Maternal and Child Health Services Title V Block Grant

Montana

FY 2022 Application/ FY 2020 Annual Report

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I. General Requirements

I.A. Letter of Transmittal

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Department of Public Health and Human Services

Early Childhood & Family Support Division ♦ 1625 11th Avenue ♦ P.O. Box 4210 ♦ Helena, MT 59620-4210

♦ Phone: 406-444-1958 ♦ Fax: 406-444-2750

Greg Gianforte, Governor

Adam Meier, Director

Jamie Palagi, Division Administrator

July 15, 2021

Christopher Dykton
Acting Director, Division of State and Community Health
Maternal and Child Health Bureau
Health Resources and Services Division
Rockville, Maryland 220857

Dear Mr. Dykton:

Enclosed is Montana's application for the 2022 Title V Maternal and Child Health Block Grant (MCHBG) and 2020 Annual Report. MCHBG funding supports Montana's state and community-based work in improving the health of the maternal and child population.

The State of Montana maintains on file all assurance and certifications required by this application. The agency also assures that MCHBG funds will be used for non-construction programs and that the agency is a drug-free and tobacco-free work place.

We look forward continuing in partnership with the Maternal and Child Health Bureau.

Sincerely,

Jamie Palagi, Division Administrator
Early Childhood & Family Support Division

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: January31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

Introduction

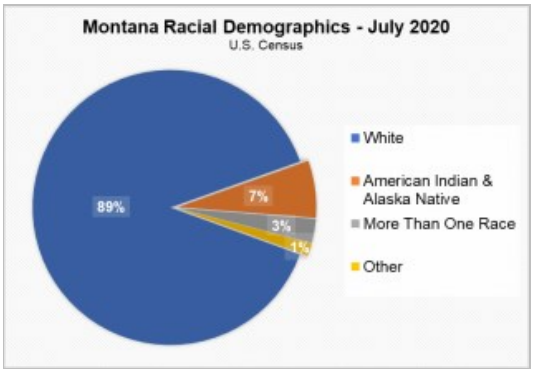
Montana's Title V Maternal & Child Health Block Grant (MCHBG) is administered by the Family & Community Health Bureau (FCHB), in the Early Childhood and Family Support Division (ECFSD) at the Department of Public Health & Human Services (DPHHS). Within the ECFSD, several programs and services aimed at social determinants of health for families and children, extend the reach of federal initiatives including the MCHB principles; and the ECFSD programs' partners, collaborations, and contractual relationships are key to its success.

The *2022 Application & 2020 Annual Report (A&R)* highlights the work to improve the health of Montana's (MT's) women, infants, and children; and covers the first year of a 5-year cycle. Priorities for Federal Fiscal Years (FFYs) 2021-2025 were selected as the result of the *2020 Statewide 5-Year Needs Assessment (NA)*. Key information on performance measures is presented under the following domain categories: Women & Maternal; Perinatal & Infant; Children; Adolescent; Children & Youth with Special Health Care Needs (CYSHCN); and, Cross-Cutting/Systems-Building.

Evaluation of NA data, paired with State Health Improvement Plan (SHIP) goals, helped to create the FFYs 2021-2025 priorities:

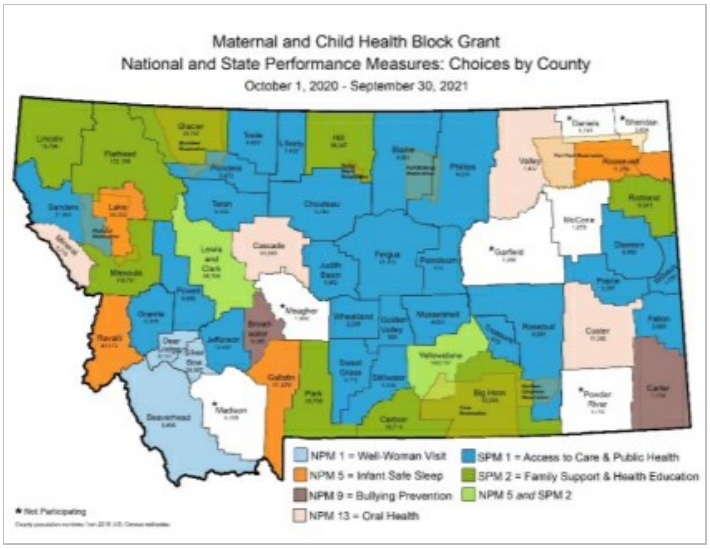
- Access to Public Health Services
- Bullying Prevention
- Family Support & Health Education
- Infant Safe Sleep
- Medical Home
- Children's Oral Health
- Women's Preventive Healthcare

Background information on MT is in the "Overview of the State" narrative of the *A&R*. It covers: geography; demographics; economy; income and poverty; education; health insurance; and, access to health care. The NA Summary and NA Update narratives in the *A&R* provide characteristics of MT's population groups. The following graph illustrates racial demographics:



The NA Summary also examines race and rurality as key factors for the American Indian and rural populations, who generally show evidence of health disparities. Additionally, access to health services may be impacted by travel distances; seasonal challenges, i.e., winter weather and wildfires; the maldistribution of providers; and barriers to broadband internet connection.

At the state level, a focus on maternal child health is present in many programs and services, not just those through the Title V funded strategies. For example, the Addictive and Mental Disorders Division (AMDD) is addressing adult substance use in parents and also targets efforts to address youth suicide prevention through programs such as the PAX Good Behavior Game administered in local schools. In addition, local public health is decentralized, resulting in County Public Health Departments (CPHDs) as the primary source of health care access throughout MT. About 40% of the Title V funding is allocated to CPHDs interested in participating in the MCHBG. The contracted CPHDs submit quarterly and annual reports on their identified National and/or State Performance Measure (N/SPM) activity and evaluation plans. The following map shows FFY 2021 N/SPMs:



The remaining Title V funds support Children & Youth Special Health Care Needs (CYSHCN); the Fetal, Infant, Child, & Maternal Mortality Prevention Act (FICMMR) Program, and state costs to manage the program. CPHDs are required to implement and report on a FICMMR injury-prevention activity. The A&R provides details of the COVID-19 pandemic's impact in 2020, especially on the CPHDs.

Women & Maternal Health:

FFY 2020 Report - Oral Health in Pregnancy *(NPM 13a)*:

Oral health partners continued to promote oral health literacy with the *Healthy Montana Mouths (HMM)* campaign, a 13-page flip chart containing information on oral health from preconception to pregnancy to a child's first dental visit. The MT Oral Health Network created a metric to support NPM 13a: "Develop innovative programs that increase the number of women seeking preventive dental care during pregnancy from 51% to 55% percent by 2023." Five counties chose NPM 13a as their priority and implemented evidence-informed activities while adhering to COVID-19 precautions.

FFYs 2021 & 2022 Activities – Annual Preventive Care Well-Woman Visit *(NPM 1)*:

Three CPHDs are implementing these NPM 1 activities in FFY 2021: community partnerships to address unmet reproductive health care needs; social marketing messages to promote women's preventative health care and preconception health; a media campaign on the importance of HPV vaccination and cervical cancer screening; and education at community events. The Montana Obstetrics and Maternal Support (MOMS) Program is an NPM 1 partner and has its own metric regarding annual well-woman visits. Staff is preparing a public education campaign to improve maternal health outcomes, and planning provider trainings to improve the frequency and quality of annual well-woman visits.

Perinatal & Infant Health:

FFY 2020 Report, FFYs 2021 & 2022 Activities - Safe Sleep *(NPM 5)*:

Six CPHDs focused on NPM 5 in FFY20, and four chose infant safe sleep for their injury-prevention activity. A common role for each was to be a convening and supporting partner for other programs and agencies. For example, staff training and family outreach educational materials were presented to: Child and Family Services Division staff for Foster Care providers; WIC and Home Visiting; United Way; Blackfeet Indian Health Service; local primary care clinics; and community college and high school health classes. MCHBG financial support of *Healthy Mothers Healthy Babies* helped CPHDs and Tribal Health Departments in obtaining portable, Pack N Play cribs for families in need.

For FFY 2021, twelve CPHDs are working on infant safe sleep, either for NPM 5 or as their injury-prevention activity. The overriding theme is educational outreach, with numerous approaches, which include: collaboration with other local programs and agencies, i.e., Child Protective Services, Home Visiting, local hospitals, and WIC; materials in packets to postpartum mothers; presentations to students; focus groups on American Indian reservations on the cultural practice of bed-sharing; and, breastfeeding assistance (a supportive practice) by providing free breast pumps to women unable to have access through other means.

Child Health:

FFY 2020 Report – Child Injury-Prevention *(NPM 7):*

Six CPHDs focused on NPM 7 for FFY20 and addressed their county's priority needs, which included: Firearm Safety; CPR Training; Baby-Sitter Class; Carseat Safety; Suicide Prevention; Social Media Campaigns on a variety of topics; and, Brain-Injury Prevention, specifically through helmet use education and distribution. Also, all CPHDs which participate in the MCHBG are required to implement an injury-prevention activity in addition to their MCHBG performance measure work. In FFY20, a total of 32% of CPHDs chose to address suicide prevention.

FFYs 2021 & 2022 Activities – Children's Annual Preventive Care Dental Visit *(NPM 13b)*:

MCHBG and Oral Health (OH) Program staff are collaborating on NPM 13b activities and are promoting *HMM,* the oral health literacy campaign. Four CPHDs, located in areas with limited access to oral health care and/or a high percentage of residents below the federal poverty level chose NPM 13b. The CPHD staff participate in the monthly MT OH Partners meetings to discuss efforts for incorporating oral health services in primary care settings, which includes leveraging their partnerships with other organizations to increase their reach and capacity for oral health education.

Adolescent Health:

FFY 2020 Report – Adolescent Preventive Care *(NPM 10):*

At the beginning of FFY 20, the FCHB shifted the emphasis of NPM 10 activities to adolescent health education programs, emphasizing teaching teens about medical providers and their services. Collaborating with the Adolescent Health Section provided opportunities to contribute and partner on awareness and education of: healthy life skills; adolescent development; and, sexual and reproductive health.

FFYs 2021 & 2022 Activities – Bullying Prevention *(NPM 9):*

Montana has a very high rate of teen suicide and high incidences of bullying. Because of a correlation between these two actions, and other risky behaviors by adolescents, NPM 9 is the focus for FFYs 2021-2025. For FFY21, eleven CPHDs

chose suicide prevention for their injury-prevention activities, and two chose NPM 9. Research has shown that youth who report bullying, being bullied, or both, are at increased and long-term risk of: suicide-related behaviors; depression; anxiety; and, negative physical and mental health. Given this relationship between bullying and suicide-related behavior, utilizing resources and programs to address them in tandem will increase impact and help address time constraints.

Children & Youth with Special Health Care Needs:

FFY 2020 Report, FFYs 2021 & 2022 Activities – Medical Home *(NPM 11):*

Children's Special Health Services (CSHS) provides many programs, which seek to enhance access; improve quality of services; and meet national standards for children and youth with special health care needs (CYSHCN), for families to access a medical home. These include:

- *HALI Project MT Parent Partner Program:* Strives to offer every parent and caregiver of a CYSHCN access to a Parent Partner.
- *Medical Home Portal:* A user friendly one-stop-shop that provides diagnosis information, treatment options, and a statewide services directory. Usage appears to have increased during the pandemic.
- *Consumer Advisory Council:* Maintains and disseminates a health care transition (HCT) guide; develops evidence-based/informed HCT training and resource materials; conducts distance learning opportunities; maintains a transition website; and provides technical assistance to other initiatives related to HCT.
- *Montana Pediatric Medical Passport:* Works to improve care coordination and communication of medical complexity, and delivery of medical care, in urgent and emergency situations.
- *CSHS Financial Assistance Program (FAP):* Families with out-of-pocket expenses for medical and enabling services i.e., occupational therapy items; adaptive equipment; and respite care may be eligible for the FAP.

Cross-Cutting/Systems-Building:

Access to Care & Public Health Services *(SPM 1):*

SPM 1 allows flexibility to these CPHDs, to supply critical safety-net services and to address multiple priorities for their maternal and child residents. In FFY 2020, 50% of the CPHDs chose SPM 1. As an indicator of their percentage of the total population, they received only 13.6% of the CPHD's total MCHBG allocation. The percentage choosing SPM 1 remains steady for FFYs 2021 and 2022. Characteristics of these CPHD's include: low population density; CPHDs with one or less FTE, some open less than 40 hours a week; services such as WIC may only be provided once a month, or even once a quarter; no economy of scale for fixed expenses; and usually, long distances to travel for program trainings.

Family Support & Health Education *(SPM 2):*

The 2020 NA recognized that support for vulnerable families and parental health education remain critical needs, which parallels nationwide findings regarding the importance of the social determinants of health (SDOH). SPM 2 allows CPHDs to provide referrals to community services and health education and continues as a performance measure for FFYs 2021-2025.

In FFY 2021, 11 CPHDs are focusing on SPM 2 activities, with four supporting the CONNECT Electronic Referral System, a secure, web-based platform designed to be inclusive of any type of service provider. Referrals can be sent from a client's home community to anywhere in the state, with referrals back to their home community for follow-up and support services. DPHHS is evaluating technology opportunities to strengthen state, community, and family level referral processes over the next several years as well, to be used by many health and human service programs.

Other FFY 2021 topic specific areas of activity include: tobacco cessation; breastfeeding; behavioral health; pre-natal care;

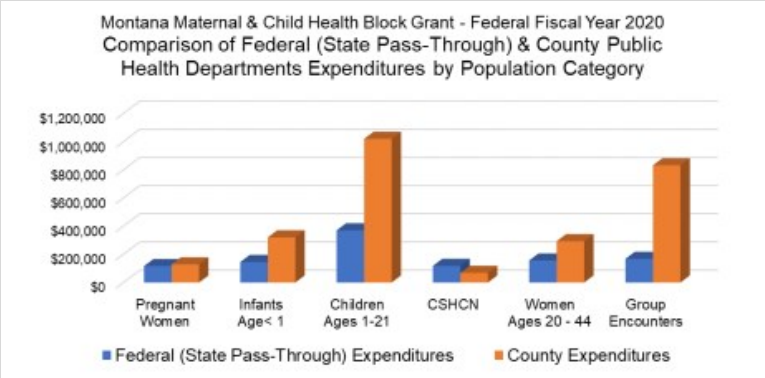
infant safe sleep; oral health, immunizations; and, childcare. Seven CPHDs requested to redirect their activities towards COVID-19 efforts, addressing SDOH and family support.

MT's Title V MCHBG program is working to maximize the health of its maternal and child population and relies on strong partnerships, collaborations, ongoing quality improvement efforts, and using evidence-based programs, with an emphasis on all the priorities identified in the 2020 NA.

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

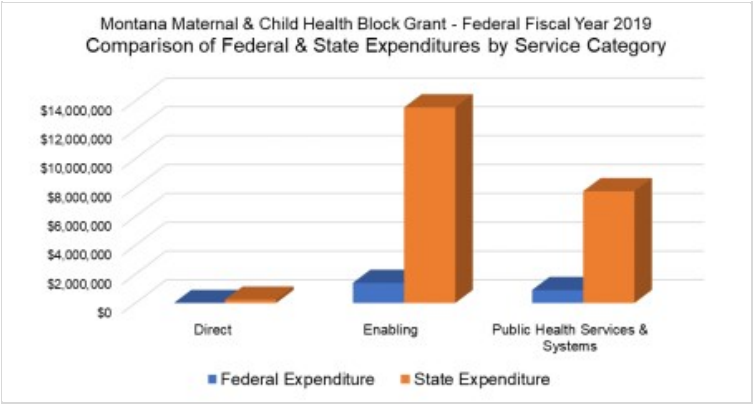
As detailed in the Program Overview, MCH efforts occur throughout a larger system of supports and through County Public Health Departments (CPHDs). CPHDs receive an average of 40% of the state's annual funding. Investing in CPHD maternal and child health activities is an effective complement to state efforts, as they have historically well-exceeded the matching funds requirement of three non-federal dollars for every MCHBG dollar and assure service prirorities are specific to community needs. Figure 1 shows the comparison for the federal fiscal year 2020 by population category.

Figure 1.



At the state level, MCHBG funding provides crucial support for the program's capacity and management structure including the MCHBG Program Specialist; Fetal, Infant, Child & Maternal Mortality Review Coordinator; Children and Youth with Special Health Care Needs (CYSHCN) Director; CYSHCN Education & Program Specialist; and a Nurse Consultant. It provides partial support for the Title V Director, and a CYSCHN Program Assistant. MCHBG funding serves as a springboard for the provision of *Enabling Services* and investment in *Public Health Services and Systems* (Figure 2.). State funds support: CYSHCN programs; state staff; contracted services; and, CPHD performance measure activities.

Figure 2.



III.A.3. MCH Success Story

The Big Horn County Public Health Department (CPHD) has established great trusting relationships with county residents. The county shares a large percentage of its geographic area with the Crow Tribe of the Crow Reservation and Northern Cheyenne Tribe of the Northern Cheyenne Reservation. These reservations were especially hard hit with COVID-19, and many levels of government collaborated to provide services and support. The lead MCHBG coordinator for Big Horn CPHD shared the following story that highlights community collaboration in supporting families facing multiple SDOH challenges.

"In September 2020, we were notified of a positive lab report on a Sunday afternoon. I phoned the positive individual to interview her and figure out who needed to be quarantined as soon as possible. This household is typical in our area, with this woman in her 40's; her preteen son; her sister; the sister's preschool-aged son; an 18-month-old girl who they are fostering; and an adult female friend who financially contributes to the household. Additionally, on this particular weekend, two preteen nephews were having a sleepover at this house. So, we had six people in the 2-bedroom house, plus the two houseguests who could not go home now that they were exposed to an active case of COVID.

Everyone was placed on quarantine for 14 days from the beginning of symptoms for our index case. They all had to stay in the house or in the backyard and not interact with any people from outside their household. Thank goodness they had a backyard! Our public health nurse (PHN) called our community food bank, Helping Hands of Hardin, and reported the number of individuals and their ages on Monday. We delivered food for a week by 4:00 pm that day. We also delivered a box of cleaning supplies, which helped them feel they were doing something useful to combat the spread. The cleaning supplies were donated by Open Doors, a local community-based organization on the Crow Indian Reservation.

Later that week, one child tested positive. This restarted the clock for all of the other members of the household to be quarantined for another fourteen days (except for the index case). At this point, we realized that it was getting increasingly stressful at this home. The PHN reached out to the the local early childhood coalition, and she suggested that we round up some child enrichment supplies to help the children make it through quarantine.

We made up kits for a toddler, a preschooler, and three elementary school-aged kids. The PHN delivered these kits the following week with the new boxes of food. Then another adult tested positive, and the quarantine date was advanced another 14 days from the onset of symptoms. This was very frustrating for the adults who understood that until all members of the household tested positive or until the 14-day quarantine was satisfied without any new positive test results, no one was free.

Then two more of the children developed symptoms and tested positive. We made another delivery of games, puzzles, books, and toys for the adults to engage with the children. This was Week three of the quarantine, and the women expressed appreciation of our efforts. We included another food delivery from Helping Hands. By now, we realized that in addition to delivering food and cleaning supplies that it would be helpful and furthering our mission to supply child enrichment kits to all households in the community with young children who were quarantined. So, the Best Beginnings workers assembled about 25 kits (in shopping bags) that were labeled for toddlers, preschoolers, six and seven-year-olds, and eight years and up. Members of our health department staff have continued to give these kits out to families who are enduring quarantine."

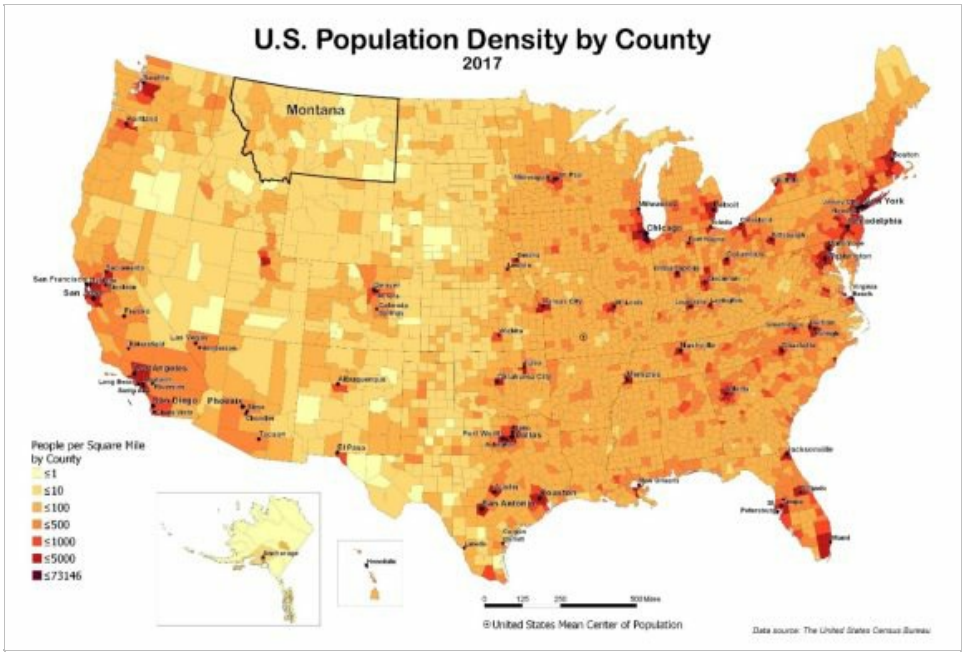
III.B. Overview of the State

Geography, Demographics, Economy, Income

The context for delivery of health care services in Montana is first formed by understanding its vast size, and secondly by its small population. These factors are inverse to the realities of providing health care in most of the nation. The population's racial composition is another characteristic that very few states share, with American Indians being the principal minority. This overview starts with basic information on these elements and then provides additional details on factors impacting Title V services.

Montana is the fourth largest state in size, at 145,546 square miles. As of July 2019, Montana's population was 1,068,778 – which averages to a population density of 7.34 people per square mile. The following map (Figure 1.) shows U.S. population density by county in 2017, with Montana outlined:

Figure 1.



More than half of the population lives in rural or frontier areas, characterized, in part, by limited access to health care in local communities. Agriculture, tourism, logging, and natural resource extraction are major industries. Economic growth is increasing in the high-tech sector; manufacturing; pulse crops such as chickpeas and lentils; and small business startups. The healthcare industry is Montana's largest economic sector by employment. The growth in health care has been steady over the past decade and is expected to experience rapid job growth as Montana's aging population requires more healthcare services.

AMontana Department of Labor and Industry report, *2020 Hindsight: A Summary of Montana's Economic Changes in 2020,* indicated that in April 2020, the unemployment rate tripled from 3.8% to 11.9%, as businesses, schools, and childcare providers closed to help slow the spread of COVID-19. It was also reported that for the first two quarters in 2020, the state was deemed to be in a recession. However, in the 2020 third and fourth quarters, the economy was on a rebound as reflected in an unemployment rate of 3.6% as of May 2021, getting closer to the pre COVID-19 unemployment rate of 4.2% in Montana and 3.5% nationally This report is accessible at: https://stats.bls.gov/eag/eag.mt.htm

Montana's racial make-up is predominately white, with a 2019 census estimate at 88.1% of the population. American

Indians make up the largest minority, at approximately 6.7% (see Table 1). The ethnic Hispanic or Latino population is 4.1%, compared to 18.3% nationwide.

Table 1: Annual Estimates of Resident Population by Race for Montana, 2019		
Race	**Population Count**	**Population Percent**
White	940,423	88.1%
American Indian	67,603	6.7%
Asian	8,927	0.9%
Black	7,787	0.6%
Native Hawaiian / Pacific Islander	224	0.1%
Two or More Races	36,517	2.8%

American Indian Reservations

Montana is home to seven American Indian reservations and the Little Shell Chippewa, a federally recognized landless tribe. State law recognizes a unique government-to-government relationship between the state government and the eight tribal governments. According to the 2019 U.S. Census estimate, American Indians equal 6.7% of Montana's population, or approximately 71,608 in number, of which 59.5% live on tribal lands. Information on culturally competent delivery of maternal and child services is detailed in the Needs Assessment Summary.

Each reservation is unique in demographics and the cultures of each tribe. The seven reservations are as follows: Blackfeet, Crow, Flathead (Confederated Salish, Pend d'Oreille and Kootenai), Fort Belknap (Gros Ventre and Assiniboine), Fort Peck (Assiniboine and Sioux), Northern Cheyenne, and Rocky Boy's (Chippewa and Cree). For more information, see http://tribalnations.mt.gov.

The Little Shell Chippewa Tribe, which received federal recognition in December 2019, is without a reservation or land base. With approximately 5,400 members, there are population concentrations in numerous cities and towns across Montana and in other states. Many changes are expected during the next decade as federal recognition is implemented. The legislation includes an accommodation for the purchase of 200 acres. The site will include buildings for tribal government, a health clinic, and college-level and vocational instruction.
Table 2 compares some of the MCHBG demographic profile information for the geographic area of each reservation. The median age for the whole state is 39.8 years.

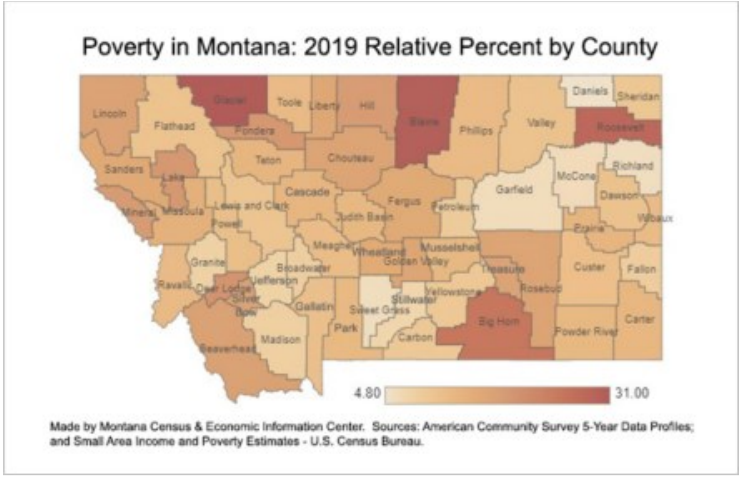
Table 2: Annual Estimates of Montana's American Indian Reservations and Off-Reservation Trust Lands							
U.S. Census: American Community Survey 2019 Estimates							
Montana's American Indian Reservations - Geographic Area Demographics							
Race and Maternal & Child Health Block Grant Population Categories							
Category	**Blackfeet**	**Crow**	**Flathead**	**Fort Belknap**	**Fort Peck**	**Northern Cheyenne**	**Rocky Boy's**
Total Population	10,629	7,623	29,926	3,204	10,376	4,827	2,304
Median Age*	30.4	29.5	40.9	26.5	29	25.8	24.2
Count A.I./A.N.	8,865	5,978	7,988	3,002	6,818	4,392	2,202
Percent A.I./A.N.	**83.4%**	**78.4%**	**26.7%**	**93.7%**	**65.7%**	**91.0%**	**95.6%**
Count White	1,482	1,424	19,265	118	2,992	297	18
Percent White	13.9%	18.7%	64.4%	3.7%	28.8%	6.2%	0.8%
Age Under 5 Years	974	585	1,940	347	1,003	586	288
Age 5-19 Years	2,712	2,253	6,172	951	2,834	1,415	768
Females Age 18-64 Years**	2,985	2,206	8,438	858	2,844	1,354	591
A.I./A.N. = American Indian / Alaska Native							
* Median Age in U.S. is 37.9, and in MT 39.8							
**Range available from data on ACS Geographic Area Table							

The 2018 American Community Survey (ACS) 5-year estimated average median household income in Montana was $52,559 compared to the U.S. total average of $60,293. Under the same survey, Montana's per capita income was $29,765, compared to the U.S. average of $32,621.

According to the Office of Public Instruction, the high school graduation rate in the 2018-2019 school year was 87%, compared to the 2017-2018 national average of 88%. The ACS reports the average percentage of high school dropouts for ages 16 – 24, for 2013-2017, was 6.6, which was close to the U.S. average of 6%. However, significant disparities existed for the American Indian population, at 18.5%. For bachelor's degrees, the U.S. Census reports the 2014-2018 5-year average for ages 25-plus for Montana was 31.2%, which is very close to the U.S. average of 31.5%.

The 2019 ACS 5-Year estimate indicates that 15.8% of MT's children under age 18 are below the federal poverty level. According to the 2019 census, the rate of poverty varies greatly by county, from a high of 31% in Glacier to a low of 4.8% in Daniels. This is shown in detail on the following map (Figure 2.).

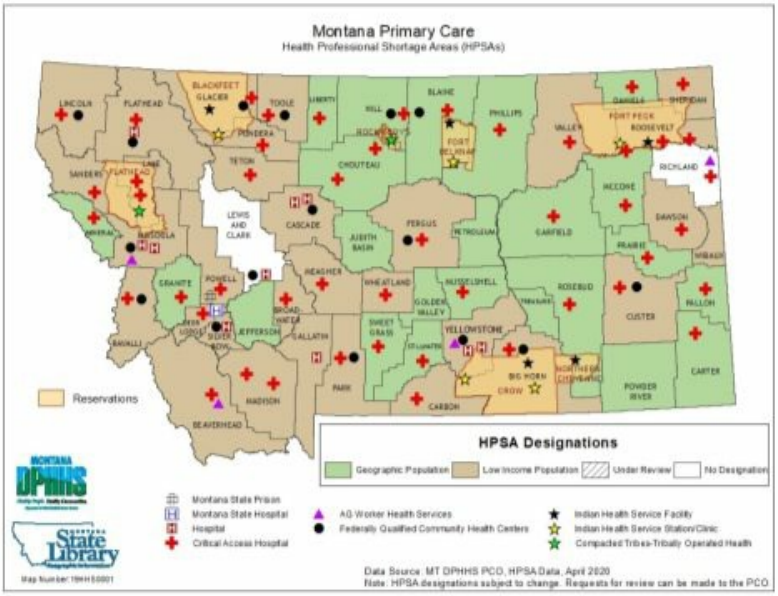
Figure 2.



Health Services Infrastructure

All of Montana's counties are designated as medically underserved in some way. According to the 2016 Montana BRFSS Annual Report, the prevalence of no personal health care provider was 26.4%, compared to the U.S. percentage of 21.9%. There are currently no medical schools in the state. The following map (Figure 3.), updated in April 2020, illustrates the Health Professional Shortage Areas (HPSA) for Primary Care:

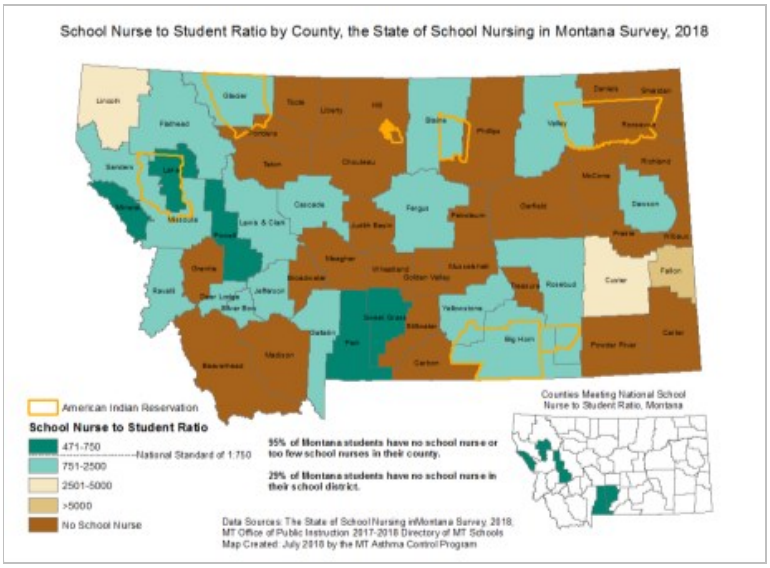
Figure 3.



In addition to the inherent challenges Montanans face when attempting to access a primary health care provider, Montana Law does not mandate school nurses. Many CPHD nurses spend time each week providing services in their local schools. The nurses' work in the schools helps to bridge gaps in care, especially in counties with geographic HPSA designations.

In 2018, data indicated a school nurse to student ratio of 1 RN school nurse to 1,517 students. This was an improvement from 2015 when the ratio in Montana was 1 RN school nurse to 1,728 students. Unfortunately, at this time, 45% of Montana's 56 counties have no school nursing services; thus, 96% of Montana students have no RN school nurse or have too few school nurses in their county, and 29% of Montana students have no school nurse in their entire school district (Figure 4.).

Figure 4.



Detailed characteristics of Montana's maternal and child population groups, with health status, needs, and emerging issues are described in the 2020 Statewide 5-Year MCH Needs Assessment Summary and 2021 Needs Assessment Update. Factors impacting Title V services delivery are also noted. Seven priority areas were identified, listed here by population domain:

- Perinatal & Infant: *Infant Mortality*
- Children: *Oral Health*
- Adolescent: *Bullying*
- Women & Maternal: *Annual Preventive Healthcare Visit*
- Children with Special Health Care Needs: *Medical Home*
- Cross-Cutting & Systems Building: *Access to Public Health Services*
- Cross-Cutting & Systems Building: *Family Support Services and Health Education*

State Health Agency Title V Service Delivery

Montana's Title V program is housed in the Department of Public Health & Human Services (DPHHS), the largest state agency in Montana. DPHHS seeks to promote and protect the health, well-being, and self-sufficiency of all Montanans. Needs covered by programs include social services, medical, physical, and behavioral/mental. It is also the agency that manages Medicaid in the state. Details on all services and programs can be found at: https://dphhs.mt.gov/.

Montana is considered a "decentralized" system when it comes to public health, and most services are provided at the local level through the County Public Health Departments (CPHDs). DPHHS has contracts with all 56 CPHDs, and much of its funding is passed through to support their work. Montana's Title V MCHBG Program provides leadership and direction to state, local, and non-governmental programs, and partners for issues affecting the health of the maternal and child population. For example, by connecting state and national performance measure strategies with local efforts.

In addition to the priority maternal and child health needs, several overarching issues pose unique challenges to health care delivery: the aging population; geographic disparities; and, access to health care. Some CPHDs are the sole source of certain maternal and child health care services, such as immunizations, for the surrounding population. Montana's Title V MCHBG funds directly supported CPHDs in 52 counties in FFY 2020 and are critical to meeting the public health needs of the maternal and child population across the state.

Statutory authority for maternal and child health services is found in the Montana Code Annotated (MCA) Title 50, Health and

Safety. General powers and duties of the state include administration of federal health programs delegated to the states; rule development for programs protecting the health of mothers and children (including programs for nutrition, family planning services, improved pregnancy outcomes, Title X, and Title V); acceptance and expenditure of federal funds available for public health services; and use of local health department personnel to assist in the administration of laws relating to public health. Montana's Initiative for the Abatement of Mortality in Infants (MIAMI) is authorized in MCA 50-19-401, and Fetal, Infant, Child and Maternal Mortality Review (FICMMR) is authorized in MCA 50-19-301.

Financing of Health Services

Montana's Title V MCHBG allocation to county health departments is based on: the total numbers of women of childbearing age (15 to 44 years); infants and children ages 0 through 18; and the number of those individuals living in poverty. Montana's Title V MCHBG funds are allocated as required by Section 501 to 510 [42 U.S.C. 701 to 710]; and ARM 37.57.1001 governing the MCHBG. Historically, based on this funding formula, the CPHDs have received 45% of the total funding.

In FFY 2020, the counties received $1,068,465 in Title V MCHBG funding to provide services to their county's maternal and child population. The CSHS section expended $709,762 providing services to *Children & Youth with Special Health Care Needs (CYSHCN),* $167,097 was spent on state-level administrative costs, and the remaining $336,499 was spent on state-level MCH programs.

DPHHS administers the Montana Medicaid Program (MMP) through several divisions including but not limited to: Human and Community Services Division for eligibility determination, Health Resources Division, Developmental Services Division including Children's Mental Health, and the Addictive and Mental Disorders Division, authorized under 53-6-101, Montana Code Annotated (MCA), and Article XII, Section XII of the Montana Constitution. The MMP complies with its state plan and waiver authorities, thus meeting the unique healthcare needs of Montanans. With multiple divisions focused on medicaid services, DPHHS partners with various providers and stakeholders to address social determinants of health on many levels. In 2015, MT's biennial legislative body passed Senate Bill (SB) 405, Montana Health and Economic Livelihood Plan, which expanded Medicaid effective January 1, 2016. House Bill (HB) 658, the Medicaid Reform and Integrity Act, passed by the 2019 Legislature, continued SB 405 through June 2025. HB 658 included a work requirement, an 80-hour monthly work or community engagement requirement for the enrollee, which was planned to be effective January 2020. The state submitted an 1115 waiver to CMS in August 2019; and is awaiting the final decision.

Montana Medicaid includes the following coverage groups that all have different eligibility requirements: Infants and Children including Newborn Coverage, Healthy Montana Kids Plus, Healthy Montana Kids (CHIP), Subsidized Adoptions, Subsidized Guardianship, and Foster Care; Pregnant Women; Low Income Adults with an SDMI; Aged, Blind/Disabled and/or receiving Supplemental Security Income; Breast and Cervical Cancer Treatment; Medically Needy or Categorically Needy; Low Income Montanans Including Medicaid and Medicaid Expansion and Montana Medicaid for Workers with Disabilities.

As of June 2021, 53,177 adult women were enrolled in Montana Medicaid Expansion, and 86,408 were enrolled in all other (traditional) Medicaid programs. As of April 2021, 1,907 women were enrolled in Pregnant Women Medicaid. The number of pregnant women covered by other types of Medicaid cannot be pulled accurately because Medicaid is not aware of most other pregnancies until receiving the global pregnancy bill after the baby is delivered.

As of April 2021, there were 28,038 children enrolled in the Healthy Montana Kids (HMK) (CHIP) and the HMK Plus CHIP Expansion population, and there were 112,177 children ages 0-20 enrolled in all other Medicaid programs.

In addition to public insurance options, private insurance also covers much of the population. The ACA Federally Facilitated Marketplace enrollment for 2020 was 43,822, and for 2021 was 44,711. Table 3. outlines sources of health insurance for Montana, according to the U.S. Census American Community Survey estimates for 2018:

Table 3: 2019 Estimates of Resident Population by Insurance Coverage Type for Montana		
Insurance Coverage Type	**Population Count**	**Population Percent**
Employer-Based	416,046	39.49%
Direct-Purchase	86,037	8.17%
Medicare	70,352	6.68%
Medicaid	161,659	15.34%
TRICARE / Military	11,879	1.13%
VA Care	4,918	0.47%
Two or More Types of Health Insurance	215,614	20.46%
No Health Insurance Coverage	87,141	8.27%
Total	1,053,646	100.00%

III.C. Needs Assessment
FY 2022 Application/FY 2020 Annual Report Update

Ongoing Assessment Activities - Data Collection and Analysis:

State Health Improvement Plan

The Family and Community Health Bureau (FCHB) programs contributed to the 2019-2023 Montana State Health Improvement Plan (SHIP) and the 2020 SHIP Update Report, published in February 2021. The 2020 SHIP Update Report highlights the state's progress aimed at improving the health of Montanans in these priority areas:

- Behavioral Health;
- Chronic Disease Prevention and Self-Management;
- Motor Vehicle Crashes; and,
- Healthy Mothers, Babies, and Youth/Adverse Childhood Experiences.

The SHIP identified objectives for monitoring improvement over time; and proposed prevention and health promotion, clinical, policy, and health equity strategies for driving improvement. It also identified each priority area's Workgroup Members, which included individuals from organizations representing: Department of Public Health & Human Services (DPHHS) and other state of Montana programs; non-profits; County and Tribal Health Departments; coalitions; healthcare providers; and clinical and social service organizations.

Throughout 2020, the Workgroups hosted 12 topic-specific, virtual meetings (three meetings per priority) and a combined virtual meeting in December 2020. From December 2019 to 2020, interest in the SHIP increased (see Table 1). The number of unique organizations also increased from 89 in 2019, to 102 in 2020.

Table 1: SHIP Workgroup Membership

Data Source: MT State Health Improvement Plan: 2020 Annual Report

Workgroup	Total # Members	
	2020 Members	Change From 2019
Behavioral Health	51	+4
Chronic Disease Prevention and Self-Management	41	+12
Motor Vehicle Crashes	28	+4
Healthy Mothers, Babies, and Youth/ACES	58	+7

The SHIP and the Update Report are included with the supporting documents, and can also be found at: https://dphhs.mt.gov/ahealthiermontana.

Family & Community Health Bureau Needs Assessments

The Title V MCHBG is housed in the FCHB. Since the completion of the MCHBG 5-Year Statewide Needs Assessment (NA), the following two FCHB programs have released results of their NAs: the Primary Care Office (PCO) and Healthy Montana Families Home Visiting (HMF/HV). This narrative includes summaries of the findings from these NAs pertinent to serving the MCHBG population and highlights of smaller-scale assessments by other programs.

Montana Primary Care Office 2021 Needs Assessment

In January 2020, under the direction of Montana's (MT's) Title V Director, the PCO contracted with the University of MT Rural Institute for Inclusive Communities (RIIC) to assist with the PCO 2021 NA. The RIIC evaluation team worked with MT PCO epidemiologists and the Program Specialist to: determine sources of data; clarify information; and, learn more about initiatives, strategies, and partnerships relevant to primary care services in MT. A copy of the complete report is included with the supporting documents for this submission.

The purpose of the statewide PCO NA was to:

- Describe the health status of MT's residents, specifically underserved and vulnerable populations;
- Describe MT's primary health care system, including factors associated with the delivery, access, and utilization of primary health care in MT; and,
- Identify community-based programs and partners that implement activities to reduce barriers to healthcare.

The assessment utilized analysis of secondary data to present a picture of MT's vulnerable populations, health care needs, health disparities, social determinants of health, and health workforce. The RIIC evaluation team compiled data from local, state, and federally recognized agencies, such as the U.S. Census Bureau, and several data sources within DPHHS (e.g., Vital Statistics, Behavioral Risk Factor Surveillance Survey). For health indicators and social determinants of health (SDOH), the most recent single-year data was captured and presented when appropriate for comparisons to national rates or averages. When single-year data was unavailable or unreliable, multi-year estimates were used.

In addition to secondary data collection, RIIC completed eight key informant interviews with stakeholders in MT's primary care system, including healthcare consumers and healthcare providers. Health care consumers were asked about their access to primary health care services, and health care providers were asked about the strengths and challenges of the state's primary care system. COVID-19 put increased pressure on MT's healthcare systems, limiting the providers' capacity to participate. Two key stakeholder groups were invited to review preliminary drafts of the report: MT Disability and Health Program; and the MT Healthcare Workforce Advisory Committee. They provided feedback on content, methods, and recommendations for the next steps.

The NA reviewed the following factors related to the access and utilization of primary care:

- SDOH, including: unemployment, poverty, food and housing insecurity, and educational attainment
- Health insurance coverage and affordability
- Preventative services such as immunizations and routine dental and medical check-ups
- Health professional workforce and shortage areas
- Medical education programs
- Primary Care Health Centers
- Partner Programs

Population to Provider Ratios

For purposes of the NA, the population-to-provider ratios for MT primary care were calculated using the total population of the county to the total Full-Time Equivalent (FTE) number of providers serving that geographic area, where 40 hours/week equal 1 FTE. The population to primary care physician FTE ratio in MT was 2231:1 as of June 2020. This ratio does not include physicians in active practice with Indian Health Services, Tribal Health, Veterans Affairs, Military Bases, Student Health, or State Agencies. The population to dentist FTE ratio was 2753:1, and the population to psychiatrist FTE ratio was 28513:1. Population to primary care provider FTE for tribal reservations ranged from 428 to 1 to 1116 to 1, which are lower than other areas of the state.

While the data show there may be a sufficient overall supply of primary care providers in MT, the supply is unevenly

distributed. Some counties have a relatively wide population to provider FTE ratios or no providers identified in the service area. *There are 13 MT counties that do not have primary care physicians and ten counties without dentists. There are 46 counties without psychiatrists.* Health professional shortages or an uneven distribution of health care providers can create barriers to accessing healthcare, among other issues.

Geographic Disparities & Access to Care Barriers

For the 13 counties without primary care physicians, there is a transportation burden for county residents. Using county seats as a centralized metric, the drive time to reach the nearest physicians ranges from approximately 27 minutes for Wibaux County residents to reach Glendive, MT to well over an hour for residents in Garfield County to reach either Glendive, MT or Miles City, MT. While counties are a crude metric for assessing distance to services, they illustrate the geographic barriers to accessing services experienced by rural Montanans.

Geographic barriers to services can also be complicated by the distance to the nearest primary care providers accepting Medicaid patients. For example, drive-times from the population centers of counties without a dentist to the nearest dentist accepting new Medicaid patients is greater than for those utilizing other payment methods. For these adults, the average drive-time from Eastern MT is 85 minutes, and 51 minutes from Central MT. For children, the average drive-times are 54 and 38 minutes, respectively.

Geographic barriers to service may be reduced for some populations, given the rapid expansion of telehealth due to the COVID-19 pandemic. However, these opportunities are limited to those with reliable internet access, capable devices, and affordable data plans.

Distance can also have an impact on recruiting and employing primary care providers in rural and frontier areas. These areas struggle to compete with metropolitan areas with regards to wages, work flexibility, social opportunities, education opportunities, and other local services. Clinics and hospitals in Montana's rural and frontier areas rely heavily on programs to recruit and retain primary care providers.

MIECHV Needs Assessment – Published September 2020

MT's MIECHV Program is also a part of the FCHB, and works closely with the Title V MCHBG. The MIECHV Statewide NA was finished approximately six months after the Title V MCHBG's. It includes unique data and insights which have provided additional information and understanding for MCHBG programming, especially in regard to at-risk counties. A copy of the full report is included with the supporting documents for this submission.

Key Findings

- Thirty-two counties in MT were identified as at-risk. In agreement with findings from the Title V MCHBG NA, the Child Abuse and Neglect Prevention Strategic Plan, and other recent statewide NAs, the most significant risk factors MT families experience include: substance use disorders (SUD); mental health concerns; a lack of mental health providers; and, increasing rates of child maltreatment. Rural and tribal communities have the largest concentration of risk factors.

- SUD and child maltreatment are growing problems for MT families, evidenced by higher rates of SUD for alcohol use (57.3%), marijuana use (19.8%), methamphetamine use (0.97%), and opioid misuse (4.03%) compared to national rates (51.2% alcohol use, 15% marijuana use, 0.7% methamphetamine, and 3.6% opioid misuse) and the increasing number of children taken into foster care due in part to parent SUD. In 2018, 65% of cases where children were taken into care were SUD-related.

- Seventy-two agencies and organizations provide home visiting services in 36 counties, including 23 MIECHV-funded agencies (Lead Implementing Agencies) serving 19 counties. In FFY 19, MIECHV-funded agencies served 1,444 households and reached 32.9% of the population estimated to need home visiting services in their counties.

- MIECHV-funded agencies support rural and tribal communities. Of the four smaller counties (populations of less than 10,000 residents) served by MIECHV-funded agencies, 61% of the estimated in-need population received home visiting services. Additionally, 14% of MIECHV home visiting clients are American Indian (American Indians comprise 6.6% of the state's population). Sustained service to rural and tribal communities will provide needed support for these populations.

- Mirroring national trends in the characteristics of the home visiting workforce and state demographics, home visitors in MT tend to be non-Hispanic, White, and female. Increasing the gender and racial diversity of home visiting staff may help to reach subgroups with unique cultural and language needs such as single fathers, American Indians, migrant workers, and Spanish-speakers.

- Home visitors reported feeling motivated by working with families and having supportive teams/colleagues. Notable barriers to providing services include client retention and lack of knowledge of home visiting services. Continuing or increasing outreach and other efforts to destigmatize home visiting may serve to reduce these barriers.

- Substance use disorder treatment capacity in the state is limited by a lack of mental health providers and limited outpatient and residential services. Additional barriers are faced by those in rural/frontier areas as many services are primarily available in urban centers. Various local and state initiatives are striving to remove barriers that previously blocked people from getting needed help.

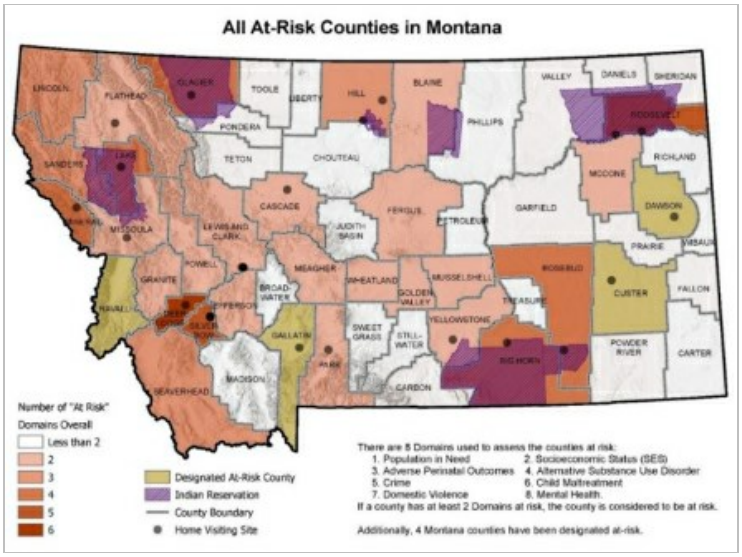
- There is a lack of infrastructure in MT to support new mothers, particularly those with current or past substance use. Home visitors report not being fully prepared to recognize or address SUD issues. Home visitors may benefit from professional development around recognizing the signs of SUD and using trauma-informed, destigmatizing approaches to reduce staff burnout and turnover.

At-Risk Counties

Thirty-two of MT's fifty-six counties were identified as at-risk (57%). Of those counties, the most frequently identified domains of risk were SUD (16 counties), Mental Health (12 counties), Child Maltreatment (11 counties), and Crime (11 counties). SUD, mental health concerns, and child maltreatment have been identified in other recent NAs as known issues in the state. A map is provided on the next page (Figure 1.).

The risks Montanans face are elevated in rural and frontier regions where services are limited or sparse. Except for Deer Lodge County, counties with the highest concentrations of risk (highest number of at-risk domains) are those where tribal reservations are located. Tribal reservations, which have Sovereign Domain governmental status, face significant health disparities and greater concentrations of risk.

Figure 1.



Family & Community Health Bureau: Additional Program Assessments

Children's Special Health Services

Children's Special Health Services (CSHS) is assessing the status of the CSHS stakeholders advisory group and the role of the Title V Family Delegate. CSHS intends to increase parent voice through improved engagement of parents in the stakeholders advisory group and build capacity within the Title V Family Delegate role. Assessment of partnering with the Part C of the IDEA Family Support Advisory Council, focused on children with developmental delays and disabilities 0-3 years of age is also planned. CSHS is working with the University of MT RIIC to append the Pediatric Mental Healthcare Access (PMHCA) NA to target behavioral health considerations for special populations that include: LGBTQI youth; youth who experience homelessness; and, American Indian youth. This will include a literature review, focus groups and the creation of population-specific care guides.

Family Planning

The Title X Family Planning Program conducted a NA to determine community need for family planning services, which will be used to determine potential new clinic locations. In addition, the Title X program collects clinical data from each family planning clinic to conduct internal medical audits to improve clinical service provision. As of June 2021, Title X is in the process of building a new database for more efficient and effective data collection and analysis. Title X has also expanded to include telehealth services to reach underserved communities. In addition, Title X is enhancing fertility awareness based method services to provide broader support of family planning preferences by individuals served.

The Rape Prevention and Education Program (RPE) conducts an annual program evaluation to examine actual and potential reach of activities, capacity of partnerships to implement community level strategies, and demonstrate the use of indicator data to track outcomes. The information from the current evaluation will be used to improve RPE's sexual violence prevention strategies and reduce sexual violence and victimization rates in Montana.

Oral Health Program

The Oral Health Program (OHP) conducts routine surveillance on the oral health status of children in Head Start, kindergarten, and 3rd grade utilizing the Basic Screening Survey (BSS). The BSS is an open-mouth survey that collects data on untreated decay, history of decay, and sealant prevalence. The OHP attempted to conduct the BSS of the Head Start population in the 2020/2021 academic year, but was limited, largely due to barriers presented by the COVID-19

pandemic. The surveillance was rescheduled for both the Head Start and kindergarten population in the 2021/2022 academic year. This data will provide valuable insight into the oral health status of children in MT.

