Michigan State Action Plan Table 2026 Application/2024 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					
Improve the quality and accessibility of respectful care before, during, and after pregnancy	A) By September 30, 2030, increase the number of Centering Pregnancy sites in Michigan by 40% B) By September 30, 2030, increase the percentage of women who attend a postpartum visit from 90.2% to 94%	A1) Support implementation of Centering Pregnancy at new prenatal care sites throughout Michigan A2) Support enrollment in Centering Pregnancy by pregnant women at new and existing Centering Pregnancy sites A3) Promote insurance reimbursement of Centering Pregnancy group prenatal care B1) Utilize the Philips Pregnancy+ smart application (app) to increase knowledge and awareness of the importance of postpartum visits among its users B2) Support implementation of postpartum module in the High Touch, High Tech (HT2) Pregnancy Checkup app B3) Promote Urgent Maternal Warning Signs education, materials, and resources across Michigan B4) Home visiting agencies will continue to support women through discussions on the importance of postpartum visits and efforts to improve access to postpartum care	ESM PPV.1 - Number of obstetric clinics implementing the group prenatal care model, Centering Pregnancy	NPM - Postpartum Visit	**Linked NOMs:** Maternal Mortality Neonatal Abstinence Syndrome Women's Health Status Postpartum Depression Postpartum Anxiety
Improve the quality and accessibility of respectful care before, during, and after pregnancy	A) By September 2030, increase the number of doulas on the Michigan Doula Registry by 1,000 doulas B) By September 2030, implement quality improvement (QI) initiatives in partnership with Michigan's nine Regional Perinatal Quality Collaboratives (RPQC) C) By September 2030, increase the number of birthing hospitals participating in Michigan Alliance for Innovation on Maternal Health (MI AIM) by 4% (Baseline 67) and enrolled in the Joint Commission	A1) Increase Michigan's doula workforce by training 300 individuals to be doulas A2) Collaborate with the Doula Advisory Council to inform the advancement of doula services in Michigan A3) Promote doula services statewide B1) Train RPQC leaders throughout the state on health outcomes and effective QI methodologies B2) All Regional Perinatal Quality Collaboratives will conduct quality improvement initiatives to improve perinatal healthcare B3) Collaborate to host statewide meetings highlighting QI initiatives to increase community engagement and partnerships C1) Partner with birthing hospitals to increase participation in the Michigan Alliance for Innovation on Maternal Health (MI AIM) C2) Provide mentorship and training to support birthing hospitals in obtaining Maternal Levels of Care Verification C3) Collaborate with the Regional Perinatal Quality Collaboratives to integrate MI AIM efforts at RPQC meetings	ESM DSR.1 - Increase the number of doulas on the Michigan Doula Registry by 1,000 doulas	NPM - Perinatal Care Discrimination	**Linked NOMs:** Severe Maternal Morbidity Maternal Mortality Low Birth Weight Preterm Birth Stillbirth Perinatal Mortality Infant Mortality Neonatal Mortality Preterm-Related Mortality Postpartum Depression Postpartum Anxiety

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	Maternal Levels of Care Verification program by 18% (Baseline 53)				
Expand awareness of and access to quality dental care for children and pregnant women	A) Increase the number of medical and dental providers trained to treat, screen, and refer pregnant women and infants to oral health services B) Increase the number of pregnant women receiving oral health education and services	A1) Offer and evaluate training for medical and dental professionals A2) Create and disseminate updated Perinatal Oral Health promotional and educational materials B1) Develop plan from Medicaid utilization data and PRAMS healthcare data to address oral health access issues B2) Collaborate with partners to facilitate alternative models of care for integrating oral health into pregnancy B3) Provide education to pregnant women 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 women on Medicaid who receive at least one dental service during the perinatal period	NPM - Preventive Dental Visit - Pregnancy	**Linked NOMs:** Women's Health Status Children's Health Status
Maintain access to and information about contraceptives and reproductive health	A) By 2030, maintain the number of Family Planning Clients who rate their experience of care as a score of 4 or 5 out of 5 on the Teen and Adult Consumer Surveys Person-Centered Contraceptive Care (PCCC) measure at 95% or higher B) By 2030, expand access to Sexual and Reproductive Health (SRH) services by increasing the number of unduplicated clients served by 5% from 2024 baseline C) By 2030, all family planning agencies will conduct community education and promotion to increase awareness of services	A1) Family Planning local agencies will address trauma informed care in their programs A2) Promote contraceptive counseling modules, inclusive of Person-Centered Contraceptive Care counseling tools to Michigan providers A3) Analyze and share Teen and Adult Consumer Survey data with the family planning network to improve reproductive health strategies and service delivery B1) Train and educate the family planning network on updated guidance, Providing Quality Family Planning Services in the United States: Recommendations of the U.S. Office of Population Affairs, 2024 (QFP) B2) Ensure the provision of a broad range of contraceptives including long-acting reversible contraception (LARC) and condoms at local family planning agencies B3) Maintain the number of males served in family planning clinics at 15% of total population served C1) Educate the family planning network on best practices regarding use of effective outreach and engagement strategies to adolescents C2) Implement an annual media plan to raise public awareness about SRH services and resources, promoting informed decision-making C3) Provide training and technical assistance to subrecipients on recruiting and	No ESMs were created by the State. ESMs are optional for this measure.	