

**Maternal and Child  
Health Services Title V  
Block Grant**

**Montana**

**FY 2020 Application/  
FY 2018 Annual Report**

Created on 9/27/2019  
at 11:26 AM

# Table of Contents

<b>I. General Requirements</b>	<b>4</b>
I.A. Letter of Transmittal	4
I.B. Face Sheet	5
I.C. Assurances and Certifications	5
I.D. Table of Contents	5
<b>II. Logic Model</b>	<b>5</b>
<b>III. Components of the Application/Annual Report</b>	<b>6</b>
III.A. Executive Summary	6
III.A.1. Program Overview	6
III.A.2. How Federal Title V Funds Support State MCH Efforts	11
III.A.3. MCH Success Story	11
III.B. Overview of the State	12
III.C. Needs Assessment	17
FY 2020 Application/FY 2018 Annual Report Update	17
FY 2019 Application/FY 2017 Annual Report Update	21
FY 2018 Application/FY 2016 Annual Report Update	26
FY 2017 Application/FY 2015 Annual Report Update	30
Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)	34
III.D. Financial Narrative	58
III.D.1. Expenditures	60
III.D.2. Budget	63
III.E. Five-Year State Action Plan	66
III.E.1. Five-Year State Action Plan Table	66
III.E.2. State Action Plan Narrative Overview	67
<i>III.E.2.a. State Title V Program Purpose and Design</i>	67
<i>III.E.2.b. Supportive Administrative Systems and Processes</i>	70
III.E.2.b.i. MCH Workforce Development	70
III.E.2.b.ii. Family Partnership	72
III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts	73
III.E.2.b.iv. Health Care Delivery System	74
<i>III.E.2.c State Action Plan Narrative by Domain</i>	76
Women/Maternal Health	76
Perinatal/Infant Health	85

Child Health	97
Adolescent Health	108
Children with Special Health Care Needs	120
Cross-Cutting/Systems Building	129
III.F. Public Input	142
III.G. Technical Assistance	145
<b>IV. Title V-Medicaid IAA/MOU</b>	<b>146</b>
<b>V. Supporting Documents</b>	<b>147</b>
<b>VI. Organizational Chart</b>	<b>148</b>
<b>VII. Appendix</b>	<b>149</b>
Form 2 MCH Budget/Expenditure Details	150
Form 3a Budget and Expenditure Details by Types of Individuals Served	157
Form 3b Budget and Expenditure Details by Types of Services	159
Form 4 Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated	162
Form 5 Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V	165
Form 6 Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX	169
Form 7 State MCH Toll-Free Telephone Line and Other Appropriate Methods Data	172
Form 8 State MCH and CSHCN Directors Contact Information	174
Form 9 List of MCH Priority Needs	177
Form 9 State Priorities-Needs Assessment Year - Application Year 2016	178
Form 10 National Outcome Measures (NOMs)	180
Form 10 National Performance Measures (NPMs)	219
Form 10 State Performance Measures (SPMs)	228
Form 10 Evidence-Based or –Informed Strategy Measures (ESMs)	230
Form 10 State Performance Measure (SPM) Detail Sheets	239
Form 10 State Outcome Measure (SOM) Detail Sheets	241
Form 10 Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets	242
Form 11 Other State Data	251

## I. General Requirements

### I.A. Letter of Transmittal



## Department of Public Health and Human Services

Director's Office ♦ PO Box 4210 ♦ Helena, MT 59620 ♦ (406) 444-5622 ♦ Fax: (406) 444-1970 ♦ [www.dphhs.mt.gov](http://www.dphhs.mt.gov)

Steve Bullock, Governor

Sheila Hogan, Director

July 10, 2019

Michele Lawler  
Director, Division of State and Community Health  
Maternal and Child Health Bureau  
Health Resources and Services Division  
Rockville, Maryland 220857

Dear Ms. Lawler:

Enclosed is Montana's application for the 2020 Title V Maternal and Child Health Block Grant (MCHBG) and 2018 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,

Kristen Rogers, Bureau Chief  
Family & Community Health Bureau

### **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 2018 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: December 31, 2020.

## **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: December 31, 2020.*

### III. Components of the Application/Annual Report

#### III.A. Executive Summary

##### III.A.1. Program Overview

### Executive Summary: Program Overview

#### Introduction:

Montana's Title V Maternal & Child Health Block Grant (MCHBG) is administered by the Family & Community Health Bureau (FCHB), which is under the Public Health & Safety Division (PHSD) at the Department of Public Health & Human Services (DPHHS). Many FCHB and PHSD programs are key contributors and partners, along with 50 County Public Health Departments (CPHDs).

The *2020 Application & 2018 Report* highlights this work to improve the health of Montana's women, infants, and children; and covers the fourth year of a 5-year cycle. Priorities were selected as the result of the *2015 Statewide 5-Year Needs Assessment*. Key information on performance measures is presented by health domains: Women & Maternal; Perinatal & Infant; Children; Adolescent; Children & Youth with Special Health Care Needs (CYSHCN); and, Cross-Cutting/Systems-Building.

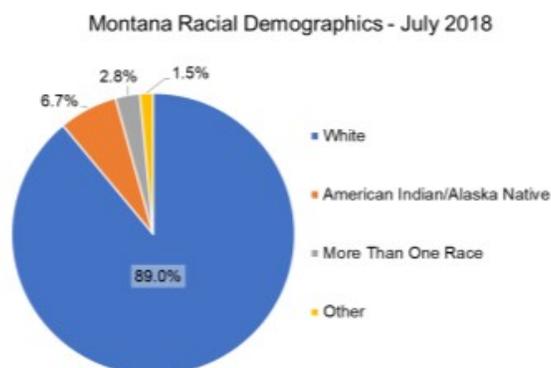
Evaluation of needs assessment data, paired with State Health Improvement Plan (SHIP) goals, created these MCHBG priorities:

- Access to Care & Public Health Services
- Breastfeeding
- Child Injuries
- Family Support & Health Education
- Immunization
- Infant Safe Sleep
- Low-Risk Cesarean Deliveries
- Oral Health
- Smoking in Pregnancy & in Households
- Teen Pregnancy Prevention

In January 2018, new MCHBG guidance decreased the required number of National and State Performance Measures (NPM/SPM), which allowed for more focused use of funding. The FCHB is directing resources and capacity toward five NPMs and two SPMs. In-depth information is available in the *2020 Application & 2018 Report* narratives.

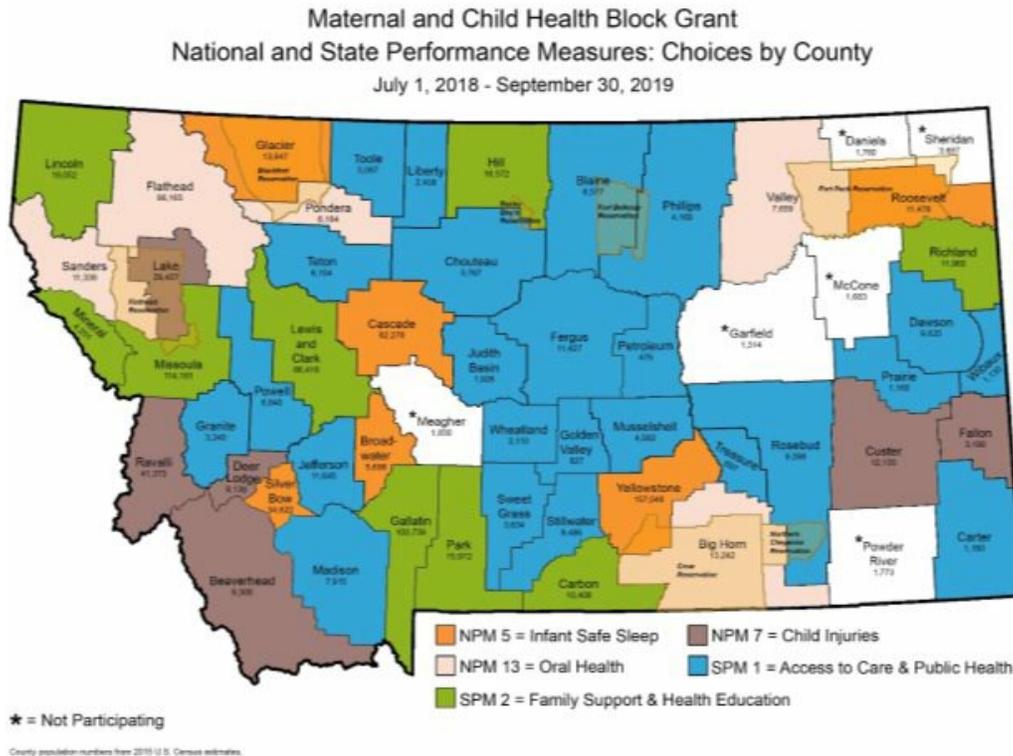
The "Overview of the State" gives information on Montana's (MT's) geography; demographics; economy; income and poverty; education; health insurance; access to health care; and, MCH programs. Characteristics of MT's population groups are in the Needs Assessment Summary. Winter weather and wildfires are some of the seasonal challenges to providing health services.

The following graph shows the breakdown of MT demographics by race, as reported by the U.S. Census for July 2018:



Public health in MT is decentralized, with much of the work done at the CPHD level. The FCHB contracts with CPHDs

interested in participating in the MCHBG. The contracts contain required deliverable quarterly and annual reporting on their identified activity and evaluation plans. On average, CPHDs receive 40% of MT's MCHBG funds. This map illustrates the participating CPHD's selected N/SPM.



At the state level, MCHBG funding is apportioned as follows: Children’s Special Health Services = 30%; other MCH programs (Fetal, Infant, Child & Maternal Mortality Review; Epidemiology; Oral Health) = 20%; and, Administration = 10%. In federal fiscal year (FFY) 2018, MT received \$2,301,521 in MCHBG funding, which was matched with \$2,984,832 in state funds, and \$12,490,557 in CPHD funds.

**Women & Maternal:**

Oral Health in Pregnancy (NPM 13a)

In FFY 2018, five CPHDs focused their MCHBG funding on NPM 13 activities. Partner input from the *Montana Oral Health Strategic Framework* continues to guide program activity with metrics for pregnant women and children. Providing resources for community-level providers was identified as an area of need.

The Oral Health Program (OHP) customized materials to support a broad oral health promotion program called *Healthy Montana Mouths*. It includes: assessment tools, a program implementation plan, training materials, and an evaluation plan to support future work. In-state dissemination included sharing the program plan and tools with existing partners for integration into community-level oral health activities.

In phase two of a pilot project, two CPHDs are using a pregnant woman dental assessment tool in both clinic and public health settings, leveraging private foundation funding. Both these contractors are in frontier areas of MT, and are doing outreach to eleven surrounding counties. This ‘hub and spoke’ model is used to efficiently disseminate the materials, collect evaluation data, and create a peer-to-peer network to support oral health promotion and prevention activities for pregnant women and children in the state’s most rural areas.

**Perinatal & Infant:**

Safe Sleep (NPM 5)

In FFY 2018, planning began to develop and implement a statewide safe sleep initiative with two purposes: share evidence-based safe sleep practices and provide a certified crib with additional educational materials. The goal is to decrease preventable sleep deaths and target high-need families and tribal communities. Each American Indian (AI) tribal leader received a personal call from the American Indian Health Director to explain the initiative and to determine their crib needs.

Two partners, who are in homes on a regular basis, were approached to help identify resource needs. The FCHB Healthy Montana Families Home Visiting Program (HMF/HV) and Child Protective Services (CPS), from the Child and Family Services Department, developed the First Years Initiative (FYI). FYI aims to prevent child abuse and neglect and deliver a more comprehensive approach to child safety. It focuses on providing targeted resources and education services to parents during a child's critical early years, while assessing the family's needs, including the sleep environment. In CY 2018, 187 families received 1186 home visits. In the first 6 months of 2019, 282 families received 2575 home visits.

For FFY 2019, six CPHDs are focusing on NPM 5, with two counties especially involved with outreach to their AI Reservation residents. As a main emphasis, all six are intentionally working with underserved populations and on public awareness campaigns.

The emphasis of the Evidence-Based Strategy Measure (ESM) for NPM 5, for both FFY 2019 and 2020, is to provide state-level support and expertise to help these CPHDs with their infant safe sleep efforts. The ESM evaluation is the percentage that meet their activity goals.

### **Children:**

#### Child Injuries (NPM 7)

In March 2018, the FCHB annual CPHD training included practical examples of injury-prevention activities which are *evidence-based/informed, emerging, promising, or best practice* (EBIBP). The presentation included education on car seat safety, which remains a high priority in MT. In FFY 2017, car seat check-stations reported over 60% of seats were incorrectly installed.

Teaching parents and caregivers the proper installation of infant and child car seats is an on-going activity for most CPHDs. These include inspecting all infant and child car seats and, if incorrectly installed, demonstrating the proper method. If possible, the CPHDs have the parents or caregivers install the car seat themselves before leaving. One activity involves awarding complimentary car seats to those who complete a childbirth education class, along with installation education.

For FFY 2019, there are six CPHDs working on two extra injury-prevention activities; which is in addition to the required one as a part of their team duties for *Fetal, Infant, Child, and Maternal Mortality Review* (FICMMR). The purpose of the ESM for NPM 7, for FFY 2019 and 2020, is to provide state-level support and expertise to help CPHDs with their injury-prevention efforts. The ESM evaluation is the percentage meeting their goals.

### **Adolescent:**

#### Adolescent Preventive Care (NPM 10)

The first MT Adolescent Preventive Healthcare Stakeholders (MAPHS) meeting was held on 10/30/2018. Kristin Teipel, Director of the State Adolescent Health Resource Center at the University of Minnesota, was the Summit's main presenter and resource person. The day's efforts included: creative strategy discussions, sharing available resources, and networking with peers.

The meeting's purpose was to "*Bring Montana health professionals together, to develop strategies for increasing the number of adolescents who receive comprehensive annual preventive healthcare visits.*" The 33 participants included: pediatricians, family practice physicians, advance practice nurses, public health nurses, physician assistants, mental health professionals, and DPHHS staff.

Shortly after the MAPHS meeting, the FCHB created a new Adolescent Health Section (AHS) which hired five new staff to support various adolescent health programs including: the Healthy Young Parent Program; Optimal Health for Montana Youth Program; and, Sexual Violence Prevention and Victim Services Program.

A MAPHS participant survey indicated the top item of interest was "in-clinic processes: analysis and improvement." A focus moving forward is facilitating provider efforts in this area. An AHS program specialist will engage MAPHS Advisory Group members to advise on program direction, and will provide updates on strategies and activities to improve adolescent well visits. The goal is to hold a minimum of two Advisory Group meetings during FFY 2020.

### **Children & Youth with Special Health Care Needs:**

#### Medical Home (NPM 11)

Children's Special Health Services (CSHS) provides many programs to improve quality and enhance access to medical homes for CYSHCN. These include: The HALI Project Parent Partner Program; Transition Improvement Group; Montana Medical Home Portal; CSHS Financial Assistance; and, Circle of Parents.

Parent Partners (PPs) are parents of CYSHCN who are personally experienced and professionally trained to help other

families navigate the complex system of care for CYSHCN. The PPs work in clinics and receive referrals from clinic providers, who identify families in need of additional support. In FFY 2018, 203 families were served.

PPs serve families in primary care clinics in Great Falls, Missoula, Kalispell, Bozeman, Billings and Butte. CSHS is working to expand the service into rural communities around the state. The priority is Indian Health Service Clinics and Urban Indian Health Centers. The goal of the ESM for NPM 11 is *“To increase the number of CYSHCN receiving services from a Parent Partner in FFY 2019 to 250.”*

The Transition Improvement Group (TIG) is a partnership between CSHS, the Billings Clinic, and the *University of Montana Rural Institute for Inclusive Communities (UMRI)*; to implement a mixed-methods pilot study. It will integrate the *Six Core Elements of Health Care Transition* into the work flow of Billings Clinic pediatric and adult clinics. The vision is a sustainable process to successfully transition adolescents into adult healthcare.

TIG membership is comprised of: providers; care managers; leadership executives; quality improvement specialists; nurse informaticists; social workers; and, policy development experts – all of whom work for Billings Clinic. The team is led by the CSHS nurse program manager and the UMRI project coordinator.

CSHS provides direct financial assistance to qualifying families, to cover out-of-pocket expenses for medical and enabling services. CSHS recently amended the financial assistance application to a shortened version for child protection workers, which expedites services to children on their caseloads.

CSHS continues to contract for a MT specific services directory on the Medical Home Portal (MHP) website. 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.

Since October 2018, CSHS has partnered with Butte 4-C’s to establish and facilitate *Circle of Parents* groups that provide a supportive environment led by parents and other caregivers throughout MT. There are currently three facilitation sites in MT; Butte, Missoula and Billings. Over the next year, Circle of Parents hopes to expand to Kalispell, Great Falls, Bozeman, and Helena.

#### **Cross-Cutting/Systems-Building (optional):**

##### Access to Care & Public Health Services (SPM 1)

Most of the counties which qualify for SPM 1 have similar challenges: very 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. SPM 1 continues to provide practical support for these CPHDs. It allows the flexibility needed to help them supply critical safety-net services to their maternal and child residents.

Twenty-four counties are currently carrying out plans they submitted for FFY 2019. This represents 48% of the CPHDs participating in the MCHBG, but due to the population-based funding formula, they receive 9.6% of the total CPHD funding allocation. The CPHDs are engaged in these MCHBG activities:

- Injury Prevention Education and Enabling Services (multiple topics) = 15
- Immunization (variety of enabling services) = 11
- Motor Vehicle Safety (i.e. car seat installation, seat belts, distracted driving) = 11
- Suicide, Mental Health, and Substance Abuse (education & enabling services) = 11
- Vision, Hearing, and Oral Health Screenings and Education = 10
- Health Education & Disease Management (multiple topics) = 9
- Campaigns to Increase Public Awareness of CPHD Services = 6

##### Family Support & Health Education (SPM 2)

The 2015 Needs Assessment identified support for vulnerable families, and parental health education, as critical needs. This parallels nationwide findings regarding the importance of the social determinants of health. SPM 2 was created to assist CPHDs with providing referrals to community services, and health education.

For effective referrals, a comprehensive list of local resources with current contact information is important, as well as good relationships with service agencies and providers. Four of the CPHDs implementing SPM 2 have been working on the measure since FFY16 and they are currently doing referral-related quality improvement projects. These activities focus both on internal processes, and external outreach to providers and agencies. Another CPHD is working with a *Trauma Sensitive School Initiative Team*, to bring the online ConnectMT referral system to their county.

Most SPM 2 health education activities focus on early childhood and pregnancy: child birth; postpartum care; breastfeeding; newborn care; development of young children; and, parenting. Two other frequently mentioned topics are car seat safety and tobacco cessation. One CPHD is including health education to inmates at the county jail, and teaching health education classes at the schools for K-12.

MT's Title V MCHBG program, at both the state and local levels, is working to maximize the health of its maternal and child population. A focus remains on all of the priorities identified in the *2015 Statewide 5-Year Needs Assessment*. Partnerships and collaboration are vital to this effort, as well as ongoing quality improvement efforts and evidence-based programs.

### III.A.2. How Federal Title V Funds Support State MCH Efforts

Title V flexibility for addressing public health services is essential to MT's maternal and child population, for access to services at CPHDs. It is also vital for 200+ families of CYSHCNs, through their local Parent Partner programs. Here are Pyramid of Services examples:

#### Direct:

- CSHS Direct Financial Assistance: CSHS paid \$8,790 for out-of-pocket medical expenses for CYSHCN. Families qualify based on income for this gap-filling funding when a service is medically necessary, and insurance does not fully cover the costs.

#### Enabling:

- Big Horn CPHD, for NPM 13 - Oral Health: Organized two Farmers' Market Dental Nights, featuring two University of Washington dental students and six medical students. They explained dental care and brushing to 80+ children. The CPHD also collaborated with a local dental clinic, screening 1,166 students over several months, and referring 196 students with urgent dental needs for follow-up care.

#### Public Health Services & Systems:

- Cascade CPHD, for NPM 7 - Injury Prevention: Distracted driving course for teens at the Spring Fling Hoop Thing, attended by 100+ children, teens and parents. They also staffed a table at the Safety-First Rally; providing injury prevention materials on poison prevention, safe sleep, and car seat safety to 300+ attendees.
- Blaine CPHD, for SPM 2 – Family Support & Health Education: Invested in performance management system software, to develop a better tracking system for health education outcomes.

### III.A.3. MCH Success Story

In the fall of 2018, Rosebud County Public Health Department (CPHD) collaborated on a project with the Family & Consumer Science teacher at Forsyth High School. This involved the purchase of eight computerized infant models that simulate the 24-hour demands of a real infant. They offer real-life experiences for addressing education on multiple topics, such as: Shaken Baby Syndrome, co-sleeping, immunization, substance abuse, prenatal care, child care, injury prevention, CPR, texting and driving, seatbelts and carseats, second hand smoke, and infant oral health. The simulators also assisted with education on family planning and objectives of the Title X educational program.

Scheduling was arranged with the school for the CPHD to provide additional infant health education to the 25 students in the class. Infant safe sleep was one of the topics covered. One class of seven girls decided to educate their peers about SIDS and safe sleep procedures. The girls were shocked at how many students had never heard of SIDS, or ways to prevent unnecessary sleep-related deaths in infants. This peer education on safe sleep gained momentum, and eventually reached the entire student body of 144 students.

The girls then made sleep sacks for the CPHD to hand out during its Christmas Joy program, or wherever needed. They then took the information home, educating family, and also made sleep sacks for parents and extended family to use.

### III.B. Overview of the State

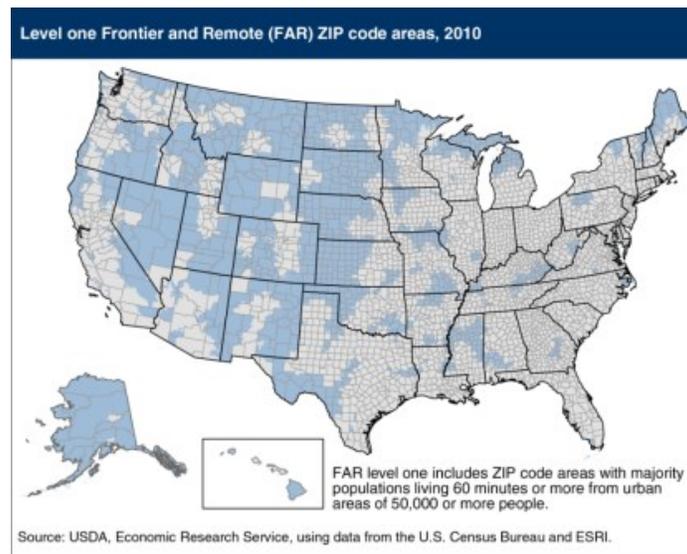
**(NOTE: This report was originally written in 2015. Updated information and statistics have been added according to availability, and/or significance of change.)**

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 racial composition of the population is another characteristic which 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. It is larger than Germany, and the ten smallest-sized states combined do not have as much area. Conversely, the city of Dallas, Texas has a significantly higher population.

Western Montana is mountainous and heavily forested, while the eastern two-thirds are semi-arid rolling plains. 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.

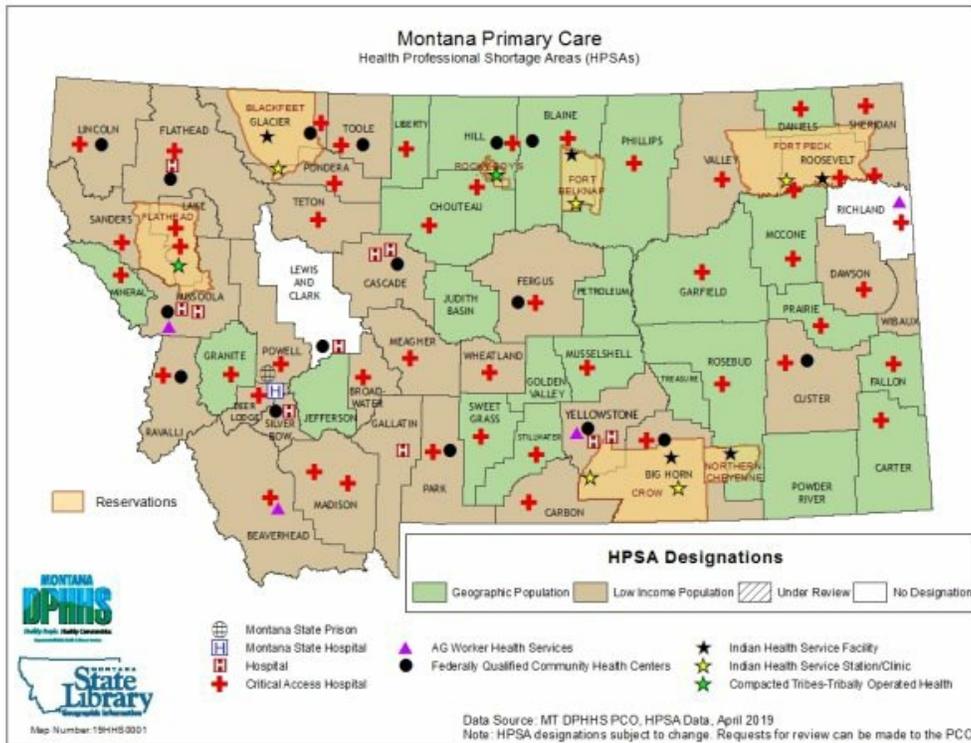
The definition of a Level 1 Frontier and Remote Area is that residents must have to travel at least 60 minutes to reach an urban area of 50,000 or more people. *Although 52 percent of the land area of the United States is in these areas, only 4 percent of Americans live there.* The map below shows the nationwide context of these areas by zip code:



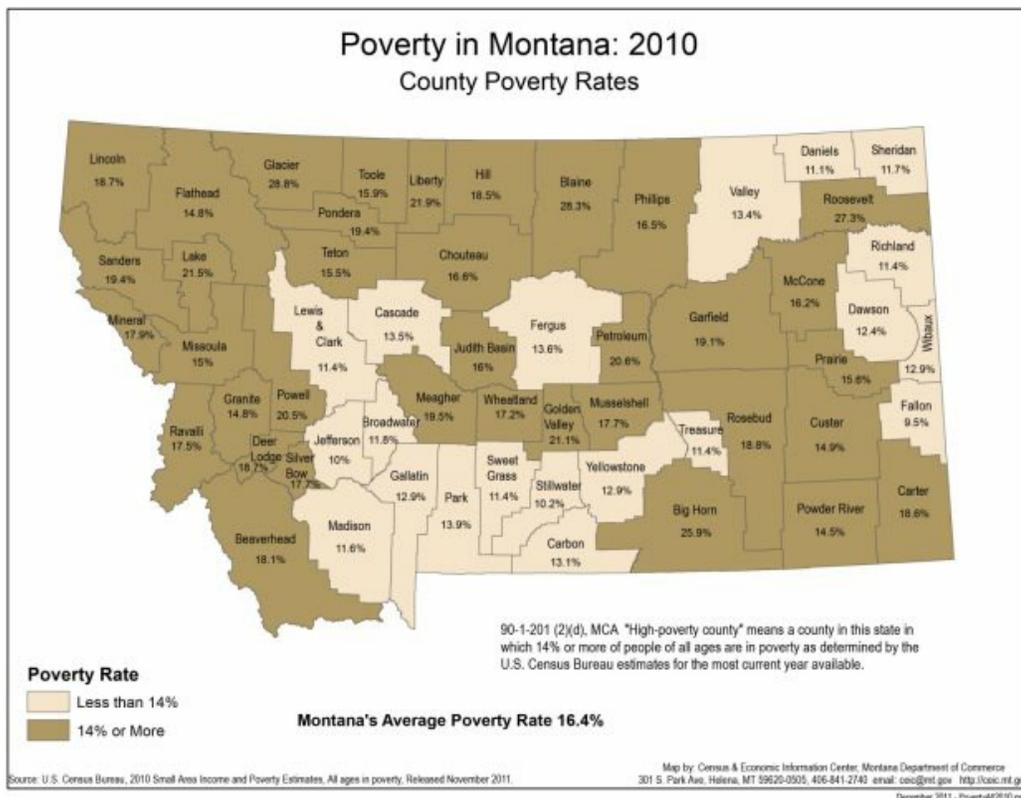
Montana's racial make-up is predominately white, with a 2017 census estimate at 89% of the population. American Indians make up the largest minority, at approximately 6.5%. The ethnic Hispanic or Latino population is only 3.6%, compared to 17.3% nationwide.

Census Population	2017 Estimate
White	89%
American Indian	6.4%
Asian	0.7%
Black	0.4%
Native Hawaiian / Pacific Islander	0.1%
Other	0.5%
Two or More Races	2.8%

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%. The following map, updated in April 2019, illustrates the Health Professional Shortage Areas for Primary Care:



The 2017 American Community Survey (ACS) 1-Year Estimate indicates that 17.5% of MT's children under age 18 are below the federal poverty level. The same ACS also shows the average poverty rate for all Montana families at 14.4%. According to the 2010 census, the rate varies greatly by county, from a high of 25.9% in Big Horn to a low of 9.5% in Fallon. This is shown in detail on the following map:



The 2013 – 2017 ACS 5-year estimated average median household income in Montana was \$50,801, compared to the U.S. total average of \$57,652. Under the same survey, Montana's per capita income was \$28,706, compared to the U.S. average of \$31,177. A positive economic indicator is an unemployment rate of 3.6% for April 2019, which is the same as the national rate.

According to the Office of Public Instruction's Statewide Dropout and Graduate Report, the status of education in the state shows a high school graduation rate in 2015 of 86%, compared to the national average of 82%. The overall high school dropout rate has improved from 4.3% in 2011 to 3.4% in 2015. However, disparities exist in the American Indian population, with a 2015 high school graduation rate of 66.6% and dropout rate of 9.5%. For bachelor's degrees, the Census & Economic Information Center reports that Montana is about equal to the national average, at 29.3% for people 25 and older.

School nurses are not mandated by Montana Law, which contributes to one of the most negative school-nurse to student ratios in the country: 1 school nurse to 1,728 students. Twenty-eight of 56 counties have no school nurse at all, and only 6% of students live in a school district that meets the national standard of 1 nurse to 750 students. Many school nurses serve more than one school and spend precious time travelling between campuses. (*Montana Association of School Nurses' - The State of School Nursing in Montana, 2015.*)

Due to a long history of natural resource extraction, Montana has 25 Superfund Sites on the National Priorities List (NPL). A Superfund Site is any land that has been contaminated by hazardous waste and identified by the Environmental Protection Agency as a candidate for cleanup, because it poses a risk to either human health or the environment.

In 2014, the Bakken Oil Field boom continued to place a major strain on infrastructure systems in eastern Montana. Especially hard hit were towns within the impact area, as they received very little tax money from oil production. The pace of explosive growth has now slowed, leaving government services to struggle with the typical effects of a "boom and bust" cycle.

The level of activity is tied to the price of oil, which went from \$105.79 per barrel in June 2014, to \$30.32 per barrel in February 2016, to a May 2019 price of \$68.94 (*U.S. Energy Information Administration Data*). County revenue collections, which support schools, were down 57% in 2016 (*MT Legislative Fiscal Division*).

Montana is home to seven American Indian reservations, and one state recognized landless tribe, (Little Shell Chippewa.) State law recognizes that there is a unique government-to-government relationship between state government and the eight tribal governments in Montana. According to the 2013 – 2017 ACS, American Indians equal 6.5% of Montana's population, or approximately 66,865 in number. Of those, 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 in 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 following table compares some of the MCH demographic profile information for the geographic area of each reservation. The median age for the whole state is 39.8 years.

2010 U.S. Census - MCH Demographic Profile							
Montana's American Indian Reservations - Geographic Area							
	Crow	Blackfeet	Flathead	Fort Belknap	Fort Peck	Northern Cheyenne	Rocky Boy's
<b>Total Population</b>	6,863	10,405	28,359	2,851	10,008	4,789	3,323
<b>Under 5 Years</b>	740	1,078	2,160	298	995	565	393
<b>Age &lt;= 19</b>	2,561	3,937	8,116	1,168	3,649	2,122	1,512
<b>Median Age</b>	29.1	28.2	40.2	25.8	30.3	23.3	22.5
<b>Females: 15 to 19 Years</b>	285	471	947	149	443	243	181
<b>Females: 20 to 44 Years</b>	993	1,626	3,863	411	1,460	766	542
<b>Race, Number: AI./ AN.</b>	5,322	8,944	7,042	2,704	6,714	4,406	3,221
<b>Race, Percent: AI./ AN.</b>	<b>77.5%</b>	<b>86%</b>	<b>24.8%</b>	<b>94.8%</b>	<b>67.1%</b>	<b>92.0%</b>	<b>96.9%</b>
<b>Race, Number: White</b>	1,398	1,222	18,655	109	2,924	271	62
<b>Race, Percent: White</b>	20.4%	11.7%	65.8%	3.8%	29.2%	5.7%	1.9%

The principal characteristics of Montana's MCH population groups, with health status, needs and emerging issues, are detailed in the Needs Assessment Summary. Priorities are also specified, as well as the competing factors impacting Title V services delivery.

The Montana Legislature passed a Medicaid expansion bill which was signed into law in April 2015, and extended in May 2019 with a work requirement. Coverage began after federal approval and a contractor was secured to assist the state in administering the program. The state received federal approval of waivers needed for the unique provisions to help with job training and placement in October 2015. The law extends health care coverage, through Medicaid, to adults between the ages of 19-64 who earn incomes less than about \$16,000/year for an individual and \$28,000/year for a family of three. Initial adult enrollment by January of 2016 was 37,928. Adult enrollment as of April 2019 was 95,246, or 9.2% of the state's population.

Children in households below 250% of the Federal Poverty Level have had access to health care coverage through the Healthy Montana Kids program since 2008. Behind the scenes it is still two programs, CHIP and Children's Medicaid. However, families only have to complete one application. In October 2018, Montana had 129,478 children enrolled in coverage. This was an increase of 4,458 over the previous October. Separate enrollment figures are as follows: Children's Medicaid at 105,773, and CHIP at 23,705.

The ACA Federally-Facilitated Marketplace enrollment for 2017 was 52,473, and for 2019 that number decreased to 45,374. The table below outlines sources of health insurance for Montana, according to the U.S. Census American Community Survey estimates for 2008-2017:

<b>Sources of Health Insurance Coverage in Montana – Total Population</b>	
Employer	44%
Medicaid	20%
Medicare	16%
Uninsured	9%
Non-Group	9%
Other Public	2%

Statutory authority for maternal and child health services are 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.

Montana's Title V Program provides leadership and direction to state and local programs and partners for issues affecting the health of the MCH population. Montana's Title V/MCHBG allocation to county health departments is based on the total numbers of women of child bearing age (15 to 44 years); infants and children ages 0 through 18; and individuals aged 0 to 44 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 County Public Health Departments have received 45% of the total funding. In FFY 2018, the counties expended \$1,031,168 to provide services to their county's maternal and child population. The CSHS section expended \$740,679 (31.18%) providing services to CYSHCN; \$132,414 (5.8%) was spent on administrative costs; and, the remaining was spent on state-level MCH programs.

The 2015 MCH Needs Assessment resulted in the establishment of ten priority areas. The aging population, geographic realities, and access to care issues all pose unique challenges to health care delivery. Some County Public Health Departments are the sole source of certain MCH health care services, such as immunizations, for the surrounding population. Montana's Title V funds will directly support County Public Health Departments (CPHDs) in 52 counties in FFY 2020, and are critical to meeting the public health needs of the MCH population across the state.

### III.C. Needs Assessment

#### FY 2020 Application/FY 2018 Annual Report Update

##### Beginning 2020 Statewide 5-Year Needs Assessment Process and Preliminary Results –

The SSDI Epidemiologist, Title V and CYSHCN Directors, and the MCHBG Coordinator are the key staff leading the process for the 2020 Statewide 5-Year Title V/MCHBG Needs Assessment. Starting in December 2018, an advisory group of 73 MCH epidemiologists and MCH program and population experts was recruited, and invited to four separate Maternal, Infant, Child, and Adolescent Domain Meetings. Data and discussion of CYSHCN and health disparities was integrated in each meeting.

Each domain meeting grouped the participants at tables of 4-6 people for small group discussions. Participants were asked to select the top areas that need attention. These will inform the foundation for developing questions or surveys to gather additional qualitative and quantitative information, about the root causes of these issues. The root causes will be analyzed to identify systems and cross-cutting issues.

The Advisory Group also identified six goals which are guiding the needs assessment process:

1. Gather meaningful feedback from as many possible disciplines and demographics;
2. Identify and address avoidable health disparities;
3. Collaborate to maximize resources and efficacy;
4. Apply a life course perspective to identify and analyze data;
5. Identify and build on strengths; and,
6. Make data-driven decisions.

These goals are also informing the collection and analysis of quantitative and qualitative data; guiding the specific roles and responsibilities of the advisory group in developing and implementing the process to select final priorities; and, facilitating a more objective data-driven selection process. Four documents with additional details have been included in the Supporting Documents of this report.

As a next step, the SSDI epidemiologist facilitated two meetings of a Leadership Advisory Board (LAB) comprised of: Title V, CYSHCN & WIC Directors; State Medical Officer; American Indian Health Director; MCHBG Coordinator; FCHB Bureau Chief and Section Supervisors; SSDI and Senior FCHB Epidemiologists; and, Healthy Mothers/Healthy Babies Executive Director. The LAB members were charged with applying criteria for selecting key MCH priorities.

As of July 2019, the domain needs assessments include: 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 at the Advisory Group meetings; and, the two highest scoring issues per domain as identified by the LAB members.

Maternal Domain:

- Areas in need of more attention: Access to healthcare, and increased mental healthcare access.
- LAB Scoring Results: Well-woman visit and postpartum depression.

Infant Domain:

- Areas in need of more attention: Parental mental health and home visiting.
- LAB Scoring Results: Infant mortality and safe sleep.

Child Domain:

- Areas in need of more attention: Comprehensive care coordination and trauma.
- LAB Scoring Results: Developmental screening, and preventive dental visit.

Adolescent Domain:

- Areas in need of more attention: Adolescents who have an adult with whom they can talk about serious problems, and life-skill needs and suicide.
- LAB Scoring Results: Vaping and suicide.

Children with Special Health Care Needs Domain:

- Areas in need of more attention: Infant, Child, and Adolescent Domains.
- LAB Scoring Results: Medical home, and foster youth.

Another key contributor to the 2020 Needs Assessment work is the *2019 – 2023 Montana State Health Improvement Plan (SHIP)*, and work completed by four workgroups assigned to address five health priority areas. The 2019 SHIP, published in February 2019, was derived from the 2017 State Health Assessment (SHA).

In 2017, the PHSD received guidance from a 24-member steering committee to determine top health priorities, using: SHA data; input from stakeholders; and, a prioritization matrix. PHSD 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.

The SHIP is transitioning into the implementation phase. Workgroups determined by the Public Health System Improvement Task Force (PHSITF) are identifying evidence-based or informed, or best/emerging practices activities and strategies - to address outcome measures for each of the following five health priority areas:

1. Behavioral health, including substance use disorders, mental health, suicide prevention, and opioid misuse;
2. Chronic disease prevention and self-management;
3. Healthy mothers, babies, and youth;
4. Motor vehicle crashes; and,
5. Adverse childhood experiences.

Workgroup membership includes public and private sector stakeholders from across the state, each with an interest or expertise in a health priority area. It was recognized that ACEs and trauma-informed strategies needed to be applied across the health priorities, and should describe key crosscutting strategies. Because many of the FCHB programs are addressing ACEs, it was determined that *Healthy Mothers, Babies, & Youth* (HMBY) and ACEs should be one workgroup.

The HMBY/ACEs Workgroup membership spans 30+ organizations, coalitions, and task forces. It is co-lead by the FCHB Bureau Chief, and includes the Title V and CYSHCN Directors. Using the collective impact model, the Workgroup will; provide recommendations to the PHSITF on activities to address the stated objectives; aid in promoting the alignment of resources and activities to improve the health of Montanans; and, maintain and/or establish new partnerships. Their initial meeting was on June 7, 2019, with the next meeting scheduled early Fall.

To access the 2017 SHA: <https://dphhs.mt.gov/Portals/85/ahealthiermontana/2017SHAFinal.pdf>.

To access the 2019-2023 SHIP: <https://dphhs.mt.gov/Portals/85/ahealthiermontana/2019SHIPFinal.pdf>

#### Key Informant Interviews –

The SSDI Epidemiologist completed 13 one-on-one interviews with key informants, to learn about their MCH programs, populations, data, and program specific needs assessments. Interviews were conducted with the following DPHHS staff: American Indian Health Director; Tribal Relations Manager; WIC Director; Head Start Collaboration Director; FICMMR Coordinator; PCO Program Specialist; CYSHCN Director; Home Visiting and Adolescent Epidemiologists; Immunization Program Manager; and, Children and Family Services Administrator. Also interviewed were: MT Healthy Mothers Healthy Babies Executive Director; and, a MT State University MCH Professor.

The interviews aided in the selection of subject matter experts to present at the domain meetings; learning of new MCH programs; and potential needs assessment partnerships with programs also targeting the MCH population.

#### Program Evaluation –

The CPHDs completed a Pre-Contract Survey (PCS) in June and submitted 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, and their potential as partners for addressing the domain priorities measures and related performance measures.

All PHSD programs complete annual program evaluations using seven mandated questions, with the option to add program specific questions. WIC is a critical MCH program, not only for providing nutrition education and food packages, but also for their many referrals to programs such as: home visiting; oral health; and, Medicaid. WIC staff determined the need for changes in response to their September 2018 survey to local WIC staff. Of the potential 160 local staff members, 43 (26.9%) completed the survey. In response to a small number of comments such as: “*state staff are at times condescending, inconsistent, or rude in their interactions,*” the state staff completed customer service training, and have made a concerted effort to be more transparent and consistent in their interactions.

## Advisory Councils –

The PHSITF, CYSHCN Consumer Advisory Council, and CYSHCN Stakeholders' Group are advisory councils providing input on Title V approaches. The MCHBG Coordinator serves as the liaison to the PHSITF, attending meetings and providing updates. The CYSHCN process is explained in the NPM 11 domain narratives.

## Emerging Public Health Issues –

The 2017 SHA identified significant health disparities, particularly among American Indian (AI) communities. AIs have higher mortality rates for many of the leading causes of death, significantly higher premature mortality, and higher prevalence rates for many risk factors and diseases compared to the state overall.

An emerging issue, which has been addressed by various programs independent of one another, is the impact of Adverse Childhood Experiences (ACEs) on the overall health of MT citizens. The 2019-2023 SHIP recognized that ACEs/trauma-informed strategies needed to be applied across the five health priority areas.

Maternal mortality and morbidity are also emerging issues. The 2013 Legislature modified the FICMMR law to include the review of maternal deaths to determine preventability. Data collected for CYs 2013- 17 has indicated that many MT maternal deaths are preventable. The FICMMR law is available at:

[http://leg.mt.gov/bills/mca/title\\_0500/chapter\\_0190/part\\_0040/sections\\_index.html](http://leg.mt.gov/bills/mca/title_0500/chapter_0190/part_0040/sections_index.html).

To address and build the infrastructure to decrease maternal mortality and morbidity, the FCHB submitted an application for both the CDC Preventing Maternal Deaths, and HRSA State Maternal Health Innovation Program grants.

## Changes in Health Status and Needs: Statistics Update -

### **Pregnant Women, Mothers and Infants:**

A snapshot of the health status of Montana's pregnant women, mothers, and infants may be seen from certain common health indicators. Data-source references are at the end of this narrative.

