaluating coverage of neurodevelopment assessments for infants with critical congenital heart disease (CCHD). CCHD refers to a group of infants with serious heart defects that are present at birth and are critical enough that heart surgery is required in their first year of life. Neurodevelopmental disorders are the most common, and potentially the most damaging, sequelae in children with CHD. The prevalence and severity of developmental delay increases with the complexity of CCHD and is associated with several genetic syndromes. CSHCS is evaluating the impact of an operational change to provide coverage for neurodevelopmental assessment for infants with CCHD.

Objective D: Support students' mental health and wellness through implementation of Handle with Care.

Handle with Care (HWC) is an initiative designed to promote communication between local law enforcement and schools. When law enforcement is on the scene of an incident that was experienced or witnessed by a school-aged child, they determine what school the child attends and a "Handle with Care" notice is sent to the child's school before the school bell rings the next day. School staff are encouraged to handle that child with care and look for potential signs that the trauma the child experienced is affecting his or her behavior in school.

The goal of HWC is to help students succeed in school. Regardless of the source of trauma, the common thread for effective intervention is the school. Research shows that trauma can undermine children's abilities to learn, form relationships, and function appropriately in the classroom. A national survey of the incidence and prevalence of children's exposure to violence and trauma revealed that 60% of American children have been exposed to violence, crime, or abuse; 38% were direct victims of two or more violent acts[6]. Prolonged exposure to violence and trauma can impact a child's ability to focus, behave appropriately, and learn in school. In turn, this can lead to school failure, truancy, suspension or expulsion, dropping out, or involvement in the juvenile justice system.

HWC promotes school-community partnerships to ensure that children who are exposed to trauma in their home, school, or community receive appropriate interventions to help them achieve academically despite experiences of trauma. HWC is a partnership between law enforcement, schools, and mental health providers, and connects students and families to mental health services. Schools that participate in HWC are encouraged to implement individual, classroom, and whole school trauma sensitive strategies so that traumatized children are "Handled with Care." If a child needs more intervention, on-site trauma-focused mental healthcare is available at the school, or a referral is made to a community provider.

Strategies to help achieve Objective D in FY 2024 include the enhancement, expansion and tracking of a centralized online notification system that streamlines and automates HWC notices from law enforcement to the appropriate school liaisons. In FY 2022, the system was developed and piloted in two counties with expansion planned for four additional sites in FY 2023. The overarching goal is to serve all 83 counties in the future. Prior to development of the online notification system, each site was tasked with manually creating, tracking, and responding to notifications. Local HWC partners expressed a need for a centralized system for reporting notices. Initial feedback from implementing counties has indicated that the notification system is simple to use, efficient and has streamlined communication for law enforcement to submit the HWC notice and for the local school entity to receive the information. The system also stores all data about notices sent for law enforcement and schools to access at any time and to provide reports and data to community partners.

Title V block grant dollars are being used to fund the expansion, maintenance, and enhancement costs associated with the online notification system. After the successful pilot, comprehensive training videos and user guides are available for each of the key roles utilizing the HWC notification system including Law Enforcement Administrators, Law Enforcement Officers, and School Administrators. Monthly check-in calls with system users in addition to collected data have been used to make quality improvements for system modifications, training, and to generate a list of future enhancements to consider. The system will assist in the expansion of the HWC program over time, as it

will decrease the amount of work needed when creating a HWC program in a new county by streamlining communication and creating efficiencies. It is anticipated that this notification system will be an incentive for additional counties to adopt the HWC program and allow for more widespread trauma-informed supports in Michigan's schools. Current plans are for the online system to be available in FY 2024 to all interested counties and to have the necessary supports to onboard them seamlessly.

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[1] Children's Hospital of Philadelphia. Perinatal or Postpartum Mood and Anxiety Disorders
[2] 2020 Birth Year: Michigan PRAMS Maternal and Infant Health Summary Tables
[3] Centers for Disease Control and Prevention. 2011-2021 Youth Risk Behavior Survey Data Summary & Trends Report
[4] Source: Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services
[5] 2020 Birth Year: Michigan PRAMS Maternal and Infant Health Summary Tables
[6] Finkelhor D, Turner H, Ormrod R, Hamby SL. Violence, abuse, and crime exposure in a national sample of children and youth. Pediatrics. 2009 Nov;124(5):1411-23. doi: 10.1542/peds.2009-0467. Epub 2009 Oct 5. PMID: 19805459.

III.F. Public Input

A draft of the Title V FY 2024 application/FY 2022 annual report will be posted on the Michigan Department of Health and Human Services (MDHHS) website for public review and comment. Public input will also be invited through notification to over 50 MCH and CSHCN advisory groups, community-based partners, nonprofit partners, advocacy groups, and other state programs. Notice will be sent to all 45 local health departments via the Local MCH program. Additionally, individuals who participated in the 2020 Needs Assessment Stakeholder Group and Population Domain Workgroups will receive notification of the posting. Public comments will then be presented to the Title V steering committee and relevant MCH program staff for review and consideration prior to submission of the final grant application.

After the application has been submitted, MDHHS will continue to work with entities representing advocates, advisory bodies, providers, 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 routinely works with parent consultants through the Family Center for Children and Youth with Special Needs (Family Center), the Family Leadership Network, and the CSHCS Advisory Committee (CAC). The Family Center provides information and support to families and input on CSHCS program operations. The Family Leadership Network provides a diverse community-based perspective on programs and policies as well as a platform for the development of new family leaders. The CAC is comprised of professionals and family members who are involved in the care for children with special needs. The CAC makes recommendations to the CSHCS Division on policy and promotes awareness to assure that services reflect the voices of individuals with special health care needs and their families.

Families and consumers are also represented in strategic planning initiatives aimed at improving maternal, infant, and child health outcomes. For example, to implement the state's *Mother Infant Health and Equity Improvement Plan* (MIHEIP), MDHHS partners with the Mother Infant Health and Equity Collaborative which consists of representatives from hospitals and local health departments, parents and community members, and partners from research institutions, professional associations, community organizations, state programs and nonprofit organizations. The current MIHEIP sunsets at the end of 2023. To obtain input from local communities and families on their experiences and priorities related to maternal and infant health, 12 in-person town hall meetings are planned in each region of the state in the spring of 2023. Regional Perinatal Quality Collaboratives will host the town halls in collaboration with the Division of Maternal and Infant Health. The feedback obtained via the town halls will inform the next iteration of the MIHEIP and provide an avenue for the voices of families and communities to help guide the work. Findings from the town halls will also be used to inform the next Title V needs assessment.

Families and consumers also serve on advisory committees for home visiting, oral health, infant safe sleep, Family Planning, Child and Adolescent Health Centers, Early Hearing Detection and Intervention, Teen Pregnancy Prevention Program local coalitions, Parent Leadership in State Government, and Fetal Alcohol Spectrum Disorder.

In addition to the annual public posting process, MDHHS completed a statewide five-year needs assessment in 2020 to identify the FY 2021-2025 state priority needs and performance measures for Title V. The Needs Assessment Planning Committee prioritized engaging a diverse group of stakeholders to assess both needs and system strengths and capacity. In total, the needs assessment engaged approximately 1,000 community members, providers, clients, and stakeholders to obtain their thoughts, opinions and perspectives on the health and wellbeing of women, mothers, infants, children, adolescents, and children with special health care needs. The System Capacity Assessment and the Forces of Change Assessment captured input and perspectives from the Stakeholder Group, which included more than 70 MCH stakeholders from across Michigan. Additionally, the three methods in the Community Themes and Strengths Assessment—a provider survey, an encounter survey, and focus groups/listening sessions—offered a variety of opportunities to capture rich qualitative information.

Twenty-two focus groups and listening sessions were completed with community members and stakeholders across the Title V population domains. A provider survey distributed to MCH providers received 526 responses, and an encounter survey distributed through Maternal Infant Health Programs and local health departments received 307 responses. The population domain workgroups, which reflected the population health domains, included state and local MCH staff, state and local MCH system partners, parents, parent consultants, consumers, and partners with expertise in health equity. Their input and experience shaped the issues and priority needs considered and included in Michigan’s application.

III.G. Technical Assistance

As Michigan's Title V program implements state action plans over the current five-year period, it will identify any areas of needed technical assistance. Based on Michigan's current priorities, these areas may include integration and implementation of health equity and family engagement strategies in Title V state action plans, as determined by MCH program areas; ongoing learning opportunities and technical assistance related to identification, refinement, and assessment of evidence-based or informed strategy measures; or sharing of best practices and other peer learning opportunities (e.g., between states or within regions).

As the Health Resources and Services Administration (HRSA) releases the next three-year Title V Guidance for the FY 2025-FY 2027 applications, Michigan's Title V program may seek out additional information and clarification on the contents and requirements of the new Guidance. The new Guidance will also outline expectations and requirements for the next five-year Title V statewide needs assessment. As needed, the Title V program may request additional information and assistance related to the five-year needs assessment process and requirements.

In addition to these potential areas of technical assistance, many training needs are met by professional development opportunities provided by HRSA and AMCHP throughout the year. These include the AMCHP Conference, HRSA learning labs, and regional meetings. For example, in 2023 staff from the Division of Maternal and Infant Health are participating in the Region V CityMatCH Alignment for Action Learning Collaborative "Culture of Equity" assessment. Training or technical assistance provided by HRSA and AMCHP, especially in relation to performance measures, the Title V Information System, and other Title V priorities or requirements, is shared with relevant MCH programs and staff throughout the year.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MichiganStatePlan - Title V Excerpt.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - Public Health Workforce and Broadband Access Lit Review TVIS.pdf

Supporting Document #02 - Title V NPM-SPM Chart FY2021-2025.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MIH-CAH-CSHCN Org Chart 3-20-23.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Michigan

	FY 24 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 19,132,100	
A. Preventive and Primary Care for Children	$ 6,226,800	(32.5%)
B. Children with Special Health Care Needs	$ 6,994,200	(36.5%)
C. Title V Administrative Costs	$ 570,600	(3%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 13,791,600	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 45,125,500	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 790,000	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 9,237,300	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 55,152,800	
A. Your State's FY 1989 Maintenance of Effort Amount $ 13,507,900		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 74,284,900	
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)	$ 398,990,439	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 473,275,339	

OTHER FEDERAL FUNDS	FY 24 Application Budgeted
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education Program	$ 1,796,700
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,453,700
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 200,000
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)	$ 551,500
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 13,010,900
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 160,161,900
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 7,483,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 235,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Epilepsy	$ 557,500
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 7,600,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 205,332,400
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Grants to States to Support Oral Health Workforce	$ 187,239

	FY 22 Annual Report Budgeted		FY 22 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 19,474,600 (FY 22 Federal Award: $ 19,132,104)		$ 17,579,527	
A. Preventive and Primary Care for Children	$ 6,381,400	(32.8%)	$ 5,872,592	(33.4%)
B. Children with Special Health Care Needs	$ 6,994,200	(35.9%)	$ 6,970,420	(39.6%)
C. Title V Administrative Costs	$ 597,100	(3.1%)	$ 547,147	(3.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 13,972,700		$ 13,390,159	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 51,089,300		$ 47,071,402	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 0		$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	$ 790,000		$ 726,486	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 7,897,800		$ 5,570,069	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 59,777,100		$ 53,367,957	
A. Your State's FY 1989 Maintenance of Effort Amount $ 13,507,900				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 79,251,700		$ 70,947,484	
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)	$ 365,627,200		$ 323,648,146	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 444,878,900		$ 394,595,630	

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 1,847,900	$ 1,920,492
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 1,568,500	$ 1,476,939
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Early Hearing Detection and Intervention (EHDI) State Programs	$ 160,000	$ 157,868
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,000	$ 152,902
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 200,000	$ 200,000
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)	$ 396,600	$ 473,371
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Vaccines For Children/Immunizations	$ 10,459,000	$ 9,552,250
Department of Health and Human Services (DHHS) > Centers for Medicare & Medicaid Services (CMS) > Title XIX -- Grants to States for Medical Assistance Programs	$ 176,519,100	$ 131,108,886
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Epilepsy	$ 416,000	$ 352,633
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 6,875,500	$ 7,469,304
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 100,000	$ 89,290
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 245,000	$ 301,743

OTHER FEDERAL FUNDS	FY 22 Annual Report Budgeted	FY 22 Annual Report Expended
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 7,600,000	$ 8,222,132
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 159,079,600	$ 162,170,336

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**1. FEDERAL ALLOCATION**
	Fiscal Year:	**2024**
	Column Name:	**Application Budgeted**
	Field Note: The FY 2024 application budgeted amount of $19,132,100 is based on the estimated FFY 2024 federal award amount. It does not include carryover dollars from FFY 2023 that will also be expended in FY 2024 (i.e., the second year of the FFY 2023 grant period, which is allowable per Title V legislation).	
2.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: The annual report expended amount of $17,579,527 reflects FFY 2022 Title V dollars spent in the state FY 2022 (October 1, 2021 - September 30, 2022). The full FFY 2022 grant amount will be fully expended in FY 2023, the second year of the two-year grant period, as allowable by Title V legislation. Per HRSA reporting instructions, Form 2, Line 1 does not include FFY 2021 carryover dollars spent in FY 2022 (i.e., spent in the second year of the FFY 2021 grant period). The original FY 2022 budget included carryover and therefore reflects a higher amount.	
3.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2022**
	Column Name:	**Annual Report Expended**
	Field Note: Newborn Screening earnings were less than originally projected.	