SPM 3: Percent of most or moderately effective contraception use among women ages 18-49 years who reported doing something to prevent unintended pregnancy during last intercourse	

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		maintaining community participation in local Family Planning Advisory Councils			
Perinatal/Infant Health					
Expand parent and provider access to person-centered breastfeeding and infant safe sleep knowledge and support	A) Increase the percent of children who are breastfed exclusively for first 6 months from 26.4% in 2023 to 39.1% by 2030 B) Increase the percent of women who initiate breastfeeding from 90.0% to 95.1% by 2030	A1) Offer online course to health care providers that includes current breastfeeding recommendations and identifies opportunities to engage families and communities in breastfeeding supportive practices 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 19.7% to 27.6% B1) Increase training opportunities to enhance the number and availability of opportunities for professional advancement of breastfeeding professionals B2) To foster collaboration and coordination, normalize and promote breastfeeding supportive messages for MDHHS and breastfeeding supporter use B3) To help all children and families flourish, promote educational resources and training opportunities that address common challenges and complications with breastfeeding	ESM BF.1 - Percent of Baby-Friendly designated birthing hospitals in Michigan	NPM - Breastfeeding	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality
Expand parent and provider access to person-centered breastfeeding and infant safe sleep knowledge and support	A) Increase the percent of infants put to sleep on their backs from 87.1% to 92.1% by 2030 B) Increase the percent of infants put to sleep on a separate approved sleep surface from 42.1% to 47.6% by 2030 C) Increase the percent of infants placed to sleep without soft objects or loose bedding from 65.3% to 76.8% by 2030 D) Increase the percent of infants put to sleep in their own separate sleep space in the same room as the parent from 65.3% to 73.7% by 2030	A1, B1, C1, D1) Support local safe sleep activities, including work to engage and elevate family and community voices A2, B2, C2, D2) Support providers with training and resources so parents and caregivers are better informed, equipped and supported in the implementation of safe sleep practices A3, B3, C3, D3) Provide an online infant safe sleep course to staff of birthing hospitals A4, B4, C4, D4) Promote the infant safe sleep guidelines to families by distributing education materials and other safe sleep information A5, B5, C5, D5) To foster collaboration to strengthen coordinated systems, promote protective factors (e.g., smoking cessation, breastfeeding, immunizations) and evidence-based programs (e.g., home visiting, community-based doula support)	***Inactive -*** *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* ***Inactive -*** *ESM SS.2 - Increase the number of agencies that receive technical assistance and support with implementing or revising/updating a safe sleep*	NPM - Safe Sleep	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality

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			policy/protocol ***Inactive -*** *ESM SS.3 - Increase the number of hospitals that receive technical assistance and support with implementing or revising/updating a safe sleep policy/protocol* ESM SS.4 - Percent of birthing hospital staff who intend to model safe sleep during the hospital stay and educate families after taking the online safe sleep training, "Infant Safe Sleep: The Basics and Beyond"		
Child Health					
Expand vaccination access and address reasons for vaccine hesitancy	A) Increase the percentage of children who have completed the full pediatric vaccine series (4:3:1:3:3:1:4:2), including 2 doses of HepA, at 24 months from 49.2% in 2024 to 60% in 2030 B) By 2030, identify areas of low vaccination coverage through collaboration with local health departments	A1) Implement provider training, via the Physician Peer Education Program on Immunization Practices (PPEPI), to increase childhood vaccination rates A2) Review and update all pediatric vaccine-focused materials in the clearinghouse. Ensure adequate inventory, including translated materials, are available for providers A3) Partner with MDHHS Office of Communications, I Vaccinate and Bellwether Public Relations and Brogan & Partners to promote timely pediatric vaccination through various medias and campaigns A4) Work with pediatric organizations, including the American Academy of Pediatrics (AAP), on an annual call-to-action letter to promote timely vaccination A5) Convene a workgroup of public and private stakeholders who work in the immunization neighborhood to come together annually to discuss best practices to promote vaccine confidence statewide A6) Partner with Michigan's Immunization Coalition to better engage families and communities through education	ESM VAX_Child.1 - Number of healthcare providers who complete education and training through one of the modules offered by the Physician Peer Education Project on Immunizations (PPEPI)	NPM - Childhood Vaccination	**Linked NOMs:** Infant Mortality Postneonatal Mortality SUID Mortality Child Mortality Children's Health Status