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. The MT Office of Vital Records 2017 birth certificate data indicates there were 11,800 births, of which 11.9% were AI children; 8% percent of the births were infants weighing less than 2,500 grams; 9.5% of births were infants less than 37 weeks gestation; mothers of 73.4% of infants received prenatal care beginning in the first trimester; mothers of 14.9% of infants smoked during pregnancy; Caesarian deliveries among low-risk births was 23.8%; and mothers of 4.5% of infants had gestational diabetes. MT's 2015 CDC/NIS data indicates that 83.9% infants were ever breastfed.

AI citizens make up 6.6% of Montana's total population; however, when 2017 birth certificate data was analyzed to determine disparities between AI and non-AI rates, the following determinations resulted:

- The number of infants born to women who received prenatal care beginning in the first trimester was 623 AI (44.2%) and 7,829 White (77.5%).<sup>1</sup>
- The number of mothers who smoked during pregnancy was 412 AI (30%) and 1,318 White (13.1%);
- The infant mortality rate was 12.4 per 1,000 live births for AI and 4.4 per 1,000 for White.

A preliminary review of the 2013-2017 CDR data, indicates that sleep-related circumstances strongly correlate to infant deaths. Of the 83 sleep-related deaths of infants, 46 were White, 32 were Native American or Alaskan Native, and 5 were Multi-Racial or Other. AI citizens make up 6.6% of the total population but constitute 38.6% of all sleep-related infant deaths.

### **Children and Adolescents:**

In 2017, there were 216,351 children ages 1-17 years in Montana and of this total, 26,590 (12.3%) are AI. Montana's childhood mortality rate for this age group was greater than the U.S. rate: 26.6 deaths per 100,000 children compared to 20.6, respectively.<sup>1,5</sup> A further breakdown for MT shows that for AI children ages 1-17 the rate was 43.7 per 100,000, and for White children 24.3.

Young drivers involved in fatal crashes continue to be a serious problem in Montana. From 2013 through 2017, Montana's motor vehicle (MV) mortality rate for children age 1 - 17 years was greater than the U.S. rate with 8.2 deaths per 100,000 children compared to 3.3 deaths per 100,000 children respectively.

The 2016 National Survey of Children's Health reported the following statistics for Montana:

- 19.2% of children aged 0-17 years lived in households where someone smoked;

- 52% of children age 0-17 years without special health care needs had a medical home;
- 79.8% of children age 12-17 years had one or more preventive medical care visits;
- 71.6% of children aged 0-17 years were adequately insured;
- 12.2% of children aged 1-17 years had oral health problems in the past 12 months;
- 81.5% of children age 1-17 years had one or more preventive dental visits.<sup>7</sup>

The rate of birth to adolescents aged 15 -17 years, was 8.2 per 1,000 teenage girls in 2017.<sup>1</sup> The 2017 rate of injury-related hospital admissions in children aged 0-19 years was 185.44 per 100,000 admissions.<sup>8</sup> Montana's suicide rate among teens (15-17) between 2015 and 2017 was over two times higher than the national rate (19.4 compared to 8.8 per 100,000 teens).<sup>5</sup>

References:

1. Office of Vital Statistics, MT DPHHS, Indicator-Based Public Health Information System website: <http://ibis.mt.gov/>, 7/8/2019
2. MT DPHHS, Montana Office of Vital Statistics Records.
3. CDC, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. Data, Trend and Maps. [https://nccd.cdc.gov/dnpao\\_dtm/rdPage.aspx?rdReport=DNPAO\\_DTM.ExploreByLocation&rdRequestForwarding=Form](https://nccd.cdc.gov/dnpao_dtm/rdPage.aspx?rdReport=DNPAO_DTM.ExploreByLocation&rdRequestForwarding=Form).
4. MT DPHHS, Oral Health Program, Dental Care Use among Pregnant Women in Montana, 2015. <https://dphhs.mt.gov/Portals/85/publichealth/documents/OralHealth/PregnancyDataBrief2017.pdf>
5. CDC, NCHS, 1999-2017, Accessed at: <https://wonder.cdc.gov/>
6. The National Center for Fatality Review and Prevention, the National Fatality Review Case Reporting System, <https://data.ncfrp.org>
7. 2016 NSCH: <https://www.cdc.gov/nchs/slait/nsch.htm>; 7/9/2019 from Data Resource Center for Child & Adolescent Health <http://childhealthdata.org/browse/survey>.
8. MT DPHHS. Montana Hospital Discharge Data System, 2017. This rate reflects reporting changes due to: updated U.S. Census population estimates; and, updated injury surveillance definition for the ICD-10-CM codes used.
9. 2009/10 National Survey of Children with Special Health Care Needs: <https://www.cdc.gov/nchs/slait/cshcn.htm>. Data Resource Center for Child & Adolescent Health: <http://childhealthdata.org/browse/survey>.

## FY 2019 Application/FY 2017 Annual Report Update

### Ongoing Assessment Activities

#### **Data Collection and Analysis:**

##### 2017 State Health Assessment -

MT's Title V Program relied heavily on the 2013 State Health Assessment (SHA), and resulting 2013-18 Strategic Plan, to guide the 2015 Needs Assessment and state action plan. Work on the 2017 SHA is underway, with input from a 24-member stakeholder coalition, and feedback from over 300 stakeholders who attended one of 12 meetings held across the state.

The SHA identifies existing and emerging health topics, including issues that disproportionately impact MT's American Indians (AI), the elderly, and individuals living in rural areas. The SHA will also inform the PHSD 2018 State Health Improvement Plan (SHIP) and Strategic Plan.

The 2017 SHA will support collaboration among DPHHS programs which address cross-cutting issues, such as: motor vehicle crashes, with current information in the narrative on NPM 7; and, the effect of Adverse Childhood Experiences (ACEs) across all areas of health. The Fetal, Infant, Child and Maternal Mortality Review and Prevention Program (FICMMR) Coordinator will be involved in the 2018 SHA discussions to determine activities and goals that address reducing the number of unintentional injuries due to automobile crashes, and increasing the number of children less than 18 years of age who regularly use a seatbelt.

FCHB programs will be integral in addressing all potential goals relating to ACEs, but specifically:

Increase awareness of and referrals to evidence-based early childhood home visitation programs among healthcare, human service, and other professionals.

The Healthy MT Families section focuses on expanding home visiting services through the First Years Initiative, and Title V support for County Public Health Departments (CPHDs) selecting SPM 1 and 2 will aid in reducing the health risks associated with a high ACEs score.

The 2017 SHA identified three top MCH concerns: Prenatal Care in the 1<sup>st</sup> Trimester; Low-birthweight; and Infant Mortality. Stakeholders are vetting these goals which will maximize current FCHB resources and prepare Montana for expansion, when feasible:

Increase home visiting services for all MCH populations by promoting the First Years Initiative  
Increase education and awareness of the importance of prenatal care; and  
Decrease the number of sleep-related infant deaths.

The Healthier Montana webpage includes SHA information, data, and materials and an avenue for public input: <https://dphhs.mt.gov/ahealthiermontana/shaship>. Approval of the 2017 SHA is anticipated in Fall 2018.

##### FICMMR Program –

The FICMMR Program continually assesses needs by examining all fetal, infant and child mortality data entered into the Child Death Review (CDR) System by local FICMMR teams. The state is currently analyzing CDR data which denotes Child Protective Services (CPS) involvement in any sleep-related death, with an aim to develop state and local work priorities to reduce preventable deaths. The State FICMMR Coordinator's focus on receiving reliable CDR data is enhanced by the periodic survey of local teams for training needs.

##### Women's and Men's Health -

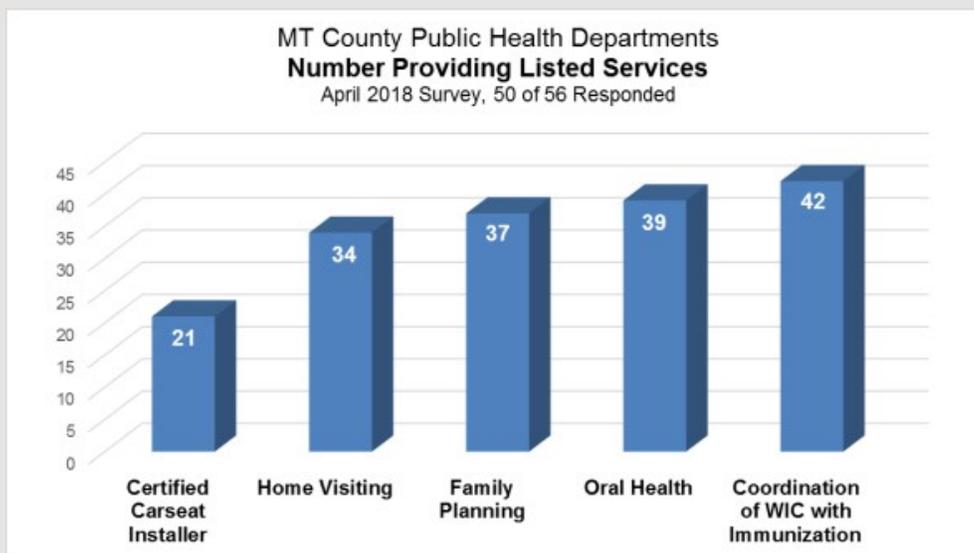
Title X Family Planning Program conducts an annual community participation survey. It is an opportunity for participation in the development, implementation, and evaluation of Title X projects by persons representing the population served, and by individuals who can speak about the community's needs for family planning services. Information from the survey completed from August 22 to October 27, 2017 was used to improve services. In the summer of 2018, WMH will be conducting focus groups and key informant interviews, focusing on their Rape Prevention and Education Program.

#### **Program Evaluation:**

##### CPHDs -

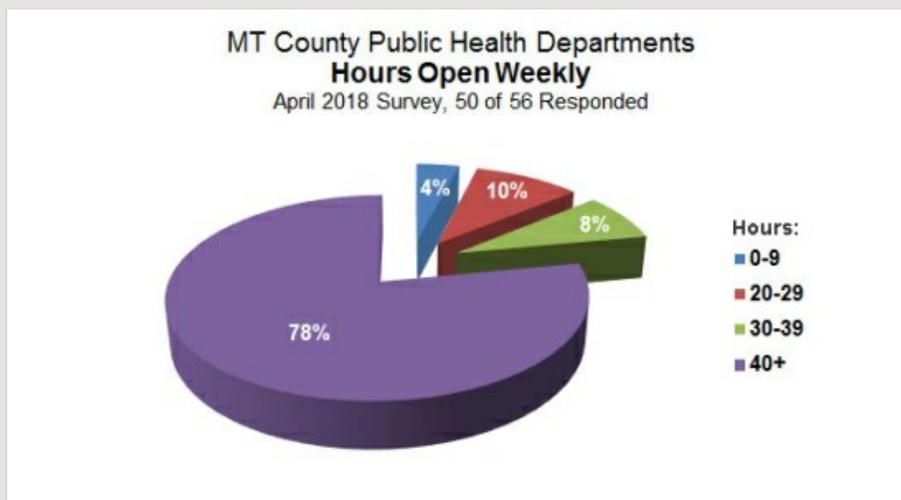
Each April, CPHDs complete a Pre-Contract Survey (PCS) and submit data on: contact information and staff responsibilities; administrative details; services provided; FICMMR information and processes; MCHBG information and processes; and, feedback on FCHB support. The survey results provide a picture of CPHD resources across the state. On the next page, Figure 1 illustrates the number of CPHDs providing listed services, and Figure 2 illustrates the weekly hours CPHDs are open to the public.

Figure 1.



The next graph reflects staffing challenges of counties with limited resources. 22% of CPHDs responding to the survey are open fewer than 40 hours a week.

Figure 2.



CPHDs, by contract, must submit quarterly and annual reports. Each quarterly report requires a detailed narrative on activities and progress towards meeting stated NPM/SPM goals. The annual report collects final outcomes, numbers

served, and full financial accounting.

#### WIC Workgroup -

In 2017, the WIC Workgroup, which met quarterly, began a PDSA project to evaluate and improve clinic efficiency. Their goal: identify best practices that could be adopted at small, medium, and large WIC clinics to manage WIC client appointments; the project is in the study phase. Recommendations will be implemented by WIC clinics in the coming year.

#### Key Informant Interviews:

##### Public Health System Improvement Task Force Input on Performance Measure Changes –

The Public Health System Improvement Task Force (PHSITF), which advocates for statewide public health improvement efforts, is the oversight board for Montana’s Title V/ MCHBG. In January 2018, PHSITF members received copies of the new MCHBG Guidance and the FCHB staff recommendations for changes to the selected NPM and SPMs. Representatives contacted their constituent counties, held discussions with FCHB staff, and generated understanding and broad-based support for recommendations.

#### Customer Satisfaction Surveys:

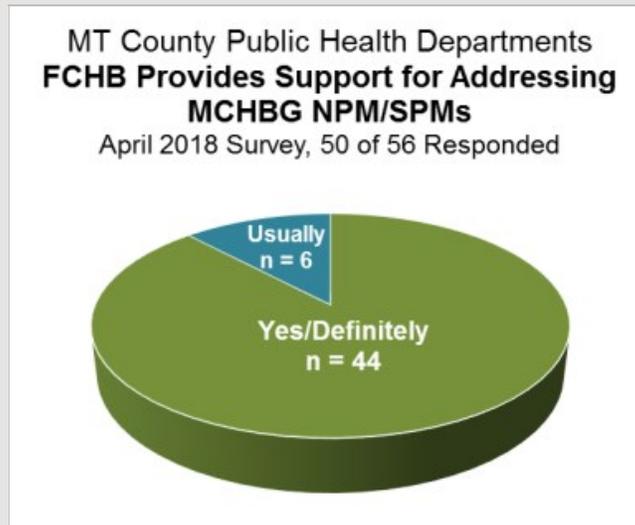
##### FCHB Pre-Contract and Training Events Surveys -

The FCHB routinely requests detailed feedback on training and support from CPHDs. The Pre-Contract survey fulfills Public Health Accreditation Board requirements for assessment on these categories:

- Timeliness;
- Accuracy;
- Demonstrated willingness to help;
- Knowledge and expertise;
- Availability of information;
- Understandable format of tools and information; and
- Meeting expectations.

On the next page, Figure 3 illustrates FCHB support for addressing MCHBG performance measures and Communication regarding national and state programs and services:

Figure 3.



## WIC Participant Survey -

WIC assessed the difference between pre- and post-Electronic Benefit Transfer (EBT) rollout. The pre-EBT WIC participant satisfaction survey was issued in the summer of 2017, and the post-EBT survey in early 2018.

WIC participants rated topics such as the importance of WIC benefits and services (education, food, support, referrals, breastfeeding information), and possible issues (appointment scheduling, shopping experience, amount and makeup of food package, customer service). Overall, results were very positive: 83% of participants reported satisfaction with appointment wait time, length, and availability; 94.7% reported the high importance of food benefits; and over 75% noted the importance of nutrition information and support from staff.

### Advisory Councils:

The PHSITF and CYSHCN Consumer Advisory Council and CYSHCN Stakeholders' Group are advisory councils providing input on Montana's Title V approaches. PHSITF is in the Key Informant Interview Section and CYSHCN is explained in the domain narratives.

### Performance Management Assessment:

HealthSTAT, the PHSD's systematic performance management tool and the database software, is used by all programs for their biannual progress reviews to PHSD management on their program-specific goals and associated challenges. The HealthSTAT progress review is an open forum where the quality, efficiency, and efficacy of a program's operational planning, tracking, and implementation are candidly evaluated and monitored through structured dialogue. For example, feedback to the FICMMR program contributed to improving Safe Sleep data standards, subsequently included in training at the 5/23/18 webinar as reported in the CDR. DPHHS shared the improved data with the Rocky Mountain Tribal Epidemiology Center for work on a collaborative Safe Sleep initiative.

### Changes in Health Status and Needs: Statistics Update

#### Pregnant Women, Mothers and Infants:

A snapshot of the health status of Montana's pregnant women, mothers, and infants may be seen from certain common health indicators. Data-source references are at the end of this narrative.

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. The MT Office of Vital Records 2016 birth certificate data indicates there were 12,271 births, of which 11.86% were AI children; 7.8% percent of the births were infants weighing less than 2,500 grams; 8.73% of births were infants less than 37 weeks gestation; mothers of 71.2% of infants received prenatal care beginning in the first trimester; mothers of 16.45% of infants smoked during pregnancy; Caesarian deliveries among low-risk births was 22.4%; and mothers of 4.3% of infants had gestational diabetes. MT's 2014 CDC/NIS data indicates that 81.9% infants were ever breastfed.

AI citizens make up 6.6% of Montana's total population; however, when 2016 birth certificate data was analyzed to determine disparities between AI and non-AI rates, the following determinations resulted:

The number of infants born to women who received prenatal care beginning in the first trimester was 593 AI (40.7%) and 7,977 White (75.4%).<sup>1</sup>

The number of mothers who smoked during pregnancy was 435 AI (29.8%) and 1,564 White (14.78%);

The infant mortality rate was 12.9 per 1,000 live births for AI and 4.7 per 1,000 for White.

In addition to analyzing the CDR data to determine CPS involvement in any sleep-related death, it is also being examined to help determine the rate of sleep-related deaths by race. The results will help inform the DPHHS Director's Office *Safe Sleep Initiative*.

#### Children and Adolescents:

In 2016, there were 214,967 children ages 1-17 years in Montana and of this total, 45,143 (12%) are AI. Montana's childhood mortality rate for this age group was greater than the U.S. rate: 32.6 deaths per 100,000 children compared to 20.6, respectively.<sup>1,5</sup> A further breakdown for MT shows that for AI children ages 1-17 the rate was 40.2 per 100,000, and for White children 32.2.

Young drivers involved in fatal crashes continue to be a serious problem in Montana. From 2013 through 2015, Montana's the motor vehicle (MV) mortality rate for children age 1 - 17 years was greater than the U.S. rate with 8.2 deaths per 100,000 children compared to 3.3 deaths per 100,000 children respectively.

The 2016 National Survey of Children's Health reported the following statistics for Montana:

17% of children aged 0-17 years lived in households where someone smoked;  
54% of children age 0-17 years without special health care needs had a medical home;  
79% of children age 12-17 years had one or more preventive medical care visits;  
67% of children aged 0-17 years were adequately insured;  
14% of children aged 1-17 years had oral health problems in the past 12 months;  
81% of children age 1-17 years had one or more preventive dental visits.<sup>7</sup>

The rate of birth to adolescents aged 15 -17 years, was 9.3 per 1,000 teenage girls in 2016.<sup>1</sup>

The rate of injury-related hospital admissions in children aged 0-19 years was 152.7 per 100,000 admissions.<sup>8</sup> Montana's suicide rate among teens (15-17) is almost three times higher the national rate (26.5 compared to 8.6 per 100,000 teens).<sup>5</sup>

### Emerging Public Health Issues

Montana's emerging public health issues and its ability to address them are being discussed by PHSD management in conjunction with vetting the 2018 SHA and SHIP with state and local partners.

The FCHB began a new partnership with the Child & Family Services Division (CFSD), with the January 2018 launch of the First Years Initiative <https://dphhs.mt.gov/aboutus/news/2018/firstyearsinitiative>. It focuses on providing targeted resources, education, and services to pregnant women, their infants, and children through their first birthday. The Initiative is the culmination of reviewing child deaths reported to the Child and Family Ombudsman during the most recent reporting period. Home visiting services are dedicated to CFSD cases, with the goal of child safety and family preservation and reunification.

Substance use disorder is a growing concern, which generated a MT Task Force representing 82 organizations/programs, including FICMMR, CSHCN, and Title X. The Task Force published Addressing Substance Use Disorder in MT, a plan outlining a series of targeted strategies in five key areas that can lessen the impact of substance use in our state. Title V provided a letter of commitment to support an activity proposed under the Addictive & Mental Disorders Division (AMDD)'s Partnership for Success grant application, i.e., developing a statewide media campaign to increase awareness of the effects of substances during pregnancy.

### References:

1. Office of Vital Statistics, MT DPHHS, Indicator-Based Public Health Information System website: <http://ibis.mt.gov/>, 4/30/18
2. MT DPHS, Montana Office of Vital Statistics Records.
3. CDC, National Center for Chronic Disease Prevention and Health Promotion, Division of Nutrition, Physical Activity, and Obesity. Data, Trend and Maps. [https://nccd.cdc.gov/dnpao\\_dtm/rdPage.aspx?rdReport=DNPAO\\_DTM.ExploreByLocation&rdRequestForwarding=Form](https://nccd.cdc.gov/dnpao_dtm/rdPage.aspx?rdReport=DNPAO_DTM.ExploreByLocation&rdRequestForwarding=Form).
4. MT DPHHS, Oral Health Program, Dental Care Use among Pregnant Women in Montana, 2015. <https://dphhs.mt.gov/Portals/85/publichealth/documents/OralHealth/PregnancyDataBrief2017.pdf>
5. CDC, NCHS, 2006-2012, Accessed at: <https://wonder.cdc.gov/>
6. The National Center for Fatality Review and Prevention, the National Fatality Review Case Reporting System, <https://data.ncfrp.org>
7. 2016 NSCH: <https://www.cdc.gov/nchs/slait/nsch.htm>; 5/4/2018 from Data Resource Center for Child & Adolescent Health <http://childhealthdata.org/browse/survey>.
8. MT DPHHS. Montana Hospital Discharge Data System, 2016.
9. 2009/10 National Survey of Children with Special Health Care Needs: <https://www.cdc.gov/nchs/slait/cshcn.htm>. Data Resource Center for Child & Adolescent Health: <http://childhealthdata.org/browse/survey>.

## FY 2018 Application/FY 2016 Annual Report Update

### Needs Assessment Summary Update –

**(NOTE: The summary of the 2015 Statewide 5-year Needs Assessment was submitted in July 2015, and that document is provided at the end of this update.)**

#### Overview of Health Status by MCH Population Group, Statistics Update -

##### Pregnant Women, Mothers and Infants:

A snapshot of the health status of Montana's pregnant women, mothers, and infants can be seen from certain common health indicators. The percent of live births of infants weighing less than 2,500 grams was 7%, while 8% of births were infants of less than 37 weeks gestation in 2015.<sup>1</sup> The percent of infants born to women receiving prenatal care beginning in the first trimester was 70% in 2015.<sup>1</sup>

In 2014-2015 National Immunization Survey, the percent of Montana infants born in 2013 who were ever breastfed was 86%.<sup>2</sup> The percent of women who smoked during pregnancy was 16% in 2015.<sup>1</sup> Caesarian deliveries among low risk births was 22% in 2015.<sup>1</sup> The percent of infants born to females with gestational diabetes was 5% in 2015.<sup>1</sup>

##### Children and Adolescents:

In the 2011/2012 National Survey of Children's Health, 26% of children aged 0-17 years lived in households where someone smoked; 59% of children without special health care needs had a medical home; 77% of children age 0-17 years had one or more preventive medical care visits ; 75% of children aged 0-17 years were adequately insured; 20% of children aged 1-17 years had oral health problems in the past 12 months; 77% of children age 1-17 years had one or more preventive dental visit.<sup>3</sup> In 2015, 79% percent of 19 to 35 month olds received the full schedule of age appropriate immunizations. In 2015, the rate of injury-related hospital admissions in children aged 0-19 years was 195 per 100,000 admissions.<sup>4</sup> The rate of birth to adolescents aged 15 -17 years, was 10 per 1,000 teenage girls in 2015.<sup>1</sup>

##### Children and Youth with Special Health Care Needs:

In the 2011/2012 National Survey of Children's Health, the percent of Montana's children and youth with special health care needs (CSHCN) having a medical home was 53%.<sup>3</sup> In the 2009-2010 National Survey of Children with Special Health Care Needs, the percent of CSHCN received coordinated, ongoing, comprehensive care within a medical home was 39%; the percent of adolescents aged 12-17 years with special health care needs who received services necessary to make transitions to adult health care was 49%.<sup>5</sup>

<sup>1</sup> Office of Vital Statistics, Montana Department of Public Health and Human Services. Retrieved on July 7, 2017 from Montana Department of Public Health and Human Services, Indicator-Based Public Health Information System website: <http://ibis.mt.gov>.

<sup>2</sup> CDC National Immunization Survey (NIS) 2014-2015, among 2013 births: <https://www.cdc.gov/breastfeeding/pdf/2016breastfeedingreportcard.pdf>

<sup>3</sup> 2011-2012 National Survey of Children's Health: <https://www.cdc.gov/nchs/slits/nsch.htm>; Retrieved on July 7, 2017 from Data Resource Center for Child & Adolescent Health <http://childhealthdata.org/browse/survey>

<sup>4</sup> Montana Department of Health and Human Services. Montana Hospital Discharge Data System, 2015.

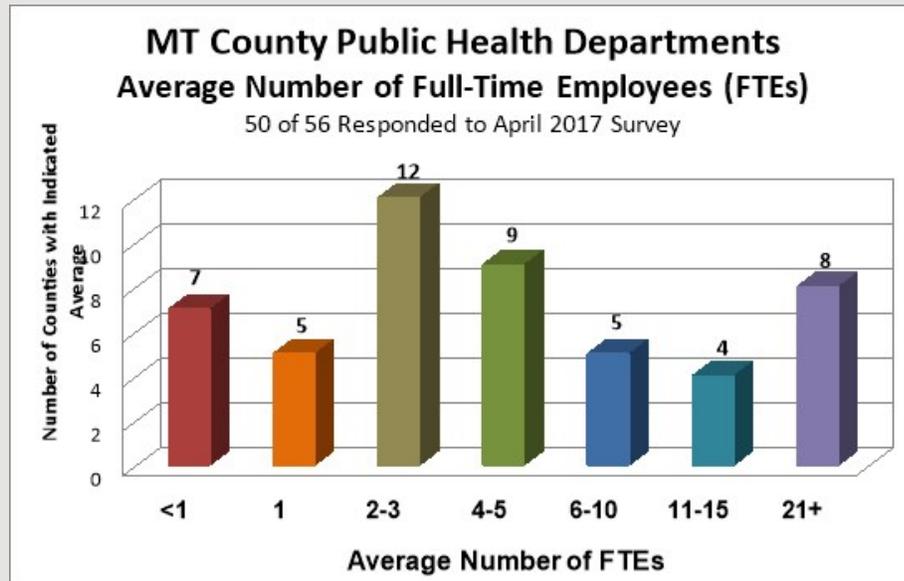
<sup>5</sup> 2009-2010 National Survey of Children with Special Health Care Needs: <https://www.cdc.gov/nchs/slits/cshcn.htm>. Retrieved on July 7, 2017 from Data Resource Center for Child & Adolescent Health: <http://childhealthdata.org/browse/survey>

Several programs in the FCHB have conducted additional Needs Assessment work since last year's report:

*Maternal & Child Health* – County Public Health Department contractors complete a Pre-Contract Survey each April. The survey is divided into sections covering: 1) contact information and staff responsibilities, 2) administrative details, 3) services provided, 4) FICMMR information and processes, 5) MCHBG information and processes, and 6)

feedback on FCHB support.

The administrative details and services provided, when combined with other data such as county population, give a picture of health department resources across the state. For instance, the question “How many hours a week is your health department open to the public?” shows that eleven are open less than 40 hours a week. A graph depicting the results of the question “On average, what is the total number of employees at your health department?” is shown in the following graph:



*Oral Health Program* - To assess the current oral health status of Montana’s Head Start children, the Oral Health Program at Montana Department of Public Health and Human Services coordinated a statewide oral health survey of children age three to five years attending Head Start in 2016. A total of 582 children received a dental screening at 18 Montana Region VIII Head Start centers. Over 35% had a history of dental decay, and 14.2% had untreated decay.

*Women’s and Men’s Health* - conducts a community participation survey each year. The survey provides an opportunity for participation in the development, implementation, and evaluation of the project by persons broadly representative of all significant elements of the population to be served; and by persons in the community knowledgeable about the community’s needs for family planning services.

The current survey was completed from October 1, 2016 to January 1, 2017. Title X clinics collected 638 surveys, with 50% of individuals responding between the ages of 15-24. Over half of all respondents indicated that they found out about the clinic from a friend or family member. Most of the respondents would like to received information from the clinic either through Facebook or email.

*Children’s Special Health Services* - has been working with the University of Montana Rural Institute since 2015 to plan, develop and execute a comprehensive survey of families of CYSHCN to determine their highest concerns and needs. The survey design was very comprehensive; questions were derived from the Standards for Systems of Care for CYSHCN. The survey was sent to over 4,000 families in September, 2016. To date around 850 surveys have been completed. A report with the results is included as a supporting document.

The following are updates to the program information submitted in last year’s Agency Capacity section of last year’s summary:

CSHS – In FY 2016, CSHS directly served 1,529 families. This work included support through the Parent Partner Program, clinic services supported by CSHS, and direct referrals to outside agencies.

Immunization (IZ) – Nineteen CPHDs choose SPM 3 for FY 2017, and will receive a total of \$273,549 in funding. The IZ Program’s budget is \$1.8 million, and the value of publically-funded vaccine distributed averages between \$8 to \$10 million. MT’s IZ Information System (imMTrax) consolidates vaccination data from vaccine providers either through manual data entry or electronic data exchange. The program also provides tools for designing,

implementing and sustaining effective immunization strategies to improve immunization rates.

HMF – The Healthy Montana Families Program sites, funded with state funding, and/or federal Maternal, Infant, and Early Childhood Home Visiting (MIECHV) funding, continue to implement their selected home visiting model. These models include: Parents as Teachers, Nurse-Family Partnership, SafeCare Augmented, and Family Spirit. In FY 2017 HMF contracted with 23 “Local Implementing Agencies”, serving 21 counties. The number of home visitors has increased to 94, and State general fund and tobacco trust settlement funding is currently \$582,000.

MCH – NPM 7, Child Injuries, was added to the CPHD performance measure selection choices for FY 2018. In FY 2016, 51 CPHDs provided group encounter services to 33,076 clients. They also served the following unduplicated numbers by population category:

- o Pregnant Women – 4,676
- o Infants age <1 – 11,683
- o Children ages 1 to 22 – 33,419
- o CYSHCN – 1,726
- o Women of Childbearing Age – 12,242

MTUPP - According to MT’s 2017 Youth Risk Behavior Survey, smoking among youth has decreased from 20% in 2005 to 12% in 2017. In FY 2017 MTUPP’s overall budget is approximately \$7.3 million. The number of tobacco-free medical campuses in MT has increased to 61, and as of June 2017, 78% of schools have adopted Comprehensive Tobacco-Free Policies. The MT Tobacco Quit Line has received over 92,000 calls since its inception in 2004 (an increase of 8,000 since last year’s report).

PCO - The Primary Care Office (PCO) is the MT National Health Corp Services (NHSC) Ambassador and oversees the MT NHSC Student Loan Repayment Program (SLRP). In FY2016, MT was home to 120 NHSC approved sites which employed 172 total NHSC participants; 163 are NHSC Loan Repayment Program awardees, and nine are Student to Service awardees. The MT NHSC SLRP awarded 11 new providers across the state with \$150,000 in federal funds, and matching funds of \$75,000 from the state and \$75,000 from local sponsoring organizations. Disciplines awarded include six registered nurses, two physicians assistants, two nurse practitioners, and one pharmacist - practicing in these counties: Hill, Yellowstone, Lake, Roosevelt, Deer Lodge, Chouteau and Phillips.

As of June 1, 2017, six of the available 30 Montana Conrad State 30 J-1 Visa Waiver Program slots are filled. The J-1 Visa program waives the requirement for foreign born Primary Care Physicians and Specialists to return to their country of origin after completing residency, in exchange for providing a minimum of three years in a primary care HPSA.

The MT PCO partners with: the Montana Medical Association; Office of Rural Health/Area Health Education Center (ORH/AHEC); WIM Tracking, LLC; Center for Rural Health in North Dakota; Foundation for Health Leadership and Innovation; and Connie Berry, an Independent Contractor who advises on J-1 Visa and H-1B policies. The PCO attends monthly Montana Healthcare Workforce Advisory Committee Meetings which is led by ORH/AHEC.

The following map shows Health Professional Shortage Area designations for Primary Care, updated as of June 2017:



## FY 2017 Application/FY 2015 Annual Report Update

### Introduction & Recap of 5-Year Needs Assessment Process

Title V MCHBG legislation requires the state to prepare and submit a statewide Needs Assessment every five years. The findings are expected to serve as the “drivers” in determining state Title V program priorities, and in developing a five-year Action Plan to address them. They should indicate where the greatest needs are for the Maternal, Child and Children with Special Health Care Needs (CSHCN) populations, and support services which can have a direct positive impact.

Based on its priority needs, the State was directed select eight of 15 possible National Performance Measures (NPMs) for programmatic emphasis over the five-year reporting period. It was also required to develop at least three State Performance Measures (SPMs) to address unique needs not addressed by any of the NPMs.

The DPHHS Maternal and Child Health (MCH) Section began work on the 2015 Needs Assessment in December 2013. The workgroup identified information gathered for the 2012 State Health Improvement Plan, and the 2013 Public Health and Safety Division Strategic Plan, as a good foundation. In order to facilitate additional stakeholder input, an online survey was created for County Health Departments to complete during May 2014. Other organizations with an interest in maternal and child health were also asked to complete a similar survey as a part of the process, and key stakeholder interviews were held.

A summary of the 2015 Statewide 5-Year Needs Assessment is included in the [2016 Annual Application & 2014 Report](#), on pages 14 - 39.

---

### Needs Assessment Summary Update –

#### Overview of Health Status by MCH Population Group, Statistics Update -

##### Pregnant Women, Mothers and Infants:

A snapshot of the health status of Montana’s pregnant women, mothers, and infants can be seen from certain common health indicators. The percent of women who smoked during pregnancy was 15.9%<sup>1</sup> in 2014. Almost seventy percent of infants were born to women receiving prenatal care beginning in the first trimester<sup>1</sup>. The percent of Caesarian deliveries in low-risk first births was 26.4% in 2014<sup>1</sup>. The percent of infants who were ever breastfed in 2014 was 91.2%<sup>2</sup>. Seven percent of live births were of infants weighing less than 2,500 grams, while 9% of births were infants of less than 37 weeks gestation in 2014<sup>1</sup>.

##### Children and Adolescents:

In the 2011/2012 National Survey of Children’s Health, 26% of Montanan children were reported to live in a household where someone smokes, 58% of children without special health care needs had a medical home, and 23% of children had a preventive services visit<sup>3</sup>. Seventy-seven percent of children, ages 0-17, had a preventive dental visit in the last year (2011/2012)<sup>3</sup>. In 2014, the 4:3:1:3:3 immunization rate for children 19-35 months of age was 75%, and routine vaccination coverage for tetanus and meningococcal vaccines in 13-17 year olds were 87 and 60%, respectively<sup>4</sup>. In the same year, the rate of injury-related hospital admissions in children less than 19 years of age was 181.9 per 100,000<sup>5</sup>. The rate of birth to adolescents ages 15 -17 years, was 13 per 1,000 in 2014<sup>1</sup>.

##### Children and Youth with Special Health Care Needs:

In the 2011/2012 National Survey of Children with Special Health Care Needs, 57% of Montana’s children and youth with special health care needs were reported to have a medical home<sup>6</sup>. Ninety-nine percent of newborns received a blood spot screening before being discharged from the hospital. 100% of infants with a condition identified by newborn screening received timely follow-up, definitive diagnosis, and clinical management<sup>7</sup>. There were 253 kids who attended the CSHS regional Cleft Craniofacial clinics which included twenty-five infants in calendar year 2015<sup>8</sup>.

<sup>1</sup> Montana Department of Health and Human Services, OESS, Special Statistical Request; June 28, 2016.

<sup>2</sup> Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity. Breastfeeding Report Card 2014 <http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf>.

<sup>3</sup> National Survey of Children’s Health. 2011/2012: <http://childhealthdata.org/browse/survey>

<sup>4</sup> National Immunization Survey. Estimated Vaccine Coverage, child and teen, 2014:

<http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/index.html>.

<sup>5</sup> Montana Department of Health and Human Services. Montana Hospital Discharge Data. Special Statistical Request; June 28, 2016.

<sup>6</sup> National Survey of Children with Special Health Care Needs: <http://childhealthdata.org/browse/survey>

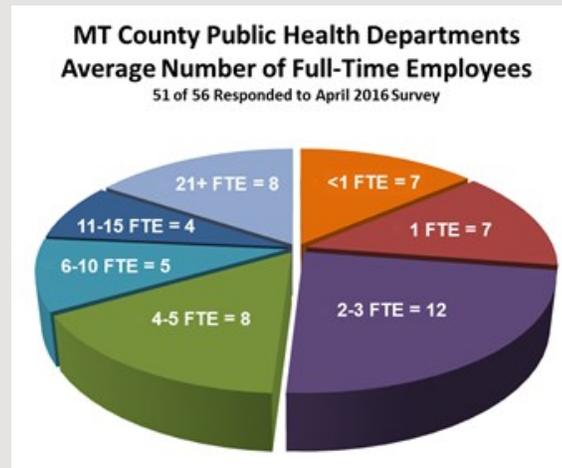
<sup>7</sup> Montana Department of Health and Human Services. Children Special Health Services, Newborn Hearing Screening Program, 2014. Special Statistical Request; May 31, 2016.

<sup>8</sup> Montana Department of Health and Human Services. Child Health Informational Referral System, 2015. Special Statistical Request; May 9, 2016.

Several programs in the FCHB have conducted additional Needs Assessment work since last year's report:

- MCH – County Public Health Department contractors complete a Pre-Contract Survey each April. The survey is divided into sections covering: 1) contact information and staff responsibilities, 2) administrative details, 3) services provided, 4) FICMMR information and processes, 5) MCHBG information and processes, and 6) feedback on FCHB support.

The administrative details and services provided, when combined with other data such as county population, give a picture of health department resources across the state. For instance, the question “How many hours a week is your health department open to the public?” shows that 25% are open less than 40 hours a week. A graph depicting the results of the question “On average, what is the total number of employees at your health department?” is shown here:



- *Oral Health Program* - The Oral Health Program (OHP) Coordinator has analyzed oral health related data from the Behavioral Risk Factor Surveillance System (BRFSS), HRSA Uniform Data System (UDS) and Medicaid claim data in preparing for presentations and correspondence with oral health stakeholders. Additionally, oral health related data is part of the OHP Surveillance System to support program planning.
- *Primary Care Office* - The 2016 MT Primary Care Needs Assessment was created to provide a better understanding of the performance and challenges of the state's primary health care system. The purposes include: explore factors associated with the delivery, access and utilization of primary health care in MT; investigate whether high health professional shortage area scores align with counties which have the highest rates of poor health outcomes, or lowest rates of primary care utilization; and identify programs and partners that could assist with activities to reduce healthcare access barriers.

A major focus of the Primary Care Needs Assessment was to identify and integrate key state and national data sources which illuminate the health status of MT communities, and review these alongside primary care workforce data. This baseline will help discussion on the best ways to advocate for the primary care workforce and prioritize funding. It will also identify additional risk factors, barriers, partners and communities in need. It will help policy-makers better understand the performance and challenges of the primary health care system, and to more effectively align the primary care workforce with health care needs. The MT Primary Care Needs Assessment can be viewed at: <http://dphhs.mt.gov/Portals/85/publichealth/documents/PrimaryCare/March2016PCOnneedsAssessment.pdf>

- The *Women's and Men's Health Section* conducts a yearly assessment on the need for services. This is defined through data on current birth rates, unintended pregnancy rates, infant mortality, low birth-weight infants, prenatal care, the number of women in need of publicly funded family planning services, and sexually transmitted infection rates.
- As part of Title X Community Education Requirement, WMHS conducts an annual community participation survey. The 2015 survey was completed by 520 individuals: 88% female; 12% were male; and 30% were between 15-19 years of age. It asks questions regarding current family planning promotion efforts, ways to market services, and pertinent health problems in the community, and identified the following top 10 health concerns for MT: child abuse; teen pregnancy; illegal drug use; mental health; no money for healthcare services; underage drinking; sexually transmitted infections; cancer; no health insurance; and violence. The survey results also indicated that Facebook is the preferred communication mode. The contractors' indicated that the concerns listed fell outside their scope of work, and they were unable to address the issues. The Fall 2016 survey will focus on health concerns regarding family planning and reproductive health.

The following are updates to the program information submitted in last year's Agency Capacity section of last year's summary:

- CSHS – CSHS has been providing direct financial assistance for medications, testing and medical services not covered by Medicaid. The direct financial assistance program, which ended March 31, 2016 expended \$11,351 to 20 families.
- Immunization (IZ) – Nineteen CPHDs have chosen SPM 3 for SFY17, and will receive a total of \$273,549 in funding. The IZ Program's budget has increased to \$1.8 million, and the value of the publically funded vaccine distributed has increased to an average of \$8 to \$10 million. MT's IZ Information System (imMTrax) consolidates vaccination data from vaccine providers either through manual data entry or electronic data exchange. The program also provides tools for designing, implementing and sustaining effective immunization strategies to improve immunization rates.
- MECHV – the home visiting program is now called Healthy Montana Families. Staffing has increased to include a program specialist, health education specialist, and financial specialist. The number of home visitors has also increased to 86. State general fund and tobacco trust settlement funding is currently \$587,000.
- MCH – NPM 13, Oral Health, was added to the CPHD performance measure selection choices for SFY17. In SFY15, 50 CPHDs provided group encounter services to 33,794 clients. They also served the following unduplicated numbers by population category:
  - Pregnant Women – 4,083
  - Infants age <1 – 6,688
  - Children ages 1 to 22 – 34,839
  - CYSHCN – 6,763
  - Women of Childbearing Age – 21,502

In November 2015 the FCHB Bureau Chief and the MCH, WIC and Home Visiting Program Directors discussed the process of developing a MCHBG Study Group. It was determined that a MCHBG Future Study Group should assess the current service delivery system to ensure that the MCHBG funds are providing quality services and meeting the HRSA reporting requirements. Title V staff have met with a facilitator to outline the goals of this work group, membership, and future direction.

- MTUPP - According to MT's 2015 Youth Risk Behavior Survey, smoking among youth has decreased from 20% in 2005 to 13% in 2015. In SFY 2016 MTUPP's overall budget was approximately \$7.3 million. The number of tobacco-free medical campuses in MT has increased to 59, and as of June 2016, 72% of schools have adopted Comprehensive Tobacco-Free Policies. The MT Tobacco Quit Line has received over 84,000 calls since its inception in 2004.
- PCO - The Primary Care Office stands as a National Health Corp Services Ambassador and oversees the MT National Health Service Corps (NHSC) Student Loan Repayment Program, now with \$150,000 in federal funds and a matching \$75,000 from the state. In FFY2015, MT was home to 60 new NHSC Loan Repayment Program awardees, and 3 new NURSE Corp awardees. Currently, there are a total of 105 "returning awardees" for the 2015 NHSC cycle. The MT NHSC State Loan Repayment Program awarded five new applicants, and four second year awardees in FFY2015. As of September 1, 2015, the PCO had filled 10 of 30 J1 Visa Waiver Program slots, available for foreign born Primary Care Physicians and Specialists who provide services for a minimum of three years in a primary care HPSA.

- WIC – as of October 2016, there will be 29 local agencies, serving an average of 18,000 participants per month statewide.
- WMH – is now administering three grants, with the addition of the Rape Prevention and Education (RPE) Program. MT's RPE program focuses on primary prevention, and preventing sexual violence crimes before they occur, on 5 college campuses. With a \$226,000 award amount, efforts are focused on influencing the knowledge, attitudes, and behaviors of those most at risk to perpetrate, and include community organizing and policy creation focused on gender equity. It also includes education on several levels, based on awareness activities that support healthy relationships and respect.  
In SFY 2015, Title X contractors provided reproductive health services, counseling, referrals, and preventive health screening to over 21,000 men and women. The PREP program is currently contracting with five agencies, serving seven counties, and in SFY 2015 1,410 youth received evidence-based classes on how to prevent teen pregnancy and sexually transmitted infections.