Data Alerts: None

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

State: Michigan

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 1,313,300	$ 1,260,916
2. Infants < 1 year	$ 1,306,000	$ 843,392
3. Children 1 through 21 Years	$ 6,226,800	$ 5,872,592
4. CSHCN	$ 6,994,200	$ 6,970,420
5. All Others	$ 2,721,200	$ 2,085,060
Federal Total of Individuals Served	$ 18,561,500	$ 17,032,380

IB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Pregnant Women	$ 2,376,700	$ 1,403,454
2. Infants < 1 year	$ 11,406,700	$ 7,907,553
3. Children 1 through 21 Years	$ 1,903,600	$ 2,042,750
4. CSHCN	$ 37,639,700	$ 40,209,678
5. All Others	$ 1,826,100	$ 1,804,522
Non-Federal Total of Individuals Served	$ 55,152,800	$ 53,367,957
Federal State MCH Block Grant Partnership Total	$ 73,714,300	$ 70,400,337

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

None

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services

State: Michigan

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 8,398,300	$ 8,396,203
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 180,500	$ 145,012
B. Preventive and Primary Care Services for Children	$ 3,589,700	$ 3,633,763
C. Services for CSHCN	$ 4,628,100	$ 4,617,428
2. Enabling Services	$ 7,358,458	$ 5,995,003
3. Public Health Services and Systems	$ 3,375,342	$ 3,188,321
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 4,686,474
Physician/Office Services		$ 1,780,271
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 265,071
Dental Care (Does Not Include Orthodontic Services)		$ 366,885
Durable Medical Equipment and Supplies		$ 179,909
Laboratory Services		$ 0
Other		
Special Projects, Local MCH and CSHCS Medical Care		$ 1,117,593
Direct Services Line 4 Expended Total		$ 8,396,203
Federal Total	$ 19,132,100	$ 17,579,527

IIB. Non-Federal MCH Block Grant	FY 24 Application Budgeted	FY 22 Annual Report Expended
1. Direct Services	$ 36,143,100	$ 38,208,706
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	$ 0	$ 0
B. Preventive and Primary Care Services for Children	$ 279,800	$ 279,800
C. Services for CSHCN	$ 35,863,300	$ 37,928,906
2. Enabling Services	$ 5,112,600	$ 5,651,850
3. Public Health Services and Systems	$ 13,897,100	$ 9,507,401
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		$ 27,333,475
Physician/Office Services		$ 2,043,248
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 5,343,516
Dental Care (Does Not Include Orthodontic Services)		$ 85,767
Durable Medical Equipment and Supplies		$ 3,200,629
Laboratory Services		$ 0
Other		
Medical Care and Treatment		$ 202,071
Direct Services Line 4 Expended Total		$ 38,208,706
Non-Federal Total	$ 55,152,800	$ 53,367,957

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

None

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated

State: Michigan

Total Births by Occurrence: 101,322 **Data Source Year: 2022**

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	100,155 (98.8%)	2,912	322	322 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methyglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Guanidinoacetate Methyltransferase (GAMT) Deficiency	Hearing Loss
Holocarboxylase Synthase Deficiency	Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-Coa Dehydrogenase Deficiency	Maple Syrup Urine Disease
Medium-Chain Acyl-Coa Dehydrogenase Deficiency	Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-Coa Mutase)	Mucopolysaccharidosis Type I (MPS I)	Primary Congenital Hypothyroidism
Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences
Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1	ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency
X-Linked Adrenoleukodystrophy				

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Early Hearing Detection and Intervention (EHDI) Program	95,657 (94.4%)	5,387	175	175 (100.0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Michigan has a robust system for follow-up beyond referral of an infant with a positive newborn screening (NBS) result. The state maintains several coordinating centers, focused on different groups of NBS disorders. Each center is designated by MDHHS and works with the family, the newborn's primary care provider, and specialists to triage infants with positive screens and facilitate prompt diagnostic testing, evaluation, and initiation of medical monitoring and/or treatment. Each center reports the number of infants seen, diagnostic work-ups provided, and results of assessments to MDHHS. Information is crucial for measuring and monitoring detection rates, positive predictive values, and other screening performance metrics including time from birth to treatment initiation. Aggregate results are included in the NBS Annual Report online. The length of follow-up monitoring varies by disorder, with the longest follow-up occurring for those will metabolic disorders and sickle cell disease.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Data Source Year**
	Fiscal Year:	**2022**
	Column Name:	**Data Source Year Notes**
	Field Note: Data Source for Births by Occurrence: 2022 Provisional Live Birth File, Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services	
2.	**Field Name:**	**Early Hearing Detection and Intervention (EHDI) Program - Total Number Receiving At Least One Screen**
	Fiscal Year:	**2022**
	Column Name:	**Other Newborn**
	Field Note: Preliminary EHDI information based on 2022 provisional data of hospital and midwife births as of April 3, 2023.	

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Michigan

Annual Report Year 2022

Form 5a – Count of Individuals Served by Title V (Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	8,770	38.1	0.0	58.9	2.6	0.4
2. Infants < 1 Year of Age	18,897	38.0	0.0	58.8	2.8	0.4
3. Children 1 through 21 Years of Age	303,822	37.0	0.0	59.0	4.0	0.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	53,164	76.5	6.3	15.6	1.6	0.0
4. Others	173,477	19.0	0.0	75.0	6.0	0.0
Total	504,966					

Form 5b – Total Percentage of Populations Served by Title V (Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	104,980	No	100,811	100.0	100,811	8,770
2. Infants < 1 Year of Age	103,992	No	101,322	100.0	101,322	18,897
3. Children 1 through 21 Years of Age	2,580,468	Yes	2,580,468	100.0	2,580,468	303,822
3a. Children with Special Health Care Needs 0 through 21 years of age^	533,880	Yes	533,880	100.0	533,880	53,164
4. Others	7,367,996	Yes	7,367,996	7.0	515,760	173,477

^Represents a subset of all infants and children.

Form Notes for Form 5:

Form 5a includes the number of individuals who received a direct or enabling service funded by either Federal (i.e., Title V Block Grant) or Non-federal (i.e., state match) dollars as reported on Form 2, line 8. Duplication in counts is possible because some individuals may have received more than one service. Michigan Home Visiting Initiative (MHVI) counts are from the state match from state general funds, not MIECHV federal funds.

Form 5b is the best estimate for each population group served by Title V programs across all levels of the MCH Pyramid. This estimate includes all individuals and populations served by the total Federal and State match dollars as reported on Form 2, line 8 and the combined totals on Form 3a and 3b for all service levels. Direct and enabling service numbers from Form 5a were added to public health services and systems to obtain a total count. To avoid duplication, programs and services with the largest reach for a given population are used in the numerators for the percentage estimate.

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2022**

Field Note:
Individuals in the pregnancy category expending funds from Federal Title V funds include Local Maternal Child Health Program pregnant women [6,804].

Individuals in the pregnancy category expending funds from both Federal Title V funds and Title V state match include Family Planning females who indicated they were pregnant/seeking pregnancy based on preliminary Family Planning Annual Report (FPAR) data, which runs January 1, 2022 – December 31, 2022 [1,247].

Individuals in the pregnancy category expending funds from the Title V state match include Michigan Adolescent Pregnancy and Parenting Program (MI-APPP) [15]; Nurse Family Partnership and Rural MHVI HFA [704]; Note that MHVI counts are from the state match from general funds, not MIECHV federal funds.

Population estimates were used for Primary Sources of Insurance Coverage from Live Birth file - Resident births, provisional 2022 (table generated 3/23/2023), Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services. Pregnant women may also receive non-pregnancy related services and be counted in other Title V participant categories.

2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2022**

Field Note:
Infant counts expending Federal Title V funds include Local Maternal Child Health Program [1,122]; Childhood Lead Prevention [46] and Infant Safe Sleep Outreach Training [12,060].

The Title V state match includes Nurse Family Partnership and Rural MHVI [578], MI-APPT and MI APP [17]; and Infant Safe Sleep initiatives [5,074]. Note that MHVI counts are from the state match from general funds, not MIECHV federal funds.

Population estimates were used for Primary Sources of Insurance Coverage from Live Birth file Occurrent births, provisional, 2022 (table generated 3/23/2023), Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services.

3.	**Field Name:**	**Children 1 through 21 Years of Age**

	Fiscal Year:	**2022**

Field Note:
Children 1-21 years category expending Federal Title V funds includes dental sealants [9,396]; childhood lead prevention program [102,736]; Local Maternal Child Health Program [114,025]; Fetal Alcohol Spectrum Disorder [401]; and Personal Responsibility Education Program (PREP) [6,373].

Federal Title V funds and Title V state match funds were used in Family Planning for an unduplicated count of adolescent women and men aged ≤15-24 years of age. Pregnant women aged ≤15-24 years old are included in this count. The Children 1-21 count for Family Planning is slightly overcounted given how age is categorized for FPAR (preliminary 2022) (≤15-19 years old and 20-24 years) [16,893].

Title V state match counts in children 1-21 include Nurse Family Partnership and Rural MHVI [780]; MI-APPP [54]. Note that MHVI counts are from the state match from general funds, not MIECHV federal funds.

The number recorded here is the number of children ages 1-21 plus the number of CSHCN ages 0-21 (line 3a). Population estimates were used for Primary Sources of Insurance coverage from American Community Survey - Children 1-21, 2021.

4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2022**

Field Note:
All counts in CSHCN [53,134] are from the Federal Title V expenditures which include medical care and treatment for CSHCN. Medical insurance coverage is reported by the CSHCS program (MDHHS, Data Warehouse). Michigan serves a much larger CSHCS Medicaid population (76.5%) than the National Survey of Children's Health – CSHCN, 2020-2021 (47%). Oral health [2,596] and Nurse Family Partnership and Rural MHVI [30] counts are also included.

5.	**Field Name:**	**Others**
	Fiscal Year:	**2022**

Field Note:
Individuals served in the Other category include women over age 21 who are not pregnant or within a 60-day postpartum window, men over age 21, fathers, families, and grandparents. Examples of direct and enabling service counts expended with Federal Title V funds include Local Maternal Child Health [140,157]; Family Planning Training [408]; FIMR family interviews [35].

Breastfeeding education projects received funding from both Federal Title V and Title V state match [13,038], as did Family Planning (FPAR preliminary 2022) which include clients served in the program who are not represented in the Children 1-21 count [18,777].

Additional Title V state match funds included in the Other count include MI-APPP men, clients over 21 and supportive adults [35]; and Nurse Family Partnership, rural MHVI, Inter-tribal MIECHV [1,027]. Note that MHVI and MIECHV counts are from the state match from general funds, not MIECHV federal funds.

Population estimates were used for Primary Sources of Insurance Coverage from American Community Survey - Adults 22+, 2021.

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women Total % Served**
	Fiscal Year:	**2022**
	Field Note: In addition to Pregnant Women Form 5a counts, numerators were used for the programs and services with the largest reach. For pregnant women, the state has nine Regional Perinatal Quality Collaborative (RPQCs) with Federal Title V support for three projects and Title V state match for five of the projects and one project with additional fiduciary support. A population estimate of births in each Title V supported region was used. Pregnant women calling Michigan 2-1-1 for services were also included, as 2-1-1 is supported by Title V funds. Duplication of services is possible. [Denominator from Live Birth file - Resident births, provisional, 2022 (table generated 3/23/2023), Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services.]	
2.	**Field Name:**	**Pregnant Women Denominator**
	Fiscal Year:	**2022**
	Field Note: Denominator from Live Birth file - Resident births, provisional, 2022 (table generated 3/23/2023), Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services.	
3.	**Field Name:**	**Infants Less Than One Year Total % Served**
	Fiscal Year:	**2022**
	Field Note: In addition to Infants from Form 5a, numerators were used for the programs and services with the largest reach. For infants less than one year of age, Early Hearing Detection & Intervention (EHDI) Program screening (provisional) was used, which correlates to live occurrences births. Newborn screening follow-up (blood spot and EHDI fees) are included in Form 2, line 6 expenditures, and support for EHDI staff is included in Title V match. 2-1-1 calls coded to infants were not included in the Form 5b due to high potential for duplication. [Reference data for denominator is 2022 provisional Live Birth file (table generated 3/23/2023), Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services.]	
4.	**Field Name:**	**Infants Less Than One Year Denominator**
	Fiscal Year:	**2022**
	Field Note: Denominator from 2022 provisional Live Birth file (table generated 3/23/2023), Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services.	
5.	**Field Name:**	**Children 1 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**

	Field Note: In addition to Children 1-21 and CSHCN counts from Form 5a, numerators were used for the programs and services with the largest reach. In 2022, the Immunization Program addressed public health infrastructure services for Michigan Care Improvement Registry (MCIR) based programs and enhancements, including distribution of brochures with numerator counts that reached all Michigan children. MCIR is Michigan's centralized immunization information system. This is the first year that Michigan recorded 100% of children reached due to this population based, wide-reaching Immunization Program activity. Counts for Children 1-21 were also collected for the Michigan Model for School Health curriculum since staff time to support the program is a Title V state match. The curriculum is widely used across Michigan for school-aged children. Media analytics from an advertising campaign targeting young parents (through age 21) for safe sleep/breastfeeding and 2-1-1 calls coded to children were also collected, which both used Title V funding. These latter counts were not included due to strong possibility of duplication with the MCIR counts. [Denominator Data Source is US Census bureau Population Estimates, 2021.]	
6.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age Total % Served**
	Fiscal Year:	**2022**
	Field Note: CSHCN is a subset of Children 1-21. Form 5a CSHCN counts using Federal Title V funds were used for the service with the largest reach. As per the Title V Guidance, CSHCN are not excluded from population-based services for all children and therefore the percent reported is the same as Children 1-21 years. [Denominator Data Source: National Survey of children's Health CSHCS Prevalence Estimates 0 – 17, (2020-2021) multiplied by US Census Bureau Population Estimates 0-21, 2021.]	
7.	**Field Name:**	**Others Total % Served**
	Fiscal Year:	**2022**
	Field Note: In addition to Others from Form 5a, numerators were used for the programs and services with the largest reach. For Others, counts from Federal Title V expenditures include Local Maternal Child Health (includes counts from media campaign analytics; distribution of materials at a health fair/outreach event), professional training for Family Planning and Health Equity, FASD media campaign, cases reviewed in the FIMR process, autopsy services, and professional training/staff development. Michigan 2-1-1 calls coded to non-pregnant women, families, or individuals of an unknown age are included. Title V state match expenditures include support of the Maternal Infant Summit. Due to the wide range of services, duplication of counts is possible. [Denominator Data Source US Census bureau Population Estimates, 2021.]	

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Michigan

Annual Report Year 2022

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non-Hispanic White	(C) Non-Hispanic Black or African American	(D) Hispanic	(E) Non-Hispanic American Indian or Native Alaskan	(F) Non-Hispanic Asian	(G) Non-Hispanic Native Hawaiian or Other Pacific Islander	(H) Non-Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	100,811	67,364	17,034	5,076	389	2,642	13	3,170	5,123
Title V Served	100,811	67,364	17,034	5,076	389	2,642	13	3,170	5,123
Eligible for Title XIX	38,400	18,912	11,170	2,903	218	337	9	1,735	3,116
2. Total Infants in State	101,322	67,764	17,079	5,091	390	2,651	13	3,190	5,144
Title V Served	101,322	67,764	17,079	5,091	390	2,651	13	3,190	5,144
Eligible for Title XIX	38,528	18,987	11,198	2,910	219	337	9	1,739	3,129

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Total Deliveries in the state is Birth by Residence. Source of data is Live Birth file - Resident births, provisional, 2022, Table 2 (Live births by race/ancestry of mother) (table generated 3/23/2023), Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: In FY 2022 on Form 5b, 100% of infants were Title V served.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Source of data is Live Birth file - Resident births, provisional, 2022, Table 3 (Live births by race/ancestry of mother and pay source) (table generated 3/23/2023), Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services.	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Total infants in state is Birth by Occurrence. Source of data is 2022 provisional Live Birth file, Table 2 (Live Births by race/ancestry of mother) (table generated 3/23/2023), Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services	
5.	**Field Name:**	**2. Title V Served**
	Fiscal Year:	**2022**
	Column Name:	**Total**

	Field Note: In FY 2022 on Form 5b, 100% of infants were Title V served.	
6.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2022**
	Column Name:	**Total**
	Field Note: Total infants in state is Birth by Occurrence. Source of data is 2022 provisional Live Birth file, Table 3 (Live Births by race/ancestry of mother and pay source) (table generated 3/23/2023), Division for Vital Records and Health Statistics, Michigan Department of Health and Human Services	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Michigan

A. State MCH Toll-Free Telephone Lines	2024 Application Year	2022 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(844) 875-9211	(844) 875-9211
2. State MCH Toll-Free "Hotline" Name	2-1-1	2-1-1
3. Name of Contact Person for State MCH "Hotline"	Jennie Pollak	Jennie Pollak
4. Contact Person's Telephone Number	(517) 664-9811	(517) 664-9811
5. Number of Calls Received on the State MCH "Hotline"		5,516

B. Other Appropriate Methods	2024 Application Year	2022 Annual Report Year
1. Other Toll-Free "Hotline" Names	Family Phone Line	Family Phone Line
2. Number of Calls on Other Toll-Free "Hotlines"		8,443
3. State Title V Program Website Address		
4. Number of Hits to the State Title V Program Website		
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

The "Number of Calls Received on the State's MCH Hotline" reflects the unique count of WIC and MCH "connections" reported by Michigan 2-1-1. A connection is defined as a call or interaction by chat, text, e-mail, or other method (such as social media contact or an in-person visit to a regional 2-1-1 center). If an individual connects multiple times with 2-1-1 during the reporting period, each connection is counted separately.