Supplemental Nutrition for Women, Infant, & Children (WIC)

Starting the summer of 2020, WIC State staff completed a NA of the MT WIC program. This assessment was focused on nutrition and breastfeeding services and is intended to identify gaps and barriers to care and opportunities for improvement, expansion, and re-engagement. The results of the NA will be used by the State staff and local WIC staff, particularly by the WIC Workgroup from September 2021-August 2022. The WIC Workgroup is a stakeholder group consisting of local WIC staff from small, medium, large, and tribal WIC clinics and State WIC staff, with the goal of completing quality improvement projects.

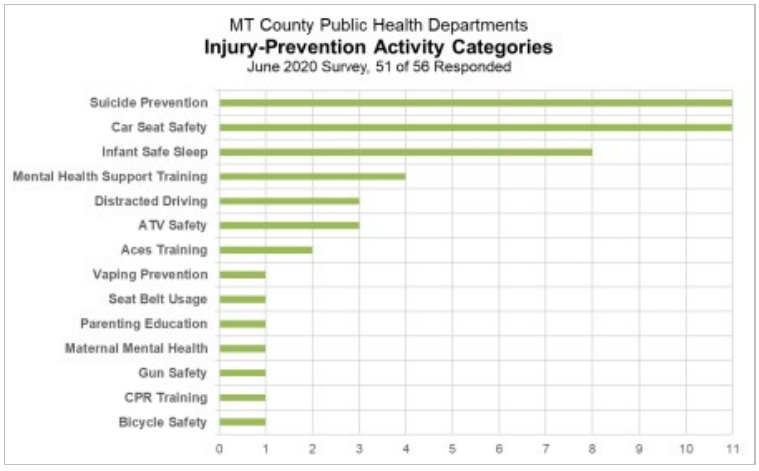
Regarding agency capacity and systems of care; WIC clinics were able to provide remote services during the pandemic because of federal waivers. State WIC staff tracked local WIC clinic capacity and remote versus in-person status via a monthly survey. This short survey allowed WIC to direct time, energy, staff, and resources towards clinics struggling due to sickness, staff time (many WIC staff were pulled for COVID-19 response at various times throughout the year), and local public health lockdowns/quarantines.

MCHBG-Participating County Public Health Departments (CPHDs)

Each June, CPHDs complete a Pre-Contract Survey (PCS) and submit data on: contact information and staff responsibilities; administrative details; services provided; FICMMR information and processes; MCHBG information and processes; and feedback on FCHB support. The survey results provide a picture of CPHD resources across the state. The survey also captures the choice of performance measure for the upcoming federal fiscal year, along with intended evidence-based or informed activities and evaluation plans.

The following graph (Figure 2.) shows the broad categories of injury-prevention activities as first planned last year, before it became clear how much COVID-19 would continue to dominate time and resources. In terms of the targeted population domains, with some overlap, we see that: infants are covered by car seat safety and safe sleep for a total of 19 activities; adolescents (and to some extent older children) are covered by: suicide prevention, distracted driving, ATV safety, vaping prevention, seat belt usage, gun safety, and bicycle safety for a total of 21 activities; and adults or PH staff are covered by trainings for: mental health support, ACES, parenting education, maternal mental health, and CPR for a total of nine activities.

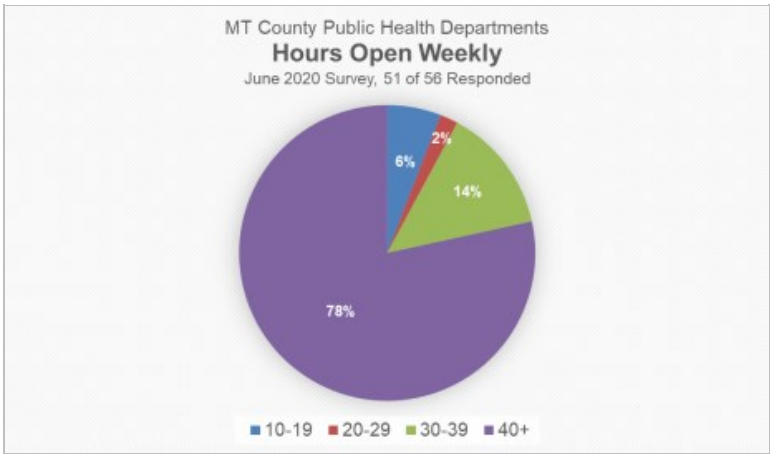
Figure 2.



The next graph (Figure 3.) reflects one of the challenges for counties with limited resources. 22% of CPHDs responding to

the survey are open fewer than 40 hours a week.

Figure 3.



Changes in Health Status and Needs Statistic Update

Pregnant Women, Mothers and Infants

A snapshot of the health status of MT's pregnant women, mothers, and infants may be seen from the following common health indicators. Data-source references are in the endnotes.

The health status data of 1) pregnant women, 2) mothers and infants, and 3) women of child-bearing age serves as an indicator of how well programs are addressing respective needs of each group. In 2019 there were 11,080 resident births, of which 1,280 (11. 6%) were to American Indian (AI) mothers; 804 (7.3%) births were infants weighing less than 2,500 grams; 1,065 (9.6%) were infants less than 37 weeks gestation; 8,302 (74.9%) infant's mothers received prenatal care beginning in the first trimester; 1,468 (13.2%) of infant's mothers used tobacco during pregnancy; and 3,150 (28.5%) of infants were born via cesarean section[i]. Of those infants born in 2019, 93.3% (95% CI: 91.3% - 94.8%) were ever breastfed[ii].

As noted above, births to American Indian mothers comprise 11.6% of Montana's resident births; however, race is correlated for the following MCH outcomes:

- The number of infants born to women who received prenatal care beginning in the first trimester was 585 AI (45.7%) and 7,512 White (78.6%). [1]
- The number of mothers who used tobacco during pregnancy was 344 AI (26.9%) and 1,099 White (11.5%);
- The infant mortality rate was 10.9 per 1,000 live births for AI and 4.1 per 1,000 for White[iii].

A preliminary review of the 2013-2019 CDR data, indicates that sleep-related circumstances strongly correlate to infant deaths. Of the 120 sleep-related deaths of infants, 72 were White, 42 were American Indian or Alaskan Native, 9 Hispanic/Latino (any race), and 6 were Multi-Racial. AI citizens make up 6.7% of the total population, but constitute 35% of all sleep-related infant deaths.

Children and Adolescents

In 2019, there were 216,929 children ages 1-17 years in MT, and of this total, 27,027 (12.5%) are AI. MT's childhood mortality rate for this age group was greater than the U.S. rate: 27.2 deaths per 100,000 children compared to 19.8, respectively.[1,5]

Young drivers involved in fatal crashes continue to be a serious problem in MT. From 2015-2019, MT's motor vehicle (MV) mortality rate for children age 1-17 years was greater than the U.S. rate with 3.2 deaths per 100,000 children compared to 1.1 deaths per 100,000 children, respectively.

The 2019 National Survey of Children's Health reported the following statistics for MT:

- 17.1% of children aged 0-17 years lived in households where someone smoked[iv];
- 53.3% of children age 0-17 years without special health care needs had a medical home[v];
- 79.0% of children age 12-17 years had one or more preventive medical care visits[vi];
- 65.6% of children aged 0-17 years were adequately insured[vii];
- 7.0% of children aged 1-17 years had oral health problems in the past 12 months[viii];
- 80.5% of children age 1-17 years had one or more preventive dental visits.7[ix]

The rate of birth to adolescents aged 15-17 years, was 6.1 per 1,000 in 2019.[1] MT's 2017-2019 suicide rate among teens (15-17) is twice that of the national rate (19.3 compared to 9.5 per 100,000 teens).[5]

Changes in Title V Program Capacity or MCH Systems of Care: MCH-Related COVID-19 Assessment

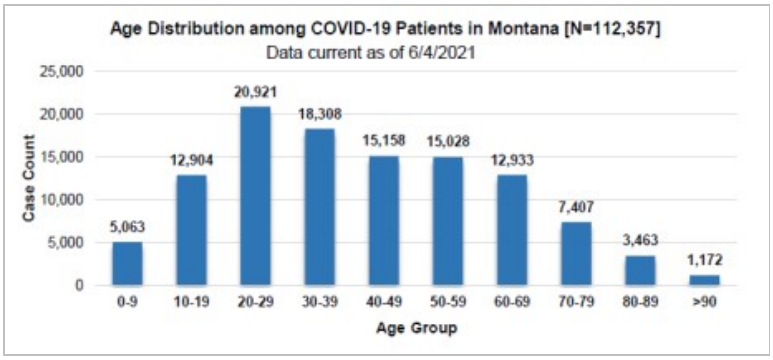
The largest impact of COVID-19 on the MCH population in the state has been the tremendous strain it put on the overall public health system, consuming staff time and resources usually devoted to MCHBG performance measure activities – especially at CPHDs. These were largely redirected to: contact tracing; quarantine support; public education; and, vaccinations.

Epidemiologists located in the DPHHS Public Health & Safety Division released an interim analysis of COVID-19 cases in MT near the beginning of every month. To provide a snapshot, most of the information in this section pulls from the report on June 4, 2021, with a focus on the maternal and child population. The whole report is included with the supporting documents for this submission. 408,908 Montanans were fully immunized as of June 11, 2021 (approximately 38% of the total population).

Age and Demographic Distribution

As of July 30, 2021, there were 116,535 reported COVID-19 cases in MT. This is approximately 11% of the total population. As of June 4, 2021, persons between 20-29 years of age accounted for 19% of the cases. The next most common age group wa 30-39 years (16%), followed by 40-49 (13%) and 50-59 years (13%). The median age for all cases was 39 years of age (range: <1-108 years). Fifty-two percent of cases were between 24-58 years of age.

Figure 4.



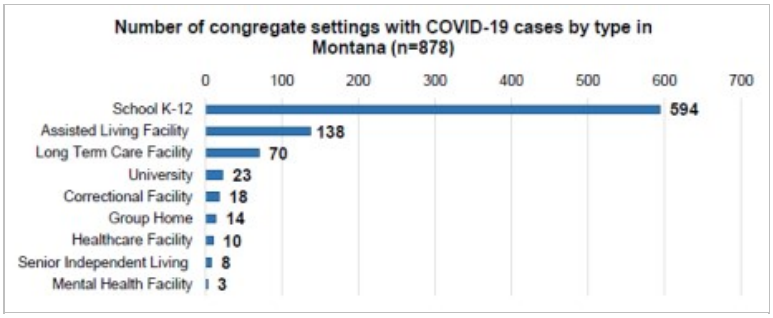
Most cases are reported in more populous counties. Yellowstone County and Gallatin County are the most impacted to-date, reporting 16% and 13% of all reported cases, respectively. Flathead (11%), Cascade (8%), Missoula (8%), and Lewis &

Clark (6%) counties report more than 6,000 cases each.

Congregate Settings

A congregate setting is an environment where a number of people reside, meet, or gather in close proximity for either a limited or extended period of time. Examples include homeless shelters, group homes, prisons, detention centers, schools, and workplaces. There are 878 congregate settings in MT which experienced a COVID-19 outbreak. *Most outbreaks occurred in schools*, assisted living facilities, and long-term care facilities, but outbreaks in correctional facilities, group homes, and mental health facilities, have also been reported (see Figure 5.).

Figure 5.



Emerging Public Health Issues

Directly related to COVID-19, foregone healthcare has increased as an emerging public health issue. With access to healthcare already a challenge for much of the state, hesitation to seek medical attention (especially preventive) was increased. CPHD staff were also unable to provide many of their regular services, with offices being closed to in-person interactions for almost a year. A significant number of staff at the state or local level involved with COVID-19 vaccination are still redirected from normal duties.

In addition, there has been about a 20% turnover of CPHD staff responsible for MCHBG implementation during FFY 2020, largely impacted by the COVID-19 environment. State-level Title V MCHBG and FICMMR staff offered communications and networking support, and flexibility for deliverables from April 2020 to the present time. The option to formally request redirection of MCHBG funding towards COVID-19 response efforts was offered in the CPHD FFY 2021 Task Orders (contracts). Many of the programs within the public health system felt impacts of COVID and have required a shift in tasks or efforts to support CPHDs during this difficult time.

As noted in the Home Visiting NA key findings section, Substance Abuse Disorder (SUD) and child maltreatment have been growing problems for MT families. The increasing number of children taken into foster care has been due, in part, to parent SUD. Various local and state initiatives are striving to remove barriers that previously blocked people from getting needed help. These include the Meadowlark Initiative, which is a collaboration between the MT Healthcare Foundation, the MT Obstetric Maternal Support (MOMS) Program, and the Strengthening Families Initiative, housed in the Addictive and Mental Health Disorders Division and supported by the SAMSHA Pregnant and Postpartum Women grant. These projects support evidence-based interventions for pregnant people with SUD and mental illness (https://mthcf.org/the-meadowlark-initiative/). Additionally, Montana's current Governor has included the Healing and Ending Addiction through Recovery and Treatment (HEART) initiative as an integral part of his agenda, with intent to inform an 1115 demonstration waiver for Medicaid.

Together, MT's Title V Director and CYSHCN Director oversee two telehealth programs that are working to alleviate ongoing access to care issues in the state:

- MAPP-net: The MT Access to Pediatric Psychiatry Network (MAPP-Net) grant strives to support primary care

providers and behavioral health specialists in serving children and youth in their communities with mental healthcare needs through education and consultation. Two activities help meet this goal:

- Project ECHO is a hub-and-spoke model out of the University of New Mexico. Billings Clinic is the contracted "hub" for this program and began Project ECHO Pediatric Mental Health sessions in March 2019. An expert hub team consisting of a Child and Adolescent Psychiatrist, Psychiatric Pharmacist, Psychotherapist and Resource Specialist meets twice per month with primary care providers across the state utilizing an online platform. A member of the hub team delivers a 25-minute didactic. Then, participants can present de-identified cases to review. The hub panel and spoke sites offer feedback and suggestions on the presented cases. This collaboration among peers helps support the presenter's care for their pediatric patients with mental health care needs and provides an opportunity for increased knowledge for everyone listening. ECHO clinics are grant-funded, and there is no cost to participate.
- A toll-free access line (1-844-922-6277) was established in 2019 for primary care providers to call and consult with a Child and Adolescent Psychiatrist during daytime business hours. Consultations are with Billings Clinic Child and Adolescent Psychiatrists. In 2021, the access line was expanded to support mental health providers across the state. This is a provider-to-provider call, and patients do not participate. There is no cost for primary care providers to participate in this service.

- The MT Obstetrics & Maternal Support (MOMS) program was created to connect rural providers to obstetrical/gynecological, perinatal, mental health and substance abuse specialists, to build competency and consistency across perinatal providers. The MOMS program guides the multidisciplinary collaboration of maternal and perinatal health providers, programs, resources, and initiatives to deliver training, resources and support to rural healthcare providers in MT as they care for their perinatal patients. Using Project ECHO (Extension for Community Healthcare Outcomes), urban-based experts are linked to rural providers to share their expertise via mentoring, guidance, feedback and didactic education. MOMS leverages existing telemedicine efforts to disperse evidence-based practices to rural providers in efforts to address shortages in OB/GYN specialists and mid-level providers of maternal healthcare across rural MT.

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Five-Year Needs Assessment Summary
(as submitted with the FY 2021 Application/FY 2019 Annual Report)

III.C.2.a. Process Description

The Family & Community Health Bureau (FCHB) administers the Title V Maternal & Child Health Block Grant (MCHBG). In October 2018, the FCHB created a team to begin work on the 2020 Statewide 5-Year Title V MCHBG Needs Assessment (hereafter referred to as NA).

Goals

The FCHB NA team identified the following goals:

- Incorporate findings from the 2015 NA to assess changes and trends;
- Develop realistic and relevant program priorities;
- Identify unmet needs and major health issues of the maternal and child population, and who is currently working to address them;
- Understand where local public health support services could have the greatest impact;
- Provide an opportunity for program partners and families to provide input on priorities; and,
- Augment with information gathered by other recent DPHHS program needs assessments.

Framework and Methods

The NA Team identified three phases outlined in Table 1.

Table 1. Overview of NA Process

Phase 1: Preliminary Assessment Steps	Phase 2: Data Review and Broader Stakeholder Engagement	Phase 3: Final Assessment
1. Key Informant Interviews	1. Administrative/Secondary Data (ASD) Review	1. Review of recommendations and data summaries
2. Collection and Analysis of Existing Data	2. Stakeholder Survey	2. Internal discussion to identify final priorities
3. Domain Meetings with Key Stakeholders	3. Additional Stakeholder Interviews	
4. Leadership Advisory Board Meetings	4. Data Analysis - Triangulation of Needs and Community Capacity	

Phase 1

Preliminary Assessment Steps – Initial Key Informant Interviews:
The process began with internal team meetings and DPHHS staff interviews in October 2018. The SSDI Epidemiologist completed 13 one-on-one interviews with key informants to learn about their MCH programs, populations, data, and program specific NAs. The interviews were beneficial for: the selection of subject matter experts to present at subsequent population domain meetings; gaining information on DPHHS programs in other divisions which serve the maternal and child population; and, potential NA partnerships with those programs.

Interviews were conducted with these DPHHS staff: American Indian Health Director; Tribal Relations Manager; WIC Director; Head Start Collaboration Director; FICMMR Coordinator; PCO Program Specialist Children & Youth with Special Health Care Needs (CYSHCN).
Director; Home Visiting and Adolescent Epidemiologists; Immunization Program Manager; and Children and Family Services Administrator. Also interviewed were the MT *Healthy Mothers Healthy Babies* (HMHB) Executive Director and a Montana State University Early Childhood Education professor.

Preliminary Assessment Steps – Domain Advisory Group Meetings:
In December 2018 an advisory group of 73 members, including MCH epidemiologists and program and population experts, was recruited and invited to separate domain meetings: Women & Maternal; Perinatal & Infant; Children; and, Adolescent. The group was split between the domains, with some overlap. Integrated into each domain meeting was data and discussion pertaining to health disparities, and CYSHCN.
The meetings included domain specific information and data. Attendees participated in small group discussions to select the top areas needing attention. These meetings developed the foundation for subsequent questions and surveys and gathering additional qualitative and quantitative information on the root causes of these issues. Root causes were then analyzed to identify systems and cross-cutting issues.

The advisory group also identified six goals for guiding the NA process:

- Gather meaningful feedback from as many possible disciplines and demographics;
- Identify and address avoidable health disparities;

- Collaborate to maximize resources and efficacy;
- Apply a life course perspective to identify and analyze data;
- Identify and build on strengths; and,
- Make data-driven decisions.

These goals also informed the collection and analysis of additional quantitative and qualitative data; and provided guidance to a Leadership Advisory Board (LAB) in the selection of final priorities.

Preliminary Assessment Steps – Leadership Advisory Board:
The LAB, comprised of the Title V, CYSHCN, and WIC Directors; State Medical Officer; American Indian Health Director; MCHBG Program Specialist; FCHB Bureau Chief and Section Supervisors; SSDI and Senior FCHB Epidemiologists; and, the HMHB Executive Director met in May and June 2019. LAB members were charged with applying criteria for selecting key MCH priorities.

As of July 2019, the domain NA information included: the SSDI Epidemiologist's data analysis; other DPHHS programs' formal and informal data collection and analysis efforts and reports; the top areas identified as needing more attention; and, the two highest scoring issues per domain identified by the LAB members. See Table 2.

Table 2. LAB Scoring Results

Leadership Advisory Board Scoring Results: Top Areas Needing More Attention & Two Highest Issues Per Population Domain

Domain	Areas Needing More Attention	Two Highest Scoring Issues
Women & Maternal	1. Access to Physical Healthcare 2. Access to Mental Health Care	1. Well-Woman Visit; 2. Postpartum Depression
Perinatal & Infant	1. Parental Mental Health 2. Home Visiting	1. Infant Mortality; 2. Safe Sleep
Children	1. Comprehensive Care Coordination 2. Trauma	1. Developmental Screening 2. Preventive Dental Visit
Adolescent	1. Relationship with Trusted Adult 2. Life-Skills	1. Vaping 2. Suicide
CYSHCN	1. See Domain Listings for Perinatal & Infant, Children, and Adolescent	1. Medical Home 2. Foster Youth

Preliminary Assessment Steps – State Health Improvement Plan:
Another key contributor to the NA work was the *2019 – 2023 Montana State Health Improvement Plan (SHIP)* and four workgroups assigned to address its five health priority areas. The 2019 SHIP, published in February 2019, was derived from the 2017 State Health Assessment (SHA). In 2017, a 24-member steering committee determined top State health priorities, using: SHA data; input from stakeholders; and a prioritization matrix. DPHHS held 12 meetings across the state and gathered input from 300+ stakeholders to identify existing and emerging health topics, including issues that disproportionately impact American Indians, the elderly, and individuals living in rural areas.

In the implementation phase, workgroups determined by the Public Health System Improvement Task Force (PHSITF) identified evidence-based or informed, or best/emerging practices activities and strategies, to address outcome measures the five health priority areas:
- Behavioral health, including substance use disorders, mental health, suicide prevention, and opioid misuse;
- Chronic disease prevention and self-management;
- Healthy mothers, babies, and youth;
- Motor vehicle crashes; and,
- Adverse childhood experiences.

The 2017 SHA is at: https://dphhs.mt.gov/Portals/85/ahealthiermontana/2017SHAFinal.pdf
The 2019-2023 SHIP is at: https://dphhs.mt.gov/Portals/85/ahealthiermontana/2019SHIPFinal.pdf

Phase 2

Administrative Data Review:
In January 2020, the FCHB contracted with the University of Montana Rural Institute for Inclusive Communities (UM-RI) to assist with Phases Two and Three: Data Review & Broader Stakeholder Engagement and Final Assessment. The UM-RI team worked with FCHB epidemiologists to identify and review additional data regarding changes and trends in the needs of MT's maternal and child health population.

From each of the Administrative/Secondary Data (ASD) sources, potential MCH needs were identified based on statistically significant differences from national averages and positive or negative trends over time. Race and rurality were also

considered as key factors in assessing data, as American Indian and rural populations generally show evidence of health disparities. Finally, effectiveness of, and capacity to implement potential strategies was considered.

Stakeholder Survey and Interviews:
The UM-RI Evaluation Team, in conjunction with the FCHB epidemiologist and the MCHBG Program Specialist, created an online survey using the 2015 NA survey as a starting point so as to allow for comparison. It was distributed to key stakeholders across the state including: the 56 County Public Health Departments (CPHD); Federally Qualified Health Centers (FQHC); non-profit organizations; existing family groups and organizations; and stakeholders from several other programs. The survey asked participants to provide:

- Input on unmet health needs of the maternal and child population in their county;
- Feedback on how their current activities relate to, and are successful in addressing the priority needs identified in the 2015 NA;
- Challenges and strengths of their activities and initiatives in addressing those priority needs;
- Identification of groups or organizations in their counties working to address maternal and child health needs; and,
- Input regarding maternal and child health priorities, and which NPM/SPMs choices they believe would be best – especially given local capacity.

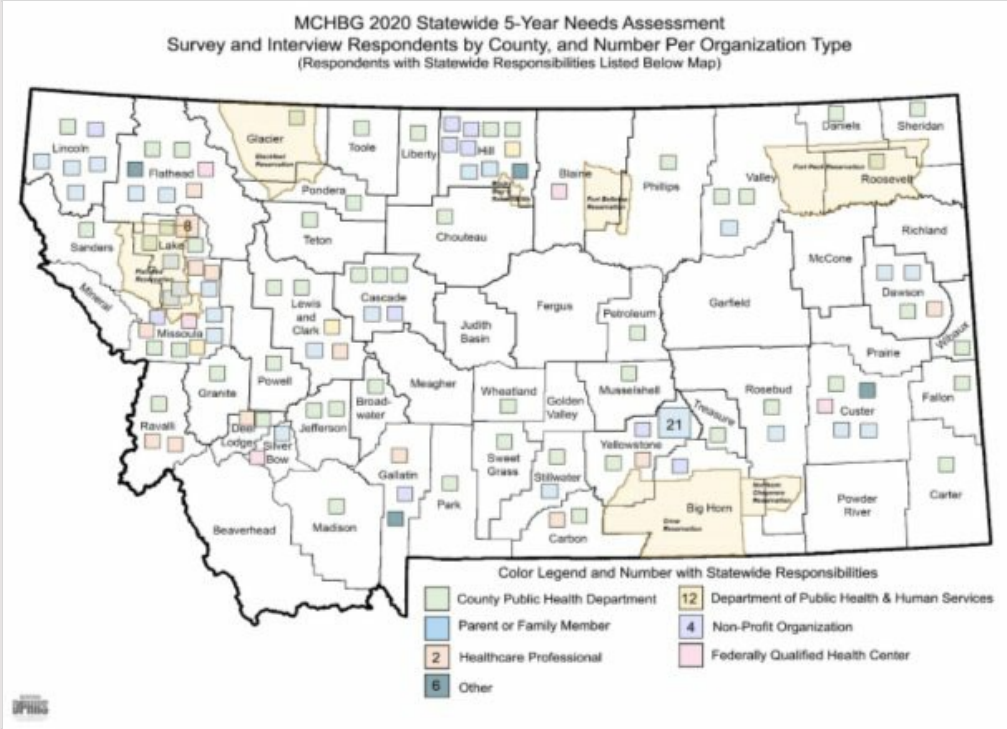
165 survey responses were received. Table 3 illustrates the responders' self-identified affiliation:

Table 3. Needs Assessment Stakeholder Survey Groups

Group	Number of Responses
County Public Health Department Staff	52
Parent or Family Member	45
Healthcare Professional	23
DPHHS Staff	15
Non-Profit Organization Staff	14
Other	11
Federally Qualified Health Center Staff	5

Forty-eight of MT's 56 counties responded and of these 24 respondents represented all counties in the state. Parent or family members from 14 counties across the state were also represented. Despite the American Indian Health Director and FCHB BC's efforts, there were no American Indian specific responses to help inform the NA. Strategies are being discussed to increase AI input in the next five years.

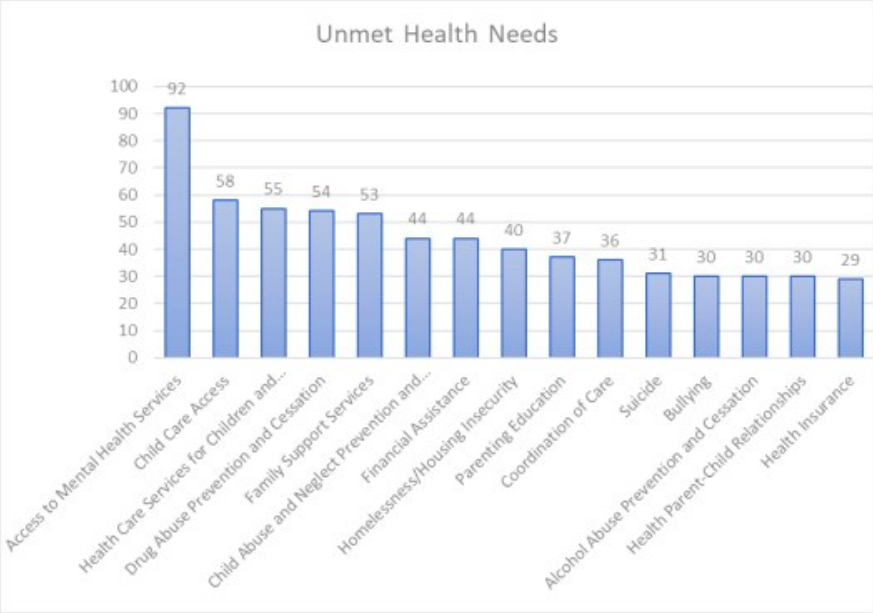
Geographic representation by stakeholders from across the state is significant because of its vast size and small population, which create significant disparities in the delivery of health care services. More than half the population of the state lives in rural or frontier areas, characterized by limited access to health care and barriers such as transportation and healthcare professional shortages. The following map illustrates the location of responses by category.



Data Analysis - Qualitative and Quantitative:
The surveys used both closed and open-ended questions to assess needs, capacity, and priorities within stakeholder communities. Survey respondents were asked to identify the most important unmet health needs in their communities. Each respondent could choose up to 7 needs from a list of 37 items. Responses were used to indicate priority needs and assess changes from the 2015 NA.

Participants provided brief explanations for their selections, which were analyzed for relevant themes. Preliminary coding focused on health needs. Secondary coding assessed capacity, barriers, and resources. A third coding round was used to assess statements as positive or negative, when applicable. Figure 1 indicates the top 15 selections for unmet health needs.

Figure 1. Survey Responses "Considering the past 12 months, please identify the top 7 unmet needs impacting the health of the maternal and child population in your county."



In March 2020, 14 stakeholder interviews were conducted from the same population as those who completed the survey. The sampling goal was to reach 15-20% of the survey respondents for follow-up interviews. However, COVID-19 activities disrupted several scheduled interviews, limiting the number. Stakeholders interviewed represented these roles: CPHD staff; health care professionals; academics; non-profit organization staff; and one FQHC.

Interviews were designed to elicit further explanation and elaboration of the following:

- Unmet needs and emerging issues for maternal and child populations;
- Existing programs or organizations working to address those needs;
- Capacity of and collaboration between existing public health activities and initiatives;
- Barriers and challenges associated with the issues in their counties; and,
- Selected priority SPMs for the next 5-year plan.

Phase 2 - Summary

The UM-RI Evaluation Team made preliminary recommendations for performance measure selections by triangulating ASD and quantitative and qualitative data from the stakeholder survey and interviews. Those preliminary recommendations were shared with the DPHHS team and evaluated considering CPHD capacity and the ability to address identified need. A summary of the survey and key stakeholder interviews is included with the supporting documents (see MCHBG Needs Assessment Data Report 2020).

Phase 3 – Final Assessment

Phase 3 involved a meeting between the NA team and FHCB leadership to make a final decision regarding state priority needs. Results from Phase 1 and Phase 2 were reviewed and potential priorities were evaluated against the following criteria:

- Ability to make a measurable impact in the short- and long-term;
- Feasibility of population-based approaches;
- State and local capacity to address;
- Incidence/prevalence;
- Severity;
- Cost of potential strategies;
- Alignment with existing programs and initiatives; and,
- Alignment with National Performance Measures.

Leadership selected seven state priority needs covering the five required MCH population domains, and the optional sixth Cross-Cutting & Systems Building domain. These priorities are covered in detail in the “MCH Population Health Status” and “Identifying Priority Needs and Linking to Performance Measures” narratives and are:

- Comprehensive preventive healthcare for women;
- Infant mortality;
- Preventive dental care for children;
- Risk factors around adolescent mental health;
- Care coordination for CYSHCN;
- Access to public health services and geographic disparities; and,
- Social Determinants of Health and family health education.

III.C.2.b. Findings

III.C.2.b.i. MCH Population Health Status

In this section, key findings are reported and organized by public health domain (PHD). The data presented are derived from Administrative/Secondary Data (ASD) and the 2020 Key Stakeholders Survey and Interviews (KSSI). The following sections outline an overview of health status as well as successes, gaps, and challenges for each population domain.

Maternal Health

ADS Overview

- In 2017, 73.2% of women received early prenatal care in Montana, which falls below the national average (for 2014) of 77.1%, and below the HP2020 Goal of 77.9%. Also, rural populations and American Indian women receive early prenatal care at lower rates. In 2018 the percentage of American Indian women was 45.3%. In 2017, the percentage for women living in counties with population less than 60,000 was 66.2%, in contrast to 77.9% for those in counties with higher populations.
- In 2017 23.8% of women had caesarean deliveries with low risk pregnancies, which meets the HP2020 goal of 23.9%.
- In 2017, 14.9% of women reported smoking while pregnant; 0.9% of women reported drinking alcohol while pregnant.

- 2017-2018 PRAMS data show 16.9% of women self-reported post-partum depressive symptoms, higher than the national average of 12.5%.
- PRAMS data also show 93.8% of mothers in MT report ever breastfeeding, and 80.3% report breastfeeding at 8 weeks.
- The CDC Breastfeeding Report Card shows that in 2018 27.9% of MT babies were born in baby-friendly facilities, one of the highest rates in the US.

KSSI Results

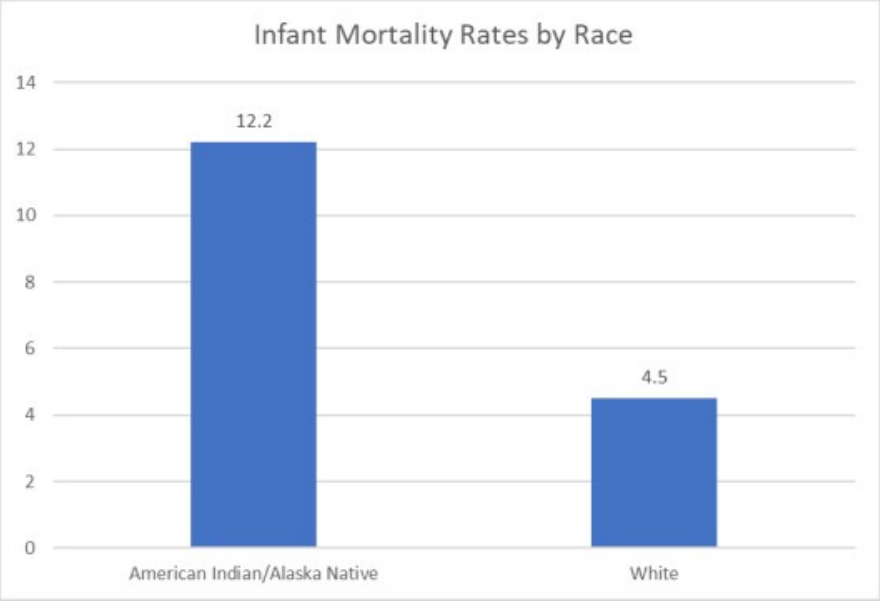
Primary challenges for the maternal domain include access to mental health services, substance use prevention and treatment, and coordination of care. There is need for more frequent screening and non-stigmatized services to address post-partum depression. Forgone health care due to distance to services or cost was also a concern.

Perinatal/Infant Health

ASD Overview

- In 2017, 9.7% of Montana births were preterm; 7.8% of infants were low-weight.
- The rate of infants born with neonatal abstinence syndrome per 1000 hospital births has increased from 4.5% in 2009 to 8.3% in 2015.
- Infant mortality rates were 5.8 in 1000 live births, with significant disparities between white (4.5 in 1000) and American Indian (12.2 in 1000) populations (see Figure 2).
- SUID rate per 100,000 live births is 138.4, an increase from 129.3 in 2013. The *2015 Health Survey of Montana's Mothers and Babies* showed that 80.6% of mothers put their infants to sleep on their back, though only 28.6% of moms reported practicing all safe sleep techniques. The survey also showed that American Indian mothers were more likely to practice co-sleeping (53.6%) than white mothers (33.1%).

Figure 2. Infant Mortality Rates in Montana by Race, 2016-2018



KSSI Results

Results confirmed the need to address infant mortality and support safe sleep programs. These are viewed by respondents as a key resource, but one where there is ongoing need. Safe sleep programs should be delivered in a culturally appropriate, non-stigmatizing manner to help ensure success.

Child Health

ASD Overview

- Montana has reduced the rate of non-fatal childhood injuries and child mortality, though they remain higher than the national average. Nonfatal injury hospitalization rates (per 100,000) for children (ages 0-9) have decreased from 127.6 in 2013 to 112.7 in 2017. The child mortality rate (ages 1-9) in 2017 was 10.5 in 100,000.
- The National Immunization Survey indicate MT remains behind the national average (63.6% compared to US covered by 70.7%). However, there has been a 27.2% increase in immunizations between 2010 and 2016. MT reached the HP2020 goal for Polio, MMR, HepB, PCV, and Rotavirus in 2017. It is important to note that religious

exemptions to vaccinations are also on the rise.

- MT has seen an increased rate of children (ages 0-17) in Foster Care from 10 (per 1,000) in 2014 to 17 (per 1,000) in 2018, one of the highest rates in the US according to data from KIDSCOUNT.
- Disparities in access to oral health services persist in MT. The percent of children (ages 1-17) with tooth decay was 9.7%; 81.9% of children (ages 1-17) received a dental visit in the last 12 months. Geographic disparity around access to oral health services remains an issue. American Indian children also experience disparities with higher rates of untreated decay (see Figures 3 And 4).

Figure 3. Prevalence of decay experience and untreated tooth decay among Montana's kindergarten children by geographic location, 2015-2016

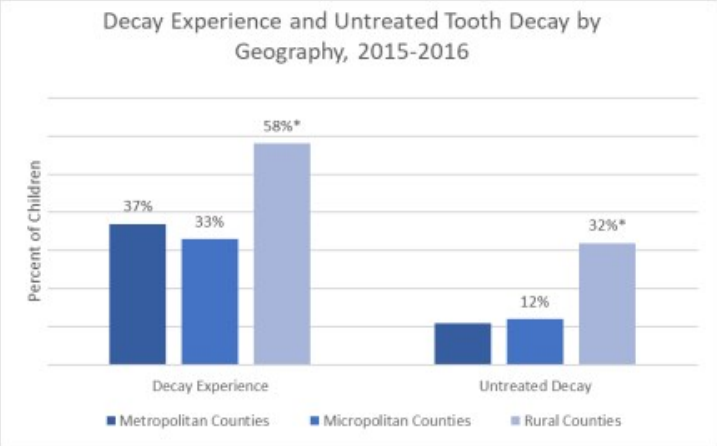
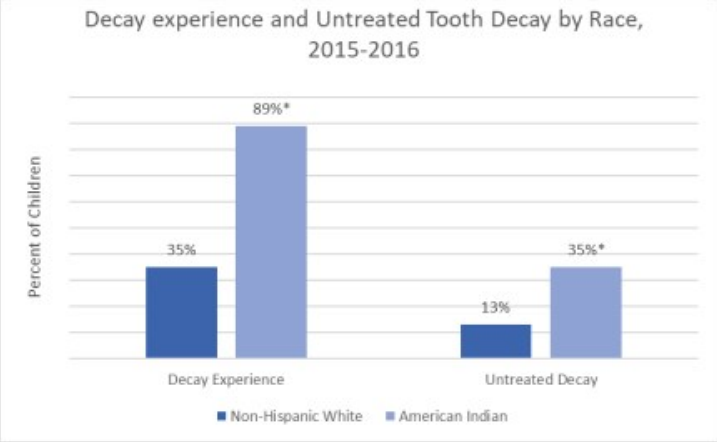


Figure 4. Prevalence of decay experience and untreated tooth decay among Montana's kindergarten children by race, 2015-2016



KSSI Results

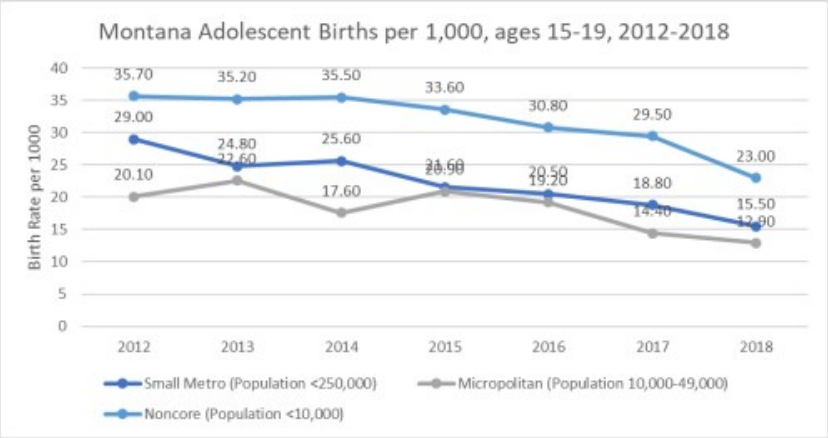
Stakeholder input supports evidence that the increasing number of children in foster care is of significant concern, connected to lack of prevention programs and limited substance use disorder treatment services. Stakeholders from rural counties also reported limited capacity to address oral health concerns; as well as significant need in areas where access to services is limited by distance, awareness, and/or affordability.

Adolescent Health

ASD Overview

- Adolescents have relatively low rates of obesity; National Survey of Children's Health, combined 2016-2017 show that 12.3% of adolescents (age 10-17) are obese, below the HP2020 goal of 14.5%.
- Teen birth rates are trending down, though they are still higher than the 2017 national average of 18.8 in 1000. In MT, 21.3 per 1000 births were among adolescents (age 15-19) in 2017, down from 27.8 in 2013. Teen birth rates continue to be higher among rural populations and with American Indian adolescents.

Figure 5. Adolescent Birth Rates among Girl age 15-19 in Montana by Geography, 2012-2018



- The 2019 Youth Risk Behavioral Survey shows 33% of high school students currently use a tobacco product (including cigarettes and e-cigarettes). While smoking tobacco is on the decline from 2011-2019 (from 44% to 32%); Vaping use is significantly higher (51% in 2015 to 58% in 2019).
- Adolescent suicide rates have increased. Using a 3-year estimate, 2015-2017 aggregate suicide rate for teens per 100,000 was 24.1, up from 21.3 in 2013-2015 (CDC data).
- According to the Youth Risk Behavior Survey (YRBS), in 2017, 21.6% of Montana adolescents in grades 9-12 reported being bullied on school property in the last 12 months, higher than the national average of 19%.
- In 2013-2016 aggregate data, 79.2% of adolescents (12-17 years old) had an adult with whom they could talk with about serious problems.
- The National Survey of Children's Health shows 85.3% of adolescents had a preventative medical visit in 2016/2017.

Key Stakeholder Survey and Interview Results

Stakeholders identified significant needs for access to mental health services for adolescents in Montana. Suicide and bullying emerged as areas where MCHBG programs could use strong existing partnerships with local schools to address these needs. Challenges that emerged from the KSSI include access to services due to cost and distance.

Children and Youth with Special Health Care Needs

ASD Overview

- According to the NSCH, the percent of children in Montana with special health care needs (ages 0-17) in 2016/2017 was 19.3%, up from 18.6% in 2016. While over the same time period, the percent of CSHCN (ages 0-1) who receive care in a well-functioning system declined from 17.1% to 14.9%.
- Between 2016-2017, MT saw an increase in the percent of children diagnosed with an autism spectrum disorder or ADD/ADHD (2.8% to 3.1%).
- 52.7% of Montana's CYSHCN have a condition that requires emotional, developmental, or behavioral treatment or counseling, and 62.7% of those children (ages 3-17) received treatment or counseling.
- 50.5% of children in Montana had a medical home in 2016-2017, while CYSHCN were less likely to have to a medical home at 39.9%.

Key Stakeholder Survey and Interview Results

Parents and family members of CYSHCN identified as areas of concern: access to mental health services; health care services for CYSHCN; coordination of care; health insurance; and, developmental screenings. Care coordination emerged as a theme among respondents that intersected with other needs. Major challenges identified by this group of stakeholders included lack of services and distance to services.

III.C.2.b.ii. Title V Program Capacity

III.C.2.b.ii.a. Organizational Structure

Montana's Title V Program is one of 150 programs in the Department of Public Health and Human Service (DPHHS), which is organized into three branches, Operations Services; Medicaid & Health Services; and, Economic Security Services, whose managers oversee 12 divisions. Appointed by the governor, the Director oversees the largest agency with approximately 3,000 employees, 2,500 contracts, and a biennial budget of about $4.2 billion. Public health services are delivered primarily through contracts with local and tribal public health agencies in each MT county and reservation and with outpatient clinics, community health centers, hospitals and other community-based organizations.

The Early Childhood & Family Support Division (ECFSD) houses the Title V Program. Established in January 2020 it

consolidated several DPHHS programs to improve collaboration; align funding, priorities, and practices; create operational efficiencies; and support the DPHHS strategic plan. The ECFSD includes: health programs for infants, children with and without special healthcare needs, adolescents, women of child bearing age, and their families; child care licensing; early childhood services, including financial assistance and quality improvement; early intervention services for young children with developmental delays; child nutrition programs; and home visiting. See the Organizational attachment.

The ECFSD, within the Economic Security Services Branch, is structured as follows:

- Division Administrator
- Bureaus: Family & Community Health (FCHB); Financial & Operations; Early Childhood Services
- Programs: No Kid Hungry and Children's Trust Fund

Title V is in the FCHB and administered by the Title V and CSHS Directors who are also the Maternal & Child Health Coordination Section (MCHC) and Children's Special Health Services (CSHS) Section Supervisors. They are responsible for their respective sections' programs addressing maternal and child health services as described in Title V of the Social Security Act.

Statutory authority for maternal and child health services are in the Montana Codes Annotated (MCA) Title 50. General powers and duties of the state include administration of federal health programs delegated to the states; rule development for programs protecting the health of mothers and children (including programs for nutrition, family planning services, improved pregnancy outcomes, and Title X and Title V); acceptance and expenditure of federal funds available for public health services; and use of local health department personnel to assist in the administration of laws relating to public health.

Rules implementing the above authority are found in Titles 16 and 46 of the Administrative Rules of Montana (ARM). These rules define the State Plan for Maternal and Child Health, including children with special health care needs, family planning, school health, and the rules authorizing case management for high risk pregnant women.

Form 2 indicates the Title V share was $2,300,122, and expenditures meeting the Title V legislation are:

- Preventive & Primary Care for Children expenditures: 39.45%
- Children with Special Health Services: 30.09%
- Administrative costs: 5.39%.

The Title V funds were supported with:

- State funds: $3,058,820
- Federal funds: $25,270,885
- Local support: $11,381,026
- Program income: $7,085,446

These FCHB sections Adolescent Health; Family Planning; Healthy Montana Families Home Visiting; and Women, Infant and Child Nutrition work with other DPHHS programs; state agencies; professional organizations; profit and non-profit agencies; CPHDs; university systems; and healthcare providers to support the Title V efforts addressing these state priorities:

- Comprehensive preventive healthcare for women
- Infant mortality
- Preventive dental care for children
- Risk factors around adolescent mental health
- Care coordination for CYSHCN
- Access to public health services and geographic disparities
- Social Determinants of Health and family health education

These CSHS programs and services, which focus on promoting a medical home (NPM 11), also support these priorities:

- Assisting parents with navigating the system of care in efforts to easily access needed services
- Supporting the non-medical social emotional needs of CYSHCN and caregivers through peer mentorship programs and support.
- Screening and follow-up for newborn metabolic and hearing, and critical congenital heart disease screening;
- Coordinating cleft and craniofacial services;
- Supporting comprehensive genetic screening;
- Promoting pediatric mental health telehealth access;
- Providing financial assistance to eligible families for services not covered by insurance;
- Participating in evidence-based and informed telehealth initiatives that aim to improve care coordination in and outside of emergency care settings and after-hours care.
- Implementing a quality improvement project to improve the transition to adult health care.

III.C.2.b.ii.b. Agency Capacity

The Maternal and Child Health Coordination (MCHC) and Children Special Health Services (CSHS) and FCHB sections' partnerships are key to ensuring Montana's Title V statewide programs and services are comprehensive, community-based,

culturally appropriate, coordinated and family-centered. These partnerships allow the state to leverage its Title V funding and to expand its capacity to effectively support statewide collaboration and coordination of numerous maternal and child health services and programs to the population domains.

CSHS is focused to provide health services that address the National Consensus Standards for Systems of Care for CYSHCN. Key to meeting these standards is the input and insight from the 40+ member CSHS Stakeholders Group, comprised of: clinicians, multidisciplinary health care providers, Medicaid, Part C Early Intervention, WIC, Home Visiting, Family-to-Family coordinators, home healthcare nurses, regional parent and self-advocate representatives, and the CSHS and Title V Directors. At their quarterly meetings, they discuss local and statewide concerns, evidence-based and informed initiatives, and NPM 11 progress.

CSHS offers a General Financial Assistance Program which provides direct financial assistance for CYSHCN and foster care families for medications, testing, medical services, and access to therapies and activities not covered by Medicaid or private insurance. Staff also work with Medicaid to ensure that Early and Periodic Screening, Diagnosis and Treatment program services are covered. CSHS staff also engage with:

Council/Committee
Part-C Early Intervention Family Support Services Advisory Council
Disability Rights Montana
Mountain State Regional Genetics Advisory Council
Emergency Medical Services for Children Advisory Council
Lifespan Respite Coalition
Partner Contracts
The HALI Project: Montana Parent Partner Program
Butte 4-C's Circle of Parents Program
Shodair Children's Hospital: State Genetics Program
University of Montana Rural Institute
Medical Home Portal
Montana Pediatric Medical Passport

The MCHBG Program Specialist and FICMMR Coordinator are instrumental in providing technical assistance and guidance to the CPHDs, who are key players connecting with and supporting community-level systems and services for the maternal and child population. The CPHDs are adept at blending their Title V MCHBG funds with their local or other MCH program funds. Their contract includes 15 MCHBG/FICMMR deliverables, i.e. N/SPM activities; evaluation; data collection; FFY expenditures; CPHD needs assessment results; and, an infant, child, or maternal injury-prevention activity.

A key goal of the 2020 Needs Assessment was to understand where local public health support services could have the greatest impact. To achieve this goal, the capacity of local organizations for addressing the unmet health needs that they identified as priorities was accessed. The results informed the N/SPMs that the CPHDs could select beginning in FFY 2021. MCHC staff, with assistance from other FCHB programs, will oversee the CPHDs' N/SPMs programmatic efforts and activities, goals, and evaluation framework plans, as reported on their FFY Pre-Contract Survey (see following table). CSHS will oversee the NPM 11: Medical Home State Action Plan.

FFY 2021 N/SPM Selection	#CPHDS includes 2 CPHDs selecting 2 N/SPM	Total Title V Funding
NPM 1	3	$51,521
NPM 5	6	$423,427
NPM 9	2	$7985
NPM 13.2	4	$103,250
SPM 1	27	$151,300
SPM 2:	9	$327,479

The MCHC section includes the FICMMR, Oral Health (OH), Primary Care Office (PCO), State Loan Repayment (SLRP), and Montana Obstetric and Maternal Support Program (MOMS) Programs. Each program has established collaborations and partnerships and contracts, all of which contribute to and support the FCHB's Title V efforts for addressing the N/SPMs. The OH Coordinator oversees the HRSA *Grants to States to Support Oral Health Workforce Activities,* which funds numerous partners' activities that support NPM 13. These include:

- From September 2018 to February 2020, University of Washington School of Dentistry students completed 1714 procedures and had 1047 patient encounters while on rotations.

- Since 2018, MT State University School of Nursing students have completed 239 screenings, 311 fluoride varnish applications, and 803 sealant applications to the eight Northern Cheyenne Nation Head Start sites located in Big Horn County;
- Providing technical assistance to the five CPHDs that selected NPM 13, which includes Big Horn County;
- Contracting with the Caring Foundation of MT (CFMT) to provide preventive dental health services using a mobile clinic. CFMT has partnerships in 42 counties, four reservations and 12 Hutterite colonies.
- Contracting with the FQHC Alluvion Health to utilize their mobile dental unit, funded by the 2019 HRSA Oral Health Infrastructure grant, to serve rural communities with no dental provider.

The PCO's mission: *to increase access to comprehensive primary and preventive health care to improve the health status of underserved and vulnerable populations in Montana,* benefits ALL the N/SPMS and ECFSD programs. In FFY 2019, the PCO:

- Approved J-1 Visa Waivers for 8 specialists and 2 primary care doctors practicing in healthcare shortage areas;
- Awarded SLRP grants to six healthcare providers, bringing the contracted total to 28;
- Provided over 14,000 hours of technical assistance to address questions about the National Health Service Corps and SLRP loan repayment programs; HPSA designations; and J-1 Visa Waiver; to partners such as the MT Primary Care Association, MT Hospital Association, Indian Health Services, Critical Access Hospitals, Rural Health Clinics and Mental Health Centers, and community stakeholders seeking a designation or working to recruit healthcare providers.