Additional activities regarding Culturally Competent Approaches to Service Delivery have also occurred in the past year:

- In April 2016, Mary Lynne Billy-Old Coyote, an enrolled member of the Chippewa Cree Tribe, started as the state's new Office of American Indian Health. The office was requested by Tribal Health Directors, to work with them on addressing health disparities. The position resides in the Director's Office at DPHHS. Billy-Old Coyote coordinates work with Tribal health stakeholders and DPHHS staff, to identify key health-related issues and develop strategies to address them. She also helps identify existing state resources that may assist tribes. Her work embodies several core values, including respect for sovereignty, collaboration, equity, integrity, and accountability.
- The 2015 Tribal Relations Report, "Partners in Building a Stronger Montana" is available at: [http://tribalnations.mt.gov/Portals/34/TribalAffairsBookletE2015web\\_041216.pdf](http://tribalnations.mt.gov/Portals/34/TribalAffairsBookletE2015web_041216.pdf)
- Since early 2016, planning has been underway for a Promising Pregnancy Care Training, which is an evidence-based health care delivery system combining the prenatal visit with group education. It is a joint collaboration between MT Medicaid and the FCHB, to reimburse state approved Medicaid providers for group prenatal care. This particular training, taking place July 21-22, is designed to work with providers who serve Native American populations. It will help them to incorporate culturally appropriate education into a group pregnancy care program and improve access to prenatal care.

## **Five-Year Needs Assessment Summary (as submitted with the FY 2016 Application/FY 2014 Annual Report)**

### **II.B.1. Process**

Montana Maternal and Child Health Block Grant  
2015 Statewide 5-Year Needs Assessment Summary

#### **Process:**

The Family and Community Health Bureau (FCHB), of the Montana Department of Public Health and Human Services (DPHHS), administers the Maternal and Child Health Block Grant (MCHBG) for Montana. In December 2013 the FCHB created a team to begin work on the formation of the 2015 Statewide 5-Year MCHBG Needs Assessment.

The team identified desired outcomes for this assessment:

- Incorporate enough of the 2010 format to see changes and trends;
- Findings which could serve as “drivers” in determining realistic and relevant program priorities, and in developing a five-year action plan;
- Indicate the greatest needs and major health issues of the maternal and child population, along with who is currently working to address those needs, and the most effective public health interventions;
- Discover where local public health support services could have the greatest impact;
- Give our partners an opportunity to provide input on priorities;
- Integrate and augment information gathered through other recent DPHHS program needs assessments.

The MCH Epidemiologist and the MCHBG Coordinator created an in-depth online survey, using questions distilled from the 2010 survey as a starting point. The top typically known responses were provided for the participants to rank, and then an “Other” category was provided for additional answers.

During March 2014, seven regional trainings were presented to county public health departments (CPHD) on MCHBG topics. These departments are the state’s main partners for delivering MCHBG services. Printed copies of the survey were presented and explained, in order to facilitate the formulation of their responses before going online. Members of the Montana Hospital Association and the Montana Primary Care Association also completed the survey. In all, 58 surveys were submitted. The response rate from the CPHDs was 76%.

The format of the online survey consisted of five sections asking a similar set of seven questions for each of five MCH population categories:

- Infants, Under 1 Year of Age
- Children, Ages 1 to 10 Years
- Adolescents, Ages 11 to 19 Years
- Children and Youth with Special Health Care Needs
- Women of Childbearing Age, 15 to 44 Years

The seven questions were asked of each population category (PC):

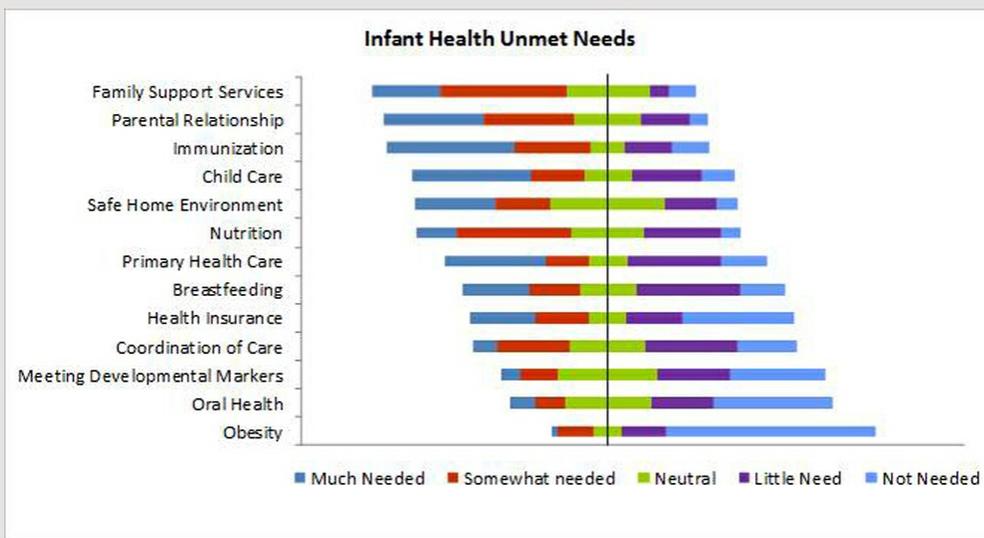
1. Please rank the following health needs, beginning with 1 as the most important (PC) health need in your service area.
2. Are there other common (PC) health needs in your service area, which were not listed in the previous question?
3. Briefly, what do you think are the barriers to addressing the (PC) health needs you identified? For instance: funding, staff time, lack of local policy support, limited local resources, or lack of specialized training?
4. Who in your county addresses the (PC) health needs previously listed? Please select all that apply for each need.
5. Please rank the following health needs beginning with 1 as the most important UNMET (PC) health need in your service area. If a need is being addressed, please check the N/A box.

6. Are there any other common UNMET (PC) needs in your county which were not listed?
7. What do you see as a NEW and EMERGING health need affecting (PC) in your county? (Please choose only 1).

The survey responses were evaluated by four main criteria:

- A ranking by importance of *all* health needs mentioned for each category
- A ranking of *unmet* needs
- A listing of which area organizations are currently working to address each need
- What are *new and emerging* needs

The MCH Epidemiologist did an initial analysis of questions 1 and 5 by using a two-dimensional approach: ranking the answers by number selected, and then by whether the choices indicated a service was: Much Needed, Somewhat Needed, Neutral, Little Need, or Not Needed. For instance, regarding the Infant Health Unmet Needs - Immunization was number 3 for unmet needs, but showed the highest “Much Needed” score, as shown in this graph:



The answers to question 4 were helpful in determining if the county public health departments saw themselves as one of the organizations who are addressing a given need. The answers to number 7 were vital to assessing changes from the 2010 Needs Assessment.

The FCHB also interviewed key informants throughout the state who are members of the Public Health System Improvement Task Force. These public health professionals have unique perspectives and insights into MCH issues. Face-to-face or phone interviews were conducted in December of 2014. The following questions covered the five MCHBG population categories, and the interviews took between 30 to 45 minutes.

- What do you see as the major health issue affecting each of these groups?
- Who is addressing these issues?
- What are the barriers associated with the issues you mentioned?
- If you could choose one public health intervention to improve the health of these groups (one for each), what would it be and why?

Analysis of the surveys and key informant interviews provided current data to pair with other recent DPHHS Needs Assessments, most specifically:

- Montana’s State Health Improvement Plan (SHIP): Work began in 2012 with compiling the health status and needs of Montanans, which was then presented to stakeholder groups and the public. Information from focus groups, on-site meetings, surveys, and webinars also informed the plan. More than 300 individuals representing more than 130 organizations participated in its development. The SHIP addresses six main health topic areas, one of which is to promote the health of mothers, infants and children.
- The Public Health and Safety Division Strategic Plan (PHSDSP): FCHB is part of the PHSD. In September 2013, the PHSD released a strategic plan to strengthen its programs, services, and operations over the next five years. The

development of the strategic plan was a collaborative effort involving expertise and input from Montana public health system stakeholders, employees throughout the PHSD, and its management team. Many of the goals and strategies within the PHSD strategic plan address both national and state MCHBG performance measures.

Tables 1 and 2 summarize the needs, wants and expectations of the PHSD's customers and key stakeholders – as expressed during assessment work for the strategic plan:

Table 1: Montana Public Health and Safety Division Strategic Plan Assessment Customer Needs, Wants and Expectations	
Customers	Combined Needs, Wants and Expectations
Local and tribal health departments Healthcare providers and facilities Emergency planners & responders Montana citizens The Governor Montana Legislature Other state agencies and DPHHS divisions Regulated entities Community-based organizations Federal agencies Universities Tribal entities Billings Area Indian Health Service Businesses	Timely and accurate service, data & information Credible and competent services Scientific support Effective services and operations Cost-effective services and operations Rapid response to public health events Responsive, courteous customer service Effective communication

Table 2: Montana Public Health and Safety Division Strategic Plan Assessment Stakeholder Needs, Wants and Expectations	
Stakeholders	Combined Needs, Wants and Expectations
Local and tribal public health departments Healthcare providers and facilities Montana citizens The Governor Montana Legislature Other state agencies and DPHHS divisions Regulated entities Community-based organizations Federal agencies Health advocates Businesses Public and private health care payers Media	Timely and accurate data and information Effective use of money Accountability Transparency Responsiveness Return on investment Credible information Effective communication Integrity

The MCHBG Needs Assessment Team made **initial performance measure selections based on highest need, the ability of CPHDs to have an impact, and availability of data**. A crosswalk was created between the new National Performance Measures (NPMs), possible State Performance Measures (SPMs), the SHIP and the PHSDSP. This helped focus NPM choices, and SPM recommendations. The MCH Epidemiologist also looked at Montana indicators in regards to the new NPMs.

While Montana is not a CDC Prams funded state, the PHSD began conducting a similar assessment in June 2015, The Health Survey of Montana's Mothers and Babies, to produce statewide MCH data.

## II.B.2. Findings

### Findings:

DPHHS identified priority areas, outlined in the PHSDSP and SHIP, for each population health domain. These areas are consistent with both the NPMs chosen and Montana's SPMs. They are also consistent with the top five unmet needs shown in the needs assessment survey results. A crosswalk with indicator data for the most recent available year, and with selected measures by domain, is included as an attachment. A more detailed discussion of the findings, and subsequent selection of MCH priority health needs, starts in the "State Health Needs Priorities" section of this document.

### MCH Population Needs

Montana's National and State Performance Measures choices *by domain* are as follows:

Women's Maternal Health:

- Low-Risk Cesarean Deliveries (NPM 2)

Perinatal/Infant Health:

- Breastfeeding (NPM 4)
- Infant Back to Sleep (NPM 5)

Child Health:

- Child Injuries (NPM 7)
- Immunizations (SPM 3-A)

Adolescent Health:

- Adolescent Preventive Care (NPM 10)
- Immunizations (SPM 3-B)
- Teen Pregnancy Prevention (SPM 5)

CYSHCN:

- Transition Services (NPM 12)
- Medical Home (SPM 4)

Cross-Cutting/Life Course:

- Oral Health (NPM 13)
- Pregnancy and Household Smoking (NPM 14)
- Access to Care (SPM 1)
- Family Support and Health Education (SPM 2)

### II.B.2.a. MCH Population Needs

Overview of Health Status by MCH Population Group

#### **Pregnant Women, Mothers and Infants:**

A snapshot of the health status of Montana's pregnant women, mothers, and infants can be seen from certain common health indicators. The percent of women who smoked during pregnancy was 16.5% in 2013<sup>1</sup> while the 67.2%<sup>2</sup> of women

reported a routine check-up in the past year. Sixty-nine percent of infants were born to women receiving prenatal care beginning in the first trimester.<sup>1</sup> The percent of Caesarian deliveries in low-risk first births was 23.4%.<sup>1</sup> The percent of infants who were ever breastfed in 2013 was 83.5%.<sup>3</sup> Seven percent of live births were of infants weighing less than 2,500 grams, while 9% of births were infants of less than 37 weeks gestation.<sup>1</sup>

### **Children and Adolescents:**

In the 2011/2012 National Survey of Children's Health, 26% of Montanan children were reported to live in a household where someone smokes, 58% of children without special health care needs had a medical home, and 23% of children had a preventive services visit.<sup>4</sup> Seventy-seven percent of children, ages 0-17, had a preventive dental visit in the last year (2011/2012).<sup>4</sup> In 2013, the 4:3:1:3:3 immunization rate for children 19-35 months of age was 74.2%, and routine vaccination coverage for tetanus, meningococcal, and human papillomavirus vaccines in 13-17 year olds were 87%, 54%, and 51%, respectively.<sup>5</sup> In the same year, the rate of injury-related hospital admissions in children less than 19 years of age was 216.3 per 100,000.<sup>6</sup> The rate of birth to adolescents ages 15 -17 years, was 12.6 per 1,000 in 2013.<sup>1</sup>

### **Children and Youth with Special Health Care Needs:**

In the 2011/2012 National Survey of Children with Special Health Care Needs, 57% of Montana's children and youth with special health care needs were reported to have a medical home.<sup>7</sup> Ninety-nine percent of newborns received a blood spot screening before being discharged from the hospital. 100% of infants with a condition identified by newborn screening received timely follow-up, definitive diagnosis, and clinical management.<sup>8</sup> Twenty-eight infants born with a cleft lip and/or palate attended one of the CSHS regional Cleft Craniofacial clinics in calendar year 2014.<sup>9</sup>

### State Health Needs Priorities

The principle guidance concerning Montana's maternal and child health need priorities is from the State Health Improvement Plan (SHIP), published in June 2013. The complete plan is included as an attachment.

The SHIP action area categories are:

- Public Health Policies
- Prevention and Health Promotion Efforts
- Access to Care, Particularly Clinical Preventive Services
- Public Health and Health Care System

There is also a specific section in the SHIP promoting the health of mothers, infants and children.

A complimentary source of guidance to the SHIP is the Public Health and Safety Division's Strategic Plan (PHSDSP), published in September 2013. The complete plan is included as an attachment. The 5-year plan includes seven key results areas:

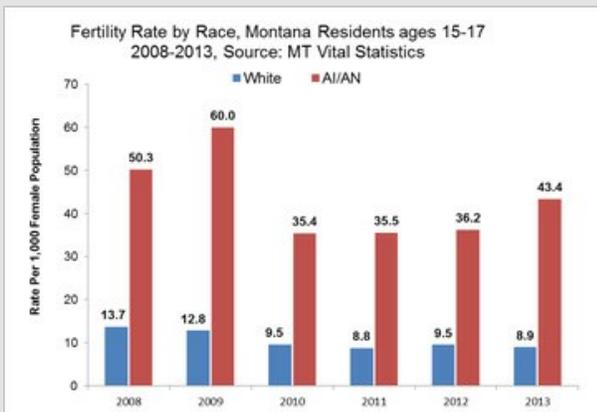
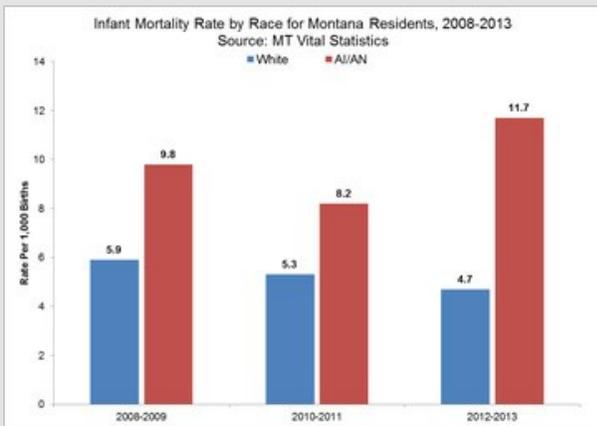
- Policy development and enforcement
- Disease and injury prevention and control, and health promotion
- Health services, particularly clinical preventive services
- Assessment and surveillance
- Public health and health care system
- Internal operations and workforce development
- Financial systems and relationships with governing entities

The main goals of the PHSDSP which effect external operations are:

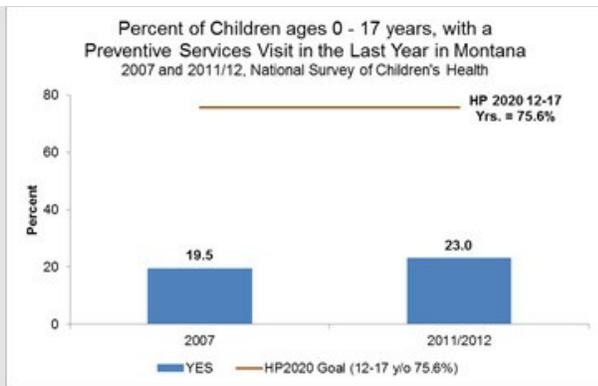
- Develop and support policies to promote and protect health
- Enforce public health laws and regulations to promote and protect health
- Implement evidence-based health promotion and prevention programs
- Promote health by providing information and education to help people make healthy choices
- Improve the delivery of clinical preventive services

- Increase use of appropriate health services, particularly by underserved and at-risk populations
- Monitor health status, health-related behaviors, disease burdens, and environmental health concerns
- Provide leadership to strengthen the public health and health care system
- Lead by engaging the community and partners to identify and solve health problems
- Strengthen public health practice to improve population-based services
- Evaluate and improve public health programs
- Assess and continuously improve the satisfaction of Montanans with services provided directly by PHSD

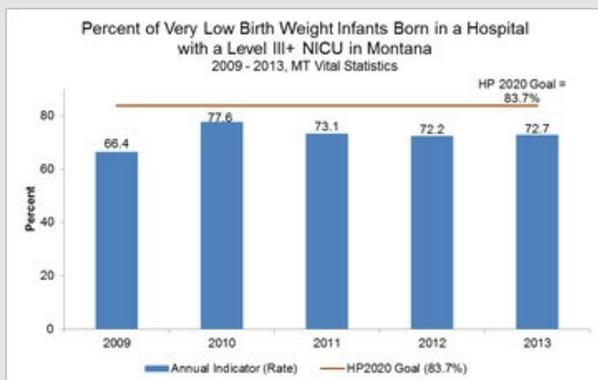
A detailed crosswalk is attached which shows the relationship between the SHIP, PHSDSP and Montana's MCHBG performance measure choices. For some performance measures, the choice was informed by rural geographic or minority American Native population health disparities. In these cases, the statewide data do not provide the whole description of need. For instance, the following graphs show a comparison for the Native American population of Birth and Infant Mortality Rate:



One indicator of geographic health disparity can be seen in the percent of children with a preventive services visit, as shown by the next graph:



Another indicator for access-to-care is the percent of very low birth weight infants born in a hospital with a Level III+ NICU:



The FCHB also gathered needs assessment information from the CPHDs in May 2014 with an extensive online survey; and from the Public Health System Improvement Task Force with key informant interviews in December 2014. Analysis of quantitative and qualitative input has resulted in the selection of the following MCH priorities for Montana:

- Family Support and Health Education
- Access to Care
- Increasing Immunization Rates
- Reducing Child Injuries
- Reducing Smoking in Pregnancy and Household Smoking
- Increasing Breastfeeding Rates
- Improving Oral Health
- Teen Pregnancy Prevention
- Reducing Low-Risk Cesarean Deliveries
- Promoting Infant Safe Sleep

SPMs were developed to address priorities not covered by any of the National Performance Measures. SPM 1 and SPM 2 were created new as a result of emerging trends, and were not available in previous years as either a national or state performance measure. The five SPMs and their data source are:

**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 2,000 or less. (County public health departments report on state provided form.)

*Rationale - 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 SHIP, and one section is focused on strengthening the public health and health care system. It is also integral to Key Results Area 3 of the PHSDSP.*

**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. (County public health departments report on state provided form)

*Rationale - Family support and parental education 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 SHIP and PHSDSP address working to improve outreach in this area.*

**SPM 3 – Immunization:** a) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Diphtheria, Tetanus, Pertussis, Polio, Measles, Mumps, Rubella, Haemophilus Influenza Type B, Hepatitis B, Varicella, and Pneumococcal and b) Percent of 13-17 year olds who have received age appropriate adolescent immunizations against Diphtheria, Tetanus, Pertussis, meningococcal, and Human Papillomavirus. (imMTrax)

*Rationale – Immunization is an ongoing need and most health departments face challenges from parents with vaccine hesitancy. Montana has included the adolescent population to make the performance measure more comprehensive.*

**SPM 4 – Medical Home:** percent of CYSHCN ages 0 – 18 years who have a medical home (NSCH and Montana specific data collected from DPHHS regional specialty clinics and from partners.)

*Rationale –Vast distances create unique challenges to serving children and youth with special health care needs and their families, especially for rural residents. A performance measure that focused specifically on medical home solutions for this population was needed, along with the use of state generated data.*

**SPM 5 - Teen Pregnancy Prevention:** Rate of birth for girls ages 15 to 17 years (MT Office of Vital Statistics)

*Rationale –the needs assessment surveys indicate that addressing teen pregnancy is an ongoing health need in many parts of Montana, and teen pregnancy and birth rates in the U.S. continue to be among the highest when compared to other developed countries. Teen pregnancy and childbearing are closely linked to other social issues, including poverty and income disparity, overall child well-being, and low educational attainment for mothers.*

#### Successes, Challenges/Gaps, and Areas of Health Disparity by Domain

##### **Maternal / Women's Health:**

When it comes to health care for women of childbearing age, MT is currently experiencing a mixture of results based on specific type of care. The percentages for women receiving primary and preventive health care are moving in a positive direction, and it is hoped that the recent passage of Medicaid expansion will continue the trend. More challenging areas are mental health treatment, substance abuse care and prevention, STD/STI education and prevention, and reproductive / sexual health care. These were identified in the top five unmet needs according to the online needs assessment surveys. Geographic disparities exist in availability of enabling services. The very low population base in Montana's frontier counties creates a double challenge from low availability of services, and limited funding for services such as home visiting.

##### **Perinatal / Infant Health:**

According to the CDC 2014 Breastfeeding Report Card, the rate of infants who were ever breastfed in Montana was 91.2%. This compares well with the Healthy People 2020 (HP2020) goal of 81%. Montana also has good rates of health care coverage for infants through the comprehensive “Healthy Montana Kids” program, which incorporates children’s Medicaid, and CHIP for families up to 250% of the Federal Poverty Level. The FCHB is working to reduce cesarean deliveries among low-risk first births. From 2009 – 2013 Montana’s rate was close to the HP2020 goal of 23.9%, but that is still too high. The Infant Mortality ColIN identified OB/GYN champions who are helping to make this a less acceptable practice. Montana still falls below the HP2020 goal of 83.7% of Very Low Birth Weight infants born in a Level III+ NICU, presumably due to geographic disparities.

**Children and Adolescents:**

There is considerable crossover between the Children and Adolescent domains when addressing successes, challenges and health disparities. While still high, the rate of non-fatal childhood injuries has been declining. In 2008 the rate per 100,000 among children aged 0-19 was 312.7, and in 2013 it was down to 216.3. This age group also has experienced the same benefits from Healthy Montana Kids as infants. An area which can be classified as both a challenge and an access-to-care health disparity is oral health. The rate of preventive visits for ages 0-17 years has stayed constant at about 76.6 percent since 2007. The CPHDs identified oral health as the top children’s unmet health need. The highest ranked unmet health needs for adolescents on the surveys were mental health and substance abuse.

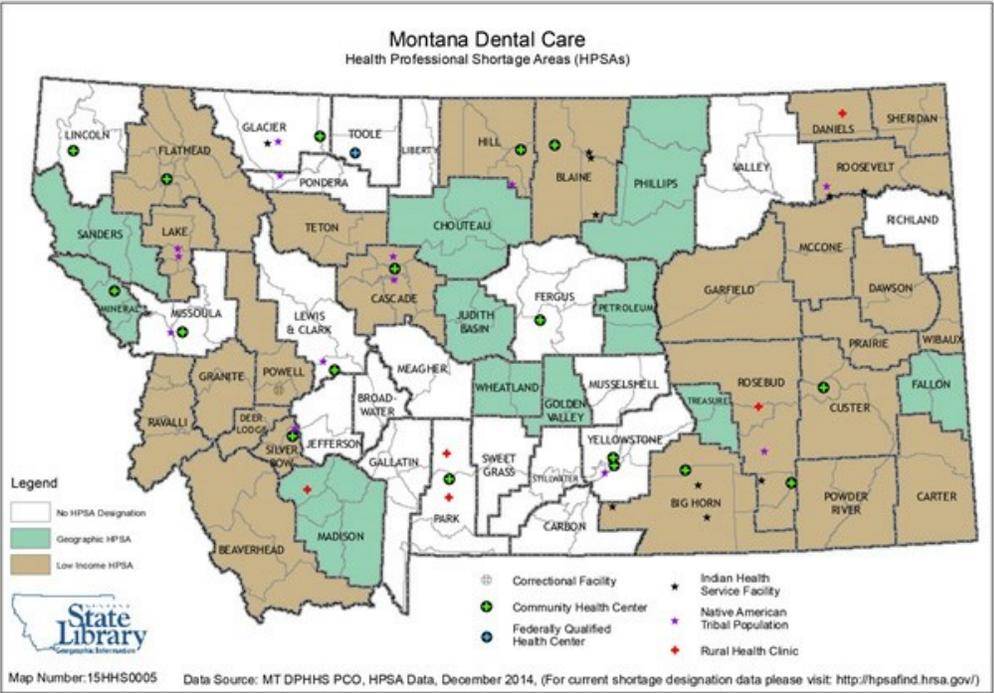
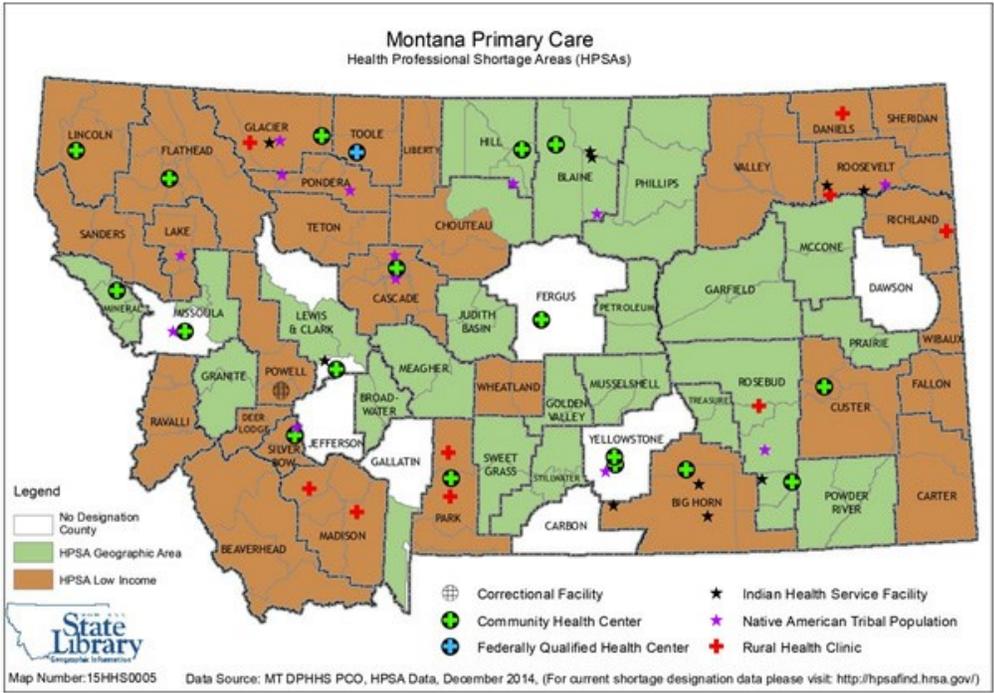
**CYSHCN:**

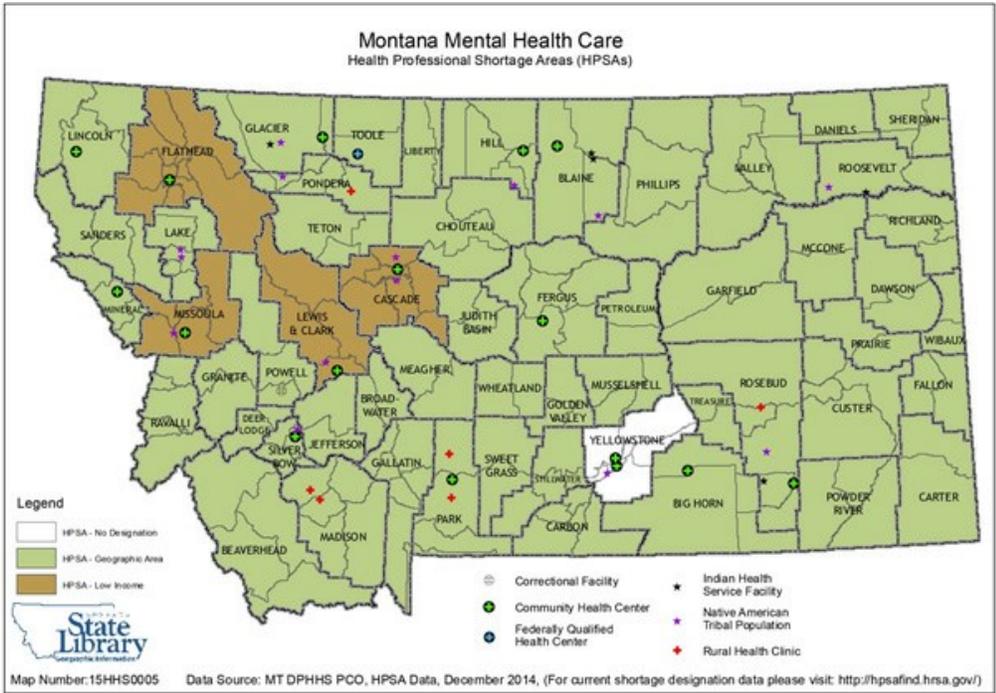
The main success for this domain in Montana is provided by CSHS regional specialty clinics. Nurse Coordinators connect to local resources as needed for providers and families. The challenge of access-to-care remains a large obstacle for many of these children. The CPHD surveys agreed that the top three CYSHCN health needs are also the top three unmet needs: specialty health care services, family support services and coordination of care. Access to timely data for medical homes and transition services also presents a challenge. Data from the 2010 NS-CYSHCN indicate the percent with a medical home is 57%; and for receiving services for transition to adult care it is 51.4%.

**Life-Course / Cross-Cutting:**

The 2015 Montana Legislature passed a Medicaid expansion bill which will improve adequate insurance coverage for those over the age of 18 years in the state. Affordable Care Act enrollment activities have already helped in this area including a jump in the numbers of children enrolled in Medicaid. Challenges include the percent of children who live in households where someone smokes at 26.4%, and in the percentage of women who smoke during pregnancy at 16.5%. The FCHB also considers State Performance Measures 1 and 2 to belong in this domain. The details for these measures are on pages 9 and 10.

Access to care challenges are illustrated in the following maps, which show the Health Professional Shortage Areas for primary care, dental, and mental health providers:





**II.B.2.b Title V Program Capacity**

Analysis of Title V Program Approaches

Responsibility for the main administration of the MCHBG resides with the Maternal and Child Health (MCH) Section of the FCHB. The Children’s Special Health Section (CSHS) is also located within the FCHB, and oversees implementation of services for CYSHCN.

The CYSHCN program continues to partner with providers, organizations and families to promote access to timely, high-quality comprehensive care. This is accomplished through support of newborn screening and follow-up services, outreach and education, provider contracts, clinic infrastructure, transition support, parent mentors, and direct financial assistance. These strategies and programs work well as an integrated system to cover many of the CYSHCN needs in Montana.

Access to specialty care, however, continues to be a hardship in Montana. For some specialty services, families must travel out-of-state. In order to reduce the burden, the CSHS works with families and staff at tertiary centers to ensure they have access to care when returning home.

CPHDs are important partners in serving the maternal and child population in Montana. In alignment with state priorities, they are given a selection of performance measures to choose from each year. MCHBG funding to the counties is distributed by a population-based formula, with a baseline amount of \$1,500 for those with the smallest populations.

There is a huge variation in the size of the maternal and child populations served by Montana’s counties. In 2015, this number ranges from 197 individuals in Petroleum County to 73,779 individuals in Yellowstone County. Of the 56 counties, in fiscal year 2015 the 10 counties eligible for baseline funding accounted for less than 1% of the state’s maternal and child population; 41 counties held only 20% of the population, and the 6 largest counties accounted for 60%. The counties with low populations are also those experiencing the greatest geographic health disparities due to access-to-care issues. These facts create challenges when it comes to program approaches.

In the past two years, the CPHD have been transitioned into increasing requirements for planning, reporting and evaluating their MCHBG activities. This transition has been accompanied by additional support at regional trainings and webinars.

The large CPHDs take these requirements in stride; but many of the smaller ones have outdated record-keeping systems, and problems aggregating enough county specific data to measure the results of their activities in the short term. As a result Montana's Title V program has gone from having 54 counties participate in fiscal year 2013, to 50 in fiscal year 2016.

In response to these challenges, the new "Access to Public Health Services" state performance measure was created. Also, during this coming year a study group will be created with representatives of different sized CPHDs to address the funding formula and provide input on the NPM and SPM State Action Plans.

The workflow to issue contracts for the MCHBG in Montana begins in January. Upcoming program changes are incorporated into new contract and reporting documents in anticipation of regional trainings for the counties in March. The counties fill out an extensive pre-contract survey in April, selecting their performance measures and letting the state program know about their planned activities. They do their work and reporting based on the state fiscal year, which starts on July 1<sup>st</sup>. This routine works well for fitting into their seasonal schedules, and for having their pre-contract survey information available for the MCHBG annual application and report.

### **II.B.2.b.i. Organizational Structure**

#### **Title V Program Capacity**

##### Organizational Structure

The Director of the Montana Department of Public Health and Human Service (DPHHS) is appointed by the Governor. The Administrator of the Public Health and Safety Division (PHSD), which contains the Title V Program, reports to the Director. DPHHS is organized into three branches, Operations Services, Medicaid and Health Services, and Economic Security Services, whose managers oversee 11 divisions. The PHSD is an independent division, not part of a branch.

The mission of the DPHHS is to improve and protect the health, well-being, and self-reliance of all Montanans. It is the largest agency in state government, with 3,000 employees, 2,500 contracts and 150 major programs, and a biennial budget of about \$4 billion.

The PHSD leads the state's public health efforts and provides state-level coordination of key public health services in collaboration with local and tribal public health agencies, community-based organizations, hospitals and community health centers. Without the centralized resources, expertise and support PHSD provides to local public health agencies, many areas of the state would be unable to provide the local services and resources necessary to protect the health of their residents.

Montana's public health services are delivered primarily through contracts with local and tribal public health agencies in every county and reservation in Montana, as well as outpatient clinics, community health centers, hospitals and other community-based organizations statewide. In fiscal year 2014, the PHSD had 192 employees and a budget of about \$61.1 million.

The PHSD contains five bureaus and two offices:

- Financial Services and Operations
- Communicable Disease Prevention and Control, and Emergency Preparedness
- Family and Community Health
- Laboratory Services
- Chronic Disease Prevention and Health Promotion
- Office of Public Health System Improvement
- Office of Epidemiology and Scientific Support

Maternal and child health services, as described in Title V of the Social Security Act, are the responsibility of the FCHB. The Bureau Chief, Denise Higgins, is the Title V Director. The Bureau has a staff of 39 employees, a budget of approximately \$32.1 million, and currently administers about 220 contracts.

The FCHB contains five sections:

- Children's Special Health Services
- Maternal and Child Health
- Maternal and Early Childhood Home Visiting
- Women, Infant and Child Nutrition
- Women's and Men's Health

The apportionment of Montana's MCHBG funding is:

- Children's Special Health Services Section – 30%
- County Public Health Departments – 44%
- Maternal and Child Health Section – 15%
- Indirects and FCHB Administration – 7%
- MCH Epidemiology – 2%
- Women's and Men's Health Section – 2%

Other programs within the FCHB are:

- Fetal, Infant, Child and Maternal Mortality Review (FICMMR)
- Oral Health
- Primary Care Office
- Newborn Screening and Genetics Programs

Statutory authority for maternal and child health services exist 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.

Organizational charts are included as attachments.

### **II.B.2.b.ii. Agency Capacity**

#### Agency Capacity

The FCHB uses a broad-based approach to providing a statewide system of Title V services which are comprehensive, community-based, coordinated and family-centered. Partnerships within the bureau, the PHSD and with the CPHDs are the most important part of the process. Valued input, coordination, and expanded services are also sought through: the Public Health System Improvement Task Force, statewide professional provider and health facility organizations, other divisions within DPHHS, and from programs in other state agencies such as the Department of Transportation.

Through this network, the FCHB is able to leverage its Title V funding to effectively support statewide collaboration and coordination. In addition, an important part of the connecting with and supporting community-level systems and services needed by the maternal and child population is the Title V funding distribution to the CPHDs.

The FCHB's capacity to promote and protect the health of the state's mothers and children through a statewide system of services is provided primary through its own programs and through contracts with CPHDs. The FCHB also has close relationships with other the programs in the PHSD. These provide additional capacity, partnerships, and expertise and are as follows:

*Children's Special Health Services (CSHS)* works closely with Medicaid to see that therapies, medication, and testing for CYSHCN are covered by the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. CSHS provides direct financial assistance for medications, testing and medical services not covered by Medicaid. CSHS also funds multidisciplinary clinics for CYSHCNs with cleft/craniofacial anomalies, cystic fibrosis, and metabolic conditions. These clinics are held regionally to limit travel for families; are coordinated by a registered nurse; include a team of multidisciplinary providers; and family involvement is sought in care planning.

CSHS staff works with Children's Medicaid, March of Dimes, the University of Montana Rural Institute, Montana's Family to Family Information Center, the state public health laboratory, provider organizations (e. g., American Academy of Pediatricians), Montana hospitals, out-of-state hospitals, and birth centers. Nurse coordinators who work in state sponsored clinics coordinate with patient primary care providers (PCPs) to ensure they are aware of treatment recommendations and care plans. Newborn Hearing and Screening Program documentation is provided to PCPs when an infant has not received a hearing screening. The CSHS section has an annual budget of approximately \$661,000.

The *Fetal, Infant, Child and Maternal Mortality Review (FICMMR) Program* is under the Maternal and Child Health (MCH) Section. Case reviews are completed at the local level by county public health departments. There are 33 county FICMMR teams and 21 counties have MOUs to use a neighboring county's team. The funding for the program coordinator's salary is 50% from the MCHBG and 50% from the state general fund. Counties use MCHBG and their own funds to support reviews and injury prevention activities.

County FICMMR teams are composed of health and social service professionals, physicians, nurses, law enforcement, coroners, and other experts who review de-identified death information to determine if the death was preventable. If a death is determined to be preventable, the local FICMMR team makes recommendations for policies and activities in their community.

The *Maternal and Early Childhood Home Visiting (MECHV)* Section supports a majority of MCH services. Staffing includes an epidemiologist and nurse consultant. Contracts cover a network of 84 home visitors. There are 19 Best Beginning Coalitions across the state which act as home visiting advisory groups. The past four years have seen an increase in program capacity to over 900 clients. Funding is from three main sources: state general fund and tobacco trust settlement of \$652,892; Maternal, Infant, and Early Childhood Home Visiting federal funding of \$1 million annually for service delivery, and one-time federal expansion grants of \$5.7 million and \$5.2 million.

MCHBG CPHD Sub-Contractors work under the direction of the *Maternal and Child Health (MCH)* Section. MCH has an annual budget of approximately \$300,000. In SFY 2014, 54 CPHDs provided group encounter services (school/daycare screenings, immunization clinics, etc.) to 28,132 clients. They also served the following unduplicated numbers by population category:

- Pregnant Women - 2,878
- Infants Under 1 Yr. Old – 5,560
- Children 1 Year to 22 Years - 20,844
- Children with Special Health Care Needs – 1,375
- Women of Childbearing Age – 10,648

Total funding to CPHDs in SFY 2014 was about \$1 million. It was apportioned according to a formula based on their county's maternal and child population and poverty rates. In alignment with state priorities, they are given a selection of performance measures to choose from each year. For FY 2016, the CPHDs were given the choice to address one of the following performance measures:

- NPM 4:Breastfeeding
- NPM 14:Pregnancy and Household Smoking
- SPM 1:Access to Public Health Services
- SPM 2:Family Support and Health Education
- SPM 3: Immunization

- SPM 5: Teen Pregnancy Prevention

CPHD contracts include 13 separate deliverables which cover both MCHBG and FICMMR requirements. These deliverables include performance measure activities and evaluation, attendance at trainings, data collection, child and maternal death reviews, an injury prevention activity, quarterly and annual reports, client satisfaction surveys, and completion of a pre-contract survey.

The *Oral Health Program* (OH) resides in the MCH Section, and is funded by a HRSA “Grants to States to Support Oral Health Workforce Activities” \$500,000/year for three years. This funding source ends in August of 2016. The Oral Health Program supports workforce development activities to increase the number of dental providers in underserved areas of Montana, has been implementing an oral health surveillance plan, and is working to increase the number of public health programs identifying the oral health needs of target populations. It promotes activities designed to encourage good oral health practices and increase awareness of the importance of oral health and preventive care. The OH Program also collaborates with and identifies oral health resources available for local health departments, schools, daycares, tribes, Head Start programs and others concerned with oral health promotion activities.

The mission of the *Montana Primary Care Office* (PCO), also in the MCH Section, is to increase access to comprehensive primary and preventive health care, and to improve the health status of underserved and vulnerable populations in Montana. The office has a regular operating budget of \$181,000 annually, and oversees the National Health Service Corps (NHSC) Student Loan Repayment Program with \$75,000 in federal funds and a matching \$75,000 from the state.

All 56 Montana counties have federally designated Health Professional Shortage Areas (HPSA) or Medically Underserved Areas or Populations (MUA/P). Many federal and state programs use these designations for eligibility and prioritization purposes. For example, NHSC uses HPSA scores to prioritize funding. In FFY2014, Montana was home to 152 NHSC Loan Repayment Program providers, 8 NHSC Scholars, and 29 MT NHSC State Loan Repayment Program providers. This is a total of 189 medical, dental, or mental health providers serving underserved populations in Montana. The J1 Visa Waiver Program also uses HPSA designations. The PCO currently has approved 16 J1 Visa Waiver Program physicians who are providing services for a minimum of three years in a primary care HPSA.

Montana's *Women, Infant and Children's Nutrition Program* (WIC) is part of the FCHB. WIC provides nutrition and breastfeeding services to low-income infants, children up to age 5 years, women who are pregnant, and women who are post-partum up to 6 months or breastfeeding up to 12 months after their infant is born. A nutritious, individualized food package is provided to each participant. Foods on the program are specifically chosen to fill a gap in the diets of participants who are at nutritional risk. WIC is federally funded through the USDA, and the annual budget is approximately \$16.9 million. There are 27 local agencies, including all 7 federally recognized tribes in Montana. They serve about 19,000 participants per month statewide.

Quarterly nutrition and breastfeeding education is provided to all participants based on health assessments and individual needs. Additional services include follow-up for those at high risk through a registered dietitian, breast pumps based on need, and distance education (online or via phone). WIC also provides referrals and assists with access to health care. Local agencies screen and refer participants for immunizations, Medicaid/SNAP/TANF, substance abuse, the Montana Tobacco Quitline, dental and medical care, and assists participants with voter registration.

The *Women's and Men's Health* (WMH) Section of the FCHB provides affordable, confidential, quality reproductive health services that respect, empower, and educate individuals, families, and communities. The section administers two grants: Title X, and the Personal Responsibility Education Program (PREP).