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		B1) Provide local health departments with county-specific vaccination data via the County Immunization Coverage Dashboard and quarterly Immunization Report Cards to identify areas of low vaccination coverage B2) Share provider-level vaccination coverage data via quarterly report cards to all Vaccines for Children (VFC) providers B3) Provide immunization education at county level provider meetings to inform providers of current recommendations and educate on ways to improve vaccine confidence B4) Provide monthly updates on immunization education, recommendations and any changes to all local health departments			
Expand awareness of and access to quality dental care for children and pregnant women	A) Increase the number of students receiving a preventive dental screening within a quality school-based dental sealant program with a focus on improving accessibility to care B) Increase the placement of dental sealants among children enrolled in Detroit Public Schools Community District (DPSCD) by enhancing access to school-based oral health services	A1) Utilize Qualtrics SEAL! Michigan electronic database to track the number of students annually receiving a preventive dental screening A2) Implement enhanced infection prevention and control training within school-based dental sealant programs A3) Prepare and analyze SEAL! Michigan all grantee report for annual growth of students receiving a preventive dental screening A4) Examine ongoing trends to identify geographic areas with high burden of disease and limited access to care, to identify populations that will benefit most from increased dental sealant placement proportionate to their disease prevalence B1) Increase access to dental consent forms for students' caretakers B2) Expand dental provider training on infection prevention and control B3) Provide oral health education to all nurses at DPSCD on a semi-annual basis and train 6-8 school nurses on applying fluoride varnish B4) Organize focus groups among teachers and principals	ESM PDV-Child.1 - Number of students who have received a preventive dental screening through the SEAL! Michigan program	NPM - Preventive Dental Visit - Child	**Linked NOMs:** Tooth decay or cavities Children's Health Status CSHCN Systems of Care
Expand awareness of and access to medical homes and improve care coordination through the medical home approach	A) By September 30, 2026, MDHHS will develop a comprehensive action plan based on the results of its medical home for children environmental scan and system gap analysis	A1) Translate findings from MDHHS's environmental scan and system gap analysis A2) Collaborate with the Children's Special Health Care Services (CSHCS) program on the medical home approach A3) Explore policy avenues with the Medicaid Program Policy and Managed Care Divisions to support the medical home approach	ESM MH.1 - Develop a comprehensive action plan based on the results of the medical home for children environmental scan and system gap analysis ESM MH.2 - Develop a training for families to learn about medical	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			home and care coordination for children and youth with special health care needs (CYSHCN)		
Increase access to information, education, and testing for lead poisoning	A) By 2030, increase by 15% blood lead testing for children at 1 and 2 years of age B) By 2030, increase by 15% blood lead testing for children at age 4 in priority communities identified by MDHHS C) By 2030, increase by 15% 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	A1) Improve notification to health care providers of patients' blood lead levels and need for venous follow-up blood lead testing A2) Conduct provider education activities to encourage providers to test all children at 1 and 2 years of age A3) Partner with agencies to provide audience-specific lead education to all populations at risk of lead exposure B1) Educate providers in high priority communities on lead hazards and blood lead testing B2) Partner with local agencies to increase testing in priority communities B3) Distribute accessible educational materials to families and community partners C1) Provide local health departments with quarterly data reports and tools C2) Conduct family engagement to obtain voice of the community data to improve educational strategies and nursing case management process and outcomes C3) Conduct provider education activities to encourage providers to order a venous blood lead test for children with an elevated capillary blood lead test	No ESMs were created by the State. ESMs are optional for this measure.	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	
Adolescent Health					