As illustrated in the NPM 5 and 7 narratives, the FICMMR Coordinator continues to enlist partners and involvement on committees to increase the county FICMMR teams' capacity to implement and evaluate evidence-based prevention activities. The Coordinator's reach includes:

- Participating on the Department of Transportation's Child Passenger Safety Committee, the State Trauma Care Committee; and Western States Child Death Review
- Facilitating annual trainings by the MT Chief Medical Examiner and the President of the Montana Coroners Association
- Supporting the Healthy Mothers Healthy Babies' Safe Sleep Initiative
- Connecting teams with the state suicide prevention resources
- Promoting the Cribs for Kids Safe Sleep Ambassador Program

Addressing NPM 1 will be enhanced with the activities funded by the MOMS program, which offers expert consultation, training, resources and support to help providers deliver effective prenatal, delivery and postpartum care. MOMS has contracted with the Billings Clinic to coordinate the delivery of a package of virtual/remote provider services from specialists to isolated providers. Billings Clinic will coordinate the delivery of these services to rural hospitals in Eastern Montana to start.

The other FCHB sections, Adolescent Health (AH), Family Planning (FP); Healthy Montana Families Home Visiting (HMF); and Women, Infant and Children's Nutrition Program (WIC) are subject matter experts on their specific programs that aide the CPHDs Title V efforts. Their impact is especially seen with CPHDs that serve as a one-stop shop for services. The 2020-2025 Needs Assessment indicated the need for SPMs 1 and 2 to remain, which supports health services such as: immunizations or hearing screening; referrals to resources such as WIC, prenatal care, or family planning; and, health education on topics which include suicide prevention or communicating with sexually active teens. Women and families served by FP reaches 14,100 clients; WIC reaches an average of 16,468 per month; and HMF's reach is felt in the 14 CPHDs, 5 non-profit agencies, and 3 tribal health agencies. Funding from the 2021 Application will support a current AH Section Program Specialist being co-located with the MCHC section, to work with two CPHDs that selected NPM 9.

III.C.2.b.ii.c. MCH Workforce Capacity

The Family and Community Health Bureau (FCHB) is one of three bureaus in the newly formed Early Childhood & Family Support Division (ECFSD). The ECFSD includes a new Fiscal & Operations Bureau (FOB) with three sections: Epidemiology; Fiscal/Budget Services; and Systems/Operations. The FOB Bureau Chief (BC) is onboarding Section Supervisors and support staff.

The Title V and CSHS Directors also serve as the Maternal and Child Health Coordination (MCHC) and CSHS Section Supervisors, and report to the FCHB Bureau Chief who has 25+ years working in the field of maternal and child health. The Title V Director/MCHC Supervisor has 14 years in this position supervising 5.5 FTE and managing a section budget of $4,986,503. The Title V Director has a Master of Public Administration degree. The MCHBG Program Specialist has been in this position for seven years, and is working on a Master of Public Health degree from the University of MT.

The FICMMR Coordinator, with a Master of Communication degree, has been in the position for five years - guiding the CPHD FICMMR Teams to implement and evaluate evidence-based and informed prevention activities. Title V funding fully supports these three individuals and for FFY 2021, a .5 FTE Adolescent Health Section Program Specialist will oversee NPM 9.

The MCHC Section also includes staff contributing as follows to the National and State Performance Measures (NPM/SPM):

- Oral Health Program Specialist: NPM 13
- Montana Obstetric and Maternal Health Program: NPM 1
- Primary Care Office Program Specialist: all N/SPMs

The Title V funding directly supports the CSHS Director/Supervisor (1 FTE). The FCHB BC and ECFSD Administrator are working with DPHHS Human Resources (HR) staff to fill the position, which became vacant in July 2020. The Title V Director will aid in the onboarding of the selected individual and will aid in referring to HRSA/ Maternal and Child Health Bureau, AMCHP, and other mentoring resources. Title V also supports these CSHS Staff:

- Health Education Specialist .75 FTE: One year on the job, with a BA in Business
- Nurse Consultant .5 FTE: Interviews are occurring to fill the position vacated on August 31, 2020
- Data Manager .25 FTE; Three years in CSHS and 21 years of data-analysis experience. Master's degree in Mathematics.

The CSHS Director/Supervisor also oversees the Program Specialists responsible for Newborn Screening and Montana Access to Pediatric Psychiatry Network grant programs.

Montana's AMCHP Family Delegate, Tarra Thomas, is completing the 5th year in this position. Ms. Thomas is the parent of a child with special healthcare needs, has a Business degree and a Master of Social Work. She is a Social Work Licensure Candidate presently practicing as a Child and Family Outpatient Therapist, working with the child protective services' population. In addition to assisting with the Title V/MCHBG throughout the years, she is: a principle member of Montana's MCH Workforce Development Center (WDC) Cohort; was a recipient of the MCH WDC's Leadership Coaching opportunity; and, was invited by Montana's Governor to participate in a conversation regarding issues affecting the CYSHCN population, to assist in informing a critical policy decision regarding program funding.

Prior to the formation of the ECFSD, the FCHB included an Epidemiology Section. This is now in the ECFSD's Fiscal and Operations Bureau. The assigned MCH/CSHS Epidemiologist is 100% Title V funded and has 10+ years in this field having earned her Master of Public Health, with epidemiology as her major field of study in 2011. She recently completed the 2017 AMCHP Leadership Lab Peer to Peer Epidemiologist Cohort and will be mentoring two staff in the 2020 AMCHP Leadership Lab Peer to Peer Epidemiologist Cohort.

At the time of this submission, individuals are being interviewed for the CSHCN Director & CSHS Supervisor, and Nurse Consultant positions. There are no foreseeable staff changes in the MCHC section.

III.C.2.b.iii. Title V Program Partnerships, Collaboration, and Coordination

The FCHB houses these grant funded programs, which support, enhance, and expand the state's Title V efforts for addressing the National and State Performance Measures (NPM/SPM):

Title X	WIC
Maternal, Infant, and Early Childhood Home Visiting	Grants to States to Support the Oral Health Workforce
State Systems Development Initiative Grant	Maternal Health Innovation Program
Newborn Hearing Screening	Rape Prevention and Education
Teen Pregnancy Prevention	Pediatric Mental Health
Pregnancy Risk Assessment Monitoring System	Primary Care
State Loan Repayment Program	WIC Farmers Market
WIC Peer Counseling	Sexual Risk Avoidance

These grant opportunities allow for formal and informal partnerships with private and public entities to improve the health of all mothers and children living in one of Montana's 56 counties. These partnerships, ranging from contractual to participating on workgroups or advisory councils, are rooted in the relationships FCHB staff have created and maintained. Many of Title V's partnerships and collaborative efforts are explained throughout Montana's FFY 2021 Application & FFY 2019 Annual Report: in the NPM/SPM narratives; and, illustrated on the 2019 MCH Services map attachment.

The creation of the ECFSD has generated these potential new partnerships to support the FCHB's Title V work.

Tribal and non-Tribal Head Start and Early Head Start Programs	Childcare centers and home day care providers participating in the Child and Adult Care Food Program
The 21 statewide Best Beginnings Community Coalitions	The 60-member Best Beginnings State Council
Part C Service providers	900+ licensed childcare providers
Child Care Resource and Referral Agencies	Montana State University Early Childhood Project
University of Montana-Western School of Outreach and Early Childhood Program	Children's Trust Fund Board
Montana No Kid Hungry Project with schools, community sites, and childcare programs	

Tables which list current and future programs, and agencies and organizations in the Title V MCHBG collaborative network, have been added to the supporting document of Montana's *MCHBG 2021 Application & 2019 Report*.

III.C.2.c. Identifying Priority Needs and Linking to Performance Measures

Drawing from the data presented in the MCH Population Health Status section, DPHHS identified priority needs for each population health domain (PHD). Data for National Outcome and Performance Measure trends were evaluated on whether there was improvement, met or unmet goals, the severity of the issues (life-threatening or disabling), and the role as a protective influence (contribution to well-being).

Significant health disparities in the population based on race and geography were also considered. In some cases the statewide data do not provide a complete description of need for this population; as seen with oral health, prenatal care, and infant mortality due to disparities.

Capacity and feasibility were accounted for by considering the impact of other agencies addressing similar issues, public support and political will, local leadership buy-in, and known evidence-based strategies for addressing needs.

The identification of priority health needs drove Montana's National and State Performance Measure (NPM/SPM) selections, as seen in the following table.

Domain	2020 Priority Health Needs	2018 Performance Measure Selection	2020 Performance Measure Selection
Perinatal & Infant	SUID and Infant Mortality	Infant Safe Sleep (NPM 5)	Infant Safe Sleep (NPM 5)
Children	Oral Health Services	Child Injury (NPM 7.1)	Preventative Dental Visit (NPM 13.2)
Adolescent	Bullying, Suicide	Adolescent Preventive Care Visit (NPM 10)	Bullying (NPM 9)
Women & Maternal	Mental health services, SUD treatment and prevention, post-partum depression, care coordination	Oral Health (NPM 13.1)	Well-Woman Visit (NPM 1)
CYSHCN	Care coordination, meeting developmental milestones, foster youth	Medical Home (NPM 11)	Medical Home (NPM 11)
Cross-Cutting & Systems Building	Limited or lack of available public health services; geographic health disparities; health equity	Access to Public Health Services (SPM 1)	Access to Public Health Services (SPM 1)
Cross-Cutting & Systems Building	Poverty, financial assistance, adequate health insurance, healthy parent-child relationships, parenting education, safe home environment, child abuse and neglect.	Family Support & Health Education (SPM 2)	Family Support & Health Education (SPM 2)

For each PHD, these areas were addressed:

- Factors that contributed to changes in the state's priority needs;
- Rationale for priority needs selections;
- Relationship between priority needs and the selected NPM/SPM; and,
- Other frequently cited needs that were NOT included and an explanation for why not.

Infant Domain—NPM 5 Safe Sleep

Changing Priority Needs**:** Infant mortality in Montana continues to be a priority need in the state.

Rationale: Montana's SUID rate is much higher than the national rate. These data show socio-economic and racial disparities as SUID rates are higher among American Indian women who also report higher rates of co-sleeping. This is also supported by a *2015 Health Survey of Montana Mothers and Babies* which found that unsafe sleep environments correlated with lower education, age, and income. KSSI data identified infant safe sleep programs as both a significant resource for supporting mothers and infants and an unmet need in the state. Given the continued need to address infant mortality, the severity of the issue, and the current strength and capacity of existing safe sleep programs in the state, NPM 5 was selected.

Other Needs: The KSSI identified breastfeeding as an infant domain need. Continued support for Montana's breastfeeding initiatives is crucial for their continued success, ASD did not provide strong support for breastfeeding as a priority *unmet* need at this time

Child Domain—NPM 13.2 Preventative Dental Visits

Changing Priority Needs: In 2018, Montana selected Child Injury Reduction NPM 7.1 and 7.2 to help reduce child hospitalization rates. While child injury rates remain higher than the national average, Montana has transitioned away from NPM 7 because efforts across several other programs and organizations are showing a positive impact on this health indicator.

Rationale: As previously noted, Montana children have high rates of tooth decay compared to children in the US population. Access to oral health services correlates with lower socio-economic status, geographic disparities, and race in Montana. American Indian children are more likely to have dental decay than white children; children in rural counties have more decay experience than those in metropolitan counties; poverty is also a stronger indicator as many periodontists do not accept Medicaid insurance. Stakeholders broadly agreed that addressing oral health needs in rural counties is an area where significant impacts can be made because of strong partnerships between CPHDs and local schools for preventative oral health education programs, transportation programs to reach dentists, and other collaborative partnerships to address barriers.

Other Needs: Other frequently cited needs by stakeholders were family support services, healthy parent-child relationships, and child abuse and neglect prevention and response. Family support and healthy parent-child relationships can be addressed by SPM 2 (see below). Child abuse and neglect prevention and response is an increasingly significant need in Montana with rising rates of children in foster care and increased caseloads. This need may also be addressed by SPM 2. Additionally, access to quality childcare was the second more frequently selected unmet need among all stakeholders who noted lack of facilities and lack of adequately trained staff.

Adolescent Domain—NPM 9 Bullying

Changing Priority Needs: Montana previously identified teen pregnancy prevention due to the relatively high teen birth rates, particularly in rural areas and among American Indian adolescents. Teen birth rates remain high but have declined significantly since 2013. In the 2020 NA other needs including adolescent bullying and suicide emerged as interrelated issues with greater severity. Capacity to address these issues is currently limited but could be increased given existing supportive partnerships between CPHDs and local schools.

Rationale**:** Adolescent suicide and bullying emerged as priority needs because of Montana's high rates of teen suicide, which have increased in recent years, and high incidence of bullying. 2017 YRBS data show that high school students who attempted suicide were more likely to have been electronically bullied (46%) during the past 12 months than students who had not attempted suicide (14%). Additionally, stakeholders identified local schools as key partners where program to address bullying could be implemented.

Other Needs: Access to mental health services, homelessness/housing insecurity, and care coordination were other significant unmet needs for adolescent populations highlighted by the KSSI. Challenges to addressing these needs include shortages of mental health care professionals in large regions of the state.

Maternal Domain—NPM 1 Well-Woman Visit

Changing Priority Needs: In 2018, Montana selected NPM 13.1, preventative oral health visit, for the maternal domain. PRAMS 2017 data show 47% of women had their teeth cleaned during pregnancy. While still low, this rate is just above PRAMS sites overall rate for participating states. Other needs were more frequently cited in the 2020 NA as significant, unmet needs; therefore, NPM 1 was selected for the maternal domain.

Rationale: The priority needs identified for the maternal PHD include mental health services, post-partum depression, coordination of care (particularly for mental health services), and substance use disorder treatment and prevention. Montana has high rates of post-partum depression and qualitative data from KSSI suggest that stigma around mental health issues is a barrier to receiving care. Additionally, getting referrals for mental health care services in a navigable and timely manner is a challenge. Well-woman visits (NPM 1) is the most appropriate means to address these priority health needs. Mothers can be screened for mental health concerns and referred to other services as deemed appropriate.

Other Needs**:** Other needs for women in Montana include homelessness and housing insecurity, food insecurity and nutrition, and prenatal care access and utilization.

CYSCHN Domain—NPM 11 Medical Home

Changing Priority Needs: Montana will continue to support efforts for NPM 11 Medical Home for CYSHCN.

Rationale: Priority needs for CYSHCN identified in the 2020 NA include Health Care Services for CYSHCN, particularly Access to Mental Health Services. Children with a special health care need were less likely to have a medical home than children without a special health care need. Montana will continue to support Medical Home initiatives given the significant need among CYSHCN for health care services and care coordination.

Other Needs: Data support findings that there has been a significant increase in the number of children in foster care and developmental screenings. Stakeholders reported increase of children in foster care as a significant area of concern.

State Performance Measures
SPMS were developed to address priorities not covered by NPMs. SPM 1 and SPM 2 will continue.

SPM 1 - Access to Public Health Services

Rationale: Access to Care was consistently identified as a continuing health care need on the NA Surveys and KSSI. Montana faces a large geographic health disparity evidenced by HPSA scores showing much of the state is a shortage area for primary care, mental health care, and dental care. Access to Care is a fundamental action area.

SPM 2 – Family Support and Health Education

Rationale**:** Family support and parental education emerged as essentials which are increasingly being unmet. Care coordination and referral follow-up were also frequently cited as unmet needs with major effects on the health of the whole MCH population, especially ages 0 to 19 years.

III.D. Financial Narrative

	2018		2019	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,323,181	$2,301,521	$2,323,181	$2,300,122
State Funds	$3,086,577	$2,984,836	$3,110,423	$3,058,820
Local Funds	$4,882,169	$12,490,557	$11,340,925	$11,381,026
Other Funds	$0	$0	$0	$0
Program Funds	$150,000	$6,243,211	$9,008,955	$7,085,446
SubTotal	$10,441,927	$24,020,125	$25,783,484	$23,825,414
Other Federal Funds	$21,842,716	$22,904,219	$22,903,139	$25,270,884
Total	$32,284,643	$46,924,344	$48,686,623	$49,096,298

	2020		2021	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	$2,323,181	$2,281,823	$2,300,122	
State Funds	$3,182,030	$3,197,388	$3,013,111	
Local Funds	$12,336,754	$5,666,253	$11,133,625	
Other Funds	$0	$0	$0	
Program Funds	$8,486,816	$6,598,569	$6,574,458	
SubTotal	$26,328,781	$17,744,033	$23,021,316	
Other Federal Funds	$23,766,761	$27,095,321	$24,660,140	
Total	$50,095,542	$44,839,354	$47,681,456	

	2022	
	Budgeted	Expended
Federal Allocation	$2,323,181	
State Funds	$3,170,955	
Local Funds	$5,644,793	
Other Funds	$0	
Program Funds	$6,548,111	
SubTotal	$17,687,040	
Other Federal Funds	$25,867,305	
Total	$43,554,345	

III.D.1. Expenditures

The FFY 2020, Title V MCHBG expenditures supported services to almost 40,000 women, infants, children and youth with and without special health care needs (CYSHCN), and adolescents living in one of the 52 County Public Health Departments (CPHDs) that opted to select their Title V funding allocation. Their *unduplicated number of persons served* reflects the following self-identified racial breakdown:

- 26,824: Caucasian
- 3,456: American Indian
- 1,552: More than one race
- 8,154: Other/Unknown

Montana's methodology ensured that the 30%-30%-10% requirements were met for the Preventive and Primary Care for Children; CYSHCN, and Administrative expenditures. The Title V MCHBG's methodology uses the ratios of the total maternal and child health population as a factor for determining state-level budget amounts for the demographic categories.

As reported on Forms 2, 3a and 3b, in FFY 2020 Montana expended $2,281,823. The expenditures met the federal requirements, with the following breakdown:

- Preventive & Primary Care for Children $842,098 36.90%
- Children with Special Health Care Needs $709,762 31.11%
- Administrative Costs $167,097 7.32%

Form 2 also reported that the 1989 Maintenance of Effort amount of $485,480 was maintained. Montana exceeded the required $3 match in non-federal funds for every $4 in Title V funds by reporting $15,462,210, which is reflected in:

- $5,666,253 from the 52 CPHDs that received Title V MCHBG funding to address their selected National/State Performance Measure (N/SPM). The CPHDs are contractually required to annually report their match amount and source.
- $3,197,388 from state general funds focused on the maternal and child health (MCH) population
- $6,598,569 program income reported by WIC, CYSHCN, and Family Planning/Title X

State funds, which are tied to legislative rules and as such may be restrictive in their expenditure, i.e., only expended on state staff or contracted services, continued to support the MCH programs in the Family and Community Health Bureau (FCHB). The Children Special Health Services (CSHS) Section received $1,845,492.27 (60%) of the FFY 2020 total of $3,197,388. The funds supported activities assisting families to establish a medical home (NPM 11); ensured that all newborns received the recommended newborn screening panel and hearing tests; and, supported the financial assistance program.

As reported on Form 2a, CYSHCN benefited from the $709,762 (31.11%) FFY 2020 Title V MCHBG allocation, which addressed the 2020-2025 Needs Assessment recommendation to continue activities supporting *NPM 11: Establishing a Medical Home.* CSHS maintained these contractual partnerships with: the HALI Project--MT Parent Partners; Circle of Parents; the University of Montana's Rural Institute for Inclusive Communities (UMRI) Transition's project; Transition Improvement Group; University of Utah Medical Home Portal; and, Montana Pediatric Medical Passport.

CSHS staff monitored these contracts monthly or quarterly to ensure funds were expended in approved categories and contract deliverables were fulfilled. CSHS staff also provided technical assistance as needed to families, healthcare providers and social service agencies. Qualifying families were assisted with out-of-pocket expenses for their child with special health care needs by the Financial Assistance Program (FAP). Eligible families could apply for a maximum of $2,000 by completing the required application and providing the necessary documentation to indicate that the expense was

unallowable by Medicaid, CHIP, and/or private insurance, and it supported the child's care plan.

The CPHDs continued as the primary providers of enabling and public health services to their county's maternal and child populations. FFY 2020 funding of $1,076,032, was allocated to the 52 CPHDs that opted to participate. Each CPHD indicated their N/SPM selection and provided details on two activities and evaluations to meet their stated N/SPM goals, which were reflected in their FFY 2020 CPHD Operational Plan. As needed, the Title V MCHBG and Fetal, Infant, Child, & Maternal Mortality Review (FICMMR) Program Specialists provided technical assistance to CPHDs on this task. The number of CPHDs addressing each performance measure was as follows: five selected NPM 13.a; six each focused on NPMs 5 and 7; nine opted for SPM 2; and, 26 chose SPM 1.

The Title V MCHBG and FICMMR Program Specialists, both in the Maternal and Child Health Coordination (MCHC) Section, completed data quality reviews of each CPHD's required reports: Quarterly; Annual Compliance & Activities; and Annual Financial & Data. Their approval is necessary prior to the release of payments, to ensure that the CPHDs met their contract deliverables. These CPHDs reports informed the NPM/SPM narratives summarizing their activities and outcomes, and provided the data to complete Forms 2, 3a & 3b, and 5a & 5b. The CPHDs reports collected the following data elements:

- Total unduplicated numbers served of women, infants, children, adolescents, and CYSHCN; and their self-identified racial demographics
- Total Title V MCHBG and Non-Federal Match funding spent on: Direct Health Care; Enabling Services; Public Health Services and Systems; and Administration.
- Total Title V MCHBG and Non-Federal Match funding spent on each of the following population categories: pregnant women; infants under 1; children 1 to 22; CYSHCNs; women of childbearing age (15 to 44 years); and group encounters i.e., school-based oral health screenings.

The CPHDs financial data reports indicated that

- $634,788 was spent on Enabling Services activities
- $359,149 was spent on Public Health Services & Systems activities
- $74,527 on Administrative costs
- Two CPHDs reported that they spent $1,179.50 from their non-federal match budgets on Direct Services; thus, Form 3b indicates no Title V MCHBG Direct Health Services expenditure.

In addition to state funds, the FCHB Sections received a total of $27,297,069 in federal grant funding, which is provided in detail on Form 2. The state and federal funds supported public and private partnerships and collaborations aimed at N/SPMs:

FCHB Section	State Funds	Federal Funds	Total
CSHS	$1,845,492	$743,329	$2,588,821
MCHC	$75,219	$2,990,986	$3,066,205
Family Planning/ Title X	$499,998	$2,510,700	$3,010,698
WIC	$7,250	$15,127,693	$15,134,943
MT Healthy Families/Home Visiting	$733,762	$4,497,053	$5,230,815
Epidemiology	$35,665	$272,500	$308,165
Adolescent Health:		$953,060	$953,060
Total	**$3,197,386**	**$27,095,321**	**$30,292,707**

167,103 women, infants, adolescents, and children with and without special health care needs received services in FFY 2020 (Form 5b). Of these, 40,236 received enabling Title V MCHBG funded services (Form 5a). This was made possible by

blending funds from: Title V MCHBG; State and Federal Funds; private funds; and, by reallocating program income.

The FFY 2020 Annual Report Domain Narratives offer more in-depth descriptions of the approaches in the State Action Plan for:

- Women & Maternal Health: NPM 13a - Oral Health for Pregnant Women;
- Perinatal & Infant Health: NPM 5 - Safe Sleep;
- Child Health: NPM 7 - Child Injuries;
- Adolescent Health: NPM 10 - Adolescent Preventive Healthcare;
- CYSHCN: NPM 11: Medical Home
- Cross-Cutting/Systems Building: SPM 1 - Access to Care and Public Health Services; and, SPM 2 - Family Support and Health Education.

III.D.2. Budget

The Title V MCHBG FFY 22 budget will support services to all women, infants, children, adolescents, and Children Youth with Special Health Care Needs (CYSHCN). MT's methodology ensures that the 30%-30%-10% requirements are met for expenditures on: Preventive and Primary Care for Children; CYSHCN, and Administration. MT's Title V MCHBG methodology uses ratios of the total maternal and child health population as factors for determining state-level budget amounts for the demographic categories.

As reported on Form 2, the FFY 22 Title V allocation is estimated to be $2,323,181. It is budgeted to meet the requirements as follows:

- Preventive and Primary Care for Children: $848,546 (36.53%)
- Children with Special Health Care Needs: $736,690 (31.71%)
- Title V Administrative Costs: $190,439 (8.3%)

In the event of an increase in the funding, the required ratios would be maintained. Any remaining funds would be allocated to supporting activities for women of childbearing age, and needs assessment.

The 1989 Maintenance of Effort amount of $485,480 will continue. The required $3 match in non-federal funds for every $4 in Title V funds is estimated to be $15,363,859 as follows:

- $5,644,793 from the 49 County Public Health Departments (CPHD) who have elected to participate to address their selected National/State Performance Measure (N/SPM);
- $3,170,955 from state maternal and child health (MCH) focused funding;
- $6,548,110 in program income as reported by these Family and Community Health Bureau (FCHB) Programs: WIC, CYSHCN; and Family Planning/Title X.

State and federal MCH focused funds, program income, and CPHDs match are all critical funding streams for MT's Title V Program capacity to address the MCH population domains, their corresponding N/SPMs, and their State Action Plans. The 2020-2025 MCH Needs Assessment indicated the need to continue with the two-cross cutting/systems building SPMs, as originally developed from the 2015 MCH Needs Assessment.

Certain state funds are tied to legislative rules, and as such, are restrictive in their expenditure, i.e., the funds can only support state staff or be expended on contracted services. The FFY 22 state funds, estimated to be $3,170,955, and federal funds, estimated at $25,867,305, will support the Early Childhood Family Support Division's (ECFSD) Programs detailed in the following paragraphs. These state funds support programs housed in the FCHB, and will support these state level and CPHDs focused efforts on their N/SPM as follows:

Children With Special Health Care Needs (CSHCN): In addition to the 30% Title V MCHBG allocation, all children with and without special health care needs will be served by these state funded programs: Genetics; Newborn Screening; CSHS Clinics; and, CSHS which totals $1,872,256. Their federal funds ($679,807) will support these programs: Newborn Hearing Screening and Intervention Program (NBHSI), the MT Access to Pediatric Psychiatry Network (MAPP-Net). The CSHCN section's total state and federal funds is about four times the FFY 22 Title V MCHBG CSHS 30% allocation.

The funds will continue to support these CSHCN staff:

- Nurse Consultant
- Program Assistant
- CSHS Title V Program Specialist (a new position created in FFY 21)
- Two Program Specialists supporting MAPP-net and NBHSI
- An AmeriCorps VISTA

- Title V CSHS Director/CSHS Supervisor

The CSHCN staff will continue their contractual oversight and partnerships to ensure that CYSCHN have access to a medical home (NPM 11) and make progress towards advancing the National Standards for Systems of Care for CYSHCN. Title V funding will continue to support:

- The HALI Project: MT Parent Partner Program which supports families in their medical home with parent mentors who work in the clinical setting. Parent partners provide emotional support, resource referral and self-advocacy tools to parents of CYSHCN.
- The Transitions Project of the University of MT Rural Institute (UM-RII) works with families, providers and agencies to provide education; training and tools about transition topics; and care coordination.
- The MT Medical Home Portal is a website with information for providers, families and agencies about diagnosis, treatment and local resources for CYSHCN.
- Circle of Parents, a nationally recognized, evidence-based parent support group for families, whose focus is on preventing child abuse and empowering parents.
- The CSHS Financial Assistance Program (FAP) aids qualifying families with a CYSHCN or foster care child and helps with assistance towards services outside the scope of Medicaid, CHIP, or private insurance.

Other programs not directly financed with Title V MCHBG funding, but maintained by staff it supports, include:

- Cleft/Craniofacial Clinics: Cleft/Craniofacial Clinics serve children and adults with interdisciplinary care team services across the state of MT in 4 locations.
- MT Statewide Genetics Program: which provides access to genetic testing and counseling services, provider consultations and education on genetic conditions.
- Resource navigation projects such as a resource tool for families who are considering moving to MT.
- Metabolic Services: Metabolic clinics and long term follow up services for metabolic NBS.

Additional programs overseen by CSHS, and that support the children's system of care include:

- MAPP-Net: which supports primary care providers and behavioral health specialists in serving children and youth in their communities with mental health needs through education and consultation.
- NBHSI: with a main goal is to ensure that all infants in MT are provided with newborn hearing screening services and resources, following the 1-3-6 Early Hearing Detection and Intervention guidelines established by the Joint Committee on Infant Hearing.
- During FFY 21, the CSHS Director and Children’s Trust Fund program director partnered on the Circle of Parents program, to provide additional funding for training and respite grants.

The Title V CSHS Director/Supervisor is completing a Request for Proposal (RFP) to expand and improve upon peer services for families of CYSCHN though the MT Parent Partners. The anticipated start date is October 1, 2022. Other programs subject to an RFP in 2022 include: the Cleft/Craniofacial clinics; MT Statewide Genetics Program; and the Metabolic services program. The intention with each RFP is to continue to refine programs to make improvements in the system of care, with increased performance and outcome monitoring.

The Title V Director is also the MCH Section Supervisor, which includes six Program Specialists: four tied to a federal grant; and two are Title V MCHBG supported. In October a Nurse Consultant will join the MCH Section.

Title V MCHBG Program Specialist; and Fetal, Infant, Child, & Maternal Mortality Review (FICMMR) Prevention Program Specialist: These two Program Specialists (PS) will work with the 49 CPHDs: providing technical assistance and resources on the N/SPMs and ensuring that Quarterly Reports (QR) and the Annual Compliance & Activities (ACA) and Financial & Data Reports reflect their FFY 22 activities and expenditures. Each also provides annual training, and program basics training to new CPHD staff. These positions will be 100% supported with the FFY 22 Title V funds.

The FICMMR PS is responsible to ensure that the statutorily required CPHDs' yearly FICMMR prevention activity has an evidence-based or informed foundation, and their QR and ACA reflect their stated activity and evaluation plan. The FICMMR position is also the subject matter expert to the seven CPHDs that opted for NPM 5 in FFY 22.

The MCHBG PS will continue as the primary CPHDs' contact for questions or concerns related to: Task Orders; QR; the ACA; and Annual Financial & Data Reports. In addition to being the subject matter expert for SPM 1 (24 CPHDs) and SPM 2 (6 CPHD), the PS triages and refers the CPHDs to FCHB and MCH staff who are positioned to address specific MCH population domain inquiries. A major responsibility of the MCHBG PS is to ensure the timely completion of the Title V MCHBG Annual Report and Application.

Oral Health Program: The *Grants to States to Support the Oral Health Workforce Activities* supports the Oral Health PS. As noted in the NPM 13 narratives, it supports contracts for oral health services from: the University School of Washington/College of Dentistry; MT State University/College of Nursing; Alluvion Health FQHC; Caring Foundation of MT; and, the four CPHDs known as Oral Health HUBS, which are contracted to provide oral health services within their county and adjoining counties. Title V funds will support: the Basic Screening Surveillance, for Kindergarten and Head Students for the 2021-2022 school year, travel to the four HUBS; and, providing technical assistance (TA) to the three CPHDs that are addressing NPM 13.2.

MT Obstetric and Maternal Support (MOMS) Program: The MOMS Program is entering its third year focusing on decreasing the state's maternal mortality and severe maternal morbidity rates, by implementing and evaluating telehealth innovations. The MOMS PS will continue working with the Billings Clinic on their telehealth demonstration, which is expanding to include: substance abuse treatment services in rural Eastern MT; and providing simulation trainings to healthcare providers. The UM-RII is evaluating the MOMS Program's activities. The MOMS PS will provide TA to the four CPHDs that selected NPM 1. Additionally, the PS and UM-RII team are developing a MOMS focused intervention aiming to expand the CPHDs NPM 1 activities, with the MOMS grant funding the work.

Title V/Sexual Risk Avoidance Education (SRAE) Program: The SRAE PS is now fully integrated into the MCH section. The PS successfully identified evidence based/informed curriculums that met the SRAE requirements and address bullying prevention. In FFY 22, the PS will be working with the two CPHDs that selected NPM 9 and recruiting additional CPHDs or other organizations to adapt the SRAE/Bullying Prevention curriculum.

Primary Care Office (PCO) and State Loan Repayment Program (SLRP): The PCO PS will continue to ensure accurate data is used to determine a county's health professional shortage area (HPSA) designation. The HPSA score is a critical number for determining if a healthcare provider is awarded federal or state loan repayment assistance to practice in that county. The PCO's functions support addressing all the N/SPMS.

Preventing Maternal Deaths in MT: In 2019, MT applied to receive Centers for Disease Control and Prevention *Enhancing Reviews and Surveillance to Eliminate Maternal Mortality* (ERASE MM) Initiative funds. The application was approved for an October 1, 2021 start date. It will support a Nurse Consultant, responsible for implementing the *Preventing Maternal Deaths in MT* (PMDM) workplan. The Nurse Consultant will also carry on the process of establishing the *MT Maternal Mortality Review Committee* which was begun by the MOMS PS.

Overarching Activities: The Title V and Title V/CSHS Director recognized an opportunity to strengthen the state level Title V MCHBG Program by reclassifying a CSHS FTE from a Health Education Specialist to a PS. The position was filled in March 2021. The goal of the position is to support a coordinated and comprehensive approach within CSHS Title V funded programs and to integrate further with the MCH section, to increase capacity and optimize efficacy of resources and programs.

In FFY 22, 49 CPHDs were allocated $975,421 to address their N/SPM to provide *Enabling, and Public Health Systems*

Services to their MCH population counties. The Title V allocation formula and the Title V funding requirements are found in the Administrative Rules of MT 37.57.1001. The allocation formula is based on the total maternal and child health population living in each county (children ages 0-19, and females 20-44), with the number of those living at or below the federal poverty level added-in again.

The MCH population is also supported by these programs:

Family Planning/Title X: In April 2021, the section was expanded to include three Adolescent Health Section staff overseeing their adolescent health grants, totaling $794,745. The federal grants support rape prevention and pregnancy prevention education services provided by community-based organizations, i.e., Domestic Violence Coalitions; CPHDs; Tribal Public Health Departments; and colleges.

By blending federal ($3,321,400) and state funds ($499,999) family planning needs will continue to be met by the 14 CBOs offering services. Beginning September 1, 2021, telehealth services will be offered by two CPHDs, awarded funding based on their RFP response. A second RFP to be released in the fall 2021 aims to expand telehealth services in three to five new clinics.

The 2021 Legislature developed a prioritization process for determining clinics in this descending order: CPHDs, Federally Qualified Health Centers; private/non-profits who offer primary care services; and private/non-profits that don't offer primary care services. In late fall an RFP will be released to meet the new process with an anticipated April 1, 2022 start date for successful awardees. The education and direct health care services provided by programs housed in the Family Planning/Title X section support all the N/SPMs.

Healthy MT Families (HMF) Home Visiting: HMF services support maternal, infant, child, and CYSHCN populations by funding four evidence-based home visiting models. The FFY 22 state ($709,700) and federal MIECHV ($4,379.043) funding supports the HMF Supervisor and three PSs. The HMF staff will oversee the organizations, selected from the RFP applicant pool, that will provide evidence-based home visiting services.

Supplemental Nutrition for Women, Infants, and Children (WIC): Families will continue to avail themselves of WIC nutritional education, food packages, breastfeeding consultations; and fresh fruits and vegetables from Farmer's Markets. WICs federal funding is $13,631,024 and state funds are $9K.

Pregnancy Risk Assessment Survey (PRAMS) and State System Development Initiative (SSDI): The MCH Epidemiologist will continue administering the PRAMS ($160,020) and SSDI ($119,569) grant workplans, which support all the MCH Programs.

III.E. Five-Year State Action Plan

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

State: Montana

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

The Department of Public Health and Human Services (DPHHS) works towards four goals:

- All Montana children are healthy, safe, and in permanent, loving homes
- All Montanans have the tools and support to be as self-sufficient as possible
- All Montanans are injury-free, healthy, and have access to quality healthcare.
- All Montanans can contribute to the above through community service.

The Early Childhood and Family Support Division (ECFSD) houses the MCHBG within the Family and Community Health Bureau (FCHB). ECFSD's vision is that children, youth, and families are healthy and thriving, which aligns nicely with MCHBG principles. The entire division serves as a convener, collaborator and partner within and outside the division. This was the primary driver in establishing a new division focused on early childhood and family support. Examples include taking a lead role in offering advanced Parent, Child Interactive Therapy (PCIT) evidence-based training aimed at meeting the needs of children in the child welfare system. This collaboration included mental health, child welfare, and prevention programs.

Primary administration of the MCHBG is provided by the Title V and CSHCN Directors, who supervise their respective section's programmatic efforts: Maternal and Child Health Coordination (MCHC) and Children's Special Health Services (CSHS).

The FCHB sections and programs all have staff who are subject matter experts in their areas. They are available to assist the County Public Health Departments (CPHDs) with the implementation of their N/SPM Operational Plans, i.e.:

- Children's Special Health Services – All N/SPMs, especially NPM 11 and SPM 2
- Healthy MT Families Home Visiting - All N/SPMs; especially NPMs 1, 5, 11, and 13.b
- Family Planning/Title X & Adolescent Health - All N/SPMs; especially NPMs 1 and 9, and SPMs 1 and 2
- Fetal, Infant, Child, and Maternal Mortality Review – NPMs 1, 5, 9; SPMs 1 and 2; and Injury-Prevention
- Montana Obstetric & Maternal Support Program - NPM 1, SPMs 1 and 2
- Oral Health Program - NPM 13.b, SPMs 1 and 2
- Primary Care Office- All N/SPMs
- WIC/Nutrition Services- All N/SPMs; especially NPMs 5 and 13.b

Closer relationships with the ECFSD's other programs, including the Children's Trust Fund, and No Kid Hungry, are providing increased support for tackling maternal and child health populations' needs and challenges. These ECFSD programs and partnerships are additional resources for enhancing and expanding the MCHBG's impact across the state. They have the potential to assist in addressing Needs Assessment opportunities, illustrated in the following table, and as listed in more detail in the 2020-2025 Needs Assessment Summary.

Needs Assessment Opportunity	New ECFSD Program Partners
Food insecurity and nutrition	MT No Kid Hungry Project
Educate parents on developmental milestones	Child & Adult Care Food Program Tribal & Non-Tribal Head Start Collaboration Director Part C Service Providers Child Care Resource & Referral Agencies Child Care Licensing Program Children's Trust Fund
Explore & expand telehealth reach	Part C Service Providers
Ongoing support for Head Start and childcare programs	Child & Adult Care Food Program Tribal & Non-Tribal Head Start Collaboration Director Child Care Resource & Referral Agencies Child Care Licensing Program
Educate about generational trauma	Children's Trust Fund Tribal & Non-Tribal Head Start Collaboration Director
Need for family support to connect families to available resources	Child & Adult Care Food Program Tribal & Non-Tribal Head Start Collaboration Director Part C Service Providers Family Support Advisory Council Part C (IDEA) Child Care Resource & Referral Agencies Child Care Licensing Program Children's Trust Fund
Invest in online training	MT State University Early Childhood Project

Public health services in Montana are provided via a decentralized system of care, as outlined in the Montana Code Annotated (MCA), Title 50: Health & Safety. Section 50-1-202: General Powers and Duties, outlines the public health duties each county must fulfill to ensure the basic health needs of all county citizens are addressed. In response to MCA 50, all 56 counties have a CPHD. Their capacity varies based on any number of issues: population; local county government support; ability to attract and retain providers (i.e., when the closest shopping center is 100 miles away); and staff capacity to implement programs which are federally funded.

Standards for distribution of MCHBG funding to CPHDs are covered in MCA Rule: 37.57.1001. The rule includes the following directive: “In distributing MCH block grant funds, the department will give priority to the counties, regions, and communities with the least resources, the largest proportion of underserved families, and the most serious maternal and child health problems, and will determine who should have priority by utilizing objective health indicators.” In Montana, geographic disparities in rural areas account for a significant percentage of underserved families. In contrast to the relatively small population, the state's large geographic area is a primary challenge in providing services to its maternal and child residents.

Montana’s Title V Maternal & Child Health Block Grant (MCHBG) program design allocates a significant percentage of funding to the CPHDs Historically, 41% to 45% of annual MCHBG funding is allocated to the CPHDs. They submit annual operational plans outlining goals and activities for their selected National or State Performance Measure (N/SPM). The CPHDs also submit details for an injury-prevention activity, as required by the Fetal, Infant, Child, & Maternal Mortality Review (FICMMR) MCA 50-19-401-406. All these activities have measurable goals, with progress reported on quarterly reports and outcomes summarized in their Annual MCHBG Compliance & Activities Report.

The CPHDs receive annual training on evidence-based/informed or best practice activities and MCHBG reporting processes. The trainings are offered by the MCHBG Program Specialist and State FICMMR Coordinator. These state staff also provide training on program basics for new CPHD staff. The basics trainings have increased in frequency, as the CPHD staff turnover rate has been impacted by an aging and shrinking workforce population and the effects of COVID-19 restrictions.

FCHB leadership considered the 2020 NA strengths and challenges when selecting the 2021-2025 National Performance Measures (NPM) per domain: 1: Well-Women Visit; 5: Infant Safe Sleep; 9: Bullying; 11: Medical Home; and, 13.b: Children's Oral Health. The 2020 NA's quantitative and qualitative data also supported the continuation of these cross-cutting State Performance Measures (SPM): 1: Access to Public Health Services; and, 2: Family Support and Health Education.

The 2015 NA initially identified State Performance Measures (SPMs) 1 and 2 as much-needed "gap fillers" that allow the CPHDs to address public health issues that may not have an identified NPM but are still needs within their community. The 2020 NA identified SPM 1 and 2 to remain as a CPHD selection. SPMs 1 and 2 continue to address the challenges with accessing health care services and resources due to: Montana's vast geographic size; maldistribution of providers; and, health disparities amongst American Indian and rural populations. The MCHBG category for these SPMs is the "Cross-Cutting System Building" domain.

The Children & Youth with Special Health Care Needs (CYSHCN) Director and section staff members are focused on continuing and improving their population health strategies to address the National Standards for Systems of Care for CYSHCN and NPM 11. These efforts include:

- Intentional relationship building and collaboration with Medicaid programs;
- Building CYSHCN workforce capacity through HRSA technical assistance and training opportunities;
- Improving program integrity through increased performance metrics, quality assurance and quality improvement standards across all programs;
- Leading collaborative opportunities between CYSHCN stakeholders, such as the National Care Coordination Academy; and
- Focusing on data and equity as foundations of CSYHCN programming.

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

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

In January 2020, the Department of Public Health and Human Services (DPHHS) established the Early Childhood and Family Support Division (ECFSD). The ECFSD includes the programs housed in the Family and Community Health (FCHB) and Early Childhood Services (ECSB) Bureaus, Child Care Licensing, No Kid Hungry, Montana Milestones/ Part C Early Intervention, Family Education and Support Program, and the Montana Children's Trust Fund. The Division Administrator (DA) oversees the FCHB, ECSB, Fiscal and Operations Bureau (FOB), Children's Trust Fund, and No Kid Hungry programs.

The ECFSD mission to better coordinate existing services for children and families remains strong. The ECFSD structure continues to evolve as DPHHS and Division programmatic needs are identified. On August 9, 2021, DPHHS leadership announced that the agency had completed an overall organizational health assessment that will guide the agency's restructuring plan. The new DPHHS structure is included as an Organizational Attachment.
https://dphhs.mt.gov/News/2021/08/DPHHSAnnouncesagencyrestructuring

In its first year, the ECFSD experienced some turnover and continues to assess the most effective organizational structure, especially related to fiscal and operations as support for the programmatic bureaus. Divisions within the department have support through centralized human resources, budget management, fair hearings, and public information.

The DPHHS Human Resources (HR) Office assists with the recruitment and hiring processes and provides onboarding training for all new hires. In addition to the HR training, an employee engagement committee within ECFSD, developed an *ECFSD New Employee Manual*, which expands on the DPHHS HR training.

Annually, all employees are required to complete refresher trainings from DPHHS HR and Technology Services Division on topics such as: HIPAA; safety in the workplace; and, internet safety. Additionally, DPPHS HR has offered monthly supervisory-focused online trainings, with topics selected from a DPHHS formal survey. Topics have included "How Managers Can Use the Employee Assistance Program (EAP)", What You Need to Know About the Human Rights Bureau and Discrimination Laws," and "COVID 19 Management."

The ECFSD Leadership Team created the ECFSD Workforce Development Policy and Procedure (WDPP). Currently, in draft form, the WDPP outlines expectations for all the ECFSD positions and encourages individualized professional development. A draft version is included with the supporting documents for this submission.

The Title V MCHBG State Action Plans are overseen by the Title V Director/Maternal and Child Health Coordination (MCHC) Section Supervisor and CSHCN Director/ Children's Special Health Services (CSHS) Section Supervisor. The MCHC Section's staff increased to six program specialists in March 2021, which includes the addition of an Adolescent Health Program Specialist (PS), enhancing a focus on NPM 9 and bullying prevention. This has allowed for plans to expand the reach of Title V services beyond County Public Health Departments to youth-based organizations, such as Boys & Girls and 4-H Clubs. The PS has identified an evidenced-based Title V/SRAE curriculum which includes bullying prevention. Beginning with FFY 2022, the PS will promote and recruit additional entities interested in expanding their adolescent reach.

The CSHS Section, now a six-person team, experienced changes in the past year. In October 2021, the CSHS Director/ Supervisor will complete her first year in the position and have hired: the CSHS Nurse Consultant; a Program Specialist to administer the MAPP-Net Grant; a CSHS Program Assistant; and a Title V/CYSHCN Program Specialist.

The CSHS and MCHC staffs' job descriptions, at a minimum, reflect the necessary skills, knowledge, abilities, and experience to bring to their positions on day one. New employees to state government are required to have a probationary performance evaluation, which includes SMART goals to be completed within the six-month probationary period. This evaluation, when combined with the staff member's annual performance review and their reflective supervision meetings, are opportunities to identify their professional development needs.

COVID-19 required the MCHC and CSHS Supervisors to adapt to how they conduct their bi-monthly reflective staff supervision meetings and weekly-scheduled staff meetings.

Staff are encouraged to avail themselves of training from the State Professional Development Center (PDC), housed in the Department of Administration. The PDC offers training on topics such as: Excel for Beginners to Advanced; planning and organizing; writing clearly and concisely; and in response to COVID-19, Telework Made Easy. Other opportunities include participating in the Public Health and Safety Division training opportunities; attending federal grantee online trainings, i.e., HRSA and CDC sponsored which are attended by the Title V/CSHS Directors and Program Specialists; and participating in section and bureau specific trainings, such as the MCHC Section received on specialized GIS Mapping. ECFSD managers

participated in Collaborative Safety Science training together as a team.

ECFSD staff were queried on their immediate and emerging training needs, and in response, bi-monthly *Lunch & Learns* were established. The *Lunch & Learns* have featured updates from these ECFSD standing committees: Diversity, Equity, Inclusion; and Employee Engagement. ECFSD subject and program matter experts have also been featured in areas such as: budget creation; and, Federal/State-funded services and programs, such as Children's Trust Fund and No Kid Hungry.

The CSHS staff have also participated in trainings specific to Diversity, Equity and Inclusion, and Budget Management, which have been offered through a partnership with a state university. Additionally, CSHS staff have applied to be part of the AMCHP CYSHCN New Director and emerging professional leadership academies. CSHS staff is currently in the process of applying for technical assistance specific to CYSHCN Standards of Care. All CSHS staff will participate in this training and identify specific elements within the standards of care for additional study. As part of the effort to improve the section's competency and practice around health and racial equity, the CSHS team spends 15 to 30 minutes at every staff meeting reviewing readings on health and racial equity topics.

The Title V and CSHCN Directors have expanded their working relationship to include their respective MCHBG Program Specialists. Monthly meetings include topics such as: collaboration on NPMs; cross-training on programs; financial/budget discussions and block grant application logistics. CSHS seeks to take on a more active role in supporting the BG application and working with local public health entities. Title V and CSHCN Directors hosted a team-building meeting with activities for all MCH and CSHS staff, with the goal of building relationships to support program collaboration.

ECFSD staff were involved in planning the 9th Annual *Great Beginnings, Great Families Conference* (GBGF), held virtually August 17 -18, 2021 The conference aims to connect programs, providers, and partners in early childhood and maternal, child and adolescent health (MCAH) systems and serves as a training andworkforce development opportunity for state and local staff. The keynote address featured "This is Us-A Story of Resilience." Several ECFSD staff, including CSHS, Lead MCH Epidemiologist; and MT No Kid Hungry Program Director, are among the presenters. For more information, go to: https://www.umt.edu/ces/conferences/gbgf/2021-agenda-breakout-sessions.php.

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

The Family & Community Health Bureau's (FCHB's) Children's Special Health Services Section (CSHS) and Maternal and Child Health Section (MCH) are primarily responsible for ensuring that Title V MCHBG input is solicited from Montana's families and consumers. Family and consumer feedback and involvement are sought directly from surveys or participation at meetings. When feasible, their input is included in the State Action Plan objectives, goals, and activities.

Family and consumer insights are also received from contractors working with the MCH population. CSHS contracts with family-led organizations to provide services and solicits their input on programs and initiatives. As FCHB has become part of the Early Childhood and Family Services Division (ECFSD), staff from across the division have partnered with external stakeholders to create a parent engagement framework.

CSHS's vision is to increase family and youth voice in program decisions. CSHS is considering several strategies that include: building capacity within the Title V Family delegate role to ensure the role is compensated for their time and that there are formal duties and mechanisms for program review and feedback; increasing the number of parents and youth on the CSHS stakeholders meeting and formalizing a relationship with the Family to Family Information Center and the Part C of the IDEA required Family Support Advisory Council, focused on family voices of infants and toddlers with developmental delays or disabilities.

Specific examples of parent engagement across MCH/CSHS programming:

- Family and consumer input were received from the Universal Newborn Hearing Screening and Intervention (UNHSI) Coordinator working with two family-based organizations: the Montana School for the Deaf and Blind (MSDB) and MT Hands and Voices (H&V). They are contracted to increase family involvement and outreach to the families with Deaf/Hard of Hearing (D/HH) children.

    - The MSDB contract requires them to offer a Deaf Mentor Program for D/HH children. The Deaf Mentors are trained through the SKI-HI Institute at Utah State University. During 2020, Deaf Mentor services were provided via Zoom. Throughout the pandemic, services were successfully provided to 13 families. Deaf Mentors also offered 9 online ASL sign classes.

    - In the past year, MT H&V suspended its activities due to COVID-19. CSHS is working on a contract for this and the next federal fiscal year to continue the work of engaging with Deaf/HH families through activities such as: outreach events; support groups; playground days; science camps; ASL story times, and gymnastic days.

    - The UNHSI Coordinator also leads the 18-member UNHSI Learning Community (LC), composed of: five parents; a D/HH adult; audiologists; Early Interventionists; an epidemiologist; data manager; nurse consultant; and, hospital screening staff. The LC focused on developing family-focused outreach and education materials, and identifying strategies to reduce *Loss to Follow-Up* for newborn hearing screenings. Program staff provide outreach to various levels across the healthcare system and directly to families. Training opportunities are provided to program staff, family support specialists, and parents. In 2020, 6 members of the LC attended the national EHDI conference.

- In FFY 21/22, a Governor-appointed Newborn Screening Committee (created by legislation in the 2021 legislative session), supported by a partnership between CSHS and the Public Health and Human Safety Division (PHSD) Metabolic Newborn Screening (NBS) Program, will begin convening on a bi-annual basis. They will review the panel of required screenings and recommend any additions or removals. The committee will include two individuals affected, or two family members of individuals affected, by conditions screened through the Metabolic NBS Program.

- Parent Partner, Peer to Peer program: The family-led HALI Project is contracted to facilitate the MT Parent Partner Program (MPPP), in communities across Montana. Parent Partners, who are parents of CYSHCN, work in clinics to support and provide referrals to families - and inform them of CSHS family, clinic, and community resources.

  In FFY20, over 364 families across MT received MPPP services in 1438 total encounters. The number of families served, and respective encounters, have decreased in FFY21 due to COVID19 impacts. A Quality Improvement project will be initiated in FFY21/22 at a new clinic site. The project will assess the satisfaction of parents served by the program and the clinic's workflow for supporting referrals to programs. The program would like to scale up the program to additional sites across Montana.

- The CSHS Stakeholders' Group, established in February 2017, includes eight family members and one consumer. The most recent meeting was in August 2019. No meetings have occurred since then, due to COVID19 restrictions. The next in-person meeting is being scheduled for the fall of 2021. CSHS is soliciting feedback from critical partners, like the Family to Family Information Center and our Title V parent delegate, on the meeting agenda and format.

