Michigan State Action Plan Table 2025 Application/2023 Annual Report

Priority Needs	Five-Year Objectives	Strategies	Evidence-Based or –Informed Strategy Measures	National and State Performance Measures	National and State Outcome Measures
Women/Maternal Health					
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	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	A1) Educate the Regional Perinatal Quality Collaboratives (RPQCs) regarding low-risk Cesarean data A2) Regional representatives will share ongoing information with RPQCs regarding the Obstetrics Initiative (OBI) and Alliance for Innovation on Maternal Health (AIM) bundle on safe reduction of primary cesarean birth A3) Continue partnering with the American College of Obstetricians and Gynecologists (ACOG) Alliance for Innovation on Maternal Health (AIM) and work through MI-AIM to increase the number of birthing hospitals participating in MI-AIM B1) Include bias and equity training as part of the MI-AIM hospital designation criteria B2) Encourage and support ongoing bias and equity training for MI-AIM Steering and Operations Committee members B3) Support ongoing education and training regarding bias and equity for the Michigan Maternal Mortality Surveillance Review Committee members	ESM LRC.1 - Number of birthing hospitals participating in Michigan AIM	NPM - Percent of cesarean deliveries among low-risk first births (Low-Risk Cesarean Delivery, Formerly NPM 2) - LRC	NOM - Rate of severe maternal morbidity per 10,000 delivery hospitalizations (Severe Maternal Morbidity, Formerly NOM 2) - SMM NOM - Maternal mortality rate per 100,000 live births (Maternal Mortality, Formerly NOM 3) - MM
Improve oral health awareness and create an oral health delivery system that provides access through multiple systems	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	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	ESM PDV-Pregnancy.1 - Number of medical and dental professionals who receive perinatal oral health education through MDHHS ESM PDV-Pregnancy.2 - Percent of pregnant people who receive at least one oral health	NPM - Percent of women who had a dental visit during pregnancy (Preventive Dental Visit - Pregnancy, Formerly NPM 13.1) - PDV-Pregnancy	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0

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			service through Medicaid during the perinatal period		through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
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	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	A1) Support the provision of contraception to low-income, uninsured, and underinsured people who can get pregnant in the Family Planning Program A2) Facilitate long-acting reversible contraceptive (LARC) training opportunities for Family Planning and other health care providers A3) Support the integration of telehealth best practices across Family Planning's provider network A4) Translate regional listening session findings into action for people of reproductive age who can get pregnant B1) Support at least 6,500 individuals' access to publicly funded contraception B2) Translate regional listening session findings into action for youth and young adults B3) Translate youth input into action on the Family Planning website C1) Include the person-centered contraceptive counseling (PCCC) measure on Family Planning's annual statewide consumer survey C2) Analyze the PCCC measure, share key findings with the Family Planning network, and promote data-driven decision-making C3) Promote MDHHS's updated Contraceptive Counseling Modules with the Family Planning network, other healthcare providers, and related public health programs		SPM 5: Percent of people assigned female at birth who had a live birth and reported that their pregnancy was intended	
	A) Conduct planning and assessment activities related to Postpartum Visit B) Increase awareness about the importance of postpartum visits among pregnant and postpartum people	A1) Assess data related to postpartum visits A2) Explore evidence-based and evidence-informed strategies and best practices related to postpartum visits B1) Develop an article in the Philips Pregnancy+ smart application (app) about the postpartum visit and conduct a survey in the Philips Pregnancy+ app to obtain information about pregnant peoples' attitudes about the importance of postpartum visits B2) Recruit up to 25 new and 8 existing CenteringPregnancy sites to increase adoption of the CenteringPregnancy model B3) Support development and implementation of a postpartum module in the High Touch, High Tech (HT2) Pregnancy Checkup app for new and existing HT2 sites B4) Promote the Michigan Hear Her website and resources	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - A) Percent of women who attended a postpartum checkup within 12 weeks after giving birth (Postpartum Visit) B) Percent of women who attended a postpartum checkup and received recommended care components (Postpartum Visit) - PPV	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Perinatal/Infant Health					
Create and	A) Increase the percent of infants	A1) Require breastfeeding education of MDHHS Maternal Infant Health	ESM BF.1 - Percent	NPM - A) Percent of	NOM - Infant mortality rate per