Partner with schools, parents, and the broader community to support students' mental health	A) By October 2030, 30 secondary schools will implement schoolwide bullying prevention initiatives emphasizing social emotional health (SEH) education and creating safe schools for all students B) By October 2030, provide bullying prevention education, awareness and support to 1,000 schools (students, staff and parents/families)	A1) Implement the Michigan Model for Health™ SEH module in all health education classrooms in six secondary schools per year A2) Provide intensive training and technical assistance on creating safe schools for all students to the six participating schools per year B1) Facilitate professional development for schools on laws, policies and best practices on bullying prevention B2) Provide technical assistance and professional development for schools on supporting all students by enhancing connectedness through student groups and/or clubs B3) Engage parents as partners in bullying prevention through facilitation of learning opportunities C1) Enhance and expand an online system to track HWC notices C2)	ESM BLY.1 - Number of secondary schools implementing the Michigan Model for Health™ Social and Emotional Health Module with 80% fidelity ESM BLY.2 - Percentage of training attendees who report increased knowledge of bullying	NPM - Bullying	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Adolescent Depression/Anxiety Adverse Childhood Experiences

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	C) By October 2030, support students' mental health and wellness in 100% of communities implementing Handle with Care (HWC)	Provide training and technical assistance for schools and counties to assist in expanding HWC C3) Facilitate professional development for schools and law enforcement on trauma-informed care, creating safe school environments and bullying prevention	prevention resources to support children with special health care needs (CSHCN)		
Expand vaccination access and address reasons for vaccine hesitancy	A) By 2030, increase the percent of adolescents 13 to 18 years of age who have received a completed series of recommended vaccines (1323213 series) from 43.4% in 2025 to 50% in 2030 B) By 2030, increase the percent of adolescents 13 years of age who have received a completed HPV vaccine series from 33.9% in 2025 to 40% in 2030	A1) Review and update all adolescent vaccine-focused materials in the Clearinghouse and ensure adequate inventory available for providers A2) Provide adolescent vaccine-focused materials in various languages and make them available at the Clearinghouse to increase vaccine access for all populations A3) Partner with Michigan's Immunization Coalition to better engage families and communities through education and improvements to the coalition website A4) Partner with MDHHS Office of Communications, I Vaccinate, Bellwether Public Relations and Brogan and Partners to promote timely adolescent vaccination through medias and campaigns A5) Build relationships with School Wellness Programs (SWPs) to provide vaccine education with the goal of expanding SWPs to administer vaccines through the Vaccines for Children Program B1) Work with internal and external partners, including the Michigan HPV Alliance, to promote timely HPV vaccination B2) Partner with the oral health community to promote HPV vaccination and provide education on HPV vaccine at dental cleanings B3) Update HPV vaccine-related materials available at the MDHHS Clearinghouse and ensure all HPV vaccine-related materials are available in multiple languages	No ESMs were created by the State. ESMs are optional for this measure.	SPM 2: Percent of adolescents 13 to 18 years of age who have received a completed series of recommended vaccines (1323213 series)	
Children with Special Health Care Needs					
Expand awareness of and access to medical homes and improve care coordination through the medical home approach	A) By September 2030, increase the percentage of families who report receiving help coordinating their child's care among different providers or services from 59.6% to 65.0% B) By September 2030, increase family knowledge related to medical homes	A1) Evaluate and expand the Children's Multi-Disciplinary Specialty (CMDS) Clinic model A2) Implement the Children with Medical Complexity (CMC) Targeted Case Management (TCM) clinic model A3) Coordinate with the Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) to improve access to care for CYSHCN who need both behavioral and medical services B1) Collaborate with the Division of Child and Adolescent Health on the medical home approach B2) Create and implement a coordinated and systemic approach to family engagement and community outreach to increase knowledge of medical home, including training	ESM MH.1 - Develop a comprehensive action plan based on the results of the medical home for children environmental scan and system gap analysis ESM MH.2 - Develop a training for families	NPM - Medical Home	**Linked NOMs:** Children's Health Status CSHCN Systems of Care Flourishing - Young Child Flourishing - Child Adolescent - CSHCN Flourishing - Child Adolescent - All

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			to learn about medical home and care coordination for children and youth with special health care needs (CYSHCN)		