With an annual budget of \$1.9 million from the Office of Population Affairs, the Title X grant encompasses 13 contracts serving 28 locations. The contractors provide reproductive health services, counseling, referrals, and preventive health screening. In SFY 2014, services were provided to over 23,000 men and women on a sliding fee scale.

With \$250,000, the PREP grant's purpose is to prevent teen pregnancy and sexually transmitted infections. PREP contracts

with six agencies serving eight counties. It uses two evidence-based curricula: Reducing the Risk, and Draw the Line/Respect the Line. During SFY 2104, PREP educated 1,687 youth in 18 regular public schools, 2 alternative schools for at-risk youth, 3 juvenile justice programs, 1 community-based organization, and 1 career development center.

The Montana *Immunization Program* (IZ) is located within the Communicable Disease Control and Prevention Bureau of the PHSD. Focus areas include: Program Stewardship and Accountability; Assessing Program Performance; Assuring Access to Vaccines; Improve and Maintain Preparedness; and Immunization Information Technology Infrastructure. The annual operations budget, excluding vaccine purchases, is approximately \$1.3 million. Twenty-six CPHDs chose SPM 3 for FFY 2016, and will receive \$365,218.

The Vaccines for Children (VFC) Program provides vaccines at no cost to children who might not otherwise be vaccinated because of inability to pay. IZ supports, on average, 230 VFC providers and the purchase and distribution of \$6 to \$8 million dollars' worth of publically funded vaccine each year. Montana's Immunization Information System (imMTrax) consolidates vaccination data from vaccine providers and provides tools for designing and sustaining effective immunization strategies.

The *Montana Tobacco Use Prevention Program* (MTUPP) is in the Chronic Disease Prevention and Health Promotion Bureau of the PHSD. MTUPP works to eliminate tobacco use, especially among young people, through statewide programs and policies. It has been highly effective and is a national model among tobacco use prevention programs. According to Montana's 2013 Youth Risk Behavior Survey, smoking among youth has decreased from 29% in 2001 to 15% in 2013.

MTUPP's overall budget is funded through state special revenue from Master Settlement Agreement funds and through a CDC Cooperative grant. In SFY 2014 the program's budget was approximately \$4.75 million.

The goal of MTUPP is to reduce disease, disability, and death related to tobacco use by:

- Preventing tobacco use among young people;
- Eliminating exposure to secondhand smoke;
- Eliminating disparities related to tobacco use and its effects among certain population groups; and
- Promoting quitting among adults and young people.

MTUPP continually works toward actively changing attitudes related to tobacco use through smoke-free and tobacco-free policies on medical campuses, college campuses and public housing complexes. Currently there are seven college campuses and 58 medical campuses with tobacco-free policies, as well as 11 Public Housing Authorities.

MTUPP has also partners with school districts and the Office of Public Instruction to increase the number of Montana schools that adopt Comprehensive Tobacco-Free School Policies (CTFSP), which go beyond the requirements of the Clean Indoor Air Act. As of June 2014, 65% of Montana's schools have adopted CTFSP. Also, MTUPP supports a program which encourages teens to educate their peers about the truth and facts of the tobacco industry. The program is called "reACT Against Corporate Tobacco." reACT groups led 158 tobacco prevention activities in 2014 and 800 youth attended regional reACT summits. Sixteen reACT groups analyzed tobacco advertising in 300 stores in 41 communities across the state. MTUPP's partnership with the Montana High School Rodeo Association has led to *the first tobacco free policy in high school rodeo in the nation*.

The following lists all (not just Montana's choices) of the national and state performance measures by domain, and the *programs most involved in providing Title V services to that area*:

Women's Maternal Health:

- Women's Preventive Care (NPM 1) – WMH, MECHV, PCO, OH
- Low-Risk Cesarean Deliveries (NPM 2) – MECHV, MCHC / IM COIIN

Perinatal/Infant Health:

- Very Low Birth Weight Deliveries (NPM 3) – MECHV, CSHS
- Breastfeeding (NPM 4) – WIC, MCHC, MECHV
- Infant Back to Sleep (NPM 5) – MECHV, MCHC / IM COIIN, FICMMR

Child Health:

- Developmental Screening (NPM 6) – PCO, MECHV, WIC, CSHS
- Child Injuries (NPM 7) – FICMMR, MCHC, MECHV
- Physical Activity (NPM 8) – WIC, MECHV
- Immunization (SPM 3a) – IZ, MCHC, MECHV, WIC

Adolescent Health:

- Bullying (NPM 9) - FICMMR
- Adolescent Preventive Care (NPM 10) – WMH, PCO
- Immunization (SPM 3b) – IZ, MCHC, WMH
- Teen Pregnancy Prevention (SPM 5) – WMH, MCHC

CYSHCN :

- Medical Home (NPM 11) – see SPM 4
- Transition Services (NPM 12) – CSHS
- Medical Home MT Specific (SPM 4) – CSHS, PCO

Cross-Cutting/Life Course:

- Oral Health (NPM 13) – OH, MCHC, PCO, WIC
- Pregnancy and Household Smoking (NPM 14) – MTUPP, MECHV, WIC, MCHC, FICMMR
- Adequate Insurance Coverage (NPM 15) – WMH, CSHS, MECHV
- Access to Care (SPM 1) – MCHC, PCO, OH, IZ, WMH, CSHS
- Family Support and Health Education (SPM 2) – MCHC, MECHV, WIC

### **II.B.2.b.iii. MCH Workforce Development and Capacity**

#### MCH Workforce Development and Capacity

The PHSD has 192 employees, of which 39 work in the FCHB. All of the FCHB state staff is located in Helena. In FY 2104, a breakdown of the average number of full-time employees *at the CPHDs*, as reported on the pre-contract survey, was:

- Less than 1 FTE = 7
- 1 FTE = 5
- 2 to 3 = 17
- 4 to 5 = 10
- 6 to 10 = 2
- 11 to 15 = 4
- 16 to 20 = 2
- 21 or More = 6

Names and qualifications of senior management and program staff:

- Title V Director and FCHB Chief, Denise Higgins -  
Denise graduated in 1992 with a B.S. in Medical Technology from Illinois State University, in Normal, Illinois. From 8/1996 to 8/1997, she did MPH coursework at the University of Illinois in Springfield, Illinois. She obtained a certificate in Public Health Management from the University of Washington, School of Public Health in 2014. Recent work history:

2000: Program Manager, Montana Birth Outcomes Monitoring System, DPHHS PHSD

2004: Laboratory Preparedness Coordinator, DPHHS PHSD Laboratory Services Bureau

2006: Manager, Newborn Screening and Serology Laboratory, DPHHS PHSD

2010: Bureau Chief, Family and Community Health Bureau, DPHHS PHSD

- MCH Supervisor, Ann Buss -

Ann graduated in 2008 with a Masters of Public Administration from the University of Montana in Missoula, Montana. She completed 15 hours of coursework in the field of public health and earned a Maternal Child Health Certificate from the University of Arizona and a Maternal Child Health Leadership Certificate from the University of South Florida. Recent work history:

1991: Employment and Training Counselor, Miles Community College

1997: Executive Director, HANDS Child Care Program

2003: CACFP Program Specialist, DPHHS, HCSD, ECSB

2006: Maternal Child Health Section Supervisor, DPHHS PHSD FCHB

- CSHS Supervisor, Rachel Donahoe -

Rachel graduated in 2007 with a B.A. in Sociology from Carroll College in Helena, Montana. Recent work history:

2006: Program Manager, Helena Food Share

2007: Program Manager, God's Love Family Transitional Center

2008: Medicaid Program Officer, DPHHS

2011: Marijuana Program Manager, DPHHS

2014: Children's Special Health Services Supervisor, DPHHS PHSD FCHB

- MECHV Supervisor, Dianna Frick -

Dianna Frick graduated in 1996 with a B.A. in International Affairs from Lewis & Clark College in Portland, Oregon. In 2003 she earned an MPH in Maternal and Child Health with a minor in Epidemiology from the University of North Carolina-Chapel Hill, in Chapel Hill, North Carolina. Recent work history:

2001: Consultant and Graduate Student Intern, Intrah/IntraHealth, University of North Carolina at Chapel Hill, Chapel Hill, NC

2003: Public Health Prevention Specialist, Centers for Disease Control and Prevention, Agency Assignment: Division of Sexually Transmitted Disease (STD) Prevention, Program Development and Support Branch, National Center for HIV, STD and TB Prevention (NCHSTP)

2004: Public Health Prevention Specialist, Centers for Disease Control and Prevention, Field Assignment: Family and Community Health Bureau, Montana DPHHS

2006: Maternal and Child Health Epidemiologist, Montana DPHHS

2008: Lead Maternal and Child Health Epidemiologist, Montana DPHHS

2012: Maternal and Early Childhood Home Visiting Section Supervisor, Montana DPHHS

- WIC Supervisor, Kate Girard -

Kate graduated in 2009 with a B.S. in Nutrition/Dietetics from California Polytechnic State University in San Luis Obispo, California. In 2011 she earned a MHS from Western Carolina University in Cullowhee, North Carolina. Recent work history:

2009: Nutritionist I, Buncombe County Health Department, North Carolina

2011: Nutritionist II/WIC Director, Madison County Health Department, North Carolina

2013: Public Health Nutritionist/Nutrition Coordinator, DPHHS, FCHB WIC Section

2014: WIC Section Supervisor, DPHHS, FCHB WIC Section

- WMH MCH Program Specialist, Kimberly Koch -

Kimberly graduated in 2001 with a B.S. in Health and Human Performance, Health Promotion Emphasis, from the University of Montana in Missoula, Montana. In 2012 she earned a Masters of Public Health from the University of Montana. Recent work history:

2003: Health Educator, Planned Parenthood of the Inland Northwest

2005: Health Education Specialist, DPHHS Montana Tobacco Use Prevention Program

2007: Health Education Specialist, DPHHS Women's and Men's Health Section

2013: MCH Program Specialist, DPHHS Women's and Men's Health Section

- PCO Manager, Brandy Kincheloe (*Hired August 2015, information updated for final application submission.*) Brandy graduated in 2004 with an A.A. in Communication from Casper Community College. In 2009, she earned a B.S. in Sociology from the University of Montana. She became a LEAN instructor in 2014, and is a certified Wellcoach.

Recent work history:

2009-2011: Director of Social Services, Hillside Health Care Center, Missoula, MT

2011-2013: Community Living Program Specialist and Nutrition Case Manager, Missoula Aging Services, Missoula, MT

2013-2015: Community Health Improvement Specialist, Clark Fork Valley Hospital, Plains, MT

- FICMMR Program Coordinator, Kari Tutwiler -

Kari graduated in 1982 with a B.S. in Journalism from Utah State University in Logan, Utah. In 1983, she earned a M.A. in Speech Communications from Eastern Illinois University in Charleston. Recent work history:

2005: Marketing Officer, Children's Mental Health Bureau, MT State Department of Public Health & Human Services, Helena, MT

2010: Marketing Program Coordinator, Gesa Credit Union, Richland, WA

2012: Communications & Event Coordinator, Washington State University- Tri-Cities Campus, Richland, WA

2015: FICMMR Program Coordinator, DPHHS FCHB

- MCHBG Coordinator, Blair Lund -

Blair graduated in 1981 with a B.S. in Business Administration, from Rocky Mountain College in Billings, Montana. In 2005 she earned an A.S. in Computer Science from the University of Montana's Helena College of Technology, in Helena, Montana. Recent work history:

1998: Executive Director, Helena Area Habitat for Humanity

2005: Medicaid Data Exchange Business Analyst, Affiliated Computer Services

2007: Internet Marketing Coordinator, Student Assistance Foundation

2010: CHIPRA Grant Coordinator, DPHHS Healthy Montana Kids

2012: ACA Exchange Grant Coordinator, MT Commissioner of Securities and Insurance

2013: MCHBG Coordinator, DPHHS FCHB

- Immunization Program Coordinator, Bekki Wehner -

Bekki graduated in 1996 with a BS in Health and Human Development / Family Science from Montana State University, Bozeman, Montana. She went on to receive an additional BS degree and teaching certification in Health Enhancement / Education from the same University in 2003. Current work history includes:

1997: Case Manager – Big Brothers Big Sisters of Helena

2004: Immunization Information System Coordinator – DPHHS, PHSD

2010: Immunization Information System Manager – DPHHS, PHSD

2012: IT Business Analyst – State of Montana

2014: Montana Immunization Section Supervisor – DPHHS, PHSD

- MCH Epidemiologist, Anya Walker -

Anya graduated in 1992 with a M.S. in Mathematics, from Tver State University in Tver, Russia. In 1999 she earned a M.B.A. in Management from Tver State University. Recent work history:

2007: Bond Program Assistant, Dept. of Commerce, Board of Investments, Helena, MT

2008: Admin. Asst., Dept. of Labor and Industry, Data Management Unit, Helena, MT

2009: Program Specialist/Contract Manager, Dept. of Comm., Housing Div., Helena, MT

2013: Senior Research Analyst/Statistician, DPHHS PHSD OESS Vital Statistics

2015: MCH Epidemiologist, DPHHS PHSD OESS

#### Culturally Competent Approaches to Service Delivery

Montana's main cultural minority, at approximately 6.5% of the population, is American Indian. There are 7 federally recognized tribes in Montana which have dedicated reservations, and one additional tribe recognized by the state which does not have reservation land. The Governor's Office of Indian Affairs facilitates annual Tribal Relations Training to support state employees in developing meaningful and productive interactions with tribes. It also publishes an annual State-Tribal Relations Report. This report includes a listing of the Governor's appointments of American Indians serving on State boards, councils and commission. Additionally, it showcases the state's nearly 550 agreements, negotiations and collaborative efforts with tribal governments which were in effect during state fiscal year 2014. The 2014 Tribal Relations Report, "Partners in Building a Stronger Montana" is accessible at: <http://tribalnations.mt.gov/>

DPHHS has been utilizing the services of a Tribal Relations Manager since 2013. The position is located in the Director's Office and reports to the agency Director. The position was created to guide the department's work with tribes and American Indian people. The Tribal Relations Manager serves as a member of the DPHHS leadership team and as a resource and advisor to staff within DPHHS. The position also works to promote and foster meaningful relationships with representatives of tribal governments, Indian Health Service and Urban Indian Health Centers, in honor of DPHHS's

commitment to work on a government-to-government basis.

In FFY 2014, Montana was home to 156 NHSC recipients. Of these, 28 were serving on one of Montana's reservations: 14 primary care providers, 5 dentists, and 9 mental health providers. An additional 16 NHSC recipients practiced in areas with a high percentage of Native Americans living in the community: 6 primary care, 2 dentists, and 8 mental health providers.

As part of workforce development, the University Of Washington School Of Dentistry is engaged with Indian Health Service dental clinics to add student rotations. One IHS site in Browning has been secured. The Oral Health Program also coordinates controlled dental screening surveillance data throughout Montana, including tribal schools.

CSHS provides outreach Cleft/Craniofacial clinics at the IHS facilities in Browning and Wolf Point. These team clinics are multi-disciplinary and bring together providers trained in the evaluation and care of cleft and craniofacial conditions. The clinics are held in these locations to address a high concentration of these conditions in the area. Local providers participate in the clinics and encourage families to attend.

MECHV contracts directly with two tribal programs to provide evidence-based home visiting services to families that include pregnant women and/or young children. Each tribal program identified the home visiting model that was the best fit for their community. Three more programs funded through MT MECHV provide services on a reservation or in coordination with tribal programs.

The Immunization Program includes all Tribal Health Departments and Indian Health Service units in the Vaccines for Children Program. This program provides vaccine without cost to all American Indian populations.

The MTUPP contracts with American Indian Tobacco Prevention Specialists to provide a variety of local programming. They are located on each of the seven reservations, with the Little Shell Tribe in Great Falls, and two Urban Indian Health Centers in Helena and Missoula. Over two-thirds of reservation school districts have adopted the Comprehensive Tobacco-Free Policy.

MCHBG funding supports services to the Native American maternal and child population through the CPHDs. The following table shows the unduplicated percentage of Native American clients served at CPHDs in counties which share a main geographic area with a reservation, and more than 20% of their total population is American Indian. The CPHD office in Rosebud County is 30 miles from the Northern Cheyenne reservation due to the long and narrow shape of the county, and members of that tribe usually travel to Yellowstone County when seeking non-tribal health services. The two counties which do not have formal MOUs still have close working relationships with their tribal counterparts.

American Indians in Montana have local tribal health departments and Indian Health Service as resources for their health care needs. They also take advantage of the services provided by their CPHDs. The following table shows the percentage of American Indian clients served by CPHDs that share a geographic area with a reservation, as well as more than a 20% American Indian population.

**Montana County Public Health Departments\***  
**Serving Local American Indian Reservations - SFY13 MCH Data**

**(PLEASE NOTE:** Clients voluntarily self-report race on CPHD intake forms)

<b>County</b>	<b>Formal MOU with Tribe</b>	<b>Total MCH Clients Served</b>	<b>AI MCH Clients Served</b>	<b>Percentage of AI MCH Clients SFY13**</b>	<b>AI Percentage of Total County Population</b>
Big Horn	Yes	415	197	47.47%	64.80%
Blaine	Yes	372	138	37.10%	48.80%
Glacier	Yes	994	308	30.99%	63.30%
Hill	No	525	144	27.43%	22.90%
Lake	Yes	553	103	18.63%	23.40%
Roosevelt	Yes	518	275	53.09%	58.30%
Rosebud	No	446	16	3.59%	35.60%
		3823	1181	30.89%	
*Counties included share a main geographic area with a reservation, and more than 20% of their total population is American Indian.					
**Statewide AI percentage of clients served = 5%, as self-reported to CPHDs					
<u>Acronyms:</u>					
MCH = Maternal and Child Health			CPHD = County Public Health Department		
AI = American Indian			SFY = State Fiscal Year (July 1 - June 30)		
MOU = Memorandum of Understanding					

**II.B.2.c. Partnerships, Collaboration, and Coordination**

Partnerships, Collaboration and Coordination

CSHS has State Implementation Grant specific collaborations with:

- The HALI Project, for a parent and mentor training program. This program puts trained parents of CYSHCNs into clinics to mentor other parents who are identified, by providers, as needing support and assistance navigating the system and accessing services for their child; and,
- The University of Montana Rural Institute on Inclusive Communities - which provides transition resources to support CYSHCN, manages the Consumer Advisory Council, and produced a Transition workbook for youth transitioning into adulthood.

Many of the FCHB's partnerships and collaborative efforts are explained throughout the previous sections of this summary. The following is a listing of programs, agencies and organizations in its collaborative network, which help to address the health care needs of the maternal and child population of the state:

### Montana Title V Agency Partnerships

Best Beginnings Advisory Council	MT Dental Hygienists Association
Billings Regional Indian Health Service Office	MT Department of Environmental Quality
Community Health Centers ABCD Partnership Project	MT Department of Justice
Comprehensive Statewide Cancer Control Coalition	MT Department of Transportation Traffic Safety Programs
Denver Children's Hospital	MT Head Start Association
DPHHS Addictive and Mental Health Division	MT Healthcare Workforce Advisory Council
DPHHS Child and Adult Care Food Program	MT Hospital Association
DPHHS Developmental Services Division	MT Hunger Coalition
DPHHS Early Childhood Services Bureau	MT Medical Association
DPHHS Medicaid (Health Resources Division)	MT Medical Genetics Program
DPHHS Nutrition and Physical Activity Program	MT Office of Public Instruction
DPHHS Office of Vital Statistics	MT Office of Public Instruction Nutrition Services
DPHHS PHSD Injury Prevention Program	MT Office of Rural Health / Area Health Education Center
DPHHS PHSD EMS and Trauma Systems	MT Primary Care Association
DPHHS Public Health Laboratory	MT Private Health Coverage Payers
DPHHS STD/HIV/Hep C Prevention Program	MT School for the Deaf and Blind
DPHHS WMHS Medical Standards Committee	MT Statewide Breastfeeding Coalition
Eat Right Montana Coalition	MT Tobacco Prevention Teams
Family Connections Montana	MT Tribal Governments
Graduate Medical Education Council	National Family Planning and Reproductive Health Association
Head Start Collaboration Office	OB/GYN Physicians
Healthy Montana Kids (CHIP)	PLUK / Family Voices
Healthy Montana Kids Plus (Children's Medicaid)	Private Health Care Providers
Healthy Mothers, Healthy Babies	RMDC Head Start Advisory Council
March of Dimes	Rocky Mountain Society of Orthodontists
Medical Advisory Committee for the Breast and Cervical Health Program	Seattle Children's Hospital
Montana Perinatal Association	Shodair Hospital
MSU College of Technology – School of Dental Hygiene and Assisting	State Family Planning Administrators Association
MSU Extension and Expanded Food and Nutrition Program	Substance Abuse and Mental Health Services Administration
MT Academy of Nutrition and Dietetics	Title X Family Planning Clinics
MT Chapter American Academy of Pediatricians	Tribal Health Departments
MT Child Care Resource and Referral Network	University of Montana School of Public and Community Health Sciences
MT Coalition Against Domestic and Sexual Violence	WIC Farmers Market Nutrition Program
MT Community Health Centers / FQHCs	WIC Futures Study Group
MT Dental Association	Wisconsin State Lab of Hygiene

Endnotes:

- <sup>1</sup> Montana Department of Health and Human Services, Office of Vital Statistics, Special Statistical Request; June 8, 2015.
- <sup>2</sup> Montana Department of Public Health and Human Services, Behavioral Risk Factor Surveillance System. MT Data Query, 2013; Available From: <http://dphhs.mt.gov/publichealth/BRFSS/MTDataQuery.aspx>.
- <sup>3</sup> Centers for Disease Control and Prevention, Division of Nutrition, Physical Activity, and Obesity. Breastfeeding Report

Card 2013. Retrieved From: <http://www.cdc.gov/breastfeeding/pdf/2013breastfeedingreportcard.pdf>.

<sup>4</sup> National Survey of Children's Health. Data Browser, 2011/2012. Available From: <http://childhealthdata.org/browse/survey>

<sup>5</sup> National Immunization Survey. Estimated Vaccine Coverage, Children 19-35 Months. 2013 Available From: <http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/index.html>.

<sup>6</sup> Montana Department of Health and Human Services. Montana Hospital Discharge Data. Special Statistical Request; June 8, 2015.

<sup>7</sup> National Survey of Children with Special Health Care Needs. Data Browser 2009/2010. Available From: <http://childhealthdata.org/browse/survey>

<sup>8</sup> Montana Department of Health and Human Services. Children Special Health Services, Newborn Hearing Screening Program, 2013. Special Statistical Request; June 8, 2015.

<sup>9</sup> Montana Department of Health and Human Services. Child Health Informational Referral System, 2013. Special Statistical Request; June 8, 2015

### III.D. Financial Narrative

	2016		2017	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$2,284,817	\$2,284,658	\$2,323,181	\$2,277,159
<b>State Funds</b>	\$2,538,188	\$3,213,408	\$2,532,524	\$3,217,892
<b>Local Funds</b>	\$3,755,312	\$4,529,617	\$3,755,312	\$11,360,771
<b>Other Funds</b>	\$0	\$0	\$0	\$100,000
<b>Program Funds</b>	\$1,933,508	\$340,066	\$1,564,889	\$8,436,391
<b>SubTotal</b>	\$10,511,825	\$10,367,749	\$10,175,906	\$25,392,213
<b>Other Federal Funds</b>	\$28,072,980	\$23,439,906	\$26,793,715	\$23,855,380
<b>Total</b>	\$38,584,805	\$33,807,655	\$36,969,621	\$49,247,593
	2018		2019	
	Budgeted	Expended	Budgeted	Expended
<b>Federal Allocation</b>	\$2,323,181	\$2,301,521	\$2,323,181	
<b>State Funds</b>	\$3,086,577	\$2,984,836	\$3,110,423	
<b>Local Funds</b>	\$4,882,169	\$12,490,557	\$11,340,925	
<b>Other Funds</b>	\$0	\$0	\$0	
<b>Program Funds</b>	\$150,000	\$6,243,211	\$9,008,955	
<b>SubTotal</b>	\$10,441,927	\$24,020,125	\$25,783,484	
<b>Other Federal Funds</b>	\$21,842,716	\$22,904,219	\$22,903,139	
<b>Total</b>	\$32,284,643	\$46,924,344	\$48,686,623	

	2020	
	Budgeted	Expended
<b>Federal Allocation</b>	\$2,323,181	
<b>State Funds</b>	\$3,182,030	
<b>Local Funds</b>	\$12,336,754	
<b>Other Funds</b>	\$0	
<b>Program Funds</b>	\$8,486,816	
<b>SubTotal</b>	\$26,328,781	
<b>Other Federal Funds</b>	\$23,766,761	
<b>Total</b>	\$50,095,542	

### III.D.1. Expenditures

Montana's Title V MCHBG FFY 2018 expenditures supported services to women, infants, children, adolescents, and CYSHCNs. Montana's methodology ensured that the 30%-30%-10% requirements were met for expenditures on: Preventive and Primary Care for Children; CYSHCNs, and, Administration.

In FFY 2018, MT's Title V allocation was \$2,301,521. As reported on Form 2a, \$740,679 (32.18%) was expended on addressing the needs of CYSHCN; with a focus on NPM 11, which integrated activities from NPM 12 and SPM 4, which are now retired. The Children Special Health Care Services (CSHS) Section was responsible for: contract oversight of the HALI Project Parent Partners; coordination for cleft clinic services; the University of Montana's Rural Institute for Inclusive Communities (UMRI) Transitions project and University of Utah Medical Home Portal.

Contract budgets were monitored monthly or quarterly to ensure funds were expended in approved categories. The Title V funds also supported CSHS staff as they: ensured contract deliverables were fulfilled; provided technical assistance as needed to families, healthcare providers and social service agencies; and, financial assistance for qualifying families with out-of-pocket medical expenses.

County Public Health Departments (CPHD) served as the state's primary contracted partners in SFY 2018. They provide very minimal direct health care services with their MCHBG funding, with primary expenditures supporting services to their maternal and child populations in the Enabling or Public Health Services and Systems categories. The percentage residents they served who are American Indian (AI) is 6.62%, which is the same as the AI percentage in the whole population. The Title V MCHBG contracts which started on July 1, 2018 were for a 15-month period, which was done to move their annual reporting from a state fiscal year (July to June) to a federal fiscal year (October to September).

The total Title V allocation to the CPHDs in SFY 2018 was \$1,031,168 which they applied to addressing one of the following NPM/SPM as the focus of their allocation: NPMs 4, 7, 13, 14, or SPMs 1, 2, 3 and 5. Annually, the CPHDs complete a Pre-Contract Survey (PCS), a tool that collects CPHD specific information on their NPM or SPMs' goals, activities, and evaluation plans. Prior to completing the PCS, the MCHBG Program Specialist informs the CPHDs of their anticipated Title V allocation. The performance measure selection and funding allocation are both referenced in the CPHD contracts.

Each CPHD receives an Operational Plan that provides a snapshot of their contractual requirements, and they are encouraged to use it as a reference when completing the required quarterly reports. The MCHBG Program Specialist ensures that prior to releasing the CPHD's quarterly payment, their quarterly report is submitted and approved. This documents progress on their selected performance measure activities, as well as challenges and successes. The NPM and SPM narratives in this report summarize the CPHDs activities and outcomes.

The CPHDs annual SFY 2018 report collected county specific information on:

- Total number of women, infants, children, and adolescents served;
- Population demographics of those served;
- Total Title V and Non-Federal Match funding spent on: Direct Health Care; Enabling Services; Public Health Services and Systems; and, Administration;
- Total Title V and Non-Federal Match funding spent on each population category: 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.

Salaries for the MCHBG Program Specialist and FICMMR Coordinator, and the MCH Epidemiologist, were 100% funded with FFY 2018 Title V funds. The MCHBG Program Specialist served as the lead for state-level activities on NPMs 2, and 10; had direct contractual oversight of the CPHD's Title V supported activities; and was responsible for progress on all the State Action Plan work for the eight NPMs and five SPMs, which entailed working with multiple FCHB and PHSD Programs.

The FICMMR Coordinator was directly responsible for providing the CPHDs support for NPMs 5 and 7, providing TA on evidence-based or evidence-informed activities to the CPHDs. During this time, the FICMMR Coordinator also focused on improving how local FICMMR teams conduct their death reviews, so as to improve the data that is reported in the Child Death Review (CDR) System. The FICMMR Coordinator also assisted with NPM 7 State Action Plan.

The MCH Epidemiologist initiated surveillance reports, and worked with the various program specialists on their completion. Data collection and analysis for the Title V MCHBG Annual Report and Application was also greatly aided by the MCH Epidemiologist's skill set. The Title V Director / MCH Supervisor's salary was supported in part by FFY 2018 Title V funding, and state funds supported the remainder.

In FFY 2018, \$788,077 (34.24%) was expended on Preventive and Primary Care for Children, applying methodology developed for FFY 2017 report. This methodology uses the ratios of Montana's total maternal and child health population as a factor for determining the percentage of state expenses by demographic category. The CPHDs annual reports included actual amounts spent on preventive and primary care for children.

The 2018 Title V Administrative Costs were \$132,414 (5.75%). The FCHB administrative costs reflected legal services, phone and computer services, and portions of the salaries for PHSD management, including the FCHB Bureau Chief who oversees the section supervisors who are also Montana's Title V and CYSHCN Directors.

The Title X Program, administered by the Family Planning Section, received \$27,000 in FFY 2018 which was allocated to contracts with Family Planning Clinics. By their very nature, Title X services (education and access to family planning services; and, referrals to other programs such as WIC and Home Visiting) supported women of child bearing age, and female and male adolescents. Title X Program work correlates with some CPHD activities for SPMs 1 and 2[BA5].

State MCH funds are critical for Montana to improve the health of its citizens. Certain funds are tied to legislative rules and as such are restrictive in their expenditure, i.e. support state staff or can only be expended on contracted services. The state MCH funds are also considered matching funds and in 2018, a total of \$2,984,836 in state funds supported the following Title V work:

- Perinatal Program
- Family Planning
- Montana Initiative for the Abatement of Mortality in Infants
- Genetics
- CSHS Clinics
- CSHS Billing
- Newborn Screening
- Tobacco Prevention
- WIC Farmers Market
- Professional Recruitment

The CPHDs are required to report their total match thus fulfilling the \$3 to \$4 match required match. Their 2018 total was: \$5,595,089 which represents 543% of the total.

The CSHS, WIC, and Title X programs are allowed to bill for select services, which is considered program income. In FFY 2018, the \$6,243,211 in program income was reallocated to the MCH clients served by the program.

The FCHB received \$25,617,563 from other federal funds, which supported MT's MCH population and the ability to meet the NPM/SPM state action plan activities and goals. In FFY 2018, the FCHB expanded their scope of services with the addition of several grants earmarked for adolescents; which resulted in the formation of the Adolescent Health Section. These federal dollars were administered by FCHB MCH programs:

- Title X, Family Planning
- Women, Infant, & Children Nutrition Services
- Newborn Hearing
- Primary Care
- State Systems Development Initiative
- Pregnancy Risk Assessment Monitoring System
- State Loan Repayment
- Oral Health
- ACA Home Visiting
- ACA Personal Responsibility Education Program
- WIC Farmers Market
- Preventive Health Block Grant
- Rape Prevention and Education
- WIC Peer Counseling
- Pregnancy Assistance
- Teen Pregnancy Prevention
- Sexual Risk Avoidance
- Pediatric Mental Health.

As reported on Form 5B, 53,761 women, infants, children, adolescents, and children with special health care needs received services in FFY 2018. Of these, 38,088 received direct and enabling Title V funded services (Form 5a). Direct

services for CYSHCN were covered by CSHS program income and State Genetics Funds.

The MCHBG Program Specialist provides training to the CPHDs on federal reporting requirements. Specific attention is given to the caveat that Title V funds may only be used as the payer of last resort. If Title V funds are used by a CPHD for direct services, supporting details must be submitted on their Annual Report. Form 3b indicates 2018 Title V funds paid for only \$371 in CPHD Direct Services. One frontier-level county spent \$244.00 pharmacy, and another \$127 on glasses.

Montana's CPHDs are charged with the main work of providing Title V services to their community's maternal and child health population. In FFY 2018, the funding focus was on: education; referrals; increasing health literacy; needs assessment; and, in rural areas, maintaining access to services.

The FFY 2018 Annual Report Domain Narratives offer more in-depth descriptions of the approaches in the State Action Plan for:

- Women's/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 (which integrated their previous years' NPM 12 - Transition Services' ESM and SPM 4 - Medical Home activities);
- 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 2020 budget will support services to women, infants, children, adolescents, and CYSHCN. Montana's methodology ensures that the 30%-30%-10% requirements will be met for expenditures on: Preventive and Primary Care for Children; CYSHCN, and, Administration. The FCHB uses a methodology whereby the ratios of Montana's total maternal and child health population are used as a factor for determining state-level budget amounts for the demographic categories.

As reported on Form 2, the 2020 Title V allocation is estimated to be \$2,323,181, which is level funding from the 2019 estimate. If Title V receives the \$27 million, as passed by the House of Representatives on June 19, 2019 and passed by the Senate Appropriations Committee, Montana's additional funding distribution will reflect, at a minimum, a 30% increase in budgeted amounts to: Preventive and Primary Care for Children; and CYSHCN. Any remaining funds will be allocated to cover costs for: providing services to women of child bearing age and pregnant women; potential increases to Title V administrative costs; and support for the 2020-2025 Title V MCHBG Needs Assessment.

During FFY 2019, the FCHB added two new sections: Adolescent Health and MCAH Epidemiology. The Adolescent Health Section (AHS) receives no Title V funds; however, the partnership is supporting the ongoing work of addressing NPM 10. The AHS's federal funding is supporting programs for junior and high school students and college-aged students. Their added funding is reflected on Other Federal Funds Detail section.

The newly formed MCAH Epidemiology Section includes the MCH/CSHS Epidemiologist, the CSHS data system manager, and the lead Epidemiologist who will be supported with Title V funds. Prior to the formation of the MCAH Epidemiology Section, epidemiologists and data system managers were embedded in separate programs, and supervised by their FCHB Section Supervisor. This structure was ineffective because most Section Supervisor don't possess the necessary skill set to oversee their specific tasks. Title V will support will include: staff salary and benefits; professional development; and, travel. Expected percentages of their total support are:

- Lead Epidemiologist: 20%
- MCH/CSHS Epidemiologist: 100%
- CSHS Data System Manager: 25%

The SSDI grant covers the SSDI Epidemiologist's salary, benefits, and indirect costs. Title V will cover costs such as travel and professional development.

In early 2019, the FCHB expanded to include two Financial Specialist (FS) 6 positions, who report directly to the FCHB Bureau Chief. The FS 6 staff supervise the work of each section's FS 5 positions, minus the Epidemiology section. The FS 5 staff are supported by their section's respective funds and the FS 6 staff support is reflected in the indirect cost amount. The indirect cost also includes the Bureau Chief salary, benefits, and technology and phone support.

For staffing details on the AHS and Epidemiology Sections and Financial Specialists 5 and 6, see the FCHB organization chart attached to this application.

Form 2 indicates that the FFY 2020 \$2,323,181 allocation will be spent as follows:

- Preventive and Primary Care for Children: \$766,191 (32.98%)
- Children with Special Health Care Needs: \$782,417 (33.68%)
- Title V Administrative Costs: \$136,966 (5.90%)

The Children Special Health Services Section allocation is projected the cover the following item percentages:

- Personnel Services: Staff salaries/benefits: \$276,079
  - CSHS Director: 100%
  - Health Education Specialist: 50%
  - Public Health Nurse Consultant: 50%
  - MCH/CSHS Epidemiologist: 50%
  - CSHS Data Manager: 25%
  - CSHC/MCH Financial Specialist 5: 12%
  - Administrative Assistant: 10 %
  - Lead Epidemiologist: 10%
- Operating Expenses: \$45,367
  - Operating expenses include required travel for the CSHS director, and miscellaneous expenses, i.e. professional development

- Contracted Services: \$382,509
  - Children's Special Health Services contracts to provide support to families through several programs focused on improving or enhancing the medical home (NPM 11), as follows:
  - The HALI Project, Montana Parent Partner Program 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 Montana Rural Institute works with families, providers and agencies to provide education, training and tools about transition topics.
  - The Montana Medical Home Portal is a website with information for providers, families and agencies about diagnosis, treatment and local resources for CYSHCN.
  - Circle of Parents is a nationally recognized, evidence-based parent support group for families. CSHS funds two trainers, to train facilitators for starting Circle of Parents support groups in communities in Montana.

The Maternal Child Health (MCH) Section's allocation totals \$328,773 And reflects:

- Personnel Services: Staff salaries/benefits: \$287,347
  - Title V Director: 100%
  - MCHBG Program Specialist: 100%
  - State FICMMR Coordinator: 100%
  - Administrative Support: 100%
  - In FFY 2020, the MCH Section will be hiring a fulltime administrative support position.
  - MCH/CSHS Epidemiologist: 50%
  - CSHC/MCH Financial Specialist 5: 13%
  - Lead Epidemiologist: 10%
- Operating Expenses: \$41,426
  - Operating expenses include required travel for the Title V Director and miscellaneous expenses, i.e. professional development

The 2020 funds will also support ongoing 2020-25 MCHBG Needs Assessment activities. The 2020 budget reflects WIC and CSHS program income, which is projected to be \$8,486,816.

After determining MCH and CSHS sections' specific budgets and the administrative costs, the remainder of Title V funding is allocated to the County Public Health Departments (CPHD). The CPHDs are the MCH Section's main contracted partners for providing Enabling and Public Health Systems Services to the maternal and child populations in their counties, by implementing activities that address their selected NPM/SPM.

The CPHDs allocation formula, as well as Title V funding requirements, is 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. For FFY 2019, the CPHDs operated under a 15-month contract (7/1/18 through 9/30/19). The 15-month contract allowed for their Title V contracts and reporting to move to the federal fiscal year, which will begin with FFY 2020.

52 CPHDs completed the 2020 Pre-Contract Survey and indicated acceptance of their projected FFY 2020 allocation, which totaled: \$1,064,965. The CPHDs quarterly reports will reflect their activities addressing their selected NPM/SPM, which are as follows (Yellowstone CPHD is addressing two):

- NPM 5 – Infant Safe Sleep = 6
- NPM 7 – Child Injuries = 6
- NPM 13 – Oral Health = 5
- SPM 1 – Access to Care and Public Health Services = 26
- SPM 2 – Family Support and Health Education = 10

In February 2019, the MCHBG Program Specialist began communicating with MCHBG liaisons of the six largest CPHDs, about an upcoming contract change which will affect them starting on October 1, 2019. These CPHDs, which represent 60% of MT's MCH population, will be required to submit a completed budget by that date on a form supplied by the FCHB. The CPHDs' FFY 2020 annual financial reports, due November 15, 2020, will be used to inform the 2020 Annual Report.

The 2020 funding will also support as follows:

- MCH/CSHS and SSDI Epidemiologists' expenses for supplies, travel, and rent: \$20,200
- 2020-25 Needs Assessment: \$25,000
- FCHB Bureau Chief expenses for travel and professional development: \$3,000

The state's ability to adequately address the health priorities and needs of the maternal and child population is dependent on additional federal and state dollars. These dollars will support: the personnel costs of those identified MCH and CSHS positions not completely funded by Title V; other FCHB staff who are subject matter experts for CPHD NPM/SPMs; and, help ensure that all Montanans have access to preventive and primary care. The FCHB FS 6 tracks this information, and with the MCH Program's FS 5 creates and tracks budgets that are shared with the respective FCHB Section Supervisor.

FFY 2020 federal funding budgets total \$24,365,047 and include:

- Title X, Family Planning
- Women, Infant, & Children Nutrition Services
- WIC EBT Implementation
- Newborn Hearing
- State Primary Care Office
- Breastfeeding Peer Counseling
- State Systems Development Initiative
- Pregnancy Risk Assessment Monitoring System
- State Loan Repayment
- Oral Health
- ACA Home Visiting
- Rape Prevention and Education Program
- Preventive Health Services Block Grant
- State Personal Responsibility Education Program
- WIC Farmers Market
- Pregnancy Assistance Fund
- Teen Pregnancy Prevention
- Sexual Risk Avoidance
- Pediatric Mental Health

The 2020 state funding totals \$3,182,030, which exceeds the required \$3 to \$4 match amount of \$1,742,385. State funds include:

- Perinatal Program
- Family Planning
- Montana Initiative for the Abatement Mortality in Infants
- Genetics
- CSHS Clinic
- CSHS Billing
- Newborn Screening
- Tobacco Prevention
- WIC Farmers Market
- Professional Recruitment

It is projected that the CPHDs will provide \$12,336,753 for their required \$3 to \$4 match. When combined with the state match, the projected total of \$15,518,783 exceeds the minimal required. Montana's Title V's 2020 budget is anticipated to be \$50,693,828.

### **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.

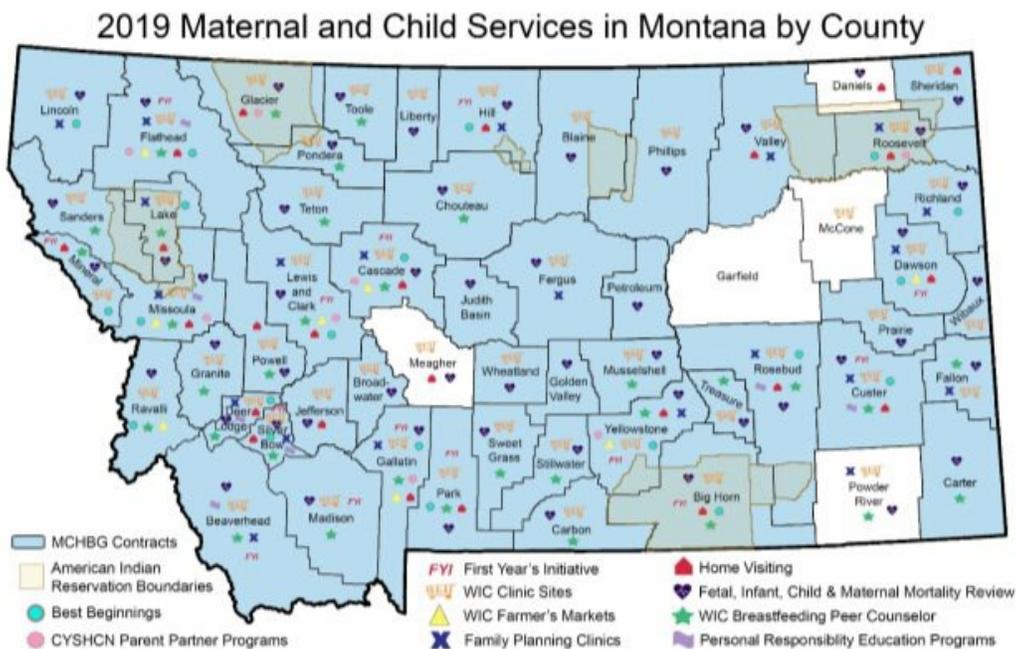
[State Action Plan Table - Entry View](#)

[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

Administration of MT's Title V MCHBG has been a part of the Family and Community Health Bureau (FCHB) for 20+ years. FCHB public health programs target the maternal and child health population, e.g. WIC, home visiting, and CSHS. In the fall of 2018, adolescent health was given more prominence with the addition of a dedicated Adolescent Health Section. Staff include a supervisor, five health education specialists and an AmeriCorps Vista volunteer. The FCHB also added an Epidemiology Section, led by the MCH Senior Epidemiologist. Other section staff are 5 epidemiologists and three data managers. See the attached FCHB organizational chart for details.



The Title V Director is also the Maternal and Child Health (MCH) Section Supervisor, and the CYSHCN Director is the Section Supervisor for CSHS. They provide programmatic oversight for their respective areas. Both report to the Bureau Chief, who reports to the Public Health and Safety Division (PHSD) Administrator.