Form 8
State MCH and CSHCN Directors Contact Information

State: Michigan

1. Title V Maternal and Child Health (MCH) Director	
Name	Dawn Shanafelt
Title	Director, Division of Maternal and Infant Health
Address 1	Elliott-Larsen Building 5-N
Address 2	320 S. Walnut Street
City/State/Zip	Lansing / MI / 48933
Telephone	(517) 614-0804
Extension	
Email	ShanafeltD@michigan.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Lonnie Barnett
Title	Director, Children's Special Health Care Services Division
Address 1	400 S. Pine Street
Address 2	
City/State/Zip	Lansing / MI / 48933
Telephone	(517) 241-7186
Extension	
Email	BarnettL@michigan.gov

3. State Family Leader (Optional)	
Name	Candida Bush
Title	Director, Family Center for CYSHCN
Address 1	400 S. Pine Street
Address 2	
City/State/Zip	Lansing / MI / 48933
Telephone	(517) 241-7197
Extension	
Email	BushC9@michigan.gov

4. State Youth Leader (Optional)	
Name	Elizabeth Stout
Title	Youth Consultant for CSHCS
Address 1	400 S. Pine Street
Address 2	
City/State/Zip	Lansing / MI / 48933
Telephone	(517) 241-7630
Extension	
Email	cshcsfc@michigan.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Michigan

Application Year 2024

No.	Priority Need
1.	Develop a proactive and responsive health system that equitably meets the needs of all populations, eliminating barriers related to race, culture, language, sexual orientation, age and gender identity
2.	Improve access to high-quality community health and prevention services in the places where women, children, and families live, learn, work, and play
3.	Ensure children with special health care needs have access to continuous health coverage, all benefits they are eligible to receive, and relevant care where they learn and live
4.	Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems
5.	Improve oral health awareness and create an oral health delivery system that provides access through multiple systems
6.	Create and enhance support systems that empower families, protect and strengthen family relationships, promote care for self and children, and connect families to their communities
7.	Create safe and healthy schools and communities that promote human thriving, including physical and mental health supports that address the needs of the whole person

Form Notes for Form 9:

None

Field Level Notes for Form 9:

Field Name:

Priority Need 1

Field Note:
For FY2022, "age" was added to this priority need statement. To stay within the form's character limit capacity, "healthcare system" was changed to "health system."

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Develop a proactive and responsive healthcare system that equitably meets the needs of all populations, eliminating barriers related to race, culture, language, sexual orientation, and gender identity	New
2.	Improve access to high-quality community health and prevention services in the places where women, children, and families live, learn, work, and play	New
3.	Ensure children with special health care needs have access to continuous health coverage, all benefits they are eligible to receive, and relevant care where they learn and live	New
4.	Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems	New
5.	Improve oral health awareness and create an oral health delivery system that provides access through multiple systems	New
6.	Create and enhance support systems that empower families, protect and strengthen family relationships, promote care for self and children, and connect families to their communities	New
7.	Create safe and healthy schools and communities that promote human thriving, including physical and mental health supports that address the needs of the whole person	New

Form 10
National Outcome Measures (NOMs)

State: Michigan

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	79.4 %	0.1 %	82,283	103,663
2020	79.6 %	0.1 %	81,703	102,677
2019	79.9 %	0.1 %	84,123	105,304
2018	79.8 %	0.1 %	85,510	107,175
2017	80.4 %	0.1 %	86,882	108,031
2016	79.8 %	0.1 %	87,826	110,125
2015	79.3 %	0.1 %	87,582	110,483
2014	79.0 %	0.1 %	88,386	111,951
2013	76.4 %	0.1 %	84,520	110,574
2012	77.6 %	0.1 %	85,436	110,069
2011	77.9 %	0.1 %	86,398	110,846
2010	77.9 %	0.1 %	86,568	111,150
2009	77.6 %	0.1 %	87,799	113,120

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	89.9	3.0	902	100,358
2019	78.3	2.7	821	104,832
2018	76.2	2.7	816	107,111
2017	71.2	2.6	773	108,494
2016	76.6	2.7	844	110,190
2015	69.4	2.9	578	83,251
2014	72.6	2.6	807	111,153
2013	73.4	2.6	810	110,390
2012	77.6	2.7	854	110,113
2011	65.7	2.4	730	111,184
2010	74.2	2.6	828	111,609
2009	63.1	2.4	722	114,473
2008	62.4	2.3	736	117,923

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017_2021	18.4	1.9	99	538,398
2016_2020	18.7	1.9	102	546,733
2015_2019	16.7	1.7	93	555,971
2014_2018	16.2	1.7	91	562,460

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 3 - Notes:

None

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	9.2 %	0.1 %	9,668	104,884
2020	8.9 %	0.1 %	9,288	104,004
2019	8.7 %	0.1 %	9,414	107,801
2018	8.5 %	0.1 %	9,302	109,955
2017	8.8 %	0.1 %	9,793	111,353
2016	8.5 %	0.1 %	9,654	113,232
2015	8.5 %	0.1 %	9,612	113,229
2014	8.4 %	0.1 %	9,545	114,290
2013	8.2 %	0.1 %	9,331	113,396
2012	8.4 %	0.1 %	9,548	112,995
2011	8.3 %	0.1 %	9,508	113,925
2010	8.4 %	0.1 %	9,610	114,413
2009	8.4 %	0.1 %	9,799	117,190

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	10.6 %	0.1 %	11,120	104,897
2020	10.2 %	0.1 %	10,639	104,033
2019	10.3 %	0.1 %	11,070	107,837
2018	10.0 %	0.1 %	11,039	109,983
2017	10.2 %	0.1 %	11,406	111,386
2016	10.1 %	0.1 %	11,490	113,276
2015	9.9 %	0.1 %	11,200	113,267
2014	9.8 %	0.1 %	11,154	114,335
2013	9.7 %	0.1 %	11,050	113,390
2012	10.1 %	0.1 %	11,409	112,976
2011	10.0 %	0.1 %	11,365	113,901
2010	10.2 %	0.1 %	11,710	114,434
2009	10.1 %	0.1 %	11,856	117,185

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	27.9 %	0.1 %	29,261	104,897
2020	26.6 %	0.1 %	27,671	104,033
2019	26.2 %	0.1 %	28,207	107,837
2018	25.2 %	0.1 %	27,675	109,983
2017	24.8 %	0.1 %	27,648	111,386
2016	24.3 %	0.1 %	27,478	113,276
2015	23.7 %	0.1 %	26,818	113,267
2014	22.8 %	0.1 %	26,120	114,335
2013	22.9 %	0.1 %	26,006	113,390
2012	23.4 %	0.1 %	26,382	112,976
2011	23.4 %	0.1 %	26,618	113,901
2010	24.0 %	0.1 %	27,507	114,434
2009	24.6 %	0.1 %	28,843	117,185

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021/Q1-2021/Q4	2.0 %			
2020/Q4-2021/Q3	2.0 %			
2020/Q3-2021/Q1	2.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	1.0 %			
2018/Q3-2019/Q2	1.0 %			
2018/Q2-2019/Q1	1.0 %			
2018/Q1-2018/Q4	1.0 %			
2017/Q4-2018/Q3	1.0 %			
2017/Q3-2018/Q2	1.0 %			
2017/Q2-2018/Q1	1.0 %			
2017/Q1-2017/Q4	1.0 %			
2016/Q4-2017/Q3	1.0 %			
2016/Q3-2017/Q2	1.0 %			
2016/Q2-2017/Q1	1.0 %			
2016/Q1-2016/Q4	1.0 %			
2015/Q4-2016/Q3	1.0 %			
2015/Q3-2016/Q2	1.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			

Year	Annual Indicator	Standard Error	Numerator	Denominator
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	3.0 %			
2013/Q2-2014/Q1	3.0 %			

Legends:

NOM 7 - Notes:

None

Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.3	0.3	662	104,367
2019	6.4	0.2	693	108,208
2018	6.2	0.2	686	110,358
2017	6.6	0.2	738	111,726
2016	6.1	0.2	689	113,623
2015	5.8	0.2	654	113,592
2014	5.9	0.2	676	114,656
2013	6.4	0.2	723	113,779
2012	6.4	0.2	727	113,359
2011	6.4	0.2	734	114,331
2010	6.8	0.2	785	114,838
2009	7.1	0.3	832	117,642

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 8 - Notes:

None

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.8	0.3	708	104,074
2019	6.4	0.2	688	107,886
2018	6.2	0.2	684	110,032
2017	6.8	0.3	755	111,426
2016	6.4	0.2	727	113,315
2015	6.5	0.2	739	113,312
2014	6.5	0.2	739	114,375
2013	7.0	0.3	800	113,489
2012	6.9	0.3	784	113,091
2011	6.5	0.2	746	114,008
2010	7.1	0.3	816	114,531
2009	7.6	0.3	892	117,294

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.1 - Notes:

None

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	4.5	0.2	464	104,074
2019	4.3	0.2	464	107,886
2018	4.0	0.2	445	110,032
2017	4.5	0.2	502	111,426
2016	4.2	0.2	479	113,315
2015	4.2	0.2	476	113,312
2014	4.3	0.2	488	114,375
2013	4.8	0.2	543	113,489
2012	4.8	0.2	540	113,091
2011	4.4	0.2	496	114,008
2010	4.8	0.2	551	114,531
2009	5.2	0.2	606	117,294

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.2 - Notes:

None

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	2.3	0.2	244	104,074
2019	2.1	0.1	224	107,886
2018	2.2	0.1	239	110,032
2017	2.3	0.1	253	111,426
2016	2.2	0.1	248	113,315
2015	2.3	0.1	263	113,312
2014	2.2	0.1	251	114,375
2013	2.3	0.1	257	113,489
2012	2.2	0.1	244	113,091
2011	2.2	0.1	250	114,008
2010	2.3	0.1	265	114,531
2009	2.4	0.1	286	117,294

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.3 - Notes:

None

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020	264.2	16.0	275	104,074
2019	266.0	15.7	287	107,886
2018	230.8	14.5	254	110,032
2017	280.9	15.9	313	111,426
2016	233.9	14.4	265	113,315
2015	236.5	14.5	268	113,312
2014	248.3	14.8	284	114,375
2013	267.9	15.4	304	113,489
2012	299.8	16.3	339	113,091
2011	264.0	15.2	301	114,008
2010	295.1	16.1	338	114,531
2009	308.6	16.3	362	117,294

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.4 - Notes:

None

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	135.5	11.4	141	104,074
2019	109.4	10.1	118	107,886
2018	113.6	10.2	125	110,032
2017	80.8	8.5	90	111,426
2016	94.4	9.1	107	113,315
2015	100.6	9.4	114	113,312
2014	104.0	9.5	119	114,375
2013	107.5	9.7	122	113,489
2012	78.7	8.4	89	113,091
2011	83.3	8.6	95	114,008
2010	89.1	8.8	102	114,531
2009	102.3	9.3	120	117,294

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 9.5 - Notes:

None

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2015	6.2 %	0.8 %	6,729	107,826
2013	7.1 %	0.8 %	7,783	109,332
2012	6.1 %	0.7 %	6,640	108,444
2011	6.2 %	0.7 %	6,761	109,422
2010	6.8 %	0.8 %	7,511	110,204
2009	7.2 %	0.7 %	8,062	112,665
2008	7.8 %	0.8 %	9,118	116,419
2007	6.8 %	0.7 %	8,160	119,804

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	5.9	0.2	600	101,574
2019	6.0	0.2	635	106,275
2018	6.8	0.3	738	108,119
2017	8.0	0.3	873	109,707
2016	7.7	0.3	863	111,474
2015	8.3	0.3	696	84,277
2014	7.4	0.3	828	112,305
2013	6.8	0.3	759	111,274
2012	5.5	0.2	609	110,704
2011	5.0	0.2	557	111,639
2010	3.6	0.2	403	112,371
2009	2.9	0.2	334	115,268
2008	2.0	0.1	241	118,761

Legends:

Indicator has a numerator ≤10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

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

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

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

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	14.0 %	1.3 %	282,801	2,024,729
2019_2020	11.2 %	1.4 %	227,418	2,030,383
2018_2019	10.6 %	1.4 %	218,787	2,055,137
2017_2018	8.9 %	1.2 %	184,690	2,081,114
2016_2017	8.1 %	0.9 %	170,205	2,108,084
2016	10.4 %	1.3 %	218,950	2,112,940

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None

Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	18.8	1.4	195	1,036,012
2020	17.5	1.3	181	1,036,299
2019	18.4	1.3	192	1,043,749
2018	21.3	1.4	223	1,048,510
2017	17.9	1.3	188	1,049,560
2016	20.1	1.4	212	1,052,423
2015	18.0	1.3	190	1,055,961
2014	15.6	1.2	166	1,063,261
2013	15.7	1.2	169	1,074,265
2012	18.6	1.3	202	1,084,513
2011	16.5	1.2	181	1,094,617
2010	16.7	1.2	187	1,119,319
2009	19.1	1.3	216	1,130,341

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 15 - Notes:

None

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	35.7	1.7	454	1,273,416
2020	37.0	1.7	458	1,238,443
2019	30.3	1.6	380	1,254,923
2018	32.8	1.6	417	1,273,169
2017	33.5	1.6	430	1,283,533
2016	35.6	1.7	461	1,293,264
2015	34.6	1.6	451	1,305,161
2014	31.1	1.5	411	1,320,994
2013	31.6	1.5	423	1,337,140
2012	35.8	1.6	486	1,356,278
2011	35.3	1.6	488	1,382,472
2010	35.3	1.6	500	1,414,815
2009	35.6	1.6	512	1,436,495

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.1 - Notes:

None

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019_2021	9.8	0.7	188	1,926,292
2018_2020	8.4	0.7	162	1,931,909
2017_2019	8.0	0.6	156	1,959,646
2016_2018	9.3	0.7	184	1,983,162
2015_2017	10.5	0.7	209	1,999,968
2014_2016	11.7	0.8	235	2,015,261
2013_2015	10.6	0.7	216	2,032,680
2012_2014	10.6	0.7	218	2,059,137
2011_2013	11.7	0.8	245	2,097,639
2010_2012	13.2	0.8	283	2,151,744
2009_2011	13.9	0.8	306	2,207,213
2008_2010	12.9	0.8	291	2,253,754
2007_2009	14.6	0.8	333	2,280,096

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.2 - Notes:

None

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2021	10.4	0.7	201	1,926,292
2018_2020	11.4	0.8	220	1,931,909
2017_2019	12.9	0.8	253	1,959,646
2016_2018	13.4	0.8	266	1,983,162
2015_2017	12.4	0.8	248	1,999,968
2014_2016	11.0	0.7	221	2,015,261
2013_2015	10.5	0.7	213	2,032,680
2012_2014	10.3	0.7	213	2,059,137
2011_2013	9.9	0.7	207	2,097,639
2010_2012	9.7	0.7	208	2,151,744
2009_2011	8.8	0.6	195	2,207,213
2008_2010	8.3	0.6	188	2,253,754
2007_2009	7.3	0.6	167	2,280,096