Improve the quality, accessibility, and coordination of care and resources for children with special health care needs	A) By September 2030, increase by 50% from baseline the percentage of youth with epilepsy requiring supports served by pilot neurology clinics that successfully transition to adult models of health care B) By September 2030, increase the percentage of CYSHCN ages 12 through 17 who receive services necessary to transition from pediatric to adult healthcare in Michigan from 25.5% to 30% C) By September 2030, increase by 10% the number of partner organizations that reach the next level on the Got Transition "Assessment of Health Care Transition Activities"	A1) Implement HRSA Youth with Epilepsy requiring Supports (YES) Demonstration Project grant strategies, including the establishment of a transition advisory council, which includes family and community engagement A2) Develop and implement a Michigan Health Care Transition (HCT) framework that provide supports as identified by clinics, youth, and families/caregivers B1) Collaborate with state and community partners on transition projects and coordinate the sharing of transition processes and resources B2) Provide expanded HCT resources, education, and outreach to partners and stakeholders B3) Utilize MHP contract and compliance review and LHD accreditation processes to improve HCT for CYSHCN C1) Implement the "Assessment of Health Care Transition Activities" annually with CSHCS partner organizations and provide HCT resources and education based on needs reflected in assessment data C2) Continue to track an Evidence-informed Strategy Measure (ESM) for the "Assessment of Health Care Transition Activities"	ESM TAHC.1 - Percentage of CSHCS partner organizations whose total score increased on the Assessment of Health Care Transition Activities.	NPM - Transition To Adult Health Care	**Linked NOMs:** CSHCN Systems of Care
Partner with schools, parents, and the broader community to support students' mental health	A) By September 2030, increase by 10% the number of youth participating in CSHCS bullying prevention programs B) By September 2030, increase the percentage of families and community members who report increased ability to navigate resources to support CSHCN with bullying	A1) Implement the CSHCS Bullying Prevention Initiative grant program for CSHCN A2) Collaborate with partners on bullying prevention and/or support students' mental health initiatives to make a larger impact at a systems level B1) Create and implement a systemic outreach plan that provides bullying education and resources for families and community members across the state B2) Collect pre-and post-survey data for CSHCN family and community trainings on bullying to track the Evidence-informed Strategy Measure (ESM)	ESM BLY.1 - Number of secondary schools implementing the Michigan Model for Health™ Social and Emotional Health Module with 80% fidelity ESM BLY.2 - Percentage of training attendees	NPM - Bullying	**Linked NOMs:** Adolescent Mortality Adolescent Suicide Adolescent Firearm Death Adolescent Injury Hospitalization Adolescent Depression/Anxiety Adverse Childhood Experiences

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			who report increased knowledge of bullying prevention resources to support children with special health care needs (CSHCN)		
Improve the quality, accessibility, and coordination of care and resources for children with special health care needs	A) By 2030, increase the percentage of CSHCS CAHPS respondents who rate their healthcare for their child's CSHCS condition with a top box score of 9 or 10 from 70.5% to 75.0% B) By 2030, increase the percentage of CSHCS CAHPS respondents who rate their service when contacting the CSHCS office in the LHD with a top box score from 82.2% to 84.5% C) By 2030, increase the percentage of CSHCS CAHPS respondents who rate their health plan with a top box score (with 9 and 10 being the best health plan possible) from 66.6% to 69.1% D) By 2030, increase by 10% the families and community members who report increased knowledge of the CSHCS program and services for CSHCN	A1) Offer program benefits to reduce financial burdens for CSHCS-eligible families A2) Evaluate opportunities to improve access to respite for children with special health care needs A3) Explore opportunities to support CYSHCN and their families with emergency preparedness A4) Explore opportunities with partners to assess the pediatric subspeciality workforce B1) Utilize the LHD accreditation process to ensure CSHCS families receive care in a high-quality, family-centered, and well-functioning system B2) Maintain a competent workforce within local health departments (LHDs) that is knowledgeable about CSHCS and able to assist families in accessing services B3) Implement a three-part quality improvement initiative with the CSHCS Customer Support Section (CSS) and LHDs C1) Convene MHP site visits to ensure CSHCS families receive care management from their health plan that is high quality and family centered C2) Maintain a competent workforce within MHPs that are knowledgeable about CSHCS and able to assist families in accessing services C3) Identify and address gaps in access experienced by CSHCS clients D1) Continue building and implementing a coordinated and systematic approach to family engagement and community outreach	No ESMs were created by the State. ESMs are optional for this measure.	SPM 4: Percent of parents/caregivers who got appointments for their child with a specialist as soon as needed	