- CSHS contracts to fund work with the University of Montana's Rural Institute for Inclusive Communities (UMRIIC) that is a key source of family and stakeholder input. The UMRIIC leads the Consumer Advisory Council (CAC), a group of 15 consumers and family members in transition, and representatives who serve the population. The CAC works with CSHS staff to revise the Healthcare Transitions Guide as needed. UMRIIC and CAC staff raise awareness and provide educational information at venues such as conferences, vendor fairs, and monthly learning webinars. Attendee's feedback is shared with CSHS; integrated into quality improvement efforts; and aids in selecting future topics.

  UMRIIC also hosted six webinars on transition topics for: families; state and private sector professionals, e. g. MT Self-Help Law Clinics and MT Developmental Disabilities Program; and interested stakeholders from other states. In the past year, UMRIIC trained 411 individuals, including representatives from 21 states and Puerto Rico in addition to MT.

- The Montana Access to Pediatric Psychiatry Network (MAPP-Net) Grant, housed in CSHS receives guidance through an advisory council that include two parents/caregivers of a child receiving community-based mental health services.

- CSHS Financial Assistance Program: A committee was formed in FFY21 which includes CSHS staff and parent leaders (two staff from Family to Family Information Center and a Title V Family Delegate) to review applications to the program.

- The above committee is also currently working on a project to support resource navigation for families of CYSHCN who are moving to Montana. The project will result in an electronic resource, with various levels of information. As many families choose to relocate to Montana, CYSHCN families do not have a centralized, reliable resource to learn about what services, resources, and challenges will meet them upon entering the state. The project will create a comprehensive, targeted, electronic resource for this need. The electronic resource will be grouped into key categories, such as health services and education services. The information in this resource has been gathered through a series of surveys and stakeholder meetings. The next stage of work on this project will include partnering with families for a final review of the material and an outreach and education stage to promote the resource.

- In September 2019, the Title V Director/MCHC Supervisor was re-appointed to serve as one of 29 members on the MT Council on Developmental Disabilities. The members are primarily: people with developmental disabilities and family members; representatives from state agencies; state legislators; and, groups that work on behalf of people with disabilities. The Council meets quarterly, at which time the members are apprised of and offered the opportunity to provide their input on the Title V Annual Report and Application.

Client and consumer satisfaction surveys are conducted regularly with the MCH population served by DPHHS programs, which include:

- Local County Health Public Departments (CPHD) accepting Title V funds conduct a client survey and use the results to help with their program planning and selection of a national or state performance measure. The CPHD survey summary is a required annual deliverable.
- The Title X Family and Reproductive Planning programs require their clinical providers to solicit feedback from clients/participants.
- WIC conducts an annual client/participant survey.
- CSHS is planning to implement a client/participant survey for those who utilize the cleft-craniofacial clinics.

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

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

Within the Early Childhood and Family Support Division, there are four Maternal and Child Health (MCH) epidemiologists, with primary focus on maternal and child health-related programs within the Family and Community Health Bureau (FCHB) The MCH Epidemiology Section is one of six sections in the FCHB and is staffed by:

- Senior MCH Epidemiologist Supervisor, Dr. Miriam Naiman-Sessions
- Pregnancy Risk Assessment and Monitoring System (PRAMS) Epidemiologist, Carrie Jo Riordan, MPH
- Maternal Infant Early Childhood Home Visiting (MIECHV) Epidemiologist, Silvana Hackett, MPP
- ECFSD/FCHB MCH Epidemiologist, Walker Hopkins, MS

Dr. Naiman-Sessions has a PhD in Sociology, with an emphasis in the social determinants of health, and over 10 years of experience working in the field of MCH. As the Senior MCH Epidemiologist Supervisor, her designated roles/responsibilities include:

- PRAMS Principal Investigator and Grant Director
- State Systems Development Initiative (SSDI) Grant Director;
- Supervision of the MCH Epidemiology Section;
- ECFSD projects as assigned.

Ms. Riordan, the PRAMS Epidemiologist, has an MPH, with an emphasis in epidemiology and evaluation and over 10 years of experience in research leadership and project management. She is funded directly from SSDI, and her duties primarily include: PRAMS data collection coordination; data quality monitoring; and, PRAMS data analysis and surveillance reporting. For example, Ms. Riordan is currently drafting a surveillance report summarizing oral health trends among the Montana maternal population and has contributed to the PRAMS Indicators Dashboard (i.e., a data querying and visualization tool).

The PRAMS Data Support Specialist, Carol Hughes, has five years of experience in this role. Her contributions include: overseeing mail operations; managing project inventory; data entry; and phone phase monitoring. This position is funded by PRAMS.

Ms. Hackett has an MPP, with an emphasis in population studies and demography and over eight years of experience in early childhood and community impact data analysis. Her duties primarily include overseeing MIECHV data collections and reporting, continuous quality improvement, and program needs assessment and evaluation. Ms. Hackett is funded by MIECHV.

Mr. Hopkins joined the ECFSD/FCHB's MCH Epidemiology Section in April 2021, bringing previous work experience using his MS in Statistics. His duties include special projects as assigned, such as surveillance reports and surveillance system evaluation. For example, Mr. Hopkins is currently drafting a report using vital records, child death review, and PRAMS data to detail the trends in sleep-related deaths and safe sleep behaviors among the infant population in Montana.

The MCH Epidemiology Section also houses the MCH Geographic Information Systems (GIS) Analyst, Kris Larson, who provides cartographic services to the ECFSD. Ms. Larson has over 20 years of GIS experience and has created maps for all the ECFSDs programs, including Title V MCHBG.

Montana has experienced fluctuations in MCH epidemiology capacity in the past three years. The MCH Epidemiology Section was formed in October 2018, when Public Health and Safety Division established state leads for its three main epidemiology subject matter areas: communicable disease, chronic disease, and maternal and child health. In 2017 Montana had four dedicated MCH epidemiologist positions; PRAMS, MIECHV, SSDI, and an FCHB generalist (which served as an epidemiologist for the remaining FCHB programs).

In 2018, the MCH Section was established, and three new positions were created: a Supervisor (i.e., the state lead for MCH epidemiology), an adolescent health epidemiologist, and an oral health/nutrition epidemiologist. These positions were directly supported by the federal funding from the respective programs being supported by the epidemiologist. The FCHB generalist epidemiologist was then restructured to be a subject matter expert position for the Children and Youth with Health Care Needs (CYSHCN) and Fetal, Infant, Child, and Maternal Mortality Review (FICMMR) programs. The section maintained this capacity until the current MCHBG reporting cycle (2020) when the agency underwent a restructuring and in some cases experienced reduced grant funding, that necessitated adjustments to personnel.

The reduction in MCH epidemiology capacity has been a major challenge for Montana, as the state's MCH programs have increased their need for epidemiological support while MCH epidemiology resources have decreased. The state has since

employed numerous strategies to address this gap in capacity, specifically contracting with external partners to oversee grant-required activities previously overseen by state MCH epidemiology staff (e.g., data collection, needs assessments, and evaluations).

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

Montana is a State Systems Development Initiative (SSDI) grant recipient. The Senior MCH Epidemiologist Supervisor serves as the SSDI Grant Director and supports Title V through Birth-Medicaid record linkages for use in MCHBG Form 6 reporting, as well as other Title V annual report activities.

Montana is currently using SSDI funds to support its maternal and infant health surveillance system (i.e., PRAMS) by directly funding the PRAMS Epidemiologist. By supporting the PRAMS Epidemiologist, Montana has been able to develop the PRAMS Indicators Dashboard. In addition, the PRAMS Epidemiologist is authoring data briefs to support Title V priorities, specifically an oral health data brief and a maternal mental health and substance use data brief. The PRAMS Epidemiologist also conducts monthly data linkages between the PRAMS sample, vital records (birth and death), and Medicaid enrollment data to support PRAMS operations and in-part support the maintenance of the Minimum/Core Dataset.

The goals and objectives of the SSDI workplan are included below, detailing activities supporting these goals and objectives for the reporting period:

Goal 1: Build and expand state MCH data capacity to support the Title V MCH Block Grant program activities and contribute to data-driven decision making in MCH programs, including assessment, planning, implementation, and evaluation.

Objective 1: Coordinate the development and implementation of the statewide MCHBG Needs Assessment.

Montana completed the 2020-2025 MCHBG Need Assessment during the spring of 2020. Ongoing SSDI-funded needs assessment activities include the development of the PRAMS Indicators Dashboard (scheduled to go live in August 2021), which will provide Title V staff with the ability to monitor key MCH indicators for the state (e.g., safe sleep practices, prenatal care utilization, breastfeeding initiation).

Objective 2: Provide technical assistance and consultation to local and state partners on assessment, planning, implementation, evaluation on maternal and child health topics.

The Senior MCH Epidemiologist provided a *Surveys 101: Best Practices for Designing Effective Surveys* training in August 2021 for inclusion in the Montana Great Beginnings, Great Families conference, providing a basic overview of how to create an effective survey that can provide the data needed to inform decision-making.

Objective 3: Develop technical assistance materials for local and state partners on key maternal and child health topics identified in the 2018 State Health Improvement Plan (SHIP) and the 2020 MCHBG Needs Assessment.

The Senior MCH Epidemiologist has developed a project plan for the potential development of an MCH Indicators Dashboard and compiled a list of potential indicators for inclusion using the Child and Adolescent Health Measurement Initiative's (CAHMI) Compendium of MCH Measures.

Objective 4: Conduct data analyses for the MCHBG application/annual report.

The Senior MCH Epidemiologist updated the statistics used in the Overview of the State narrative, as well as the data provided in Form 6 of the MCHBG 2022 Application & 2020 Annual Report.

Objective 5: Provide epidemiological support to the Children Special Health Services program.

No activities were completed for this objective during the reporting period, largely due to staff and management turnover. As the program looks to the future, CSHS is interested in a cleft, cranio-facial needs assessment and patient satisfaction survey.

Objective 6: Enhance quality assurance activities, enabling local programs to make data-driven decisions concerning quality improvement efforts.

No activities were completed for this objective during the reporting period. This work is currently on hold pending MCH epidemiology staffing capacity development.

Goal 2: Advance the development and utilization of linked information systems between key MCH datasets in the state.

Objective 1: Collaborate with state partners to overcome barriers to linking remaining data sources to the MCH Dataset.

In February 2021, the Senior MCH Epidemiologist presented an overview of the SSDI grant and the purpose, history, goals, and objectives to the ECFSD upper management team (i.e., bureau chiefs and division administrator). This presentation included an overview of the accomplishments and challenges for SSDI, including the steps needed to overcome remaining barriers to linking remaining data for the minimum/core dataset.

Objective 2: Coordinate with partnering DPHHS divisions to arrange data sharing agreements, facilitating the linkage of additional maternal, child, and adolescent health data sources with the MCH Dataset.

Within the ECFSD, a data sharing agreement template has been created and secures agreements from partners as needed.

Objective 3: Facilitate the data governance and data use processes across MCH programs to expand the use of the MCH dataset.

Within the ECFSD, the Business Systems and Operations section oversees data governance and consistency.

Goal 3: Support program evaluation activities around the NPMs that contribute to building the evidence base for the Title V MCH Block Grant.

Objective 1: Develop and apply evaluation plans for programs and activities supporting the MCHBG national performance measures.

The Senior MCH Epidemiologist, Title V Director, and Rape Prevention and Education (RPE) Grant Director have discussed the potential for completing an evaluation of the *Power Up! Speak Out!* (PUSO) bullying prevention curricula, which is being implemented with RPE funding in middle schools across the state.

The PUSO Evaluation Plan was developed in partnership with CDC and the Harvard T.H. Chan School of Public Health as part of the 2019 MCH Evaluation Practicum. Data collection tools and systems were developed prior to program implementation and are currently in use. The Title V/Sexual Risk Avoidance Education (SRAE) program submitted a formal request on July 30, 2021, to allow Title V/SRAE Project funds to be used to support evaluation activities.

Objective 2: Develop and apply evaluation plans for programs and activities supporting the MCHBG state performance measures.

No activities were completed for this objective during the reporting period.

Objective 3: Provide technical assistance on program evaluation and quality improvement efforts to state and local partners.

No activities were completed for this objective during the reporting period. This work is currently on hold pending MCH epidemiology staffing capacity development.

Objective 4: Produce reports on program evaluation findings.

No activities were completed for this objective during the reporting period.

Objective 5: Improve the functionality of Montana's Indicator-Based Information System (IBIS), an interactive public health data resource.

Montana is exploring the potential for replacing IBIS with another querying system. The MCH Epidemiology Section has since developed a Tableau-based PRAMS Indicators Dashboard and is in the early stages of planning a MCH Indicators Dashboard.

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

In addition to the epidemiology support described in the previous two sections, additional MCH data capacity efforts are managed through the Early Childhood and Family Support Division's (ECFSD) Business Systems and Operations (BSO) Section.

The BSO team is led by Chris Santucci, who completed one year as the BSO Supervisor in August 2021. Mr. Santucci's background includes: Master of Arts degree in Sociology; seven years of leadership experience gained in the military and private sectors; five years' experience in the technology field, specializing in cybersecurity practices; and current pursuit of a Master of Business Administration. He directly supervises the following BSO team members (areas of focus included):

- Blair Hendricks: WIC M-SPIRIT System Lead;
- Nathan Senn: Computer Support Specialist for WIC M-SPIRIT System and Child Care Under the Big Sky (CCUBS);
- Lanny Wilbur: Children and Youth with Special Health Care Needs (CYSHCN) Database Administrator for CSHS HiTrack data system and the Child Health Referral Information System (CHRIS);
- Tom Wolff: Montana Maternal and Early Childhood Home Visiting (MTmechv) Database Administrator;
- Melody Olson: Child Care Under the Big Sky (CCUBS) Data Steward and Analyst; and,
- Laura Brown: Business Analyst and Technical Writer for all ECFSD programs.

The BSO manages and offers technical support to the majority of the maternal and child health (MCH) programs' data information systems. The systems specific to the FCHB are as follows:

- WIC M-SPIRIT System;
- Title X Family Planning database Ahlers;
- Maternal, Infant, Early Childhood Home Visiting (MIECHV) case management data system MTmechv;
- Children and Youth with Special Health Care Needs (CYSHCN) Child Health Referral Information System (CHRIS), HiTrack system for hearing assessment and management and newborn screening follow-up;
- The Fetal, Infant, Child, and Maternal Mortality Review (FICMMR) Prevention Program records the data for fetal, infant, and child mortality reviews into the National Center for Fatality Review and Prevention, Child Death Review (CDR) System.

BSO staff are currently overseeing several enhancement initiatives for these FCHB-housed data systems. These enhancements, not funded by the State Systems Development Initiative (SSDI), include:

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

- The WIC M-SPIRIT system has been in its current form of operation since 2010 and is part of a multi-state consortium. It is being enhanced into a web-based system called SPIRIT Web. SPIRIT Web will provide real-time, quality data to local, state, and federal partners. Before it is released to the 85 WIC clinics within the state of Montana, it will be beta tested by a select number of WIC Clinics. Training will be provided by both the consortium and Montana state-level staff. It is anticipated SPIRIT Web will be live by early 2022.

Title X Family Planning

- Staff are working with the State Information Technology Services Division to develop a new SQL-based system called FPAccess, replacing the Title X Family Planning database Ahlers. FPAccess will allow for easier data quality management, data entry, and reporting for 13 Title X contractors, at 20 service sites. Additionally, state Title X staff will have access to their contractors' data in "real time" thus assisting staff with their federal reporting requirements. It will be tested by contracted staff and state staff, and is anticipated to go live in early 2022

Fetal, Infant, Child, and Maternal Mortality Review (FICMMR)

- Montana's FICMMR program entered into a Data Use Agreement (DUA) with the National Center for Fatality Review and Prevention in September 2012, for the purposes of allowing local FICMMR Teams' review data to be entered into the Child Death Review (CDR) System. FICMMR Teams continue to enter the data for their fetal, infant, and child death reviews into CDR Version 5.1.

  Preliminary discussions have begun with the MT Office of Vital Records, the MCH Epidemiologist, the FICMMR Coordinator, and the Title V Director to explore proceeding with a business process enhancement project. The goal is to mitigate errors by standardizing key data fields and keep death certificate numbers static across the system.

These data fields include:

- State ID
- Child's First Name
- Child's Last Name
- Child's Date of Death
- Child's Age
- Child's Age Category

Additionally, staff are collaborating to develop a process which will standardize the MT Office of Vital Records death certificate number naming convention. That future conversation will occur after the process is shared with the Office of Vital Records, with the aim to have the new process in place by the end of calendar year 2021.

It is anticipated that Montana's recent data quality recognition by the National Center for Fatality Review and Prevention, in preparation for their *5 Years of the National Center's Data Quality Initiative*, will be enhanced by the discussions with the Office of Vital Records. Montana is one of three states that will be recognized for their data quality improvements: "Montana's average proportion of missing and unknown responses for the 48 CORE priority variables declined from 9.75% to 4.8%, a 51% reduction."

Healthy Montana Families (HMF) Home Visiting Program

- MT's HMF is supported with federal MIECHV and state *Montana Initiative for the Abatement of Mortality in Infants* (MIAMI) funds. This has allowed 20 counties, and four tribal areas, to implement the home-visiting models of: Parents as Teachers; Nurse Family Partnerships (NFP); Family Spirit; and, Safecare. The MTmechv Database Administrator created a HMF Administrative Database which collects the administrative and financial data for the four models. The data can be entered by program staff through forms that are included in the database within the Access application. The Admin database is used by program staff to track all administrative aspects of the models and implementing agencies, including: budgets; expenses; contracts; and, personnel data.

- In October 2022, HMF will update the NFP forms used by sites to ensure that the NFP data meets the annual HRSA/MIECHV Performance Report requirements. Currently, the MIECHV Database Administrator acquires the NFP HRSA data through a monthly export of text files from NFP. Having all HRSA required data within MTmechv will greatly improve the efficiency of completing the annual HRSA report.

- The MIECHV vendor contract with Sunquest terminates on January 31, 2023. Staff have begun discussions to explore the internal application process that would identify next steps related to procurement and ongoing database maintenance and operations.

Children and Youth with Special Health Care Needs (CYSHCN)

- ~~In January of 2021, HiTrack went through a state security review, which identified opportunities to strengthen controls. The CYSHCN Database Administrator established the security documentation for the 80 HiTrack users, comprising 26 hospitals, and enforced security best practices to bring the HiTrack system into compliance with DPHHS Technology Services Division policy and best practices.~~
- The division is working to implement Okta authentication into the CHRIS System. to provide an easier user experience when logging in to the system and provides industry-standard security.

Maternal Health Innovation

The CDC Wonder Online Database reports Montana's 2011-2015 maternal mortality ratio was 25.7 deaths per 100,00 births, ranking Montana as having the 12th highest maternal mortality ratio nationwide and the third highest in the Western States. This data, plus Montana's innovative approach to decrease maternal mortality, led to HRSA funds to launch the Montana Obstetric and Maternal Support (MOMS) program.

The division created an Access-based Maternal Mortality (MM) database to house the data collected on maternal deaths occurring between October 1, 2013 through December 31, 2019. Local FICMMR teams submitted a 20-page Maternal Mortality Review (MMR) form to the State FICMMR Coordinator, who conducted a data quality review prior to officially closing any maternal death cases. The MMR database mirrored the paper form, which because of its size and complexity, was designed to allow for multiple data queries. The MM database went live in Fall, 2020 and is now ready to be used by program partners.

Also within the ECFSD, are these three Early Childhood Services Bureau (ECSB) data systems:

Child and Adult Care Food Program (CACFP): Currently designed to manage the food programs claiming and approval system.

Child Care Under The Big Sky (CCUBS): CCUBS is the primary data system used to manage childcare provider licensing, family eligibility for childcare assistance through the Best Beginnings Child Care Scholarship Program, and contracts for professional services and staff support.

CCUBS is undergoing a large-scale modernization effort, which is focused on optimizing current infrastructure with enhancements designed to: streamline business processes; employ security best practices; and, better serve Montanans by replacing legacy processes and infrastructure with current technology.

MedCompass: MedCompass is a care-management system currently under development to aid the Part C Early Intervention for Children with Developmental Disabilities program. The system, developed in coordination with the Montana Developmental Disabilities Program (DDP) and the Montana Program for Automating and Transforming Healthcare (MPATH) Medicaid modernization project, consolidates all program data, benefits, and care coordination for individual members into one place.

MedCompass aims to streamline and enhance Part C's services, claims management, and the member experience while consolidating program processes and payment services into one system that directly connects with the Montana Medicaid database. The member experience will be enhanced by providing members and their guardians access to their information and care coordination in one place through the member self-service portal.

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

The Department of Public Health & Human Services (DPHHS) has an Emergency Operations Plan (EOP), which is written and maintained by the DPHHS Public Health Emergency Preparedness (PHEP) Program. The EOP is reviewed annually with a major update every two to three years or upon the appointment of a new department Director. The current EOP was fully updated in 2017. As required by federal funding guidelines for the PHEP program and EOP development, all populations are considered in the plan, including at-risk and medically vulnerable women, infants, and children.

Ann Buss, Title V Director and Maternal & Child Health Section Supervisor, has been part of the *Montana Emergency Support Function #8: Public Health and Medical Services* committee since 2019. This group meets three times per year but did not meet in 2020 due to COVID-19. The group is scheduled to resume meetings in September 2021. Every Division within DPHHS has set responsibilities for how to respond during an emergency and has the opportunity to participate in the state's emergency preparedness planning, review, and update of the EOP. This activity is implemented through the appropriate workgroup and provides direct input from subject matter experts as requested by PHEP staff.

DPHHS programs contribute to their Bureau/Division's Continuity Of Operations Plan (COOP) as required under Executive Order. The following is an excerpt from the MT DPHHS manual, Continuity of Operations:

> "DPHHS maintains continuity plans to ensure the function of the agency and the continuity of its assigned State Essential Functions under all conditions. In an event that interrupts the functional operation of the Department, the Continuity of Operations Plan (COOP) guides recovery priorities to move it back to an operable status. The Montana Department of Administration manages the State Government Continuity Program."

The DPHHS Incident Management Structure (IMS) does not directly include Title V leadership. The Incident Command (IC) team is supported within Public Health & Safety Division (PHSD) and consults with subject matter experts in the MCH field as needed when responding to an emergency based on the populations impacted. Following all emergency response, the PHEP and IC teams complete an After-Action Report (AAR) of the incident. These AARs are used to develop and update plans for future response.

At the onset of the COVID-19 pandemic and corresponding to when the Governor of Montana declared a state of emergency on March 12, 2020, Department Administrators were charged with completing *An Assessment of the Most Essential Tasks* of their Department Programs. DPHHS Programs were asked to identify their service(s) and determine the following:

- If their services were deemed essential for their customers.
- If Yes, alternative strategies for service delivery if unable to provide in person.
- Federal Guidance, if applicable.
- Resources that could be shared with the customers.

The Early Childhood & Family Support (ECFS) Division Administrator directed all programs to create a COVID-19 plan and identify resources. The Title V MCHBG Program's assessment indicated that many of the contractors serving children and youth with special health care needs (CYSHCN), were prepared to provide the services virtually. Some services, such as specialty clinics, would be unable to offer a virtual visit; however, CSHS staff indicated their capacity to assist families with rescheduling.

Other FCHB programs focused on serving women and children also completed their specific COVID-19 plans and available resources. The Healthy Montana Families Home visiting program determined that in-person home visiting was essential for potential situations of safety concerns for the child and family. State and Local Agency staff of the Supplemental Nutrition Program for Women, Infants, & Children (WIC) Staff jointly determined solutions to continue these essential WIC services: benefit issuance and required certifications for families. Additionally, the WIC program's Information Technology (IT) support for the local agencies was fostered by WIC staff's ability to offer remote IT support.

The County Public Health Departments (CPHDs) were apprised of the ability to redirect their Title V allocation for addressing COVID-19 in their county. The lessons learned from the DPPHS' COVID-19 pandemic *An Assessment of the Most Essential Tasks* will serve as the foundation for addressing gaps in the Department's emergency preparedness process.

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

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

Montana's Title V Program is in the Maternal Child Health Coordination (MCHC) Section, one of six in the Family & Community Health Bureau (FCHB), in the Early Childhood Family Support Division (ECFSD). Through public and private partnerships and collaborations with FCHB and ECFSD programs and the County Public Health Departments (CPHDs) contributions, the Title V program focuses on improving health care delivery for the maternal and child population.

Maternal & Child Health Coordination Section

The Title V Director, also the MCHC Supervisor, oversees programs supporting Title V: Oral Health (OH); Fetal, Infant, Child and Maternal Mortality Review (FICMMR); Montana Obstetrics and Maternal Support (MOMS); Primary Care Office (PCO); State Loan Repayment Program (SLRP); and, Title V/Sexual Risk Avoidance Education (SRAE). Many of these programs rely on key partners such as universities, private hospital and health care systems, physicians, the Montana Health Care Foundation, and the Montana Primary Care Association.

The OH Coordinator provides support to the CPHDs implementing NPM 13 activities. In-depth activity details are provided in the Women & Maternal Domain report for FFY20 and the Child Domain Application for FFY22, which also includes FY 2021 activity information. The Hub-Spoke model, whereby a larger populated county, the Hub, supports the smaller-size Spoke counties' oral health activities. An OH focus is increasing the number of Spokes for the purpose of professional staff applying fluoride varnish and dental referrals. Public Private Partnerships specific to oral health include, but is not limited to: Blue Cross Blue Shield, Montana Dental Association, and Montana Dental Hygienist Association.

The FICMMR Coordinator ensures that the CPHDs' local FICMMR teams', composed of pertinent local professionals, death reviews focus on determining its preventability. The review results are used for planning, implementing, and evaluating their county injury prevention activity. The Coordinator conducts a QI review of the team's review prior to its submission to the National Child Death Review database. FICMMR requirements are included in the CPHDs' MCHBG contracts.

The MOMS program aims to deliver training, resources, and support to rural healthcare providers by connecting them to obstetrical/gynecological, perinatal, mental health and substance abuse specialists; thus, creating competency and consistency across perinatal providers. The MOMS/Billings Clinic (BC) contract connects rural providers to urban-based experts using Project ECHO (Extension for Community Healthcare Outcomes). ECHO facilitates mentoring, guidance, feedback, and education amongst the healthcare providers. The BC is expanding its existing telemedicine efforts to address rural area shortages of OB/GYN, substance use disorder, and mid-level providers of maternal healthcare in Eastern MT.

The MOMS/University Montana Rural Institute for Inclusive Communities (UMRIIC) partnership is focused on assessing, evaluating, and offering recommendations to increase the percentage of women receiving an annual well-woman visit. UMRI is coordinating their MOMS needs assessment with the MCHBG, PCO, and Children's Special Health Service needs assessment. The results will inform program managers how to address access issues preventing a higher engagement in the annual well-woman visit.

The PCO works to improve the health status of underserved and vulnerable populations. The PCO's collaborative work with the MT Primary Care Association and MT Office of Rural Health & Area Health Education Center aligns with the MCHBG's emphasis on improving access to care in MT's Health Professional Shortage Areas (HPSAs). The PCO administers loan repayment programs; the J-1 Physician Visa Program for physicians from other countries; and provides resources and support to medical facilities seeking help with recruiting for Primary Care positions.

The Title V/SRAE program uses evidence-based approaches to implement education exclusively on sexual risk avoidance. It is designed to teach youth self-regulation; success-sequencing for poverty prevention; healthy relationships; goal setting; how to resist sexual coercion; facts of dating violence; and, how to minimize youth risk behaviors such as underage drinking and illicit drug use, without normalizing teen sexual activity. The Title V/SRAE Program Specialist also is responsible for the NPM 9 - Bullying Prevention State Action Plan.

Family & Community Health Bureau and Early Childhood Family Support Division Partnership Programs

Critical to Title V services are these FCHB's sections: Children's Special Health Services Section (CSHS); Healthy Montana Families Home Visiting (HMF); Supplemental Nutrition for Women, Infants & Children (WIC); Family Planning (FP); and, Epidemiology.

The CSHS Supervisor oversees the MCHBG specific work focused on NPM 11: Medical Home activities, which are supported by these other CSHS programs: Genetic & Cleft Clinics, Newborn Screening and the MT Access to Pediatric Psychiatry Network. Through partnerships and collaborations established by these programs, all children are afforded health care services, such as referrals for audiology or metabolic services and newborn screenings.

Home visiting services, offered through HMF's contracts with CPHDs and non-profits, are voluntary and family-centered to pregnant women; new parents; or families or caregivers with infants and young children under five years of age. The professionally trained home visitor focuses on improving maternal and child health outcomes such as child development and school readiness; child and maternal health; family economic self-sufficiency; positive parenting practices; and reductions in child maltreatment and family violence. Several CPHDs integrate their *NPM 5: Infant Safe Sleep* and *NPM 13: Oral Health* activities into their home visiting curriculum.

WIC provides healthcare and nutrition services to low-income pregnant women, breastfeeding women, and children under the age of five with a family income below 185% of the federal poverty level. WIC's mission is to partner with other services that are key to childhood and family well-being. ECFSD programs and WIC collaborate by supporting breastfeeding and immunization services and referrals to social service programs.

By administering MT's Title X Clinics, the FP program ensures accessible, quality family planning services to adults and teens. There are 22 Title X Clinics, many of which are co-located with CPHDs, often sharing staffing and office resources while serving the same clients as the local MCHBG program.

County Public Health Departments

Public health in MT is decentralized, with much of the work done by CPHDs. Annually, the FCHB contracts with an average of 50 CPHDs interested in participating in the MCHBG, who submit quarterly and annual reports on their identified National and/or State Performance Measure activity and evaluation plans. MCHBG funding, when combined with their local or other state funding, plays a critical role in the CPHD's capacity for providing needed services to their county residents.

University of Montana Rural Institute for Inclusive Communities

UMRI has been a long-standing partner with CSHS to provide evidence-based transition resources to Montana's youth and families. UMRI works to: maintain and expand the 15-member Consumer Advisory Council; maintain and disseminate a health care transition (HCT) guide; develop evidence-based/informed HCT training and resource materials; conduct distance learning opportunities; maintain a transition website; and, provide technical assistance to other initiatives related to HCT.

As described in the MOMS section, UMRI continues to support updates to the MCHBG Needs Assessment. In 2020, UMRI assisted with collecting CPHDs' information on the MCHBG 5-Year Needs Assessment through surveys and key informant interviews, as well as analyzing results and final selection of performance measures.

Healthy Mothers Healthy Babies (HMHB)

The ECFSD continues to support HMHB's *Safe Seats for Baby* and *Safe Sleep for Baby* programs. At no cost to families, the *Safe Seats for Baby* provides car seats and training by a Child Passenger Safety Technician on correctly installing and using the seat. Their *Safe Sleep for Baby* Program supports a safe sleep environment for babies by providing families in need with a Pack 'N Play.

ECFSD Programs

ECFSD programs, such as the Child & Adult Care Food Program; Child Care Development Fund; No Kid Hungry and Early Learning/Family Support; are staunch supporters of sharing maternal and child health information, educational resources, and training opportunities with their stakeholders including child care providers, local non profits, and schools. In return, their information is shared with the Title V partners.

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

Montana's Medicaid program is embedded in several Department of Public Health and Human Services (DPHHS) divisions and programs. The Medicaid Division Administrator in the Health Resources Division (HRD), is the Title XIX signatory. The Title V signatory is the Early Childhood Family Support Division (ECFSD) Administrator, where the Title V Program is located. In the Overview of the State narrative, specific enrollment data for Medicaid, Medicare, private insurance, and other insurance coverage is included in Table 3: 2019 Estimates of Resident Population by Insurance Coverage Type for Montana.

Several Family and Community Health Bureau (FCHB) maternal and child health-focused programs have been working on specific projects with Medicaid in the last year. The 2021 Legislative Session caused a brief halt in progress; but conversations resumed in early June 2021.

The Children's Special Health Services (CSHS) section has made specific efforts to build collaborative partnerships with Medicaid. Efforts include:

- Partnering with Medicaid and Child and Family Services leadership, and using *Montana Access to Pediatric Psychiatry Network* (MAPP-Net) funding to support training mental health professionals in Parent Child Interactive Therapy (PCIT). The partnership will train two cohorts of mental health professionals to increase capacity for this service across the state of MT and ensure access for Children and Family Services clients.

- Quarterly collaborative meetings with the Children's Mental Health Bureau Chief and the Developmental Disabilities Bureau Chief to discuss programs, provide updates and identify partnership opportunities.

- Monthly meetings with the Tribal Health Services and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program Section Supervisor to discuss funding for: Cleft Craniofacial services; EPSDT program: and Targeted Case Management for Children and Youth with Special Health Care Needs (CYSHCN). These meetings have ceased since the position became vacant several months ago.

- Monthly meetings with the Meadowlark Initiative leadership, which includes the Medicaid Bureau Chief responsible for primary care and medical home services, to discuss efforts around the sustainability of Project ECHO clinics and the psychiatric consultation access line. Information on state Medicaid policy changes to support Project ECHO clinics has been shared. The Meadowlark Initiative is the term used to describe the collaborative efforts between the MT Healthcare Foundation and HRD staff administering the HRSA Perinatal Behavioral Health Grant, which was awarded to DPHHS in 2017.
- The CYSHCN Director is co-leading the Montana team participating in the National Care Coordination Academy, which includes participants from various Medicaid divisions. The CYSHCN Director has recruited Medicaid staff to present information on children's mental health services and medical homes to an audience which includes providers, the University of Montana Rural Institute for Inclusive Communities, and family leaders.

- Medicaid representation for children's mental health services is on the MAPP-Net advisory committee and the MAPP-Net Symposium planning committee.

- CSHS participates in the Community Health Worker (CHW) taskforce and recruited Medicaid's participation to support identifying a sustainable funding source for CHW. The goal is to advance equitable systems of care.

The Supplemental Nutrition for Women, Infants, and Children (WIC) Program is required to meet with Medicaid at least annually to discuss coverage of medical formulas and nutritionals for mutual participants. Montana WIC met with Medicaid in July 2020 and again in June 2021 to discuss this topic and other program updates. Montana WIC clinics regularly make referrals to Medicaid for any family that appears to qualify and states they are not enrolled. Likewise, Medicaid staff may refer families to WIC when appropriate.

Additionally, WIC added specific language to the general program booklet, the participant cardholder, and the "resources" section of the website to ensure participants are aware of how to contact and apply for Medicaid, especially for minors eligible for EPSDT. The local WIC agencies referred 3,005 individuals who self-reported as not being enrolled in Medicaid but appeared to qualify.

In September 2020, the Oral Health Program (OHP) began collaborating with HRD to determine if the Montana Healthcare Program Public Health Clinic (PHC) fee schedule can be updated. The goal is to allow PHCs to bill and receive reimbursement when a public health nurse applies fluoride varnish on Montana Healthcare Program members under the

standing orders of a supervising physician. The OHP last met with HRD staff to discuss the decision matrix in January 2021. According to the latest update received, HRD staff are working on the reimbursement schedule for public health clinics, which will include oral health services.

The OHP is also collaborating with HRD on a potential project to increase the number of preventative oral health services provided. This specifically targets services for members under 36 months of age delivered by Medicaid enrolled physicians, physician assistants, and nurse practitioners. If approved, the program would provide enhanced reimbursement for oral health services provided by enrolled primary care providers who have completed the *Smiles for Life* online curriculum.

The Title X Family Planning Program (FPP) is collaborating with HRD to attempt to increase the reimbursement for family planning clinics located in rural public health departments for women's reproductive health visits. In the last year, staff have met twice to identify the issue and begin to discuss solutions. HRD is working on the reimbursement schedule for public health clinics, which will include oral health and family planning. FPP is also working with HRD to better understand the reimbursement for telehealth visits.

Montana Obstetric and Maternal Support (MOMS) Program, Addictive and Mental Disorders Division (AMDD) staff and HRD staff have initiated discussions to work toward a common definition of care coordination. These staff oversee the HRSA and private foundation funded *Meadowlark Initiative,* and the Substance Abuse and Mental Health Services Administration (SAMHSA) funded *The Strengthening Families Initiative for Pregnant and Postpartum Women.* These three grant-funded programs are exploring sustainability through Medicaid reimbursement for care coordination, which is a component of the three programs.

Additionally, the MOMS and Meadowlark staff are co-leads of the Center for Medicare and Medicaid Services (CMS) *Montana Postpartum Care Affinity Group* (PCAG), which is receiving technical assistance from Mathematica. As one of nine teams, Montana will learn from CMS's quality improvement advisors and subject matter experts in improving postpartum care. The goal of this effort is to improve postpartum care visits and the quality of visits among Medicaid and the Children's Health Insurance Program beneficiaries.

The year-long learning commitment is anticipated to help guide interventions that could be adapted by the County Public Health Departments (CPHD) that selected NPM 1: Well Woman Visit. The PCAG will reach out to CPHDs and encourage them to choose an intervention supporting NPM 1, which would also align with the goals of the PCAG and MOMS. The MOMS grant could provide supplemental funding in addition to MCHBG funds to support the CPHD's NPM 1 intervention activity.

The Healthy Montana Families (HMF) Home Visiting program was one of 11 Maternal Infant Early Childhood Home Visiting (MIECHV) funded states to participate on the National Academy for State Health Policy (NASHP) *State Policy Institute on Public Insurance Financing of Home Visiting*, which convened in January 2021. The Title V and MIECHV Project Directors, HRD Branch Chief, and ECFSD leadership participated in the three training sessions. Beginning in August 2021 and ending in April 2022, Montana is one of three states participating in the NASHP's in-depth technical assistance opportunity. The anticipated outcome is for Montana to identify and advance innovative strategies on public insurance financing of home visiting services and how Medicaid could also be tapped for home visiting sustainability.

HMF refers all families to needed services, including referrals to Medicaid; however, Medicaid referrals are not a required data element for MIECHV reporting purposes. For the 2020 performance year, HMF reported to HRSA the following:

- 72.5% of caregivers in MIECHV funded services had Medicaid as their insurance source;
- 78.6% of children enrolled in MIECHV funded services had Medicaid as their insurance source.

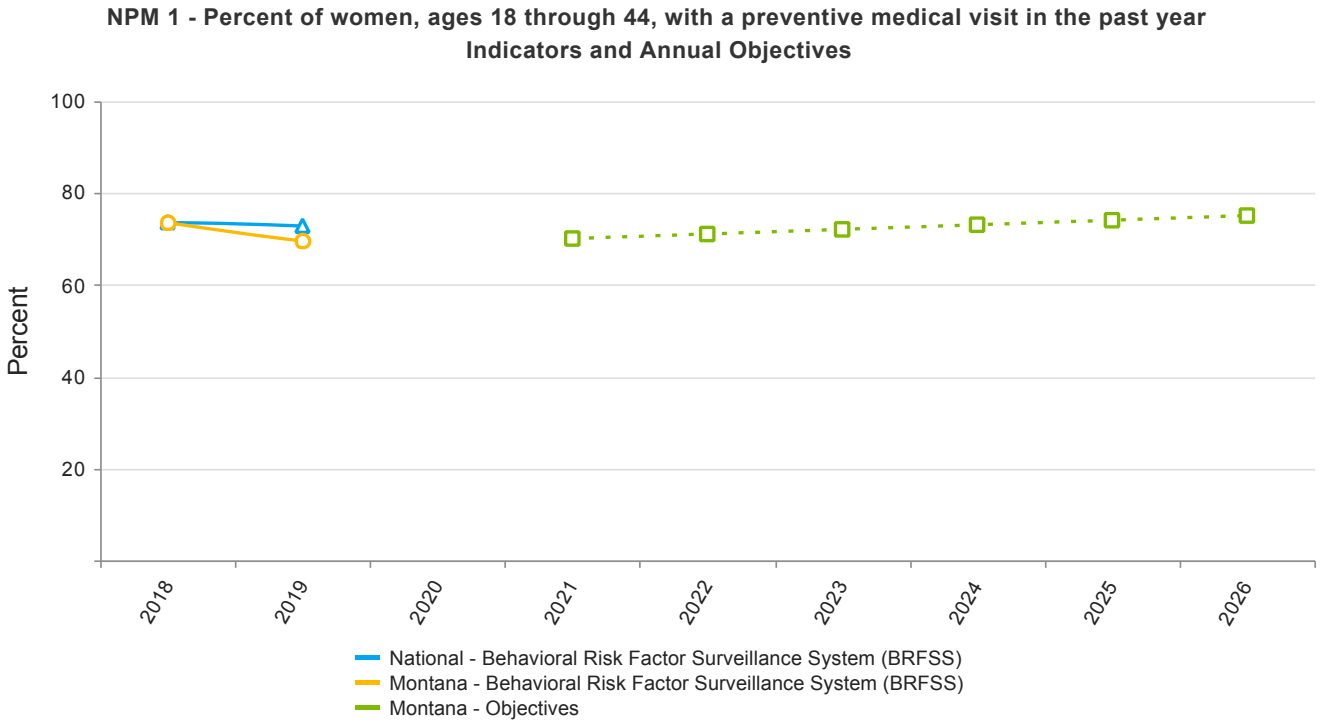
III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations	SID-2018	38.6	NPM 1
NOM 3 - Maternal mortality rate per 100,000 live births	NVSS-2015_2019	16.9	NPM 1
NOM 4 - Percent of low birth weight deliveries (<2,500 grams)	NVSS-2019	7.3 %	NPM 1
NOM 5 - Percent of preterm births (<37 weeks)	NVSS-2019	9.6 %	NPM 1
NOM 6 - Percent of early term births (37, 38 weeks)	NVSS-2019	27.1 %	NPM 1
NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths	NVSS-2018	4.9	NPM 1
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	4.8	NPM 1
NOM 9.2 - Neonatal mortality rate per 1,000 live births	NVSS-2018	3.0	NPM 1
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.7	NPM 1
NOM 9.4 - Preterm-related mortality rate per 100,000 live births	NVSS-2018	156.3	NPM 1
NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy	PRAMS-2019	9.0 %	NPM 1
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations	SID-2018	7.8	NPM 1
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	9.9 %	NPM 13.1
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	14.4 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.5 %	NPM 13.1
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	16.3	NPM 1
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth	PRAMS-2019	15.2 %	NPM 1

National Performance Measures



Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2019	**2020**
Annual Objective		
Annual Indicator	73.3	69.3
Numerator	123,845	119,515
Denominator	168,903	172,352
Data Source	BRFSS	BRFSS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	70.0	71.0	72.0	73.0	74.0	75.0

Evidence-Based or –Informed Strategy Measures

ESM 1.1 - Percent of activity goals to increase preventive medical visits for women which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	82.0	83.0	84.0	85.0	86.0

State Action Plan Table

State Action Plan Table (Montana) - Women/Maternal Health - Entry 1	
Priority Need	
Women's Preventive Healthcare	
NPM	
NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year	
Objectives	
To increase the percentage of women, ages 18 through 44, who receive a comprehensive annual preventive "well-women" medical visit.	
Strategies	
Support County Public Health Departments who choose NPM 1 as their priority need, providing technical assistance and resources.	
The MOMS program is considering offering mini-grants to all interested CPHDs. Discussions are addressing the specific data to be collected, which will include learning about the number of women receiving a postpartum depression screening and education. The data will also be used by the University of Montana for some of the MOMS reporting requirements.	
MOMS and Medicaid are participating in the Post-Partum Affinity Group, which is focusing on increasing postpartum depression screening. The first discussion on how to work more closely with CPHDs which select NPM 1 is in August 2021.	
ESMs	**Status**
ESM 1.1 - Percent of activity goals to increase preventive medical visits for women which are met by county public health departments using MCHBG funding for the work.	Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

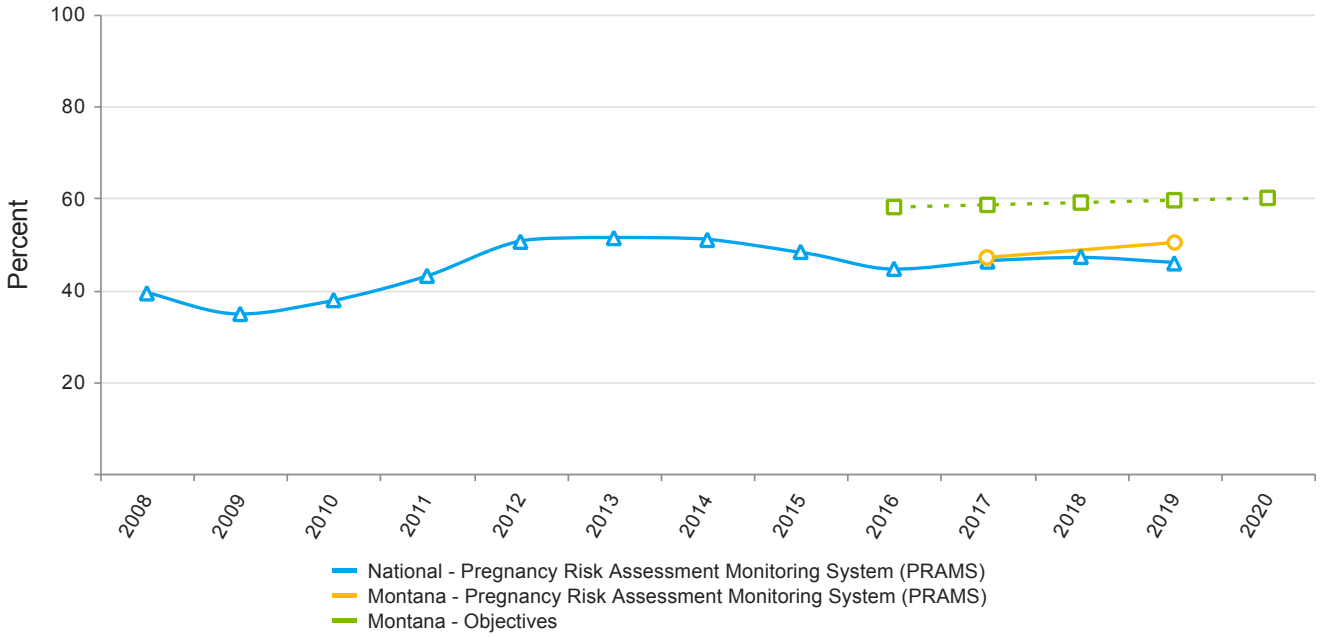
NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

2016-2020: National Performance Measures

2016-2020: 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)		
	2019	**2020**
Annual Objective	59.5	60
Annual Indicator	47.0	50.4
Numerator	5,308	5,364
Denominator	11,296	10,649
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	58	58.5	59	59.5	60
Annual Indicator	51.6	51.6	51.6		
Numerator					
Denominator					
Data Source	2015 The Health Survey of Montana's Mothers and Ba	2015 The Health Survey of Montana's Mothers and Ba	2015 Health Survey of Montana's Mothers and Babies		
Data Source Year	2015	2015	2015		
Provisional or Final ?	Final	Final	Final		

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 13.1.3 - Percent of activity goals to increase dental care during pregnancy which are met by county public health departments using MCHBG funding for the work.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			80	83
Annual Indicator			83.3	69.2
Numerator			10	9
Denominator			12	13
Data Source			FCHB	FCHB
Data Source Year			FFY 2019	FFY 2020
Provisional or Final ?			Final	Final

NPM 13 - Oral Health: a) Percent of women who had dental visit during pregnancy; and b) Percent of infants and children, ages 1 – 17 years, who had a preventive dental visit in the last year.

Barriers due to COVID-19:
Due to COVID-19 precautions and rescheduling of elective medical appointments, oral health partners experienced several barriers during FFY20. The University of Washington School of Dentistry (UW-SOD) had to cancel three 4th year dental student rotations scheduled for Spring 2020 but was able to resume rotations in July 2020. Montana State University College of Nursing (MSU-CON) had to cancel Head Start classroom visits scheduled for April and September 2020 due to COVID-19 precautions, including transitioning Head Start to a virtual platform and the reservation restricting entry from any outside contractors.

Oral health services in county health department "hub" locations were largely postponed alongside non-emergency medical services early in the pandemic and then were offered inconsistently when staff time unassigned to COVID-19 response permitted. The Caring Foundation of Montana (CFMT) had to cancel mobile dental clinics from March through May 2020 and experienced many barriers in scheduling clinics for the remainder of FFY20. Lastly, the Oral Health Program (OHP) experienced reduced capacity as the Oral Health Program coordinator was intermittently on leave due to the unavailability of daycare.

Activities to Support NPM 13:
During FFY20, MCHBG and OHP staff collaborated on activities for NPM 13a. The programs continued to promote the oral health literacy campaign, *Healthy Montana Mouths*. The *Healthy Montana Mouths* book is a 13-page flip chart containing information on oral health from preconception to pregnancy and through the child's first dental visit. The book is available upon request, free of charge to providers. The complementary toolkit includes oral health screening tools, assessment guidelines, and referral forms. The toolkit forms are available to download from the OHP website at https://dphhs.mt.gov/ecfsd/oralhealth. Initial informal feedback from providers suggests these are excellent resources to promote the discussion of oral health in the primary care setting.

During FFY20, the following organizations included blurbs in their newsletter to promote *Healthy Montana Mouths* materials: WIC; MT Hospital Association; MT Chapter of the American Academy of Pediatrics; and the MT Medical Association. Additionally, the OHP exhibited at the MT Academy of Family Physicians' Big Mountain Medical Conference in January 2020. The OHP collaborated with the Home Visiting program to distribute sample materials to 23 programs. A total of 213 *Healthy Montana Mouths* books were distributed during the reporting timeframe.

The OHP and the MCH program continued to collectively advocate for the MCH population within the Montana Oral Health Network (MOHN), including activities to support NPM 13a. This network is guided by the *Montana Oral Health Strategic Framework*, which has these specific metrics related to the MCH population:

- Objective 3A: Develop innovative programs that increase the number of women seeking preventive dentalcare during pregnancy from 51% to 55% percent by 2023. Prospective parents and health care providers will participate in programs that increase oral health knowledge.
- Objective 3B: Educate dentists, medical providers, WIC counselors, and parents that a child's first dental visit should occur before one year of age and include a risk assessment. By 2023 infant dental visits prior to the first birthday will increase by at least 2 percent.
- Objective 3C: Conduct an assessment to determine the number of schools and clinics that include oral exams as part of health screenings. Once a baseline has been determined, increase by 10 percent over the next five years.
- Objective 3D: Advocate for a state-level policy that requires dental exams be part of an entering student's health examination.
- Objective 3E: Work closely with the Office of Public Instruction to encourage Montana school districts to include oral health strategies and education as part of their district's Wellness Policy.

The OHP provided in-kind administrative support to this network. In December 2019, the OHP organized a full network meeting to discuss progress towards objectives and next-step activities. Based on assimilated feedback, the OHP secured funding for facilitators to assist in revitalizing the momentum of the MOHN. The first facilitated steering committee meeting was held in August 2020. During this meeting, the steering committee voted to continue supporting the existing *Montana Oral Health Strategic Framework* and reestablish work groups to accomplish the outlined objectives.

The known disparities, based on geographic locations and race in Montana, continued to drive targeted programming related to oral health. The OHP had several projects to support growth of the oral health workforce in MT. The OHP had contracts

with four County Public Health Departments (CPHD): Valley, Pondera, Deer Lodge, and Custer. In this "Hub and Spoke" model, hub locations provide guidance and support for oral health activities to surrounding (spoke) health departments. These counties' oral health efforts were supported by the HRSA Grants to States to Support Oral Health Workforce Activities, which has defined grant deliverables complimenting but not duplicating the Title V requirements. This program facilitated early childhood risk assessments, oral health education, and fluoride varnish application in the primary care setting. From September 1, 2019 to August 31, 2020, 947 children were provided oral health services by county health department staff, including 57 fluoride varnish applications.

The OHP continued a partnership with the Caring Foundation of Montana (CFMT) to pilot the integration of preventive oral health services in mobile health clinics and non-traditional settings to address dental needs, promote prevention and increase the capacity of community-based preventive dental care for high-risk, high-need populations. The CFMT had partnerships in 42 counties, four reservations, and 12 Hutterite colonies in Montana. From September 1, 2019 to August 31, 2020, 595 screenings, 606 fluoride varnish applications, 1396 sealants, and 709 referrals to a dental provider were completed.

In May 2020, the OHP partnered with Alluvion Health, a Federally Qualified Health Center (FQHC) in Cascade County, on a teledentistry pilot project. Alluvion Health was awarded the HRSA Oral Health Infrastructure grant to purchase a mobile dental unit. The OHP provided additional funding towards the purchase of necessary equipment for the mobile dental unit and provided administrative support during the early stages of program development.