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 16.3 - Notes:

None

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	19.9 %	1.3 %	422,455	2,126,475
2019_2020	21.3 %	1.5 %	455,735	2,144,486
2018_2019	20.7 %	1.6 %	447,060	2,161,379
2017_2018	19.8 %	1.7 %	431,476	2,177,152
2016_2017	20.5 %	1.6 %	448,832	2,192,727
2016	20.2 %	1.6 %	444,614	2,199,932

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.1 - Notes:

None

Data Alerts: None

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

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	13.1 %	2.1 %	55,490	422,455
2019_2020	14.8 %	2.9 %	67,434	455,735
2018_2019	17.2 %	3.0 %	76,812	447,060
2017_2018	15.9 %	2.9 %	68,445	431,476
2016_2017	17.2 %	3.0 %	77,383	448,832
2016	17.8 %	3.7 %	79,079	444,614

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	2.9 %	0.6 %	52,987	1,801,930
2019_2020	2.6 %	0.8 %	48,107	1,820,405
2018_2019	2.9 %	0.9 %	53,351	1,833,949
2017_2018	3.2 %	1.0 %	58,419	1,845,774
2016_2017	2.8 %	0.8 %	52,901	1,858,721
2016	2.4 %	0.5 %	43,444	1,841,205

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.3 - Notes:

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	10.7 %	1.1 %	192,768	1,800,640
2019_2020	9.7 %	1.2 %	175,649	1,816,458
2018_2019	9.2 %	1.2 %	167,152	1,816,967
2017_2018	10.0 %	1.6 %	182,715	1,821,576
2016_2017	10.2 %	1.4 %	188,503	1,845,607
2016	9.9 %	1.2 %	180,655	1,832,465

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	54.6 %	4.3 %	146,167	267,760
2019_2020	60.6 %	4.7 %	167,502	276,511
2018_2019	65.0 %	4.8 %	165,018	253,918
2017_2018	57.8 %	6.2 %	143,894	248,906
2016_2017	55.4 %	5.9 %	134,110	242,058
2016	65.3 %	5.7 %	143,720	220,148

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	90.4 %	1.1 %	1,910,570	2,114,375
2019_2020	90.6 %	1.2 %	1,942,111	2,142,491
2018_2019	89.4 %	1.4 %	1,928,648	2,158,291
2017_2018	88.6 %	1.5 %	1,921,968	2,169,294
2016_2017	91.4 %	1.2 %	1,994,495	2,182,883
2016	93.2 %	1.0 %	2,044,871	2,193,776

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	13.8 %	0.1 %	8,457	61,119
2018	13.7 %	0.1 %	10,479	76,573
2016	13.3 %	0.1 %	11,211	84,387
2014	13.4 %	0.1 %	11,553	86,139
2012	13.9 %	0.1 %	12,787	91,932
2010	14.4 %	0.1 %	12,273	85,293
2008	14.3 %	0.1 %	12,268	85,493

Legends:

Indicator has a denominator <20 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2019	15.3 %	1.2 %	61,855	404,273
2017	16.7 %	2.0 %	68,699	410,229
2015	14.3 %	0.9 %	59,911	419,182
2013	13.0 %	0.9 %	56,333	432,033
2011	12.1 %	0.8 %	59,594	493,753
2009	11.9 %	0.7 %	56,213	473,335
2007	12.4 %	1.0 %	60,426	488,806
2005	12.0 %	1.1 %	58,930	492,546

Legends:

Indicator has an unweighted denominator <100 and is not reportable

Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2020_2021	17.1 %	1.8 %	162,930	952,173
2019_2020	15.7 %	2.2 %	147,214	938,438
2018_2019	17.3 %	2.5 %	157,972	913,180
2017_2018	18.9 %	2.7 %	173,600	919,783
2016_2017	17.3 %	2.4 %	156,793	904,564
2016	13.9 %	2.2 %	123,218	887,288

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None

Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend				
Year	**Annual Indicator**	**Standard Error**	**Numerator**	**Denominator**
2021	3.1 %	0.2 %	67,507	2,146,208
2019	3.2 %	0.2 %	68,740	2,139,769
2018	2.9 %	0.2 %	61,744	2,161,263
2017	2.8 %	0.2 %	61,529	2,171,692
2016	2.9 %	0.2 %	63,999	2,185,729
2015	3.3 %	0.2 %	71,886	2,205,601
2014	3.7 %	0.2 %	81,249	2,218,195
2013	4.2 %	0.3 %	94,466	2,241,806
2012	4.3 %	0.2 %	96,150	2,264,117
2011	3.9 %	0.3 %	88,603	2,287,224
2010	4.2 %	0.3 %	98,185	2,333,517
2009	4.4 %	0.2 %	101,999	2,347,431

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 21 - Notes:

None

Data Alerts: None

NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months

Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	72.7 %	3.3 %	81,000	112,000
2017	70.3 %	3.4 %	79,000	113,000
2016	70.0 %	3.5 %	80,000	114,000
2015	68.2 %	4.0 %	78,000	114,000
2014	67.5 %	3.9 %	77,000	115,000
2013	62.0 %	4.2 %	71,000	114,000
2012	59.8 %	4.9 %	68,000	114,000
2011	70.1 %	3.8 %	80,000	115,000

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021_2022	57.8 %	1.5 %	1,151,297	1,991,866
2020_2021	54.7 %	2.0 %	1,106,248	2,022,391
2019_2020	54.9 %	1.5 %	1,103,989	2,010,909
2018_2019	56.7 %	1.9 %	1,160,321	2,045,700
2017_2018	54.0 %	1.8 %	1,106,263	2,049,234
2016_2017	55.7 %	2.7 %	1,160,747	2,083,553
2015_2016	55.5 %	2.2 %	1,175,624	2,118,242
2014_2015	52.6 %	2.0 %	1,128,562	2,144,332
2013_2014	54.5 %	2.1 %	1,173,013	2,151,267
2012_2013	50.5 %	2.1 %	1,104,144	2,185,520
2011_2012	45.5 %	2.1 %	1,012,029	2,222,082
2010_2011	45.9 %	2.2 %	1,021,330	2,225,120
2009_2010	37.1 %	2.3 %	888,940	2,396,064

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	79.0 %	3.0 %	489,166	619,558
2020	76.9 %	2.6 %	481,916	626,327
2019	73.7 %	3.0 %	465,543	631,758
2018	72.5 %	3.1 %	461,285	636,563
2017	67.3 %	3.1 %	434,131	644,686
2016	61.3 %	3.5 %	400,347	653,090
2015	59.8 %	3.1 %	395,586	661,834

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	85.4 %	2.8 %	529,129	619,558
2020	91.9 %	1.8 %	575,366	626,327
2019	89.2 %	2.2 %	563,675	631,758
2018	93.8 %	1.6 %	597,278	636,563
2017	93.4 %	1.7 %	602,005	644,686
2016	93.6 %	1.7 %	611,119	653,090
2015	74.0 %	2.8 %	489,955	661,834
2014	79.3 %	2.8 %	530,881	669,523
2013	81.0 %	2.7 %	545,205	672,858
2012	84.2 %	2.4 %	572,289	679,895
2011	71.0 %	3.3 %	489,318	689,393
2010	66.2 %	3.2 %	462,403	698,032
2009	46.2 %	2.8 %	333,108	720,421

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.4 - Notes:

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	89.7 %	2.5 %	555,659	619,558
2020	95.7 %	1.3 %	599,189	626,327
2019	95.4 %	1.4 %	602,575	631,758
2018	95.9 %	1.3 %	610,491	636,563
2017	93.5 %	1.7 %	602,651	644,686
2016	95.0 %	1.3 %	620,674	653,090
2015	95.0 %	1.3 %	629,015	661,834
2014	90.7 %	2.0 %	607,555	669,523
2013	90.7 %	2.0 %	610,110	672,858
2012	87.5 %	2.1 %	594,639	679,895
2011	77.9 %	3.0 %	537,339	689,393
2010	70.9 %	3.1 %	494,777	698,032
2009	52.6 %	2.8 %	378,858	720,421

Legends:

Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable

NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2021	12.2	0.2	3,871	316,304
2020	13.5	0.2	4,190	310,009
2019	15.1	0.2	4,758	315,633
2018	15.8	0.2	5,042	320,027
2017	16.4	0.2	5,307	323,738
2016	17.7	0.2	5,792	326,851
2015	19.4	0.2	6,356	328,084
2014	21.1	0.3	6,967	330,522
2013	23.5	0.3	7,872	334,483
2012	26.2	0.3	8,913	340,348
2011	27.8	0.3	9,658	347,543
2010	30.3	0.3	10,835	357,400
2009	31.9	0.3	11,709	366,494

Legends:

Indicator has a numerator <10 and is not reportable

Indicator has a numerator <20 and should be interpreted with caution

NOM 23 - Notes:

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	16.1 %	1.2 %	15,799	97,859
2019	14.8 %	1.2 %	15,090	101,871
2018	16.4 %	1.1 %	16,965	103,497
2017	12.9 %	1.0 %	13,526	104,743
2016	14.3 %	1.0 %	15,290	106,820
2015	14.1 %	1.1 %	14,980	106,503
2013	13.3 %	1.1 %	14,486	108,565
2012	13.8 %	1.1 %	14,895	108,047

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 24 - Notes:

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	2.3 %	0.4 %	47,914	2,117,675
2019_2020	2.2 %	0.6 %	46,175	2,134,338
2018_2019	2.5 %	0.7 %	53,381	2,156,185
2017_2018	2.2 %	0.5 %	46,684	2,168,786
2016_2017	1.9 %	0.4 %	42,521	2,185,942
2016	2.4 %	0.6 %	52,234	2,197,678

Legends:

Indicator has an unweighted denominator <30 and is not reportable

Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)

State: Michigan

NPM 2 - Percent of cesarean deliveries among low-risk first births

Federally Available Data				
Data Source: National Vital Statistics System (NVSS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			25.6	25.6
Annual Indicator	27.3	26.5	28.1	28.1
Numerator	9,510	9,054	9,273	9,273
Denominator	34,845	34,117	33,009	33,009
Data Source	NVSS	NVSS	NVSS	NVSS
Data Source Year	2018	2019	2021	2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	25.4	25.2	25.0

Field Level Notes for Form 10 NPMs:

None

NPM 4A - Percent of infants who are ever breastfed

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	80.5	81.2	82.7	84.1	84.1
Annual Indicator	77.7	83.0	85.3	83.1	83.1
Numerator	88,168	86,380	88,053	75,064	75,064
Denominator	113,401	104,098	103,283	90,308	90,308
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2019	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	84.8	85.5	86.2

Field Level Notes for Form 10 NPMs:

None

NPM 4B - Percent of infants breastfed exclusively through 6 months

Federally Available Data					
Data Source: National Immunization Survey (NIS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	31.1	32.9	34.4	38	38
Annual Indicator	23.9	28.4	25.8	25.1	25.1
Numerator	25,921	28,764	25,629	22,387	22,387
Denominator	108,464	101,206	99,495	89,287	89,287
Data Source	NIS	NIS	NIS	NIS	NIS
Data Source Year	2015	2016	2017	2019	2019

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	39.8	41.6	43.4

Field Level Notes for Form 10 NPMs:

None

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		87.6	86.8	88.9	88.9
Annual Indicator	83.3	82.5	84.9	85.4	85.4
Numerator	87,247	85,511	85,912	83,784	83,784
Denominator	104,718	103,596	101,194	98,121	98,121
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2020

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		87.6	86.8	87.7	88.9
Annual Indicator	83.5	82.5	84.9		
Numerator	87,247	85,511	85,912		
Denominator	104,517	103,596	101,194		
Data Source	PRAMS	PRAMS	PRAMS		
Data Source Year	2017	2018	2019		
Provisional or Final ?	Final	Final	Final		

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	90.0	91.1	92.3

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		35.7	45	47.3	47.3
Annual Indicator	39.2	38.9	40.6	41.5	41.5
Numerator	39,142	38,781	39,451	38,620	38,620
Denominator	99,861	99,669	97,218	92,994	92,994
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2020

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		35.7	45	45.2	47.3
Annual Indicator	34	39.2	38.9		
Numerator	34,751	39,142	38,781		
Denominator	102,182	99,861	99,669		
Data Source	PRAMS	PRAMS	PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	49.3	51.4	53.5

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Weighted numbers were used to represent the general population.

All PRAMS states began asking different safe sleep questions in 2016. In prior years this measure was based on only two sleep risk factors - does the infant sleep in his or her own crib, and does the infant sleep with other people. Starting in 2016 this measure is now based on a combination of 5 different sleep risk factors (always or often sleeps alone in own bed; in a crib, bassinet or pack and play; does not sleep on a twin or larger mattress; does not sleep on couches, sofas, armchairs; does not sleep in a car set or swing). Asking about whether infants sleep in a car seat or swing - a new question - has had an especially large impact on this measure. The proportion of Michigan mothers meeting this goal is lower than in prior years, but the measurement now provides a more comprehensive picture of infant safe sleep.

2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Weighted numbers were used to represent the general population. In birth year 2016, Michigan was ranked 17th out of 29 total PRAMS states for this measure. In the 2017 birth year, Michigan was ranked 2nd out of 26 total PRAMS states for this measure.

3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Weighted numbers were used to represent the general population.

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		54.4	68.2	73.1	73.1
Annual Indicator	58.3	59.8	63.1	66.7	66.7
Numerator	58,277	59,314	61,216	62,663	62,663
Denominator	99,994	99,167	96,949	93,957	93,957
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2020

State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		54.4	68.2	70	73.1
Annual Indicator	51.8	58.3	59.8		
Numerator	52,803	58,277	59,314		
Denominator	101,994	99,994	99,167		
Data Source	PRAMS	PRAMS	PRAMS		
Data Source Year	2016	2017	2018		
Provisional or Final ?	Final	Final	Final		

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	75.9	78.5	80.9

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Weighted numbers were used to represent the general population.
All PRAMS states began asking different safe sleep questions in 2016. In prior years this measure was based on whether or not the infant often slept with any of four different sleep space objects (soft or plush blankets, pillows, stuffed toys, bumper pads). Starting in 2016 this measure is now based on a combination of 3 different sleep space items (blankets, toys or pillows, bumper pads). Due to changes in the wording of the blanket question [any blanket vs only plush or thick blankets], many more mothers now report that their infants have at least one soft item in the sleep space. Although the number here differs from the number reported in the past, in 2016 Michigan had the highest proportion of mothers reporting that their infants do not sleep with soft objects (compared to 28 other PRAMS states reporting this data).

2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Weighted numbers were used to represent the general population. All PRAMS states began asking different safe sleep questions in 2016. In prior years this measure was based on whether or not the infant often slept with any of four different sleep space objects (soft or plush blankets, pillows, stuffed toys, bumper pads). Starting in 2016 this measure is based on a combination of three different sleep space items (blankets, toys or pillows, bumper pads). Due to changes in the wording of the blanket question [any blanket vs only plush or thick blankets], many more mothers now report that their infants have at least one soft item in the sleep space. Although the number here differs from the number reported in the past, in 2016 Michigan had the highest proportion of mothers reporting that their infants do not sleep with soft objects (compared to 28 other PRAMS states reporting this data).