The five PHSD Bureaus work together with following direction:

- **Vision:** Healthy people in healthy communities;
- **Mission:** Improve and protect the health of Montanans by advancing conditions for healthy living; and,
- **Guiding Principles:**
  1. Evidence-based decision making: Use scientific evidence to select and implement programs that address documented health issues.
  2. Collaboration: Engage in collaborations to build public trust and Division effectiveness
  3. Equal access: Ensure conditions of health are accessible to all.
  4. Individual rights: Achieve community health in a way that respects the rights and confidentiality of the individual.

The PHSD Vision, Mission, and Guiding Principles steer the efforts of the Title V MCHBG funded programs. Following the PHSD's earning of Public Health Department Accreditation status in 2016, FCHB programs' work plans, i.e. the Title V's state action plans, have been influenced by Public Health Accreditation Board (PHAB) guiding principles.

For example, PHAB requires ongoing program quality improvement. The PHSD developed HealthSTAT, a systematic performance management tool and the database software that captures a program's point in time status. HealthSTAT provides metrics, and measures for data-driven trends in decision making at the program and core activity work plan levels.

Bi-annually, all PHSD programs present progress reviews to the PHSD Management Team on their program-specific goals and associated challenges, with data entered in HealthSTAT. These reviews are an open forum where the quality, efficiency, and efficacy of a program's operational planning, tracking, and implementation are candidly evaluated and monitored

through structured dialogue.

At the October 2018 FICMMR HealthStat, the state FICMMR coordinator shared the county FICMMR Teams' evidence-based/evidence-informed/best practices (EBIBP) activities. These fulfill a contractually-required injury prevention activity. During SFY19, additional one-time only funds were secured from a partnership with another state program. One county had selected educating their community on a suicide prevention program called *Question, Persuade, Respond* (QPR). The Management Team provided input on how this training could be sustained after the one-time funding was expended.

Public health services 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 that each county must fulfill to ensure the basic health needs of all county citizens are addressed. This responsibility is under the purview of the county's Board of Health.

Throughout the year, new County Board of Health members attend a one-day training in Helena learning about the programs offered by the PHSD and their relationship to MCA 50-1-202. The Title V and CSHS Directors explain how this section references Title V MCHBG requirements such as: screening and testing programs; developing and promoting training for members of the public health workforce; developing, administering, and promoting activities for the protection and improvement of oral health; and, developing, adopting, and administering rules setting standards for the operation of programs to protect the health of mothers and children, including programs for nutrition, family planning services, and improved pregnancy outcome

Each county's Community Health Needs Assessment (CHA) guides its Board of Health in selecting and accepting federal and state funds. Once accepted, each county is bound to the guidelines for fund expenditures, which for Title V funds is outlined in the County Public Health Department (CPHD) yearly contract.

Historically, 41% to 45% of MT's Title V funds have supported CPHDs. Yearly, the CPHDs must submit an operational plan outlining goals and activities for their selected N/SPM, which should address a need identified in their CHA. One need most CPHDs voiced in the 2015 MCHBG Needs Assessment can be summed up as one stated: "*MT's vast geographic size and subsequent impact on accessing care and support services puts the MCH population at risk.*" As a result, SPM 1 and SPM 2 were developed and remain options for CPHDs to select.

The MCHBG guidance change in January 2018 allowed MT to focus its funding on fewer performance measures. Beginning in FFY 2019, CPHDs could select one to address from NPMs 5, 7, and 13 or SPMs 1 and 2. All MT's NPM/SPM choices, including NPMs 10 and 11, are addressed by state-level programs.

Title V funds supports the Title V Director/MCH Section Supervisor who oversees the following staff and programs addressing the listed NPM/SPMs:

- MCHBG Program Specialist: Title V funds support this position 100%. The Program Specialist ensures the state's progress with all MT's NPMs and SPMs. The position also ensures that CPHDs are addressing the health status of their county's MCH population by achieving locally determined NPM or SPM goals, objectives, activities, and evaluations.
- FICMMR Coordinator: Title V funds support this position 100%. The Coordinator ensures that the local FICMMR teams follow the state law in MCA 50-19-401-406. This position also provides expertise and support for CPHD injury-prevention activities.
- Oral Health Program Coordinator: Funds from *HRSA Grants to States to Support Oral Health Workforce Activities*, and the Montana Tobacco Use Prevention Program (MTUAPP), support this position and NPM 13 activities.
- Primary Care Office Program Specialist: Daily PCO operations encourage health care providers to reside and practice in MT Health Professional Shortage Areas, indirectly impacting all NPM/SPMs. HRSA supports the coordinator's salary via State Primary Care Office funds and State Loan Repayment Program funds; and state general funds support healthcare providers' practices.
- MCH/CSHS and SSDI Epidemiologists: Title V funds (100%) support the MCH/CSHS Epidemiologist's salary, professional development; travel; and other necessary costs. The SSDI Epidemiologist's salary is supported by the SSDI grant; however, Title V funds professional development, travel, and other necessary costs. Epidemiologist's duties include:
  - investigate health issues;
  - research evidence-based practices;
  - create data collection tools;
  - analyze data;
  - assist and evaluate programmatic efficacy;
  - produce surveillance reports; and,

- inform all NPM/SPM programmatic activities.

The MCH Section has been without an Administrative Assistant position following a reorganization whereby the FCHB Administrative Assistant assumed these duties for the CSHS Section. The 2020 MCHBG Application includes the addition of this position.

The CYSHCN Director administers the Title V 30% allocation for CYSHCN, supporting 7 positions, and programs which work to ensure that CYSHCN and their families receive access to a medical home and transition services. CSHS staff and stakeholders participate in an annual in-person meeting to review program goals and plan new strategies to address the needs of our population. The CYSHCN Director/CSHS Section Supervisor oversees these program staff:

- Newborn Screening Program Specialist: Funded by HRSA's Universal Newborn Hearing Screening and Intervention (UNHSI) Grant and state funds for newborn screening (NBS), this position ensures all newborns in Montana receive mandated screening tests and provides family support to enhance medical home care for children with disorders identified via NBS.
- MAPP-Net Program Specialist: Funded by HRSA, this position manages the Montana Access to Pediatric Psychiatry Network. The program provides training and consultation to primary care providers who see CYSHCN with behavioral or mental health issues.
- Nurse Program Manager: Funded by MCHBG and state funds for NBS and genetic services, the Nurse Program Manager directly oversees CSHS programs that enhance and improve the medical home, and provides limited care coordination to families.
- Health Education Specialist: Funded by the MCHBG and state funds for genetics services, this position provides support, outreach and education to all CSHS programs.
- Financial Specialist: Funded by the MCHBG and MAPP-Net, this position provides support to all CSHS and MCH Section programs.
- Administrative Support: Funded by MCHBG, state genetic funds and NBS funds, this position supports all CSHS programs and staff with administrative support.

The remaining FCHB Sections' funding and NPM/SPM relationships are illustrated below:

FCHB Section	Funding	Relationship to NPM/SPM
<b>Healthy MT Families</b>	Home Visiting Programs: Title V/HRSA-funded State Funds: MIAMI	NPM: 5, 7, 11, 13 SPM: 1, 2 NPM retired: 2, 4, 12, 14 SPM retired: 3, 4
<b>WIC/Nutrition Services</b>	USDA grants for: WIC Services, Breastfeeding Peer Counseling Support, Farmers' Market	NPM: 5 SPM: 1, 2 NPM retired: 4 SPM retired: 3
<b>Family Planning</b>	Title X Programs: HHS/OPA-funded Preventive Health & Health Services Block Grant: CDC-Funded/State-matched	NPM: 10 SPM: 1, 2 NPM retired: 2 SPM retired: 3, 5
<b>Adolescent Health</b>	Personal Responsibility Education Program: ACF-funded MT Rape Prevention & Education Program: CDC-funded Personal Responsibility Education Program: ACF-funded	NPM: 10 SPM: 1, 2
<b>Epidemiology</b>	PRAMS: CDC-funded SSDI: HRSA-funded	Data informs: NPM: 5, 7, 10, 11, 13 NPM retired: 2, 4, 12, 14 SPM retired: 3, 4, 5

### III.E.2.b. Supportive Administrative Systems and Processes

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

The FCHB increased in size and capacity with the addition of: two sections (Adolescent Health and MCAH Epidemiology), four section-dedicated, level 5 Financial Specialists (FS); and two level 6 bureau FS.

The DPHHS Director's Office supported the FCHB in applying for and receiving \$2,281,636 in federal funding, earmarked for addressing the health care needs of MT's adolescents. This funding was the basis for creating the Adolescent Health Section (AHS). The AHS is contracting with public, private and tribal college campuses; tribal and county health departments; middle and high schools; and non-profits. The work addresses a variety of topics such as: rape prevention education; comprehensive pregnancy and STI prevention; and, prevention of youth risk behaviors such as drug and alcohol use. The AHS staff, supervisor, five program staff, and an AmeriCorps Vista member have attended over a dozen grant specific trainings and conferences in the past 6 months.

The Director's Office also supported the PHSD's decision for each bureau to have a designated Lead Epidemiologist, supervising the work of program-specific epidemiologists. The Maternal, Child, & Adolescent Epidemiology section includes: the lead epidemiologist; five program epidemiologists; and, three data managers.

DPHHS and PHSD management supported the FCHB Bureau Chief's (BC) request to expand the capacity and number of financial specialist positions. These staff provide oversight of approximately \$31 million in Federal funds and \$3 million in State funds. The FCHB includes 7 sections and 54 positions. Some of the sections share an FS 5, and the FS 6s directly supervise two of the FS 5s. The attached FCHB organizational chart provides details.

Recruiting for open positions is coordinated with the Section Supervisors (SS) and DPHHS Human Resources (HR) staff, who post positions on: appropriate websites; in professional journals; post-secondary job placement offices; and, statewide job posting links. Every effort is made to ensure that new FCHB hires meet minimum qualifications for their positions and that the onboarding training, overseen by the SS, meets the needs of the new hire. The SS completes a new employee job evaluation within the first week/s of employment, which offers the new hire the opportunity to share their training needs so as to be successful in their position. Whenever possible, the training is provided either in-house or through attending trainings and conferences.

DPHHS-HR provides onboarding training for all new hires. Annually, all employees are required to complete refresher trainings on topics such as HIPAA; safety in the workplace; and internet safety.

<http://ours.hhs.mt.gov/personnel/newemployeeorientation.shtml>

The SS or BC conduct annual staff performance evaluations, including the identification of professional development needs. Out-of-state travel which is grant required is summarily deemed approved by PHSD management, provided the staff complete the request-to-travel process. PHSD management reviews out-of-state travel, and non-grant-required trainings and conferences on a case-by-case basis.

Children's Special Health Services was awarded a grant from HRSA to provide capacity building and workforce development to primary care providers (PCPs) of CYSHCN with mental health needs. The Montana Access to Psychiatry Network is supporting PCPs by providing education through Project Echo, and will launch a toll-free hotline so PCPs can call and consult with a child and adolescent psychiatrist as needed. The line will be available starting in October 2019.

Professional development of MCHBG affiliated FCHB staff included:

- MCHBG Program Specialist: Attending 15+ webinars in FFY18 on topics ranging from Improving Adolescent-Centered Care, to Keeping Children Ages 8-14 Years Safe as Motor Vehicle Occupants. She also attended a two-day seminar on Planning & Conducting Program Evaluations. Information learned was shared with FCHB staff and CPHD contractors.
- Three epidemiologists attended the Council of State and Territorial Epidemiologist Annual Conference in June 2019. It included presentation blocks for: oral health; maternal morbidity and mortality; and, infant health and first years initiatives. There were also sessions on methodology challenges and successes which can be adapted to public health in MT.
- FICMMR Coordinator: April 2019 training on Mental Health First Aid; and June 2019 Child Death Review & Prevention Conference, and NICHQ Maternal Depression Training.
- The March 2019 AMCHP Conference attendance by: Title V and CYSCHN Directors; CSHS Family Delegate; CSHS Nurse Program Manager; MCHBG Program Specialist; PRAMS Coordinator; Home Visiting Program Lead; Epidemiology Section Supervisor; and, AHS Supervisor.
- OH Program Coordinator: Apr. 2019 National Oral Health Conference
- Three home visiting staff attended the Ounce's Home Visiting Summit, January 2019.

The PHSD Workforce Development Training Plan (2018-2020) serves as the foundation for the PHSD's ongoing commitment to the development of its workforce. From 2018 to present, FCHB staff have attended PHSD trainings on: Program Evaluation; Gathering Evidence: From Literature Reviews to Data Collection; and, Systems & Strategic Thinking: Social Determinants of Health.

In addition to in-person trainings, PHSD supports staff participation in higher education programs with several universities. PHSD has agreements with: the University of Montana (UM) – School of Public and Community Health Sciences; University of Washington (UW) – Northwest Center for Public Health Practice; and, Arizona State University (ASU) – School of Public Affairs to provide graduate-level certificate programs to staff who participate. In 2018, three FCHB staff earned a certificate from UM, and one earned a certificate from UW.

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

The CSHS and MCH Sections of the FCHB are primarily responsible for ensuring that Title V input is solicited from MT's families and consumers, and when feasible, included in the State Action Plan objectives, goals, and activities. Family and consumer feedback and involvement is sought directly from surveys or through participation at meetings. In addition, family and consumer insights are often received from contractors who work with our state's MCH population. Comments from the MCH population served by other DPHHS/PHSD programs is also invited and considered.

FCHB reach for input is wide-ranging, and often program and grant driven. The CSHS section has oversight of intentional partnership with families, as follows:

- The Universal Newborn Hearing Screening and Intervention (UNHSI) program is committed to family and consumer partnerships, as demonstrated by contracts with family-based organizations. These comprise 25% of the UNHSI budget, and are viewed as an approach to increase family involvement and outreach to families with children who are Deaf/Hard of Hearing (D/HH).
- An 18-member UNHSI learning community meets twice a year to focus program activities on areas including medical home, care coordination, and policy. Program staff provide outreach to various levels across the healthcare system, as well as to families directly. Through the program, training opportunities are provided to program staff, family support specialists, and parents.
- The Montana School for the Deaf and Blind (MSDB), a key partner, sponsors a peer mentor program for D/HH children. Parent-to-parent support is provided by the Montana Parent Partner Project (MPPP).
- The family-led HALI Project is contracted to facilitate the MPPP, and is located in six communities. Parent Partners (parents of CYSHCN) work in clinics to support and provide resource referrals to families. In this role, CSHS is apprised of concerns from family, clinic, and community resources. In FFY18, Parent Partners offered peer-to-peer support to 203 families across Montana.
- The CSHS Stakeholders' Group, established in February 2017, includes eight family members and one consumer. On August 13, 2018, MCH Workforce Development Center Staff facilitated the annual in-person meeting of the Stakeholder's Group. The group used the Results-Based Accountability process to determine areas of focus for the upcoming year. Stakeholder calls occur six times annually. The next in-person meeting will be held on August 13<sup>th</sup>, 2019.
- The University of Montana's Rural Institute for Inclusive Communities (UMRI) partnership is a key source of input. The UMRI guides the work of:
  - Consumer Advisory Council (CAC), a group of consumers and family members in transition.
  - Revising, as needed, the Healthcare Transitions Guide, using input from the CAC and information submitted directly to the CSHS and UMRI staff.
  - Raising awareness and providing educational information at venues such as conferences, vendor fairs, and monthly learning webinars. Attendees comments and suggestions are shared with CSHS.
  - As a new *Family to Family Health Information Center* grantee, UMRI will work closely with CSHS to share information about programs and resources for families across both programs. Both parents of CYSHCN staffing this new project will be part of the CSHS Stakeholder's Group.

The CPHDs participating in the MCHBG all conduct client surveys as a part of their contractual requirements. The results of these surveys are submitted to the MCHBG Program Specialist with their annual reports. They use the feedback to improve delivery of services, and for insights into the best venues and means for health education.

### III.E.2.b.iii. States Systems Development Initiative and Other MCH Data Capacity Efforts

Despite a 5-month SSDI position vacancy, accomplishments were achieved in building MCH data capacity. Six new MCH epidemiologists were hired, significantly increasing the state's capacity to manage, link, and analyze MCH data to inform policy and practice.

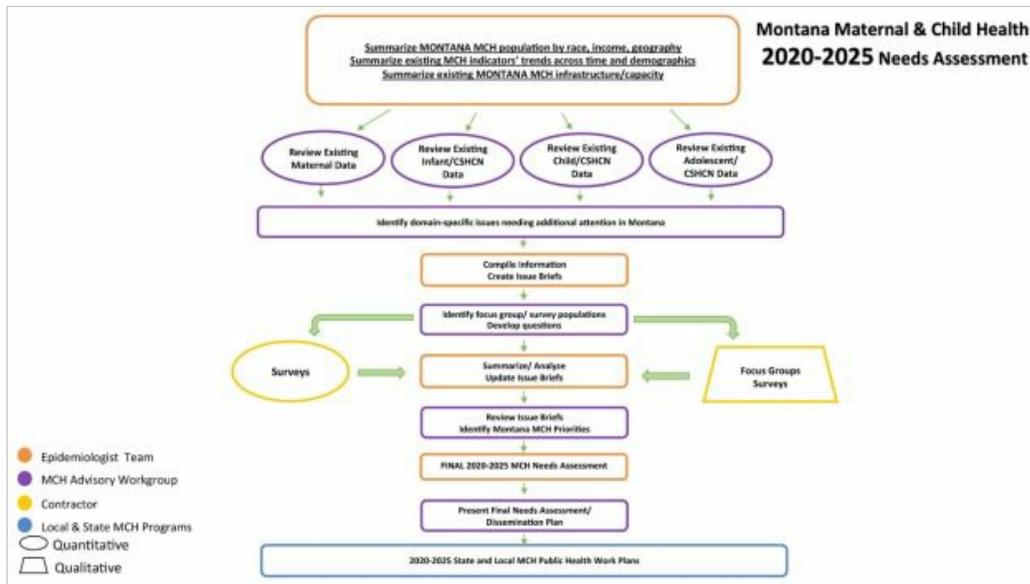
The SSDI workplan was distributed among the epidemiologists. The senior epidemiologist worked with other Bureaus to gain access to MCH datasets. MCH epidemiologists now have access to: vital statistics (i.e., birth, infant and fetal death records); Medicaid; PRAMS; FICMMR reviews; Oral Health; WIC; BRFSS; YBRS, NSFG; and, NSCH.

WIC and Medicaid data were linked to identify eligible non-participating individuals for outreach purposes. The SSDI Epidemiologist updated Montana's minimum core dataset; interviewed MCH program staff to learn about existing and possible sources of MCH data\*; developed and began implementing a data-driven Needs Assessment process (see diagram at the end of this narrative); and, summarized the most recent data for the MCHBG performance report.

To start work on the upcoming MCHBG Needs Assessment, SSDI worked with an MCH advisory committee to establish decision-making roles and responsibilities for program and epidemiology staff\*; developed a two-step prioritization criteria process\*; and, facilitated four domain-specific meetings with 73 Montana MCH leaders.

Trend and disparity data were shared at each meeting, and initial information about MCH needs was gathered. Issues were narrowed by applying high-level prioritization criteria. Root cause analyses of the narrowed issues will occur this summer. After root causes are summarized and a review of the evidence-base is conducted, additional prioritization criteria will be applied to select the final MCH priorities to focus on during the next 5 years.

\*Included in the Supporting Documents provided for this application.



### III.E.2.b.iv. Health Care Delivery System

#### Montana Medicaid Expansion –

The 2015 legislature passed the Montana Health and Economic Livelihood Plan (HELP), which expanded Medicaid to adults up to age 64 earning up to 138% of the federal poverty level (FPL). Coverage was effective January 2016 and was scheduled to end on June 30, 2019.

By April 2019, 95,246 adults (9.2% of the state's population) were enrolled. The 2019 Legislature passed HB 658, *Medicaid Reform and Integrity Act*, that continues Montana's Medicaid expansion program for another six years, as long as federal funding continues. HB 658 adds an 80-hour monthly work or community engagement requirement for enrollees. It also mandates a re-evaluation of the work program if more than 5% of the adults currently enrolled are dropped from coverage, due to not complying with the new work and reporting requirements.

The plan is open to individuals who earn less than \$16,000 a year (the amount, however, adjusts based on household size, i.e., \$33,000 for a family of four), most of whom work in businesses that traditionally do not offer health care coverage. It includes premiums and co-pays (not to be more than 5% of an individual's income total), personal asset limits, increases Medicaid claim reimbursements; and includes a \$2.5 million workforce development component.

The Governor's Office analysis of the bill reports that, due to the number of exemptions, approximately 8,000 people will be impacted and about half are expected to lose coverage. DPHHS has responsibility for creating a reporting system for people to report compliance with the work requirements. DPHHS must also submit a waiver to federal Medicaid by the end of August 2019, prior to the January 1, 2020 effective date.

Since 2009, children up to age 19, living below 250% of the federal poverty level, have been eligible for Healthy Montana Kids (children's Medicaid and CHIP). As of February 2019, enrollment was 127,034.

#### FCHB Organizational Activities and Partnerships -

The FCHB programs continue to provide outreach, referrals, direct enrollment assistance, resource sharing, developing and maintaining partnerships, and training to their partners, which are often determined by the funding requirements. Partners include federally qualified community health centers; private non-profit and for-profit clinics; hospitals; county and tribal health departments; public, private and tribal colleges; middle and high schools; and non-profit organizations, i.e. Boys and Girls Club.

The program's funding parameters guide the activities that are provided. Examples include:

- CSHS: Annually, Parent Partners (PP) serve about 200 families. At each encounter they assess each family's/child's insurance status as well as other social services, i.e. SNAP. Eligible referrals are sent to the Office of Public Assistance (OPA) and the PP assists, as needed, in completing the enrollment paperwork.
- WIC: Access to healthcare and other social services are mandatory questions of all participants during the WIC certification process, with referrals to the appropriate agency or program. In FFY 2019, WIC referral numbers included: 2200 to Medicaid; over 6900 to SNAP; over 1100 to Healthy Montana Families (Home Visiting); 2150 infants and children under 2 whose immunizations were not up to date; and 7080 to health care providers for primary care.
- Healthy Montana Families Program (Home Visiting): In FFY 2018, 1,357 families were provided referrals to Medicaid, presumptive eligibility, Office of Public Assistance, ACA navigators, certified application counselors, and primary care providers. At subsequent home visits, the client is assessed for referral follow through and outcome, or referred again.
- CSHS: In September 2018, CSHS was awarded the HRSA Pediatric Mental Health Care Access Program grant. For the next five years, this program is providing education and consultation to primary care providers serving CYSHCN with mental or behavioral health needs. The Billings Clinic (BC) is providing a bi-weekly ECHO consultation to primary care providers, on child and adolescent mental health topics. Starting in October 2019, BC providers will staff a 1-800 number for primary care providers to access one-on-one consultation with a BC child or adolescent psychiatrist.
- Family Planning Program (FPP): FPP provides Title X services, which are provided to men and women using a sliding fee scale based on income and family size. In 2018, Title X clinics served approximately 18,000 men and women, and determined: 4,600 had public health insurance; about 7,800 had private insurance; and, about 5,400 were uninsured. Clients were referred to FCHB programs, i.e. WIC, Title V, and home visiting as well as to Medicaid.
- CPHDs: In State Fiscal Year 2018, CPHDs used their MCHBG funding to serve a total of 54,829 residents (unduplicated count). A sub-category of Enabling Services is described as: non-clinical services that enable individuals to access health care and improve health outcomes. Examples include: case management, care coordination, transportation, health education, and health professional salaries. Approximately 68% received these

types of services.

- Adolescent Health Section (AHS), houses three programs: Healthy Young Parent Program (HYPP), Optimal Health for Montana Youth (OHMY), and Sexual Violence Prevention and Victim Services (SVPVS). AHS staff are establishing contractual partnerships to expand the reach of these programs by providing training and technical assistance on the program's evidence-based curriculum; hosting monthly or quarterly contractor progress conference calls; and sharing resources with other FCHB programs.

In late 2018, the FCHB expanded to include an Epidemiology Section. The Section Supervisor, or Lead Epidemiologist, supervises five epidemiologists and three data quality specialists - all supporting MCH programs. The staff has access to the MT Medicaid Information System database and ability to conduct Medicaid data queries. This assists FCHB program capacity for service delivery and reporting. Examples include:

- PRAMS - uses Medicaid data to update the contact information for Medicaid-eligible moms and babies sampled for survey participation. This improves the survey's contact and response rates for the Medicaid-eligible population.
- The Family Planning Program - uses Medicaid data to examine which reproductive health services are provided to the Medicaid population, including those services offered through Title X grantee and non-grantee providers.
- WIC - will be using Medicaid data to help calculate the potentially eligible population. Medicaid data can also be used for a reference population in comparison to the WIC population, in data analysis.
- The Oral Health Program - uses Medicaid data to look at billing patterns, active Medicaid dental providers, and to help evaluate whether dental providers have increased their Medicaid claims after educational sessions.
- Adolescent Health - will be using Medicaid data to look at well-child visits. For the MCHBG, the percent of adolescents eligible for Medicaid who received a well-child visit within a given year will be used as a proxy measure for state-level adolescent well visits. Medicaid data is the best source available for this, as there is no population-based or good representative state-wide data source.

The Oral Health Program completed a pilot in one rural county, to understand the unique challenges in accessing care for low-income families with children enrolled in Medicaid. The qualitative information garnered was used to develop a "hub and spoke" model of community-based health promotion and preventive dental program in two rural counties: one at the pilot site of the Pondera County Public Health Department (CPHD) and another at Valley CPHD. Both CPHDs have completed outreach to surrounding counties to share their integrated preventive oral health services and assist with program development and implementation.

As of June 2019, Pondera CPHD staff have collected assessment data in county schools, including one American Indian school and at five Hutterite Colonies. Both settings have high rates of dental decay experience among school-aged children: 93% in the American Indian population; and, approximately 80% in Colony school children. The rate of untreated decay was 48% in the American Indian school, but only 1% in the Hutterite population due to access to Medicaid providers in surrounding counties.

The two hub CPHDs have reached out to 11 surrounding counties for implementation of the health promotion activities, all in the state's most rural counties. Through April 2019, 464 families received oral health education during the hub activities. The health promotion activities include preventive education for children aged six years or less in WIC clinics, at immunization appointments, and at additional settings.

A comprehensive communication plan was developed, called *Healthy Montana Mouths*, and activities began in collaboration with the hubs and WIC clinics throughout the state. An evaluation plan includes: another review of county-level Medicaid claim data analysis; qualitative data collection on the utility of the health promotion material; and, school dental screening data. The health promotion materials were developed through partner meetings from 2016-2018, and shared with partners during an April 26, 2019 Network meeting. It included 45+ attendees who: shared innovative dental activities happening in the state; identified gaps in activities; and, created a plan to move the goals and objectives of the Network forward (<https://dphhs.mt.gov/Portals/85/publichealth/documents/OralHealth/MontanaOralHealthStrategicFramework.pdf>)

The only Medicaid-covered services provided by MT's Title V agency come from CYSHCN Cleft Clinics. CSHS is reimbursed by Medicaid for these expenditures. In FFY 2018 the amount was \$107,105.

MT Medicaid includes information on MCH topics in its newsletter to members. In FFY18, articles appeared on: Teen Pregnancy; Long-Acting Reversible Contraceptives (LARCS); Opioid Abuse & Naloxone; Infant Safe Sleep, Immunization; Substance Abuse Disorder Treatment; Teen Suicide; and, Back-to-School Health Questions. The newsletters are posted online at: <https://dphhs.mt.gov/MontanaHealthcarePrograms/Welcome/MemberServices/MemberEducation>.

### 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 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year	NSCH-2016_2017	9.7 %	NPM 13.1
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	89.2 %	NPM 13.1

**National Performance Measures**

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

**Federally available Data (FAD) for this measure is not available/reportable.**

State Provided Data			
	2016	2017	2018
Annual Objective	58	58.5	59
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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	59.5	60.0	60.5	61.0	61.5	61.5

**Evidence-Based or –Informed Strategy Measures**

**ESM 13.1.2 - Oral Health Pilot Project - Dissemination of Successful Processes and Lessons Learned**

Measure Status:		Inactive - Completed	
State Provided Data			
	2017	2018	
Annual Objective	0	1	
Annual Indicator	0	1	
Numerator			
Denominator			
Data Source	FCHB	FCHB	
Data Source Year	2018	2018	
Provisional or Final ?	Final	Final	

**ESM 13.1.3 - Support county public health departments who have identified increasing dental care during pregnancy as a priority need in their communities.**

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	83.0	87.0	90.0	93.0	93.0

**State Action Plan Table**

State Action Plan Table (Montana) - Women/Maternal Health - Entry 1

Priority Need

Oral Health

NPM

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

Objectives

Increase the percent of women who have a dental visit during pregnancy to 61.5% by 2023.

Increase the percent of women who have a dental visit during pregnancy to 61.5% by 2023.

Strategies

Ongoing strategies in addition to ESMs are: 1) Data collection to foster program evaluation and future planning related to the oral health of MT children. The data is also being included in the Montana OH surveillance system, where analysis can help to address disparities in the 0 to 6 year old population. 2) The OH Coordinator is collaborating with Sealants for Smiles, and the Ronald McDonald Care Mobile, to establish a sustainable foundation for future school-based sealant activities.

ESMs

Status

ESM 13.1.1 - Pregnancy care and dental access integration, pilot project between a County Public Health Department and a co-located Community Health Center, to increase the dental visits of pregnant clients. Inactive

ESM 13.1.2 - Oral Health Pilot Project - Dissemination of Successful Processes and Lessons Learned Inactive

ESM 13.1.3 - Support county public health departments who have identified increasing dental care during pregnancy as a priority need in their communities. 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

## Women/Maternal Health - Annual Report

### Women & Maternal Health – Annual Report FFY 2018

#### **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.**

Early in FFY 2018, Oral Health Program (OHP) staff collaborated with Maternal and Child Health (MCH) staff to review data from the pilot project related to NPM 13A. The main purpose was to determine effective strategies for addressing barriers to dental care during pregnancy. Activity assessment tools and implementation strategies, along with evaluative planning templates, are recognized as excellent resources for county-level staff to support primary prevention of dental decay.

A public health doctoral student evaluated the NPM 13A pilot project activities and prepared theoretical-based assessment tools, a program implementation plan, training materials, and an evaluation plan to support future work. The OHP Coordinator 'branded' the related materials to support a broader oral health promotion program, *Healthy Montana Mouths*. The assessment tool and training materials were disseminated to current contractors and partners to test the usability. Additionally, the OHP Coordinator is seeking funding to support full implementation of the materials, including broader dissemination, as part of Oral Health Program activities.

For the remainder FFY18, the OHP Coordinator continued to prepare *Healthy Montana Mouths* materials to share NPM 13A resources with contractors and county staff working with pregnant women to support oral health promotion activities. Two existing contracts with county health departments were amended to include the pregnant woman dental assessment tool in the clinic and public health settings, leveraging private foundation funding. Both these contractors are in frontier areas of the State and began outreach to 11 surrounding counties. A 'hub and spoke' model was used to efficiently disseminate the materials, collect evaluation data, and create a peer-to-peer network to support oral health promotion and prevention activities for pregnant women and children in our most rural areas.

During this reporting period, the hub counties provided technical assistance to OHP staff in development of a toolkit and conducted initial outreach and community assessment data for adjacent counties. They also conducted outreach in their own counties, conducting 19 health promotion events with settings including: WIC, home visiting, obstetric clinics and hospitals, primary care clinics, Children and Family Services, and Head Start. They also provided oral health education to 223 families, conducted oral health risk assessments for 90 children, and applied fluoride varnish to 35. As the hub and spoke model is fully implemented, the OHP Coordinator will collect aggregate data through an electronic reporting system to support effective evaluation and quality improvement activities in collaboration with hub contractors. OHP staff will continue to provide additional technical assistance and support for implementing the assessment tools for MCH county staff who are working on NPM 13 and any dental providers working in community-based settings. The theoretical framework used for NPM 13A materials were utilized to develop NPM 13B programming assessment tools, trainings, and education materials which are being prepared for testing with hub contractors.

A primary focus of OHP activities included diversifying the oral health workforce and enhancing community-based settings for health promotion and preventive care delivery. MCH and OHP staff continued to build capacity for services by non-dentist providers, this was accomplished through MCH and OHP collaborations on a comprehensive communication plan by providing technical assistance, assessment, and training materials.

The collaboration provided oral health promotion materials to hub locations and an additional 54 primary medical providers in high-need areas of MT. During this reporting period, 1,897 communications were documented through the OHP communication plan including: the release of a state oral health workforce assessment and data brief on the oral health of Kindergarten children. A quality improvement (QI) project on the communication plan was completed by MCH and OHP staff during this reporting period and resulted in revisions to the plan to improve data collection and coordination with contractors.

The number of Medicaid-enrolled children who received an oral health service from a non-dentist provider increased from 98 in 2015 to 460 in 2017, with over one-third (35%) aged 5 years or less (CMS 416 data 12f). This and other metrics to monitor work force and population oral health are maintained as part of the *Oral Health Surveillance System*, to support program activities related to NPM 13 and the addition of epidemiology OHP staff will enhance data use and availability, especially Medicaid queries.

During FFY18, the OHP prepared grant proposals to HRSA and the Centers for Disease Control and Prevention (CDC) to support increased state-level staffing, workforce development, and community-based preventive interventions. The HRSA proposal was funded and work plan activities focus on addressing barriers to perinatal and early childhood preventive interventions, while maintaining existing state staff and the addition of an epidemiologist. Other projects included: piloting a model of care coordination in one rural county using of Medicaid utilization data for children aged 0 to 6 years and a

presentation at an early childhood conference on the integration of health promotion and preventive interventions in non-dental settings.

OHP activities culminated in understanding the unique needs in our rural state and staff development of the *Healthy Montana Mouths* health promotion and preventive materials to support NPM 13A and 13B. Resources to address needs are within the theoretical-based evaluation plan. Partner input from the *Montana Oral Health Strategic Framework*, a strategic plan, continued to guide program activity with metrics for pregnant women and children.

Four CPHDs used their MCHBG funding to implement NPM 13 activities during SFY 2018: Big Horn, Fergus, Flathead and Valley. The following activity examples are excerpts from their quarterly reports:

- *"We attended a community event on July 10, and distributed toothbrushes, paste, flossers and timers and books to 112 children, preschooler through intermediate school age. They were educated on the reasons to brush one's teeth and conversations were had on why people don't brush their teeth."*
- *"We participated in two local farmers' markets in which we offered interactive learning games about dental issues and dental skills and gave away toothbrushes, toothpaste, 2-minute timers, flossers and motivational charts for establishing brushing routines. We also gave away some toddler and preschooler books about brushing your teeth. Our effort is to send the message that it is normal to brush your teeth 2 times each day."*

*At the first farmers' market dental night, we had two dental students from Washington State on site to interact with the kids; at the second farmers' market dental night, we had six medical students from the WAMI program on site to interact with the kids and play lots of dental games. Both sets of professional students were introduced to a quick training on using Motivational Interviewing to improve dental care/ brushing in the home setting. On August 10, 38 toothbrushes and other items were given out. On August 24, 42 toothbrushes and other items were distributed.*

- *"Clients who present to the Health Department for vaccines are given a pre-survey. This survey is a positive promotion of our new oral health services, with an inquiring and educational tone. 26 surveys were returned in this time period:*
  - *32% reported knowing about the oral health (OH) service in our county.*
  - *31% knew that fluoride (FI) varnish is covered by insurance*
  - *58% knew that dentists recommend FI varnish twice yearly*
  - *69% know the benefits of FI varnish*
  - *For barriers to making an appointment for FI varnish: 27% reported time; 8% reported cost; 42% stated their child has no teeth yet; 31% were previously unaware of the benefits of FI varnish; 11% were unaware of the service at the health department; and 27% reported that their child already sees a dentist.*
  - *When asked what the health department can do to help parents prioritize FL varnish application, the responses were: 15% requested a reminder; and, 46% indicated that they would let us know when they wanted an appointment."*
- *"The Oral Health flyer was sent home with all students (estimate 400) from the local elementary school. The same flyer was emailed to eight other schools in the county, with requests to send home with students. The flyer was also emailed to all registered day care providers and preschools in the county, with a request to send home with each child. Public Service announcements were placed with the local radio station, two local newspapers, and on the health department Facebook page."*
- *"A local dental clinic scheduled screenings for all students in all grades in the school system. The dentist requested health department assistance in working with the two school nurses to achieve better follow up of the students who were found to need urgent dental attention. Communication was facilitated, and a good plan was formed: the dental office sent a list of students needing urgent care. The school nurses were very willing to assist in getting the students to the dental office if parent/guardian was not able."*

*Out of a total of 1,166 students screened, 196 students were identified as having 5 or more incidents of caries. This is 16.8% of the student body that needs to be seen by a dentist "urgently". As of the first week of January, 30 students have been seen at the local private dental clinic. Steps have been initiated to ascertain how many of these students have been seen at the tribal dental clinic. The school nurses plan to visit with parents of identified children at the Parent-Teacher conferences coming in early February. We will meet again after these events and discuss other ways to get these students in to see the dentist."*

## Women/Maternal Health - Application Year

### Women & Maternal Health – Plan for the Application Year, FFY 2020

This narrative contains activities and upcoming plans for NPM 13A.

**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.

During FFY 2019, the Maternal and Child Health (MCH) and Oral Health Program (OHP) staff continue to collaborate on activities for NPM 13. One activity is using evaluation findings of a pilot project in one community health center, to increase the number of women referred to and treated in other co-located dental clinics. The evaluation yielded a program plan and assessment tools for NPM 13A activities, framed on the Health Belief Model to support health promotion activities and healthy behaviors.

MCH staff presented the evaluation at the 2019 Association of Maternal and Child Health Programs (AMCHP) conference and the April 26, 2019 MT Oral Health Network Meeting , via a poster titled: *Building Safety-Net Capacity to Integrate Oral Health Promotion for Rural Low-Income Pregnant Women*. In-state dissemination included sharing the program plan and tools with existing partners for integration into community-level oral health activities. Materials will be disseminated broader as the OHP prepares to launch a branded oral health literacy campaign, *Healthy Montana Mouths*.

The tagline was vetted by partners and will be paired with logos for the Public Health and Safety Division on education materials and assessment tools. To date, the MCH and OHP staff have developed: a dental referral form; pregnant woman survey tool; goal setting for parents; and, age-appropriate education material. Additionally, print education materials have been assembled and prepared for dissemination to public health and non-dental settings in high-need areas.

Through program evaluation and quality improvement, providing resources for community-level providers was identified as an area of need. Print education materials were vetted and subsequently purchased through the Kansas Head Start Association. The materials include: information on pregnancy; age one dental visits; choosing containers; snacking frequency; fluoride; and, other relevant dental topics. There are 13 topic cards, which were made into a booklet for educating parents and caregivers. Tools to assess education needs are available on the OHP website for users to effectively evaluate the use of the materials within their setting.

The OHP will be hosting in-person and web-based trainings to assist partners in using the materials effectively and providing additional training materials. The Health Belief Model will remain the framework for the health promotion materials, to provide the skills and resources to collectively foster self-efficacy. Evaluation of the materials at the state-level includes tracking of posted resources through website analytics, reach and usability of the materials through surveys of partners, and qualitative data on the materials.

The Healthy Montana Mouths oral health literacy activities are the first time Montana has used a comprehensive communication plan aimed to increase the awareness of the importance of oral health to overall health. Communication planning includes messaging to specific target populations, to support health promotion on a community-level with existing partners. A partnership with state WIC staff will be leveraged for launching.

OHP staff have survey data from WIC staff from 2014 and 2017 to assist in evaluation of the print material content and impact. Another survey of the WIC clinics is planned for 2020, using the same survey tool to assess changes in perception, knowledge and available resources. Additionally, collaborations with tobacco, diabetes, and communicable disease programs continued to increase the integration of oral health.

During this reporting period, the OHP staff collaborated with tobacco prevention staff to produce a poster for the National Oral Health Conference titled: *Public Health Integration: Creating a Tobacco Prevention Network among Dental Providers in Montana*. These integrations support the MCH population, by creating opportunities for health promotion activities by an array of providers, through a common message supporting health promotion.

These activities were developed through partner meetings hosted in 2016 and 2017 and the development of the *Montana Oral Health Strategic Framework*, a strategic plan. The plan was developed by a network of stakeholders, and has specific metrics related to the MCH population. The Framework was leveraged to write proposals for continued oral health funding.

Goal 1 of the Framework is focused on the development of the network, by fostering a cohesive and active group of professionals to communicate, work, and learn together; to improve oral health and implement the Framework. MCH and OHP staff are dedicated to fostering the network to promote NPM 13 activities and outcomes. HRSA NPM 13 metrics align

with metrics in the Framework and OHP evaluation data: the number of pregnant women and children with a preventive dental visit.

An update report on Framework progress was produced in February 2019, and a meeting of the network occurred in April 2019. For the meeting, MCH and OHP staff targeted professionals from organizations that serve American Indian residents - to increase the inclusion of this population in activities. The effort resulted in a collaboration with the Rocky Mountain Tribal Leaders Council, to fund travel for attendees from each of the seven American Indian Reservations. Ten representatives of tribal organizations attended. The Public Health and Safety Division Administrator has joined the AI outreach effort on behalf of MCH and OHP staff, to highlight the level of importance oral health issues in American Indian populations has for DPHHS.

The known disparities, based on geographic location and race in Montana, will continue to drive targeted programming related to oral health. Currently the OHP has contracts with two non-core county health departments to disseminate health promotion activities and five counties have chosen NPM 13. This work will continue to develop through a hub and spoke model, where experienced counties will offer technical assistance and resources to surrounding counties.

Additionally, the OHP has fostered a partnership with a mobile health clinic to integrate oral health promotion activities and the contract is in the final stages of approval. The mobile clinic has reach into most of Montana's non-core counties and will be an excellent partner to improve the reach of health promotion activities. All reporting from partners is framed on the current OHP work plan and is tracked in a reporting system to collect aggregate data on communications and reach, to foster collective impact and quality improvement activities. OHP staff prepare progress reports for partners bi-annually and host partner meetings to foster sharing of activities, ideas, and outcomes. Collective work with partners will continue to collect communication data, preventive interventions, and Montana-specific models of health promotion and service models for NPM 13.

## 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-2016	5.8	NPM 5
NOM 9.3 - Post neonatal mortality rate per 1,000 live births	NVSS-2016	2.8	NPM 5
NOM 9.5 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births	NVSS-2016	138.4	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 (FAD) for this measure is not available/reportable.**

State Provided Data			
	2016	2017	2018
Annual Objective	50	78	80
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	82.0	84.0	86.0	87.0	88.0	88.0

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data		
	2017	2018
Annual Objective		
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	88.0	89.0	90.0	91.0	92.0	92.0

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

Federally available Data (FAD) for this measure is not available/reportable.

State Provided Data		
	2017	2018
Annual Objective		
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	81.0	82.0	83.0	84.0	84.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 5.2 - Infant Safe Sleep - Montana Specific Targeted Messaging and Education Campaign**

<b>Measure Status:</b>		<b>Inactive - Completed</b>	
<b>State Provided Data</b>			
	<b>2017</b>	<b>2018</b>	
Annual Objective	0	1	
Annual Indicator	0	1	
Numerator			
Denominator			
Data Source	FCHB	FCHB	
Data Source Year	2017	2018	
Provisional or Final ?	Final	Final	

**ESM 5.3 - Support county public health departments who have identified decreasing infant deaths due to unsafe sleep conditions as a priority need in their communities.**

<b>Measure Status:</b>					<b>Active</b>	
<b>Annual Objectives</b>						
	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>
Annual Objective	80.0	83.0	87.0	90.0	93.0	93.0

## 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

Ongoing strategy in addition to ESMs are: 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.