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enhance support systems that empower families, protect and strengthen family relationships, promote care for self and children, and connect families to their communities	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	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	of Baby-Friendly designated birthing hospitals in Michigan	infants who are ever breastfed (Breastfeeding, Formerly NPM 4A) B) Percent of infants breastfed exclusively through 6 months (Breastfeeding, Formerly NPM 4B) - BF	1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID
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	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	A1, B1, C1, D1) Support safe sleep activities of local health departments and the Inter-Tribal Council of Michigan A2, B2, C2, D2) Support providers to implement safe sleep policies/ protocols/programming so families receive infant safe sleep education and access to resources A3, B3, C3, D3) Develop and share tools with providers, staff, and families regarding client/patient centered conversations about safe sleep A4, B4, C4, D4) Provide professionals and families with culturally congruent guidance on protective factors (e.g., smoking cessation, breastfeeding, immunizations) and evidence-based programs (e.g., community-based doula support, home visiting) to enhance the overall health and well-being of moms and babies A5, B5, C5, D5) Engage hospitals in areas with a high rate of sleep-related infant deaths and disparities to explore needed policies and resources to support families of NICU infants in practicing safe sleep behaviors after discharge	ESM SS.1 - Increase the number of Maternal Infant Health Program agencies that have staff trained to use the concepts of motivational interviewing with safe sleep ESM SS.2 - Increase the number of agencies that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol ESM SS.3 - Increase the number of	NPM - A) Percent of infants placed to sleep on their backs (Safe Sleep, Formerly NPM 5A) B) Percent of infants placed to sleep on a separate approved sleep surface (Safe Sleep, Formerly NPM 5B) C) Percent of infants placed to sleep without soft objects or loose bedding (Safe Sleep, Formerly NPM 5C) D) Percent of infants room-sharing with an adult during sleep (Safe Sleep) - SS	NOM - Infant mortality rate per 1,000 live births (Infant Mortality, Formerly NOM 9.1) - IM NOM - Post neonatal mortality rate per 1,000 live births (Postneonatal Mortality, Formerly NOM 9.3) - IM-Postneonatal NOM - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births (SUID Mortality, Formerly NOM 9.5) - IM-SUID

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			hospitals that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol		
Child Health					
Improve oral health awareness and create an oral health delivery system that provides access through multiple systems	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)	A1) Utilize the Qualtrics SEAL! Michigan electronic database to track the number of students annually receiving a preventive dental screening A2) Promote dental sealant programs through school health professionals A3) Prepare and analyze the annual SEAL! Michigan all grantee reports to monitor for annual growth of students receiving a preventive dental screening A4) Examine ongoing trends to identify geographic areas experiencing a high burden of disease and identify populations that will benefit from an increase in dental sealant placement in proportion to disease and population B1) Increase access to dental consent forms for students' caretakers B2) Provide oral health education to all nurses at DPSCD on a semi-annual basis B3) Increase the number of dental providers and their services at DPSCD to allow additional access to care and increase sealant placement	ESM PDV-Child.1 - Number of students who have received a preventive dental screening through the SEAL! Michigan program	NPM - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year (Preventive Dental Visit - Child, Formerly NPM 13.2) - PDV-Child	NOM - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year (Tooth decay or cavities, Formerly NOM 14) - TDC NOM - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC NOM - Percent of children, ages 0 through 17, in excellent or very good health (Children's Health Status, Formerly NOM 19) - CHS
Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-	A) By 2025, increase screening for lead exposure risk factors for children less than 72 months of age B) By 2025, increase the percentage of Medicaid-enrolled children less than 72 months of age receiving blood lead testing by 10% C) By 2025, increase by 10% the	A1) Improve notification to health care providers of patients' blood lead levels and need for blood lead testing A2) Conduct provider education activities to encourage providers to screen all children less than 72 months of age for lead exposure risk factors A3) Partner with agencies to provide culturally-appropriate and audience-specific lead education to populations at risk of lead exposure B1) Provide local health departments with monthly data reports of Medicaid-enrolled children that have not had blood lead testing B2) Conduct provider education activities to encourage providers to provide blood lead tests to Medicaid-enrolled children at the recommended times		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	