3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Weighted numbers were used to represent the general population

NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Federally Available Data				
Data Source: Youth Risk Behavior Surveillance System (YRBSS)				
	2019	**2020**	**2021**	**2022**
Annual Objective			25.4	25.4
Annual Indicator	29.8	28.0	28.0	28.0
Numerator	127,314	117,383	117,383	117,383
Denominator	426,596	418,810	418,810	418,810
Data Source	YRBSS	YRBSS	YRBSS	YRBSS
Data Source Year	2017	2019	2019	2019

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Perpetration				
	2019	**2020**	**2021**	**2022**
Annual Objective			25.4	25.4
Annual Indicator	20.0	16.1	11.9	11.9
Numerator	145,381	116,534	88,231	88,231
Denominator	727,587	723,002	741,127	741,127
Data Source	NSCHP	NSCHP	NSCHP	NSCHP
Data Source Year	2018	2018_2019	2020_2021	2020_2021

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - Victimization				
	2019	**2020**	**2021**	**2022**
Annual Objective			25.4	25.4
Annual Indicator	48.0	44.5	32.8	32.8
Numerator	349,295	321,323	242,215	242,215
Denominator	727,587	721,708	738,767	738,767
Data Source	NSCHV	NSCHV	NSCHV	NSCHV
Data Source Year	2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	2024	2025
Annual Objective	24.7	24.0	23.3

Field Level Notes for Form 10 NPMs:

None

NPM 12 - Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	17	17.2	17.4	34.1	34.1
Annual Indicator	16.0	21.6	32.3	20.0	20.0
Numerator	34,325	48,634	69,326	40,729	40,729
Denominator	215,008	225,148	214,341	204,129	204,129
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	38.1	42.3	46.7

Field Level Notes for Form 10 NPMs:

None

NPM 13.1 - Percent of women who had a preventive dental visit during pregnancy

Federally Available Data					
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	56.4	57.4	58.5	54.1	54.1
Annual Indicator	49.8	49.2	51.3	40.8	40.8
Numerator	53,356	51,874	53,228	40,909	40,909
Denominator	107,079	105,470	103,825	100,195	100,195
Data Source	PRAMS	PRAMS	PRAMS	PRAMS	PRAMS
Data Source Year	2017	2018	2019	2020	2020

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	54.7	55.2	55.7

Field Level Notes for Form 10 NPMs:

None

NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year - Child Health

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	77.6	78.4	88.2	80.4	80.4
Annual Indicator	77.9	77.7	76.5	76.2	76.2
Numerator	1,629,730	1,618,664	1,574,401	1,540,558	1,540,558
Denominator	2,092,116	2,083,849	2,058,613	2,020,499	2,020,499
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2020_2021	2020_2021

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	81.0	81.6	82.2

Field Level Notes for Form 10 NPMs:

None

Form 10
State Performance Measures (SPMs)

State: Michigan

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

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	24.6	27.1	29.6	50	52.5
Annual Indicator	43.4	45.8	48.1	45.3	49.2
Numerator	1,308	1,671	994	718	636
Denominator	3,017	3,646	2,068	1,586	1,293
Data Source	MDHHS Data Warehouse	MDHHS Data Warehouse	MDHHS Data Warehouse	MDHHS Data Warehouse	MDHHS Data Warehouse
Data Source Year	2018	2019	2020	FY2021	FY2022
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	55.0	57.5	60.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
Results reported are for initial elevated capillary blood tests conducted in CY 2017 (Jan. 1 2017 – Dec. 31 2017) with confirmatory testing completed before Feb 2, 2018. DATA REPORTED SHOULD BE CONSIDERED PROVISIONAL: data collection for FY2017 are incomplete, and subject to change. Blood lead test results were downloaded from the MDHHS Data Warehouse on 2/2/2018. The numerator was calculated as the number of children under 72 months with at least one capillary or unknown type test ≥ 5 µg/dL from 1/1/2017 to 12/31/2017 followed by a venous blood test within 30 days. The denominator was all children under 72 months with a capillary or unknown type test ≥ 5 µg/dL from 1/1/2017 to 12/31/2017.

2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
Results reported are for initial elevated capillary blood tests conducted in CY 2018 (January 1, 2018 - December 31, 2018) with confirmatory testing completed before February 2, 2019.

DATA REPORTED SHOULD BE CONSIDERED PROVISIONAL: data collection for the last quarter of 2018 (October – December 2018) are incomplete, and subject to change. Blood lead test results were downloaded from the MDHHS Data Warehouse on 2/08/2019. The numerator was calculated as the number of children under 72 months with at least one capillary or unknown type test ≥ 5 µg/dL (> 4.5 µg/dL – Michigan began storing test results as unrounded numbers in 2017: this number was chosen maintain consistency in identifying elevated levels with past years when blood lead test results were rounded to the nearest whole number) from 01/1/2018 to 12/31/2018 followed by a venous blood test within 30 days. The denominator was all children under 72 months with a capillary or unknown type test ≥ 4.5 from 01/01/2018 to 12/31/2018.

NOTE: There have been significant improvements in the algorithm used by the MDHHS Data Warehouse to assign unique identifiers to individual children, which has corrected instances wh

3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
Results reported are for initial elevated capillary blood tests conducted in CY 2019 (Jan. 1 2019 – Dec. 31 2019) with confirmatory testing completed before Feb 2, 2020

DATA REPORTED SHOULD BE CONSIDERED PROVISIONAL: data collection for the last quarter of 2019 (October – December 2019) are incomplete, and subject to change. Blood lead test results were downloaded from the MDHHS Data Warehouse on 1/13/2020. The numerator was calculated as the number of children under 72 months with at least one capillary or unknown type test ≥ 5 µg/dL (> 4.5 µg/dL – Michigan began storing test results as unrounded numbers in 2017: this number was chosen maintain consistency in identifying elevated levels with past years when blood lead test results were rounded to the nearest whole number) from 01/1/2018 to 12/31/2018 followed by a venous blood test within 30 days. The denominator was all children under 72 months with a capillary or unknown type test ≥ 4.5 from 01/01/2018 to 12/31/2018.
NOTE: Ther

4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
DATA REPORTED SHOULD BE CONSIDERED PROVISIONAL: data collection for the last quarter of 2020 (October – December 2020) are incomplete, and subject to change. Blood lead test results were downloaded from the MDHHS Data Warehouse on 2/1/2021. The numerator was calculated as the number of children under 72 months with at least one capillary or unknown type test ≥ 5 µg/dL (> 4.5 µg/dL – Michigan began storing test results as unrounded numbers in 2017: this number was chosen to maintain consistency in identifying elevated levels with past years when blood lead test results were rounded to the nearest whole number) from 01/1/2018 to 12/31/2018 followed by a venous blood test within 30 days. The denominator was all children under 72 months with a capillary or unknown type test ≥ 4.5 from 01/01/2018 to 12/31/2018.
NOTE: There has been another significant improvement in the algorithm used by the MDHHS Data Warehouse to assign unique identifiers to individual children, which has corrected instances where children have been assigned incorrect identifiers in the past. This may contribute to the differences between the previously reported 2016 and 2017 indicators. NOTE: The annual indicator for CY 2020 already exceeded future annual objectives, so the annual objectives for 2021-2026 were adjusted.

5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

Field Note:
Results reported are for initial elevated capillary blood tests conducted in FY 2021 (October 1, 2020-Sept 30, 2021) with confirmatory testing completed and reported before December 4, 2021.

DATA REPORTED SHOULD BE CONSIDERED PROVISIONAL: Data collection for the last quarter of 2021 are incomplete, and subject to change. Blood lead test results were downloaded from the MDHHS Data Warehouse on 12/4/2021. The numerator was calculated as the number of children under 72 months with at least one capillary or unknown type test ≥ 5 µg/dL (> 4.5 µg/dL – Michigan began storing test results as unrounded numbers in 2017: this number was chosen to maintain consistency in identifying elevated levels with past years when blood lead test results were rounded to the nearest whole number) from 10/1/2020 to 09/30/2021 followed by a venous blood test within 30 days. The denominator was all children under 72 months with a capillary or unknown type test ≥ 4.5 10/01/2020 to 09/30/2021.

NOTE: Beginning in FY21, data is reported to align with the grant reporting cycle. Previous years' data are calculated for calendar year and therefore FY21 data can not be compared to prior years. Since this is the start of a new reporting period, the decision was made by CLPPP to align with the FY grant reporting period to better reflect the activities of the grant. All future reports will be reported using FY data. The target of 50% for FY21 remains in place and subsequent targets remain unchanged. For past data by FY, there has been a steady increase of the percent of EBLL capillary results that have had a venous confirmatory within 30 days, FY16: 27.8%, FY17: 34.7%, FY18: 37.9%, FY19: 39.1%, FY20: 41.5%.

6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
Results reported are for initial elevated capillary blood tests conducted in FY 2022 (October 1, 2021- September 30, 2022) with confirmatory testing completed and reported before October 31, 2021.

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

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	77	75	76	77	78
Annual Indicator	74.1	74.1	70.7	69.4	66.1
Numerator	123,596	121,707	119,786	113,259	107,075
Denominator	166,746	164,167	169,474	163,218	162,076
Data Source	Michigan Care Improvement Registry	Michigan Care Improvement Registry	Michigan Care Improvement Registry	Michigan Care Improvement Registry	Michigan Care Improvement Registry
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	79.0	80.0	80.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The Immunization rates have remained static for children 19-35 months of age in the last fiscal year.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: The immunization rates are dropping for children 19-36 months over the past year.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The COVID-19 pandemic is impacting the immunization rates in children.	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The COVID-19 pandemic has negatively impacted childhood immunization rates.	
5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The COVID-19 pandemic and an increasing trend in vaccine hesitancy has negatively impacted immunization rates of children in Michigan.	

SPM 3 - Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus vaccine

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		44	54	56	58
Annual Indicator	41.9	52.4	44.1	42.8	44.2
Numerator	313,144	334,188	331,995	326,193	334,398
Denominator	746,563	637,751	752,019	762,977	756,464
Data Source	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)	Michigan Care Improvement Registry (MCIR)
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	60.0	62.0	64.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: We have increased the number of adolescents who have completed the HPV vaccination series. Part of the reason for the significant increase was due to the change in the recommended schedule to receive the HPV series. Adolescents less than 15 years of age can complete the HPV series with only two doses of vaccine if they are separated by at least 5 months. The change in the recommended schedule resulted in a 7% increase in our vaccination rates for adolescents of this age.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: We continue to see adolescent rates increase. HPV completion rate had a slow but steady increase, as we continue to encourage parents and providers to vaccinate at the early recommended ages as to complete with just 2 doses.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: HPV completion rate continues to increase. Posting male and female combined rates for state and counties on website on immunization report card.	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The COVID-19 pandemic has negatively impacted vaccination rates among pediatric and adolescent patients.	
5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: While pediatric vaccination coverage has decreased due to the COVID-19 pandemic, adolescent rates, including HPV, are on an upward trend.	

SPM 4 - Percent of children with special health care needs enrolled in CSHCS that receive timely medical care and treatment without difficulty

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	90.9	91.9	92.9	89.5	90
Annual Indicator	88.9	88	88	88.6	88.4
Numerator	14,678,590	10,365,782	7,297,774	4,977,264	5,731,114
Denominator	16,507,392	11,783,520	8,289,380	5,616,000	6,481,200
Data Source	CAHPS	CAHPS	CAHPS	CAHPS	CAHPS
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	90.5	91.0	91.5

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Question 2 reads: “In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?” The CSHCS Program intended this measure to reflect the average of the marginal probabilities, as opposed to the joint probability of the two specified questions. Therefore, in order to provide a numerator and denominator, the individual fractions were converted using the following formula: ((A*2D) + (C*2B)) / (2B*2D) where: “In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?” A: Number who reported “usually” or “always” (2768) B: Number of respondents who answered this question (3287) “In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?” C: Number who reported “usually” or “always” (1649) D: Number of respondents who answered this question (1755).	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

	Field Note: Question 2 reads: “In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?” The CSHCS Program intended for this measure to reflect the average of the marginal probabilities, as opposed to the joint probability of the two specified questions. Therefore, in order to provide a numerator and denominator, the individual fractions were converted using the following formula: ((A*2D) + (C*2B)) / (2B*2D) where: “In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?” A: Number who reported “usually” or “always” (2,471) B: Number of respondents who answered this question (2,931) “In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?” C: Number who reported “usually” or “always” (1,317) D: Number of respondents who answered this question (1,408)	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Question 2 reads: “In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?” The CSHCS Program intended for this measure to reflect the average of the marginal probabilities, as opposed to the joint probability of the two specified questions. Therefore, in order to provide a numerator and denominator, the individual fractions were converted using the following formula: ((A*2D) + (C*2B)) / (2B*2D) where: “In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?” A: Number who reported “usually” or “always” (2,099) B: Number of respondents who answered this question (2,520) “In the last 6 months, when your child needed care right away, how often did your child get the care as soon as he or she needed?” C: Number who reported “usually” or “always” (1,083) D: Number of respondents who answered this question (1,169)	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Question 2 reads: “In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?” The CSHCS Program intended for this measure to reflect the average of the marginal probabilities, as opposed to the joint probability of the two specified questions. Therefore, to provide a numerator and denominator, the individual fractions were converted using the following formula: ((A*2D) + (C*2B)) / (2B*2D) where: “In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?” A: Number who reported “usually” or “always” (1,848) B: Number of respondents who answered this question (2,255) “In the last 6 months, when your child needed care right away, how often did your child get the care as soon as he or she needed?” C: Number who reported “usually” or “always” (865) D: Number of respondents who answered this question (919)	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**

	Field Note: To determine the percent of CSHCN enrolled in CSHCS that receive timely medical care and treatment without difficulty, CSHCS considered responses to two CAHPS questions. In 2021, the first question was number 4, “In the last 6 months, how often did you get appointments for your child with a specialist as soon as he or she needed?” and the second question was number 8, “In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?”. The following formula was used to calculate the average of independent probabilities: ((A*2D) + (C*2B)) / (2B*2D). For question 4, A: Number who reported “usually” or “always” (1,716) B: Number of respondents who answered this question (2,000). For question 8, A: Number who reported “usually” or “always” (642) B: Number of respondents who answered this question (702). For 2021, the result is 88.6%.	
6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: To determine the percent of CSHCN enrolled in CSHCS that receive timely medical care and treatment without difficulty, CSHCS considered responses to two CAHPS questions. In 2022, the first question was number 4, “In the last 6 months, how often did you get appointments for your child with a specialist as soon as he or she needed?” and the second question was number 8, “In the last 6 months, when your child needed care right away, how often did your child get care as soon as he or she needed?”. The following formula was used to calculate the average of independent probabilities: ((A*2D) + (C*2B)) / (2B*2D). For question 4, A: Number who reported “usually” or “always” (1,657) B: Number of respondents who answered this question (1,964). For question 8, C: Number who reported “usually” or “always” (763) D: Number of respondents who answered this question (825). For 2022, the result is 88.4%.	

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

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

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	61.9	63.0	64.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Weighted numbers were used to represent general population	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Weighted numbers were used to represent general population.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Weighted numbers were used to represent general population.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Weighted numbers were used to represent the general population.	