#### ESMs

#### Status

ESM 5.1 - Understand the knowledge level and behaviors of caregivers regarding infant safe sleep practices. Inactive

ESM 5.2 - Infant Safe Sleep - Montana Specific Targeted Messaging and Education Campaign Inactive

ESM 5.3 - Support county public health departments who have identified decreasing infant deaths due to unsafe sleep conditions as a priority need in their communities. 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 - Sleep-related Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

## Perinatal/Infant Health - Annual Report

### Perinatal & Infant Health – Annual Report for FFY 2018

**NPM 5 – Infant 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; and, c) percent of infants placed to sleep without soft objects or loose bedding.**

A *Safe Sleep Hospital* certification program was presented to CPHD FICMMR leaders as a partnership opportunity with local birthing hospitals. Five regional trainings were provided statewide in March 2018, which were attended by a total of seventy-two county FICMMR personnel.

*Cribs for Kids* manages the National Safe Sleep Hospital Certification Program (NSSHC) partnering with birthing hospitals to standardize and strengthen hospital safe sleep education. Specifically, the NSSHC awards recognition to hospitals which commit to reducing infant sleep-related deaths: by promoting and modeling safe sleep practices; and, educating on infant sleep safety. The goal is to proactively eliminate as many sleep-related deaths as possible.

There are 28 birthing hospitals across Montana, and two achieved Certified Safe Sleep Hospital status in FFY18, bringing the total to three. The newly certified hospitals are both located in Lake county, St. Joseph's and St. Luke's. They join Community Medical in Missoula. NCCHCP offers three levels of certification with varying criteria for bronze, silver or gold. St. Joseph Hospital attained gold, while St. Luke's reached bronze.

In Spring 2018, the HRSA regional officer brought Montana's FICMMR program together with the Rocky Mountain Tribal Epidemiology Center (RMTEC). They explored possibilities for working together to reduce the disproportionate number of American Indian infant sleep deaths. RMTEC partners with tribes statewide to improve the health and well-being of tribal community members, by offering culturally competent approaches for eliminating health disparities faced by AI/AN populations.

Meetings began with RMTEC staff, and an agreement was forged to collaborate on two major points: work to strengthen relationships with Montana tribes to open up data sharing; and, work to reduce preventable sleep deaths. RMTEC staff conducted a roundtable tour and met with tribal leaders to open up dialogue and plant seeds to strengthen partnerships between tribal communities, RMTEC, and the state.

Planning was started to develop and implement a statewide safe sleep initiative. The purpose was: decrease preventable sleep deaths; and, target high-need families and tribal communities. The initiative is two-prong: 1) share evidence-based safe sleep practices; and, 2) provide a certified crib with additional educational materials.

Multiple partners were approached; and two, by the nature of their mission, were ideal to help identify resource needs: the FCHB/Healthy Montana Families Home Visiting Program; and, Child Protective Services (CPS), from the Child and Family Services Department. The rationale stems from staff being in homes on a regular basis.

The two programs joined in forming the "First Years Initiative," to prevent child abuse and neglect, and deliver a more comprehensive approach to child safety. The initiative focuses on providing targeted resources and education services to parents during a child's critical early years: the pregnancy; the weeks and months after birth; and, extending through the first years of a child's life. It extends to assessing all needs in a home, including the sleep environment.

Other partners in Montana contributing to the safe sleep initiative included: the CPHDs; several of the federally-recognized American Indian reservations; Healthy Mothers Healthy Babies, Children's Trust Fund; the FCHB Adolescent Health Section; and, the Attorney General's Office. Additional information is provided in the NPM 5 application narrative.

Seven CPHDs chose safe sleep education for their evidence-based FICMMR injury prevention activity in SFY18. Some of their work is summarized below:

- Contact with five local CPS staff who were willing to become trained on safe sleep education, and work with parents in the homes as needed. The CPHD also partnered with WIC staff to educate families on safe sleep. WIC parents receive the education just prior to delivery and at postpartum safe sleep certification. A short video was offered to all WIC clients, and nine watched. Those nine engaged in discussion following the film and received a complimentary sleep sack, and information to take home. Those who decline the video still received safe sleep education.
- Partnering with the local hospital and CPS staff, providing safe sleep education to patients and clients using the American Academy of Pediatrics (AAP) Safe Sleep Guidelines. CPS staff assessed sleep environments while

conducting home visits. Thirty-seven parents, and soon to be parents, were educated. Additionally, the public health nurse reached out to welcome the new Indian Health Services (IHS) Community Health Director. At a second meeting she presented information on safe sleep education occurring in the county; and encouraged IHS to develop a safe sleep program.

- Approached the local OB/GYN labor and delivery nurses to insure they were up-to-date on the AAP Recommendations; and supplied them with an assortment of educational materials for educating new mothers. One popular item is a newborn t-shirt that reads, 'This Side Up when Sleeping.' This county also educated 30 WIC clients on the AAP Guidelines, on a rotating basis.
- A focus group of mothers from diverse backgrounds helped one county re-direct and simplify their safe sleep messaging. Feedback consensus informed the health department their safe sleep messages were off-putting and preachy. The county adjusted by: eliminating the authoritative tone; went with less text; and, using a simple visual of an infant in a safe crib. The image had a baby wearing a sleeper with nothing else in the crib. The message stated "What's missing from this crib? Everything, but safe sleep."
- One CPHD participated at the local community health fair, which attracts prime audiences: soon-to-be parents; new parents; and, other parties interested in health and safety. A total of 300 people stopped by the county's full-size, safe sleep display. County staff spoke with many attendees about safe sleep and twenty-five stayed for in-depth conversations. They learned about multiple safety scenarios; and took home the popular, evidence-based materials from the Charlie's Kids Foundation.
- A county met their goal to educate and distribute 200 of the "Sleep Baby Safe and Snug" books (Charlie's Kids Foundation) in 2018. The county has a life-size demonstration of what safe sleep looks like, which helps increase the number of people who stay for a quality conversation. The county also participated at the Urban Indian Health Fair. They utilized the safe sleep demonstration display and materials to: reinforce the importance of a safe sleep environment; safer alternatives to current practices; and, co-sleeping dangers.

The State FICMMR Coordinator sent eighteen safe sleep informational emails to CPHDs. Examples included:

- an interactive, safe sleep video quiz
- baby box education
- tactics and examples to support infant safe sleep conversations
- overview of bed-sharing alternatives
- safe sleep: 3 ways dads can help
- a successful safe sleep city-wide campaign by another state

Beginning with the timeframe of July 2018 through November 2019, NPM 5 is one of the choices for CPHD MCHBG activities. Six counties are making it their focus: Broadwater, Cascade, Glacier, Roosevelt, Silver Bow, and Yellowstone.

**Perinatal/Infant Health - Application Year**

**Perinatal & Infant Health – Plan for the Application Year, FFY 2020**

This narrative contains current activities and upcoming plans for NPM 5.

**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.**

DPHHS Maternal and Child Health leadership began implementing a statewide safe sleep initiative in November 2018; with multiple partners and funding sources, and input from many agencies. The overarching goal is to reduce preventable infant sleep-related deaths by working in partnership with high-risk families and tribal communities.

On-going partners include: Children’s Trust Fund; DPHHS’ American Indian Health Director; Healthy Mothers Healthy Babies (HMHB); MT Department of Justice (DOJ); and, *‘First Years Initiative,’* which is a partnership between FCHB Healthy Montana Families Home Visiting, DPHHS Child & Family Services, and DOJ.

The safe sleep initiative focuses on education, to equip and empower families and caregivers to provide safe sleep environments for their infants. As a starting point, HMHB first developed a survey to assess interest and need - and sent it to multiple programs and partners. The response was high.

Surveys were not sent to tribal entities, as a different approach was taken. The new DPHHS American Indian Health Director made initial contact with tribal organizations statewide, informing them of the safe sleep initiative and providing an endorsement to pave the way for HMHB to follow up.

The next stage was program planning; and a comprehensive, educational safe sleep kit was identified and selected from Cribs for Kids, a national organization. The initiative focus is sharing evidenced-based safe sleep practices with families in need. Training occurs when parents and caregivers receive their safe sleep kit. The kit contains: sleep wear; a *Pack N’ Play* crib; a tight-fitting sheet; children’s book with a story that reinforces safe sleep; and, other educational materials that speak to grandparents, smoking around a baby, and room temperature guidelines.

The statewide safe sleep initiative will continue beyond 2019. As of April 2019, the scope of education and number of safe sleep kits distributed is detailed in the following lists:

<b>Number of Kits</b>	<b>County Public Health Departments</b>
25	Great Falls City County Public Health Dept
10	Custer County Public Health, DBA OneHealth
10	Park County Health Dept
20	City County of Butte Silverbow Health Dept
4	Mineral County Public Health Dept
50	Missoula City County Health Dept.
10	Teton County Public Health Dept.
45	Roosevelt County Health Dept.
12	Fergus County Nurses Office
12	Lake County Public Health Dept.
10	Hill County Health Dept.
12	Lincoln County Public Health
12	Glacier County Health Dept.
30	Flathead City County Public Health Dept.
<b>262</b>	<b>TOTAL Safe Sleep Kits Distributed to CPHDs</b>

Number of Kits	American Indian Organizations
10	Billings Urban Indian Health and Wellness Center
20	Indian Family Health Clinic (Great Falls)
100	Confederated Salish Kootenai Tribal Health
60	Verne E Gibbs Clinic, Fort Peck Indian Health Service
6	Family Promise of Billings
10	Fort Belknap WIC
100	Crow Indian Health Service
<b>306</b>	<b>TOTAL Safe Sleep Kits Distributed to AI Sites</b>

Many CPHDs choose safe sleep efforts for their FICMMR injury prevention activities, for example:

- Glacier County safe sleep training continues with reaching out to WIC clients. They presented the training to six families with newborns who received a safe sleep Halo product for participating. They also visited a day care center that cares for 22 infants and children and provided safe sleep education to the staff, along with information on the requirements in Montana's ARM 37.95.1005 - safe sleep practices for daycare providers.
- Missoula County is focusing on safe sleepwear for infants and the correct use of these products, utilizing the evidence-based training *\*Ticks Rules for Safe Babywearing*. The CPHD is partnering with several local hospitals: St. Patrick's Hospital OB Manager and Childbirth Educator; and, the Community Medical Center OB Manager. Both hospitals are open to having a unified safe baby sleepwear message out in the community, and work continues with these new partners. The CPHD will also reach out to local providers.
- Sanders County recently educated 15 families with newborns who are part of the WIC program. Safe sleep practices are shared with families, followed by discussion, and they leave with educational materials in-hand. This county is also working to secure side cribs/bedside sleepers (a separate sleep surface product) for families at risk.
- Yellowstone County is working to educate pregnant women, clients, and infant caregivers on safe sleep practices. They look for opportunities to pair safe sleep information with a crib demonstration, to provide a more realistic portrayal of an infant (model) in a safe sleep environment. This method provides a good lead for staff to initiate conversations. The staff reports that people they interact with often voice their opinions on some aspect of safe sleep, and that starts a dialog.

Additionally, this county performed periodic surveys to assess the impact of selected educational tools. They did a pre-test, provided the safe sleep education, and followed with a post-test. Seventy-seven percent stayed the same when the Charlie's Kids Foundation Book and magnet were provided while twenty-three percent scored better. No one scored worse. Almost all the "stay the same" had received a perfect score in the first place, so the message is being well received. The question "Does breastfeeding reduce the risk of Sudden Infant Death Syndrome?" prompted the biggest improvement in score.

As of mid-April 2019, 11 safe sleep resource emails were distributed to the CPHDs by the state FICMMR Coordinator. The information varied from new videos and handouts, to alerts on dangerous infant products (necklaces, Fisher Price Rock 'N Play sleeper). The emails also included: multiple webinars, including one on Improving Infant Safe Sleep Conversations; Strategies for Helping Families Adopt Safe Sleep Habits; and, articles from *Pediatrics* and the Children's Safety Network organization.

Six CPHDs choose to focus their MCHBG funding specifically on NPM 5 for the timeframe of July 2018 – September 2019: Broadwater, Cascade, Glacier, Silver Bow, Roosevelt, and Yellowstone. The activities are in addition to any of their FICMMR infant safe sleep-related injury prevention work. Glacier and Roosevelt are especially involved with outreach to their residents on local American Indian Reservations. Intentional work with underserved populations is a main emphasis for all six, and well as public awareness campaigns.

The purpose of the Evidence-Based Strategy Measure (ESM) for NPM 5, for both FFY 2019 and 2020, is to provide state-level support and expertise to help CPHDs with their safe sleep efforts. The ESM evaluation is the percentage that meet their goals.



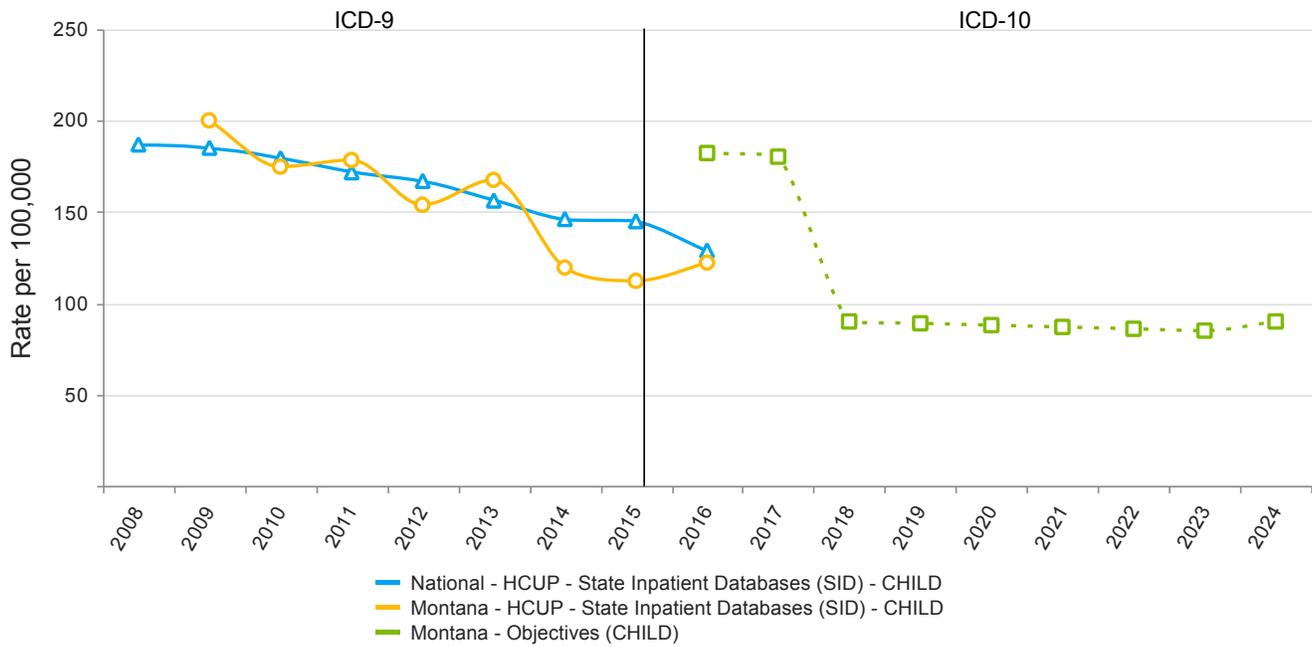
## Child Health

### Linked National Outcome Measures

National Outcome Measures	Data Source	Indicator	Linked NPM
NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000	NVSS-2017	10.5	NPM 7.1
NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000	NVSS-2017	42.3	NPM 7.1
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	24.1	NPM 7.1
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	24.1	NPM 7.1

**National Performance Measures**

**NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9  
Indicators and Annual Objectives**



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) - CHILD			
	2016	2017	2018
Annual Objective	182	180	90
Annual Indicator	88.5	111.8	122.1
Numerator	111	106	155
Denominator	125,378	94,803	126,908
Data Source	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016

State Provided Data			
	2016	2017	2018
Annual Objective	182	180	90
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	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	89.0	88.0	87.0	86.0	85.0	90.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 7.1.2 - Disseminate Report Findings to Facilitate Targeted Injury-Prevention Activities by County Public Health Departments**

Measure Status:		Inactive - Completed	
State Provided Data			
	2017	2018	
Annual Objective	0	100	
Annual Indicator	0	100	
Numerator	0	51	
Denominator	51	51	
Data Source	FCHB	FCHB	
Data Source Year	2018	2018	
Provisional or Final ?	Final	Final	

**ESM 7.1.3 - Support county public health departments who have identified decreasing preventable child injuries as a priority need in their communities.**

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	83.0	87.0	90.0	93.0	93.0

**State Action Plan Table**

State Action Plan Table (Montana) - Child Health - Entry 1

Priority Need

Child Injuries

NPM

NPM 7.1 - Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9

Objectives

Decrease the rate of hospitalization for non-fatal injury per 100,000 for children ages 0 through 9, to 85 by 2023.

Strategies

Ongoing strategies in addition to ESMs are: 1) Providing training and technical assistance to schools and childcare settings to implement evidence-based programs for preventing injuries, and promoting safety by providing information and education to CPHDs. 2) Development of DPHHS approved injury prevention messages, developed from evidence-based approaches. These will be distributed among the FCHB's established partner network.

ESMs

Status

ESM 7.1.1 - Analyze hospital discharge data for child injury causes and produce a report with county-level data on trends, which will assist County Public Health Departments in targeting future injury-prevention activities. Inactive

ESM 7.1.2 - Disseminate Report Findings to Facilitate Targeted Injury-Prevention Activities by County Public Health Departments Inactive

ESM 7.1.3 - Support county public health departments who have identified decreasing preventable child injuries as a priority need in their communities. Active

## NOMs

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

---

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

---

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

---

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

## Child Health - Annual Report

### Child Health – Annual Report for FFY 2018

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

The FCHB has devoted the past two annual CPHD trainings to evidence-based/informed, emerging, promising, and best practices education (EBIBP). The latter training in Spring 2018 offered concrete examples, with many tailored to older children and youth. The 72 CPHD participants also received education on infant car seat safety, which remains a high priority in Montana. Many CPHD's focused their education efforts on suicide prevention and motor vehicle safety while two others addressed outdoor recreational safety and lead poisoning prevention.

While suicide prevention has garnered increasing funding and attention in recent years, it is a deeply entrenched and complex problem. Montana's youth suicide rate was more than twice national amount in 2016-2017. 2016 data is included due to statistical analysis requiring a minimum of 20 deaths. Youth is defined here as age 10-17 and includes all races and both sexes.

During this time, Montana had 26 youth suicides from a population of 202,861 for a rate of 12.82 per 100,000. In comparison, the national rate was 4.95 based on 3,301 youth suicides out of a population of 66,722,011. In 2017 alone, and including all ages (youth and adults), Montana had the highest suicide rate in the country with 312 total suicides for a rate of 29 per 100,000.

CPHD suicide prevention work increasingly includes EBIBP caliber programs including:

- Spending significant time educating their county on mental illness/mental health, and suicide prevention. First, they secured a Licensed Clinical Professional Counselor to set-up a part-time counseling office in a small town that had no such services. They partnered several times with the State Suicide Prevention Coordinator over the course of the year to provide trainings on *Question, Persuade, Refer* (QPR), an evidence-based protocol of inquiry and response. Their first effort drew 52 community members. A second QPR training attracted 32 middle and high school students.

Rodeo is big in this county, so the CPHD also focused on head injury prevention - providing 28 rodeo/equestrian helmets and 73 bicycle helmets at several rodeos and outdoor, child-oriented events.

- Develop county-wide suicide prevention trainings, reaching a total of 50 school personnel in QPR - covering the three largest towns in the county with a combined total population of just over 4,000. They also offered two classes of Youth Mental Health First Aid (YMHFA) training for school staff and community members. With an eye on sustainability, this county committed a staff person to be certified as a facilitator for QPR and YMHFA training and to continue educating their communities.
- Reaching out to local schools to provide YMHFA; and the Applied Suicide Intervention Skills Training (ASIST) training, an evidence-based curriculum. Twenty teachers participated in these trainings.
- Offered a first-time training on the PAX Good Behavior Game, to combat suicide, for all three school districts in their county. This evidence-based suicide prevention training was voluntary (small steps) and 10 teachers plus two administrators participated. Six of the teachers are implementing this model in the classroom. The CPHD checks in with the teachers regularly and initial reports, while premature, are positive.

Many CPHSs worked on infant and child passenger car seat safety. Overwhelmingly across the state, when car seat check stations are conducted over 60% of seats are incorrectly installed. Examples of activities include:

- Partnering with the nearby American Indian Reservation and the Service Unit of Indian Health Services. Together they enlisted the help of five certified child car seat technicians, who inspected 41 child seats for safe travel. The CPHD donated 25 car seats to qualifying families following education sessions. The CPHD also planted seeds with area high schools for an opportunity to work together, to initiate a Montana chapter of *Teens in the Driver's Seat*. This is an evidence-based, national peer-to-peer motor vehicle safety program. These efforts continue.
- Two neighboring CPHDs combined resources and expanded their audience outreach to provide education on child passenger safety. They educated 25 parents and caregivers; conducting infant/child car seat inspections, demonstrations, and hands-on education when a seat was incorrectly installed.

- One CPHD struggled with drawing in parents/caregivers to participate at check station events, even after developing a no-appointment, drive-through option at their physical facility. They re-directed, and secured participation from two-day care centers - training all six employees on a variety of seats.
- A CPHD reached out to a highway patrol officer who was also a qualified car seat technician. At their first event they inspected eight cars and provided two car seats to needy families. Another CPHD awarded nine complimentary car seats, along with the installation education, to those who completed a child birth education class. A CPHD that had no certified car seat technicians in the county committed two staff members to the week-long training, and both received certification.
- A northwest CPHD teamed up with both local hospitals, and the Confederation of Salish and Kootenai Tribes, to expand the number of certified technicians for a larger event. They inspected 22 child car seats and replaced one outdated seat. A fourth partner, Bishop Insurance, donated 12 infant/child car seats – which were distributed to qualifying families. This county also partnered with local police, offering a bicycle safety and helmet-fitting exhibition. Fifteen children were fitted, received complimentary helmets and the county was able to access and inspect eight more child car seats at the event.
- Another CPHD provided a pre and a post training assessment with seven families, using nine car seats. All participants indicated an increased confidence level after the hands-on training.

Two other injury-prevention efforts were lead poisoning and outdoor recreational safety. Examples of activities include:

- Working on lead poisoning prevention education, offering testing to all Head Start children. This county has potential lead poisoning problem due to its ore smelting history. They tested 36 children and four had detectable lead levels. If a child tested above the blood-lead action level of 5 micrograms per deciliter ( $\mu\text{g}/\text{dL}$ ), then the family was sent to their primary care provider for a venous draw to confirm the initial screening result. Once confirmed, the family followed a required protocol. The four children who surpassed the threshold are now successfully below the threshold level due to the collaboration and persistence of the CPHD, their families, and physicians.

They also conducted educational in-home visits to: 1) identify potential pathways of exposure; 2) provide recipes for fun simple snacks which boost the immune system; and, 3) learn best practices for cleaning the home, especially during renovation activities. Home visits are also offered to children who test positive but did not meet the threshold level. To offer additional services, the CPHD partners with the County Superfund Community Protective Measure Program, providing free garden boxes and sand boxes for families. This is done in case there is arsenic or lead in the soil around the house. Clean garden soil to grow vegetables and safe sandboxes reduces risk.

- A CPHD began developing an outdoor safety plan, as they are located in a recreational area of rugged mountains, deep forests, rivers, and waterfalls. They are in heavy use for day-hikes, backpacking, summer and ice fishing, mountain biking, snowmobiling, and more. Too many times when a child dies or is hospitalized due to activities in these locations, the root cause can be traced to poor decision making and planning by adults. The safety plan campaign is comprehensive, adaptive and focuses on the PREP core principles, i.e. the difference between a bad day and a good story is a little PREP:
  - Plan? - Risks? - Equipped? - Prepared?

This CPHD is working to identify a variety of communication outlets, some permanent, to place and position the PREP message deep and wide within their county. They are partnering with the Forest Service. Updates on this project will appear in future reports.

In closing, forty-four injury prevention informational emails were sent to CPHDs from July 1, 2017 to September 30, 2018. Specific webinar opportunities were on:

- Suicide Prevention;
- Bullying; and,
- Fire safety.

The CPHDs also received:

- Resources on open water swimming safety, the second leading cause of accidental deaths of Montana children;
- All-Terrain Vehicle (ATV) Safety Resources;
- Crash risks of cellphone use while driving, and understanding the distracted brain;

- Information on examining the link between weight suppression and non-suicidal self- injurious behaviors; and,
- *Children's Safety Network* e-newsletters that cover a wide array of injury prevention topics.

## Child Health - Application Year

### Child Health – Plan for the Application Year, FFY 2020

This narrative contains current activities and upcoming plans NPM 7, for ages 0 through 9.

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

Teaching parents and caregivers the proper installation of infant/child car seats is an on-going priority for most CPHDs, and eight currently have specific MCHBG activities in this area. This includes inspecting all infant and child car seats and, if incorrectly installed, demonstrating the proper method. If possible, they have the parents or caregivers install the car seat themselves before leaving.

Some CPHDs struggle with attracting parents and caregivers to take advantage of the service. They have held stand-alone check station events in high traffic areas, some coupled with flu shot clinics and tied in with a kindergarten screening at an elementary school, but the numbers are low. Carter County took a different approach after these experiences:

*“Lesson learned: I found that trying to bring my audience to me for educational purposes does not work in our area. So, I sought audiences that would benefit from this education and went to them. I secured an invite to a child development family consumer science class.*

*I brought a variety of car seats and instructed the class how to properly put a child in a car seat, how to properly install the seat and where to look for safety information such as expiration dates, weight/height requirements, and serial number in case of recalls. All five students in the class trained on each car seat.” Shannon Volmer, RN, Carter County (2017 MCHBG population = 426)*

Silver Bow County has an easier time attracting people to participate in car seat check services, due to a much larger population (2017 MCHBG population = 13,168). Additionally, Silver Bow CPHD partners with the full-time, professional fire department in town. This further expands their outreach to families. Carter County, like most frontier counties in the state, has volunteer fire stations that can only focus on fire operations.

The Silver Bow Fire Department offers a permanent child car seat station in-house. Once a month, the CPHD and Fire Department offer a car seat clinic together. Certified technicians inspect for proper installation, recalls, and correct make/size for the child. From October 2018 through March 2019, forty car seats have been donated to families who received the education, and 82 car seats inspected. The CPHD also has an in-house certified car seat technician who assists families as needed.

Additionally, the six other CPHDs have inspected, educated and/or donated infant and child car seats to 56 families. One is currently planning a seat-check in conjunction with the town library story time for kids.

Multiple CPHDs are bringing suicide prevention training to their communities before the end of FFY 19. Lincoln County has provided two *Mental Health First Aid* training sessions to 31 community members including 3 school faculty. Stillwater County recently had 18 participants attend a 2-day community *Mental Health First Aid Training* (16 certified). The training drew an impressive array of county leaders:

- Assistant County Attorney;
- CEO of Stillwater Billings Clinic;
- Deputy Sheriff;
- Alternatives Director of a probational group that serves children;
- Elementary School, principal and a teacher;
- Director of Education for the Stillwater Sweet-Grass Cooperative;
- County-wide school psychiatrist and a school counselor;
- Two private-practice Licensed Clinical Professional Counselors; and,
- Two county advocates for Domestic Violence.

One CPHD brought the *Signs of Suicide* (SOS) Prevention Program to the high school, for the first time. They had 106 students, ages 16-18, participate in this evidence-based prevention initiative. The remaining CPHDs addressing suicide will implement SOS or *Question, Persuade, Refer* (QPR) late this spring.

Five CPHDs recently collaborated with an adolescent mental health expert, who presented a research-based program on the importance of good decision making. This training helps with development of healthy relationships and addresses issues such as bullying prevention and risky behaviors prevention. A total of 650 students attended from Sixth Grade up through High School, and were given four proven tools to work with:

- Leaders choose to believe in themselves;
- Leaders choose to outsmart the bullies;
- Leaders choose to set healthy boundaries; and,
- Leaders choose to forgive and move forward.

Cascade County is providing an interactive, childhood poison prevention activity in a number of settings: a pre-school fair, Boys & Girls Clubs, at the Cascade County Child Bridge/Foster Parent Support Program, a Young Parent's Education Center, and more. They engaged children early with helping to build the props. Their visual consists of small, color-filled medicine bottle examples attached to large poster boards. These can easily be mistaken as candy. Some bottles have a drinkable juice, while other bottles hold cough syrup, multipurpose cleaner or dish soap. Side by side, parents and kids cannot visually tell the difference. The samples teach children and adults how to compare poisonous items from non-poisonous. The preschool fair targeted children ages 2-4 and drew in over 200 families.

Two CPHDs are providing Safe Sitter education to youngsters in their communities. Patricia Keener M.D. developed the program after her child died in the care of a babysitter. Keener recognized the vulnerability of young children when cared for by unprepared caregivers. The program provides youth with the skills they need to be safe while home alone, watching younger siblings, or babysitting. For more than 35 years, Safe Sitter® has been a leader in providing life skills, safety skills, and childcare training for youth. Safe Sitter is a national nonprofit organization with over 900 registered providers in all 50 states. Class ratio is 8 students per instructor. Thus far, the two counties have certified 22 youth in three classes.

Big Horn County is working to develop a new approach in teen motor vehicle (MV) safety. The Crow Reservation occupies a large portion of the county with over two million acres. Approximately 7,900 residents live on this largest reservation in Montana. Total county population is 13,300 (2017). The challenges are monumental: a driver's license is not required to operate a vehicle on the Crow Reservation, no seatbelt laws exist, and many vehicles are old with broken seat belts or none at all.

There have been many MV safety initiatives implemented in Big Horn County over the years, but not one that is student-driven at the high-school level. The program is *Teens in the Driver's Seat*, an evidence-based, MV safety program that is student-centered. The underlying concept is to form, engage and empower a student organization. This group plans and delivers safety programming and messages to influence behavior change in their peers. The CPHD continues to meet with area high schools to secure buy-in from school administration.

Between October 1, 2018 through April 30, 2019, a variety of injury-prevention training opportunities were sent to the CPHDs. Thirty emails were sent offering webinar opportunities, articles, website resources, tip sheets, and more.

State-level staff disburse injury-prevention information on an ongoing basis. So far in FFY 19 the range of topics includes:

- Teen driving
- Motor vehicle injuries
- Suicide
- Lead testing
- Carbon monoxide poisoning
- Firearm deaths
- All-terrain vehicle resources (ATV)
- Drowning
- Bullying
- Infant and Toddler choking hazards

For FFY 2019, there are six CPHDs working on two extra injury-prevention activities, in addition to the required one that all of them implement as a part of their FICMMR team duties. These are Beaverhead, Custer, Deer Lodge, Fallon, Lake, and Ravalli. The purpose of the Evidence-Based Strategy Measure (ESM) for NPM 7, for both FFY 2019 and 2020, is to provide state-level support and expertise to help CPHDs with their injury-prevention efforts. The ESM evaluation is the percentage that meet their goals.

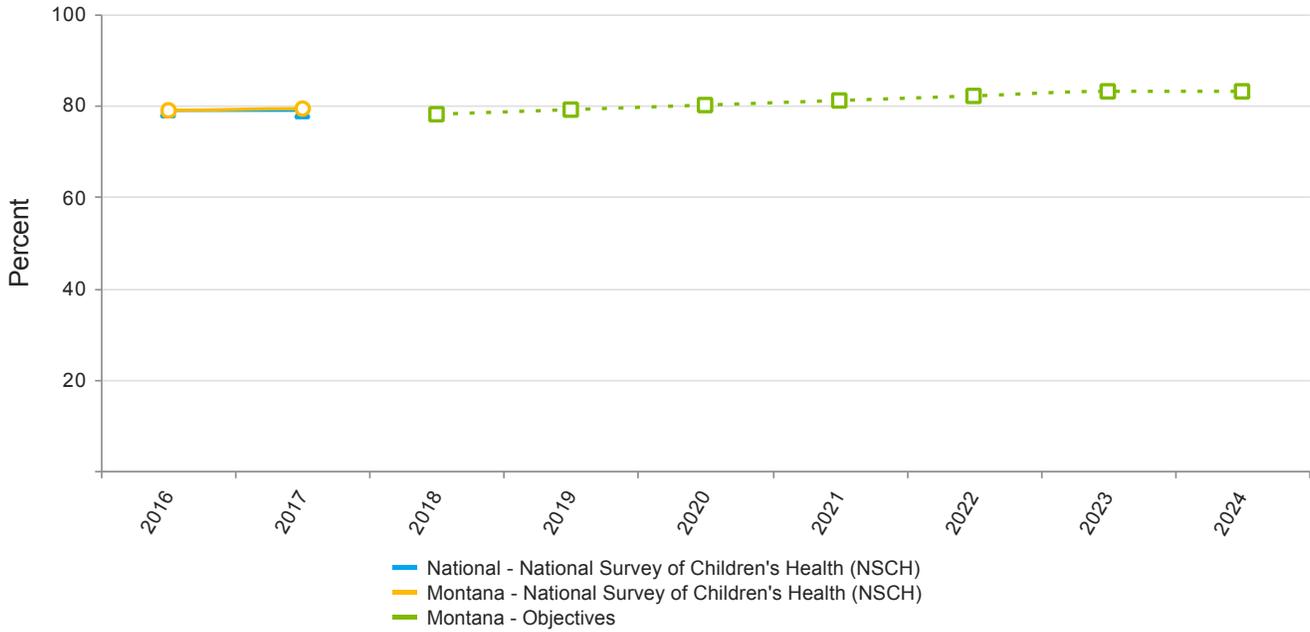
## Adolescent Health

### 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-2017	42.3	NPM 10
NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000	NVSS-2015_2017	24.1	NPM 10
NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000	NVSS-2015_2017	24.1	NPM 10
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	62.7 %	NPM 10
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	89.2 %	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-2016_2017	12.3 %	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-2014	12.5 %	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)	YRBSS-2017	11.7 %	NPM 10
NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza	NIS-2017_2018	50.3 %	NPM 10
NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine	NIS-2017	65.5 %	NPM 10
NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine	NIS-2017	90.4 %	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-2017	71.2 %	NPM 10
NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females	NVSS-2017	21.2	NPM 10

**National Performance Measures**

**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
Annual Objective			78
Annual Indicator		78.7	79.3
Numerator		55,013	56,264
Denominator		69,906	70,972
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

**i** 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**

	2019	2020	2021	2022	2023	2024
Annual Objective	79.0	80.0	81.0	82.0	83.0	83.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 10.2 - Adolescent Preventive Care Stakeholders Group - Foundational Partnership Building and Collaboration**

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1.0	0.0	0.0	0.0	0.0	0.0

**ESM 10.3 - Optimal Health for Montana Youth - Evaluation Report**

Measure Status:		Active				
Annual Objectives						
	2020	2021	2022	2023	2024	
Annual Objective	1.0	0.0	0.0	0.0	0.0	

## State Action Plan Table

### State Action Plan Table (Montana) - Adolescent Health - Entry 1

#### Priority Need

Access to Care

#### NPM

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

#### Objectives

Increase the percent of adolescents who have received a preventive medical visit in the past year to 83% by 2023.

#### Strategies

In addition to the ESMs: Development of DPHHS approved messages on the importance of adolescent preventive medical care. These will be developed from evidence-based approaches, and distributed to the FCHB's established partner network.

#### ESMs

#### Status

ESM 10.1 - Adolescent preventive care advocates survey, to identify organizations and individuals involved with adolescent wellness and health who are interested in collaborating to promote the importance of preventive care for this population. Inactive

ESM 10.2 - Adolescent Preventive Care Stakeholders Group - Foundational Partnership Building and Collaboration Active

ESM 10.3 - Optimal Health for Montana Youth - Evaluation Report Active

## NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

---

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

---

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

---

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 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

---

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

---

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

---

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

---

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

---

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

State Action Plan Table (Montana) - Adolescent Health - Entry 2

Priority Need

Teen Pregnancy Prevention

NPM

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

Objectives

Decrease the rate of birth for girls ages 15 to 17 years to 9% by 2021.

Strategies

Ongoing strategies are: 1) WMHS contracts with, and provides technical assistance to 13 Delegate Agencies (DAs), offering services in 28 locations and representing all 56 MT counties. 2) WMHS maintains contracts with, and provides technical assistance to five Personal Responsibility Education Programs (PREP), through funding from the Administration for Children and Families. These programs offer evidenced-based teen pregnancy prevention, and sexually transmitted infections curriculum, to middle and high school aged youth. Draw the Line/Respect the Line is the curriculum for middle school, and Reducing the Risk is for high school students. Both curriculums were created by ETR Associates.

ESMs

Status

ESM 10.1 - Adolescent preventive care advocates survey, to identify organizations and individuals involved with adolescent wellness and health who are interested in collaborating to promote the importance of preventive care for this population.	Inactive
ESM 10.2 - Adolescent Preventive Care Stakeholders Group - Foundational Partnership Building and Collaboration	Active
ESM 10.3 - Optimal Health for Montana Youth - Evaluation Report	Active

## NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

---

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

---

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

---

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 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

---

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

---

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

---

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

---

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

---

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

State Action Plan Table (Montana) - Adolescent Health - Entry 3

Priority Need

Immunization Rates

NPM

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

Objectives

Increase the percent of 13-17 year olds who have received age appropriate adolescent immunizations to 66% by 2021.

Strategies

Ongoing strategy: The IZ Program and its contractors are: meeting quarterly with key partners to review data provided and discuss strengths and opportunities for improvement; maintaining records received from local schools for children entering kindergarten and 7th grade, reviewing for completeness and accuracy, and following up on children who are conditionally attending.

ESMs

Status

ESM 10.1 - Adolescent preventive care advocates survey, to identify organizations and individuals involved with adolescent wellness and health who are interested in collaborating to promote the importance of preventive care for this population.	Inactive
ESM 10.2 - Adolescent Preventive Care Stakeholders Group - Foundational Partnership Building and Collaboration	Active
ESM 10.3 - Optimal Health for Montana Youth - Evaluation Report	Active

## NOMs

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

---

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

---

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

---

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 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

---

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

---

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

---

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine

---

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

---

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

## Adolescent Health - Annual Report

### Adolescent Health – Annual Report FFY 2018

#### **NPM 10 - Adolescent Preventive Care: Percent of adolescents with a preventive services visit in the last year.**

In October 2017, the Title V Director and MCHBG Program Specialist met with the State Medical Officer, Dr. Greg Holzman. The purpose was to receive ideas and feedback from Dr. Holzman, on the initial structure and activities of the Adolescent Preventive Healthcare Stakeholders Group. He was brought up-to-date on the status of the group's formation and given a list of the providers interested in participating. The following were some of his insights and suggestions:

- The complete list of those interested was probably too large to work with collectively on a day-to-day basis (over 40 providers) and would be well served by a steering committee.
- It is important to stay in communication and seek continued involvement with the pertinent professional provider organizations, i.e.: MT Chapter American Academy of Pediatrics; MT Association of Family Physicians; MT Primary Care Association.
- For issues beyond the capacity of the provider to address; share information regarding resources available at the community-level for treatment, follow-up and support.
- Training on evidence-based and effective tools could include:
  - A protocol, and/or most effective questions, for addressing risky behavior at any healthcare visits for adolescents, including acute care;
  - Use of the 'Screening, Brief Intervention, and Referral to Treatment' tool, or SBIRT.

Funding was secured to allow up to 35 stakeholders to attend an in-person meeting scheduled for October 30, 2018, and most of the planning occurred during FFY18. A primary purpose was to enlist participation in creating an effective foundational structure for the group. This framework should support efficient use of the member's time and provide a mechanism for raising awareness on the importance of adolescent preventive healthcare visits.

The MCHBG Program Specialist secured the services of a facilitator experienced in working with provider groups, who assisted with achieving meeting goals. The Director of the *State Adolescent Health Resource Center*, Kristen Teipel, was a part of the planning team and was also the main presenter. Title V Technical Assistance funds covered her travel costs.

A second purpose was to begin focusing on two main objectives: 1) increasing the annual percentage of adolescents who receive annual preventive healthcare visits; and, 2) encouraging the comprehensive set of services and discussions these visits should cover.

Outreach to pertinent provider organizations was renewed in December 2017. Conference calls were held with the Executive Director of the MT Academy of Family Physicians and the President of the MT Chapter of the American Academy of Pediatrics. They were brought up-to-date on current activities and asked for their insights and feedback on possible steering committee members.

It was important to solicit representation from: different provider types; different regions of the state; and, key established professional societies. To this end, the stakeholders' membership list was cross-referenced with any organizational affiliations, and the region of the state where they practice. The purpose was to assure good leadership representation from different providers types, organizations, and regions.

Throughout FFY18, information was forwarded to the group on the following resources and training webinars:

- Updated Adolescent Clinical Preventive Service Guidelines from the University of California San Francisco, which can be accessed at: [http://nahic.ucsf.edu/resource\\_center/adolescent-guidelines/](http://nahic.ucsf.edu/resource_center/adolescent-guidelines/)
- Information from the Adolescent Health Initiative at the University of Michigan:
  1. Sparks – which are free, pre-packaged mini-trainings on a variety of adolescent health topics, designed to be delivered at team meetings in 15-30 minutes, available at: [http://www.umhs-adolescenthealth.org/improving-care/spark-trainings/?utm\\_source=newsletter&utm\\_medium=email&utm\\_content=sparks&utm\\_campaign=NewTraining](http://www.umhs-adolescenthealth.org/improving-care/spark-trainings/?utm_source=newsletter&utm_medium=email&utm_content=sparks&utm_campaign=NewTraining)
  2. Separate webinars (one for providers and one for healthcare staff) on improving adolescent-centered care.

## Adolescent Health - Application Year

### Adolescent Health – Plan for the Application Year, FFY 2020

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

The Montana Adolescent Preventive Healthcare Stakeholders (MAPHS) meeting was held on 10/30/2018, with 33 participants from across the state. Kristin Teipel, Director of the State Adolescent Health Resource Center at the University of Minnesota, was the Summit's main presenter and resource person. Teipel has 20+ years working in the field of adolescent healthcare. The day's efforts included: creative strategy discussions, sharing available resources, and networking with peers

The meeting's purpose was to *"Bring Montana health professionals together, to develop strategies for increasing the number of adolescents who receive comprehensive annual preventive healthcare visits."* Participants included: pediatricians, family practice physicians, advance practice nurses, public health nurses, physician assistants, mental health professionals, and DPHHS staff. The MCHBG provided funding for the meeting, and the purpose originated from NPM 10.

#### **Participant Survey - Interests, Planned Actions, and Barriers to Participation:**

Participants completed "What Interests Me?" questionnaires. Analysis revealed seven main categories of interest. These are supplied below, with the number of comments per each:

- In-Clinic Processes: Analysis and Improvement = 22
- Youth Access to Services - Particularly: Hard to Reach; High Risk; Rural = 19
- Marketing Adolescent Well Visits and Resource Distribution = 12
- Community Collaboration and Outreach = 9
- Advisory Group Participation = 7
- Data: Most Beneficial Portion of Well-Visit; and, Overall MT Specific = 7
- Outreach to Schools and School-Based Clinics = 7

The concerns and barriers mentioned can be summarized into two categories:

- Funding/Cost = 4
- Time/Distance = 8

#### **Interactive Presentations:**

The day's agenda included presentations, break-out sessions, and discussions among the whole group on the following topics:

- Adolescents (11-18): What Do We Understand?
- Preventive Care Strategies in Montana?
- Challenges to Quality Adolescent Preventive Care
- What's Needed to Provide Quality, Effective Healthcare for Adolescents
- Approaches to Implementation: How are Other States and Montana Making the Annual Wellness Visits Work? What Can We Learn and Apply?