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informed providers, and integrated service delivery systems	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	C1) Provide local health departments with quarterly data reports C2) Conduct family engagement to obtain information to improve nursing case management outcomes and process C3) Conduct provider education activities to encourage providers to order a venous test after an elevated capillary test			
Improve access to high-quality community health and prevention services in the places where women, children, and families live, learn, work, and play	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	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		SPM 2: Percent of children 19 to 36 months of age who have received a completed series of recommended vaccines (4313314 series)	
	A) By September 30, 2025, MDHHS will complete an environmental scan, including an equity gap analysis to identify Title V's role for the Medical Home for Children system	A1) Identify and convene a group of multisector partners and stakeholders alongside parents of children aged 0 to 17 who have lived experience with the Medical Home for Children system A2) Design and conduct an environmental scan, including an equity gap analysis for the Medical Home for Children system across the state A3) Select at least one identified equity gap related to the Medical Home for Children system to focus Title V support	No ESMs were created by the State. ESMs were optional for this measure in the 2025 application/2023 annual report.	NPM - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	This NPM was newly added in the 2025 application/2023 annual report. The list of associated NOMs will be displayed in the 2026 application/2024 annual report.
Adolescent Health					
Create safe and healthy schools and communities that promote	A) By October 2025, 30 secondary schools will implement schoolwide bullying prevention initiatives emphasizing social emotional health (SEH) education and	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	ESM BLY.1 - Number of secondary schools implementing the Michigan Model for Health™ Social and	NPM - Percent of adolescents, with and without special health care needs, ages 12 through 17, who are bullied or who	NOM - Adolescent mortality rate ages 10 through 19, per 100,000 (Adolescent Mortality, Formerly NOM 16.1) - AM

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human thriving, including physical and mental health supports that address the needs of the whole person	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	B1) Facilitate professional development for schools and school health coordinators on PA 241 and State Board of Ed Model Anti-Bullying policy B2) Provide technical assistance to school health coordinators working directly with schools B3) Support and promote professional development for schools on the creation and sustainability of Gender and Sexuality Alliances (GSAs) C1) Implement the CSHCS Bullying Prevention Initiative grant program C2) Assess lessons learned from the grant program and evaluate how these lessons can be embedded across the state C3) Disseminate information, successes, and lessons learned from the grant program to organizations at the state and national levels	Emotional Health Module with 80% fidelity	bully others (Bullying, Formerly NPM 9) - BLY	NOM - Adolescent suicide rate, ages 15 through 19, per 100,000 (Adolescent Suicide, Formerly NOM 16.3) - AM-Suicide
Improve access to high-quality community health and prevention services in the places where women, children, and families live, learn, work, and play	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	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		SPM 3: Percent of adolescents 13 to 18 years of age who have received a completed series Human Papilloma Virus vaccine	
Children with Special Health Care Needs					
Ensure children with	A) By 2025, increase the percent of CYSHCN ages 12 and older	A1) Establish a Transition Advisory Collaborative to guide the development of a Michigan HCT framework for health care providers A2) Continue	***Inactive -*** *ESM TR.1 - Percent of CSHCS*	NPM - Percent of adolescents with and	NOM - Percent of children with special health care needs