SPM 6 - Support access to developmental, behavioral, and mental health services through Title V activities and funding

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			Yes	Yes
Annual Indicator			Yes	Yes
Numerator				
Denominator				
Data Source			State Title V and MCH Programs	State Title V and MCH Programs
Data Source Year			FY2021	FY2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	Yes	Yes	Yes

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Michigan

ESM 2.1 - Number of birthing hospitals participating in Michigan AIM

Measure Status:			Active	
State Provided Data				
	2019	**2020**	**2021**	**2022**
Annual Objective			72	
Annual Indicator		50	62	65
Numerator				
Denominator				
Data Source		Michigan AIM/Michigan Hospital Association	Michigan AIM/Michigan Hospital Association	Michigan AIM/Michigan Hospital Association
Data Source Year		2019	2020	2021
Provisional or Final ?		Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	73.0	74.0	75.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: For the 2020 reporting year, 2019 designation awards were used as the definition of "participating in MI AIM."	
2.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: MI AIM designation awards are used as the data source for MI AIM participation. 2020 designation data was used for FY21, as 2021 designations were not available at the time of reporting.	
3.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: MI AIM designation awards are used as data source for MI AIM participation. 2021 designation was used for FY 2022, as 2022 designations won’t be available until spring 2023. 65 out of 80 birthing hospitals participated in MI AIM, which equates to 81% participation.	
4.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: The annual objectives were updated for 2023-2025 to reflect goals based on the current number of birthing hospitals in Michigan.	

ESM 4.1 - Percent of Baby-Friendly designated birthing hospitals in Michigan

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	20	23	26	29	18
Annual Indicator	19.5	18.8	18.8	16.3	16.5
Numerator	16	15	15	13	13
Denominator	82	80	80	80	79
Data Source	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.	Baby-Friendly USA, Inc.
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	19.0	20.0	21.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: One birthing hospital closed which decreased # of hospitals from 83 to 82. Sparrow (Carson City) closed in 2018.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: The number of Michigan birthing hospitals decreased from 82 (in FY 2018) to 80 (in FY 2019)	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: One birthing unit in Michigan closed in November 2020, bringing the total number of birthing hospitals from 80 to 79. This will not affect FY 2020 data but will need to be noted for FY 2021. Annual objectives for FY2022-2026 were updated due to the closing of a birthing hospital and the impact of the COVID-19 pandemic.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: One birthing unit in Michigan closed as of June 2022, bringing the total number of birthing hospitals from 80 to 79.	

ESM 5.1 - Increase the number of Maternal Infant Health Program agencies that have staff trained to use the concepts of motivational interviewing with safe sleep

Measure Status:				Active	
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective		85	84	83	73
Annual Indicator		83	83	78	72
Numerator					
Denominator					
Data Source		Maternal Infant Health Program (MIHP) staff	Maternal Infant Health Program (MIHP) staff	Maternal Infant Health Program (MIHP) staff	Maternal Infant Health Program (MIHP) staff
Data Source Year		2019	2020	2021	2022
Provisional or Final ?		Final	Final	Final	Final

Annual Objectives			
	2023	**2024**	**2025**
Annual Objective	72.0	72.0	72.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: There were 85 MIHP agencies in FY 2019.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: There were 83 MIHP Agencies in FY 2020. Staff at all agencies have been trained.	
3.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: There were 78 MIHP agencies in FY 2021. Staff at all agencies have been trained.	
4.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: There were 72 MIHP agencies in FY 2022. Staff at all agencies were trained.	
5.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: Annual objectives were updated to reflect the total current number of MIHP agencies (72) in Michigan in 2023.	

ESM 5.2 - Increase the number of agencies that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			10	20
Annual Indicator			1	5
Numerator				
Denominator				
Data Source			Infant Safe Sleep Program	Infant Safe Sleep Program
Data Source Year			2021	2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	10.0	15.0	20.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The original ESM active in 2021 was "Number of agencies that have implemented or revised/updated a safe sleep policy/protocol." In 2021, eight programs volunteered to participate in this project. Due to a variety of constraints (staff turnover, COVID-19 pandemic) only one program was able to implement a policy. This ESM was updated in 2022 to focus on technical assistance to agencies.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Four agencies received technical assistance and support with implementing and/or updating a safe sleep policy in 2022. Of those, one agency implemented a policy and another updated their policy. The annual indicator represents a cumulative count. The annual objectives for 2023-2025 were updated in 2023 to establish more attainable targets, given the impact of the COVID-19 pandemic.	

ESM 5.3 - Increase the number of hospitals that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			2	4
Annual Indicator			2	3
Numerator				
Denominator				
Data Source			Infant Safe Sleep Program	Infant Safe Sleep Program
Data Source Year			FY2021	FY2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	6.0	8.0	10.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The original ESM active in 2021 was "Number of hospitals that have implemented or revised/updated a safe sleep policy/protocol for the NICU." Two hospitals participated in this project. Both had an existing safe sleep policy. One did not make any revisions and the other plans to finalize updates next fiscal year. This ESM was updated in 2022 to focus on technical assistance to hospitals.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Annual objectives reflect a cumulative count based on the goal of Infant Safe Sleep staff obtaining/reviewing policy/protocols for two birthing hospitals per year.	

ESM 9.1 - Number of secondary schools implementing the Michigan Model for Health™ Social and Emotional Health Module with 80% fidelity

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			5	11
Annual Indicator			5	5
Numerator				
Denominator				
Data Source			Classroom Implementation Logs	Classroom Implementation Logs
Data Source Year			2020-2021	2021-2022
Provisional or Final ?			Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	16.0	22.0	28.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data reported over the 2020-2021 school year. Six schools were recruited, but one school was unable to continue with the Michigan Model for Health-Social and Emotional Health module implementation due to COVID-19.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Six schools were participating but one didn’t complete all grant activities due to staff turnover. School re-enrolled for FY 2023.	
3.	**Field Name:**	**2023**
	Column Name:	**Annual Objective**
	Field Note: The 2023-2025 annual objectives were updated in 2023 to account for five schools instead of six schools that participated at the beginning of the project, while maintaining the goal of six schools for the remainder of the five-year cycle. COVID-19 reduced staff time and instruction time available to dedicate to this project in 2020-2022, resulting in one school in 2020 and one school in 2021 that didn’t complete the project.	

ESM 12.1 - Percent of CSHCS clients age 18 to 21 years in selected diagnosis groups that have transferred care from a pediatric to an adult provider

Measure Status:	Inactive - Replaced				
State Provided Data					
	2018	**2019**	**2020**	**2021**	**2022**
Annual Objective	43	46	49	49.2	49.4
Annual Indicator	49.9	46.7	46.5	45.3	42.8
Numerator	1,725	1,787	1,995	1,923	1,869
Denominator	3,459	3,828	4,289	4,245	4,366
Data Source	CSHCS database, Medicaid Claims, UM Provider Datab	CSHCS database, Medicaid Claims, UM Provider Datab	CSHCS database, Medicaid Claims, UM Provider Datab	CSHCS database, Medicaid Claims, UM Provider Datab	CSHCS data, CHAMPS, UM provider database
Data Source Year	2017	2018	2019	2020	2021
Provisional or Final ?	Provisional	Provisional	Provisional	Provisional	Provisional

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: The ESM combines three separate data sources: 1) the CSHCS database; 2) the CHAMPS (Medicaid Claims) database; and 3) University of Michigan provider database. These three databases provide information on CSHCS clients, and the providers they see. Percent of children enrolled in CSHCS within a selected diagnosis groups who had an outpatient visit with adult specialists only, based on administrative claims. The selected diagnosis groups included: cardiology, endocrinology, gastroenterology, hematology-oncology, nephrology, neurology, pulmonology and rheumatology.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

	Field Note: The ESM combines three separate data sources: 1) CSHCS database, 2) CHAMP (Medicaid claims) database; and 3) University of Michigan provider database. These three databases provide information on CSHCS clients and the providers they see. In FY 2017, 49.9% of CSHCS clients ages 18-20 in selected diagnosis groups had outpatient visits only with adult specialists, based on administrative claims. The selected diagnosis groups were cardiology, endocrinology, gastroenterology, hematology-oncology, nephrology, neurology, pulmonology and rheumatology.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: ESM includes clients ages 18, 19 and 20. Clients age out on their 21st birthday. In FY 2018, 46.7% of CSHCS clients ages 18 to 21 in selected diagnosis groups had outpatient visits only with adult specialists, based on administrative claims. The selected diagnosis groups were cardiology, endocrinology, gastroenterology, hematology-oncology, nephrology, neurology, pulmonology and rheumatology.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: ESM includes clients ages 18, 19 and 20. Clients age out on their 21st birthday. In FY 2019, 46.5% of CSHCS clients ages 18-20 in selected diagnosis groups had outpatient visits only with adult specialists, based on administrative claims. The selected diagnosis groups were cardiology, endocrinology, gastroenterology, hematology-oncology, nephrology, neurology, pulmonology, and rheumatology. In FY2021, due to consistent performance near 46.0%, CSHCS adjusted targets for FY2021 to FY2026 to be more realistic with performance and to adjust goals to conform to changing practice standards regarding age of transfer to an adult provider.	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The ESM combines three separate data sources: 1) CSHCS database, 2) CHAMP (Medicaid claims) database; and 3) University of Michigan provider database. These three databases provide information on CSHCS clients and the providers they see. The ESM includes clients ages 18, 19 and 20. Clients age out on their 21st birthday. In FY 2020, 45.3% of CSHCS clients ages 18-20 in selected diagnosis groups had outpatient visits only with adult specialists, based on administrative claims. The selected diagnosis groups were cardiology, endocrinology, gastroenterology, hematology-oncology, nephrology, neurology, pulmonology, and rheumatology.	
6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**

Field Note:
The ESM combines three separate data sources: 1) CSHCS database, 2) CHAMP (Medicaid claims) database; and 3) University of Michigan provider database. These three databases provide information on CSHCS clients and the providers they see. University of Michigan implemented a change in their transition policy which shifted the age at which transfer of care occurs from age 18 to age 21. Since this ESM is targeting transfer of care to an adult provider by age 21, this change directly impacts the annual indicator. The COVID-19 pandemic is also a contributing factor.

ESM 12.2 - Percentage of CSHCS partner organizations whose total score increased on the Assessment of Health Care Transition Activities.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives		
	2024	2025
Annual Objective	30.0	40.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2024**
	Column Name:	**Annual Objective**

Field Note:
This ESM was newly created and added in 2023 for the FY 2024 application. Prior baseline data is not available.

ESM 13.1.1 - Number of medical and dental professionals who receive perinatal oral health education through MDHHS

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective		390	410	430	450
Annual Indicator	648	401	423	439	253
Numerator					
Denominator					
Data Source	FY2018 MDHHS Tracking Database	FY2019 MDHHS Tracking Database	FY2020 MDHHS Tracking Database	FY2021 MDHHS Tracking Database	FY 2022 MDHHS tracking database
Data Source Year	FY2018	FY2019	FY2020	FY2021	FY2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	470.0	490.0	510.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: This ESM was newly established in 2018 to align with NPM 13.1. Therefore, there is no column for reporting 2018 data. In FY2018, 648 medical and dental professionals received perinatal oral health education through MDHHS. FY2018 exceeded expectations regarding provider education. This was due to the continued addition of different education activities across the state.	
2.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: FY 2019 exceeded the annual target for provider education due to the addition of educational activities across the state. Note: the perinatal oral health consultant was on maternity leave for several months of the reporting period, resulting in a decrease in the number of professionals trained in comparison to previous years.	
3.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: FY 2020 slightly exceeded the annual target for provider education due to the addition of educational activities across the state. Due to COVID-19, many educational events and conferences were cancelled or held virtually with lesser attendance. In addition, preventative dental services ceased for several months due to the pandemic and much education shifted to COVID-19 related provider education. It was challenging to keep provider education counts high regarding perinatal and infant oral health.	
4.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: FY 2021 slightly exceeded the annual target for provider education due to the addition of educational activities across the state. COVID-19 continued to cause challenges to the OHP, including education. The OHP worked diligently to offer virtual educational opportunities and meet the changing needs of the health professional community and seek out new partners to promote perinatal and infant oral health.	
5.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: FY 2022 did not meet the annual target due to an extended maternity leave for the MDHHS Perinatal Oral Health Consultant. As in previous years, COVID-19 continued to cause challenges in many facets of the Oral Health Program (OHP), including education. The OHP worked diligently to offer virtual educational opportunities, meet the changing needs of the health professional community, and seek out new partners to promote perinatal and infant oral health.	

ESM 13.1.2 - Percent of pregnant people who receive at least one oral health service through Medicaid during the perinatal period

Measure Status:	Active

State Provided Data				
	2019	2020	2021	2022
Annual Objective			40	41
Annual Indicator			21.2	20
Numerator			8,466	7,722
Denominator			39,940	38,517
Data Source			Medicaid Data 2020	Medicaid Data 2021
Data Source Year			FY2020	FY2021
Provisional or Final ?			Provisional	Provisional

Annual Objectives			
	2023	2024	2025
Annual Objective	42.0	43.0	44.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: Data have a one-year lag time for reporting. COVID-19 was a barrier to the receipt of dental care during pregnancy for women on Medicaid in 2020.	
2.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: Data have a one-year lag time for reporting. Community partners report COVID-19, a lack of dentists who accept Medicaid, and dental staffing shortages as barriers to the receipt of dental care during pregnancy for women on Medicaid in 2021.	

ESM 13.2.1 - Number of students who have received a preventive dental screening through the SEAL! Michigan program

Measure Status:	Active

State Provided Data					
	2018	2019	2020	2021	2022
Annual Objective	6,127	6,327	6,527	6,727	6,927
Annual Indicator	6,964	6,897	6,168	3,639	9,396
Numerator					
Denominator					
Data Source	SEAL MI 2018 All Grantees Data Report	SEAL MI 2019 All Grantees Data	SEAL MI 2020 All Grantees Data Report	SEAL MI 2021 All Grantees Data Report	SEAL MI 2022 All Grantees Data Report
Data Source Year	2018	2019	2020	2021	2022
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives			
	2023	2024	2025
Annual Objective	6,927.0	7,127.0	7,327.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Goal was achieved, this is likely due to the additional funding under Title V.	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Goal was exceeded, likely due to funding opportunities that supported program expansion.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: In 2019 there was a loss of dental programs due to a loss of federal funding. However, the programs cut served the lowest number of students--and existing programs grew internally in each school and also added new schools to serve students. Thus, annual objectives were still achieved.	
4.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: The original 2020 annual objective (which was set before the COVID-19 pandemic) was not achieved due to challenges resulting from the COVID-19 pandemic. As a response to the COVID-19 pandemic, schools and preventive dentistry were closed under Executive Order No. 2020-17 between March 21, 2020 and May 29, 2020. Thus, SEAL! Michigan providers were unable to serve students via school-based care for several months as the Executive Order expanded into summer vacation, and various school closures extended into the fall.	
5.	**Field Name:**	**2021**
	Column Name:	**State Provided Data**
	Field Note: The annual objective was not reached due to the COVID-19 pandemic.	
6.	**Field Name:**	**2022**
	Column Name:	**State Provided Data**
	Field Note: The 2022 goal was exceeded, likely due to additional funding acquired from the Delta Dental Foundation.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Michigan

SPM 1 - Percent of children less than 72 months of age who receive a venous lead confirmation testing within 30 days of an initial elevated capillary test
Population Domain(s) – Child Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To reduce the number of young children in Michigan with an unconfirmed elevated blood lead level</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of children 0-71 months of age who received a venous blood lead test within 30 days of an initial capillary or unknown test result of greater than or equal to 5 µg/dL</td></tr>
<tr><td>Denominator:</td><td>Number of children 0-71 months of age with an initial capillary or unknown test result of greater than or equal to 5 µg/dL</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>These data are provided by the Michigan Department of Health and Human Services (MDHHS) Childhood Lead Poisoning Prevention Program (CLPPP). Some blood lead levels are reported to CLPPP as decimal values, but currently all are recorded in the data warehouse as integers (decimals are rounded up at ≥0.5).</td></tr>
<tr><td>Significance:</td><td>Exposure to lead, which can enter the body through ingestion or inhalation, can result in negative health effects. Children less than six are vulnerable to the effects of lead poisoning, especially at younger ages when they are likely to put contaminated hands and items (such as toys) into their mouths. Exposure to high levels of lead can result in brain damage and even death in extreme cases. Low levels of lead in the body have been shown to affect IQ, the ability to pay attention, and academic achievement. 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.</td></tr>
</table>

SPM 2 - Percent of children 19 to 36 months of age who have received a completed series of recommended vaccines (4313314 series)
Population Domain(s) – Child Health

Measure Status:	Active
Goal:	To increase the percent of all children 19 to 36 months of age to have a completed immunization series for all vaccines recommended by the Advisory Committee on Immunization Practices.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 19-36 month old children who have a completed 4313314 series. **Denominator:** Population of 19-36 month old children
Data Sources and Data Issues:	Data will be obtained from the Michigan Care Improvement Registry (MCIR). Since 1998, Michigan has operated the MCIR to collect all immunizations administered to individuals less than 20 years of age and born after December 31, 1993. MCIR has become a robust immunization tool used by immunization providers to assure that all children are vaccinated according to the ACIP schedules. Tracking immunizations in the MCIR help immunization providers forecast for needed doses of vaccine and at the same time prevent over-vaccination of individuals due to poor record-keeping or moving from one provider to another.
Significance:	Children die or are hospitalized every year from vaccine preventable diseases. These are avoidable outcomes if we can assure that all children have received all recommended vaccines based on the schedule recommended by the ACIP. Note: This was formerly a two-part measure. As of 2018, the second part of this measure (Percent of adolescents age 13-18 who have received a completed HPV vaccine series) is included in a separate SPM.