In FFY20, Alluvion Health acquired the mobile dental unit, completed the analysis, including a needs assessment, and began early planning stages. The FQHC plans to utilize the mobile dental unit to serve small, rural communities that do not currently have independent local dental providers. This organization made many connections through its expanded medical services and will utilize the mobile dental unit to begin offering oral health services to underserved populations in their area. Implementation of services was anticipated to begin in May 2021.

To further promote workforce development of providers prepared to address oral health services in vulnerable populations of women and children, the OHP contracted with the University of Washington School of Dentistry (UW-SOD) and Montana State University College of Nursing (MSU-CON). The program's aim with UW-SOD is to improve access to oral health care in Montana through development and delivery of community-based training programs for dental students with a focus on rural and underserved vulnerable pediatric populations. From September 1, 2019 to August 31, 2020, 587 dental procedures were completed by 4th-year dental students, 25 of whom were with pediatric patients aged 0-17.

The program with MSU-CON consisted of two activities to promote oral health workforce development. The first activity was centered around interprofessional collaboration of Bachelor of Science in nursing students and Limited Access Permit (LAP) dental hygienists to provide screenings and preventive oral health services. Due to COVID-19, the team could only visit the Northern Cheyenne Nation head start classrooms once during FFY20. Services completed include: 85 screenings, 49 cleanings, 187 sealants, 83 fluoride varnish applications, four applications of silver diamine fluoride, and 25 referrals to a dental provider.

The second activity was integrating oral health education into a senior nursing course titled, "Population Based Nursing Care in the Community." In the 2019/2020 academic year, 104 senior students in the baccalaureate nursing program read and reflected on *Teeth* by Mary Otto. Additionally, MSU-CON faculty worked on an activity to increase oral health literacy in high-risk patient populations. This activity aimed to test the utility of a pediatric oral health messaging campaign across a statewide network of American Indian clinics. As of September 2020, a video featuring four Blackfeet families undergoing treatment with silver diamine fluoride had been finalized, and pilot tested in the Northern Cheyenne WIC clinics.

Lastly, a collaboration between the OHP and MT Tobacco Use Prevention Program (MTUPP) continued to increase the integration of oral health. During FFY20, OHP staff collaborated with MTUPP staff to produce a poster that was accepted for presentation at the National Oral Health Conference titled: *Associations Between Smoking Status and Edentulism Among Montana Adults: An Analysis of Behavioral Risk Factor Surveillance System Data.* Due to COVID-19, the Conference was canceled. Furthermore, the OHP, in collaboration with MTUPP, developed a presentation entitled *E-Cigarettes: Information for the Dental Professional*. The webinar was co-presented by tobacco prevention specialists as a state-wide webinar on June 19, 2020. Twenty individuals attended the live webinar, and an additional 37 registered with the option to view the webinar recording on-demand. Following the live presentation, 80% of respondents to the follow-up survey indicated they felt confident or very confident in discussing e-cigarette use with patients, and 67% indicated they felt very or extremely knowledgeable of available referral resources for e-cigarette use. These integrations supported the MCH population by creating opportunities for health promotion activities by an array of providers.

The five counties that chose NPM 13a for their MCHBG performance measure were invited to participate in monthly

Montana Oral Health Partners meetings to discuss challenges and successes to incorporating oral health services in the primary care setting. These counties were: Big Horn, Broadwater, Silver Bow, Pondera, and Valley. They are in areas of the state which either have especially limited access to oral health care, and/or have a higher percentage of residents below the federal poverty level. These counties have a combined maternal and child population of 27,349, and MCHBG funding of $73,623 for FFY20.

These CPHDs leveraged partnerships to increase their reach and capacity for oral health education. This included collaboration with WIC, medical clinics, dental clinics, and community organizations that serve families. Another main area of partnership (pre-COVID) was with surveillance screenings at schools, for children in Kindergarten and 3rd Grade. Follow-up was done with the help of area dentists. Activities within health departments included the distribution of oral health packets to all clients, which contain items such as toothbrushes, timers, toothpaste, and educational materials. Several CPHDs also have in-house hygienists who provided preventative oral health services as able, with COVID precautions.

Based on the results of the MCHBG 5-Year Needs Assessment, Montana continued to address NPM 13. However, the emphasis moved to the child population (13b). The OHP will continue to collaborate with MCH staff on current activities. The term of contracts for the oral health partners previously discussed is through August 31, 2022. As data from these partners is received, rapid quality improvement will be utilized to determine best practices for providing oral health services to the maternal and child population. Distribution of *Healthy Montana Mouths* materials will continue with a formal evaluation using an online survey platform planned for spring 2021. Lastly, the OHP and MCH programs will continue to serve as advocates for the maternal and child population in the Montana Oral Health Network.

Women/Maternal Health - Application Year

NPM 1 - Well-Women Visit: Percent of women, ages 18 through 44, with a preventive medical visit in the past year.

Three County Public Health Departments (CPHDs) chose NPM 1 as their priority for FFY21: Silver Bow, Deer Lodge, and Beaverhead. These three CPHDs share boundaries and often collaborate on programs. Silver Bow also often acts as a regional hub for many of the smaller population-size counties in the area. Combined FFY21 MCHBG funding for the three NPM 1 CPHDs is $51,521, of which Silver Bow receives 68%.

The first activity Silver Bow has in their MCHBG operation plan is as follows:

- Develop and sustain community partnerships to address unmet reproductive health care needs and eliminate health disparities among women ages 18-44 from the following communities: sexual and gender minorities, women of color, tribal members, women who have disabilities and/or mental health diagnoses, women who are experiencing homelessness, women who use substances, women of faith communities, and women who have experienced sexual violence.

  The Evaluation Plan and Goal states: By 9/30/2021, increase the number of community partnerships by 20% to coordinate reproductive healthcare and reduce health disparities. Baseline data will be pulled from the CONNECT web-based referral system.

At the beginning of the grant cycle, Silver Bow established their baseline data for community partnerships related to NPM 1 was four: SCL Health Medical Group; Southwest Montana Community Health Center; Butte Family Planning Clinic; and, Amber Edwards, NP. Six months in, they added two new partners: North American Indian Alliance; and Montana Chemical Dependency Center.

Silver Bow's second activity and evaluation plan focuses on public education:

- Create and publicize social marketing public awareness messages that promote preventative health care and preconception health for women of reproductive age. (brochures, blogs, videos, social media, website content, etc.).

  Evaluation Plan and Goal: By 9/30/2021, at least 12 unique social marketing strategies will be created and distributed.

Work on this activity started with recruiting a Health Marketing Specialist position, which was filled by the end of March 2021. In the interim, eight unique Facebook posts were distributed via the Butte Family Planning Clinic's and Butte-Silver Bow HIV Outreach pages. Also, a brochure was created titled "What is a Preventative Visit." A copy is included in the Supporting Documents section of this application.

Deer Lodge CPHD's initial plans include outreach on well-woman visits to 100% of the female high school seniors in the county and providing education at community events and via social media. They started by collaborating with the Anaconda School District school nurse and are planning a presentation on how to access health services following high school. This will be followed by an optional "lunch and learn" session to allow additional time for those interested. As indicated, appointments will be set up at the family planning clinic or referrals made to the attendees' primary care provider.

Deer Lodge also applied for and was awarded a grant which allowed them to start an independent Title X Family Planning Clinic. Telehealth services are available, along with increased appointment times for well-woman visits. The launch date was April 1, 2021. As an indicator of reach, 1,192 females ages 20-44 in the county will have access to these expanded services.

Beaverhead CPHD requested flexibility on their planned NPM 1 activities due to COVID-19. As those extra duties decrease during the second part of FFY21, they expect to begin implementation. These efforts include:

- Develop a process to send reminders/recalls to women, age 18-44, who are in WIC, Family Planning, and imMTrax programs every quarter to remind them about receiving HPV vaccine and cervical cancer screening. The evaluation will be the number of reminders sent each quarter; the number of women who came in for each service by program; the number of women who had either HPV and/or cervical cancer screening done elsewhere; and the number of women who obtained service because of the reminder process.
- Develop a media campaign utilizing print, radio, and social media to educate women in Beaverhead and Madison Counties about the importance of HPV vaccination and cervical cancer screening. The intent is to provide: an article for print every quarter; radio Public Service Announcements two times; and social media once a month. The evaluation will be the number of print articles and content; the number of people reached by media type; the number of radio ads and content; the number of social media posts and content; and number of women coming for public health services stating they saw or heard at least one of these media messages.

The Montana Obstetrics and Maternal Support (MOMS) Program is housed within the MCHC section, and the MOMS Program Specialist reports directly to Montana's Title V MCHBG Director. MOMS is a 5-year funded HRSA Maternal Health Innovation Program. Its logic model's long-term outcome is to increase the percent of women receiving an annual well-woman visit; therefore, a partner program on NPM 1. Currently, MOMS is not directly engaging in activities to address this objective but plans to address the measure in FFY22 through FFY24.

Through their contract with the University of MT-Rural Institute UM-RI), MOMS continues to review and evaluate the 5-year strategic plan for maternal health initiatives. In year 1, the MOMS contractor, Billings Clinic led a statewide needs assessment effort; however, COVID-19 hampered the Clinic's efforts to host regional listen and learn meetings and complete key informant interviews. Launching this summer (2021), UM-RI will be engaged in completing a more intensive needs assessment structured according to the World Health Organization's (WHO) strengthening health systems framework. The UM-RI evaluation staff is coordinating their MOMS needs assessment with their updating of the FHCB's Primary Care Office 2021 Needs Assessment, which assessed access to care and provider distribution.

Additionally, the MOMS needs assessment will support and inform ongoing needs assessment updates for the Title V 2021-2025 Needs Assessment. The result will inform program managers how to better address access issues preventing a higher engagement in the annual well-woman visit. Additionally, MOMS is administering the CDC's Levels of Care Assessment Tool (LOCATe) this summer. The needs assessment and LOCATe will inform activities like expanding telemedicine services across Montana to increase the percent of well-woman visits.

The MOMS program has established the Project Extension for Community Healthcare Outcomes (ECHO) which focuses on maternal health education. ECHO is a model for peer collaboration and medical education that empowers clinicians in remote settings to deliver better care. It promotes knowledge sharing, expands treatment capacity, and offers guidance to otherwise isolated rural providers. There are ECHO clinics for the future planned to focus on the importance of the annual well-woman visit, aimed at improving the frequency and quality of those visits. ECHO clinics are offered twice a month to health care professionals across the state and regularly have an average of 40-50 multidisciplinary attendees. MOMS Project ECHO also offers continuing education credits for nurses and physicians.

MOMS staff is preparing to launch a public education campaign to improve maternal health outcomes. An experienced and qualified professional media firm, Windfall, is on contract with the Family and Community Health Bureau and is working with the MOMS Program Specialist and members of the MOMS Leadership Council to develop a campaign promoting best practices in maternal health. The culturally appropriate campaign will include messaging on the following topics: 1) promoting annual well-woman visits; 2) initiating 1st-trimester prenatal care; 3) maintaining prenatal care; 4) seeking insurance coverage, and 5) receiving postpartum screening and care. The campaign will utilize television, radio, newspapers, billboards, internet digital advertising, and social media.

The campaign plan has been informed by strategic research on effective messaging and message channels to promote behaviors that lead to improvement in the selected maternal health outcomes. Windfall and state staff are consulting with the MOMS Maternal Health Leadership Council on the implementation of the campaign, anticipated to be in the Fall of 2021. MOMS and Title V staff will coordinate with their respective state, county, and community level partners for its distribution.

In FFY 2022, the FCHB will contract with and support these CPHDs which have chosen to focus on NPM 1: Beaverhead, Petroleum, Richland, and Silver Bow. They will implement and evaluate at least two community-level activities during the fiscal year. The FCHB will provide these counties with training, resources, and support on evidence-informed activities, goal setting, and evaluation.

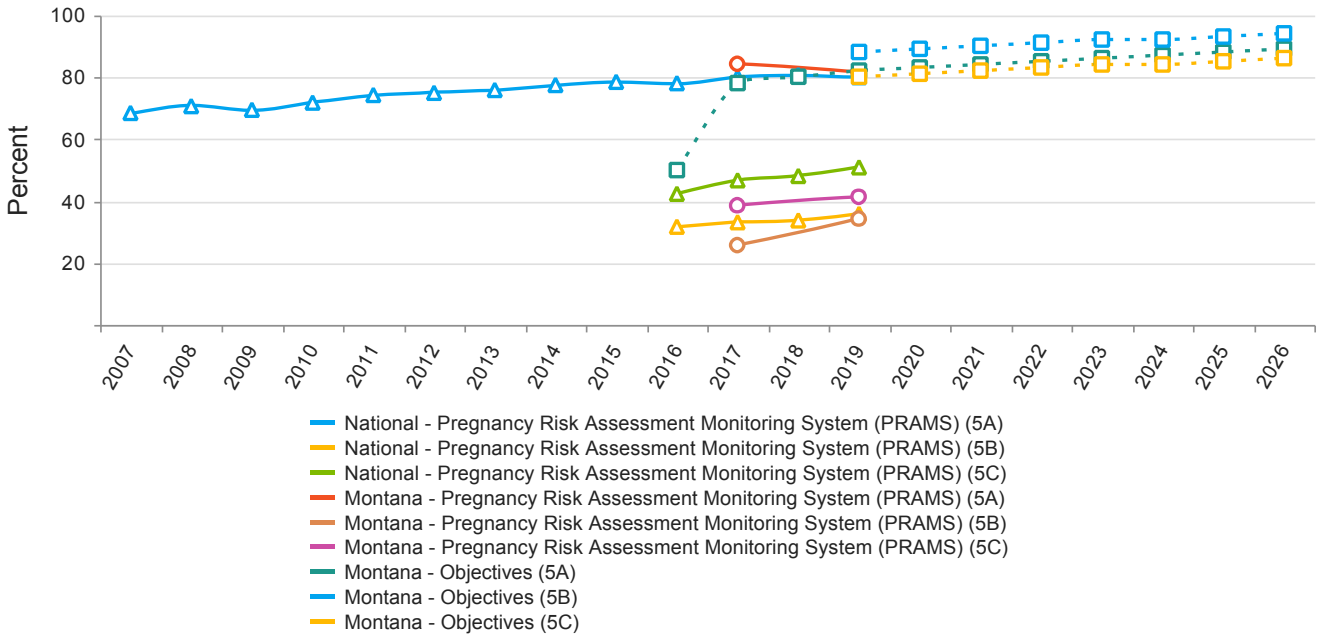
Perinatal/Infant Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 9.1 - Infant mortality rate per 1,000 live births	NVSS-2018	4.8	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2018	1.7	NPM 5
NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2018	95.5	NPM 5

National Performance Measures

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)		
	2019	**2020**
Annual Objective	82	83
Annual Indicator	84.3	81.7
Numerator	9,362	8,632
Denominator	11,104	10,565
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	50	78	80	82	83
Annual Indicator	77.8	77.8	77.8		
Numerator					
Denominator					
Data Source	2015 Health Survey of Montana's Mothers and Babies	2015 Health Survey of Montana's Mothers and Babies	2015 Health Survey of Montana's Mothers and Babies		
Data Source Year	2015	2015	2015		
Provisional or Final ?	Final	Final	Provisional		

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	84.0	85.0	86.0	87.0	88.0	89.0

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)		
	2019	**2020**
Annual Objective	88	89
Annual Indicator	25.9	34.2
Numerator	2,795	3,557
Denominator	10,810	10,387
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			88	89
Annual Indicator	86.5	86.5		
Numerator				
Denominator				
Data Source	2015 Health Survey of Montana's Mothers and Babies	2015 Health Survey of Montana's Mothers and Babies		
Data Source Year	2015	2015		
Provisional or Final ?	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	90.0	91.0	92.0	92.0	93.0	94.0

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)		
	2019	**2020**
Annual Objective	80	81
Annual Indicator	38.5	41.6
Numerator	4,169	4,335
Denominator	10,815	10,409
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			80	81
Annual Indicator	78.6	78.6		
Numerator				
Denominator				
Data Source	2015 Health Survey of Montana's Mothers and Babies	2015 Health Survey of Montana's Mothers and Babies		
Data Source Year	2015	2015		
Provisional or Final ?	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	82.0	83.0	84.0	84.0	85.0	86.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - Percent of activity goals to decrease infant deaths due to unsafe sleep conditions which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			80	83
Annual Indicator			100	91.7
Numerator			15	11
Denominator			15	12
Data Source			FCHB	FCHB
Data Source Year			FFY 2019	FFY 2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	92.0	92.0	93.0	93.0	94.0	94.0

State Action Plan Table

State Action Plan Table (Montana) - Perinatal/Infant Health - Entry 1	
Priority Need	
Infant Safe Sleep	
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	
Increase the number of infants who are placed to sleep on their backs to 88% by 2023.	
Increase the number of infants placed to sleep on a separate approved sleep surface to 92% by 2023.	
Strategies	
The FICMMR Coordinator continues to lead CDR quality improvement initiatives, which focus on CDR sections of critical importance for local teams to complete accurately. One of these sections is sleeping or sleep environment.	
Support County Public Health Departments who choose NPM 5 as their priority need, providing technical assistance and resources.	
ESMs	**Status**
ESM 5.1 - Percent of activity goals to decrease infant deaths due to unsafe sleep conditions which are met by county public health departments using MCHBG funding for the work.	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	

NPM 5 - Safe Sleep: 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.

The ability of County Public Health Departments (CPHDs) to perform in-person safe sleep education was severely curtailed in early 2020 due to the COVID-19 pandemic. The CHPHs working on infant safe sleep activities had to re-prioritize quickly to learn about the COVID-19 virus, implement safeguards, apply for PPE equipment and other resources, educate community members, and spend time on contact tracing. COVID-19 response efforts significantly changed standard service delivery and operations as CPHDs quickly switched to managing the influx of work, which included helping to support families in quarantine.

Every CPHD which participates in the MCHBG implements an injury-prevention activity in addition to their selected national or state performance measure activities. The injury prevention activity is required of their CPHD *Fetal, Infant, Child and Maternal Mortality Review* (FICMMR) team. In FFY20, four CPHD FICMMR teams chose infant safe sleep injury-prevention activities: Glacier, Missoula, Sanders, and Yellowstone. Glacier and Yellowstone also selected NPM 5 for their MCHBG specific activities. Other CPHDs choosing NPM 5 were Cascade, Gallatin, Mineral, and Roosevelt. Specific details of their FFY 2020 activities are below.

In January 2020, the Glacier County FICMMR leader gave a presentation to key staff members at the Blackfeet Indian Health Service Clinic (IHS) on the National Safe Sleep Hospital Certification Program. The national certification program offers three levels of varying responsibilities that model and teach infant safe sleep best practices. The IHS Director of Nursing, the supervisor, a nurse practitioner from the IHS Women's Clinic, and a charge nurse for inpatient nursing all attended the presentation and immediately commented on how well it fit with their Baby Friendly status affirming the need to put this in place. COVID-19 hit the following month, and the CPHD focused all resources on the pandemic. The CPHD provided IHS with four Pack N' Play cribs to distribute as needed and provided the direct contact information so IHS staffers could more quickly place their own orders directly through the partnership with Healthy Mothers Healthy Babies.

Missoula County FICMMR's partnership with St. Patrick's Hospital and Community Medical Center continued as they worked to provide infant safe sleep education and consistent community-wide messaging utilizing the Cribs for Kids Safe Sleep Ambassador Training Curriculum. Missoula FICMMR identified a wide range of target audiences, including grandparents, youth babysitters, agencies working with prenatal and infant populations by offering prenatal classes, YMCA, a Foster Parent Support Group, Early Head Start, Missoula Aging Services, Child & Family Services, Mountain Home, Partnership Health Center (Federally Qualified Health Center), medical provider offices, and the two hospitals labor and delivery departments. These organizations were approached and encouraged to participate in the online safe sleep training/certification program. Many of these organizations were temporarily closed and/or were limiting their services due to COVID-19. The Missoula FICMMR team received a firm commitment from two organizations that requested the training materials to review and then possibly participate at a future date. DPHHS, Missoula Child and Family Services Office, Early Head Start, and two others requested the materials and committed to the training at a later time. See link for the training: https://cribsforkids.org/safe-sleep-ambassador.

Due to COVID-19, Missoula FICMMR changed their activity to an inward emphasis, and 21 CPHD staff completed safe sleep training. Seven WIC staff attended the virtual training, and the feedback was positive, and participants felt it was beneficial. Fourteen Missoula County Home Visiting Program nurses also completed the training. Additionally, Missoula FICMMR team members from partner organizations were encouraged to take the online training and likewise encourage it for agency colleagues. Unfortunately, COVID-19 impact was felt, as the FICMMR Team Leader was involved with addressing the pandemic; therefore, follow-through was lost. The team leader is back and will persist with her team on this endeavor during FFY21.

Sanders FICMMR presented a display at the annual women's health fair to grab attendees' attention and increase dialogue opportunities. Their infant sleep display featured precisely what one does not want to see: an infant/doll sleeping face down. However, the doll wore an eye-catching tee-shirt, stating, "*If you can read this, turn me over.*" For increased exposure, they also placed the sleep display next to the WIC office. All WIC and CPHD staffers were informed on safe sleep best practices and the purpose of the display design, ensuring any staffer could engage with the public regardless of who was in the office at any point in time. In addition, infant safe sleep education was provided to 33 families and 14 Pack N' Play certified infant cribs were distributed to families in need. Sanders FICMMR continued to partner with and supply infant safe sleep materials to local provider offices and the nearby hospital.

In the fall of 2019, the Yellowstone FICMMR team generated a list of possible partner organizations that might be interested in attending safe sleep training in 2020. The agency list included first-time partner organizations, including a women's shelter, a case management team from a hospital, YMCA Child Care, and the AWARE and Young Families Early Head Start. The team had scheduled several 2020 safe sleep trainings and was engaged in ongoing outreach to additional community

partners. COVID-19 curtailed their plans for in-person trainings, which caused them to explore developing their own professional safe sleep training video and offering the training via Zoom technology. Unfortunately, the agencies were unable to commit the time.

The FICMMR Coordinator ensured that the FICMMR teams were apprised of safe sleep educational resources through email. During this grant cycle, nine safe sleep educational resources were sent to FICMMR teams. The materials included a safe sleep digital toolkit, social media block party on safe sleep, a safe sleep webinar from the National Center for Fatality Review and Prevention (CFRP), SIDS Awareness Month activities with suggestions on how to engage parents and caregivers, safe sleep live presentation on Facebook by CDC experts, safe sleep focus group opportunities and, the articles 'Ideas that Resist Inequities as American Indians and Black Babies Die from Sleep-Related Deaths at More than Twice the Rate of White Babies.' Additionally, emails were sent that provided a safe sleep quiz as a tool to interact with parents and caregivers, along with an educational article quoting leaders from the National CFRP.

For FFY 2020, NPM 5 was the focus of Cascade, Gallatin, Glacier, Mineral, Roosevelt, and Yellowstone, who received a total of $312,170 in MCHBG funding. These six CPHDs did an admirable job of revising activities as needed to accommodate the realities of COVID-19 and of meeting their goals. A common role for each of them was being a convening and supporting partner for other programs and agencies in their departments and communities. For example, staff training and family outreach educational materials were presented to Child and Family Services Division staff for Foster Care and Kinship providers, close collaboration with WIC and Home Visiting, community United Way, Blackfeet Indian Health Service, local primary care clinics, and community college and high school health classes.

Roosevelt CPHD aired an infant safe sleep messaging through video in their waiting room, where patients while completing the process for immunizations for their children and/or self, could see the message. Roosevelt estimated that their reach was at least 12 families a day during the week. The Yellowstone CPHD partnered with their WIC clinic in promoting breastfeeding as a preventive intervention for supporting infant safe sleep.

The FCHB partnership and Title V financial support of Healthy *Mothers Healthy Babies* was an aid to CPHDs and Tribal Health Departments in obtaining portable, certified, Pack N' Play cribs for families in need. From October 1, 2019 through September 30, 2020, a total of 266 cribs were ordered and distributed. When the pandemic's impact began a steep climb in Montana, the orders dropped to a low of 34 in a 3-month period, down from an average of 90 the previous two quarters. The number increased to 52 cribs in the final quarter, which ended September 30, 2020. At that point in time, the Roosevelt County Health Department (located within the Fort Peck American Indian Reservation) and the Crow/Northern Cheyenne Hospital continued to order the highest number of cribs.

As a result of the 2020 5-Year Statewide Needs Assessment, the FCHB continued with the choice of NPM 5 for FFYs 2021 – 2025, and CPHDs were afforded the opportunity to select NPM 5 as their performance measure going forward.

Perinatal/Infant Health - Application Year

NPM 5 - Safe Sleep: 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.

Fetal, Infant, Child & Maternal Mortality Review Teams: Infant Safe Sleep Activities

Healthy Mothers Healthy Babies-Montana (HMHB-MT) is a long-time partner of the Montana Department of Public Health & Human Services (DPHHS), Maternal Child Health, and WIC programs. Their mission is to improve the health, safety, and well-being of Montana families by creating strong beginnings and supporting mothers and babies up to three years of age. HMHB-MT continues to meet a critical need in the state by supplying complimentary, certified cribs to families in need. The cribs are portable, *Pack N' Plays* that families receive along with an educational packet of safe sleep best practices and other supporting materials.

The following nine agencies requested 21 cribs to distribute to families in their communities from October 1, 2020 through December 31, 2020, down from 31 cribs the previous quarter: The County Public Health Departments (CPHDs) from Dawson, Gallatin, Missoula, Roosevelt, Yellowstone; two community organizations working with the DPHHS Child and Family Services Division and the Family & Community Health Bureau (FCHB) Healthy Montana Families; and two hospitals. Seven cribs were requested from the Crow Northern Cheyenne Hospital, Fort Peck Reservation and Confederated Salish and Kootenai Tribe for their American Indian families, down from 21 cribs the previous quarter. Preliminary figures show approximately 31 cribs were requested from January 2021 through March 30, 2021, roughly one-third from American Indian agencies.

Several CPHDs chose safe sleep education as their FICMMR evidence-based or best practice, injury-prevention initiative. Highlight examples of FFY 21 year-to-date activities include:

- Lake County Public Health Department (MCH population = 11,758) asked their volunteer community FICMMR team members for additional help in raising safe sleep education levels in the county. The team was requested to recruit individuals to become Safe Sleep Ambassadors. This is not a standard task of team members whose primary responsibility is meeting to comprehensively review fetal, infant, child, and maternal deaths; and provide prevention recommendations or initiatives on deaths deemed preventable. The educational vehicle team leadership chose for their new goal is the Safe Sleep Ambassador online training program from the National Cribs for Kids organization. To increase credibility, team members were asked to first take the training themselves, then approach their agency leadership to get buy-in for all agency employees to enroll in the training.

  The initial goal was 20 people certified, as evidenced by submitting Safe Sleep Ambassador certificates of completion. Initially, 21 people 'committed' to completing the course, and six did so early. By early Spring 2021, they surpassed their goal confirming 21 people from a variety of agencies: both local hospitals, healthcare provider offices, Child Protective Services, Tribal Child Protective Services, Early Childhood Services, and other CPHD staff. St. Luke's Hospital went further, and set their own goal for 20 hospital staff members to complete the online safe sleep education.

- The Sanders CPHD (MCH population = 3,508) established a unique partnership with the local Elks Lodge, who had received a literacy grant. The Elks Lodge agreed to apply some of the funds towards a new collaborative. Together along with WIC, they hosted an educational baby shower for local women who were breastfeeding, pregnant, or postpartum. Twenty-nine women participated at the shower, an exceptional showing in this remote, frontier county. While only four women agreed to take a safe sleep pre-test at the event, the pre-test information results (anonymously, of course) helped kick off the safe sleep presentation to all attendees. Incorporated into the presentation Q & A, several women commented on the unusual Pack N' Play crib display that was set up with a doll lying face down wearing a t-shirt that said, "If you can read this, turn me over," this helped engage additional audience members in the discussion. Also, two Pack N' Plays were raffled off at the shower.

  As a separate activity, Sanders CPHD also administered pre and post safe sleep tests to six families identified as at-risk for co-sleeping with their infants. All six women took the pre-test, with most of the six stating they co-slept with their infants. The health department provided additional safe sleep education along with portable, complimentary Pack N' Play cribs. A month later, the six women came in for their WIC appointment and took the post-test. All infants were reported sleeping in the Pack N' Plays and no longer sleeping in a bed with their parents.

- Yellowstone County has the highest population in the state (MCH population = 66,405). The CPHD, known as RiverStone Health, had plans to connect with multiple organizations that have significant exposure to infants (sleep on premises, under care of) to provide safe sleep training to the agency's clients and customers. However, COVID-

19 has halted that plan as many of these organizations temporarily shut down during the pandemic or didn't want outside presenters coming into their building. In talking with this county, their confidence is buoyed due to vaccine rollouts. They intend to re-approach these agencies to determine if they will be open to online or in-person (if conducted safely) safe sleep training for their clients. A few of these agencies are Early Head Start, Head Start, YMCA Child Care, Young Families, AWARE, and more.

Additionally, RiverStone Health became a part of a newly formed alliance organized as a pilot to better serve and treat pregnant mothers with Substance Use Disorders (SUD). Once this initiative is launched Riverstone Health will provide maternal child health education, including safe sleep best practices. Healthy Spark (Support-Prevention-Awareness-Resilience-Knowledge) brought together SCL- St. Vincent Healthcare, Rimrock Foundation, and RiverStone Health to develop a supportive pilot program to:

- increase healthy deliveries
- promote ongoing stability
- reduce harm to women and their babies

RiverStone Health will manage health care surrounding pregnancy outside of the clinical setting and Maternal Child Health (MCH) supportive resources to reduce harm from social and behavioral determinants of health. A full spectrum of MCH preventative services will include:

- safe sleep best practices
- Pack N' Play cribs
- depression screening
- Purple Crying shaken baby prevention
- smoking cessation
- infant car seats and other resource referrals provided

- Below are FFY21 FICMMR safe sleep efforts to-date, from Mineral (MCH population = 1,337) and Lincoln (MCH population = 5,867) CPHDs:
  - Provided young mother a Pack N' Play who was living in a motel room
  - NICHQ photos and education blurbs were shared through the CPHD's Facebook, and posts from Healthy Mother's Healthy Babies Facebook page
  - During cold months, showed families how to bundle babies for night sleep to maintain temperature
  - Provided safe sleep literature to all four medical clinics in the county (Lincoln)

While Valley CPHD (MCH population = 2,814) does not have safe sleep as their official designated injury-prevention initiative, they provided best-practice safe sleep information as part of other efforts:

- During the COVID-19 pandemic, while direct interactions were down with soon-to-be moms, they mailed safe sleep literature to 33 families with newborns.
- Staff also worked with six daycare providers providing safe sleep education using Healthy Mothers Healthy Babies – MT materials

<u>County Public Health Department NPM 5 Plans and Activities</u>

Six CPHDs are working on NPM 5 activities for FFY 21: Gallatin, Lake, Lewis & Clark, Ravalli, Roosevelt, and Yellowstone. While Roosevelt and Yellowstone chose to redirect their MCHBG funding towards COVID-19 response, they continue focusing on NPM 5 as time and resources allow.

Educational outreach is the overriding theme for most CPHD planned activities, with many different avenues of approach:

- Collaboration with other local programs and agencies includes:
  - Child Protective Services – providing training to staff;
  - Home Visiting – education to all enrolled families, and periodic tracking of results;
  - Local hospitals and WIC – provide Pack N' Plays to any families in need, along with safe sleep materials and follow-up assessments;
  - Materials in welcome packets to all postpartum mothers, then follow-up calls to see if there is a need for more adequate equipment or supplies, with assessments offered for anyone interested;
  - Presentations to High School and Community College students in Life Skills or science classes;
  - Focus groups led by a Native American nurse on local reservation, to begin a dialog on the culturally predominate practice of bed-sharing;
  - Unsafe sleep risk factors education to all Family Health Service clients of the department, with evidence-based materials provided, then follow-up assessments; and,

- Support for exclusive breastfeeding (which is a preventive measure) by providing free breast pumps, both reusable and single user, to women unable to have access through other means.

The most recent report from Gallatin CPHD (MCH population = 46,760) captures the essence of how all the CPHDs are making a slow transition from activities completely dominated by COVID-19 restrictions towards a hybrid with regular procedures:

> *"As we have started to transition to more in-home visits and being able to see the actual rooms and sleep set ups that families have, it has been easier to facilitate discussions with families on safe sleep. Many families seem to answer "yes" they are utilizing safe sleep models, however when doing the in-home assessments we are able to see that more education is needed on what safe sleep means and are able to help families understand how to fully implement safe sleep practices. Additionally, we have been encouraging better tracking from the home visitors. As always we continue to provide safe sleep assessments and education, however some of those conversations and education pieces seem to have more effect in an in-person home setting.*
>
> *We continue to focus on women's maternal health and perinatal/infant health through our home visiting program and our prenatal and parenting classes that are available to all community members. These classes include Breastfeeding Basics, Labor and Delivery, Enjoying Your Newborn, and a Working and Breastfeeding class. We have been able to adapt our classes to virtual learning during this pandemic. The hope is to be able to transition back to in-person classes in the future.*
>
> *We continue our collaboration with Bozeman Health Hospital in an effort to get all appropriate home visiting referrals at the birth of the child. Due to the hospital restrictions we are not able to go in person to get referrals and meet with families of newborns at the hospital. Our home visiting program has worked hard to quickly adjust our home visiting model to help keep everyone safe but also provide much needed support and resources to families during this COVID crisis.*
>
> *We continue to provide support for families in a variety of ways to maximize our effectiveness in these unprecedented times. Phone visits, texting, virtual and in-home visits are all ways in which we can connect with families and still maintain safety precautions. Case management for families navigating limited resources has also been at an all-time high. As the Gallatin City-County Health Department moves in toward new systems for contact tracing and vaccine distribution, home visiting staff is slowly pulling back on COVID response activities and we starting to be able to transition more back into our designated roles."*

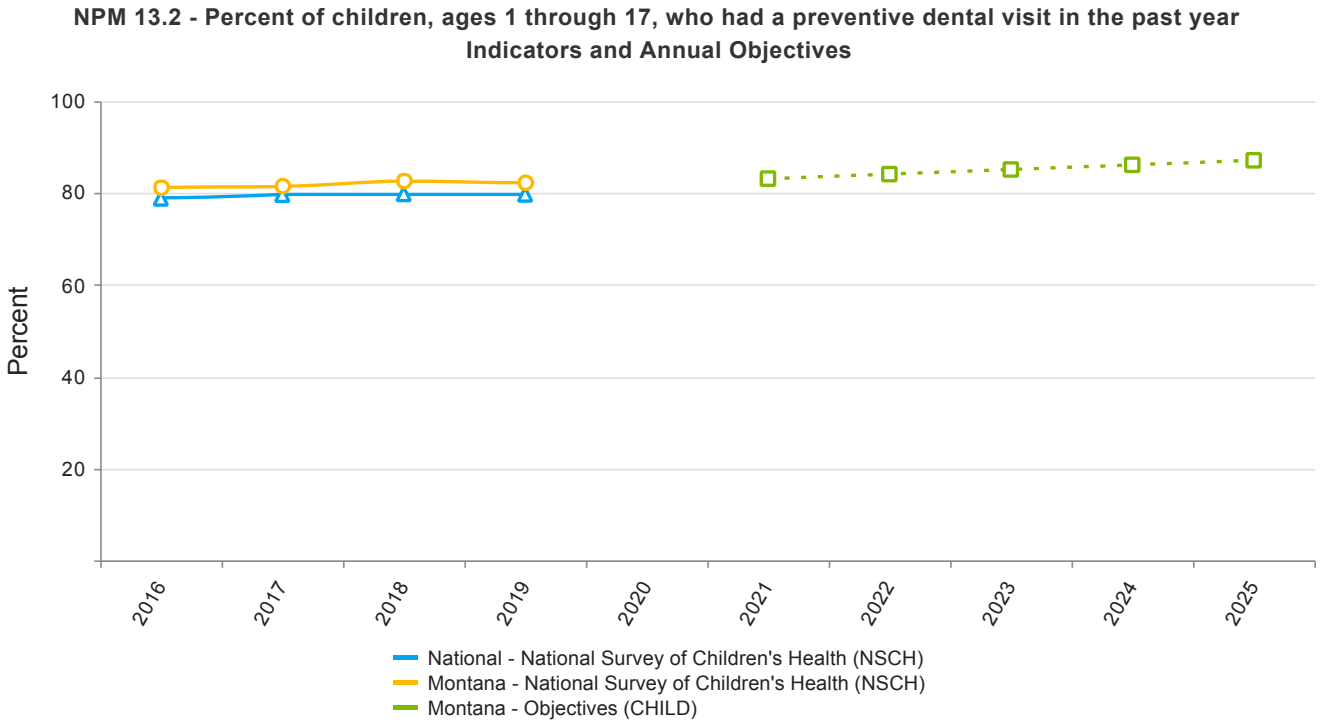
In FFY 2022, the FCHB will contract with and support these CPHDs which have chosen to focus on NPM 5: Flathead, Gallatin, Glacier, Lake, Lewis & Clark, Ravalli, Roosevelt, and Yellowstone. These counties will implement and evaluate at least two community-level activities during the fiscal year. The FCHB will provide these counties with training, resources, and support on evidence-informed activities, goal setting and evaluation.

Child Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2018_2019	9.9 %	NPM 13.2
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2019	22.1	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	50.2	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	21.4	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	27.2	NPM 7.1
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	14.4 %	NPM 13.2
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.5 %	NPM 13.2

National Performance Measures



NPM 13.2 - Child Health

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH)			
	2016	**2019**	**2020**
Annual Objective			
Annual Indicator		82.6	82.1
Numerator		179,033	177,165
Denominator		216,777	215,773
Data Source		NSCH	NSCH
Data Source Year		2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	83.0	84.0	85.0	86.0	87.0	88.0

Evidence-Based or –Informed Strategy Measures

ESM 13.2.1 - Percent of activity goals to increase preventive dental visits for children which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

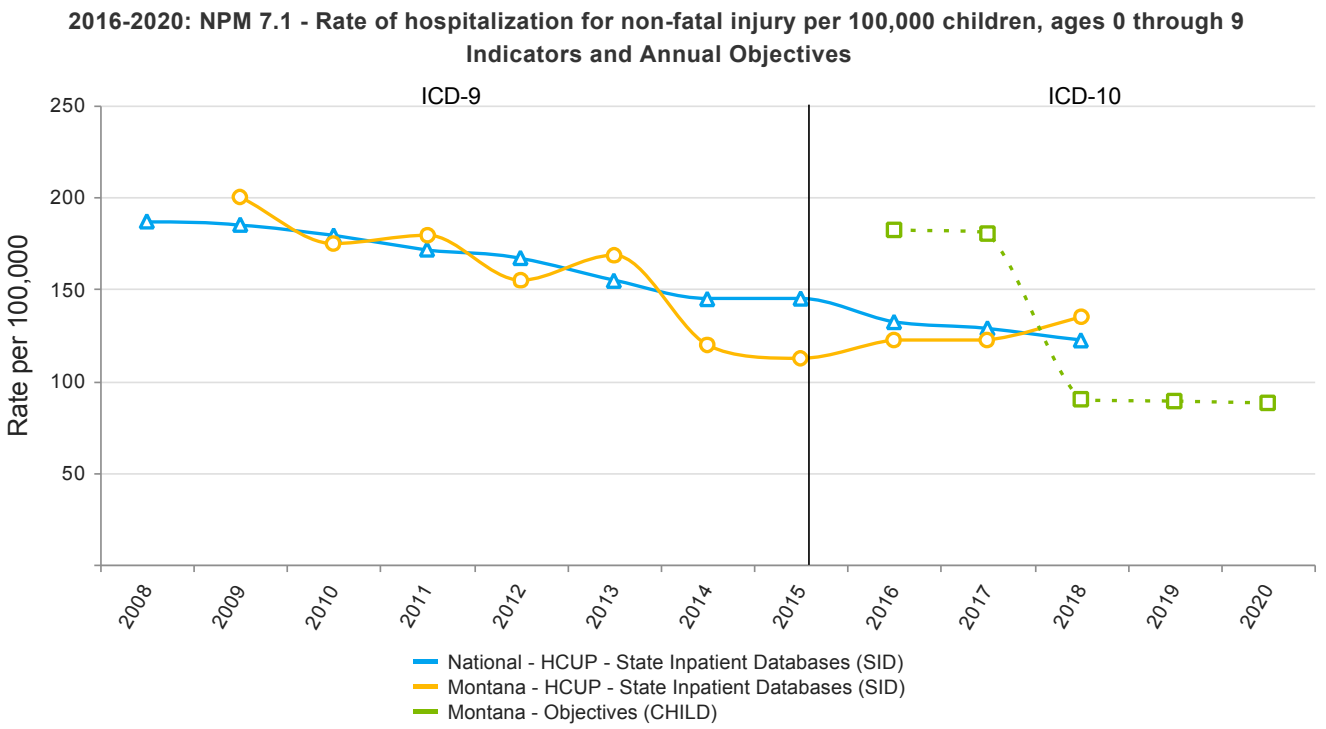
Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	82.0	83.0	84.0	85.0	86.0

State Action Plan Table

State Action Plan Table (Montana) - Child Health - Entry 1	
Priority Need	
Children's Oral Health	
NPM	
NPM 13.2 - Percent of children, ages 1 through 17, who had a preventive dental visit in the past year	
Objectives	
Increase the percent of children, ages 1 though 17, who receive annual preventive care dental visits.	
Strategies	
Support County Public Health Departments who choose NPM 13.2 as their priority need, providing technical assistance and resources.	
Additional Oral Health questions are being to added PRAMS, thanks to MCHBG funding.	
ESMs	Status
ESM 13.2.1 - Percent of activity goals to increase preventive dental visits for children which are met by county public health departments using MCHBG funding for the work.	Active
NOMs	
NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	

2016-2020: National Performance Measures



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	182	180	90	89	88
Annual Indicator	88.5	111.8	122.1	122.2	134.9
Numerator	111	106	155	155	170
Denominator	125,378	94,803	126,908	126,831	126,062
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective	182	180	90	89	88
Annual Indicator	101	91.8			
Numerator	127	116			
Denominator	125,724	126,404			
Data Source	SID	SID			
Data Source Year	2014	2015			
Provisional or Final ?	Final	Final			

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 7.1.3 - Percent of activity goals to decrease preventable child injury which are met by county public health departments using MCHBG funding for the work.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			80	83
Annual Indicator			100	71.4
Numerator			14	10
Denominator			14	14
Data Source			FCHB	FCHB
Data Source Year			FFY 2019	FFY 2020
Provisional or Final ?			Final	Final

NPM 7 – Child Injuries: Rate of hospitalization for non-fatal injury per 100,000 children ages 0 through 9, and adolescents 10 through 19.

Of the 52 County Public Health Departments (CPHDs) participating in the MCHBG in FFY20, 46 had limited or severely limited staffing. The COVID-19 pandemic sent most into emergency activation mode. The CPHDs shifted their activities to prepare, safeguard, and educate target populations and county residents. Many designated injury-prevention initiatives were put on hold. Highlights are provided on the efforts they were able to complete. However, two public health nurses related a positive effect of the virus. They stated that some community members learned about the public health department for the first time and developed an appreciation for their work.

FICMMR Teams Injury-Prevention Activities:

Thirty-two FICMMR teams are managed by CPHDs, and the remaining 24 counties have Memorandum of Understanding agreements in place, which allows them to utilize a neighboring county FICMMR Team if needed to review a death. Three of the seven American Indian (AI) reservations have members who participate on the local mortality review teams. A fourth reservation's team is led by a Native American nurse for Roosevelt County.

County FICMMR activities are included in a section of their MCHBG contracts, and each is required to implement an evidence-based or best practice, injury-prevention activity in addition to their MCHBG national or state performance measure activities. The counties that choose NPM 7 for their FFY20 performance measure carried out at least three separate but often interrelated activities.

Six CPHDs had intended for their staff to attend the June 2020 4-day National Child Car Seat Safety Training Certification to address a severe shortage of technicians in their region. However, the training was postponed to the fall of 2020 due to COVID-19, then canceled again. Eventually, all of the remaining and rescheduled training sessions were canceled except one. The nature of this training requires proximity with instructors to learn the correct installation of infant/child car seats. Five of the six CPHDs recommitted to this endeavor for the next grant year.

Eight other CPHDs moved forward in implementing child car seat safety education as their designated injury-prevention initiative for FFY 2020. A few other counties provided this service on an ongoing basis, although it is not their designated injury-prevention activity. Total child car seat data is noted below:

- 233 infant/child car seats inspected
- 124 seats were incorrectly installed
- 187 total seats were donated to parents in need
- 45 additional seats were donated on/near the Crow Reservation, Big Horn County

The number of incorrectly installed car seats dropped significantly in FFY20, with just under 50% incorrect compared to a 75-80% misuse range in the previous year.

Sixteen FICMMR teams planned to implement evidence-based suicide prevention initiatives in the 2019-2020 grant year. A few began early and were able to serve youth until COVID-19 hit critical mass in Montana. Those planning for the Spring 2020 launch could not implement, as schools were overwhelmed with transitioning to virtual classrooms in the home, and some schools closed early for the year.

The Blaine County FICMMR leader became certified in October 2019 on Question, Persuade, Refer (QPR) and quickly provided training the following two months. The leader delivered QPR education to:

- 28 staff at the Sweet Medical Center in November 2019

- 9 Turner School staff and school board members in December 2019
- 17 students in grades 7 through 12, and motivated two school staff members to also become QPR certified in February 2020

Also trained in Signs of Suicide (SOS), the FICMMR leader teamed up with a school counselor and delivered SOS to a total of 192 middle and high school students

The Sweet Grass County FICMMR team leader is trained in SOS. The leader partnered with a high school teacher to deliver this curriculum to 22 sophomores in late Winter 2020. They administered a pre and post-education survey to measure student's confidence in their ability to implement the *Acknowledge, Care, Tell (ACT)* skill set; if needed to assist a peer they thought was suicidal. The average pre-survey score was 70%, average post-education was 85%.

Teton County FICMMR leader secured a SAMHSA grant to address mental health and substance use disorder. She also secured a grant through the state to implement the PAX Good Behavior Game, an evidence-based suicide prevention program implemented in school classrooms. The Teton FICMMR team and CPHD collaborated and achieved the following:

- 318 total elementary students from 4 schools received the PAX curriculum
- Four teachers took the advanced PAX training to mentor teachers as they learn PAX
- A second, advanced PAX training was offered, and 25 teachers/school staff participated
- A total of 90 9th graders participated in Youth Aware of Mental Health (YAM), an evidence-based, interactive classroom program where students learn and discuss mental health
- Teton County partnered with the Montana State University Extension Program, and extension agents implemented the YAM program in 4 schools

Teton County also initiated the *HANDLE WITH CARE* program, which is a communication system to provide trauma-informed response and extra support as needed to students who have experienced a traumatic event. In response to social distancing and increased social isolation for youth and families due to Covid-19, Teton also:

- Developed and distributed a list of local mental health resources for families
- Posted the list on social media; and shared with county partner agencies, service providers, churches, and sent home to all students' households
- Produced a video series interviewing mental health professionals about the struggles people may be experiencing during the pandemic and strategies

Roosevelt CPHD continued providing PAX leadership and support to schools in their county, which has a geographic area that includes the Fort Peck Indian Reservation. Seven schools opted-in to learn and begin implementing the PAX Good Behavior Game. PAX is a 3 to 5-year evidence-based program that aims to increase and improve self-regulation and resiliency and reduce suicides and suicide attempts. Roosevelt's progress in the first two quarters of FFY 2020 before COVID-19 curtailed efforts included:

1. Classroom visits: brought in PAX trainers to visit classrooms, observe, and support with additional feedback and training;
2. PAX Partner Training: trained 12 teachers who excelled with PAX in their classrooms to serve as mentors for other teachers in their school
3. Next Steps Training: 35 teachers participated in a one-day training that delved deeper into helping children with more severe trauma and behavioral difficulties.

Hill CPHD partnered with a Montana State University extension agent who facilitated the Youth Aware Mental Health (YAM) program for local freshmen high school students. YAM provides basic information on mental health, depression, anxiety, and

protective factors; while also focusing on coping skills, problem-solving, and positive peer relations. Hill presented YAM to 77 freshmen students before COVID-19 halted their plans.

Three other FICMMR teams provided QPR education to their communities, and their outreach numbers as of March 2020 were:

Community	Attendees
Park County: general community members	15 attendees
Park County: LiveWell49 Mental Health Coalition	8 committee members
Park County Ministerial Association and Rural school staff members	9 attendees 25 attendees
Richland County Health staff and the general public. Also provided Adult Mental Health First Aid to veterans and Youth Mental Health First Aid	9 staff; 11 general public 8 veterans; 6 youth
Wibaux County High School	All 9 graduating seniors

During the Fall of 2019, Lake CPHD provided the Signs of Suicide (SOS) education to high school and middle school students in their county, the majority being American Indian students. Lake CPHD is on the Flathead Indian Reservation, home to the Confederated Salish and Kootenai Tribes. As part of SOS, the Brief Screen for Adolescent Depression (BSAD) depression screening tool was administered to the students. A total of 401 high school and 372 middle school students took the BSAD, with 73 and 83 students respectively identified needing a more comprehensive assessment. The number of at-risk youth out of a total of 773 students is 20% of the student body. This is two times higher than the national average of students initially flagged by the BSAD Assessment when SOS is implemented in schools outside reservations. Therefore, the schools and CPHD focused their efforts for the remainder of the school year on this need.

The Lewis & Clark County FICMMR team provided SOS education to youth throughout the county in addition to four other evidence-based interventions: QPR; YAM; Youth Mental Health First Aid (YMHFA); and, Adverse Childhoods Experiences (ACES). The CPHD also focused on rural districts in the county, alternative and private schools, and Shodair Children's Hospital, a specialized psychiatric care facility. Total outreach numbers for FFY20:

Location/Audience	Curriculum	# Trained
Shodair Children's Hospital – Staff	YMHFA	19
Career Training Institute-Youth Build Program – Staff	YMHFA	7
Lincoln High School – Employees	YMHFA	20
Cottonwood Alternative Learning Center (K-12) – Staff	ACES	9
MT Parent Partner Program – Parents	Adult MH First Aid	10
Capital High School – Sophomores	QPR	136
Capital High School – Juniors	SOS	360
Helena High School – Freshmen	YAM	296
Helena High School – Sophomores	SOS	200
Helena High School – Juniors	SOS	351
General public, including parents	QPR	37
Crisis Line counselor volunteers	QPR	11

The CPHDs which chose to focus on NPM 7 for FFY20 were: Beaverhead, Custer, Deer Lodge, Fallon, Lake, and Ravalli. Their combined maternal and child population is 37,882, and MCHBG funding for FFY20 was $101,421. As possible in FFY 2020, they addressed a wide range of injury-prevention categories, each based on priority needs in their county. These activities included: Firearm Safety; CPR Training; Baby-Sitter Class; Car seat Safety; Suicide Prevention; Social Media Campaign on a variety of topics; and Brain-Injury Prevention, specifically through helmet use education and distribution.

Examples of completed CPHD NPM 7 activities are as follows:

- Beaverhead collaborated with the Sheriff's office, and deputies gave firearm safety presentations at six rural schools to grades K-8, reaching approximately 75 children. In a separate activity CPHD staff gave Hands-Only CPR training to 13 middle-school aged children.
- Custer worked with licensed daycare providers to distribute poison control cards, stickers, and safe home environment brochures to 66 families. They also taught poison control lessons to four different grade-school levels, reaching 132 children – who were also given stickers and pencils with poison control messaging.
- Deer Lodge held a successful car seat installation day by partnering with technicians from neighboring communities. Eleven installs were completed. They had intended to send a staff person to a training which was cancelled due to COVID-19.
- Fallon was able to provide a distracted driving course in collaboration with the local school and law enforcement. In a second activity, they moved from a car seat safety day to individual appointments – utilizing social distancing and proper PPE.
- Lake checked 27 car seats and distributed another 11 through their fitting station, and made follow-up calls to 26 participants. They also made 39 separate Facebook posts with injury-prevention messages.
- Ravalli implemented the Skull Savers program, providing 50 sports helmets to area children who were fitted by trained staff.