#### **Strategies were divided into three evidence-based types:**

- Get youth to the door;
- Improve clinic quality;
- Improve policies and practices.

The afternoon session was focused on developing promising strategies for realistic, near-term, next step actions. There was a break-out session for in-depth discussion on seven topics, which the group as a whole had chosen:

- Improving Clinical Practices for Adolescents
- Bringing Well-Visits to Youth
- Hard to Reach Youth
- Promoting Adolescent Wellness Visits
- Outreach and Community Partnerships for Wellness Promotion
- Use of Social Media to Reach Parents and Adolescents
- Improving State-Level Policies

The groups brain-stormed answers to the following questions:

- What is the goal or desired result?
- What is achievable in an 18 to 24-month timeline?
- Who are the important partners or collaborators you need to engage?
- What resources or support do you need in the next 12 to 18 months?
- What are your 1 or 2 immediate next steps?

**Key decisions and/or follow-up activities:**

- Summit participants would like to form an “Informational Network”;
- Need for more data;
- Perhaps form a youth advisory board, or collaborate with an existing youth association;
- DPHHS support necessary to forward the emerging ideas and efforts discussed;
- Participants were excited to learn about the *Montana Medical Home Portal* (<https://mt.medicalhomeportal.org>);
- A number of participants expressed interest in participating in an Advisory Group;
- Explore opportunities for professional organization affiliation (i.e. AAP, AFP).

Following the MAPHS meeting, seven individuals from the larger stakeholder group indicated that they were interested in participating in the MAPHS advisory group.

During this time frame the Family and Community Health Bureau created a new Adolescent Health Section (AHS) which hired and on boarded several new staff to support various adolescent health programs including Healthy Young Parent Program, Optimal Health for Montana Youth Program (OHMY), and Sexual Violence Prevention and Victim Services Program.

The OHMY program is geared towards teen pregnancy prevention education with additional optimal health subjects taught to enhance the overall health of Montana Youth. Optimal health encompasses five different areas of health: physical, emotional, social, intellectual, and spiritual (which is defined by the individual). Optimal health can be achieved when people have access to skill development classes/workshops, educational opportunities and other community resources that allow them to adopt a healthy lifestyle, believe in self-advocacy, and pursue motivating life goals.

The current funding for the OHMY program comes from the Teen Pregnancy Prevention Tier 2 grant (TPP Tier 2), the Personal Responsibility Education Program (PREP) grant, and the Sexual Risk Avoidance Education (SRAE) grant.

The four teen pregnancy prevention programs within these funding streams promote and implement several curriculums in public schools, tribal communities, juvenile detention centers and foster care settings. These evidence-based and innovative curriculums focus on the following objectives:

Educate teens about a variety of health topics, including:

- What constitutes a healthy relationship
- Protective factors in high-risk situations
- Peer pressure
- Alcohol/Drug use
- Dating/Relationships/Sexual Violence
- Teen pregnancy prevention behavior

Teach teens valuable skills that they will take with them into adulthood, like how to:

- Establish personal boundaries
- Communicate effectively and actively listen
- Resist peer pressure and speak up for themselves
- Set long-term goals that drive healthy decision-making

## Children with Special Health Care Needs

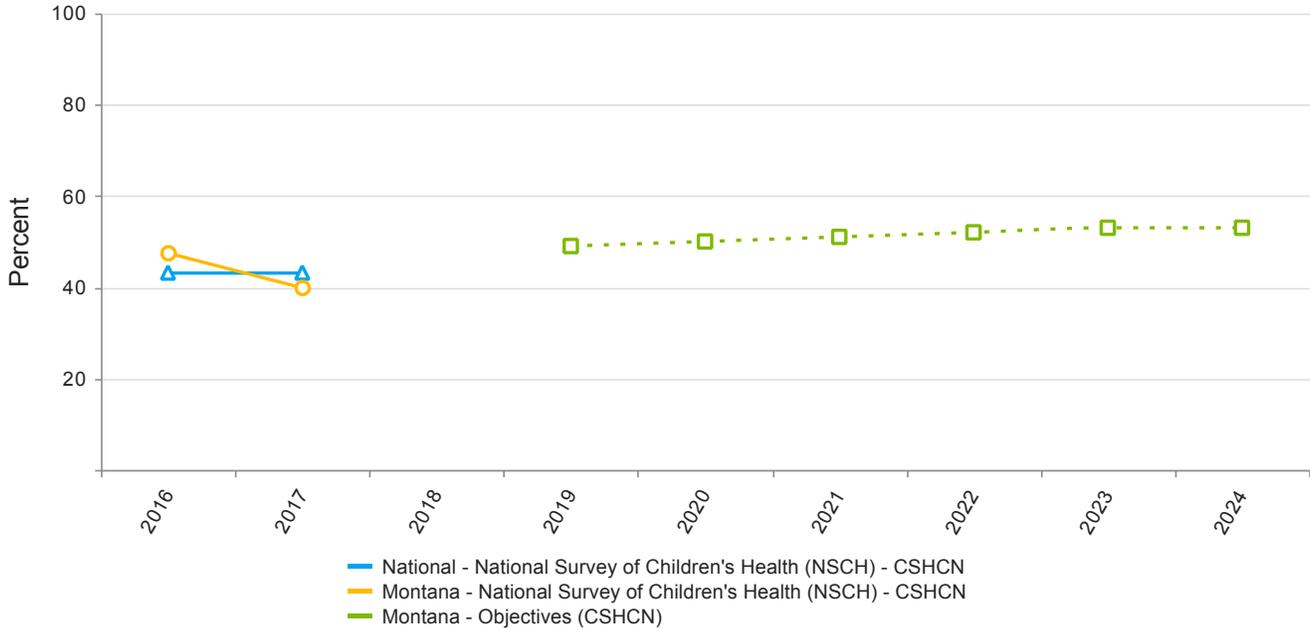
### Linked National Outcome Measures

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-2016_2017	14.9 %	NPM 11
NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling	NSCH-2016_2017	62.7 %	NPM 11
NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health	NSCH-2016_2017	89.2 %	NPM 11
NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year	NSCH-2016_2017	2.7 %	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
Annual Objective		
Annual Indicator	47.5	39.9
Numerator	19,838	17,364
Denominator	41,760	43,541
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017

State Provided Data		
	2017	2018
Annual Objective		
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	49.0	50.0	51.0	52.0	53.0	53.0

**Evidence-Based or –Informed Strategy Measures**

**ESM 11.1 - Expansion of Parent Partner Services for CYSHCN**

Measure Status:		Active				
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	25.0	27.5	30.0	32.5	35.0	35.0

## State Action Plan Table

### State Action Plan Table (Montana) - Children with Special Health Care Needs - Entry 1

#### Priority Need

Access to Care

#### 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

Ongoing strategies in addition to ESM are: 1) CSHS will continue to support Cystic Fibrosis, 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. 2) Montana will continue the medical home portal project.

#### ESMs

#### Status

ESM 11.1 - Expansion of Parent Partner Services for CYSHCN

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 not able to obtain needed health care in the last year

## Children with Special Health Care Needs - Annual Report

### Children with Special Health Care Needs – Annual Report FFY 2018

#### **NPM 11 – Medical Home: percent of children with and without special health care needs having a medical home.**

Children's Special Health Services provided these services to improve and enhance the medical home for CYSHCN during FFY 2018:

##### *The HALI Project Parent Partner Program -*

Parent Partners are parents of CYSHCN who are personally experienced and professionally trained to help other families navigate the complex system of care for CYSHCN. The Parent Partners work in clinics and receive referrals from clinic providers, who identify families in need of additional support. Parent Partners help families by:

- connecting them with community resources;
- supporting their mental and emotional health as they navigate the complexities of their journey;
- helping to improve communication with their child's medical providers;
- teaching them to be effective advocates for their children;
- connecting them with programs and individuals to help them better understand their child's rights in the school system; and,
- helping families prepare to transition from pediatric to adult healthcare.

From October 1, 2017 to September 30, 2018, 203 families were served with 662 separate encounters and approximately 550 hours dedicated to supporting Montana's CYSHCN population.

Eleven Parent Partners participated in bi-annual in-person training, and monthly individual and group calls with the Project Director, Brad Thompson, LCPC. A cornerstone of this program model is the consistent personal support offered to the Parent Partners, as they work to support other families while continuing to navigate their own child(ren)'s special healthcare needs.

The HALI Project Parent Partner Program served families in primary care clinics in Missoula, Kalispell, Bozeman, Billings, Great Falls, and Butte. These sites worked to expand capacity by adding hours and, at some sites, additional partners. The goal was to have a parent partner working in these clinics a minimum of 16 hours per week depending on the site location. The program worked towards adding partners to clinics in Bozeman, Helena, Polson, and at two additional locations in Billings. Two new Parent Partners received virtual training to support families with a genetic diagnosis, and those with deaf/hard of hearing diagnosis.

##### *Montana Medical Home Portal –*

CSHS continued to contract with the University of Utah Medical Home Portal, for hosting the Montana Medical Home Portal (MHP). The MHP is an easy to navigate, one-stop shop, providing diagnosis information, treatment options and state and local resources to families, providers, and agencies. The portal includes vetted, up-to-date clinical information, materials on accessing care, and a statewide services directory.

CSHS staff added 435 new resources to the Portal during FFY18. The Parent Partners assisted in adding these resources through the "suggest a resource" function of the Portal. CSHS staff continued to review all services in the MHP directory to ensure each service is still available and associated information is accurate. Work started on contracting with Montana's 2-1-1 to obtain their resources to add to the Portal. This could potentially add over 1,000 new resources. During this reporting period the average hits per month to the Portal was 773, with the number of hits increasing following targeted marketing events.

Marketing of the Portal occurred at the following events: Montana AAP Chapter Conference; Montana Public Health Association; Rocky Mountain Childbirth Conference; and, The Great Beginnings, Great Families conference hosted by DPHHS. Staff demonstrated the Portal, answered questions and provided outreach materials to attendees. Marketing the Portal continued through Facebook advertisements and marketing materials. Staff is exploring new ways to advertise and increase usage. CSHS staff also met with University of Utah Medical Home Portal staff in bi-monthly meetings, to discuss possible marketing ideas as well as discuss any changes, issues, or additions to the Portal.

##### *Financial Assistance –*

CSHS provided direct financial assistance to qualifying CYSHCN to cover out-of-pocket expenses for treatment, medication,

and medical equipment. During this reporting period CSHS staff processed 21 applications and paid out a total of \$11,640. The financial assistance program benefit has been underutilized for several years. Due to state budget cuts, there were many inquiries for enabling services such as case management, respite, room and board for treatment, and travel. In FFY 2018, CSHS began the process to change the Administrative Rules to expand this program to include a broader definition of CYSHCN and allow for coverage of enabling services.

#### *CSHS Stakeholder's Group –*

The CSHS Stakeholder's Group held our annual in-person meeting in August 2018. There were twenty-four individuals in attendance which included: parents; primary care providers; and, agencies and service providers for CYSHCN. Dorothy Cilenti and Oscar Fleming, from the National MCH Workforces Development Center, attended this meeting and facilitated a Results Based Accountability session with stakeholders. Three main areas of focus emerged:

1. Expansion of Circle of Parents support group to other cities throughout Montana. Leverage Parent Partners with additional training, and for facilitating groups if they are interested;
2. Increase awareness of services and supports by partnering with 211 and the CONNECT referral system, and with more outreach and advertising for the Montana Medical Home Portal and MCH Hotline; and,
3. Develop and pilot a transition project with a clinic, to implement policy and procedure into clinical practice.

#### *SSI Referrals and limited Nurse Care Coordination –*

CSHS employs a fulltime nurse program manager, whose primary duties are to manage and consult on CSHS programs. CSHS received referrals from the Disability Determination Bureau for any child or youth applying for SSI benefits. Referrals are coded and, when appropriate, the nurse program manager forwards them to Early Intervention, or the Montana School for the Deaf and Blind. The nurse also sends a letter and a brochure to each family explaining the programs they might access.

During FFY 2018, the nurse began phone follow-up calls with referral families to assess their needs and, where applicable, refer them to other programs. This new approach led to increased contact with families and more referrals from CSHS. Approximately 300 families were called during this reporting period. CSHS staff also marketed the Montana MCH hotline throughout the state which led to more opportunities for the nurse to speak with families and provide support and referrals.

Calls were tracked through an internal Bureau Events Tracking System (BETS). Every call that staff received was logged into this system to include: a brief description of the encounter; the number of people impacted; and, county of residence. A primary and secondary "staff assignment" was required, to ensure that events were tracked by at least two staff. There was a reminder and open/closed status option to assist with follow-up. Once an event was created, the system e-mailed both CSHS employees assigned to the event, and identified if it was open or closed. A user could also filter events by program, status (open/closed), event type (direct line, MCH 800, and e-mail) and subject/keyword. Approximately 70 calls related to care coordination were tracked using this system.

## Children with Special Health Care Needs - Application Year

### CYSHCN – Plan for the Application Year, FFY 2020

This narrative contains current activities and upcoming plans for NPM 11.

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

Children's Special Health Services will continue to provide many services to improve and enhance the medical home for CYSHCN during FFY 2020. These include:

##### The HALI Project Parent Partner Program -

Parent Partners (PPs) are parents of CYSHCN who are personally experienced and professionally trained to help other families navigate the complex system of care for CYSHCN. They work in clinics and receive referrals from clinic providers who identify families in need of additional support. PPs can help families by connecting them with community resources; helping to improve communication with their child's medical providers; teaching them to be effective advocates for their children; connecting them with programs and individuals to help them better understand their child's rights in the school system; and helping families prepare to transition from pediatric to adult healthcare.

Parent Partners participate in bi-annual, in-person training, and monthly individual and group calls with the Project Director, Brad Thompson, LCP-S. A cornerstone of this program model is the consistent personal support offered to the PPs, as they work to support other families while continuing to navigate their own child(ren)'s special healthcare needs.

In FFY 2020, The Montana Parent Partner Program will continue to serve families in primary care clinics in Great Falls, Missoula, Kalispell, Bozeman, Billings and Butte. The State Coordinator and Program Director will resume efforts to expand into rural communities around Montana. The priority will be expanding to an IHS Clinic or Urban Indian Health Center. The goal of the Evidence-Based Strategy Measure (ESM) for NPM 11 is *"To increase number of CYSHCN receiving services from a Parent Partner in FFY 19 to 250, a percentage increase of approximately 25%."* The work to increase the number will continue in FFY20, with the objective to add another 2.5%.

Each clinic site is budgeted a PP to help support families 24 hours per week. Currently, most clinic sites are not utilizing the available hours. Parent Partners availability and low physician referral rates were identified as contributing factors to lower utilization. Starting April 2019, quality improvement efforts began to improve referral rates and increase utilization of budgeted hours. The State Coordinator and Program Director will initiate a visual communication campaign and redesign the website to increase program awareness.

##### Transition Improvement Group -

CSHS has partnered with the Billings Clinic and the *University of Montana Rural Institute for Inclusive Communities (UMRI)*, to implement a mixed-methods pilot study. The study will integrate the *Six Core Elements of Health Care Transition* into the work flow of Billings Clinic pediatric and adult clinics. The vision is to pilot a sustainable process to successfully transition young adults into adult healthcare. The project is currently in the analysis and design stage.

The Transition Improvement Group (TIG) is comprised of: both an adult and pediatric provider; adult and pediatric care managers; leadership executives; quality improvement specialists; nurse informaticists; social workers; and, policy development experts – all of whom work for Billings Clinic. The team is led by the CSHS nurse program manager and the project coordinator for the UMRI. To date, the group has had 8 conference calls and 1 in-person meeting. The leaders are participating in monthly technical assistance calls from The National Alliance to Advance Adolescent Health/Got Transition with Dr. Patience White and Peggy McManus.

The members of the TIG have been divided into 5 focused workgroups; Adult, Pediatric, Electronic Health Record/Informaticist, Education and Policy Development. Each workgroup is in the process of defining and developing actions items with an associated timeline. Because this is still in the development phase, a comprehensive timeline is not currently available. However, CSHS intends for this project to continue until January 2021.

##### Montana Medical Home Portal -

CSHS continued to contract for a Montana specific services directory on the Medical Home Portal (MHP). The MHP 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 MHP includes vetted, up-to-date clinical information, materials on accessing care, and a statewide services directory.

CSHS staff continue to update services and added over 435 new resources during this reporting period. The PPs assisted in adding these resources as well as CSHS staff and users of the Portal suggested new resources. The upcoming PP program expansion should lead to additional resources as well. CSHS staff continued to review all services included in the MHP directory, this ensures each service is still available and associated information is accurate.

Work has begun on contracting with Montana's 2-1-1 to obtain their resources and add them to the Portal. This could potentially add over 1000 new resources to the Portal. During this reporting period the average hits to the MHP was 773 per month with the number of hits increasing after targeted marketing events.

Marketing for the MHP is planned at events targeting providers and families, such as the Montana AAP Chapter Conference and the Montana Public Health Association annual meeting. Staff demonstrate the MHP, answer questions and provide outreach materials to attendees. Marketing the Portal will continue through Facebook advertisements, and staff will explore new ways to advertise and increase usage. Demonstrations and/or presentations, and outreach and education materials, will be made available to any group upon request.

#### CSHS Financial Assistance -

CSHS provides direct financial assistance to qualifying families to cover out-of-pocket expenses for medical and enabling services. CSHS amended the financial assistance application to a shortened version for child protection workers, to get services to the children on their caseload quickly. As of May 2019, the expedited process has helped five families receive services sooner than they would have in the past.

Additionally, CSHS has helped over 21 needy families with the approval of \$20,000 in funds to provide services. Staff has promoted the program through education and outreach at different events such as Montana AAP Chapter Conference, Montana Public Health Association, Rocky Mountain Childbirth Conference, and the Great Beginnings Great Families conference sponsored by DPHHS.

#### Circle of Parents -

Since October 2018, CSHS has partnered with Butte 4-C's to establish and facilitate Circle of Parents groups in Montana. There are currently three facilitation sites in Montana; Butte, Missoula and Billings. These groups provide a supportive environment led by parents and other caregivers throughout Montana. Over the next year, the Montana Circle of Parents hopes to expand to Kalispell, Great Falls, Bozeman, and Helena.

There are currently two trainers in Montana, funded by CSHS. To date, there have been two trainings for new facilitators, with five facilitators trained. Approximately 32 parents have attended these groups. Also, approximately 27 children participated in the childcare provided by these groups.

#### SSI Referrals and Limited Nurse Care Coordination -

CSHS employs a fulltime nurse program manager. The primary duties of this position are to manage and consult on CSHS programs. Historically, CSHS received referrals from the Disability Determination Bureau for any child or youth who applied for Social Security Income (SSI) benefits. The referrals were coded, and the nurse program manager forwarded them to Early Intervention, or the Montana School for the Deaf and Blind, if appropriate. The nurse also sent families a letter and a brochure describing services offered by CSHS.

During FFY 2018, the nurse piloted phone calls to families who were referred from the Disability Determination Bureau. The nurse assessed their needs and referred them to other state programs or community-based organizations when appropriate. This new approach led to increased contact with families and more referrals from CSHS. CSHS stopped receiving these SSI referrals due to issues of privacy raised by a project officer in the regional SSI office. CSHS is working with the DPHHS Information Technology department and SSI remedy the problem.

In FFY 2020, CSHS staff will plan to market the Montana Maternal Child Health hotline throughout the state. This number goes to the CSHS nurse program manager. It is anticipated increased marketing will lead to more opportunities for the nurse to speak with families and provide support and referrals.

**Cross-Cutting/Systems Building**

**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 who choose SPM 1.**

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			30	29
Annual Indicator	33.8	27.9	37.1	
Numerator	1,484	2,184	9,142	
Denominator	4,397	7,839	24,666	
Data Source	FCHB	FCHB	FCHB	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
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	
Annual Objective			40	40
Annual Indicator	45	40	39.5	
Numerator	2,837	2,663	2,004	
Denominator	6,305	6,658	5,077	
Data Source	FCHB	FCHB	FCHB	
Data Source Year	FY 2016	SFY 2017	SFY 18	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	40.0	40.0	40.0	40.0	40.0	40.0

## State Action Plan Table

### State Action Plan Table (Montana) - Cross-Cutting/Systems Building - Entry 1

#### Priority Need

Low-Risk Cesarean Deliveries

#### 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

To decrease the number of low-risk cesarean deliveries among first births to 21.5% by 2021.

#### Strategies

Ongoing strategies are: 1) Montana's Infant Mortality (IM) Collaborative Improvement & Innovation Network (CoIIN) team plays a pivotal role in developing and maintaining public and private organization partnerships, which aim to promote a 39 week gestational period.

### Priority Need

Breastfeeding Rates

### 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

Increase the percent of infants who are ever breastfed to 93% by 2021, and the percent of infants breastfed exclusively through 6 months to 21.3% by 2021.

### Strategies

Ongoing strategies are: 1) Use USDA/WIC infrastructure grant funding to increase the number of IBCLCs available as WIC employees, to address the shortage of such certified individuals. Other funds from the grant are planned for use in a more extensive Breastfeeding Learning Collaborative, partnering with the NAPA Program, with expanded dates and presenters. Also, for the development of a toolkit for local program staff to use to build relationships with local hospitals and staff in the promotion and support of breastfeeding. 2) WIC will continue to provide breastpumps to participants who meet the criteria found in the State Plan policy addressing breastpumps. Work is underway and will continue to develop methods of coordination with Medicaid in the provision of breastpumps.

#### Priority Need

Access to Care

#### SPM

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 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 30% of their MCH population through 2023.

#### Strategies

Ongoing strategies are: 1) Eighteen frontier-level population CPHDs are collaborating with the FCHB on this performance measure for SFY 2018. 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 have submitted plans and methods of evaluation. 2) Annual training is provided to the CPHDs on a wide variety of MCH topics and programs.

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

Ongoing strategy: Six CPHDs are implementing SPM 2 for FY18, and nine for FY19. Training and tracking templates are provided . Going forward, there is more emphasis on the role of the health education component to cover a variety of MCH priorities.

#### Priority Need

Smoking During Pregnancy and Household Smoking

#### 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

Decrease the percent of women who smoke during pregnancy to 14.4% by 2021, and the percent of children who live in a household where someone smokes to 24% by 2021.

#### Strategies

Ongoing strategies are: 1) MTUPP is requiring local tobacco prevention specialists to provide outreach and education about their quit-line pregnancy program to the health clinics in their communities which serve pregnant women. 2) MECHV funded home visitors at implementing sites assess primary caregivers and pregnant enrollees for tobacco use, and refer to appropriate assessment programs if appropriate. The program will also collaborate with MTUPP on tobacco cessation efforts.

## Cross-Cutting/Systems Building - Annual Report

### Cross-Cutting & Systems Building – Annual Report FFY 2018

FFY 2018 reporting for the Cross-Cutting & Systems Building domain include the following two State Performance Measures:

- SPM 1 – Access to Care and Public Health Services
- SPM 2 – Family Support & Health Education

#### **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.**

Most of the counties which qualify for SPM 1 have similar challenges: very low population density; public health departments 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. This performance measure was created to support and sustain the public health system in these counties, and the ability of their health departments to help vulnerable families.

Three counties in the central part of the state are leveraging a regional approach to serve the maternal and child population. The Central Montana Health District provides a public health nurse, and administration staff, to assist with implementing MCHBG activities. These counties (Golden Valley, Judith Basin, and Wheatland) have a combined total population of 4,863, and a combined MCH population of 1,582.

In March 2018, the MCHBG and FICMMR Coordinators provided regional trainings in five locations throughout the state. There was a total of 72 attendees. The FICMMR Coordinator presented on practical, evidence-based injury prevention activities which CPHDs can realistically implement, given staff capacity. The MCHBG Coordinator's training introduced the "Appreciative Inquiry" program planning model and its adaptability to any size CPHD, as well as performance measure and contract changes.

Eighteen counties choose SPM 1 for SFY 2018. This is 35% of the counties participating in the MCHBG for that timeframe, representing only 6.2% of Montana's population. Funding is distributed to the counties on a population basis. Even with a minimum baseline amount, these counties only receive 7% of the allocation. SPM 1 is measured by the percentage of MCH population served, with an annual objective of 30%. The percentage served in SFY 2018 was 37%.

The staff at these rural and frontier-level CPHDs provided a wide range of public health services and education. The main categories were: motor vehicle and agricultural equipment safety education; immunization; and, suicide prevention and mental health education. Additional activity categories included: conducting Community Needs Assessments; safety education on multiple topics; pregnancy and postpartum support; certified lactation counseling; community outreach to promote services; hearing and oral health screenings in the schools; and, child abuse prevention.

The following are some specific examples from CPHD quarterly report narratives, with the size of the maternal and child population demographic noted:

- **Madison** (2,172) – "We have our audiometer machine calibrated and are ready to start scheduling hearing screenings at the identified schools. Two staff members have completed training. We also have our documentation template almost completed for Car Seat Safety Checks and are also working on some flyers to advertise this service."
- **Musselshell** (1,725) – "MCH continues home visiting support in the community; and providing referrals and education for health care access, dental access, safe sleep, breastfeeding support, suicide awareness, nutrition support, smoking cessation, obesity dangers, and immunization/vaccination availability.

To increase numbers and access for more residents of Musselshell County, we are doing more referrals and coordinating without formally entering persons in our more in-depth tracking systems. This tends to be more compatible with this very rural culture, where many are somewhat suspicious of any government-related service. We are now engaging more persons with this approach. We do steer persons toward entering a more comprehensive client status where we can."

- **Toole** (1,688) – "This quarter we distributed gun locks for suicide and accidental injury prevention at National Night Out. This event was planned in coordination with Gateway Prevention Services, the Toole County Sheriff's Dept., Border Patrol, Marias Medical Center, Core Civic, and the City of Shelby. At this event, we also conducted car seat

safety checks.

We have also spent this quarter planning a student health and wellness fair, to be held in conjunction with parent/teacher conferences at our largest school district. We are working with the MSU College of Nursing, the Toole County Sheriff's Department, Marias Medical Center, Marias Healthcare, Gateway Prevention, the local office of the MT Agricultural Extension Agency, and Youth Dynamics - to provide education for students and their families on a variety of health and safety topics. This activity also aligns with our Community Health Improvement Plan.”

- **Treasure (268)** – “Treasure County Health Department sponsored a Spring Health Clinic and partnered with St. Vincent Hospital mobile mammography van in April 2018. We had great participation and many walk-in clients (18). An additional mammography on site clinic will be scheduled in conjunction with a fall health fair.

We have started a collaboration with the local swimming pool and are planning an evidence-based drowning prevention campaign as our FICMMR project. We are targeting women (Age 22-44), infants, and children under age 10 for this project - and sponsoring swimming lessons and distributing/presenting education on a variety of water safety topics. The topics will expand past the pool, as Treasure has multiple open waterways, ditches, and canals in the county.”

- **Wheatland (778)** –
  - Provided lead and hematocrit screening to Head Start children in Harlowton;
  - Delivered medication disposal bags to the pharmacy, clinic, and hospital in Harlowton. These disposal bags inactivate medications to properly dispose of them, to reduce possibilities for misuse or abuse of medications;
  - Mailed 29 immunization reminders/recalls to CMHD clients;
  - Participated in monthly meetings of the Central MT Youth Challenge Group, to help make prevention activities for kids possible, such as speakers, poster contests, and simulated emergency events.
  - Continued to participate in activities with Fergus Coalition for Family & Child Health, including: purchasing lice kits for families that cannot afford them, and diapers, wipes and prenatal vitamins for those in need. Referral forms are available at our office and at all outreach clinics/activities we perform. Fliers with contact instructions are posted at key hubs.

Twenty-four counties chose SPM 1 as the focus of their MCHBG activities for the timeframe of 7/1/18 – 9/30/19.

**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.**

During FY 2018, CPHD operational plans for SPM 2 were focused on two main areas: the referral process; and, effective ways to deliver health education on the topics most needed by their clients.

Providing referrals to social services means having a comprehensive list of resources, with current contact information. The CPHDs have also learned the value of good relationships and communication channels with the agencies and providers of these services. There are many points in the referral process open to ongoing quality improvement efforts, especially for CPHDs who are new to SPM 2. Specific examples of current work and plans follow later in this narrative.

The CPHDs identified similar health education needs among the families they serve. This part of SPM 2 is growing in emphasis as a way to address a variety of topics. Early life is of particular focus: pregnancy; child birth; postpartum care; breastfeeding; newborn care; the growth and development of young children; and, parenting. Two other frequently mentioned activities involve car seat safety and tobacco cessation.

Planning and implementation of SPM 2 activities, along with learning curves and problem solving, tends to be cyclical in nature. The culture and available resources of each county is unique. Community outreach to advertise services has also proven to be a necessary component for success.

The following examples are from CPHD quarterly reports, with the size of the maternal and child population demographic noted:

- **Blaine (3,234)** – “Our office has invested in performance management system software which will be implemented next quarter. Our goals for this software is to develop a better tracking system for our educational opportunities, and

help us improve with distribution of the family needs assessment surveys.

Our Family Education series will continue this quarter. With local partners we are currently working on 3 topics: 1) partnering with our local library to present a health literacy class the end of January; 2) working on a group presentation on preteen/teen health for parents, using local partners to present on: tobacco use in adolescents (using the “Catch My Breath” curriculum); YAM(Youth Aware of Mental Health); reproductive health curriculum; and, partnering with our local clinic to present on mental health topics (some options are Mental Health First Aid, ASIST, or something similar).”

- **Richland** (4,952) – “This quarter we renewed our efforts to increase the number of documented referrals. We did this through staff education, and review of work that we’ve not previously counted. One example of this is the newborn public health referrals we receive from the Sidney Health Center. We get these on the majority of babies born there. For those we receive that are out-of-county residents, we copy the form and mail it to the appropriate county and/or Indian Health Service if listed.

We are working on our next Richland County Health Department strategic plan and have had multiple discussions about referrals, follow up, ways to improve the quality of referrals and how to know if clients felt well served by both our department and our partners.”

- **Lewis & Clark** (27,129) – “The community coordination of parenting classes is a project of our local Early Childhood Coalition [ECC], which involves 21 different agencies across the community. The purpose of collaborating is to ensure parents have a variety of parenting education options at a variety of times and dates. The ECC website now houses all known parenting education classes offered ([www.echelena.org](http://www.echelena.org)).

Additionally, public health staff is working collaboratively with PureView Health Center staff to ensure women who are enrolled in the First Breath Tobacco Cessation program also have primary care follow-up, support, and monitoring to address health issues related to tobacco use.

The partnership with St. Peter's Health is also starting to come along nicely. The staff on the OB/Peds floor are committed to talking with families about breastfeeding support and making referrals to the health department.”

- **Missoula** (49,761) – “Each client who either: 1) is enrolled in services at MCCHD; 2) is contacted via our hospital Postpartum Breastfeeding/Newborn referrals; or, 3) calls our Breastfeeding Helpline phone; is assessed for health education or social service needs and referred to and/or linked with information and community resources/agencies as needed. Additionally, information about our services were distributed to Western Montana Clinic obstetric providers in January, and at the Parenting Place Mini Resource Fair in February. Topics covered, referred for, or followed up with this quarter include:
  - adult employment resources;
  - childcare needs;
  - primary provider access;
  - medical care including dental, nutrition, speech, vision, PT, OT, other medical specialists;
  - housing resources;
  - emergency housing;
  - teen parent housing;
  - food bank;
  - WIC;
  - DV shelter and advocacy;
  - OPA for Medicaid, SNAP, TANF;
  - counseling services;
  - mental health services,
  - social work services;
  - Head Start;
  - Early Head Start;
  - pregnancy support services;
  - parenting support resources;
  - parenting classes;
  - newborn care classes;
  - breastfeeding support and information;
  - immunization services;

- Child and Family Services;
- Child Support Enforcement; and,
- SSI/SSDI application assistance.”

Beginning in July 2018, four CPHDs entered their 4<sup>th</sup> year of work on SPM 2: Gallatin, Lewis & Clark, Missoula, and Richland. Five counties new to the performance measure joined them: Carbon, Hill, Lincoln, Mineral, and Park. The new CPHDs were supplied with sample survey and tracking documents, and also attended a training webinar in June 2018.

## Cross-Cutting/Systems Building - Application Year

### Cross-Cutting & Systems Building – Plan for the Application Year, FFY 2020

This narrative contains current activities and upcoming plans for:

- SPM 1 – Access to Care and Public Health Services
- SPM 2 – Family Support and Health Education

#### **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.**

In April 2018, the CPHDs completed a Pre-Contract Survey (PCS). This included information regarding the activities they planned to implement from July 2018 – September 2019. The next PCS was completed in June 2019, for the timeframe of October 2019 – September 2020. Information from that survey is still being analyzed and tabulated. Thirty-Nine CPHDs qualify for SPM1, based on their maternal and child populations.

Twenty-four counties are currently carrying out the plans they presented for SPM 1. This represents 48% of the CPHDs participating in the MCHBG. Due to the population-based funding formula, however, they only receive 9.6% of the total CPHD funding allocation. Here is a high-level category list of their present MCHBG activities:

- Injury Prevention Education and Enabling Services (multiple topics) = 15
- Immunization (variety of enabling services) = 11
- Motor Vehicle Safety (i.e. car seat installation, seat belts, distracted driving) = 11
- Suicide, Mental Health, and Substance Abuse (education & enabling services) = 11
- Vision, Hearing, and Oral Health Screenings and Education = 10
- Health Education & Disease Management (multiple topics) = 9
- Campaigns to Increase Public Awareness of CPHD Services = 6

One of the main challenges arising over the past year came from the elimination of 19 Offices of Public assistance (OPAs) across the state, all from counties with lower populations. This was due to actions taken by the 2017 state legislature. Since many CPHDs were co-located in the same buildings, their staff have faced frequent requests for help from past OPA clients. They struggle with no training or addition of resources to address these needs. Notwithstanding, they attempt to provide assistance as able – often on their own time. One example is providing access a computer and helping to walk through the online application.

SPM 1 continues to provide practical support for these CPHDs. It allows the flexibility needed to help them supply critical safety-net services to their maternal and child residents.

#### **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.**

There are four CPHDs which have been implementing SPM 2 since FFY16: Gallatin, Lewis & Clark, Missoula, and Richland. All four are currently working on referral-related quality improvement projects. These activities focus both on internal processes, and external outreach to providers and agencies.

Missoula has installed a new electronic health records program which has a greater capability for tracking referral and follow-up. They also have new internal workplans for increasing referrals, which are reviewed quarterly with staff.

Gallatin is targeting OB/GYN offices in the county for building relationships; and implementing increased training to their home visitors regarding referral to support services. The following is from their 3<sup>rd</sup> quarter report: “Our continued collaboration with the OB/GYN offices at Bozeman Health have provided an increase in prenatal referrals, which leads to better outcomes for mother and baby. Also, in our increased effort to promote prenatal referrals we have continued to build our partnership with several of the local pregnancy resource clinics.”

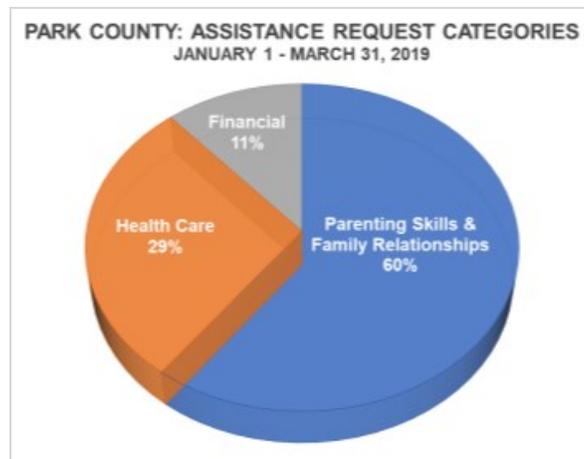
Lewis & Clark is focusing health education efforts on tobacco cessation, breastfeeding, and *Circle of Security* classes and

support. Circle of Security is a parenting program based on decades of research on how secure parent-child connections can be supported and strengthened. Richland CPHD is working on a goal to meet with at least one referring partner or potential referring partner each month. They are also reviewing processes with staff quarterly; and completing a referral gap analysis.

For CPHDs new to SPM 2, the front-end timeline for full implementation is often six months or more. This has to do with developing new business processes, such as: creating a practical survey for clients; policy and procedure training for staff; updating and expanding a referral contacts list; and, refining a specific data collection system. As of May 2019, the state MCHBG Program Specialist has made two on-site visits to CPHDs new SPM 2 (Carbon and Park). This was to provide more in-depth training, especially on data collection.

Most health education activities continue to focus on early childhood. Lincoln CPHD is an exception, with outreach to: 1) inmates at the Lincoln County jail; and, 2) teaching health education classes at the schools in Libby for K-12. Also, Hill CPHD is working with a *Trauma Sensitive School Initiative Team*, to bring the online ConnectMT referral system to the county.

After the site-visit to Park County, they made great strides in implementing their data-collection system. The following graph shows the percentages of the high-level categories selected on their client surveys for assistance, during the timeframe of January 1 – March 31, 2019:



In June 2019 the CPHDs submitted information on their performance measure plans for FFY 2020. This is still being analyzed. Any choosing SPM 2 for the first time will receive extra training for implementation. They will also be a priority for site visits during the year to provide additional support.

### III.F. Public Input

Public input on the MCHBG Application & Report (MCHBG-AR) relies heavily on feedback and contributions solicited from: the Public Health System Improvement Task Force (PHSITF); County Public Health Departments (CPHDs); CSHS stakeholders and contractors; and, other programs housed within the FCHB which impact the maternal and child population.

The PHSITF has 14 members, representing a cross section of agencies, statewide associations, and four 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 PHSTIF, attending meetings and providing updates. The attendees are offered the opportunity to provide input on MCHBG activities and administration at these meetings, and are tasked with ensuring their constituents are aware of and encouraged to comment on the MCHBG-AR. PHSITF members are provided with a copy of the initial submission soon after July 15 each year for additional comments, and offered the opportunity to participate in the August MCHBG-AR review.

The PHSITF was instrumental in providing direction and guidance to the steering committee for the recent State Health Improvement (SHA) and State Health Improvement Plan (SHIP) The steering committee was charged with vetting and gathering of information related to the health needs of the maternal and child health population. The 2019-2023 SHIP is now transitioning to the implementation phase. Members of five different health-priority workgroups are being asked to identify how their state or public-facing programs currently address, or through collaboration could address, the 2023 objectives. The MCH and CSHS Directors are engaged with the other 30+ members of the Mothers, Babies, and Youth/ACEs Workgroup and are well positioned to provide input based on their familiarity with the MCHBG-AR.

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 during: online surveys; in-person site visits; annual training sessions; and, through the Pre-Contract Survey (PCS). The PCS gathers a wealth of information, e.g. populations served, hours of operation, and needs of their community's maternal and child population. More details on recent input from both the PHSTF and the CPHDs is in the Needs Assessment Summary Update.

Both the MCHBG Program Specialist and 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 2019, 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 2020 Pre-Contract Survey (PCS) and upcoming deliverables for FFY 2020. Attendee comments, questions, and suggestions were compiled into an email which was shared with all the MCHBG liaisons.

The PCS serves multiple purposes: 1) the CPHD identifies their selected 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 CPHD has identified through their own needs assessment. The MCHBG Program Specialist informs the appropriate FCHB or PHSD program of the CPHD's request or emerging health concern.

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 seven young adults with special healthcare needs, seven parents, and representatives from several agencies including the Office of Public Instruction, Social Security Administration, Developmental Disability Program and Montana Vocational Rehabilitation.

CSHS convenes a Stakeholder's Group and hosts bi-monthly calls and an annual in-person meeting. The goal of the CSHS Stakeholder's Group is to involve parents, agencies, providers and state program staff in annual strategic planning activities to ensure input from a variety of stakeholders. Monthly calls focus on program updates and sharing across programs and agencies. The annual meeting is a facilitated workday, where stakeholder's provide input on annual CSHS activities.

The August 2018 meeting was facilitated by Oscar Flemming and Dorothy Cilenti of the MCH Workforce Development Center. Stakeholder's were led through the *Results-Based Accountability* process and planning was done for the following year. The 2019 meeting will be held in August. Stakeholder's will hear about FCHB progress on the 2020MCHBG Needs Assessment, and will make plans for the upcoming year.

The Montana Parent Partner Program (MPPP) has expanded to two additional clinics this year. Parent Partners are parents of CYSHCN who work in clinics and offer support and connect families with 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. Tarra Thomas is the statewide coordinator for the MPPP. Ms. Thomas also serves as the Montana AMCHP Family Delegate and on 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.

CSHS convenes an advisory group as part of the Universal Newborn Hearing Screening and Intervention Program (UNHSI). In-person meetings are held bi-annually. The group includes parents, adults with hearing loss, audiologists, early interventionists, medical practitioners, and program staff. Meetings are focused on the nine focus areas outlined in the grant (see below), and include program updates and quality improvement strategy development:

- Joint Committee on Infant Hearing (JCIH) 1-3-6 timeline
- Significant risk factors for late onset early childhood hearing loss
- Peer to peer information sharing
- Improving care coordination through the patient centered home family model
- Partnering with state/territory Title V CYSHCN program
- Providing family centered care
- Developing collaborative leadership skills for members of family organizations
- Engaging and including family partners in the child's health care
- Developing possible strategies to link or integrate data systems.

The Montana Access to Pediatric Psychiatry Network (MAPP-Net) recruited and maintains an 18-member Advisory Council who 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 meets quarterly by phone and annually in-person. The goal of the Advisory Council is to seek stakeholder input from across the state on the activities of the MAPP-Net grant. The Advisory Council members also champion the grant and disseminate information to their communities and colleagues.

MAPP-Net is in the process of conducting a needs assessment to understand the needs of primary care and behavioral health providers, for better serving children and youth in their communities with mental healthcare needs. The needs assessment has been disseminated in-person, and by mail and email to primary care and behavioral health stakeholders across the state for their input. The evaluators are also conducting key information interviews to acquire a deeper understanding of the challenges facing providers. The needs assessment is targeted to be completed in late July 2019.

Beginning May 2019, CSHS was asked to participate in an Innovation Advisory Council for the MCHB HRSA Care Coordination Grand Challenge. The advisory group comprises a multidisciplinary team which provides input, perspective and expertise. The aim of this group is to develop a sustainable technology-based shared plan of care that will improve access and quality care for CYSHCNs in Montana. From May 2019 through July 2019, the team's primary focus was to engage caregivers and medical providers in an effort to capture lived experiences in rural, urban and Native American reservation settings. The feedback will inform development of this project. CSHS connected with a variety of stakeholders, providers, state programs and community-based organizations to gain their perspectives.

The FCHB is in its second year of taking the lead on the Annual Great Beginnings/Great Families Conference. The target for attendance is maternal, child and adolescent professionals, advocates, support staff and providers. The 2019 Conference will include the Title V and CSHS Directors providing a high-level overview of the services and programs offered through the Title V/MCHBG and how to provide their input on the 2020-2025 Needs Assessment.

FCHB staff provide information about the MCHBG-AR at meetings with their respective program's stakeholders or contractors or through their membership on advisory boards or workgroups. For example:

- April 26, 2019: At the MT Oral Health Network meeting, the Title V Director shared with the 40+ attendees the connection between the MCHBG-AR and the MT Oral Health Strategic Framework.
- January 18, 2019: The CSHS Director, the SSDI and Lead FCHB Epidemiologists, and the FCHB Bureau Chief participated in the Early Childhood Services Bureau's Needs Assessment Meeting - which was facilitated by the MT Early Childhood System Needs Assessment Contractor.
- Rocky Mountain Tribal Epidemiology Center (RMTEC) Meetings: The Title V and State FICMMR Coordinator and RMTEC staff met twice in FFY 2019. At these meetings, the connection between the MCHBG-AR and the work addressing NPM 5 was shared. This was due in large part to the DPHHS Director's Safe Sleep Initiative, which was

launched in response to the significant rate of American Indian infant deaths from unsafe sleep environments.