SPM 3 - Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus vaccine
Population Domain(s) – Adolescent Health

Measure Status:	Active
Goal:	To increase the adolescent HPV coverage rate.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of 13 to 18 year old adolescents in the MCIR who have a completed the HPV 3 dose series **Denominator:** Population of 13 to 18 year old adolescents in MCIR
Data Sources and Data Issues:	Data will be obtained from the Michigan Care Improvement Registry (MCIR). MCIR is a population-based registry. Since 1998, Michigan has operated the MCIR to collect all immunizations administered to individuals less than 20 years of age and born after December 31, 1993. MCIR has become a robust immunization tool used by immunization providers to assure that all children are vaccinated according to the ACIP schedules. Tracking immunizations in the MCIR helps immunization providers forecast for needed doses of vaccine and simultaneously prevent over-vaccination of individuals due to poor record-keeping or moving from one provider to another.
Significance:	HPV is a safe and effective vaccine. It is estimated that 79 million Americans are currently infected with HPV. Every year in the United States, 27,000 people are diagnosed with cancer caused by HPV in both females and males. In 2011, over 11,000 newly diagnosed cases of cervical cancer in women and 4,000 attributable deaths occurred. Routine vaccination will prevent over 90% of cases of cervical cancer. Data from other countries have shown that obtaining at least a 50% coverage level has decreased the prevalence of HPV by at least 68%.

SPM 4 - Percent of children with special health care needs enrolled in CSHCS that receive timely medical care and treatment without difficulty
Population Domain(s) – Children with Special Health Care Needs

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To reduce the proportion of CYSHCN who are unable to obtain, or are delayed in obtaining, necessary medical care.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The combined score of respondents who reported they usually or always got an appointment for their child to see a specialist as soon as needed and it was easy to get the care, tests, or treatment their child needed in the past 6 months</td></tr>
<tr><td>Denominator:</td><td>Number of questions contributing to the numerator</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Consumer Assessment of Healthcare Providers and Systems (CAHPS) – Children with chronic conditions custom survey. Challenges with the data include the following: the survey is conducted bi-annually; limited number of respondents when controlled for certain demographic factors.</td></tr>
<tr><td>Significance:</td><td>This measure is significant because it provides insight into parents’/caretakers’ assessment of their ability to get needed care for their child with special needs. The numerator for the measure is determined by taking the average score from two questions of the CAHPS survey: “In the last 6 months, how often did you get an appointment for your child to see a specialist as soon as you needed?” and “In the last 6 months, how often was it easy to get the care, tests, or treatment your child needed?” Questions are scored by calculating the percentage of respondents that answer “Usually” or “Always.”</td></tr>
</table>

SPM 5 - Percent of people assigned female at birth who had a live birth and reported that their pregnancy was intended
Population Domain(s) – Women/Maternal Health

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the proportion of women with an intended pregnancy</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Women who had a live birth who reported, at the time of conception, that they had wanted to get pregnant either right then or had wanted to be pregnant sooner.</td></tr>
<tr><td>Denominator:</td><td>All Michigan mothers of live born infants</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Data collected from the Michigan Pregnancy Risk Assessment Monitoring System (MI PRAMS) survey. MI PRAMS uses responses from a randomly selected sample of new mothers each year in Michigan to describe characteristics for the whole population of mothers of live born infants.

Pregnancy intention is related to the concept of desired pregnancy timing. PRAMS responders are asked the question: "Thinking back to just before you got pregnant with your new baby, how did you feel about becoming pregnant?"

Women who respond "I wanted to be pregnant sooner" or "I wanted to be pregnant then" are classified as having an intended pregnancy. Women answering, "I wanted to be pregnant later," "I didn’t want to be pregnant then or at any time in the future," or "I wasn’t sure what I wanted" are not classified as having an intended pregnancy.</td></tr>
<tr><td>Significance:</td><td>Assisting women and families to decide when and if they want to have children leads to improved health outcomes and financial stability. Assuring that women enter pregnancy in the best possible health is critical for both healthy babies and mothers. For women, reproductive health is critical in that nearly three decades are spent avoiding an unintended pregnancy (Sonfield, Hasstedt, & Gold, 2014) to address educational attainment, career prospects, and financial stability. When pregnancies are unintended, entering pregnancy healthy can prove difficult and result in higher health care costs for mothers and infants. Short inter-pregnancy intervals are associated with increased risk for preterm birth, low birthweight, small for gestational age, and perinatal death. Optimal birth spacing allows for recovery from pregnancy and parent/infant attachment. Two key tools for increasing intended pregnancy and healthy birth spacing are access to contraception and assessing pregnancy intention. While no single method of contraception is right for everyone, the type of method used by women is strongly associated with her risk of unintended pregnancy. Assessing pregnancy intention assists individuals to think about when and under what circumstances they would like to become pregnant or conversely, how pregnancy will be prevented, with the primary focus on increasing the overall health and well-being of the individual regardless of reproductive intentions.

American College of Obstetricians and Gynecologists. Prepregnancy counseling. Committee Opinion No. 762. Obstet Gynecol 2019; 133(1): e78-89. https://www.acog.org/Committee-Opinions/no.762

Gavin L, Moskosky S, Carter M, et al. Providing Quality Family Planning Services: Recommendations of CDC and the U.S. Office of Population Affairs, 2014. MMWR Recomm Rep 2014:63 (No. RR-4): 1-29. DOI: http://dx.doi.org/10.15585/mmwr.rr6304a1</td></tr>
</table>

SPM 6 - Support access to developmental, behavioral, and mental health services through Title V activities and funding
Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Support the work of state and local MCH programs that are addressing developmental, behavioral, and mental health services and needs.
Definition:	**Unit Type:** Text **Unit Number:** Yes/No **Numerator:** N/A **Denominator:**
Data Sources and Data Issues:	State Title V and MCH Programs
Significance:	During Michigan's five-year needs assessment, needs related to mental and behavioral health were identified throughout the Mobilizing for Action through Planning and Partnerships (MAPP) assessments. These needs were identified across population domains but especially within women's health, adolescent health, and children with special health care needs. A person's mental health impacts their thoughts, behaviors, and overall well-being. Access to timely and appropriate mental and behavioral health services is critical, and yet access to care remains a barrier (America's Mental Health 2018; Cohen Veterans Network and the National Council for Behavioral Health). This SPM was created to 1) better capture Title V work related to mental and behavioral health and 2) promote an increased focus on mental and behavioral health across Title V and MCH programs.

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Michigan

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Michigan

ESM 2.1 - Number of birthing hospitals participating in Michigan AIM
NPM 2 – Percent of cesarean deliveries among low-risk first births

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the number of birthing hospitals participating in Michigan AIM.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>78</td></tr>
<tr><td>Numerator:</td><td>Number of birthing hospitals participating in Michigan AIM</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Michigan AIM</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>This ESM measures the number of birthing hospitals that participate in the Michigan Alliance for Innovation on Maternal Health (MI AIM). AIM offers a Safe Reduction of Primary Cesarean Birth patient safety bundle. The evidence indicates that cesarean delivery is overused and is a significant maternal health safety issue. ACOG Obstetric Care Consensus: https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery and Obstetrics & Gynecology journal article: National Partnership for Maternal Safety: Consensus Bundle o... : Obstetrics & Gynecology (lww.com). The number of birthing hospitals participating in MI AIM correlates with a commitment to patient safety and utilizing standardized, evidence-based resources and recommendations to reduce maternal morbidity and mortality, including that related to low-risk, non-medically necessary cesarean deliveries.</td></tr>
<tr><td>Significance:</td><td>For some medical indications, like placenta previa, cesarean birth is the safest delivery method and at times can be a life-saving measure. However, for most low-risk pregnancies, a cesarean delivery increases preventable risks for maternal mortality and morbidity outcomes. Such outcomes include mortality due to hemorrhage or morbidities such as infection, uterine rupture, cardiac arrest and anesthesia complications. A low-risk delivery is often defined as full-term (at least 37 completed weeks of gestation), singleton pregnancy (not a multiple pregnancy), with vertex presentation (head facing downward position in the birth canal). From 2012-2016, 15.3 % of pregnancy-related deaths in Michigan were due to hemorrhage and 54.2% of pregnancy-related deaths were deemed preventable. In 2018, the percentage of low-risk cesarean deliveries in Michigan was 28.7%, which is above the Healthy People 2020 goal (24.7%) and the average in the United States (25.9%). In addition, Michigan also has a higher percentage of low-risk cesarean deliveries in women of color.

To address the high percentage of low-risk cesarean deliveries, including the disparate numbers among women of color, Michigan will increase the number of birthing hospitals participating in Michigan AIM. It is expected that birthing hospitals engaging and participating in Michigan AIM will experience improved birth outcomes.</td></tr>
</table>

ESM 4.1 - Percent of Baby-Friendly designated birthing hospitals in Michigan
NPM 4 – A) Percent of infants who are ever breastfed B) Percent of infants breastfed exclusively through 6 months

Measure Status:	Active
Goal:	By increasing the number of Michigan birthing hospitals with Baby-Friendly designation, the proportion of live births that occur in Michigan birthing hospitals that provide recommended care for lactating mothers and their babies will increase.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of Michigan birthing hospitals with Baby-Friendly designation **Denominator:** Number of Michigan birthing hospitals
Data Sources and Data Issues:	Baby-Friendly USA, Inc. (BFUSA)
Evidence-based/informed strategy:	This ESM measures the proportion of birthing hospitals in Michigan that have successfully achieved the Baby-Friendly designation, which is conferred by BFUSA. The evidence shows that the implementation of the Ten Steps to Successful Breastfeeding as part of the Baby-Friendly Hospital designation can effectively increase rates of breastfeeding initiation and the percentage of infants who are breastfed exclusively. https://doi.org/10.1542/peds.108.3.677. By expanding the number of Baby-Friendly Hospitals in Michigan, more pregnant people in Michigan will have access to birthing hospitals that have implemented Baby-Friendly practices, which have shown to effectively promote and support breastfeeding.
Significance:	Baby-Friendly designated birthing hospitals and centers 1) promote breastfeeding as the best method of infant feeding; 2) implement evidence-based practices to support breastfeeding and lactation; 3) facilitate informed health care decision-making for mothers and families; 4) ensure health care delivery that is sensitive to cultural and social diversity, 5) protect mothers and families from false or misleading product promotion and advertising, and 6) educate parents on safe and appropriate methods for formula mixing, handling, storage, and feeding when a mother has chosen not to breastfeed or has chosen to supplement. The Baby-Friendly Hospital Initiative is a global program launched by the World Health Organization and the United Nations Children's Fund in 1991 to encourage and recognize hospitals and birthing centers that provide the best level of care for infant feeding and mother/baby bonding. Baby-Friendly designation is built on the implementation of Ten Steps to Successful Breastfeeding and the International Code of Marketing of Breast-Milk Substitutes, which empowers birthing facilities to examine maternity care policies and procedures, requires training and skill building for all levels of staff, and involves the development of quality assurance mechanisms within all aspects of maternity care operations. Baby-Friendly designated birthing hospitals and centers support healthy outcomes for both baby and mom, and can help to reduce breastfeeding disparities, especially within communities of color and low socioeconomic status communities.

ESM 5.1 - Increase the number of Maternal Infant Health Program agencies that have staff trained to use the concepts of motivational interviewing with safe sleep
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Improvements in how home visitors talk to families about infant safe sleep will lead to improvements in parent behavior, with the ultimate goal to reduce the number of sudden unexpected infant deaths.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** N/A - this is a count **Denominator:**
Data Sources and Data Issues:	Maternal Infant Health Program (MIHP). MIHP Agencies provide the data after staff have completed the training Helping Families Practice Infant Safe Sleep (Safe Sleep 201).
Evidence-based/informed strategy:	This ESM measures the number of MIHP agencies that have their staff trained to use the concepts of Motivational Interviewing with safe sleep. The recommendations from the AAP Task Force on Sudden Infant Death Syndrome (SIDS) indicate that providers need to have "open and non-judgmental" conversations with families about their sleep practices. Using the concepts from Motivational Interviewing, an evidence-based intervention, is a way to provide education to providers on how to do that. https://publications.aap.org/pediatrics/article/150/1/e2022057990/188304/Sleep-Related-Infant-Deaths-Updated-2022; Motivational Interviewing: An Evidence-Based Approach for Use in Medical Practice - PMC (nih.gov)
Significance:	Positively impacting parental behavior requires addressing known barriers to implementing safe sleep practices: parental knowledge and misconceptions, preference and situation; social determinants of health; and family practices and culture. Increased skills by MIHP providers on how to promote behavior change will increase the likelihood families will follow the safe sleep guidelines. MIHP agencies serve approximately 20,000 pregnant moms on Medicaid annually. Targeting MIHP providers helps to reach the most high-risk mothers and families.

ESM 5.2 - Increase the number of agencies that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Ensure staff are knowledgeable about safe sleep guidelines and how to support parents. Ensure parents receive safe sleep messaging and resources to reduce the number of sudden unexpected infant deaths.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** N/A – this is a count **Denominator:**
Data Sources and Data Issues:	Data Source is the Infant Safe Sleep Program. The Infant Safe Sleep Program will track all the agencies that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol.
Evidence-based/informed strategy:	This ESM measures the number of agencies that receive technical assistance and support with implementing or revising a safe sleep policy. MCH Evidence, Evidence Tools for NPM 5 suggests that there is moderate evidence that caregiver education improves outcomes. When agencies have a policy requiring caregiver education, it ensures that the education is happening. https://www.mchevidence.org/tools/npm/5-safe-sleep.php
Significance:	Strategies to increase the percentage of infants sleeping safely include supporting the implementation of safe sleep practices through policies and protocols. When agencies implement an infant safe sleep policy/protocol, they are more likely to have staff knowledgeable about safe sleep and how to educate and support parents.