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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	receiving services necessary to transition from pediatric to adult health care from 21.6% to 25% B) By 2025, increase by 10% the number of partner organizations that reach the next level on the Got Transition “Assessment of Health Care Transition Activities”	serving on the Michigan Interagency Transition Taskforce (MITT) to ensure HCT is included in the Michigan Model for Secondary Transition and collaborate on creating transition resources A3) Provide HCT resources and education to partners and stakeholders and promote the CSHCS Transition to Adulthood website A4) Continue to contract with U of M CHEAR to monitor transition data A5) Utilize the MHP contract, site review, and compliance review processes to improve HCT for CYSHCN enrolled in MHPs A6) Utilize the LHD accreditation processes to improve HCT for CSHCS enrollees B1) Annually implement the “Assessment of Health Care Transition Activities” with CSHCS partner organizations and provide HCT resources and education based on need reflected in assessment data B2) Develop and track an Evidence-informed Strategy Measure (ESM) for the “Assessment of Health Care Activities”	*clients age 18 to 21 years in selected diagnosis groups that have transferred care from a pediatric to an adult provider* ESM TR.2 - Percentage of CSHCS partner organizations whose total score increased on the Assessment of Health Care Transition Activities.	without special health care needs, ages 12 through 17, who received services to prepare for the transition to adult health care (Transition, Formerly NPM 12) - TR	(CSHCN), ages 0 through 17, who receive care in a well-functioning system (CSHCN Systems of Care, Formerly NOM 17.2) - SOC
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	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%	A1) Continue implementing special programs to reduce financial burdens for CSHCS-eligible families A2) Expand the capacity of specialty clinics to provide delivery of patient-centered, family-friendly, equitable care through Children’s Multi-Disciplinary Specialty (CMDS) clinics A3) Disseminate findings and project successes of the HRSA-funded Children and Youth with Epilepsy (CYE) grant B1) Continue building and implementing a coordinated and systematic approach to family engagement B2) Continue implementation of a multi-staged approach to improve provider engagement B3) Maintain a competent workforce that is knowledgeable about CSHCS and able to assist families accessing the system of care C1) Implement a statewide targeted case management benefit to improve care for children with medical complexity (CMC) C2) Continue monitoring the comprehensive evaluation to assess and improve CSHCS’s capacity and ability to provide effective, efficient, and high-quality services to clients C3) Implement initiatives so that CSHCS families receive care coordination in a high-quality, family-centered, and well-functioning system C4) Improve the system of care by identifying and responding to health inequities		SPM 4: Percent of children with special health care needs enrolled in CSHCS that receive timely medical care and treatment without difficulty	
	A) By 2025, explore existing medical home activities in Michigan and identify program	A1) Analyze medical home metrics for disparities A2) Collaborate with statewide partners to identify strategies to increase utilization of the medical home model for clinics in Michigan A3) Develop an action plan to	No ESMs were created by the State. ESMs were optional	NPM - Percent of children with and without special health care needs, ages 0	This NPM was newly added in the 2025 application/2023 annual report. The list of associated

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	opportunities	increase the number of clinics that meet medical home criteria	for this measure in the 2025 application/2023 annual report.	through 17, who have a medical home (Medical Home, Formerly NPM 11) - MH	NOMs will be displayed in the 2026 application/2024 annual report.
Cross-Cutting/Systems Building					
Expand access to developmental, behavioral, and mental health services through routine screening, strong referral networks, well-informed providers, and integrated service delivery systems	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)	A1) Provide Title V funding to local health departments to address developmental, behavioral, and mental health needs B1) Provide resources to Regional Perinatal Quality Collaboratives to implement and expand use of universal perinatal screening at prenatal care clinics within their respective regions B2) Provide resources and support to Regional Perinatal Quality Collaboratives to address behavioral and mental health needs C1) Ensure the challenges of CYSHCN and their families are reflected in the discussions and decisions related to the MDHHS behavioral health restructuring C2) Continue providing CSHCS, Family Center and CSN Fund educational sessions at conferences for the community mental health workforce C3) Continue collaborative efforts between CSHCS and BCCHPS to process Tax Equity and Fiscal Responsibility Act (TEFRA) applications for families D1) Enhance and expand an online system to track HWC notices D2) Monitor HWC notices among counties participating in the initiative D3) Provide training and onboarding support to new schools and counties to assist in expanding HWC		SPM 6: Support access to developmental, behavioral, and mental health services through Title V activities and funding	