The FICMMR injury-prevention activity requirement continued in FFY 2021 for all CPHDs participating in the MCHBG. Due to this ongoing focus and Needs Assessment results, Montana moved to NPM 13b for the Children's Health Domain performance measure for FFYs 2021-2025.

Child Health - Application Year

NPM 13 - Oral Health: a) Percent of women who had dental visit during pregnancy; and **b) Percent of infants and children, ages 1 – 17 years, who had a preventive dental visit in the last year.**

Barriers due to COVID-19

Although most oral health activities resumed by Fall 2020, COVID-19 continues to significantly impact partners. The University of Washington School of Dentistry (UWSOD) student rotations started up again in Montana in July 2020, but are now navigating new challenges presented by COVID-19 precautions. These challenges include COVID-19 testing prior to rotations, potential exposures, and providing students with appropriate personal protective equipment (PPE).

Montana State University College of Nursing (MSUCON) was able to return to Head Start classrooms on the Northern Cheyenne Reservation in November 2020. This was their first visit in approximately ten months. Oral health activities in county health department "hub" locations have resumed, but are significantly reduced due to limited staff time from responding to COVID-19 cases and providing vaccinations.

The mobile dental unit purchased by Alluvion Health for a teledentistry pilot project was repurposed for COVID-19 testing during the second wave cases, causing delays in program development. Lastly, with many people losing insurance, or simply not being able to get to a dentist during COVID-19, the Caring Foundation of Montana (CFMT) has seen an incredible increase in demand for services.

Oral Health Literacy

Healthy Montana Mouths: During FFY 2021, MCHBG and Oral Health Program (OHP) staff are continuing to collaborate on activities supporting NPM 13b. The programs are promoting the oral health literacy campaign, *Healthy Montana Mouths*. These materials are designed for healthcare providers caring for infants, young children, and pregnant women. They include a 13-page flip chart containing information on oral health from preconception to pregnancy and through the child's first dental visit. The book is available upon request, free of charge.
Additionally, a toolkit of resources is available on the OHP website at https://dphhs.mt.gov/ecfsd/oralhealth. The toolkit includes the American Academy of Pediatrics (AAP) Oral Health Risk Assessment, an example child dental referral, oral health guidance during the well-child visits, and an oral health goal setting form.

Healthy Montana Mouths is promoted by county health departments serving as oral health "hubs" and those that selected NPM 13b. The materials are also disseminated through: WIC, the MT Hospital Association, MT Chapter of the American Academy of Pediatrics, and MT Medical Association newsletters. The Oral Health Program plans to further promote the literacy campaign in-person at conferences and stakeholder meetings once COVID-19 restrictions allow.

National Oral Health Observances

The OHP continues to promote national observances relevant to oral health. To publicize National Children's Dental Health Month (NCDHM) in February 2021, the OHP developed an electronic newsletter article providing background on the observance, discussing the campaign slogan, and providing ideas for easy-to-do activities to promote NCDHM. The newsletter was shared with all Early Childhood and Family Support Division (ECFSD) programs, Montana Oral Health Network (MOHN) members, and distributed to local stakeholders by the county health department "hub" locations. Posters provided by the American Dental Association were distributed to county health department partners. Furthermore, OHP staff presented on NCDHM and Oral Health in Montana during a WIC local agency conference call with approximately 45 local WIC agency staff.

To promote Oral Cancer Awareness month, OHP staff submitted a *Health in the 406* article on the topic of human papillomavirus (HPV) and oral cancer. The article is distributed to all Montana DPHHS employees and posted on the Public Health and Safety Division website. The OHP plans to expand promotion of oral health observances, such as National Dental Hygiene Month in October.

Networks & Partnerships

Montana Oral Health Network (MOHN): The OHP provides administrative support for the MOHN, including organizing a quarterly meeting of the Steering Committee, a team of 8-10 dental and non-dental stakeholders that provide leadership for the full network. Once the MOHN becomes more established, the full network of oral health stakeholders will meet annually.

The OHP collaborates with the MOHN on activities to support NPM13b. This network is guided by the Montana Oral Health Strategic Framework, which has specific metrics related to the MCH population:

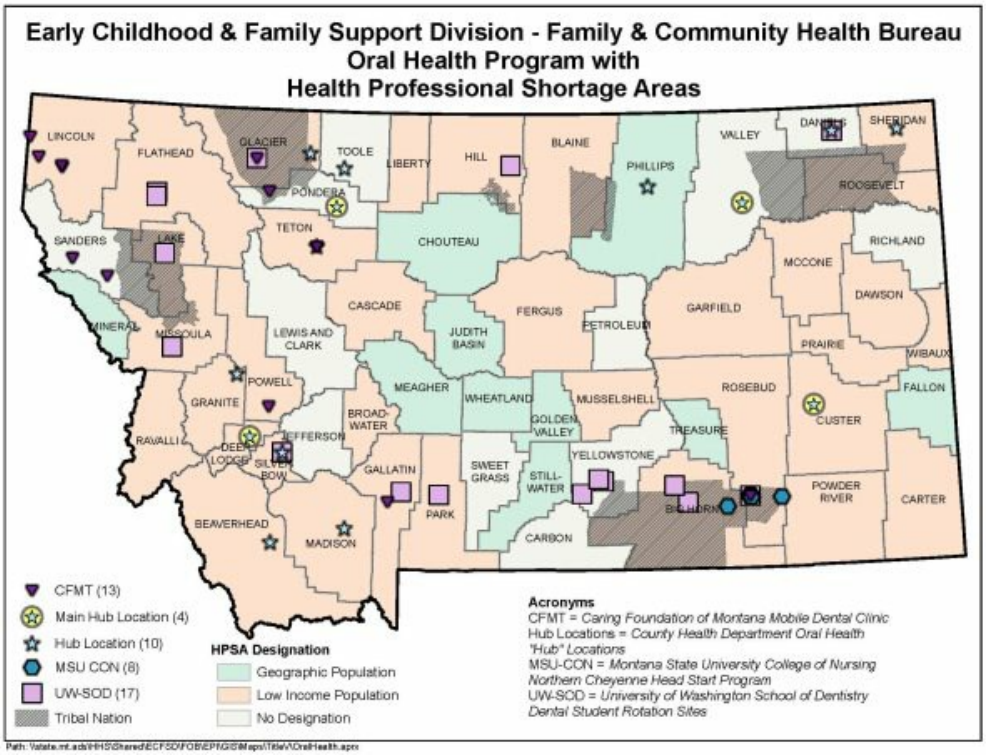
- *By 2023, develop materials and educational programs to inform practicing health and human service professionals about the necessity of oral health care to systemic health, resulting in at least 50 non-dental providers appropriately including oral health preventive education, referrals, and/or services in their patients visits.*
- *Educate dentists, medical providers, WIC counselors, and parents that a child's first dental visit should occur before one year of age and include a risk assessment. By 2023, infant dental visits prior to his/her first birthday will increase by at least 2 percent.*
- *Conduct an assessment to determine the number of schools and clinics that include oral exams as part of health screenings. Once a baseline has been determined, increase by 10% over the next five years.*
- *Work closely with the Office of Public Instruction to encourage Montana school districts to include oral health strategies and education as part of their district's Wellness Policy.*

Montana Tobacco Use Prevention Program (MTUPP): The OHP is partnering with MTUPP to sponsor a speaker at the Montana Dental Hygienists' Association (MDHA) Annual Session in September 2021. The speaker will present on the implications of human papillomavirus (HPV) and vaping/e-cigarettes on oral health. This partnership supports the MCH population by educating dental providers on topics currently impacting the oral health of children and adolescents.

Montana Healthcare Programs: The OHP is collaborating with Montana Healthcare Programs on a potential project to increase the number of preventative oral health services provided. This specifically targets services for members under 36 months of age delivered by Medicaid enrolled physicians, physician assistants, and nurse practitioners. If approved, the program would provide enhanced reimbursement for oral health services provided by enrolled primary care providers who have completed the *Smiles for Life* online curriculum.

Oral Health Workforce

Known disparities, based on geographic locations and race in Montana, are continuing to drive targeted programming related to oral health. The OHP has several projects to support the growth of the oral health workforce in MT. These activities are supported by *HRSA Grants to States to Support Oral Health Workforce Activities* T12HP30538. The following partnerships (details following map) have contract agreements through August 2022. As data from these partners is received, rapid quality improvement will be utilized to determine best practices for providing oral health services to the maternal and child population. See the map below demonstrating the location of oral health workforce activities throughout the state.



University of Washington School of Dentistry (UWSOD): The OHP has contracted with the UWSOD to promote workforce development for providers prepared to address oral health services in vulnerable populations of women and children. This program aims to improve access to oral health care in Montana by developing and delivering community-based training programs for dental students, focusing on rural and underserved pediatric populations. Faculty from UWSOD contact preceptor sites prior to student rotations to encourage them to have students treat children on rotation and inquire about off-site opportunities to treat children in the area. Furthermore, prior to departing, dental students rotating in Montana complete learning modules developed by the UWSOD's HRSA grant-sponsored Early Childhood Oral Health Training (EchoTrain) Program. Since September 2018, 2187 dental procedures have been completed by 4th-year dental students, 230 of which were with pediatric patients aged 0-17 years old.

Montana State University College of Nursing (MSUCON): The aim of the program with MSUCON is to support innovative projects to increase oral health care utilization for American Indian (AI) children during early childhood. One activity is to implement an oral health program with the Northern Cheyenne Nation Head Start. Limited Access Permit (LAP) dental hygienists accompany nursing students on rotations to provide preventative oral health services. The students gain interprofessional education and hands-on experience providing oral health services to young children. Following COVID-19 closures, the team was able to return to the Northern Cheyenne Nation in November 2020. Since September 2018, services provided include: 266 screenings, 250 cleanings, 333 fluoride varnish applications, and 819 sealants. Additionally, 122 referrals have been made, of which 32 have been completed as of January 2020.

Another activity is to test oral health messaging via GoodHealth Television (GHTV) to support increased utilization of dental care during early childhood and the use of silver diamine fluoride (SDF). MSUCON developed a video featuring four Blackfeet families undergoing treatment with SDF. Pilot testing of the message conducted with Northern Cheyenne WIC demonstrated the messaging was effective. As GHTV is displayed in tribal health waiting rooms, this activity was significantly delayed during COVID-19 when waiting rooms were not being utilized. However, MSUCON was able to alter the implementation plan so that the message will be played in facilities offering the COVID-19 vaccine. As individuals are asked to wait following vaccination to monitor for reactions, this provides an ideal audience for a messaging campaign.

Caring Foundation of Montana (CFMT): The OHP has partnered with the CFMT, a non-profit organization administered as an in-kind gift by Blue Cross and Blue Shield of Montana. The aim of this program is to pilot the integration of access to preventive dental health services in mobile health clinics and non-traditional settings. The goals are to address dental needs, promote prevention and increase the capacity of community-based preventive dental care for high-risk, high-need populations. The focus is on the early utilization of dental care and the establishment of a dental home for children. This activity utilizes LAP dental hygienists and mobile dental equipment to deliver preventative oral health services in a variety of settings, including Head Start, schools, and WIC clinics. Since September 2019, services provided include: 1134 screenings, 797 cleanings, 1097 fluoride varnish applications, and 1913 sealants. All children provided services by a LAP dental hygienist are referred to a dental provider for routine oral health care.

Health Department "Hubs": The OHP has established task orders with four County Public Health Departments (CPHD): Valley, Pondera, Anaconda Deer-Lodge, and Custer. This program facilitates early childhood risk assessments, oral health education, and fluoride varnish application in the primary care setting. In the "Hub and Spoke" model, hub locations provide guidance and support for oral health activities to surrounding (spoke) health departments. CPHD staff meets monthly to discuss successes, challenges and to collaborate on activities. Additionally, the OHP has started providing quarterly trainings on oral health-related topics and developing newsletter articles for the "hubs" to share with stakeholders in their area. The task order deliverables for this program compliments but does not duplicate Title V requirements.

Alluvion Health: The OHP has partnered with Alluvion Health, a Federally Qualified Health Center (FQHC) in North Central MT, on a teledentistry pilot project. Alluvion Health secured outside funding to purchase a mobile dental clinic. The OHP is providing financial support towards the purchase of additional equipment and in-kind administrative support. Alluvion Health completed a needs analysis and is currently in the planning phase of program development. The implementation phase began in April 2021. Alluvion Health plans to utilize the mobile dental unit to serve small, rural communities that do not currently have independent local dental providers. This organization has made many connections through their expanded medical services. It will utilize the mobile dental clinic to begin offering oral health services to underserved populations in their area with an initial focus on pediatric populations.

Surveillance

The OHP attempted to conduct the Basic Screening Survey (BSS) of the Head Start population during the 2020/2021 academic year. However, the surveillance was ultimately postponed due to challenges associated with the COVID-19 pandemic. The BSS of the Head Start population has been rescheduled and will be conducted in addition to the BSS of the Kindergarten population in the 2021/2022 academic year. The OHP has elected to add questions to the 2021 BRFSS regarding fluoride testing of private wells and public perception of community water fluoridation. Although not specific to the

infant and child population, the OHP also elected to add a question to the 2021 PRAMS questionnaire regarding obstacles to visiting a dentist during pregnancy, supported with Title V funds. Routine surveillance of the MCH population is vital to targeting effective oral health interventions.

NPM 13 Counties

For FFY 2021, four County Public Health Departments (CPHDs) have chosen NPM 13b for their MCHBG performance measure: Cascade, Custer, Mineral, and Valley. These counties are in areas of the state which either have minimal access to oral health care, and/or have a higher percentage of residents below the federal poverty level. These counties have a combined child population (0-19) of 25,422, and MCHBG funding of $103,250.

Staff from these counties are invited to participate in monthly Montana Oral Health Partners meetings to discuss challenges and successes to incorporating oral health services in the primary care setting. The OHP offers support, guidance, and resources to CPHD staff. These CPHDs are leveraging partnerships to increase their reach and capacity for oral health education. This includes collaboration with WIC, medical clinics, dental clinics, and community organizations that serve families.

Another main area of partnership involves the surveillance of kindergarten and 3rd-grade students and appropriate referrals to local area dentists. Activities within health departments include distributing "oral health packets" to clients containing items such as toothbrushes, timers, toothpaste, and educational materials.

The following information in a recent report from Cascade CPHD gives good examples of MCHBG NPM 13b activities:

> *"Staff from all our programs consistently encounter parents, foster parents, grandparents who do not know about the latest research and schedule for preventative oral health care for the children in their care, and how infant feeding behaviors can influence oral health. Many measures have been taken to help attain this goal including the following information to be shared at outreach events, clinic visits, and during home visits:*
>
> *Access to Oral Health Care*
>
> - *A list of dentists who take Medicaid patients and are currently accepting new Medicaid patients. This list was created by the Access to Dental Care Committee and reviewed by the 4th District Dental Society. It will be shared with parents and clients. The list will be kept current by the Dental Assistant teacher at the College of Great Falls.*
> - *MCH Program Resource flyers were created and distributed to community partners which included the Oral Health Education program's availability to help parents in need of finding dental care for their children.*
>
> *Create postcard for outreach and education purposes with age specific oral health information to be shared with parents during outreach events, clinic visits and during home visits.*
>
> - *We are currently sharing age-specific oral health information for expectant mothers and parents of babies/toddlers from postcards and brochures. Recently however, I was contacted by Katie Glueckert, (Oral Health Program Coordinator for Montana, DPHHS) who provided me with many oral health resources and current, research-based oral health information. She is currently sending samples from "Montana Healthy Mouths" (DPHHS). I have also been looking at Consumer Materials: OHRC.*
>
> *Provide oral health education through PSAs and social media to create awareness of how feeding habits can influence oral health.*
>
> - *Oral Health Lessons on Brushing and Flossing are being provided to 2nd and 4th grade students in Cascade County. Students are also being provided with toothbrushes, toothpaste, floss, and a corresponding information/activity page to take home.*
> - *In February 2021, National Children's Dental Health Month, Kindergarten classrooms in Cascade County will be sent a video link to Dr. Rabbit's, "How to Have a Bright Smile" (Colgate). After watching video, they will be sent home with a "How to Have a Bright Smile" activity book, toothbrush, toothpaste, and How to Brush Your Teeth information page.*
> - *We are currently working on a PSA to be used in February, National Children's Dental Health Month, listing "5 Tips for Healthy Teeth" (America's ToothFairy.org). This will be read by a child.*
> - *Planning for February's Parents as Teachers Zoom meeting has also begun. The theme will be Oral Health*

for Kids. Parents will be presented with Oral Health Information and Tips. Age appropriate activities will be given to parents either through the Zoom meeting or Home visits. These activities are to be completed with parents and child.

- *2 of 12 Monthly Face Book posts have been posted on the CCHD web page to create awareness of how infant feeding and the eating habits of young children can influence oral health.*
- *With schools reopening this fall and limited visitation access, promoting our goal of optimal oral health to Kindergarten, 2nd, and 4th grade students in Cascade County has been a bit of a challenge. However, with the help of Tracy Milton and her Business Professional's Class at Great Falls High, we have created two easy to use and engaging You Tube video lessons for teachers to use in their classrooms. Using these videos are getting important oral health information out to the students who then can take corresponding materials home with them for independent use. These video lessons, along with toothbrushes, toothpaste, floss, and corresponding information/activity page started going out to schools starting in January. By teaching good oral health habits now, you help a child develop skills that can last a lifetime."*

For FFY 2022, the OHP plans to conduct the following activities to support NPM 13.b:

- Provide ongoing technical assistance and support to the CPHDs that select NPM 13.b.
- Continue promoting the oral health literacy campaign, *Healthy Montana Mouths*.
- Continue promotion of national oral health observances with outreach specific to the child and parent population.
- Continue providing administrative support to the Montana Oral Health Network in the establishment of an interprofessional network of stakeholders.
- Conduct ongoing oral health surveillance of the child population to guide evidence-based program development.
- Develop and submit a competitive grant application for the next HRSA *Grants to States to Support Oral Health Workforce Activities* grant cycle to include objectives specific to supporting and developing an interprofessional healthcare workforce prepared to address oral health of children.

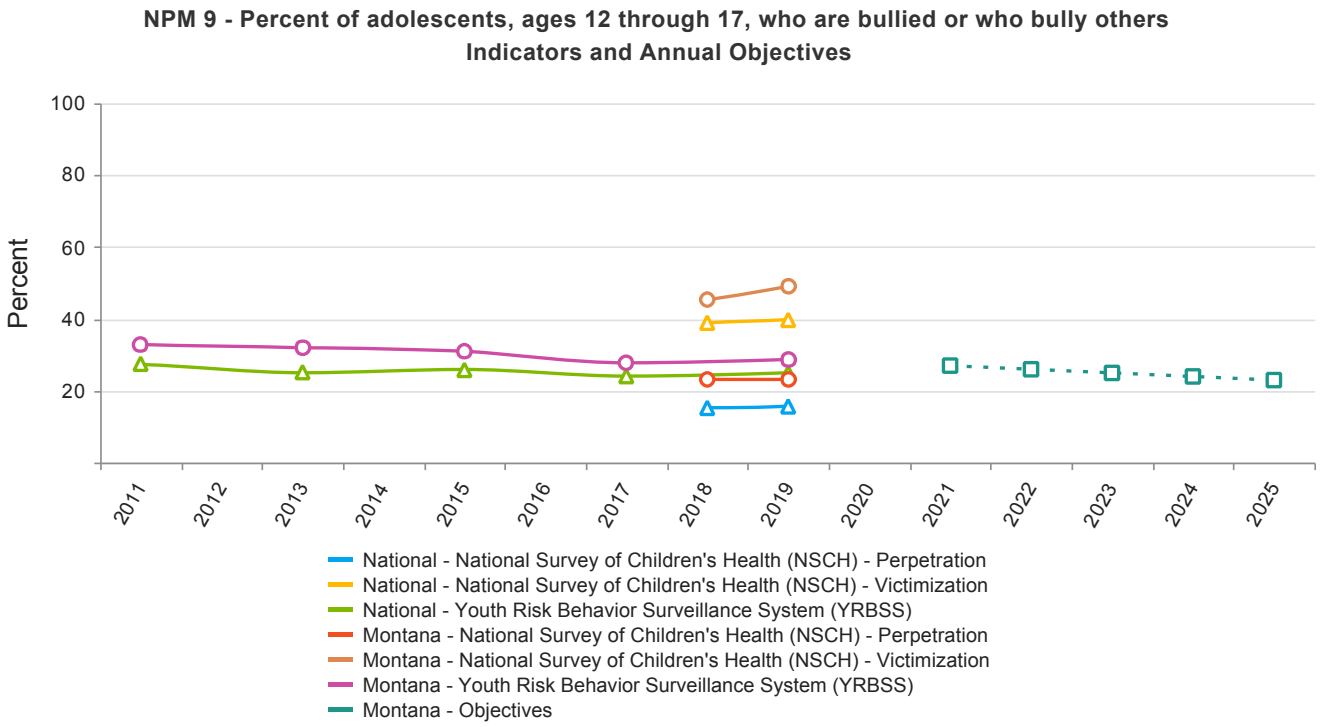
In FFY 2022, the Family & Community Health Bureau (FCHB) will contract with and support the CPHDs who chose to focus on NPM 13b: Cascade, Custer, Deer Lodge, Granite, Lincoln, and Mineral. These counties will implement and evaluate at least two community-level activities during the fiscal year. The FCHB will provide these counties with training, resources, and support on evidence-informed activities, goal setting and evaluation.

Adolescent Health

Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2019	50.2	NPM 9 NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2017_2019	21.4	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2017_2019	27.2	NPM 9 NPM 10
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	14.4 %	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	62.2 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.5 %	NPM 10
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)	NSCH-2018_2019	10.6 %	NPM 10
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)	WIC-2018	11.9 %	NPM 10
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)	YRBSS-2019	11.5 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2019_2020	57.0 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2019	63.7 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2019	90.1 %	NPM 10
NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine	NIS-2019	73.1 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2019	16.3	NPM 10

National Performance Measures



Federally Available Data		
Data Source: Youth Risk Behavior Surveillance System (YRBSS)		
	2019	**2020**
Annual Objective		
Annual Indicator	27.8	28.5
Numerator	11,393	11,853
Denominator	40,974	41,603
Data Source	YRBSS	YRBSS
Data Source Year	2017	2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Perpetration		
	2019	**2020**
Annual Objective		
Annual Indicator	23.2	23.2
Numerator	16,058	16,805
Denominator	69,345	72,374
Data Source	NSCHP	NSCHP
Data Source Year	2018	2018_2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Victimization		
	2019	**2020**
Annual Objective		
Annual Indicator	45.2	48.9
Numerator	31,448	35,450
Denominator	69,617	72,511
Data Source	NSCHV	NSCHV
Data Source Year	2018	2018_2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	27.0	26.0	25.0	24.0	23.0	22.0

Evidence-Based or –Informed Strategy Measures

ESM 9.1 - Percent of activity goals to reduce adolescent bullying which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

Baseline data was not available/provided.

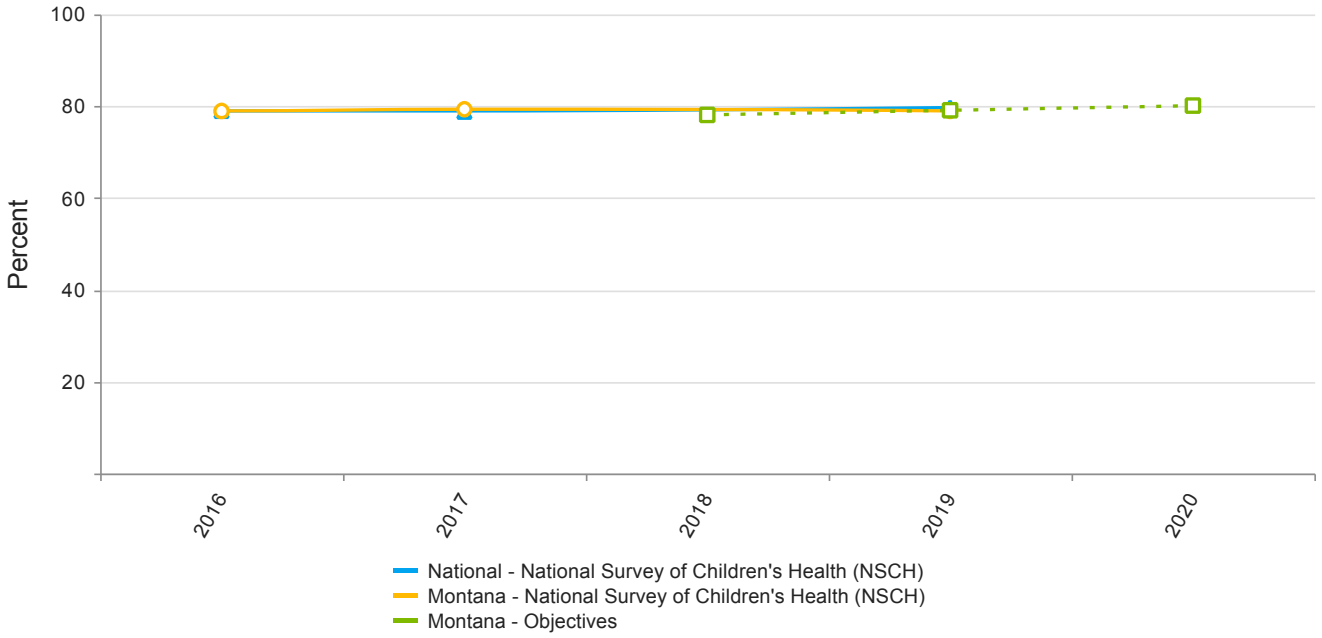
Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	82.0	83.0	84.0	85.0	86.0

State Action Plan Table

State Action Plan Table (Montana) - Adolescent Health - Entry 1	
Priority Need	
Bullying Prevention	
NPM	
NPM 9 - Percent of adolescents, ages 12 through 17, who are bullied or who bully others	
Objectives	
Decrease the percent of adolescents, ages 12 through 17, who are bullied or who bully others.	
Strategies	
Support County Public Health Departments who choose bullying prevention as their priority need, providing technical assistance and resources.	
Conduct an evaluation of the "Power Up Speak Out" curriculum, to determine if could be considered a promising/best practice evidence based curriculum	
Mini-grants to CPHDs or other organizations that work with youth on positive youth development.	
ESMs	**Status**
ESM 9.1 - Percent of activity goals to reduce adolescent bullying which are met by county public health departments using MCHBG funding for the work.	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	

2016-2020: National Performance Measures

2016-2020: NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year. Indicators and Annual Objectives



Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			78	79	80
Annual Indicator		78.7	79.3	79.3	79.0
Numerator		55,013	56,264	56,264	59,661
Denominator		69,906	70,972	70,972	75,548
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

2016-2020: Evidence-Based or –Informed Strategy Measures

2016-2020: ESM 10.2 - Hold one day-long meeting to explore interest in, and provide education for, a Montana Adolescent Preventive Healthcare Stakeholders Group.

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	0	0	1	0
Annual Indicator	0	0	1	0
Numerator				
Denominator				
Data Source	FCHB	FCHB	FCHB	FCHB
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

2016-2020: ESM 10.3 - Create one evaluation report for the Optimal Health for Montana Youth program.

Measure Status:			Active
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			1
Annual Indicator			1
Numerator			
Denominator			
Data Source			FCHB
Data Source Year			FFY 2020
Provisional or Final ?			Final

Adolescent Health - Annual Report

NPM 10 - Adolescent Preventive Care: Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

At the beginning of FFY 20, the Family & Community Health Bureau (FCHB) turned the emphasis of NPM 10 activities toward adolescent health education programs. Part of the emphasis was teaching teens about medical providers and the services they offer. Through collaboration with the Adolescent Health Section (AHS), Title V had the opportunity to contribute and partner with their work in these compatible topic areas, which included education on healthy life skills, adolescent development, and sexual and reproductive health.

The AHS provides services to adolescents (aged 10-24) as they develop from children to adults. Adolescents make up 19% of Montana's population, and the AHS has objectives to provide education, resources, and services for improving their health outcomes. AHS advocates that behaviors developed in adolescence are key determinants for health outcomes in adulthood and later life. Their goals are to ensure that Montana youth have optimal physical, mental, social, and reproductive health.

In FFY20, the *Optimal Health for Montana Youth (OHMY) programs* aimed to provide youth with the knowledge, skills, and tools needed to: help them focus on their future; make healthy decisions when it comes to having sex; set personal boundaries; resist peer pressure and speak up; and understand what constitutes a healthy relationship. OHMY worked to teach teens how to better protect themselves from risky situations, unintended pregnancies, and put their health first. Local public health clinic information was provided, along with what services are offered and what to expect at the appointment. CPHD employees facilitated AHS programs in schools or served as guest speakers during health-content specific lessons. Power Up, Speak Out curriculum reached a total of 32 middle schools. Personal Responsibility Education Program (PREP) reached 16 middle schools and eight high schools.

COVID-19 delayed and ultimately halted some teen programs offered through AHS. Due to schools shutting down and lessons occurring on-line, the number of students receiving curriculum through PREP decreased from what has typically been seen in previous years. For example, in the previous fiscal year 2,182 students were reached, whereas only 973 were reached during this fiscal year. Montana's Governor ordered a stay-at-home mandate which halted all in-person programs for Spring 2020. The AHS's Healthy Young Parents Program, funded through Pregnancy Assistance Fund, adapted to virtual case management and maintained its services.

The AHS also utilized the PREP. It was created to replicate evidence-based effective program models that are scientifically supported to change behaviors and result in youth delaying sexual activity, increasing condom or contraceptive use, and reducing unintended pregnancies. PREP educates youth on abstinence, contraception, and adulthood preparation subjects. Adulthood preparation subjects include:

- Healthy relationships
- Adolescent development
- Healthy life skills
- Parent-child communication

The number of students reached before COVID-19 restrictions went into effect in FFY 20 was 973. Therefore, 973 is the number of students reached in the Fall of 2019 and the beginning of the Spring semester of 2020. Of these students, 27 high school students and 8 Job Corps students received the Making Proud Choices curriculum. The 938 middle school students received the Draw the Line Respect the Line Curriculum. The Northern Cheyenne contractor is tribal; therefore, the youth served by this contractor are primarily Native American/American Indian.

Contractor	Curriculum and location	Students Reached
Anaconda Family Resource	Draw the Line – 6th grade, Fred Moodry Middle school	67
Beaverhead County	Draw the Line – 6th grade, Dillon Middle School	74
Beaverhead County	Draw the Line – 7th grade, Dillon Middle School	86
Butte Silver Bow Health Department	Draw the Line – 7th grade, Dillon Middle School	317
Butte Silver Bow Health Department	Draw the Line – 8th grade, Dillon Middle School	281
Deer Lodge County	Making Proud Choices, Job Corps	12
Flathead Family Planning	Draw the Line – 6th grade, Helena Flats School	35
Flathead Family Planning	Making Proud Choices, MT Academy	8
Northern Cheyenne	Draw the Line – 6th grade, Northern Cheyenne Tribal School	22
Northern Cheyenne	Draw the Line – 7th grade, Northern Cheyenne Tribal School	56
Northern Cheyenne	Making Proud Choices, Lame Deer High School	15
Total Students		**973**

The results of the 2020 Statewide Needs Assessment, indicated the need to focus on NPM 9: Bullying Prevention, for FFYs 2021 – 2025. Bureau efforts addressing adolescent preventive healthcare are a continued focus of the AHS. The activities and grant deliverables for these federally funded programs: *Personal Responsibility Education Program*, Sexual Risk Avoidance Education (both funded through the Administration for Children and Families, Family and Youth Services Bureau or FYSB through Health and Human Services), and Sexual Violence Prevention and Victim Services (SVPVS) through the CDC continue have provided and will continue to address adolescent's health educational needs.

Additionally, housed in the FCHB is the Title X Section. Youth who accessed Title X programs received healthcare and education services.

Adolescent Health - Application Year

NPM 9 - Bullying: Percent of adolescents, ages 12 through 17, who are bullied or who bully others.

As detailed in last year's 5-year needs assessment, Montana has high rates of teen suicide and a high incidence of bullying. Adolescent suicide rates have increased. Using a 3-year estimate, 2015-2017 aggregate suicide rate for teens per 100,000 was 24.1, up from 21.3 in 2013-2015 (CDC data). According to the Youth Risk Behavior Survey (YRBS), in 2017, 21.6% of Montana adolescents in grades 9-12 reported being bullied on school property in the last 12 months, higher than the national average of 19%. Because of a correlation between these two actions, and other risky behaviors by adolescents, the Family & Community Health Bureau (FCHB) selected NPM 9 for the years 2021-2025. Research has shown youth who report bullying, being bullied, or both (bully-victims) are at increased and long-term risk of suicide-related behaviors, depression, anxiety, and negative physical and mental health.

Program Specialists who had been working in the Adolescent Health Section (AHS) were reassigned, either to the Title X/Adolescent or Maternal and Child Health (MCH) Sections within the FCHB. The MCH Section expanded to include the Program Specialist who has been a co-lead on the Title V/Sexual Risk Avoidance Education (SRAE) Program. Montana's initial SRAE grant was awarded on October 1, 2018, and the funding reflects a two-year funding (project) and obligation period.

AHS staff had assisted with promoting adolescent well visits (NPM 10) throughout FFY20 as part of addressing the grant deliverables for their funding streams, which are continuing through FFY22. In addition to Title V and SRAE funding, staff are supported by the Personal Responsibility Education Program (PREP) and Sexual Violence Prevention and Victim Services (SVPVS) grants, which are now housed in the Title X section.

Under the direction of the Administration for Children and Families, the purpose of the Title V State SRAE Program is to fund states and territories to provide education to youth which normalizes the optimal health behavior of avoiding non-marital sexual activity. The program is designed to teach youth personal responsibility, self-regulation, goal setting, healthy decision-making, a focus on the future, and the prevention of youth risk behaviors such as drug and alcohol usage without normalizing teen sexual activity.

The goal of the SRAE program is to provide messages to youth that promote the optimal health behavior of avoiding non-marital sexual activity. The SRAE program objectives are to:

- Implement education and/or strategies that include medically accurate and complete information referenced in peer-reviewed publications by educational, scientific, governmental, or health organizations.
- Select sexual risk avoidance education and/or strategies with an evidence-based approach based on adolescent learning and developmental theories for the age group receiving the culturally appropriate education recognizes the experiences of youth from diverse communities, backgrounds, and experiences.
- Teach sexual risk avoidance skills through methods that do not normalize teen sexual activity.
- Target youth ages 10 to 19.

States must design SRAE projects to address the following requirements:

- Medically Accurate and Complete, and Age-Appropriate
- Evidence-based interventions or strategies
- Positive youth development approach
- Target Population
- Research
- Performance Measures
- National Evaluation
- Sustainability Plan
- Brief evaluation plan (if planning to conduct a local evaluation)

The goal in FFY21 is to complete a five-year workplan and logic model, using input from: stakeholders currently being served by the PREP, SVPVS, and Title V/SRAE programs; and, data from the 2017 and 2019 Youth Risk Behavior Surveys (YRBS). Stakeholders have identified local schools as key partners for implementing programs to address bullying, which is supported by the 2017 and 2019 YRBS.

The 2017 YRBS indicated that high school students who attempted suicide were more likely to have been electronically bullied (46%) during the past 12 months than students who had not attempted suicide (14%). The 2019 YRBS, completed by 3,819 students in 47 public high schools during February 2019, reported that over a 12-month period, 22% of those

responding reported being bullied on school property, and 17.9% were electronically bullied. The percent of students reporting to be the victim of teasing or name-calling due to LGBTQ2S identity or perceived identity was 13.3%.

In regard to actual physical violence, in the last 12 months, 11.4% of high school students reported being in one physical fight with 7.2% in two or three fights; 5.2% had a physical fight on school property; 3.5% reported to have been threatened or injured by a weapon (gun, knife, club) on school property; and in the last 30 days, 4.9% reported not attending at least One day of school because they did not feel safe at or on their way to or from school.

The Title V/SRAE Program Specialist has begun collaborating and establishing a relationship with the Office of Public Instruction (OPI). The communication is with staff who work closely with schools on bullying prevention curriculum development and implementation. This connection will aide in conducting an environmental scan of current bullying prevention activities offered in Montana's high schools. This in-depth picture of existing bullying prevention programs and unmet needs will help guide the tailored technical assistance conversations with the National MCH Workforce Development Center (MCH-WDC).

The Title V/SRAE Program Specialist initiated discussions with the MCH-WDC with the goal to identify an evidence-based or promising practice intervention that meets the SRAE requirements and also focuses on bullying prevention methods that could be implemented by a County Public Health Department (CPHD) partnering with their local schools or solely by the school.

In May 2021, the CPHDs were asked about their involvement with their local schools and their interest in receiving dedicated funding for addressing bullying prevention by partnering with their schools. Eleven CPHDs expressed interest, with four already having a working relationship with their local schools. CPHDs also identified time constraints and staffing shortages as barriers to participating in mini-grant opportunities. This feedback will help direct the mini-grant requirements and funded activities to accommodate CPHDs' concerns to be successful in implementation and impact.

In May 2021, the Title X and MCH/Title V Directors and the PREP/ SVPVS and SRAE Program Specialists met with the Chronic Disease Prevention and Health Promotion (CDPHP) School Health Program Manager. The Program Manager provided information on their process for awarding mini-grants to local schools and CPHDs, and lessons learned for recruiting and retaining mini-grant awardees.

Additional collaboration partners and possibilities to expand the reach of mini-grant opportunities are being explored, such as: school nurses; the teachers' union; Parent Teacher Association; puberty educators; Boys and Girls clubs; and, 4-H clubs. Pending the outcome of the environmental scan, and input from the MCH-WDC, the SRAE Program Specialist will work with the Title V/SRAE Project Officer to ensure that the suggested bullying prevention intervention addresses the Title V/SRAE requirements.

The FCHB has partnered with Windfall, a Montana marketing firm, to develop a workplan and budget for a statewide bullying prevention media campaign. The target audiences are youth, parents, and teachers. Research is being conducted to learn the most effective strategies. This includes seeking technical assistance from the MHC-WDC. The collaboration with Windfall's media expertise and MCH-WDC expansive knowledge has helped understand the dynamics of bullying, identify relevant media strategies, and gain insight from other campaign's successes and barriers.

As CPHDs continue to focus on COVID-19 testing and vaccinations, FCHB will accommodate their needs and concerns and adjust strategies to proceed with NPM 9 for the remainder of FFY21. For FFY21, two CPHDs selected NPM 9 and are: utilizing informational bulletin boards; sponsoring a bullying prevention poster contest; surveying community knowledge; providing in-classroom education; and, training teachers to identify, deter and prevent bullying behaviors. Pre- and post-surveys of both students and teachers, and collaboration with school counselors and teachers will be conducted to evaluate bullying prevention efforts.COVID-19 has impacted these CPHDs ability to fully implement their in-person activities. Revised strategies used by CPHDs to address bullying prevention during COVID-19 include flyers provided to students ages 12 to 17 years old, and an informational bulletin board that includes on-line bullying prevention.

For FFY21, Eleven CPHDs have chosen suicide prevention for their injury-prevention activities. Youth who feel connected to their school, have healthy coping skills, and solve problems peacefully are less likely to engage in suicide and bullying-related behaviors. With this relationship between bullying and suicide-related behavior, utilizing resources and programs to address them in tandem will increase impact, and address time constraints.

In FFY 2022, the FCHB will contract with and support CPHDs interested in decreasing the percent of adolescents who are bullied, either by their NPM 9 selection (Big Horn and Broadwater), or as an injury-prevention activity. These counties will implement and evaluate community-level activities during the fiscal year. The FCHB will provide these counties with training, resources and support on evidence-informed activities, goal setting, and evaluation.

Children with Special Health Care Needs

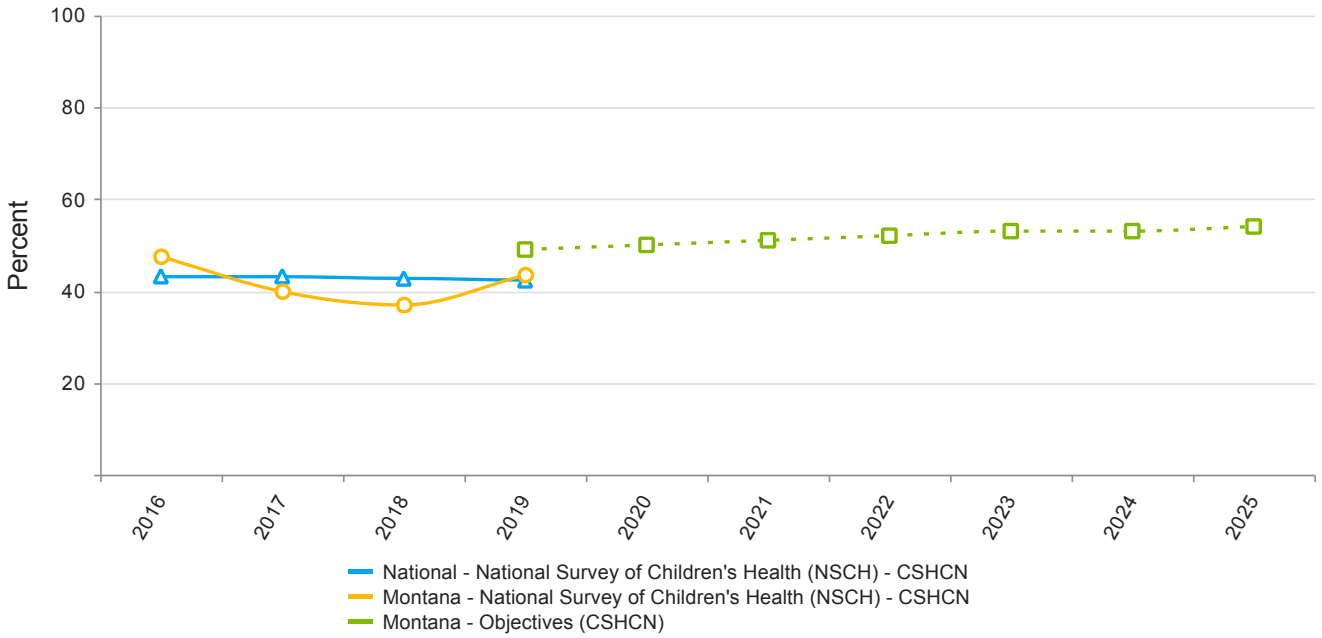
Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system	NSCH-2018_2019	14.4 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2018_2019	62.2 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2018_2019	92.5 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	NSCH-2018_2019	2.4 %	NPM 11

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2017	**2018**	**2019**	**2020**
Annual Objective			49	50
Annual Indicator	47.5	39.9	36.8	43.5
Numerator	19,838	17,364	16,404	19,378
Denominator	41,760	43,541	44,607	44,583
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019

State Provided Data				
	2017	2018	2019	2020
Annual Objective			49	50
Annual Indicator	47.5			
Numerator	19,838			
Denominator	41,760			
Data Source	National Survey of Childrens Health NSCH			
Data Source Year	2016			
Provisional or Final ?	Final			

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	51.0	52.0	53.0	53.0	54.0	55.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Percent of CYSHCN receiving services from a Parent Partner.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			25	5
Annual Indicator			18.4	56.9
Numerator			36	132
Denominator			196	232
Data Source			FCHB	FCHB
Data Source Year			FFY 2019	FFY 2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	5.0	5.0	5.0	5.0

State Action Plan Table

State Action Plan Table (Montana) - Children with Special Health Care Needs - Entry 1	
Priority Need	
Medical Home	
NPM	
NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home	
Objectives	
Increase the percent of CYSHCN which have a medical home to 53% by 2023.	
Strategies	
CSHS will continue to support Cleft/Craniofacial, and Metabolic Clinics in Montana. Contracts include language requiring clinics to promote medical homes to CYSHCN who attend clinics. CSHS will collaborate with providers to define, implement and evaluate strategies in clinics.	
CSHS will continue the medical home portal project.	
ESMs	**Status**
ESM 11.1 - Percent of CYSHCN receiving services from a Parent Partner.	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	
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year	

NPM 11 – Medical Home: percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Meeting National Standards for Systems of Care for CYSHCN
By offering programs free to all children and their families in Montana, Children's Special Health Services (CSHS) addressed NPM 11 by intentionally aligning the work with National Standards for Systems of Care for CYSHCN.

The HALI Project: Montana Parent Partner Program
The Montana Parent Partner Program (MPPP) continued to work toward fulfilling its mission of offering every Montana parent and caregiver of a child with special health care needs access to a Parent Partner.

Parent Partners (PP) continued to expand and deepen their reach within clinics and rural communities. In FFY 20, PP served 364 children with special health care needs in 1438 different encounters, nearly tripling the number of encounters compared to the previous FFY. The MPPP served families of children with special health needs in 28 Montana counties and four tribal reservations. An average of 60 minutes was spent among an average of 4 encounters with each family.

MPPP addressed barriers identified in FFY19. A quality improvement project was completed to develop consistency across MPPP branding and materials. Additional progress was made to improve access to services by developing a HIPAA compliant portal for electronic completion of referral and consent forms and expanding the social media presence to include: a MPPP website; a Facebook page, and a link from the Children's Special Health Services webpage.

MPPP and CSHS worked in FFY2020 to develop an evaluation protocol; however, due to the impact of COVID and staff transitions, the evaluation has not taken place. The program does not anticipate continuing this evaluation project as there is sufficient evidence on the efficacy of peer models.

A considerable challenge during FFY 20 was the global COVID-19 pandemic which required creative problem-solving approaches. MPP identified alternate at-home work plans which allowed PPs to reach out and connect with families and offer encouragement, information, and resources amidst the pandemic. MPPP was able to conduct one of two scheduled semi-annual staff training events for Parent Partners. In addition to receiving continuing education in the key elements of peer support, they received supplemental training in Mental Health First-Aid (MHFA). The second training event of FFY 20 was postponed because of the inability to do an in-person training. Alternative training through readings and discussion was provided.

MPPPs explored setting up additional locations. However, because the COVID-19 pandemic changed clinic priorities and availability, additional sites were not secured. Retaining and engaging new Parent Partners was also a challenge as families with children, particularly children with special health needs, had to manage school closures and working from home.
Circle of Parents

CSHS continued to partner with Butte 4-C's to establish and facilitate Circle of Parents (COP) groups in Montana. In FFY20 COP facilitators hosted different support groups across 6 locations- however one location, Billings, struggled to start due to parent leader health issues.

COP group locations:

1. Butte: parents with children with special needs and or mental healthcare needs and grandparents raising grandchildren;
2. Missoula: parents with children with special needs and or mental healthcare needs;
3. Billings: parents with children with special needs and or mental healthcare needs;
4. Mission Valley: parents with children with special needs and or mental healthcare needs;
5. Havre: parents with children with special health needs and or mental healthcare needs (they have not started group yet, due to COVID);
6. Great Falls: parents with children with special health needs and or mental healthcare needs; parents that have been in recovery; Positive Parenting.

There are still two national trainers funded by CSHS. However, due to COVID no trainings occurred. Approximately 316 parents and caregivers were served in support groups in FFY20. The majority of these groups occurred over Zoom.

University of Montana Rural Institute (UMRI): Transitioning Youth into Adulthood

CSHS continued to partner with UMRI to provide evidence-based transition resources to Montana's youth and families. This program works to: maintain and expand the 15-member Consumer Advisory Council (CAC); maintain and disseminate a health care transition (HCT) guide; develop evidence-based/informed HCT training and resource materials; conduct distance learning opportunities; maintain a transition website, and provide technical assistance to other initiatives related to HCT.

The CAC facilitated quarterly meetings and work groups, at which members have leadership roles. Meetings took place virtually, which allowed for greater access to meetings for individuals with disabilities.

The CAC continued to promote the Community Investment Fund (CIF), which is an **"***annual funding opportunity for innovative projects that help people with disabilities live, learn, work and play in their communities alongside people without disabilities."* Any Montana organization, agency, non-profit group, or individual with a creative idea, developed by or with people with disabilities to promote community inclusion, is eligible to apply. In FFY20, the CAC awarded the $4000 grant to the Montana Independent Living Project to continue and expand their "Feel Great and Recreate" all-ability adaptive ice-skating project.

Project staff at UMRI continued collecting and developing new resources and distance learning opportunities for families and medical providers in Montana, including resources on alternatives to guardianship. Project staff continued to disseminate this information via the Transition and Employment Projects website (http://transition.ruralinstitute.umt.edu/), which was reviewed and updated quarterly.

Work continued in late 2019 and early 2020 on the Transition Improvement Group (TIG). However, due to significant staff transitions and the pandemic, the TIG suspended their efforts. The TIG was led by the CSHS Nurse Program Manager who left her position at the end of FFY20. The CYSHN State Director left her position at the beginning of the pandemic and the Nurse Program Manager filled in for many of those duties while the position remained vacant until late September 2020.

Montana Pediatric Medical Passport (MP2)

CSHS partnered with the MP2 initiative to fund participation incentives for families and providers in several health systems across Montana. This was an extension of previous MP2 participation to improve care coordination and communication of medical needs for children and youth with special health care needs and medical complexity due to COVID-19. CSHS continued to coordinate with the MP2 initiative through its participation in the HRSA challenges.

Montana Medical Home Portal

CSHS continued to contract for a Montana specific services directory on the Montana Medical Home Portal (MMHP) https://mt.medicalhomeportal.org/, which is a website developed by the University of Utah. It is an easy to navigate, one-stop-shop which provides diagnosis information, treatment options and state and local resources to families, providers, and agencies. The MMHP includes vetted, up-to-date clinical information, materials on accessing care, and a statewide services directory specific to Montana.

MMHP was frequently utilized during the pandemic. In the last quarter of FFY20 there were 12,645 page views, by 6,682 unique viewers. In the last quarter of FFY19 there were only 7,185 page views by 4,370 unique viewers. The MMHP resource was maintained by the University of Utah during most of FFY20, due to CSHS staff transitions.

Historically, CSHS attended and tabled at approximately 10-15 conferences a year to provide education and outreach for all programs, including the MMHP. CSHS staff would display the MMHP for conference attendees and provide an interactive experience that allowed attendees to demo the website. In FFY20 CSHS was unable to do this, as many conferences were cancelled due to COVID-19.

Financial Assistance Program

The CSHS Financial Assistance Program (FAP) serves underinsured families. Qualifying families can apply for the FAP to cover out-of-pocket expenses for medical and enabling services, such as therapeutic services, occupational therapy items, adaptive equipment, and respite care. Qualifying families are eligible to receive up to $2000 per federal fiscal year, per child in need.

In FFY20 CSHS received 192 applications, a nearly 80% increase from the previous fiscal year. Of the received applications, 152 applications were approved and over $150,000 was expended. The increase in applications demonstrated the need for improved access to information and resources. In response, CSHS instituted bi-weekly collaboration calls through the Summer of 2020 for stakeholders, families, and partners to share resources available across the state that

assisted in supporting children and families during COVID-19. These calls occurred bi-weekly with an average of 30 participants on each call. All resources shared during these calls were then posted on the CSHS website.

These CSHS Programs, supporting the advancement of medical homes for CYSHCN and their families, and aligned with National Standards for Systems of Care for CYSHCN. Further details are available at: http://www.amchp.org/programsandtopics/CYSHCN/.

Children with Special Health Care Needs - Application Year

NPM 11 – Medical Home: percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

Meeting National Standards for Systems of Care for CYSHCN

Children's Special Health Services (CSHS) addresses NPM 11 by offering gap-filling programs, such as peer support services and resource coordination programs, to all children and their families in Montana. CSHS offers a variety of population health and direct service programs while collaborating with CYSHCN programs across DPHHS. CSHS has 4.75 program staff and 1.0 Americorps VISTA, supervised by the CYSHCN Director/Section Supervisor.

There were significant staff transitions in the first six months of FFY21. The CYSHCN Director began her position at the beginning of the time-period, and these four program staff have since been hired: Nurse Program Manager; MAPP-net Program Specialist; CYSHN Health Education Specialist; and CSHS Program Assistant. The CYSHCN Specialist and Program Assistant are new positions in the section.

CSHS manages critical programs for children and youth with special health needs: Cleft/Craniofacial Clinics; Statewide Genetics and Metabolic program; Newborn Hearing Screening Program; and the Montana Access for Youth Psychiatry Program. Through Title V funding, CSHS supports initiatives to increase parent leaders and peer-to-peer support through the Parent Partner program and Circle of Parents. Population-based initiatives are supported through the Transitions Project and the Medical Home Portal.