ESM 5.3 - Increase the number of hospitals that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol
NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active
Goal:	Ensure parents receive safe sleep messaging and that infant safe sleep is modeled by hospital staff, thereby reducing the number of sudden unexpected infant deaths.
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** N/A – this is a count **Denominator:**
Data Sources and Data Issues:	Data Source is the Infant Safe Sleep Program. The Infant Safe Sleep Program will track all hospitals that receive technical assistance and support with implementing or revising/updating their safe sleep policy/protocol.
Evidence-based/informed strategy:	This ESM measures the number of hospitals that receive technical assistance and support with implementing or revising a safe sleep policy. Recommendations from the AAP Task Force on SIDS indicate that hospitals should ensure that patient care and staff training policies are consistent with updated safe sleep recommendations. In addition, the National Action Partnership to Promote Safe Sleep (NAPPSS-IIN) project recommended strategy/change idea is that hospitals have a safe sleep policy that is consistent with the recommendations from the AAP Task Force on SIDS. https://publications.aap.org/pediatrics/article/150/1/e2022057990/188304/Sleep-Related-Infant-Deaths-Updated-2022; Successful Strategies Hospitals Can Use to Support Safe Sleep
Significance:	When health care providers, including nurses, are educated on infant safe sleep, families are more likely to follow recommended infant safe sleep practices. One study showed that those who are educated on safe sleep by their health care provider were more likely to intend to sleep safely and follow through with that intention (Factors Associated with Choice of Infant Sleep Position, http://pediatrics.aappublications.org/content/140/3/e20170596). Nursing education and role modeling increases parental adherence to infant safe sleep practices (TodaysBaby Quality Improvement: Safe Sleep Teaching and Role Modeling in 8 US Maternity Units, http://pediatrics.aappublications.org/content/early/2017/10/11/peds.2017-1816).

ESM 9.1 - Number of secondary schools implementing the Michigan Model for Health™ Social and Emotional Health Module with 80% fidelity
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

Measure Status:	Active
Goal:	Annually increase by six the number of secondary schools implementing the Michigan Model for Health™ Social and Emotional Health Module with 80% fidelity
Definition:	**Unit Type:** Count **Unit Number:** 100 **Numerator:** The number of secondary schools implementing the Michigan Model for Health™ Social and Emotional Health Module with 80% fidelity **Denominator:**
Data Sources and Data Issues:	Teacher implementation logs. Classroom teachers will complete implementation logs tracking the lessons taught from the Michigan Model for Health™ Social and Emotional Health Module. The measure will reflect a cumulative count over time.
Evidence-based/informed strategy:	1) This ESM measures the number of secondary schools providing skills-based instruction on social and emotional health through implementing the Michigan Model for Health with fidelity (80% of lessons taught). 2) The Michigan Model for Health curriculum is recognized as an evidence-based SEL program by the Collaborative for Social and Emotional Learning (CASEL), https://casel.org/. A randomized control study found that students who received instruction from the MMH curriculum showed statistically significant improvements in social emotional health skills and less reported aggression in the past 30 days. J Sch Health 81 no6 Je 2011 p. 320-30 3) A large body of research indicates that a whole school approach is required to impact bullying incidents in schools. One essential component of the whole school approach is skills-based health education that centers social emotional learning. Implementing curriculum with fidelity is required to ensure that evidence-based outcomes are realized. Ensuring that all students receive the instruction ensures that the health education component of bullying prevention equips all students with skills that will impact bullying schoolwide.
Significance:	Bullying takes a toll on the entire school community, with potentially lasting harm. Nearly 30% (29.6%) of Michigan high school students report experiencing bullying (MI YRBS 2017). For those who are bullied, the resulting trauma can persist into adulthood. The link between bullying and suicide also illuminates the need to recognize the damage bullying can inflict. At the school level, educational achievement can be hampered by bullying experiences through reduced test scores. A student who is stressed and feels unsafe may struggle to succeed academically. Students who bully also suffer emotionally and academically, with a higher likelihood of defiant and delinquent behaviors, school drop-out and poor academic performance. A lack of respect for and understanding of others increases stress, violence and trauma. Addressing the environment that allows bullying to thrive means teaching all students the importance of empathy, respect for differences and managing emotions. Social emotional learning (SEL) incorporates the skills that help to prevent bullying behavior. Teaching all

students those skills arms them against participating, on any level, in bullying.

The Michigan Model for Health™ (MMH) is a Pre-K-12, comprehensive school health education curriculum recognized by the Collaborative for Social and Emotional Learning (CASEL) as an evidence-based SEL program. Evaluators found in a 2011 randomized control study that students who received the MMH curriculum showed statistically significant positive changes, including better interpersonal communication skills, stronger social and emotional health skills, and less reported aggression in the past 30 days. SEL is a structured way to improve a wide range of students' social and emotional competencies and impact bullying at the individual and peer levels.

ESM 12.1 - Percent of CSHCS clients age 18 to 21 years in selected diagnosis groups that have transferred care from a pediatric to an adult provider
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Inactive - Replaced</td></tr>
<tr><td>Goal:</td><td>To monitor and increase the number of young adults that appropriately transfer care from a pediatric to an adult health care provider.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>The number of CSHCS enrollees, aged 18 to 21, that have transferred care from a pediatric to an adult provider.</td></tr>
<tr><td>Denominator:</td><td>The total number of CSHCS enrollees, aged 18 to 21, that have received care from a pediatric provider.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>This ESM combines three separate data sources: 1) the CSHCS database, 2) the CHAMPS (Medicaid Claims) database, and 3) a University of Michigan provider database. These three databases provide information on CSHCS clients, and the providers they see.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>1. This ESM measures the percentage of adolescents and young adults with special health care needs that have only seen an adult provider within the past 12 months indicating a transfer of care from pediatric to adult health care.
2. Although the importance of health care transition is well recognized, evidence indicates there is limited research on effective data collection methods(strategies?) that measure successful transition outcomes. The transitional care literature has supported the importance of attending the first adult clinic appointments as a marker for ongoing adult care. Measurable Outcomes After Transfer From Pediatric to Adult Providers in Youth With Chronic Illness - Journal of Adolescent Health (jahonline.org)
3. Tracking the percentage of CSHCS clients ages 18 to 21 that have only seen an adult provider in the last year, will provide an additional data collection method for CSHCS to monitor HCT in Michigan. The data obtained can be utilized to guide the dissemination of resources to youth and providers, monitor the effectiveness of the outreach efforts, and lead to an increase the percentage of CYSHCN who receive services to prepare for the transition to adult health care in Michigan.</td></tr>
<tr><td>Significance:</td><td>This measure allows us to evaluate the percentage of adolescents and young adults with special needs who transfer care from a pediatric to an adult provider. By analyzing the providers these young adults are seeing (CSHCS authorized providers and Medicaid Claims), we can determine if new providers have been identified, and if the initial visit with the adult provider was completed.</td></tr>
</table>

ESM 12.2 - Percentage of CSHCS partner organizations whose total score increased on the Assessment of Health Care Transition Activities.
NPM 12 – Percent of adolescents with and without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To develop a successful QI process with CSHCS partners that will expand Health Care Transition (HCT) services for CYSHCN (reflected in an increase assessment score) by incorporating the Six Core Elements of HCT into their program.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of CSHCS partner organizations whose total score increased on the Assessment of Health Care Transition Activities.</td></tr>
<tr><td>Denominator:</td><td>Total number of CSHCS partner organizations that participated in the Assessment of Health Care Transition Activities.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The MDHHS CSHCS program will contract with the Michigan State University Institute of Health Policy (MSU-IHP) to disseminate the Assessment of Health Care Transition Activities survey annually to CSHCS partners, collect survey responses, and analyze data. The assessment questions were based on Got Transition’s Six Core Elements of Health Care Transition survey tool and scored utilizing Got Transition’s scoring method (Level 1-basic to level 4-most comprehensive). Data limitations may occur with decreased survey responses.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>1) This ESM measures the percent of CSHCS partner organizations who have implemented additional Six Core Elements of HCT activities (as indicated by an improvement in their Assessment of HCT Activities score)
2) This ESM aligns with the MCH Best Strategy “Six Core Elements Adaption with Quality Improvement (QI). MCHbest. NPM 12: Health Care Transition | MCH Evidence.
3) Got Transition’s Six Core Elements of HCT define the basic components of a structured transition process. By implementing this QI process, CSHCS can accurately measure current HCT activities for CSHCS partners and provide HCT training and education based on the feedback and scores received to assist them with increasing the support and/or improve the consistency with which they provide HCT services to CYSHCN. The implementation of additional Six Core Elements of HCT activities (as indicated by an improvement in their Assessment of HCT activities score) indicates they are improving the quality and quantity of transition related services for youth and their families. This increase and improvement will result in an increase in NPM 12.</td></tr>
<tr><td>Significance:</td><td>The Assessment of Health Care Transition Activities survey provides a snapshot of how well CSHCS partner organizations are implementing the Six Core Elements of Health Care Transition for CYSHCN. To improve their HCT assessment score, partners must increase the support and/or improve the consistency with which they provide HCT services to CSHCS clients. The implementation of additional activities that utilize Got Transition’s Six Core Elements of Health Care Transition will lead to an increase in the percentage of CYSHCN that are receiving services necessary to transition to adult health care.</td></tr>
</table>

ESM 13.1.1 - Number of medical and dental professionals who receive perinatal oral health education through MDHHS
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

Measure Status:	Active
Goal:	Increase provider knowledge of perinatal oral health as well as provider comfort in discussing the importance of oral health with patients.
Definition:	**Unit Type:** Count **Unit Number:** 1,000 **Numerator:** N/A - This is a count **Denominator:**
Data Sources and Data Issues:	The data source for this measure will be a tracking database developed by the MDHHS oral health program. This database includes a monthly count of the number and types of providers trained in perinatal oral health as well as the location and mechanism of education.
Evidence-based/informed strategy:	1) This ESM measures the numbers of providers trained to treat and refer pregnant people for oral health care as well as provider feedback when applicable. 2) The evidence is clear that providers need additional information surrounding the importance of perinatal and infant oral health. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/08/oral-health-care-during-pregnancy-and-through-the-lifespan 3) By training providers on practical ways to integrate perinatal and infant oral health into their practice, more pregnant people will have access to appropriate oral health care during their pregnancy.
Significance:	This ESM measures the number of providers who receive appropriate training on the treatment and referral of pregnant people for oral healthcare services during their pregnancy. It is important to measure as it shows the progress the initiative is making towards adequate knowledge in the health community. Studies indicate that the medical community may not be prepared to discuss the importance of oral health with patients, specifically during pregnancy. Furthermore, the dental community may be misinformed about practices and protocol surrounding dental treatment during the perinatal period. By educating providers, patients will in turn be better informed of the significance of perinatal oral health and will be more likely to seek dental care during the perinatal period.

ESM 13.1.2 - Percent of pregnant people who receive at least one oral health service through Medicaid during the perinatal period
NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Increase the percentage of individuals who utilize the perinatal adult dental benefit for pregnant people within the state of Michigan.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Percentage</td></tr>
<tr><td>Unit Number:</td><td>100</td></tr>
<tr><td>Numerator:</td><td>Number of pregnant people on Medicaid with at least one oral health service between the time the plan becomes aware of their pregnancy until 3 months postpartum (perinatal period)</td></tr>
<tr><td>Denominator:</td><td>Number of pregnant people on Medicaid during the perinatal period</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>The MDHHS Oral Health Program will obtain data on an annual basis through a data use agreement and IRB with the CHEAR (Child Health Evaluation and Research) Center at the University of Michigan. CHEAR has access to the data warehouse and the technical ability to analyze the data. Data issues may include delays in obtaining data as well as the inability to determine type of oral health services rendered.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>1) The ESM measures the percent of pregnant people who have a dental service during pregnancy.
2) The evidence indicates that a dental visit during pregnancy is important and safe. ACOG Guidance: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2013/08/oral-health-care-during-pregnancy-and-through-the-lifespan
3) By having an accurate measure of actual utilization rates in targeted Michigan regions, the program will be able to make evidence-informed decisions to address gaps in care across the state.</td></tr>
<tr><td>Significance:</td><td>This ESM measures the actual utilization of Medicaid dental services for pregnant people in Michigan. This is critical to determine if progress is being made and if new strategies need to be addressed to increase the number of pregnant people with a dental visit during pregnancy. To improve outcomes and increase dental benefit utilization for pregnant people in Michigan, significant effort has been made to enhance the adult dental Medicaid benefit. Pregnant people are now placed within a Medicaid health plan which leads to greater availability of providers who accept that plan. Recent analysis has shown that actual utilization is even lower than previous estimates. COVID-19 has further reduced utilization rates. The data will continue to be analyzed to track rates in targeted areas across the state, with the goal of developing interventions to address racial and geographic disparities.</td></tr>
</table>

ESM 13.2.1 - Number of students who have received a preventive dental screening through the SEAL! Michigan program
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Increase the number of students who have received a preventive dental screening within a school based dental program.
Definition:	**Unit Type:** Count **Unit Number:** 10,000 **Numerator:** N/A - This is a count measure **Denominator:**
Data Sources and Data Issues:	The SEAL! Michigan annual all grantee report will be used for the data source. Annual data are gathered each October at the end of the fiscal year and reports are developed by the following August. This timeframe could cause the annual indicator to be delayed by one year. In addition, the Sealant Coordinator position and epidemiologist position are funded under the CDC cooperative agreement.
Evidence-based/informed strategy:	1) The ESM for this measure is the number of students who have received a preventative dental screening through the SEAL! Michigan Program. 2) Evidence for this strategy is robust and dental sealants are an established nationwide best practice. Placement of dental sealants on children's teeth has been a longstanding part of the Healthy People national objectives. Upon the release of the 2030 national objectives in 2020, the baseline for children ages 3–19 who had dental sealants placed on one or more primary or permanent molar was 37%. The target for 2030 is 42.5%. ASTDD best Practice report: school-based-dental-sealant-programs-bpar-2022-final.pdf (astdd.org) 3) This strategy contributes to the NPM (The percent of children ages 1-17 who had a preventative dental visit in the past year) by providing data regarding school aged children in Michigan specifically regarding preventative dental care.
Significance:	A school-based dental program is an ideal environment to prevent dental decay across the population. This goal helps meet the Healthy People 2020 indicator for oral health, with the objective to increase the amount of dental screenings that are completed in children ages 1 to 17.

Form 11
Other State Data

State: Michigan

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Michigan

Annual Report Year 2022

	Access				Linkages	
Data Sources	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Quarterly	12		
2) Vital Records Death	Yes	Yes	Quarterly	12	Yes	
3) Medicaid	Yes	Yes	More often than monthly	3	Yes	
4) WIC	Yes	No	Quarterly	12	No	
5) Newborn Bloodspot Screening	Yes	Yes	More often than monthly	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	More often than monthly	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	12	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	14	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None