CSHS also serves as a key collaboration facilitator across state programs. For example, CSHS is leading an inter-division collaboration between Medicaid and Child & Family Services to increase the number of Parent Child-Interactive Therapy (PCIT) trained mental health practitioners in the state, and create referral pathways for children involved in child welfare services.

Overview of Programs Directly Funded through Title V

The HALI Project: Montana Parent Partner Program - FFY21 Update

The Montana Parent Partner Program (MPPP) continues to provide peer services to families of children with special health needs across Montana. The impact of COVID-19 endures into FFY21, resulting in: Parent Partner turnover; a decrease in referrals; and, barriers to starting programs in new practices. However, training is ongoing via telecommunications.

In the first half of FFY21, PP has served 87 distinct clients in 357 different encounters; offering valuable support, encouragement, and hope to families. The number of distinct clients this fiscal year is currently trending to be less than last fiscal year. This may be due to a decrease in the number of sites and PPs. There are currently 5 PPs at four clinic locations in Billings, Kalispell, Butte, and Great Falls.

The COVID-19 pandemic has significantly impacted the effort to increase parent partners and the needs of practices and families to shift their priorities and adhere to public health protocols and social distancing. It is anticipated that with the implementation of vaccines, recruitment and retention of PP will increase. Expansion is expected to one additional clinical site in this fiscal year, Shodair Children's Hospital. They will provide services via telecommunications.

CSHS is collaborating with the University of Montana Rural Institute (UMRI) to host a Montana team's participation in the National Care Coordination Academy. The CSHS Section Supervisor and a UMRI staffer co-lead an interdisciplinary team that includes family leaders, payer representation (Medicaid and Blue Cross Blue Shield), Title V CYSHCN, pediatricians, and clinicians. The State Director for the Parent Partner program participates in the workshop-structured learning opportunities, regular virtual meetings, and targeted technical assistance. She will be presenting the MPPP model to the MT team as part of an ongoing series of cross-education on care coordination and care coordination allied programs across the state.

As detailed later in this narrative, CSHS is collaborating with the State Director and the Family to Family Information Center to review applications for the financial assistance program. This collaborative effort has: resulted in opportunities to refer new families to the MPPP program; highlights opportunities for improved integration between programs for CSHS; and, ensures referrals for CSHS programs are not siloed.

MPPP - Plans for FFY22

CSHS remains committed to expanding peer services for families of CYSHCN in Montana. CSHS will meet with potential

partner agencies like the MT Peer Network to explore sustainable peer models, and further work with the PP program to evaluate efficacy and operations. CSHS applied for the Early Childhood Support Systems Grant (ECSS) to expand capacity for the prenatal-to-three population. If awarded, one focus will include assessing opportunities for scaling and growth for the PP program, and care coordination for children with special health conditions. ECFSD was recently notified that we were not awarded the funding; however, the division will continue to pursue other relevant opportunities to support the same goals when such opportunities are available. CSHS intends to increase the number of parent partners in the state by providing technical assistance to the Hali Project and improving program oversight by implementing quality and performance metrics. CSHS will partner with the Hali Project to expand peer services provided via telecommunications.

Circle of Parents

CSHS continues to partner with Butte 4-C's to establish and facilitate Circle of Parents (COP) groups in Montana. Through a collaboration with the Children's Trust Fund, CSHS has expanded the partnership to support the growth of new COP groups in different parts of the state. Each group is founded on eight principles: Trust; reciprocity; leadership and personal accountability; respect; parenting in the present; shared leadership; responsibility; and non-violence. These groups aim to decrease isolation, prevent child abuse and neglect and strengthen families through free monthly caregiver support groups.

Each caregiver leading a group is provided a stipend to coordinate a supportive environment with a free meal and free childcare. COP facilitators host seven possible groups depending on their specific communities' needs: Grandparents raising Grandchildren; Families with CYSHCN or Mental Health Concerns; Parents in Recovery; Positive Parenting; and Love and Laundry. As of January 2021, there are currently seven facilitation sites providing specific services as indicated:

Butte: parents of children with special health care needs and or mental health care needs, and grandparents raising children;
Missoula: parents of children with special health care needs and or mental health care needs;
Billings: parents of children with special health care needs and or mental health care needs (expected to begin later in FFY21);
Helena: parents of children with special health care needs and or mental health care needs;
Mission Valley: parents of children with special health care needs and or mental health care needs;
Havre: parents of children with special health care needs and or mental health care needs (expected to begin later in FFY21);
Great Falls: parents of children with special health care needs and or mental health care needs, parents that have been in recovery; Positive Parenting.

CSHS currently funds two national trainers. They intend to conduct trainings in person in FFY21 and 22 to onboard new parent leaders in new communities. COP intends to expand to Kalispell, Bozeman, Helena, Lame Deer, located on the Northern Cheyenne Indian Reservation, and other rural and tribal communities in FFY21 and 22.

University of Montana Rural Institute (UMRI): Transitioning Youth into Adulthood

UMRI FFY 21 Update

CSHS continues to partner with UMRI to provide evidence-based transition resources to Montana's youth and families. This program works to: maintain and expand the 15-member Consumer Advisory Council (CAC); maintain and disseminate a health care transition (HCT) guide; develop evidence-based/informed HCT training and resource materials; conduct distance learning opportunities; maintain a transition website; and, provide technical assistance to other initiatives related to HCT.

The CAC continues to recruit new members and provide member orientation. This team facilitates ongoing leadership development and mentoring of all members, with a focus on youth engagement and self-advocacy. The CAC facilitates quarterly meetings and work groups, and they participate in an annual Montana Youth Transition conference, in which they can exercise their leadership skills.

On an ongoing basis, project staff at UMRI collect and develop new resources and distance learning opportunities for families and medical providers in Montana. Project staff continues to disseminate this information via the Transition and Employment Projects website (http://transition.ruralinstitute.umt.edu/), which is reviewed and updated quarterly.

UMRI Plans for FFY22

UMRI will continue the FFY21 activities in FFY22. CSHS is collaborating with UMRI on hosting the Montana team (MT) within the National Care Coordination academy. CSHS will continue to coordinate the MT team into FFY22, to support ongoing

resource sharing and identification of care coordination improvement opportunities across stakeholder groups.

Montana Medical Home Portal (MMHP)

MMHP FFY21 Update

CSHS continues to contract for a Montana-specific services directory on the Montana Medical Home Portal (MMHP) https://mt.medicalhomeportal.org/, a website developed by the University of Utah. It is an easy to navigate, one-stop-shop which provides diagnosis information, treatment options and state and local resources to families, providers and agencies. The MHP includes vetted, up-to-date clinical information, materials on accessing care, and a statewide services directory specific to Montana. CSHS is dedicating a partial FTE of an Americorps VISTA to support the maintenance and growth of the resource directory.

In Montana, the MMHP tool can be utilized as an up-to-date and accurate resource directory for professionals and families. CSHS is exploring several different partnerships to advance that effort. The MPPP program was re-trained in the tool in March; and will be required to continue to enter, edit and maintain resources specific to CYHSCN and their communities. In January 2021, CSHS and MMHP met with the "211" resource locator to explore sharing resource databases and to help ensure that the MMHP has up-to-date information.

MMHP FFY22 Plans

CSHS will work this year and next to ensure that the resource directory is up-to-date while partnering with similar platforms for synergy and data sharing. Other platforms identified across the state include CONNECT, a bi-directional referral system supporting clinic-community linkages. CSHS, MCH, and other MCH partners are discussing how to ensure programs are maintained within CONNECT, and explore opportunities specific to CSYHCN populations. CSHS is in discussion to start a sub-group of the State Health Improvement Plan Committee, which would be devoted to creating a workplan to improve resource and system collaboration for CYSHCN populations.

Financial Assistance Program

FAP FFY21 Update

The CSHS Financial Assistance Program (FAP) was in operation through the beginning of FFY 21 and moved to a temporarily closed status in December 2020, due to increased number of applicants and limited funding. Through the FAP, qualifying families can apply for the FAP to cover out-of-pocket expenses for medical and enabling services, such as therapeutic services, occupational therapy items, adaptive equipment, and respite care. Qualifying families are eligible to receive up to $2000 per federal fiscal year, per child.

In response to increased applications, the program processes in place, and limited funding, CSHS made changes to the program, including organizing a committee of: three-parent leaders (PP); the Parent Partner State Director; two staff from the Family Information Center, and, three state staff who reviewed all FFY21 applications. In instances where funding was not possible, the committee compiled resources and reached out to partners like Medicaid and Part C to redirect the applicants to other available resources.

FAP FFY22 Plans

CSHS plans to reopen the FAP and will continue utilizing the review committee with a focus on referral and resource navigation.

Other CSHS Programs

The CYSHCN Title V Director/CSHS Section Supervisor oversees other programs including: Newborn Hearing Screening; a statewide genetics program; metabolic clinics; and the Montana Access to Pediatric Psychiatry Network (MAPP-net).

In FFY21 MAPP-net has implemented: Project Echo clinics; an access line for providers; and the second annual Symposium of Pediatric Mental Health. Monthly meetings with Medicaid were initiated to partner on similar initiatives and discuss options for sustainability. In FFY22 MAPP-net will continue these activities and focus on sustainability. The advisory council will expand to include more primary care representation. MAPP-net will continue to partner with Medicaid; and build upon the Bright App, a behavioral health telehealth provider directory. This work will align with other section programs with the goal of improving service navigation for families.

In FFY21 Cleft/Craniofacial clinics restarted with COVID regulations in place. Attendance per clinic has decreased, and CSHS is reviewing and assessing data on clients. The remaining portion of FFY21 and FFY22 will focus on supporting consistency and continuity of care at the cleft clinics and an assessment on the outcomes of care. CSHS will engage with providers and families of CYSHCN to determine the strategy for FFY23 to ensure that children with cleft and craniofacial anomalies are receiving quality care in their communities.

These CSHS Programs support the advancement of medical homes for CYSHCN and their families and align with National Standards for Systems of Care for CYSHCN. Further details are available at: http://www.amchp.org/programsandtopics/CYSHCN/.

Cross-Cutting/Systems Building

State Performance Measures

SPM 1 - Access to Public Health Services: Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less who choose SPM 1.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		30	29	30	30
Annual Indicator	33.8	27.9	37.1	35.5	41.4
Numerator	1,484	2,184	9,142	14,149	19,550
Denominator	4,397	7,839	24,666	39,874	47,216
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	30.0	30.0	30.0	30.0	30.0

SPM 2 - Family Support & Health Education: Number of clients ages 0 - 21, and women ages 22 - 44 who are assessed for social service and health education needs; and are placed into a referral and follow-up system, or provided with health education as needed.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		40	40	40	40
Annual Indicator	45	40	39.5	51.1	70.1
Numerator	2,837	2,663	2,004	7,166	7,513
Denominator	6,305	6,658	5,077	14,036	10,714
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	FY 2016	SFY 2017	SFY 18	FFY19	FFY20
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.0	45.0	45.0	45.0	45.0	45.0

State Action Plan Table

State Action Plan Table (Montana) - Cross-Cutting/Systems Building - Entry 1
Priority Need
Family Support and Health Education
SPM
SPM 2 - Family Support & Health Education: Number of clients ages 0 - 21, and women ages 22 - 44 who are assessed for social service and health education needs; and are placed into a referral and follow-up system, or provided with health education as needed.
Objectives
County Public Health Departments who choose this performance measure will be providing family support referrals and health education, in the physical setting of their facilities, to 40% of their clients on an annual basis.
Strategies
State staff provide training and resources, including tracking templates.
Emphasis on the role of the health education component to cover a variety of MCH priorities/
Supporting the CONNECT referral system.

State Action Plan Table (Montana) - Cross-Cutting/Systems Building - Entry 2

Priority Need

Access to Public Health Services

SPM

SPM 1 - Access to Public Health Services: Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less who choose SPM 1.

Objectives

For counties with frontier-level populations who choose this performance measure, support the public health department's ability to continue providing Enabling Services, Public Health Services, and Group Encounter activities to at least 30% of their MCH population through 2023.

Strategies

Twenty-six frontier-level population CPHDs are collaborating with the FCHB on this performance measure for FFY 2021, and it is anticipated that a similar number will continue in FFY 2022. The main focus is to help provide support for all of the MCH services they provide. Although activities do not have to fit into any one performance measure, these partners submit plans and methods of evaluation.

Provide ongoing training to the CPHDs on a wide variety of MCH topics and programs.

Cross-Cutting/Systems Builiding - Annual Report

(This narrative covers two State Performance Measures)

SPM 1 - Access to Care and Public Health Services: Number of clients ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less.

SPM 1 continued to be the performance measure best suited to support the maternal and child population in Montana's most rural counties, with frontier-level populations and very low population density. For FFY 20, 26 counties chose SPM 1, or 50% of the total number of counties. However, as an indicator of their percentage of the state's total population, they received 13.6% of the total funding allocated to the counties from the population-based formula as outlined in Administrative Rules of Montana 37.57.1001.

These small County Public Health Departments (CPHDs), often with only one FTE, are experts in the needs of their county residents. They were particularly hard hit by the additional work created by COVID-19 and other challenges related to the pandemic response which has led to a high rate of turnover in the public health workforce. The following is a quote regarding a specific situation (identifying details removed).

> *"The Lead Public Health Nurse quit in -----. Her last day is December 31. I don't know if they have hired a replacement for her yet. She did family planning, WIC, immunizations, school nursing, home visiting and was the health department director. She was threatened physically, her high school girls were threatened, her home was threatened and she and her family were harassed almost daily. Most of this was a result of the mask mandate by the governor and asking positive patients and close contacts to quarantine. I don't know that the people of ------ realized just how much she did for the community."*

On April 16, 2020, the Family and Community Health Bureau (FCHB) sent guidance to the CPHDs regarding all the different pass-through federal funding programs it administers and if that funding could be used for COVID-19 response activities. The ability to use MCHBG funding to support these efforts was especially important to the SPM 1 counties due to the limited staffing mentioned above. As this vital work takes priority, that leeway is extremely important.

Regarding COVID-19, the following is a quote from the Treasure CPHD quarterly report (MCH population = 249) for the time period of January 1 – March 31, 2020:

> *"CoVid 19 has made life difficult across the world and Treasure County is no exception. Staffing is quite limited in the county and while we are attempting to be pro-active and prepared for potential cases, the situation overall has consumed our local resources. We are grateful for the additional funding that is being provided to support the efforts but the staffing and the endless list can at times be overwhelming.*
>
> *There are only so many people to provide information, field the calls, figure out how to get the services provided that are needed (the basics). As others are experiencing, the unknown of when things will get back to normal is frightening for all of us. We strive to remain a positive voice in the community and provide factual, quality information to all community residents and to be receptive to our families who are definitely in a unique situation now that schools have been closed.*
>
> *Day to day clinic activities are minimal, office is still open but most are sheltering in place in our community. Much of the normal face to face is now being done via telephone call outreach, referrals, and updates via community Facebook pages, materials left in the local post office and signage posted around town. Attempting to provide services is difficult and our SPM 1 is not seeing a lot of clients in person at this time so is hard to gauge the impact the public health department is having on the population."*

Regarding regular MCHBG activities, the flexibility permitted through SPM 1 allowed CPHDs to each address more than one topic, if desired and as able. The 26 CPHDs involved served 41.4% of the combined maternal and child population of their counties. The table below provides the topics intended initially for coverage in FFY 20 and the number of activities proposed for each. In addition, each SPM 1 county also implemented a FICMMR-related injury-prevention activity.

Topic	Number of Activities
Immunizations	14
Injury Prevention (multiple topics)	8
Suicide Prevention & Mental Health	8
Oral Health	6
School Nursing & Health Education Classes	5
Screening Services (Vision, Hearing, Lead)	4
Women's Health	4
Adolescent Health	3
Adult Health Education	3
CPHD Services Awareness Campaign	3
Infant Care & Breastfeeding	3

Here is an excerpt from Blaine CPHD's quarterly report for the timeframe of October 1 – December 2019 on their "Question, Persuade, Refer" (QPR) evidence-based strategy for suicide prevention (MCH population = 3,166):

> *"QPR trained Blaine CHD representative Jana Hauer, RN, became certified in October to offer the QPR course. She has taught 2 classes already – the first being to the Sweet Medical Center's staff (28 participants) and the second to a group of Turner School staff and school board members (9 participants). Beginning in January, she will begin teaching the course to students at Chinook and reach out to other Blaine County schools to get their staff and students trained as well."*

The following list of activities is from Chouteau CPHD's quarterly report for the same timeframe (MCH population = 2,301):

1. *We provided vision screenings in the four county schools and screened 194 out 202 students for an average of 96% (and made ten referrals 2019-2020).*

2. *We provided "Hidden In Plain Site" program to two schools reaching 55 adults. This program is designed to educate parents on signs of problem behavior in their teens.*

3. *We have four new clients in the mental health program this quarter. We have added two adults and two children from October - December 2019. Our mental health providers are providing counseling services. We are continuing to work with our local providers to educate the public on county-wide services available. We have been posting mental health education for children and adults on our public health Facebook page.*

4. *We have one existing client involved in our family planning program that receives contraceptive care.*

5. *We manage the Chouteau County Foodbank program. This helps food insecure families. We are currently*

serving 25 families this service this quarter, October - December 2019.

6. *We facilitate the Backpack Buddy program with 4 of the larger county schools. We are currently serving 53 kids. We have a food pantry for the junior high/high school kids in 4 schools serving ten students.*

7. *We provided approximately 300 flu vaccines this quarter in schools, senior centers, and walk-in clinics.*

8. *We reached out to the Office of Public Assistance and have been able to secure a worker in our community two days a month to provide needed services such as SNAP, TANF, Healthy Montana Kids/Kids Plus, and Medicare Savings Program. We plan to track the number of clients using services and evaluate with the State in June if this is viable to continue.*

As per the results of the 2020 Statewide Needs Assessment, SPM 1 was continued as a performance measure for FFYs 2021 – 2025.

SPM 2 – Family Support and Health Education: Number of clients ages 0 – 21, and women ages 22 – 44 who are assessed for social service and health education needs; and then are placed into a referral and follow-up system, or provided with health education as needed.

For federal fiscal year 2020, ten counties chose to focus on SPM 2 activities. Two counties that were involved in FFY 19 moved to other performance measures: Gallatin and Mineral. The three new counties were Flathead, Petroleum, and Yellowstone. The remaining seven counties were: Carbon, Hill, Lewis & Clark, Lincoln, Missoula, Park, and Richland.

Petroleum County is very unique, as it has a very small maternal and child population (139) and no in-county health department. Public Health services are provided by Central Montana Family Planning (CMFP), which is based 54 miles away in Lewistown. CMFP felt that SPM 2 was a good choice because they have an electronic health records system, which helps track referral and follow-up.

Flathead County joined four other SPM 2 counties (Hill, Lewis & Clark, Lincoln, and Park) in having at least one activity supporting their work with the CONNECT Electronic Referral System. CONNECT is a secure, web-based platform that was developed in Helena, Montana, in 2009. It is designed to be inclusive of any type of service provider, with the goal of creating the most comprehensive local, regional, and statewide referral networks possible.

Referrals can be sent from a client's home community to anywhere in the state, with referrals back to their home community for follow-up and support services. The closed-loop system facilitates a bi-directional flow of information, allowing provider-to-provider referrals to be tracked in real time from the moment they're sent until the referral is closed, with status updates and progress notes along the way.

An updated, state-wide version of CONNECT rolled out in September of 2019 allows for more fluid referral and reporting processes. It puts responsibility on each service organization to contact individuals who are referred to their programs and engage them in services, rather than an individual having to seek out services when they are referred. Agencies are brought together under a single information-sharing agreement Memorandum of Understanding (MOU) and Release of Information (ROI) that is HIPAA, FERPA, 42CFR, and IDEA compliant.

The comprehensive enhancement package transformed CONNECT from six siloed systems to an interconnected statewide network. CONNECT is housed in DPHHS, in the Public Health and Safety Division, Chronic Disease Prevention and Health Promotion Bureau. DPHHS is able to provide in-person support via CONNECT team members across Montana through grant funding and partnerships with the Montana Office of Public Instruction; PacificSource; Linking Systems of Care; Partnership for Success; Overdose Data to Action; and, Children's Trust Fund.

Along with the CONNECT system focus, FFY 20 activities by SPM 2 counties covered the following range of categories: working on common-sense approaches to identify family needs; and topic-specific emphasis in the areas of tobacco cessation, breastfeeding, behavioral health, pre-natal care, infant safe sleep, oral health, immunizations, and child care. The main challenge identified was staff turn-over.

The following is an excerpt from Lincoln CPHD's quarterly report for the timeframe of October 1 – December 31, 2019, that discussed a collaborative effort:

> *"We created an engagement form for pregnant and new moms to fill out during the prenatal period and post-delivery. This form collects general demographics and information about the pregnancy and birth. It helps to identify any needs or resources that the parents or infant may qualify for. The individuals are given the appropriate information and referrals when needed. This form is a collaborative effort between the NWCHC (Northwest Community Health Center), Cabinet Peaks Medical Center, Dr. Bell, and Dr. Rice. The goal is for providers to give this form to mothers during prenatal care for early interventions and connection to resources when needed."*

On April 16th, the FCHB sent guidance to the CPHDs regarding all the different pass-through federal funding programs it administers and that MCHBG funding could be used for COVID-19 response activities. As this vital work took priority, the ability to use MCHBG funding in support of these efforts was especially important to the SPM 2 counties. The percent of their maternal and child clients provided with referral and follow-up services actually saw a spike over FFY19, from 50% to 68%.

The 2020 Statewide Needs Assessment recognized family support and health education as a continuing priority. Care coordination and referral follow-up were also frequently cited as unmet needs with major effects on the health of the whole maternal and child population, especially ages 0 to 19 years. Survey and interview respondents noted needs for: more family support in terms of community connectedness; family-friendly events; helping families gain access to public assistance; peer groups, especially peer groups for parents with children with special health care needs; and means to connect families with available services.

Many respondents also saw a need to address child abuse and neglect and to support healthy parent-child relationships. Broad support for meeting these health needs provided strong evidence to continue SPM 2 for Family Support Services. The FCHB chose to keep SPM 2 as a performance measure for the timeframe of FFYs 2021-2025, and eleven CPHDs selected it for FFY21.

Cross-Cutting/Systems Building - Application Year

(This narrative covers two State Performance Measures)

SPM 1 - Access to Care and Public Health Services: Number of clients ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less.

For many of Montana's counties with frontier-level populations, their County Public Health Departments (CPHDs) are made up of just one or two dedicated healthcare professionals – usually with deep personal ties to the area. Public health professionals across the state have seen unprecedented challenges related to COVID-19. Nevertheless, they have stepped up to go above and beyond in protecting, educating, and serving the most vulnerable residents of their counties.

The total number of CPHDs participating in the MCHBG for FFY21 decreased in number by three. Of the 49 remaining, 25 selected SPM 1 as their performance measure. The selections take place in June for the upcoming federal fiscal year. All of the CPHDs have been allowed to redirect MCHBG funding towards COVID-19 response efforts as needed. Most are also attempting to implement performance measure specific activities as time and resources permit.

Another characteristic of these counties with very small populations is the central importance of schools to the whole community. Most do not have school nurses, so the CPHD nurses often pull double-duty, working in and with their schools. Many SPM 1 activities are dependent on school access. In June 2020, it was a general hope that sometime in the 2020-21 school-year, the children would be able to return to in-person classes. While this was the case by spring of 2021, CPHD staff have been too involved with providing COVID-19 vaccinations to resume much of their routine work.

The following shows the category breakdown for planned SPM 1 activities in FFY21 as submitted on the Pre-Contract Survey in June 2020, from the 25 CPHDs which chose SPM 1:

Activity Category	Number of Activities	Percent of Total
School-Based Screenings & Health Education =	18	32%
Immunization Related =	10	18%
Injury-Prevention =	10	18%
Oral Health Related =	7	12%
Mental Health & Suicide Prevention =	5	9%
Women & Infant Health Related =	4	7%
Family Social Services Support =	3	5%
Total Number of Activities =	57	

CPHD reporting to date provides examples of the range of activities they have been able to implement:

- Prairie (MCH population = 455) – "Hand Hygiene/Respiratory Hygiene: The Prairie County Public Health Nurse went to the school to give hand hygiene and respiratory hygiene education to the teachers and students in grades K-5th. The nurse demonstrated how to properly wash hands, as well as how and when to wear a mask, how to properly sneeze or cough, how to use and dispose of facial tissues, and what objects tend to have germs because of frequent touching of surfaces. This was performed September 10-11th to coincide with the beginning of the school year, and getting children an early start on proper hygiene. Eighty students participated in the education. Each student also received a "FirstAid for Feelings" workbook to help kids cope during the Coronavirus pandemic."

- Phillips (MCH population = 1,534) - "Infant health - We are sending out baby packets to new parents in the county with some sample baby items. These include diaper rash cream, diaper samples, breast pads, etc., along with a

letter welcoming their new baby and encouraging them to schedule with us for vaccinations. We also include a schedule of vaccinations. We have had good success with this and have received phone calls to schedule because they read our letter.

Once they bring baby in for the first time, we always try to schedule their next set of shots before they leave or put a reminder on the outlook calendar when they are due. We are still promoting our injury prevention activity focused on safe sleep. I have made up a survey with various questions including sleeping practices, environment, etc. I am starting to see a pattern of blankets/bumpers being used in the sleep environment and have done some education on our Facebook page regarding this issue. We continue to share this information as often as we feel we need to. The surveys are sent out with the new baby packets and if they are returned they are given a sleep sack to promote safe sleep. We are giving out safe sleep kits this quarter which includes a sleep sack, a room thermometer, a magnet with the ABC's of safe sleep, and a brochure on safe sleep practices regarding the sleep environment specifically.

Child health- Every week someone from our staff runs a report off imMTrax to see which children are due or overdue for vaccinations. Phone calls, text messages, Facebook messages, or a postcard is sent to get in touch with parents to try and get them to schedule. When they do make it in, we utilize our recall-reminder process for the next set of shots. We are still collaborating with Valley County, county seat in Glasgow, as they approached us to join their oral health program for children ages 0-6. We are offering fluoride varnish to this population during every visit. Our visits for immunizations and oral health were still down overall but we have started to work them back into our weeks as COVID-19 allows. We finished in-school flu clinics around the county during the months of October and November and immunized students in the elementary with parental consent and COVID-19 precautions in place."

- Sweet Grass (MCH population = 1195) – "Most planning efforts are currently focused on the COVID-19 response. I was able to offer 4 different influenza clinics this quarter. These were all at different locations and available to the public. My influenza numbers were down this year, but I did 174 influenza vaccines at these 4 different clinics. Other activities have been focusing on COVID cases and contact tracing of direct contacts. I have worked very closely with the Pioneer Medical Center, our local schools, and many other businesses in relation to this. I am beginning to plan for COVID vaccination clinics. I hope to do this in an area that is convenient for people to access and offers enough room for social distancing, etc."

The Family & Community Health Bureau (FCHB) expects to see continued movement towards normal performance measure activities. In FFY 2022, the FCHB will contract with and support the twenty-four CPHDs who chose to focus on SPM 1. These counties will implement and evaluate at least two community community-level activities during the fiscal year. The FCHB will provide these counties with training, resources, and support on evidence-informed activities, goal setting and evaluation.

SPM 2 – Family Support and Health Education: number of clients ages 0 - 21, and women ages 22 - 44 who are assessed for social service and health education needs; and are then placed into a referral and follow-up system, or provided with health education as needed.

SPM 2 continues to meet the priority needs of many mid to larger-population size counties. Nine County Public Health Departments (CPHD) carry on with activities from the previous federal fiscal year, and two are new to the performance measure, Big Horn and Glacier. Two of the CPHDs working on SPM 2 have also chosen to implement activities for NPM 5: Lewis & Clark and Yellowstone.

Supplementing CONNECT is a main endeavor for four of these CPHDs. Plans include outreach to the community; training for both internal staff and external providers; increasing usage; and, provider recruitment. For the remainder of their SPM 2 activities, the CPHDs are focusing on internal referral and follow-up systems: creating new ones; increasing usage with

clients; training staff; and quality improvement, i.e., upgrading forms and process flows.

Seven of the CPHDs originally choosing SPM 2 for FFY 21 eventually made formal requests to redirect their MCHBG funding towards COVID-19 efforts. These counties were: Big Horn, Carbon, Flathead, Glacier, Park, Richland, and Yellowstone. Their efforts certainly apply to addressing social determinates of health and family support.

Counties close to or sharing geographic areas with American Indian reservations have been especially hard hit by the virus. The following is an excerpt from Big Horn CPHD's quarterly report. Big Horn County includes the Crow Reservation and is next to the Northern Cheyenne:

> *"During the first quarter of this cycle, our health department was answering questions about COVID19, arranging for testing, contact tracing positive cases, notifying individuals about their quarantine status, coordinating with the schools to identify students who were exposed to positive cases, and assisting school nurses in their investigations of positive cases. We also made home deliveries of school-supplied computers to those who were placed on quarantine, food boxes for families who were all quarantined, and activity kits for children who were quarantined at home for 14 days.*
> *Big Horn County Health Department coordinated daily, often several times each day, with the Crow & Northern Cheyenne Indian Hospital Service Unit's Public Health Nursing Department. We split up the cases according to where they lived and our own resources."*

In its report for the 1st quarter timeframe of October 1, 2020 through December 31, 2020, Lewis & Clark CPHD spoke about their focus on mental health:

> *"It is essential for families to find the proper supports for mental health issues. Mental health clinicians may have a wait time before a family can access their services. Providing other community supports can help resolve some issues that can cause anxiety for a family. During the first quarter 100% of clients requiring mental health services were referred to the proper clinician within 90 days of enrollment. In addition to mental health clinicians, home visitors are facilitating the connection of informal or secondary supports to their clients. These additional supports include, MOPS (Mothers of Preschoolers), NAMI (National Alliance for Mental Illness), the Food Resource Center, Helena Food Share, and The Awareness Network among many others."*

Yellowstone CPHD has been able to devote some staff time for implementing a new SPM 2-related activity, detailed as follows:

> *"We are also excited to be a partner in development and launch of the "Healthy Spark" program, which is a substance abuse prevention/intervention/treatment pilot project for pregnant mothers and those with infants at risk of substance abuse. This is a partnership between The Montana Healthcare Foundation, St. Vincent Hospital, RiverStone Health evidence-based programs, Rimrock Treatment Services, and Kurt Alme - US. Attorney General for Montana (subsequently chosen as Gov. Gianforte's Budget Director). Mothers enrolled in the St. Vincent Healthcare mid-wifery program will be enrolled to pilot this program.*
>
> *The service consists of enrolling pregnant women, evaluating substance abuse risk and providing both virtual support via: a GoMo Health texting platform; RiverStone FHS home visiting; and, access to chemical dependency treatment options through the Rimrock Treatment Services. Clients are assessed in collaboration with client (self) feedback. The appropriate level of needed services and resources are provided. There is flexibility to take into account that a person's situation might change during the case life. The goal is to see if this combination provides an economically sustainable means to reduce the substance abuse impact on pregnant women.*
>
> *A researched menu of texts are sent to women at timely intervals, depending on the status of their pregnancy, post-natal status, and chemical dependency status. The messages are designed to be in synchronicity with the persons*

needs and therein be of more interest and value."

In FFY 2022, the Family & Community Health Bureau (FCHB) will contract with and support these CPHDs who chose to focus on SPM 2: Carbon, Glacier, Flathead, Hill, Lewis & Clark, Missoula, Park, Sanders, and Yellowstone. These counties will implement and evaluate at least two community-level activities during the fiscal year. The FCHB will provide these counties with training, resources and support on evidence-informed activities, goal setting and evaluation.

III.F. Public Input

Public input on the MCHBG Application & Report (MCHBG-AR) relies heavily on feedback and contributions solicited from committees, task force members, advisory councils, and stakeholders. Notably, the Public Health System Improvement Task Force (PHSITF), County Public Health Departments (CPHDs), CSHS stakeholders and contractors; and, other programs housed within the Family and Community Health Bureau (FCHB) which impact the maternal and child population are tasked with providing input.

The PHSITF has 14 members, representing a cross-section of agencies, statewide associations, and CPHDs with differing population levels. They offer their respective entities' input on the MCHBG-AR throughout the year. The MCHBG Program Specialist serves as the liaison to the PHSITF. The attendees are offered the opportunity to provide input on MCHBG activities and are tasked with ensuring their constituents are made aware of the MCHBG-AR process. PHSITF members are provided with an initial copy of MCHBG-AR for additional input and comments and offered the opportunity to observe the federal review. The MCH and CSHS Directors are also engaged as members of the Mothers, Babies, and Youth/ACEs Workgroup and receive input from the 30+ other participants.

The CPHDs which receive MCHBG funds are contractually required to conduct client satisfaction surveys and report the results to the FCHB. They also use the results for quality improvement in their MCHBG service delivery and for MCHBG program planning. The CPHDs provide feedback on the performance measure they are implementing, and on MCHBG priorities through online surveys; in-person site visits; annual training sessions; and, through the Pre-Contract Survey (PCS).

The PCS gathers information such as populations served, hours of operation, and the needs of their community's maternal and child population. The PCS serves multiple purposes: 1) the CPHD identifies their selected National Performance Measure/State Performance Measure (NPM/SPM) and the coming year's activities, goals and evaluation to address the N/SPM; 2) it collects CPHD information such as requests for program technical assistance or materials; and 3) gathers information about emerging MCH issues which the CPHDs have identified through their own needs assessment.

Both the MCHBG Program Specialist and Fetal, Infant, Child, and Maternal Mortality Review (FICMMR) Coordinator support the work of CPHD MCH-focused programs. This includes partnership with 31 local FICMMR teams, some of whom serve more than one CPHD, so all 56 counties are covered. In May 2021, the MCHBG Program Specialist facilitated three web-based Title V/MCHBG Annual Trainings, attended by a total of 60 CPHD staff. The focus was the June 2021 Pre-Contract Survey (PCS) and upcoming deliverables for FFY 2022. Similar training was offered to the FICMMR Liaisons in June 2021, which was attended by at least one FICMMR team member from each CPHD.

Children's Special Health Services (CSHS) supports the Consumer Advisory Council (CAC) of the University of Montana Rural Institute for Inclusive Communities (UMRI) in planning strategies to educate families about CYSHCN's transition to adult services. The CAC is made up of four young adults with special healthcare needs, four parents, and representatives from several agencies, including the Office of Public Instruction and Montana Vocational Rehabilitation. CSHS plans to convene a Stakeholder's Group in the fall of 2021 with the goal of to involve parents, agencies, providers, and state program staff in annual strategic planning activities.

The Montana Parent Partner Program (MPPP) is a peer-support program, whereby, parents of CYSHCN work in clinics to offer support and connect all, with an emphasis on CYSHCN families with clinical and non-clinical services. The goal of the MPPP is to support and empower families of CYSHCN when making decisions about their child's care and accessing services. The Parent Partners participate in monthly calls with CSHS and provide input regarding issues facing Montana families, led by the MPPP Coordinator, Tarra Thomas. Ms. Thomas also serves as the Montana AMCHP Family Delegate and is a member of the CSHS Stakeholder's Group. In each of these roles she provides regular input on CSHS Programs and services, specific challenges facing Montana families, and the annual MCHBG report.

The Montana Access to Pediatric Psychiatry Network (MAPP-Net) recruited and maintains an Advisory Council that oversees the activities of the grant. Council members from across the state include: primary care providers; behavioral health providers; families of children and youth receiving behavioral health services; Tribal Health representatives; educators; Child and Adolescent Psychiatrists (CAPs); and representatives from other grant programs working with similar populations.

The MAPP-Net Advisory Council met twice in FFY 2021. The goal of the Advisory Council is to seek stakeholder input from across the state on the activities of the MAPP-Net grant. MAPP-Net is in the process of appending the needs assessment conducted in 2019 to better include: youth experiencing homelessness; LGBTQI youth; American Indian Youth; and, the needs of primary care and behavioral health providers to better serve children and youth in their communities with mental

healthcare.

The Early Childhood and Family Support Division (ECFSD) Leadership team is committed to enhancing ongoing and meaningful public input into the development of the MCHB plan as well as program design. Examples of work in other areas of the divisoin include a Home Visiting Strategic Planning Committee which held four public meetings with opportunity for public input, state plan public hearings for the child care state plan, and advisory council meetings with open public comment periods as regular agenda items. The ECFSD has continued to evolve since it's formation a little more than a year ago, with focused energy on website modernization and social media strategies.

III.G. Technical Assistance

Since January of 2020, the creation of the new Early Childhood Family Services Division (ECFSD) has been progressing. Technical assistance opportunities are being identified and pursued to support individual sections, division-wide collaborative efforts, and overall systems change. Identification of these topics has surfaced from internal discussion, stakeholder feedback, and HRSA staff input.

Technical Assistance Request Topics (**higher priority)*:

1. **Diversity and Health Equity Approaches* – Ensuring diversity, equity, and inclusion (DEI) are pillars of ECFSD programming, systems-building, and incorporate Montana-specific needs, including an approach that addresses frontier populations and tribal populations.

2. *Strategic Planning* – Synergistic opportunities in ECFSD, specifically Maternal & Child Health (MCH), Children's Specials Health Services (CSHS), and Maternal, Infant, & Early Childhood Home Visiting (MIECHV), have been identified. Intentional collaboration, shared goals, and systems perspective will allow for the implementation of population health strategies with the goal of positively impacting health outcomes.

3. **Data, Evaluation and Continuous Quality Improvement* - How to build internal capacity and build data infrastructure to support early childhood and maternal child outcome metrics.

4. *Workforce Development*
    a. *CYSHCN Standards of Care:* Title V and ECFSD leadership training on national standards to inform program planning and decision making
    b. DEI training to build baseline ECFSD and Title V staff competencies on health and racial equity.

5. *Title V Technical Assistance*
    a. **Skills to Support National Performance Measures*
        1. *Medical Home indicators*- Structured support in how the Medical Home National Performance measure should be extrapolated to Title V contractors.
    b. *Family and Youth Engagement* – Understand the most impactful way for families and youth to be engaged in systems-building work.

Each technical assistance topic will further Title V goals. MCH and CSHS have identified higher priority TA requests as indicated by the asterisks in the above list. CSHS is in the process of pursuing technical assistance to further workforce development and skills to support National Performance Measure 11.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - MT_MCHBG_TitleV_MedicaidIAAMOU.pdf

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - MT_SupportingDocumentsTableOfContents_AndSectionIII_Narratives.pdf

Supporting Document #02 - MT_SupportingDocuments_COVID19_Related.pdf

Supporting Document #03 - MT_SupportingDocuments_NeedsAssessmentRelated.pdf

Supporting Document #04 - MT_SupportingDocuments_PerformanceMeasureDomains.pdf

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - MT_MCHBG_OrganizationChartFCHB_April2021.pdf

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Montana

	FY 22 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,323,181	
A. Preventive and Primary Care for Children	$ 848,546	(36.5%)
B. Children with Special Health Care Needs	$ 736,690	(31.7%)
C. Title V Administrative Costs	$ 190,439	(8.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,775,675	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,170,955	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 5,644,793	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 6,548,111	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 15,363,859	
A. Your State's FY 1989 Maintenance of Effort Amount $ 485,480		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 17,687,040	
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)	$ 25,867,305	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 43,554,345	

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 3,321,400
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 13,331,125
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program	$ 1,917,324
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 159,003
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	$ 119,569
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 160,020
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Loan Repayment	$ 127,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 4,379,043
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 22,123
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > Sexual Risk Avoidance Education (SRAE)	$ 177,870
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 240,117
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 444,807
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 522,622
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Grants to States to Support the Oral Healthcare Workforce	$ 400,000
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Farmers Market	$ 59,782

OTHER FEDERAL FUNDS	FY 22 Application Budgeted
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Newborn Hearing	$ 235,000

	FY 20 Annual Report Budgeted		FY 20 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	$ 2,323,181		$ 2,281,823	
A. Preventive and Primary Care for Children	$ 766,191	(33%)	$ 842,098	(36.9%)
B. Children with Special Health Care Needs	$ 782,417	(33.7%)	$ 709,762	(31.1%)
C. Title V Administrative Costs	$ 136,966	(5.9%)	$ 167,097	(7.4%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	$ 1,685,574		$ 1,718,957	
3. STATE MCH FUNDS (Item 18c of SF-424)	$ 3,182,030		$ 3,197,388	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	$ 12,336,754		$ 5,666,253	
5. OTHER FUNDS (Item 18e of SF-424)	$ 0		$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	$ 8,486,816		$ 6,598,569	
7. TOTAL STATE MATCH (Lines 3 through 6)	$ 24,005,600		$ 15,462,210	
A. Your State's FY 1989 Maintenance of Effort Amount $ 485,480				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	$ 26,328,781		$ 17,744,033	
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)	$ 23,766,761		$ 27,095,321	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	$ 50,095,542		$ 44,839,354	

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
Department of Health and Human Services (DHHS) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	$ 250,000	$ 250,000
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	$ 172,500	$ 172,500
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	$ 515,600	$ 519,749
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Preventive Health and Health Services Block Grant	$ 22,123	$ 22,123
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	$ 4,680,084	$ 4,497,053
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	$ 400,000	$ 446,692
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	$ 444,794	$ 508,329
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Loan Repayment	$ 127,500	$ 127,500
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Primary Care Office (PCO)	$ 159,003	$ 163,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	$ 247,355	$ 235,000
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	$ 970,000	$ 0
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	$ 1,900,000	$ 2,510,700
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	$ 5,652,698	$ 6,782,488

OTHER FEDERAL FUNDS	FY 20 Annual Report Budgeted	FY 20 Annual Report Expended
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	$ 175,308	$ 245,123
US Department of Agriculture (USDA) > Food and Nutrition Services > Food Distribution Program	$ 7,190,014	$ 8,057,446
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Maternal Health Innovation Program		$ 2,253,794
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Grant	$ 100,000	$ 100,000
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Teen Pregnancy Prevention	$ 375,000	$ 0
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Sexual Risk Avoidance Fund	$ 325,000	$ 161,188
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Farmers Market	$ 59,782	$ 42,636

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**

Field Note:
The Title V/MCHBG program is housed in the Early Childhood Family Support Division (ECFSD), Family & Community Health Bureau. The program indirect charges are determined by the ECFSD Administrative Cost Allocation Pool.

Effective on 7/1/2021, ECFSD consolidated into two distinct indirect plans for cost allocation expenses, both based on the number of staff/FTE directly charging a program/fund.

The ECFSD staff/FTE, who provide service and support for multiple ECFSD programs or funds charge their time to the ECFSD Administrative Cost Allocation Pool. This method allows for the necessary day to day required duties, i.e. management, administrative, fiscal, business/operating systems, and epidemiological support to be covered. It also allows for ECFSD emerging programmatic needs to be addressed, i.e. creation of a new program due to the receipt of new federal funding.

Additionally, the program will also have indirect costs from a second distinct plan, the FCHB Cost Allocation Pool. The FCHB Cost Allocation Pool is also based on staff/FTE.

Additional indirect costs are allocated based on the current Montana's Department of Public Health and Human Services Indirect Cost Plan, which was revised on February 23, 2018.

2.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**

Field Note:
These FCHB programs are anticipated to receive state appropriated funds: CSHS, WIC, Family Planning/Title X, Healthy MT Families/Home Visiting; Primary Care Office/State Loan Repayment Program.

3.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**

Field Note:
FCHB programs receiving federal funds support services for the MCH Population provided by County Public Health Departments; healthcare clinics; community based organizations; middle and high school students; UW/School of Dentistry student rotations; MT State University College of Nursing Students providing oral health screenings and education; WIC Clinics; FQHCs; as well as support state staff making data driven decision.

4.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2022**
	Column Name:	**Application Budgeted**
	Field Note: Program income is from WIC; CSHS, and Family Planning/Title X Programs.	
5.	**Field Name:**	**1.FEDERAL ALLOCATION**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Total amount reflects the 5 NOAs received on: 10/25/19; 12/13/19; 3/3/20; 3/17/20; and 7/6/20. Fiscal Bureau confirmed this amount as expended for FFY 2020.	
6.	**Field Name:**	**Federal Allocation, C. Title V Administrative Costs:**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: Administrative costs reflect the Title V program being moved to the Early Childhood Family Support Division (ECFSD) in January 2020. The FY 2020 budgeted amount was calculated based on the Title V being housed in the Public Health & Safety Division.	
7.	**Field Name:**	**3. STATE MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: NOTE--8/4/21--Lisa will gather the other ECFSD state funds to combine with the FCHB identified funds. Children's trust fund, child care, etc.	
8.	**Field Name:**	**4. LOCAL MCH FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The FFY 2020 budgeted amount did not anticipate the COVID-19 pandemic impact to the County Public Health Departments.	
9.	**Field Name:**	**5. OTHER FUNDS**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**

	Field Note: NOTE: Need to detrmine if ECFSD programs get any outside funds. like no kid hungry--08 funds term from Lisa.	
10.	**Field Name:**	**6. PROGRAM INCOME**
	Fiscal Year:	**2020**
	Column Name:	**Annual Report Expended**
	Field Note: The FFY 2020 program income amount did not anticipate the COVID-19 pandemic impact to the County Public Health Departments, WIC, Title X/Family Planning, and CSHS programs which report program income.	

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served

State: Montana

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 119,692	$ 128,580
2. Infants < 1 year	$ 190,722	$ 198,761
3. Children 1 through 21 Years	$ 848,546	$ 842,098
4. CSHCN	$ 736,690	$ 709,762
5. All Others	$ 237,092	$ 235,525
Federal Total of Individuals Served	$ 2,132,742	$ 2,114,726

IB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Pregnant Women	$ 198,731	$ 224,829
2. Infants < 1 year	$ 4,775,465	$ 4,754,189
3. Children 1 through 21 Years	$ 3,570,375	$ 3,778,634
4. CSHCN	$ 266,406	$ 335,782
5. All Others	$ 3,275,366	$ 3,326,162
Non-Federal Total of Individuals Served	$ 12,086,343	$ 12,419,596
Federal State MCH Block Grant Partnership Total	$ 14,219,085	$ 14,534,322

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: Montana

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 50,000	$ 0
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	$ 0	$ 0
C. Services for CSHCN	$ 50,000	$ 0
2. Enabling Services	$ 1,350,524	$ 1,355,659
3. Public Health Services and Systems	$ 922,657	$ 926,164
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		$ 0
Physician/Office Services		$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 0
Direct Services Line 4 Expended Total		$ 0
Federal Total	$ 2,323,181	$ 2,281,823

IIB. Non-Federal MCH Block Grant	FY 22 Application Budgeted	FY 20 Annual Report Expended
1. Direct Services	$ 315,000	$ 184,320
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	$ 0	$ 0
C. Services for CSHCN	$ 315,000	$ 184,320
2. Enabling Services	$ 7,721,968	$ 7,850,372
3. Public Health Services and Systems	$ 7,280,181	$ 7,406,905
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		$ 0
Physician/Office Services		$ 22,815
Hospital Charges (Includes Inpatient and Outpatient Services)		$ 0
Dental Care (Does Not Include Orthodontic Services)		$ 0
Durable Medical Equipment and Supplies		$ 0
Laboratory Services		$ 22,958
Other		
Therapies		$ 138,547
Direct Services Line 4 Expended Total		$ 184,320
Non-Federal Total	$ 15,317,149	$ 15,441,597

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: Montana

Total Births by Occurrence: 11,166 **Data Source Year: 2020**

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	11,166 (100.0%)	51	10	10 (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	Cystic Fibrosis
Glutaric Acidemia Type I	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)	Primary Congenital Hypothyroidism
Propionic Acidemia	S, ßeta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiences
ß-Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	

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
Hearing	10,367 (92.8%)	35	2	2 (100.0%)
Critical Congenital Heart Disease	9,884 (88.5%)	4	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

The Montana Newborn Screening Program does not provide or monitor long-term follow-up for all conditions identified through newborn screening. However, programs do provide family and clinical support for some conditions. The Universal Newborn Hearing and Intervention Program provides supportive services to families when a baby is diagnosed deaf or hard of hearing. This support is provided through family led organizations. Any individual with a metabolic disorder (including infants diagnosed through newborn screening) can receive long-term follow-up services through a contractor funded by CSHS.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	**Field Name:**	**Core RUSP Conditions - Total Number Confirmed Cases**
	Fiscal Year:	**2020**
	Column Name:	**Core RUSP Conditions**

Field Note:
Cases identified by bloodspot screening include:
MCADD (1 infant)
Glutaric acidemia type I (1 infant)
Cystic fibrosis (8 infants)

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Montana

Annual Report Year 2020

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	2,587	38.8	0.3	8.5	2.8	49.6
2. Infants < 1 Year of Age	4,886	46.8	2.7	13.0	2.0	35.5
3. Children 1 through 21 Years of Age	24,341	50.6	4.0	32.1	5.3	8.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,076	55.5	5.0	18.2	10.7	10.6
4. Others	8,422	29.2	0.2	40.2	6.6	23.8
Total	40,236					

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	11,079	Yes	11,079	32.0	3,545	2,587
2. Infants < 1 Year of Age	11,122	No	22,073	82.8	18,276	4,886
3. Children 1 through 21 Years of Age	270,863	Yes	270,863	30.0	81,259	24,341
3a. Children with Special Health Care Needs 0 through 21 years of age^	55,374	Yes	55,374	100.0	55,374	1,076
4. Others	786,256	Yes	786,256	1.1	8,649	8,422

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	**Field Name:**	**Pregnant Women Total Served**
	Fiscal Year:	**2020**
	Field Note: Number provided enabling services by County Public Health Departments using MCHBG funding.	
2.	**Field Name:**	**Infants Less Than One YearTotal Served**
	Fiscal Year:	**2020**
	Field Note: Number provided enabling services by County Public Health Departments using MCHBG funding.	
3.	**Field Name:**	**Children 1 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Number provided enabling services by County Public Health Departments using MCHBG funding.	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Number provided enabling services by County Public Health Departments using MCHBG funding.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Number provided enabling services by County Public Health Departments using MCHBG funding.	

Field Level Notes for Form 5b:

1.	**Field Name:**	**Pregnant Women**
	Fiscal Year:	**2020**
	Field Note: Pregnant Women = 3,542 Source: WIC FFY2020 “certified pregnant women”	
2.	**Field Name:**	**InfantsLess Than One Year**
	Fiscal Year:	**2020**
	Field Note: Denominator is from Form 6. Infant <1 Year = 18,268 Sources: CSHS Newborn Screenings FFY2020 (10,604) + MIECHV FFY2020 (256) + WIC FFY2020 (7,408)	
3.	**Field Name:**	**Children 1 Through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Children 1 through 21 Years (without CSHCN) = 25,238 Sources: Oral Health 9/1/19-8/31/2020 (1,882) + Title X FFY2020 (3,001) + WIC FFY2020 (20,018) + MIECHV FFY2020 (337)	
4.	**Field Name:**	**Children with Special Health Care Needs 0 through 21 Years of Age**
	Fiscal Year:	**2020**
	Field Note: Four CSHS programs (Medical Home Portal, Newborn Screening, Genetic Financial Assistance, and Transition Care) all take a systems and population-based approach to serving 100% of the CYSHCN population.	
5.	**Field Name:**	**Others**
	Fiscal Year:	**2020**
	Field Note: Others actual number is = 8,422. Could not get the percentage field to take the correct input. Source: MCHBG Participating County Public Health Departments.	

Data Alerts:

1.	Others, Form 5a Count is greater than or equal to 90% of the Form 5b Count (calculated). Please check that population based services have been included in the 5b Count and not in the 5a Count.

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Montana

Annual Report Year 2020

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	10,870	8,670	61	573	1,072	114	9	338	33
Title V Served	10,870	8,670	61	573	1,072	114	9	338	33
Eligible for Title XIX	4,870	3,370	25	288	940	16	4	214	13
2. Total Infants in State	22,073	17,518	120	1,198	2,172	229	27	721	88
Title V Served	22,073	17,518	120	1,198	2,172	229	27	721	88
Eligible for Title XIX	11,605	8,184	63	748	1,969	82	18	498	43

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	**Field Name:**	**1. Total Deliveries in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Source: Montana Birth Certificate Vital Records. Records include all infants born in the state of Montana between 10/1/2019 - 9/30/2020 to Montana residents and non-residents. Total is 10,870 with 10,645 resident and 225 non-resident births, and 377 plural births.	
2.	**Field Name:**	**1. Title V Served**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Source: Montana State Lab. Total includes all infants born in Montana who received newborn screening, which is partially funded by MCHBG.	
3.	**Field Name:**	**1. Eligible for Title XIX**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Source: Birth Certificate Vital Records and Medicaid Eligibility (Montana Minimum/Core Dataset). Records include a distinct count of women listed as the mother in "deliveries in state" (as defined in field note 1) wherein the woman had a Medicaid eligibility span between the estimated last menstrual period (date based on obstetrical estimate of gestational age and date of birth) and infant's date of birth. Total is 4,870 with 46.4% of resident women being eligible (4,870) compared to 4.6% of non-resident women (13).	
4.	**Field Name:**	**2. Total Infants in State**
	Fiscal Year:	**2020**
	Column Name:	**Total**
	Field Note: Source: Montana Birth Certificate Vital Records. Records include all infants born in the state of Montana between 10/2/2018 - 9/30/2020 (who were thus under 1 year of age at some point during the 10/1/2019 - 9/30/2020 reporting period) to Montana residents and non-residents. Total is 22,073 with 21,630 resident and 443 non-resident births.	
5.	**Field Name:**	**2. Eligible for Title XIX**
	Fiscal Year:	**2020**

Column Name:	**Total**

Field Note:
Source: Birth Certificate Vital Records and Medicaid Eligibility (Montana Minimum/Core Dataset). Records include all infants in state (as defined above) wherein the infant had a Medicaid eligibility span between the infant's date of birth and the infant's first birthday. Total is 11,605 with 53.5% of infants of a mother who was a Montana resident at time of birth being eligible (11,563) compared to 9.5% of infants of non-residents (42).

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Montana

A. State MCH Toll-Free Telephone Lines	2022 Application Year	2020 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 362-8313	(800) 362-8313
2. State MCH Toll-Free "Hotline" Name	Montana Healthcare Help Line	Montana Healthcare Help Line
3. Name of Contact Person for State MCH "Hotline"	Heather Monday	Heather Monday
4. Contact Person's Telephone Number	(406) 444-1220	(406) 444-1220
5. Number of Calls Received on the State MCH "Hotline"		40,861

B. Other Appropriate Methods	2022 Application Year	2020 Annual Report Year
1. Other Toll-Free "Hotline" Names	Children's Special Health Services, 800-762-9891; Benefits Eligibility Assistance, 888-706-1535; WIC, 800-433-4298	Children's Special Health Services, 800-762-9891 (calls number listed below); Benefits Eligibility Assistance, 888-706-1535; WIC, 800-433-4298
2. Number of Calls on Other Toll-Free "Hotlines"		461
3. State Title V Program Website Address	DPHHS.mt.gov	DPHHS.mt.gov
4. Number of Hits to the State Title V Program Website		1,880,267
5. State Title V Social Media Websites	https://www.facebook.com/MTDPHHS	https://facebook.com/MTDPHHS
6. Number of Hits to the State Title V Program Social Media Websites		2,245

Form Notes for Form 7:

The State MCH Toll-Free Hotline changed it's Interactive Voice Response (IVR) System options, which resulted in a change in how calls tracked.

CHSH Toll-Free Number - Calls in FFY20 = 461

Stats for MCH Webpages are for "Visits."

DPHHS COVID-19 Specific Webpages Visits = 2,667,361 (not included in stats for MCH webpages).

Other statistics for the DPHHS Facebook page:
Total followers from 10/1/19 to 9/30/20 = 8668
Posts from 10/1/19 to 9/30/20 = 61
Female Followers - 82%
Male Followers 17%

DPHHS Twitter:
Followers = 828
Total Tweets from 10/1/19 to 9/30/20 = 75
Total likes from 10/1/19 to 9/30/20 = 185
Female followers = 74%
Male followers = 26%

DPHHS YouTube Channel
Total subscribers = 168
Total views from 10/1/19 to 9/30/20 = 12,995
Subscribers from 10/1/19 to 9/30/20 = 43
Watched hours from 10/1/19 to 9/30/20 = 471
Top 3 subjects watched from 10/1/19 to 9/30/20:
1. Mask-Up Montana = 3889
2. Stroke Treatment & Recovery = 1458
3. Suicide Prevention (Firearms) = 636

Public Health & Safety Division Facebook:
PHSD posts from 10/01/19 to 9/30/20 = 1,300
PHSD total likes as of 6/2/121= 4,078
Total people following PHSD = 4,386
Female followers = 86%
Male followers = 14%

Form 8
State MCH and CSHCN Directors Contact Information

State: Montana

1. Title V Maternal and Child Health (MCH) Director	
Name	Ann Buss
Title	Title V Director
Address 1	1625 11th Avenue
Address 2	
City/State/Zip	Helena / MT / 59620
Telephone	(406) 444-4119
Extension	
Email	abuss@mt.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director	
Name	Mackenzie Petersen
Title	CSHCN Director
Address 1	1625 11th Avenue
Address 2	
City/State/Zip	Helena / MT / 59620
Telephone	(406) 444-3716
Extension	
Email	mackenzie.petersen@mt.gov

3. State Family or Youth Leader (Optional)	
Name	Tarra Thomas
Title	HALI Project Parent Partner and State Coordinator
Address 1	229 Avenue D
Address 2	
City/State/Zip	Billings / MT / 59601
Telephone	(406) 697-4631
Extension	
Email	tarrathomasfa@outlook.com

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Montana

Application Year 2022

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Women's Preventive Healthcare	New
2.	Infant Safe Sleep	Continued
3.	Bullying Prevention	New
4.	Medical Home	Continued
5.	Children's Oral Health	New
6.	Access to Public Health Services	Continued
7.	Family Support and Health Education	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

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.	Women's Preventive Healthcare	New
2.	Infant Safe Sleep	Continued
3.	Bullying Prevention	New
4.	Medical Home	Continued
5.	Children's Oral Health	New
6.	Access to Public Health Services	Continued
7.	Family Support and Health Education	Continued

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 10
National Outcome Measures (NOMs)

State: Montana

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
2019	78.7 %	0.4 %	8,714	11,066
2018	77.5 %	0.4 %	8,884	11,465
2017	77.4 %	0.4 %	9,106	11,765
2016	75.3 %	0.4 %	9,205	12,232
2015	74.6 %	0.4 %	9,340	12,525
2014	75.2 %	0.4 %	9,258	12,317
2013	71.1 %	0.4 %	8,700	12,235
2012	73.5 %	0.4 %	8,774	11,941
2011	73.4 %	0.4 %	8,757	11,928
2010	73.9 %	0.4 %	8,654	11,718
2009	73.4 %	0.4 %	8,074	10,996

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
2018	38.6	6.0	41	10,613
2017	37.4	5.9	40	10,696
2016	57.5	7.3	63	10,963
2015	64.8	8.8	54	8,338
2014	50.4	6.9	53	10,509
2013	66.1	8.0	69	10,440
2012	71.6	8.4	73	10,192
2011	68.9	8.2	72	10,449
2010	77.7	8.5	84	10,814
2009	70.1	8.0	77	10,977

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
2015_2019	16.9	5.3	10	59,256
2014_2018	NR	NR	NR	NR

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
2019	7.3 %	0.3 %	804	11,074
2018	7.4 %	0.2 %	855	11,505
2017	8.0 %	0.3 %	942	11,793
2016	7.9 %	0.2 %	966	12,273
2015	7.1 %	0.2 %	887	12,575
2014	7.4 %	0.2 %	920	12,429
2013	7.4 %	0.2 %	913	12,370
2012	7.4 %	0.2 %	891	12,109
2011	7.2 %	0.2 %	867	12,061
2010	7.5 %	0.2 %	901	12,054
2009	7.1 %	0.2 %	865	12,247

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
2019	9.6 %	0.3 %	1,064	11,075
2018	9.1 %	0.3 %	1,047	11,507
2017	9.5 %	0.3 %	1,118	11,794
2016	8.8 %	0.3 %	1,074	12,271
2015	8.4 %	0.3 %	1,059	12,575
2014	9.3 %	0.3 %	1,157	12,423
2013	9.0 %	0.3 %	1,111	12,356
2012	9.4 %	0.3 %	1,136	12,099
2011	8.8 %	0.3 %	1,065	12,052
2010	10.1 %	0.3 %	1,222	12,042
2009	9.0 %	0.3 %	1,101	12,225

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
2019	27.1 %	0.4 %	3,005	11,075
2018	24.8 %	0.4 %	2,858	11,507
2017	23.7 %	0.4 %	2,795	11,794
2016	23.8 %	0.4 %	2,915	12,271
2015	22.7 %	0.4 %	2,855	12,575
2014	22.9 %	0.4 %	2,849	12,423
2013	23.0 %	0.4 %	2,837	12,356
2012	23.8 %	0.4 %	2,879	12,099
2011	24.5 %	0.4 %	2,953	12,052
2010	25.0 %	0.4 %	3,008	12,042
2009	26.2 %	0.4 %	3,197	12,225

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
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	3.0 %			
2017/Q3-2018/Q2	3.0 %			
2017/Q2-2018/Q1	4.0 %			
2017/Q1-2017/Q4	3.0 %			
2016/Q4-2017/Q3	4.0 %			
2016/Q3-2017/Q2	3.0 %			
2016/Q2-2017/Q1	3.0 %			
2016/Q1-2016/Q4	3.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	2.0 %			
2015/Q1-2015/Q4	3.0 %			
2014/Q4-2015/Q3	3.0 %			
2014/Q3-2015/Q2	4.0 %			
2014/Q2-2015/Q1	4.0 %			
2014/Q1-2014/Q4	4.0 %			
2013/Q4-2014/Q3	5.0 %			
2013/Q3-2014/Q2	7.0 %			
2013/Q2-2014/Q1	8.0 %			

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
2018	4.9	0.7	56	11,540
2017	4.3	0.6	51	11,823
2016	5.0	0.6	61	12,312
2015	4.8	0.6	61	12,615
2014	6.4	0.7	80	12,470
2013	5.3	0.7	66	12,415
2012	6.4	0.7	78	12,158
2011	5.9	0.7	72	12,103
2010	5.5	0.7	66	12,094
2009	5.5	0.7	68	12,294

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
2018	4.8	0.7	55	11,513
2017	5.5	0.7	65	11,799
2016	5.8	0.7	71	12,282
2015	5.8	0.7	73	12,583
2014	5.8	0.7	72	12,432
2013	5.6	0.7	69	12,377
2012	5.9	0.7	72	12,118
2011	6.0	0.7	72	12,069
2010	6.0	0.7	72	12,060
2009	6.2	0.7	76	12,257

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
2018	3.0	0.5	35	11,513
2017	3.1	0.5	36	11,799
2016	2.9	0.5	36	12,282
2015	3.5	0.5	44	12,583
2014	3.9	0.6	49	12,432
2013	2.9	0.5	36	12,377
2012	3.5	0.5	42	12,118
2011	4.4	0.6	53	12,069
2010	3.5	0.5	42	12,060
2009	3.3	0.5	41	12,257

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
2018	1.7	0.4	20	11,513
2017	2.5	0.5	29	11,799
2016	2.8	0.5	35	12,282
2015	2.3	0.4	29	12,583
2014	1.9	0.4	23	12,432
2013	2.7	0.5	33	12,377
2012	2.5	0.5	30	12,118
2011	1.6	0.4	19	12,069
2010	2.5	0.5	30	12,060
2009	2.9	0.5	35	12,257

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
2018	156.3	36.9	18	11,513
2017	93.2	28.1	11	11,799
2016	187.3	39.1	23	12,282
2015	79.5	25.1	10	12,583
2014	201.1	40.3	25	12,432
2013	113.1	30.3	14	12,377
2012	132.0	33.0	16	12,118
2011	124.3	32.1	15	12,069
2010	141.0	34.2	17	12,060
2009	146.9	34.6	18	12,257

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
2018	95.5 ϟ	28.8 ϟ	11 ϟ	11,513 ϟ
2017	127.1 ϟ	32.9 ϟ	15 ϟ	11,799 ϟ
2016	138.4 ϟ	33.6 ϟ	17 ϟ	12,282 ϟ
2015	182.8	38.2	23	12,583
2014	112.6 ϟ	30.1 ϟ	14 ϟ	12,432 ϟ
2013	129.3 ϟ	32.3 ϟ	16 ϟ	12,377 ϟ
2012	165.0	36.9	20	12,118
2011	132.6 ϟ	33.2 ϟ	16 ϟ	12,069 ϟ
2010	165.8	37.1	20	12,060
2009	228.4	43.2	28	12,257

Legends:

⚑ Indicator has a numerator <10 and is not reportable

ϟ 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
2019	9.0 %	1.1 %	957	10,689
2017	10.5 %	1.0 %	1,185	11,319

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
2018	7.8	0.9	85	10,830
2017	9.0	0.9	98	10,855
2016	7.6	0.8	83	10,976
2015	8.3	1.0	68	8,154
2014	7.8	0.9	80	10,321
2013	7.2	0.8	75	10,470
2012	4.4	0.7	47	10,633
2011	4.2	0.6	45	10,603
2010	3.5	0.6	38	10,856
2009	4.5	0.7	48	10,581

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
2018_2019	9.9 %	1.1 %	21,388	215,811
2017_2018	10.2 %	1.2 %	22,130	216,739
2016_2017	9.7 %	1.1 %	20,619	213,206
2016	11.8 %	1.5 %	24,614	209,436

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**
2019	22.1	4.4	25	113,373
2018	14.9 ϟ	3.6 ϟ	17 ϟ	113,963 ϟ
2017	10.5 ϟ	3.0 ϟ	12 ϟ	114,293 ϟ
2016	27.1	4.9	31	114,264
2015	32.6	5.4	37	113,460
2014	13.3 ϟ	3.4 ϟ	15 ϟ	112,885 ϟ
2013	18.7	4.1	21	112,420
2012	25.2	4.8	28	111,151
2011	28.9	5.1	32	110,879
2010	29.7	5.2	33	111,031
2009	30.0	5.2	33	109,878

Legends:

Indicator has a numerator <10 and is not reportable

ϟ 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
2019	50.2	6.2	65	129,384
2018	54.1	6.5	70	129,304
2017	42.3	5.8	54	127,681
2016	51.3	6.4	65	126,595
2015	52.2	6.4	66	126,408
2014	43.6	5.9	55	126,045
2013	48.4	6.2	61	125,995
2012	35.7	5.3	45	126,186
2011	46.9	6.1	60	127,899
2010	58.7	6.8	75	127,848
2009	51.7	6.3	67	129,656

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
2017_2019	21.4	3.4	41	191,418
2016_2018	18.8	3.1	36	191,102
2015_2017	24.1	3.6	46	190,925
2014_2016	29.3	3.9	56	191,405
2013_2015	32.3	4.1	62	192,049
2012_2014	28.0	3.8	54	193,188
2011_2013	25.0	3.6	49	196,016
2010_2012	26.2	3.6	52	198,457
2009_2011	31.3	3.9	63	201,589
2008_2010	33.3	4.0	68	204,191
2007_2009	33.7	4.0	70	207,573

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
2017_2019	27.2	3.8	52	191,418
2016_2018	26.7	3.7	51	191,102
2015_2017	24.1	3.6	46	190,925
2014_2016	22.5	3.4	43	191,405
2013_2015	21.3	3.3	41	192,049
2012_2014	19.2	3.2	37	193,188
2011_2013	19.9	3.2	39	196,016
2010_2012	17.1	2.9	34	198,457
2009_2011	18.9	3.1	38	201,589
2008_2010	17.1	2.9	35	204,191
2007_2009	13.5	2.6	28	207,573

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
2018_2019	19.6 %	1.5 %	44,583	227,910
2017_2018	19.6 %	1.6 %	44,607	227,585
2016_2017	19.3 %	1.5 %	43,541	226,022
2016	18.6 %	1.7 %	41,760	224,664

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
2018_2019	14.4 %	2.7 %	6,433	44,583
2017_2018	13.9 %	2.9 %	6,223	44,607
2016_2017	14.9 %	2.7 %	6,499	43,541
2016	17.1 %	3.2 %	7,139	41,760

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
2018_2019	1.7 %	0.7 %	3,318	190,661
2017_2018	2.5 %	0.9 %	4,823	190,889
2016_2017	3.1 %	0.9 %	5,905	190,205
2016	2.8 %	0.8 %	5,255	190,286

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
2018_2019	8.4 %	1.3 %	15,679	187,491
2017_2018	8.9 %	1.5 %	16,795	187,997
2016_2017	9.7 %	1.5 %	18,430	189,336
2016	8.0 %	1.4 %	15,152	188,751

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
2018_2019	62.2 %	4.9 %	20,154	32,404
2017_2018	54.2 %	5.5 %	14,813	27,339
2016_2017	62.7 %	5.1 %	18,112	28,889
2016	63.1 %	6.4 %	19,097	30,281

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
2018_2019	92.5 %	1.1 %	209,356	226,386
2017_2018	89.5 %	1.5 %	202,292	226,045
2016_2017	89.2 %	1.4 %	201,219	225,626
2016	91.5 %	1.3 %	205,239	224,213

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
2018	11.9 %	0.4 %	772	6,491
2016	12.1 %	0.4 %	801	6,647
2014	12.5 %	0.4 %	913	7,288
2012	11.3 %	0.4 %	893	7,886
2010	13.4 %	0.4 %	963	7,194
2008	13.5 %	0.4 %	1,096	8,142

Legends:

Indicator has a denominator <50 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	11.5 %	0.8 %	4,655	40,435
2017	11.7 %	0.7 %	4,739	40,406
2015	10.3 %	0.6 %	4,215	40,843
2013	9.4 %	0.5 %	3,866	41,112
2011	8.5 %	0.5 %	3,583	42,261
2009	10.3 %	1.1 %	4,474	43,345
2007	10.1 %	0.6 %	4,614	45,914
2005	9.3 %	0.7 %	4,312	46,302

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
2018_2019	10.6 %	1.9 %	10,230	96,693
2017_2018	10.8 %	2.0 %	10,330	96,025
2016_2017	12.3 %	2.0 %	10,818	87,975
2016	12.4 %	2.2 %	10,317	83,358

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**
2019	6.6 %	0.8 %	14,902	227,442
2018	4.9 %	0.8 %	10,969	225,588
2017	6.4 %	1.0 %	14,636	229,879
2016	4.2 %	0.7 %	9,543	228,642
2015	7.6 %	1.1 %	17,206	225,498
2014	8.6 %	1.2 %	19,239	224,105
2013	10.3 %	1.5 %	23,082	223,805
2012	10.9 %	1.3 %	24,004	219,888
2011	12.7 %	1.3 %	28,123	220,707
2010	12.7 %	1.2 %	28,315	222,903
2009	13.3 %	1.2 %	29,339	220,142

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
2016	60.2 %	3.9 %	7,000	12,000
2015	64.6 %	3.9 %	8,000	12,000
2014	67.9 %	3.8 %	8,000	12,000
2013	57.8 %	4.0 %	7,000	12,000
2012	65.6 %	4.3 %	8,000	12,000
2011	65.3 %	3.9 %	8,000	12,000

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
2019_2020	57.0 %	2.0 %	123,995	217,535
2018_2019	55.7 %	2.4 %	119,209	213,904
2017_2018	50.3 %	2.1 %	108,374	215,516
2016_2017	49.0 %	2.2 %	103,213	210,639
2015_2016	50.0 %	2.5 %	105,587	211,132
2014_2015	45.3 %	2.5 %	95,231	210,363
2013_2014	50.4 %	2.2 %	106,072	210,648
2012_2013	45.8 %	2.2 %	96,850	211,476
2011_2012	42.4 %	2.3 %	87,608	206,624
2010_2011	37.3 %	4.0 %	77,543	207,890
2009_2010	33.9 %	2.4 %	69,998	206,484

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
2019	63.7 %	3.4 %	41,180	64,676
2018	66.4 %	3.3 %	42,323	63,771
2017	65.5 %	3.2 %	40,700	62,166
2016	55.3 %	3.3 %	34,816	62,957
2015	50.4 %	3.0 %	31,598	62,694

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
2019	90.1 %	2.1 %	58,274	64,676
2018	86.7 %	2.4 %	55,294	63,771
2017	90.4 %	2.0 %	56,211	62,166
2016	85.7 %	2.4 %	53,951	62,957
2015	89.5 %	1.9 %	56,095	62,694
2014	84.7 %	2.4 %	52,910	62,436
2013	84.3 %	2.6 %	51,921	61,570
2012	90.2 %	1.9 %	56,070	62,190
2011	85.0 %	3.1 %	53,577	63,063
2010	76.1 %	2.6 %	49,007	64,401
2009	63.8 %	3.1 %	41,526	65,085

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
2019	73.1 %	3.1 %	47,275	64,676
2018	75.6 %	3.0 %	48,189	63,771
2017	71.2 %	3.0 %	44,265	62,166
2016	67.6 %	3.1 %	42,555	62,957
2015	65.8 %	2.8 %	41,246	62,694
2014	60.3 %	3.3 %	37,615	62,436
2013	51.6 %	3.4 %	31,763	61,570
2012	58.7 %	3.4 %	36,472	62,190
2011	39.8 %	4.3 %	25,114	63,063
2010	40.2 %	3.0 %	25,884	64,401
2009	26.9 %	2.9 %	17,524	65,085

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
2019	16.3	0.7	502	30,795
2018	17.2	0.8	531	30,787
2017	21.2	0.8	645	30,363
2016	23.7	0.9	720	30,382
2015	25.6	0.9	770	30,108
2014	26.6	0.9	807	30,342
2013	27.9	1.0	855	30,610
2012	28.7	1.0	892	31,106
2011	29.3	1.0	930	31,763
2010	35.2	1.1	1,128	32,089
2009	38.4	1.1	1,264	32,930

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
2019	15.2 %	1.4 %	1,612	10,606
2017	15.0 %	1.2 %	1,688	11,239

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
2018_2019	2.4 %	0.5 %	5,452	227,328
2017_2018	2.6 %	0.7 %	5,990	227,168
2016_2017	2.7 %	0.7 %	6,196	225,698
2016	2.8 %	0.8 %	6,214	224,268

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: Montana

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data		
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)		
	2019	**2020**
Annual Objective		
Annual Indicator	73.3	69.3
Numerator	123,845	119,515
Denominator	168,903	172,352
Data Source	BRFSS	BRFSS
Data Source Year	2018	2019

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	70.0	71.0	72.0	73.0	74.0	75.0

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)		
	2019	**2020**
Annual Objective	82	83
Annual Indicator	84.3	81.7
Numerator	9,362	8,632
Denominator	11,104	10,565
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	50	78	80	82	83
Annual Indicator	77.8	77.8	77.8		
Numerator					
Denominator					
Data Source	2015 Health Survey of Montana's Mothers and Babies	2015 Health Survey of Montana's Mothers and Babies	2015 Health Survey of Montana's Mothers and Babies		
Data Source Year	2015	2015	2015		
Provisional or Final ?	Final	Final	Provisional		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	84.0	85.0	86.0	87.0	88.0	89.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**

Field Note:
2017 PRAMS raw data has finally been released to the FCHB. Analysis of the infant safe sleep information will be available for the next report.

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)		
	2019	**2020**
Annual Objective	88	89
Annual Indicator	25.9	34.2
Numerator	2,795	3,557
Denominator	10,810	10,387
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			88	89
Annual Indicator	86.5	86.5		
Numerator				
Denominator				
Data Source	2015 Health Survey of Montana's Mothers and Babies	2015 Health Survey of Montana's Mothers and Babies		
Data Source Year	2015	2015		
Provisional or Final ?	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	90.0	91.0	92.0	92.0	93.0	94.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Sleeps in crib or portable crib	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2017 PRAMS raw data has finally been released to the FCHB. Analysis of the infant safe sleep information will be available for the next report.	

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)		
	2019	**2020**
Annual Objective	80	81
Annual Indicator	38.5	41.6
Numerator	4,169	4,335
Denominator	10,815	10,409
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			80	81
Annual Indicator	78.6	78.6		
Numerator				
Denominator				
Data Source	2015 Health Survey of Montana's Mothers and Babies	2015 Health Survey of Montana's Mothers and Babies		
Data Source Year	2015	2015		
Provisional or Final ?	Final	Final		

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	82.0	83.0	84.0	84.0	85.0	86.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Sleeps without plush or thick blankets	
2.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2017 PRAMS raw data has finally been released to the FCHB. Analysis of the infant safe sleep information will be available for the next report.	

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**
Annual Objective		
Annual Indicator	27.8	28.5
Numerator	11,393	11,853
Denominator	40,974	41,603
Data Source	YRBSS	YRBSS
Data Source Year	2017	2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Perpetration		
	2019	**2020**
Annual Objective		
Annual Indicator	23.2	23.2
Numerator	16,058	16,805
Denominator	69,345	72,374
Data Source	NSCHP	NSCHP
Data Source Year	2018	2018_2019

Federally Available Data		
Data Source: National Survey of Children's Health (NSCH) - Victimization		
	2019	**2020**
Annual Objective		
Annual Indicator	45.2	48.9
Numerator	31,448	35,450
Denominator	69,617	72,511
Data Source	NSCHV	NSCHV
Data Source Year	2018	2018_2019

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	27.0	26.0	25.0	24.0	23.0	22.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Using YRBS	

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data				
Data Source: National Survey of Children's Health (NSCH) - CSHCN				
	2017	**2018**	**2019**	**2020**
Annual Objective			49	50
Annual Indicator	47.5	39.9	36.8	43.5
Numerator	19,838	17,364	16,404	19,378
Denominator	41,760	43,541	44,607	44,583
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019

State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			49	50
Annual Indicator	47.5			
Numerator	19,838			
Denominator	41,760			
Data Source	National Survey of Childrens Health NSCH			
Data Source Year	2016			
Provisional or Final ?	Final			

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	51.0	52.0	53.0	53.0	54.0	55.0

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**

Field Note:
This number is Percent of children with special health care needs (ONLY), ages 0 through 17, who have a medical home;
NPM 11 - Percent of children without special health care needs, ages 0 through 17, who have a medical home is 54% (2016 National Survey of Children's Health Data)

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)			
	2016	**2019**	**2020**
Annual Objective			
Annual Indicator		82.6	82.1
Numerator		179,033	177,165
Denominator		216,777	215,773
Data Source		NSCH	NSCH
Data Source Year		2017_2018	2018_2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Annual Objectives						
	2021	**2022**	**2023**	**2024**	**2025**	**2026**
Annual Objective	83.0	84.0	85.0	86.0	87.0	88.0

Field Level Notes for Form 10 NPMs:

None

Form 10
National Performance Measures (NPMs) (2016-2020 Needs Assessment Cycle)

State: Montana

2016-2020: NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	182	180	90	89	88
Annual Indicator	88.5	111.8	122.1	122.2	134.9
Numerator	111	106	155	155	170
Denominator	125,378	94,803	126,908	126,831	126,062
Data Source	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016	2017	2018

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	182	180	90	89	88
Annual Indicator	101	91.8			
Numerator	127	116			
Denominator	125,724	126,404			
Data Source	SID	SID			
Data Source Year	2014	2015			
Provisional or Final ?	Final	Final			

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: 2014, 10-19 year old: 266.2;	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: 2015, 10-19 year old: 298.3	

2016-2020: NPM 10 - Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH)					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective			78	79	80
Annual Indicator		78.7	79.3	79.3	79.0
Numerator		55,013	56,264	56,264	59,661
Denominator		69,906	70,972	70,972	75,548
Data Source		NSCH	NSCH	NSCH	NSCH
Data Source Year		2016	2016_2017	2016_2017	2019

Historical NSCH data that was pre-populated under the 2016 Annual Report Year is no longer displayed, since it cannot be compared to the new NSCH survey data under the 2017 Annual Report Year.

Field Level Notes for Form 10 NPMs:

None

2016-2020: 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)		
	2019	**2020**
Annual Objective	59.5	60
Annual Indicator	47.0	50.4
Numerator	5,308	5,364
Denominator	11,296	10,649
Data Source	PRAMS	PRAMS
Data Source Year	2017	2019

State Provided Data					
	2016	**2017**	**2018**	**2019**	**2020**
Annual Objective	58	58.5	59	59.5	60
Annual Indicator	51.6	51.6	51.6		
Numerator					
Denominator					
Data Source	2015 The Health Survey of Montana's Mothers and Ba	2015 The Health Survey of Montana's Mothers and Ba	2015 Health Survey of Montana's Mothers and Babies		
Data Source Year	2015	2015	2015		
Provisional or Final ?	Final	Final	Final		

Field Level Notes for Form 10 NPMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: 2017 PRAMS raw data has finally been released to the FCHB. Analysis of the oral health information will be available for the next report.	

Form 10
State Performance Measures (SPMs)

State: Montana

SPM 1 - Access to Public Health Services: Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less who choose SPM 1.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		30	29	30	30
Annual Indicator	33.8	27.9	37.1	35.5	41.4
Numerator	1,484	2,184	9,142	14,149	19,550
Denominator	4,397	7,839	24,666	39,874	47,216
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	2016	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	30.0	30.0	30.0	30.0	30.0	30.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Number of CPHDs implementing changed from 6 to 10. Original objective for 2016 was 19.3.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: This SPM targets very small population counties which continue to loose population, so the objective is a minimum target percentage. A small change in numbers can make a large change in percentage in any given year - so will be looking at five year trends before changing objective.	

SPM 2 - Family Support & Health Education: Number of clients ages 0 - 21, and women ages 22 - 44 who are assessed for social service and health education needs; and are placed into a referral and follow-up system, or provided with health education as needed.

Measure Status:	Active

State Provided Data					
	2016	2017	2018	2019	2020
Annual Objective		40	40	40	40
Annual Indicator	45	40	39.5	51.1	70.1
Numerator	2,837	2,663	2,004	7,166	7,513
Denominator	6,305	6,658	5,077	14,036	10,714
Data Source	FCHB	FCHB	FCHB	FCHB	FCHB
Data Source Year	FY 2016	SFY 2017	SFY 18	FFY19	FFY20
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	45.0	45.0	45.0	45.0	45.0	45.0

Field Level Notes for Form 10 SPMs:

1.	**Field Name:**	**2016**
	Column Name:	**State Provided Data**
	Field Note: Change due to standardizing data collection formula for all CPHDs choosing SPM 2. Baseline objective for 2016 was 15%.	
2.	**Field Name:**	**2017**
	Column Name:	**State Provided Data**
	Field Note: Number of counties implementing SPM 2 changed (from 6 to 9), encompassing different population levels and numbers per MCH categories.	
3.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: Number of counties participating increased from 6 to 9. Also, moved tracking from state fiscal year to federal fiscal year.	
4.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Keeping a conservative objective for now, and waiting for 5-year trend results.	

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Montana

ESM 1.1 - Percent of activity goals to increase preventive medical visits for women which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	82.0	83.0	84.0	85.0	86.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Work on this ESM didn't begin until October 1, 2020, for FFY 2021.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Realization of this objective goal will likely by impacted the redirection of staff time and resources to COVID-19 response.	

ESM 5.1 - Percent of activity goals to decrease infant deaths due to unsafe sleep conditions which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			80	83
Annual Indicator			100	91.7
Numerator			15	11
Denominator			15	12
Data Source			FCHB	FCHB
Data Source Year			FFY 2019	FFY 2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	92.0	92.0	93.0	93.0	94.0	94.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
Realization of this objective goal will likely by impacted the redirection of staff time and resources to COVID-19 response.

ESM 9.1 - Percent of activity goals to reduce adolescent bullying which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	82.0	83.0	84.0	85.0	86.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Work on this ESM didn't begin until October 1, 2020, for FFY 2021.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Realization of this objective goal will likely by impacted the redirection of staff time and resources to COVID-19 response.	

ESM 11.1 - Percent of CYSHCN receiving services from a Parent Partner.

Measure Status:	Active

State Provided Data				
	2017	2018	2019	2020
Annual Objective			25	5
Annual Indicator			18.4	56.9
Numerator			36	132
Denominator			196	232
Data Source			FCHB	FCHB
Data Source Year			FFY 2019	FFY 2020
Provisional or Final ?			Final	Final

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	5.0	5.0	5.0	5.0	5.0	5.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**

Field Note:
With the increase of 36 more CYHSCN served by Parent Partners in FFY19, the percentage of increase is logically slowing, due to saturation at current locations. FFY20 numbers show that even more children are being reached, but objectives are being adjusted to reflect known population.

2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
232 families of children with special health needs were served in FFY19. 364 families were served in FFY20. We believe the increase was partially due to COVID19 related impacts on families as many of the encounters were for an initial meeting and referral. As COVID19 continued into FFY21, the number of parent partners declined and new parent partners did not replace them. We anticipate the number served in FFY21 will be less than FFY19 or FFY20 due to the impact COVID19 had on the Parent Partner workforce and clinic priorities.

3.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**

Field Note:
232 families of children with special health needs were served in FFY19. 364 families were served in FFY20. We believe the increase was partially due to COVID19 related impacts on families as many of the encounters were for an initial meeting and referral. As COVID19 continued into FFY21, the number of parent partners declined and new parent partners did not replace them. We anticipate the number served in FFY21 will be less than FFY19 or FFY20 due to the impact COVID19 had on the Parent Partner workforce and clinic priorities.

ESM 13.2.1 - Percent of activity goals to increase preventive dental visits for children which are met by county public health departments using MCHBG funding for the work.

Measure Status:	Active

Baseline data was not available/provided.

Annual Objectives						
	2021	2022	2023	2024	2025	2026
Annual Objective	80.0	82.0	83.0	84.0	85.0	86.0

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Work on this ESM didn't begin until October 1, 2020, for FFY 2021.	
2.	**Field Name:**	**2021**
	Column Name:	**Annual Objective**
	Field Note: Realization of this objective goal will likely by impacted the redirection of staff time and resources to COVID-19 response.	

Form 10
Evidence-Based or -Informed Strategy Measures (ESMs) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 7.1.3 - Percent of activity goals to decrease preventable child injury which are met by county public health departments using MCHBG funding for the work.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			80	83
Annual Indicator			100	71.4
Numerator			14	10
Denominator			14	14
Data Source			FCHB	FCHB
Data Source Year			FFY 2019	FFY 2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Ability of county public health departments to implement activities was impacted by COVID-19: 1) redirection of staff time and resources to response; and, 2) cancellation of in-person events; and, 3) closing of instruction venues.

2016-2020: ESM 10.2 - Hold one day-long meeting to explore interest in, and provide education for, a Montana Adolescent Preventive Healthcare Stakeholders Group.

Measure Status:			**Active**	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective	0	0	1	0
Annual Indicator	0	0	1	0
Numerator				
Denominator				
Data Source	FCHB	FCHB	FCHB	FCHB
Data Source Year	2017	2018	2019	2020
Provisional or Final ?	Final	Final	Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2018**
	Column Name:	**State Provided Data**
	Field Note: Work on this measure spans FFY18 and FFY19. The stakeholders meeting took place on October 30, 2018.	
2.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**
	Field Note: Measure completed in FFY 2019.	

2016-2020: ESM 10.3 - Create one evaluation report for the Optimal Health for Montana Youth program.

Measure Status:			Active
State Provided Data			
	2018	**2019**	**2020**
Annual Objective			1
Annual Indicator			1
Numerator			
Denominator			
Data Source			FCHB
Data Source Year			FFY 2020
Provisional or Final ?			Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2019**
	Column Name:	**State Provided Data**
	Field Note: This ESM is for FFY 2020.	

2016-2020: ESM 13.1.3 - Percent of activity goals to increase dental care during pregnancy which are met by county public health departments using MCHBG funding for the work.

Measure Status:			Active	
State Provided Data				
	2017	**2018**	**2019**	**2020**
Annual Objective			80	83
Annual Indicator			83.3	69.2
Numerator			10	9
Denominator			12	13
Data Source			FCHB	FCHB
Data Source Year			FFY 2019	FFY 2020
Provisional or Final ?			Final	Final

Field Level Notes for Form 10 ESMs:

1.	**Field Name:**	**2020**
	Column Name:	**State Provided Data**

Field Note:
Oral health activities were hit especially hard in Big Horn County, which shares most of its geographic area with the Crow American Indian Reservation. Staff at their health department had to completely switch to COVID-19 response. (Accounts for 3 of the activities which were unable to meet their goals.)

Form 10
State Performance Measure (SPM) Detail Sheets

State: Montana

SPM 1 - Access to Public Health Services: Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 4,500 or less who choose SPM 1. Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active
Goal:	Support and sustain the public health system in counties with small population bases, and the ability of their health departments to serve the MCH population.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of clients' ages 0 – 21, and women ages 22 – 44 who are served by public health departments in counties with a corresponding population of 2,000 (4,500 starting in FY18) or less who choose SPM 1. **Denominator:** Total population ages 0 – 21, and women ages 22 – 44 in counties with a corresponding population of 2,000 (4,500 starting in FY18) or less who choose SPM 1.
Healthy People 2030 Objective:	ECBP-D07: Increase number of community organizations that provide preventive services.
Data Sources and Data Issues:	MCHBG County Public Health Department Annual Data Reports
Significance:	Access to care was consistently identified as a continuing health care need on the Needs Assessment Surveys and Key Informant Interviews. Montana faces a large geographic health disparity. Access to Care is a fundamental action area in five sections of the State Heatlh Improvment Plan, and one section is focused on strengthening the public health and health care system. It is also integral to a key results area of the Public Health & Safety Division Strategic Plan.

SPM 2 - Family Support & Health Education: Number of clients ages 0 - 21, and women ages 22 - 44 who are assessed for social service and health education needs; and are placed into a referral and follow-up system, or provided with health education as needed.
Population Domain(s) – Cross-Cutting/Systems Building

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Address the social determinants of health by supporting County Public Health Department's ability to provide referrals to social services and health education to their clients.</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>Annual number of MCH clients referred to social services or provided health education by County Public Health Departments choosing SPM 2</td></tr>
<tr><td>Denominator:</td><td>Annual number of County Public Health Department MCH clients in counties choosing SPM 2</td></tr>
</table>
</td></tr>
<tr><td>Healthy People 2030 Objective:</td><td>ECBP-D07: Increase # of community organizations that provide prevention services.</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>MCHBG County Public Health Department Annual Data Reports</td></tr>
<tr><td>Significance:</td><td>Family support and parental education have emerged as essentials which are increasingly unmet; and as having a major effect on the health of the whole MCH population, especially ages 0 to 19 years. Numerous strategies in the State Health Improvement Plan, and Public Health & Safety Division Strategic Plan address working to improve outreach in this area.</td></tr>
</table>

Form 10
State Outcome Measure (SOM) Detail Sheets

State: Montana

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Montana

ESM 1.1 - Percent of activity goals to increase preventive medical visits for women which are met by county public health departments using MCHBG funding for the work.
NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To support county public health departments who have identified increasing preventive medical visits for women as a priority need in their communities.</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 activity goals met to increase preventive medical visits for women, by county public health departments using MCHBG funding to support the work.</td></tr>
<tr><td>Denominator:</td><td>Total number of activity goals to increase preventive medical visits for women, by county public health departments using MCHBG funding to support the work.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>FCHB - The number of counties choosing to use MCHBG funding to address this performance measure may change from year to year. Details on activities, goals, and evaluation plans are submitted by the CPHDs on their yearly pre-contract survey. Outcomes are reported on their annual Compliance & Activities report.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The CDC recognizes the value of state departments of health providing technical assistance to local health departments. The role includes help with: problem identification; problem analysis; strategy development; implementation; and evaluation.

Also, Montana's FCHB has a role similar to a backbone organization in a collective impact model. The CPHD's working on NPM 1 have these characteristics of agencies working in a collective impact framework: 1) common agenda; 2) shared measurement systems; 3) mutually reinforcing activities; 4) continuous communication; and 5) a backbone organization.

Research at the National Institutes of Health shows that improvements in health outcomes are associated with an increase in local health department expenditures, FTEs per capita, and location of health department within local networks. (https://pubmed.ncbi.nlm.nih.gov/22502924/)</td></tr>
<tr><td>Significance:</td><td>The FCHB will contract with CPHDs interested in increasing preventive medical visits for women. These counties will implement and evaluate at least two community-level activities during the fiscal year. As part of supporting these activities, the FCHB provides resources on evidence-based/informed strategies and best practices. This will raise community-level understanding on the importance of preventive medical visits for women, and the range of needs which can be addressed. The FCHB also provides training and support on community needs assessment, and on activity goal setting and evaluation.</td></tr>
</table>

ESM 5.1 - Percent of activity goals to decrease infant deaths due to unsafe sleep conditions which are met by county public health departments using MCHBG funding for the work.
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

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>To support county public health departments who have identified decreasing infant deaths due to unsafe sleep conditions as a priority need in their communities.</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 activity goals met to decrease infant deaths due to unsafe sleep conditions, by county public health departments using MCHBG funding to support the work.</td></tr>
<tr><td>Denominator:</td><td>Total number of activity goals to decrease infant deaths due to unsafe sleep conditions, by county public health departments using MCHBG funding to support the work.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>FCHB - The number of counties choosing to use MCHBG funding to address this performance measure may change from year to year. Details on activities, goals, and evaluation plans are submitted by the CPHDs on their yearly pre-contract survey. Outcomes are reported on their annual Compliance & Activities report.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The CDC recognizes the value of state departments of health providing technical assistance to local health departments. The role includes help with: problem identification; problem analysis; strategy development; implementation; and evaluation.

Also, Montana's FCHB has a role similar to a backbone organization in a collective impact model. The CPHD's working on NPM 5 have these characteristics of agencies working in a collective impact framework: 1) common agenda; 2) shared measurement systems; 3) mutually reinforcing activities; 4) continuous communication; and 5) a backbone organization.

Research at the National Institutes of Health shows that improvements in health outcomes are associated with an increase in local health department expenditures, FTEs per capita, and location of health department within local networks. (https://pubmed.ncbi.nlm.nih.gov/22502924/)</td></tr>
<tr><td>Significance:</td><td>The FCHB will contract with CPHDs interested in decreasing the rate of infant deaths due to unsafe sleep conditions. These counties will implement and evaluate at least two community-level activities during the fiscal year. This will raise community-level understanding on the importance of implementing safe sleep recommendations for infants.
The FCHB also provides training and support on community needs assessment, and on activity goal setting and evaluation.</td></tr>
</table>

ESM 9.1 - Percent of activity goals to reduce adolescent bullying which are met by county public health departments using MCHBG funding for the work.
NPM 9 – Percent of adolescents, ages 12 through 17, who are bullied or who bully others

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Support county public health departments who have identified decreasing the percentage of adolescents who are bullied or who bully others as a priority need in their communities.</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 activity goals met to reduce bullying, by county public health departments using MCHBG funding to support the work.</td></tr>
<tr><td>Denominator:</td><td>Total number of activity goals to reduce bullying, by county public health departments using MCHBG funding to support the work.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>FCHB - The number of counties choosing to use MCHBG funding to address this performance measure may change from year to year. Details on activities, goals, and evaluation plans are submitted by the CPHDs on their yearly pre-contract survey. Outcomes are reported on their annual Compliance & Activities report.</td></tr>
<tr><td>Evidence-based/informed strategy:</td><td>The CDC recognizes the value of state departments of health providing technical assistance to local health departments. The role includes help with: problem identification; problem analysis; strategy development; implementation; and evaluation.

Also, Montana's FCHB has a role similar to a backbone organization in a collective impact model. The CPHD's working on NPM 5 have these characteristics of agencies working in a collective impact framework: 1) common agenda; 2) shared measurement systems; 3) mutually reinforcing activities; 4) continuous communication; and 5) a backbone organization.

Research at the National Institutes of Health shows that improvements in health outcomes are associated with an increase in local health department expenditures, FTEs per capita, and location of health department within local networks. (https://pubmed.ncbi.nlm.nih.gov/22502924/)</td></tr>
<tr><td>Significance:</td><td>The FCHB will contract with CPHDs interested in decreasing the percentage of adolescents who are bullied or who bully others. These counties will implement and evaluate at least two community-level activities during the fiscal year. As part of supporting these activities, the FCHB provides resources on evidence-based/informed strategies and best practices. This will raise community-level understanding on the importance of bullying prevention, and the related negative behaviors which can be reduced. The FCHB also provides training and support on community needs assessment, and on activity goal setting and evaluation.</td></tr>
</table>

ESM 11.1 - Percent of CYSHCN receiving services from a Parent Partner.
NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active
Goal:	Increase number of CYSHCN receiving services from a Parent Partner in FFY 2021.
Definition:	**Unit Type:** Percentage **Unit Number:** 100 **Numerator:** Number of CYSHCN receiving services from a Parent Partner in FFY21 divided by the number of CYSHN receiving services from a Parent Partner in FFY20. **Denominator:** Number of CYSHCN receiving services from a parent partner in FFY20.
Data Sources and Data Issues:	Child Health Referral Information System (CHRIS) and Montana NSCH Data
Significance:	The definition for numerator was modified to accurately capture the equation needed to determine percent increase of CYSHCN served. The Montana Parent Partner Program will continue to expand in FFY21 and FFY 22 through increased operational efficiency and performance monitoring metrics. Parent Partners assist families with the 'non-medical' parts of the medical home, helping them to access much needed services and supports in their communities

ESM 13.2.1 - Percent of activity goals to increase preventive dental visits for children which are met by county public health departments using MCHBG funding for the work.
NPM 13.2 – Percent of children, ages 1 through 17, who had a preventive dental visit in the past year

Measure Status:	Active
Goal:	Support county public health departments who have identified increasing preventive dental visits for children as a priority need in their communities.
Definition:	<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 activity goals met to increase preventive dental visits for children, by county public health departments using MCHBG funding to support the work.</td></tr><tr><td>**Denominator:**</td><td>Total number of activity goals to increase preventive dental visits for children, by county public health departments using MCHBG funding to support the work.</td></tr></table>
Data Sources and Data Issues:	FCHB - The number of counties choosing to use MCHBG funding to address this performance measure may change from year to year. Details on activities, goals, and evaluation plans are submitted by the CPHDs on their yearly pre-contract survey. Outcomes are reported on their annual Compliance & Activities report.
Evidence-based/informed strategy:	The CDC recognizes the value of state departments of health providing technical assistance to local health departments. The role includes help with: problem identification; problem analysis; strategy development; implementation; and evaluation. Also, Montana's FCHB has a role similar to a backbone organization in a collective impact model. The CPHD's working on NPM 1 have these characteristics of agencies working in a collective impact framework: 1) common agenda; 2) shared measurement systems; 3) mutually reinforcing activities; 4) continuous communication; and 5) a backbone organization. Research at the National Institutes of Health shows that improvements in health outcomes are associated with an increase in local health department expenditures, FTEs per capita, and location of health department within local networks. (https://pubmed.ncbi.nlm.nih.gov/22502924/)
Significance:	The FCHB will contract with CPHDs interested in increasing preventive dental visits for children. These counties will implement and evaluate at least two community-level activities during the fiscal year. As part of supporting these activities, the FCHB provides resources on evidence-based/informed strategies and best practices. This will raise community-level understanding on the importance of preventive dental visits for children. The FCHB also provides training and support on community needs assessment, and on activity goal setting and evaluation.

Form 10
Evidence-Based or -Informed Strategy Measure (ESM) (2016-2020 Needs Assessment Cycle)

2016-2020: ESM 7.1.3 - Percent of activity goals to decrease preventable child injury which are met by county public health departments using MCHBG funding for the work.
2016-2020: NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Measure Status:	Active
Goal:	To support county public health departments who have identified decreasing preventable child injuries as a priority need in their communities.
Definition:	<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 activity goals met to decrease preventable child injuries, by county public health departments using MCHBG funding to support the work.</td></tr><tr><td>**Denominator:**</td><td>Total number of activity goals to decrease preventable child injuries, by county public health departments using MCHBG funding to support the work.</td></tr></table>
Data Sources and Data Issues:	FCHB - The number of counties choosing to use MCHBG funding in this way may change from year to year.
Significance:	The FCHB will contract with CPHDs interested in decreasing the rate of preventable injuries to children. These counties will implement and evaluate at least two community-level activities during the fiscal year. This will raise community-level awareness of the importance of injury prevention strategies. The FCHB also provides training and support on community needs assessment, and on activity goal setting and evaluation.

2016-2020: ESM 10.2 - Hold one day-long meeting to explore interest in, and provide education for, a Montana Adolescent Preventive Healthcare Stakeholders Group.
2016-2020: NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

<table>
<tr><td>Measure Status:</td><td>Active</td></tr>
<tr><td>Goal:</td><td>Bring together adolescent healthcare provider from across the state for a day to explore interest in a new adolescent preventive care stakeholders group, and provide education and raise awareness on the importance of adolescent preventive healthcare.</td></tr>
<tr><td>Definition:</td><td>
<table>
<tr><td>Unit Type:</td><td>Count</td></tr>
<tr><td>Unit Number:</td><td>1</td></tr>
<tr><td>Numerator:</td><td>One day-long educational and planning meeting for those interested in adolescent preventive healthcare.</td></tr>
<tr><td>Denominator:</td><td></td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>Family & Community Health Bureau</td></tr>
<tr><td>Significance:</td><td>During FY 2017, the FCHB is worked to identify and survey anyone in the state who might be interested in serving on an adolescent preventive healthcare stakeholders group. Moving forward, the activities and structure of the group will largely be decided by the members. Interested stakeholders from across the state will be brought together for a day-long educational and planning meeting. Initial assistance requested from the group will be feedback on content and drafts for targeted messaging, and ideas for promoting the importance of adolescent preventive healthcare visits.</td></tr>
</table>

2016-2020: ESM 10.3 - Create one evaluation report for the Optimal Health for Montana Youth program.
2016-2020: NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.

Measure Status:	Active
Goal:	Development, completion, and dissemination of Optimal Health for Montana Youth Evaluation Report.
Definition:	**Unit Type:** Count **Unit Number:** 1 **Numerator:** One evaluation report. **Denominator:**
Data Sources and Data Issues:	Family & Community Health Bureau.
Significance:	FCHB's newly created Adolescent Health Section houses the Optimal Health for Montana Youth Program, currently funded through Teen Pregnancy Prevention Tier 2, Sexual Risk Avoidance Education, and Personal Responsibility Education Program grant funds. The Optimal Health for Montana Youth Evaluation Report will assist by evaluating coordinated programmatic activities to inform on the impact, successes, challenges and gaps of services that this program offers to Montana adolescents. The expected outcomes for this evaluation include an increase in protective factors towards risky behaviors, a decrease in risk factors towards risky behaviors, and an increase in utilization of community resources and reproductive health services. Ultimate goals of the programs are to decrease pregnancy and birth rates for youth aged 15-19, reduce birth rate disparities seen in American Indian and rural youths, and decrease the number of youth accounting for new STI/STDs.

2016-2020: ESM 13.1.3 - Percent of activity goals to increase dental care during pregnancy which are met by county public health departments using MCHBG funding for the work.
2016-2020: 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>To support county public health departments who have identified increasing dental care during pregnancy as a priority need in their communities.</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 activity goals met to increase dental care during pregnancy, by county public health departments using MCHBG funding to support the work.</td></tr>
<tr><td>Denominator:</td><td>Total number of activity goals to increase preventive medical visits for women, by county public health departments using MCHBG funding to support the work.</td></tr>
</table>
</td></tr>
<tr><td>Data Sources and Data Issues:</td><td>FCHB - The number of counties choosing to use MCHBG funding in this way may change from year to year.</td></tr>
<tr><td>Significance:</td><td>The FCHB will contract with CPHDs interested in increasing the percentage of women who have a dental visit during pregnancy. These counties will implement and evaluate at least two community-level activities during the fiscal year. This will raise community-level understanding on the importance of dental care during pregnancy.</td></tr>
</table>

Form 11
Other State Data

State: Montana

The Form 11 data are available for review via the link below.

Form 11 Data

Form 12
MCH Data Access and Linkages

State: Montana

Annual Report Year 2020

	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	Monthly	3		
2) Vital Records Death	No	No	Never	NA	Yes	
3) Medicaid	Yes	Yes	Daily	0	No	
4) WIC	Yes	Yes	Daily	0	No	
5) Newborn Bloodspot Screening	No	No	Never	NA	Yes	
6) Newborn Hearing Screening	Yes	Yes	Daily	0	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	6	No	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	4	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None