- CSHS staff partnered with the Billings Clinic, a recipient of an AAP CATCH grant, on the May 5, 2019 Special Needs Day & Resource Fair. The CSHS Nurse Consultant and Health Education Specialist staff attended the event and talked to over 300 attendees, parents and children, about the role of Title V in providing services to CYSHCNs.
- Quarterly, the PHSD Management provides in-person training to the new Local County Health Department Leads. At these trainings, all the PHSD bureaus provide a high-level overview of their programs' funding, reporting requirements, and connection to the SHIP. The Title V funding overview and information on the most recent MCHBG-AR is provided by the Title V and CSHS Directors.
- The PCO and OH Program Coordinators participate on the MT Office of Rural Health/Area Health Education Center's MT Healthcare Workforce Advisory Committee (MHWAC). The 100+ members focus on recruiting healthcare professionals to MT and meet monthly.

### III.G. Technical Assistance

#### Technical Assistance

CSHS has been working to expand its reach, in order to serve more families with children at risk of developing a special healthcare need. The program has also determined to take a more overarching population health approach. With that in mind, CSHS would like to understand how to how to appropriately fit these strategies into the CYSHCN options for the Medical Home and Transition NPMs.

For example, CSHS funds training and support for Circle of Parents (COP). COP is a nationally recognized parent support group model aimed at preventing child abuse and neglect. This program supports families in many ways; and may lead to improved management of their child's medical needs, thus improving their access to a medical home. However, this is not the main objective of COP.

This is just one example, but as the FCHB continues with the upcoming MCHBG Needs Assessment, there is more and more input about the need for family support: in the foster care system; for CYSHCN with incarcerated parents; for families facing homelessness and addiction; and, in other challenging situations. These are big problems, affecting the health of MT's children and leaving many at risk of developing a special health care need. As CSHS continues to move forward, staff would like more assistance in linking strategies back to NPMs.

The Title V Director and the DPHHS American Indian Health Director are exploring options for a trauma-informed care and ACES training with Mark Johnson, Founder & Director, Seattle Constellations Institute and Essential Journeys: Personal Development Counseling. Mr. Johnson has expertise working with State of Washington American Indian Tribal Reservations and health department staff. The vision is for Mr. Johnson to spend a week in Montana to:

- Provide DPHHS staff training on trauma-informed care;
- Accompany the MCHBG Program Specialist and FICMMR Coordinator to their regional in-person trainings for County Public Health Departments and FICMMR teams members; and,
- Offer specific training for interested Tribal Health Departments.

#### **IV. Title V-Medicaid IAA/MOU**

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [MT\\_TitleV\\_HRD\\_HCSD\\_InteragencyAgreement.pdf](#)

## V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [MT\\_SupportingDocuments\\_TableOfContents\\_PlusStateReports.pdf](#)

Supporting Document #02 - [MT\\_SupportingDocuments\\_SectionIII\\_Narratives.pdf](#)

Supporting Document #03 - [MT\\_SupportingDocuments\\_WomenMaternal\\_PerinatalInfant.pdf](#)

Supporting Document #04 - [MT\\_SupportingDocuments\\_ChildAdolescent.pdf](#)

Supporting Document #05 - [MT\\_SupportingDocuments\\_CYSHCN\\_CrosscuttingSystemsBuilding.pdf](#)

## VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [MT\\_FCHB\\_OrgChartApril2019.pdf](#)

## VII. Appendix

This page is intentionally left blank.

**Form 2**  
**MCH Budget/Expenditure Details**

State: Montana

	FY 20 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	\$ 766,191	(32.9%)
B. Children with Special Health Care Needs	\$ 782,417	(33.6%)
C. Title V Administrative Costs	\$ 136,966	(5.9%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,685,574	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 3,182,030	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 12,336,754	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 8,486,816	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 24,005,600	
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	
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	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 50,095,542	

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
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) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 172,500
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 515,600
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) > Health Resources and Services Administration (HRSA) > Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) Formula Grants	\$ 4,680,084
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 400,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Care Access Program	\$ 444,794
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) > State Primary Care Office (PCO)	\$ 159,003
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 247,355
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Support for Pregnant and Parenting Teens	\$ 970,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 1,900,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 5,652,698
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 175,308
US Department of Agriculture (USDA) > Food and Nutrition Services > Food Distribution Program	\$ 7,190,014
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Grant	\$ 100,000

OTHER FEDERAL FUNDS	FY 20 Application Budgeted
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Teen Pregnancy Prevention	\$ 375,000
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Sexual Risk Avoidance Fund	\$ 325,000
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC Farmers Market	\$ 59,782

	FY 18 Annual Report Budgeted		FY 18 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 2,323,181		\$ 2,301,521	
A. Preventive and Primary Care for Children	\$ 884,478	(38.1%)	\$ 788,077	(34.2%)
B. Children with Special Health Care Needs	\$ 698,279	(30.1%)	\$ 740,679	(32.1%)
C. Title V Administrative Costs	\$ 195,560	(8.4%)	\$ 132,414	(5.8%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 1,778,317		\$ 1,661,170	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 3,086,577		\$ 2,984,836	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 4,882,169		\$ 12,490,557	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 150,000		\$ 6,243,211	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 8,118,746		\$ 21,718,604	
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)	\$ 10,441,927		\$ 24,020,125	
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)	\$ 21,842,716		\$ 22,904,219	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 32,284,643		\$ 46,924,344	

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
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) > Administration for Children & Families (ACF) > State Personal Responsibility Education Program (PREP)	\$ 250,000	\$ 250,000
US Department of Agriculture (USDA) > Food and Nutrition Services > The Loving Support Peer Counseling Program (Breastfeeding)	\$ 113,207	\$ 176,666
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Pregnancy Risk Assessment Monitoring System (PRAMS)	\$ 157,500	\$ 182,800
Department of Health and Human Services (DHHS) > Centers for Disease Control and Prevention (CDC) > Rape Prevention and Education (RPE) Program	\$ 226,434	\$ 515,600
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > ACA Maternal, Infant and Early Childhood Home Visiting Program	\$ 4,315,889	\$ 4,281,362
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Oral Health	\$ 250,000	\$ 400,000
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Systems Development Initiative (SSDI)	\$ 100,000	\$ 100,000
Department of Health and Human Services (DHHS) > Office of Population Affairs (OPA) > Title X Family Planning	\$ 2,051,000	\$ 1,453,000
US Department of Agriculture (USDA) > Food and Nutrition Services > Women, Infants and Children (WIC)	\$ 13,236,097	\$ 12,968,198
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Universal Newborn Hearing Screening and Intervention	\$ 142,848	\$ 247,355
US Department of Agriculture (USDA) > Food and Nutrition Services > Farmers Market	\$ 38,382	\$ 59,782
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Primary Care Program	\$ 181,000	\$ 159,003

OTHER FEDERAL FUNDS	FY 18 Annual Report Budgeted	FY 18 Annual Report Expended
US Department of Agriculture (USDA) > Food and Nutrition Services > WIC EBT Fund	\$ 598,286	\$ 0
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > State Loan Repayment Fund	\$ 159,950	\$ 127,500
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Pregnancy Assistance Fund		\$ 970,000
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Teen Pregnancy Prevention Fund		\$ 375,000
Department of Health and Human Services (DHHS) > Office of Adolescent Health > Secual Risk Avoidence		\$ 171,036
Department of Health and Human Services (DHHS) > Health Resources and Services Administration (HRSA) > Pediatric Mental Health Fund		\$ 444,794

**Form Notes for Form 2:**

None

**Field Level Notes for Form 2:**

1.	<b>Field Name:</b>	<b>Federal Allocation, A. Preventive and Primary Care for Children:</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The 2018 budgeted amount was an estimate only. The total expended, as reported, reflects the amount spent by county public health departments and the percentage of state level support.
2.	<b>Field Name:</b>	<b>Federal Allocation, C. Title V Administrative Costs:</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The 2018 administrative costs was an estimate. The total expended is reflected here.
3.	<b>Field Name:</b>	<b>4. LOCAL MCH FUNDS</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The 2018 MCH Local Funds was an estimate. Historically, the local county public health departments' MCH Funds is greater than estimated.
4.	<b>Field Name:</b>	<b>6. PROGRAM INCOME</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>
	<b>Field Note:</b>	The 2018 program income reflects income from WIC, Title X, and CSHS. WIC and Title X receive rebates which is reallocated to their respective programs. In 2018, CSHS began billing again and this income is used by CSHS to provide services. The 2018 budget was an estimate only.

**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 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 136,929	\$ 141,730
2. Infants < 1 year	\$ 228,781	\$ 194,896
3. Children 1 through 21 Years	\$ 766,191	\$ 788,077
4. CSHCN	\$ 782,417	\$ 740,679
5. All Others	\$ 271,897	\$ 303,725
Federal Total of Individuals Served	\$ 2,186,215	\$ 2,169,107

IB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Pregnant Women	\$ 454,924	\$ 440,660
2. Infants < 1 year	\$ 4,451,841	\$ 4,156,383
3. Children 1 through 21 Years	\$ 6,876,135	\$ 6,648,532
4. CSHCN	\$ 623,260	\$ 440,512
5. All Others	\$ 4,891,303	\$ 3,908,372
Non-Federal Total of Individuals Served	\$ 17,297,463	\$ 15,594,459
Federal State MCH Block Grant Partnership Total	\$ 19,483,678	\$ 17,763,566

**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**

<b>IIA. Federal MCH Block Grant</b>	<b>FY 20 Application Budgeted</b>	<b>FY 18 Annual Report Expended</b>
1. Direct Services	\$ 50,000	\$ 9,162
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	\$ 371
C. Services for CSHCN	\$ 50,000	\$ 8,791
2. Enabling Services	\$ 1,345,812	\$ 1,357,166
3. Public Health Services and Systems	\$ 927,369	\$ 935,193
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		\$ 825
Physician/Office Services		\$ 2,199
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 3,023
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 1,191
Laboratory Services		\$ 0
Other		
therapies		\$ 1,924
Direct Services Line 4 Expended Total		\$ 9,162
<b>Federal Total</b>	<b>\$ 2,323,181</b>	<b>\$ 2,301,521</b>

IIB. Non-Federal MCH Block Grant	FY 20 Application Budgeted	FY 18 Annual Report Expended
1. Direct Services	\$ 310,000	\$ 63,609
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	\$ 844
C. Services for CSHCN	\$ 310,000	\$ 62,765
2. Enabling Services	\$ 15,053,582	\$ 14,085,736
3. Public Health Services and Systems	\$ 8,565,695	\$ 7,516,964
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		\$ 238
Physician/Office Services		\$ 19,966
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 31,375
Other		
Therapies		\$ 12,030
Direct Services Line 4 Expended Total		\$ 63,609
<b>Non-Federal Total</b>	\$ 23,929,277	\$ 21,666,309

**Form Notes for Form 3b:**

None

**Field Level Notes for Form 3b:**

---

1.	<b>Field Name:</b>	<b>IIA. Federal MCH Block Grant, 1. B. Preventive and Primary Services for Children</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Annual Report Expended</b>

---

**Field Note:**

A county health department provided funds for pharmacy and other medical expenses.

**Form 4**  
**Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated**

**State: Montana**

**Total Births by Occurrence: 11,511**

**Data Source Year: 2018**

**1. Core RUSP Conditions**

<b>Program Name</b>	<b>(A) Aggregate Total Number Receiving at Least One Screen</b>	<b>(B) Aggregate Total Number Presumptive Positive Screens</b>	<b>(C) Aggregate Total Number Confirmed Cases</b>	<b>(D) Aggregate Total Number Referred for Treatment</b>
Core RUSP Conditions	11,458 (99.5%)	55	12	12 (100.0%)

<b>Program Name(s)</b>				
3-Hydroxy-3-Methylglutaric 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, $\beta$ eta-Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiencies
$\beta$ -Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-Coa Dehydrogenase Deficiency	

## 2. Other Newborn Screening Tests

Program Name	(A) Number Receiving at Least One Screen	(B) Number Presumptive Positive Screens	(C) Number Confirmed Cases	(D) Number Referred for Treatment
Hearing	11,259 (97.8%)	55	6	6 (100.0%)
Critical Congenital Heart Disease	10,951 (95.1%)	18	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.	<b>Field Name:</b>	<b>Core RUSP Conditions - Receiving At Least One Screen</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Core RUSP Conditions</b>

---

**Field Note:**

Cases identified by bloodspot screening as listed on the drop down menu include:

3-Methylcrotonyl-CoA carboxylase deficiency (1 infants)

Carnitine uptake defect/ carnitine transport defect (2 infants)

Classic galactosemia (2 infants)

Classic phenylketonuria (1 infant)

Cystic fibrosis (2 infants)

Medium-chain acyl-CoA dehydrogenase deficiency (1 infant)

Primary congenital hypothyroidism (3 infants)

The drop down list includes conditions added to the nationally recommended newborn screening panel for which Montana DOES NOT screen:

X-linked Adrenoleukodystrophy

Mucopolysaccharidosis, type 1

Glycogen storage disease, type II (Pompe)

Hearing and Critical Congenital Heart Disease screening data listed on "Other Newborn" page.

**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 2018

**Form 5a – Count of Individuals Served by Title V**  
**(Direct & Enabling Services Only)**

Types Of Individuals Served	(A) Title V Total Served	Primary Source of Coverage				
		(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	2,276	45.0	0.0	9.0	2.0	44.0
2. Infants < 1 Year of Age	6,803	45.0	2.0	6.0	1.0	46.0
3. Children 1 through 21 Years of Age	22,381	34.0	3.0	19.0	3.0	41.0
3a. Children with Special Health Care Needs	2,433	53.0	2.0	8.0	2.0	35.0
4. Others	6,628	25.0	0.0	31.0	5.0	39.0
Total	38,088					

**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	11,799	Yes	11,799	100	11,799	2,276
2. Infants < 1 Year of Age	11,752	Yes	11,752	100	11,752	6,803
3. Children 1 through 21 Years of Age	269,958	Yes	269,958	31	83,687	22,381
3a. Children with Special Health Care Needs	52,615	Yes	52,615	100	52,615	2,433
4. Others	767,997	Yes	767,997	7	53,760	6,628

**Form Notes for Form 5:**

None

**Field Level Notes for Form 5a:**

---

1.	<b>Field Name:</b>	<b>Pregnant Women Total Served</b>
----	--------------------	------------------------------------

---

	<b>Fiscal Year:</b>	<b>2018</b>
--	---------------------	-------------

---

**Field Note:**  
Sources: County Financial Data Reports  
State program (Oral Health, Title X, CYSHCN) numbers

County Number Calculation for each domain:  
(Percent spent on enabling services (per county)) \* (Number of individuals served in each domain (per county))

Total in Each Domain  
Number served by county health departments + Number served by state program at non-county health department sites

---

2.	<b>Field Name:</b>	<b>Infants Less Than One YearTotal Served</b>
----	--------------------	---

---

	<b>Fiscal Year:</b>	<b>2018</b>
--	---------------------	-------------

---

**Field Note:**  
Sources: County Financial Data Reports  
State program (Oral Health, Title X, CYSHCN) numbers

County Number Calculation for each domain:  
(Percent spent on enabling services (per county)) \* (Number of individuals served in each domain (per county))

Total in Each Domain  
Number served by county health departments + Number served by state program at non-county health department sites

---

3.	<b>Field Name:</b>	<b>Children 1 through 21 Years of Age</b>
----	--------------------	---

---

	<b>Fiscal Year:</b>	<b>2018</b>
--	---------------------	-------------

---

**Field Note:**  
Sources: County Financial Data Reports  
State program (Oral Health, Title X, CYSHCN) numbers

County Number Calculation for each domain:  
(Percent spent on enabling services (per county)) \* (Number of individuals served in each domain (per county))

Total in Each Domain  
Number served by county health departments + Number served by state program at non-county health department sites

---

4.	<b>Field Name:</b>	<b>Children with Special Health Care Needs</b>
----	--------------------	--

---

	<b>Fiscal Year:</b>	<b>2018</b>
--	---------------------	-------------

---

---

**Field Note:**

Sources: County Financial Data Reports  
State program (Oral Health, Title X, CYSHCN) numbers

County Number Calculation for each domain:

(Percent spent on enabling services (per county)) \* (Number of individuals served in each domain (per county))

Total in Each Domain

Number served by county health departments + Number served by state program at non-county health department sites

Note 1 from CYSHCN (Lanny): Numbers include counts from CHRIS referrals, clinic participants, and Parent Partner contacts, and the financial assistance program

Note 2 Numbers differ from last year because the numbers last year were inflated due to an error pulling the information. "The cleft clinic numbers were inflated because the system prints out everyone instead of just that fiscal year." The number should have been 1287 total CYSHCN served from the state program.

---

5. **Field Name:** Others

**Fiscal Year:** 2018

---

**Field Note:**

Sources: County Financial Data Reports  
State program (Oral Health, Title X, CYSHCN) numbers

County Number Calculation for each domain:

(Percent spent on enabling services (per county)) \* (Number of individuals served in each domain (per county))

Total in Each Domain

Number served by county health departments + Number served by state program at non-county health department sites

---

6. **Field Name:** Total\_TotalServed

**Fiscal Year:** 2018

---

**Field Note:**

Sources: County Financial Data Reports  
State program (Oral Health, Title X, CYSHCN) numbers

County Number Calculation for each domain:

(Percent spent on enabling services (per county)) \* (Number of individuals served in each domain (per county))

Total in Each Domain

Number served by county health departments + Number served by state program at non-county health department sites

**Field Level Notes for Form 5b:**

1.	<b>Field Name:</b>	<b>Pregnant Women</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Field Note:</b>	All birth certificates and PRAMS are analyzed to identify preconception, prenatal, and postpartum needs of women
2.	<b>Field Name:</b>	<b>Infants Less Than One Year</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Field Note:</b>	All infants receive newborn screenings
3.	<b>Field Name:</b>	<b>Children 1 Through 21 Years of Age</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Field Note:</b>	Children 1-21 (31092)= CNTY HLTH (30,041) + Oral Health (1842) + Title X (19)
4.	<b>Field Name:</b>	<b>Children With Special Health Care Needs</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Field Note:</b>	MCHBG funding provides infrastructure for all children with special health care needs in Montana (e.g., Medical Home Portal, Newborn Screening, Genetic Financial Assistance, Transition Care)
5.	<b>Field Name:</b>	<b>Others</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Field Note:</b>	Number includes: Total served by county health departments + "Group Encounters" from county health departments + Numbers served by state programs at non-county health department sites.  "Others" (50903) = Total from CNTY HLTH (9785) + TITLE X (36) + Group Encounters (41082)

**Data Alerts: None**

**Form 6**  
**Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX**

**State: Montana**

**Annual Report Year 2018**

**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	11,818	9,407	52	557	1,196	81	14	396	115
Title V Served	11,818	9,407	52	557	1,196	81	14	396	115
Eligible for Title XIX	4,866	3,330	16	298	935	21	4	235	27
2. Total Infants in State	12,024	9,477	67	615	1,235	110	13	421	86
Title V Served	12,024	9,477	67	615	1,235	110	13	421	86
Eligible for Title XIX	4,928	3,348	31	316	918	21	9	251	34

**Form Notes for Form 6:**

None

**Field Level Notes for Form 6:**

1.	<b>Field Name:</b>	<b>1. Total Deliveries in State</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Total</b>
	<b>Field Note:</b>	
		11818 Source: MT Vital Statistics
2.	<b>Field Name:</b>	<b>1. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Total</b>
	<b>Field Note:</b>	
		The birth record of every mother/infant and PRAMS are continuously assessed to identify the preconception, prenatal, and postpartum needs of mothers. The needs identified using MCHBG funds are address by MCHBG strategies as needed, or by other state programs.
3.	<b>Field Name:</b>	<b>1. Eligible for Title XIX</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Total</b>
	<b>Field Note:</b>	
		4,866 Source: Montana Vital Statistics Deliveries with Medicaid as the principle source of payment
4.	<b>Field Name:</b>	<b>2. Total Infants in State</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Total</b>
	<b>Field Note:</b>	
		12,024 Source: Montana Vital Records Number of infants born 10/01/2016-9/30/2017
5.	<b>Field Name:</b>	<b>2. Title V Served</b>
	<b>Fiscal Year:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>Total</b>

---

**Field Note:**

All infants in Montana receive newborn screening, which is partially funded by MCHBG

---

6. **Field Name:** **2. Eligible for Title XIX**

---

**Fiscal Year:** **2018**

---

**Column Name:** **Total**

---

**Field Note:**

4,928

Number of infants born 10/01/2016-9/30/2017 with deliveries covered by Medicaid. Infants born with Medicaid are automatically eligible for Medicaid for the first 12 months of life.

**Form 7**  
**State MCH Toll-Free Telephone Line and Other Appropriate Methods Data**

**State: Montana**

<b>A. State MCH Toll-Free Telephone Lines</b>	<b>2020 Application Year</b>	<b>2018 Annual Report Year</b>
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 362-8312	(800) 362-8312
2. State MCH Toll-Free "Hotline" Name	Montana Healthcare Help Line	Montana Healthcare Help Line
3. Name of Contact Person for State MCH "Hotline"	Laura Brown	Laura Brown
4. Contact Person's Telephone Number	(406) 444-9291	(406) 444-9291
5. Number of Calls Received on the State MCH "Hotline"		64,606

<b>B. Other Appropriate Methods</b>	<b>2020 Application Year</b>	<b>2018 Annual Report Year</b>
1. Other Toll-Free "Hotline" Names	Children's Special Health Services: 800-762-9891; Healthy Montana Kids: 877-543-7669; Supplemental Nutrition Assistance: 888-706-1535	Children's Special Health Services: 800-762-9891; Healthy Montana Kids: 877-543-7669; Supplemental Nutrition Assistance: 888-706-1535
2. Number of Calls on Other Toll-Free "Hotlines"		222
3. State Title V Program Website Address	DPHHS.mt.gov	DPHHS.mt.gov
4. Number of Hits to the State Title V Program Website		1,364,723
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		2,543

**Form Notes for Form 7:**

Previous year's website stats were for "apply.mt.gov" which for FFY18 equals 85,830. The change to selected DPHHS website pages is felt to be a better representation, and includes pertinent divisions and programs affecting maternal and child health.

Number of Calls to Other Toll-Free Hotlines: amount listed in field is for calls to the CSHS hotline, which go to the CSHCN Nurse.

For the Facebook page, the number is actually "likes." A further breakdown of the statistics shows: 80% women, and 20% men.

Twitter Statistics:

- DPHHS follows 208 others,
- DPHHS has 345 followers,
- During FFY18, DPHHS posted 111 Tweets.

DPHHS YouTube Channel:

Total Views = 2,278

Total Subscribers = 131

**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 Maternal and Child Health Director
Address 1	1625 11th Avenue
Address 2	PO Box 202951
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	Rachel Donahoe
Title	Children's Special Health Services Supervisor
Address 1	1625 11th Avenue
Address 2	PO Box 202951
City/State/Zip	Helena / MT / 59620
Telephone	(406) 444-3617
Extension	
Email	rdonahoe@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 / 59101
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 2020**

No.	Priority Need
1.	Family Support and Health Education
2.	Access to Care
3.	Immunization Rates
4.	Child Injuries
5.	Smoking During Pregnancy and Household Smoking
6.	Breastfeeding Rates
7.	Oral Health
8.	Teen Pregnancy Prevention
9.	Low-Risk Cesarean Deliveries
10.	Infant Safe Sleep

**Form 9 State Priorities-Needs Assessment Year - Application Year 2016**

<b>No.</b>	<b>Priority Need</b>	<b>Priority Need Type (New, Replaced or Continued Priority Need for this five-year reporting period)</b>	<b>Rationale if priority need does not have a corresponding State or National Performance/Outcome Measure</b>
1.	Family Support and Health Education	New	
2.	Access to Care	Continued	
3.	Immunization Rates	Continued	
4.	Child Injuries	Continued	
5.	Smoking During Pregnancy and Household Smoking	Continued	
6.	Breastfeeding Rates	New	
7.	Oral Health	Continued	
8.	Teen Pregnancy Prevention	New	
9.	Low-Risk Cesarean Deliveries	New	
10.	Infant Safe Sleep	New	

**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.**

Number of county participating has increased to 18.

**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
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
2015	99.5	11.0	83	8,338
2014	135.1	11.4	142	10,508
2013	136.0	11.5	142	10,439
2012	126.6	11.2	129	10,192
2011	121.5	10.9	127	10,449
2010	126.7	10.9	137	10,813
2009	113.9	10.2	125	10,977

**Legends:**

- Indicator has a numerator  $\leq 10$  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**

**Federally available Data (FAD) for this measure is not available/reportable.**

**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
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
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
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
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:**  
 Indicator results were based on a shorter time period than required for reporting

**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
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
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
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
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
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 - Sleep-related 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
2016	138.4 ⚡	33.6 ⚡	17 ⚡	12,282 ⚡
2015	182.8	38.2	23	12,583
2014	112.6 ⚡	30.1 ⚡	14 ⚡	12,432 ⚡
2013	129.3 ⚡	32.3 ⚡	16 ⚡	12,377 ⚡
2012	165.0	36.9	20	12,118
2011	132.6 ⚡	33.2 ⚡	16 ⚡	12,069 ⚡
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
- ⚡ Indicator has a numerator <20 and should be interpreted with caution

**NOM 9.5 - Notes:**

None

**Data Alerts: None**

**NOM 10 - The percent of infants born with fetal alcohol exposure in the last 3 months of pregnancy**

**Federally available Data (FAD) for this measure is not available/reportable.**

**NOM 10 - Notes:**

None

**Data Alerts: None**

**NOM 11 - The rate of infants born with neonatal abstinence syndrome per 1,000 hospital births**

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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
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
2017	10.5 	3.0 	12 	114,293 
2016	27.1	4.9	31	114,264
2015	32.6	5.4	37	113,460
2014	13.3 	3.4 	15 	112,885 
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
-  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
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
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
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
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
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
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
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
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
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
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 or a relative standard error ≥30% and is not reportable
- Indicator has a confidence interval width >20% and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	11.7 %	0.7 %	4,739	40,406
2015	10.4 %	0.6 %	4,250	40,796
2013	9.3 %	0.5 %	3,815	40,942
2011	8.4 %	0.5 %	3,543	42,120
2009	10.3 %	1.1 %	4,435	43,071
2007	10.1 %	0.6 %	4,597	45,708
2005	9.3 %	0.7 %	4,319	46,234

**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
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
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, ages 19 through 35 months, who completed the combined 7-vaccine series (4:3:1:3\*:3:1:4)**

Data Source: National Immunization Survey (NIS)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	66.2 %	4.0 %	11,792	17,804
2016	63.6 %	3.8 %	10,784	16,946
2015	68.1 %	3.6 %	11,649	17,101
2014	67.1 %	4.2 %	11,407	16,994
2013	65.4 %	4.2 %	11,245	17,205
2012	66.5 %	3.6 %	11,335	17,053
2011	59.6 %	4.5 %	10,492	17,599
2010	50.0 %	3.6 %	8,781	17,573
2009	38.7 %	3.9 %	7,012	18,121

**Legends:**

- 🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 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
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 95% confidence interval half-width/estimate > 0.6
- ⚡ 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
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 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
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 half-width/estimate > 0.6
- ⚡ Estimates with 95% confidence interval half-widths > 10 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
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**

**Federally available Data (FAD) for this measure is not available/reportable.**

**NOM 24 - Notes:**

None

**Data Alerts: None**

**NOM 25 - Percent of children, ages 0 through 17, who were not able to obtain needed health care in the last year**

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend				
Year	Annual Indicator	Standard Error	Numerator	Denominator
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 5A - Percent of infants placed to sleep on their backs**

**Federally available Data (FAD) for this measure is not available/reportable.**

State Provided Data			
	2016	2017	2018
Annual Objective	50	78	80
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	82.0	84.0	86.0	87.0	88.0	88.0

**Field Level Notes for Form 10 NPMs:**

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**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 (FAD) for this measure is not available/reportable.

State Provided Data		
	2017	2018
Annual Objective		
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	88.0	89.0	90.0	91.0	92.0	92.0

**Field Level Notes for Form 10 NPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Sleeps in crib or portable crib
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	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 (FAD) for this measure is not available/reportable.**

State Provided Data		
	2017	2018
Annual Objective		
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	81.0	82.0	83.0	84.0	84.0

**Field Level Notes for Form 10 NPMs:**

1.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	Sleeps without plush or thick blankets
2.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	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 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) - CHILD			
	2016	2017	2018
Annual Objective	182	180	90
Annual Indicator	88.5	111.8	122.1
Numerator	111	106	155
Denominator	125,378	94,803	126,908
Data Source	SID-CHILD	SID-CHILD	SID-CHILD
Data Source Year	2014	2015	2016

State Provided Data			
	2016	2017	2018
Annual Objective	182	180	90
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	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	89.0	88.0	87.0	86.0	85.0	90.0

**Field Level Notes for Form 10 NPMs:**

---

1.	<b>Field Name:</b>	<b>2016</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2014, 10-19 year old: 266.2;

---

2.	<b>Field Name:</b>	<b>2017</b>
	<b>Column Name:</b>	<b>State Provided Data</b>
	<b>Field Note:</b>	2015, 10-19 year old: 298.3

---

**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
Annual Objective			78
Annual Indicator		78.7	79.3
Numerator		55,013	56,264
Denominator		69,906	70,972
Data Source		NSCH	NSCH
Data Source Year		2016	2016_2017

**i** 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						
	2019	2020	2021	2022	2023	2024
Annual Objective	79.0	80.0	81.0	82.0	83.0	83.0

**Field Level Notes for Form 10 NPMs:**

None

**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
Annual Objective		
Annual Indicator	47.5	39.9
Numerator	19,838	17,364
Denominator	41,760	43,541
Data Source	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017

State Provided Data		
	2017	2018
Annual Objective		
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						
	2019	2020	2021	2022	2023	2024
Annual Objective	49.0	50.0	51.0	52.0	53.0	53.0

**Field Level Notes for Form 10 NPMs:**

---

1.	<b>Field Name:</b>	<b>2017</b>
----	--------------------	-------------

---

	<b>Column Name:</b>	<b>State Provided Data</b>
--	---------------------	----------------------------

---

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

**Federally available Data (FAD) for this measure is not available/reportable.**

State Provided Data			
	2016	2017	2018
Annual Objective	58	58.5	59
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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	59.5	60.0	60.5	61.0	61.5	61.5

**Field Level Notes for Form 10 NPMs:**

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**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 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 who choose SPM 1.**

Measure Status:		Active		
State Provided Data				
	2016	2017	2018	
Annual Objective			30	29
Annual Indicator	33.8	27.9	37.1	
Numerator	1,484	2,184	9,142	
Denominator	4,397	7,839	24,666	
Data Source	FCHB	FCHB	FCHB	
Data Source Year	2016	2017	2018	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	30.0	30.0	30.0	30.0	30.0	30.0

**Field Level Notes for Form 10 SPMs:**

- 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.
- Field Name:** 2019

---

**Column Name:** Annual Objective

---

**Field Note:**  
The annual objective will remain at 30% for now, to allow more years for trend data. Due to the low population numbers involved, a small change in one year could make a significant difference.

**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	
Annual Objective			40	40
Annual Indicator	45	40	39.5	
Numerator	2,837	2,663	2,004	
Denominator	6,305	6,658	5,077	
Data Source	FCHB	FCHB	FCHB	
Data Source Year	FY 2016	SFY 2017	SFY 18	
Provisional or Final ?	Final	Final	Final	

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	40.0	40.0	40.0	40.0	40.0	40.0

**Field Level Notes for Form 10 SPMs:**

- 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%.
- 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.

**Form 10  
Evidence-Based or –Informed Strategy Measures (ESMs)**

State: Montana

**ESM 5.2 - Infant Safe Sleep - Montana Specific Targeted Messaging and Education Campaign**

Measure Status:	Inactive - Completed	
State Provided Data		
	2017	2018
Annual Objective	0	1
Annual Indicator	0	1
Numerator		
Denominator		
Data Source	FCHB	FCHB
Data Source Year	2017	2018
Provisional or Final ?	Final	Final

**Field Level Notes for Form 10 ESMs:**

None

**ESM 5.3 - Support county public health departments who have identified decreasing infant deaths due to unsafe sleep conditions as a priority need in their communities.**

Measure Status:					Active	
Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	80.0	83.0	87.0	90.0	93.0	93.0

**Field Level Notes for Form 10 ESMs:**

None

**ESM 7.1.2 - Disseminate Report Findings to Facilitate Targeted Injury-Prevention Activities by County Public Health Departments**

Measure Status:	Inactive - Completed	
State Provided Data		
	2017	2018
Annual Objective	0	100
Annual Indicator	0	100
Numerator	0	51
Denominator	51	51
Data Source	FCHB	FCHB
Data Source Year	2018	2018
Provisional or Final ?	Final	Final

**Field Level Notes for Form 10 ESMs:**

None

**ESM 7.1.3 - Support county public health departments who have identified decreasing preventable child injuries as a priority need in their communities.**

<b>Measure Status:</b>					<b>Active</b>	
<b>Annual Objectives</b>						
	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>
Annual Objective	80.0	83.0	87.0	90.0	93.0	93.0

**Field Level Notes for Form 10 ESMs:**

None

**ESM 10.2 - Adolescent Preventive Care Stakeholders Group - Foundational Partnership Building and Collaboration**

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

Annual Objectives						
	2019	2020	2021	2022	2023	2024
Annual Objective	1.0	0.0	0.0	0.0	0.0	0.0

**Field Level Notes for Form 10 ESMs:**

1.	<b>Field Name:</b>	<b>2018</b>
	<b>Column Name:</b>	<b>State Provided Data</b>

**Field Note:**

Work on this measure spans FFY18 and FFY19. The stakeholders meeting took place on October 30, 2018.

**ESM 10.3 - Optimal Health for Montana Youth - Evaluation Report**

<b>Measure Status:</b>				<b>Active</b>	
<b>Annual Objectives</b>					
	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>
Annual Objective	1.0	0.0	0.0	0.0	0.0

**Field Level Notes for Form 10 ESMs:**

---

1.	<b>Field Name:</b>	<b>2020</b>
	<b>Column Name:</b>	<b>Annual Objective</b>
	<b>Field Note:</b>	This is a one-year project.

---

**ESM 11.1 - Expansion of Parent Partner Services for CYSHCN**

<b>Measure Status:</b>					<b>Active</b>	
<b>Annual Objectives</b>						
	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>
Annual Objective	25.0	27.5	30.0	32.5	35.0	35.0

**Field Level Notes for Form 10 ESMs:**

None

**ESM 13.1.2 - Oral Health Pilot Project - Dissemination of Successful Processes and Lessons Learned**

<b>Measure Status:</b>		<b>Inactive - Completed</b>	
<b>State Provided Data</b>			
	<b>2017</b>	<b>2018</b>	
Annual Objective	0	1	
Annual Indicator	0	1	
Numerator			
Denominator			
Data Source	FCHB	FCHB	
Data Source Year	2018	2018	
Provisional or Final ?	Final	Final	

**Field Level Notes for Form 10 ESMs:**

None

**ESM 13.1.3 - Support county public health departments who have identified increasing dental care during pregnancy as a priority need in their communities.**

<b>Measure Status:</b>					<b>Active</b>	
<b>Annual Objectives</b>						
	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>2024</b>
Annual Objective	80.0	83.0	87.0	90.0	93.0	93.0

**Field Level Notes for Form 10 ESMs:**

None

**Form 10**  
**State Performance Measure (SPM) Detail Sheets**

**State: Montana**

**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 who choose SPM 1.**

**Population Domain(s) – Cross-Cutting/Systems Building**

<b>Measure Status:</b>	Active									
<b>Goal:</b>	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.									
<b>Definition:</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 25%;"><b>Numerator:</b></td> <td>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.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>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.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>		<b>Numerator:</b>	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.	<b>Denominator:</b>	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.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	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.									
<b>Denominator:</b>	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.									
<b>Unit Type:</b>	Percentage									
<b>Unit Number:</b>	100									
<b>Healthy People 2020 Objective:</b>	ECBP-10.1, ECBP-10.4, ECBP-10.6, ECBP-10.7, ECBP-10.8									
<b>Data Sources and Data Issues:</b>	MCHBG County Public Health Department Annual Data Reports									
<b>Significance:</b>	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 Health Improvement 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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	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.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></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><b>Denominator:</b></td> <td>Annual number of County Public Health Department MCH clients in counties choosing SPM 2</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Annual number of MCH clients referred to social services or provided health education by County Public Health Departments choosing SPM 2	<b>Denominator:</b>	Annual number of County Public Health Department MCH clients in counties choosing SPM 2	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Annual number of MCH clients referred to social services or provided health education by County Public Health Departments choosing SPM 2								
<b>Denominator:</b>	Annual number of County Public Health Department MCH clients in counties choosing SPM 2								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Healthy People 2020 Objective:</b>	NWS-12, SDOH-1, SDOH-3.2								
<b>Data Sources and Data Issues:</b>	MCHBG County Public Health Department Annual Data Reports								
<b>Significance:</b>	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.								

**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 5.2 - Infant Safe Sleep - Montana Specific Targeted Messaging and Education Campaign**  
**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**

<b>Measure Status:</b>	Inactive - Completed									
<b>Goal:</b>	Create a social marketing campaign with messages and education for the public, regarding proper safe sleep techniques and the main causes of sleep-related deaths for infants in Montana.									
<b>Definition:</b>	<table border="1" style="width: 100%;"> <tr> <td style="width: 30%;"><b>Numerator:</b></td> <td>One Social Marketing Campaign</td> </tr> <tr> <td><b>Denominator:</b></td> <td>One Social Marketing Campaign</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1</td> </tr> </table>		<b>Numerator:</b>	One Social Marketing Campaign	<b>Denominator:</b>	One Social Marketing Campaign	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1
<b>Numerator:</b>	One Social Marketing Campaign									
<b>Denominator:</b>	One Social Marketing Campaign									
<b>Unit Type:</b>	Count									
<b>Unit Number:</b>	1									
<b>Data Sources and Data Issues:</b>	Family & Community Health Bureau									
<b>Significance:</b>	Results of the 2015 Health Survey of Montana's Mothers and Babies indicate that only 28.6% of moms put their babies to sleep in a safe manner. Full analysis of the survey, along with data from the Child Death Review system for 2013-2015, will be used to create a targeted messaging and education campaign about proper safe sleep techniques and their importance.									

**ESM 5.3 - Support county public health departments who have identified decreasing infant deaths due to unsafe sleep conditions as a priority need in their communities.**

**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**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To support county public health departments who have identified decreasing infant deaths due to unsafe sleep conditions as a priority need in their communities.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Total number of counties choosing to use MCHBG funding for infant safe sleep education activities which have met their activity goals.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Total number of counties choosing to use MCHBG funding for infant safe sleep education activities.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Total number of counties choosing to use MCHBG funding for infant safe sleep education activities which have met their activity goals.	<b>Denominator:</b>	Total number of counties choosing to use MCHBG funding for infant safe sleep education activities.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Total number of counties choosing to use MCHBG funding for infant safe sleep education activities which have met their activity goals.								
<b>Denominator:</b>	Total number of counties choosing to use MCHBG funding for infant safe sleep education activities.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	FCHB - The number of counties choosing to use MCHBG funding in this way may change from year to year.								
<b>Significance:</b>	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.								

**ESM 7.1.2 - Disseminate Report Findings to Facilitate Targeted Injury-Prevention Activities by County Public Health Departments**

**NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9**

<b>Measure Status:</b>	Inactive - Completed	
<b>Goal:</b>	Distribute a report to CPHDs on the leading causes of child injury in Montana.	
<b>Definition:</b>	<b>Numerator:</b>	Number of CPHDs in Montana Participating in the MCHBG Which Receive Report
	<b>Denominator:</b>	Number of CPHDs in Montana Participating in the MCHBG
	<b>Unit Type:</b>	Percentage
	<b>Unit Number:</b>	100
<b>Data Sources and Data Issues:</b>	Family & Community Health Bureau	
<b>Significance:</b>	During FY 2017, the DPHHS Office of Epidemiology and Scientific Support is conducting an assessment of hospital discharge data for the time period of 2012-2014. The assessment is looking at inpatient admissions and emergency department encounters of children ages 0 through 19, with a primary diagnosis of unintentional or intentional injury. The purpose of ESM 7.1.2 is to use the information to help CPHDs implement targeted injury-prevention activities in FY 2018, to address the leading causes of injury in children across the state.	

**ESM 7.1.3 - Support county public health departments who have identified decreasing preventable child injuries as a priority need in their communities.**

**NPM 7.1 – Rate of hospitalization for non-fatal injury per 100,000 children, ages 0 through 9**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To support county public health departments who have identified decreasing preventable child injuries as a priority need in their communities.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Total number of counties choosing to use MCHBG funding for child injury prevention education activities, which have met their activity goals.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Total number of counties choosing to use MCHBG funding for child injury prevention education activities.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Total number of counties choosing to use MCHBG funding for child injury prevention education activities, which have met their activity goals.	<b>Denominator:</b>	Total number of counties choosing to use MCHBG funding for child injury prevention education activities.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Total number of counties choosing to use MCHBG funding for child injury prevention education activities, which have met their activity goals.								
<b>Denominator:</b>	Total number of counties choosing to use MCHBG funding for child injury prevention education activities.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	FCHB - The number of counties choosing to use MCHBG funding in this way may change from year to year.								
<b>Significance:</b>	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.								

**ESM 10.2 - Adolescent Preventive Care Stakeholders Group - Foundational Partnership Building and Collaboration**  
**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Create an effective foundational structure for the new adolescent preventive care stakeholders group. This framework will allow for efficient use of the member's time, and provide a mechanism for raising awareness on the importance of adolescent pre								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>One organization purpose and basic process guidelines document</td> </tr> <tr> <td><b>Denominator:</b></td> <td>One organization purpose and basic process guidelines document</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1</td> </tr> </table>	<b>Numerator:</b>	One organization purpose and basic process guidelines document	<b>Denominator:</b>	One organization purpose and basic process guidelines document	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1
<b>Numerator:</b>	One organization purpose and basic process guidelines document								
<b>Denominator:</b>	One organization purpose and basic process guidelines document								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1								
<b>Data Sources and Data Issues:</b>	Family & Community Health Bureau								
<b>Significance:</b>	During FY 2017, the FCHB is working 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. The 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.								

**ESM 10.3 - Optimal Health for Montana Youth - Evaluation Report**

**NPM 10 – Percent of adolescents, ages 12 through 17, with a preventive medical visit in the past year.**

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Development, completion, and dissemination of Optimal Health for Montana Youth Evaluation Report.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>One evaluation report.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>One evaluation report.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1</td> </tr> </table>	<b>Numerator:</b>	One evaluation report.	<b>Denominator:</b>	One evaluation report.	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1
<b>Numerator:</b>	One evaluation report.								
<b>Denominator:</b>	One evaluation report.								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1								
<b>Data Sources and Data Issues:</b>	Family & Community Health Bureau.								
<b>Significance:</b>	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.								

**ESM 11.1 - Expansion of Parent Partner Services for CYSHCN**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	Increase number of CYSHCN receiving services from a Parent Partner in FFY 2019 to 250, a percentage increase of approximately 25%.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Number of CYSHCN receiving services from a Parent Partner in FFY 2018.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Number of CYSHCN receiving services from a Parent Partner in FFY 2019.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Number of CYSHCN receiving services from a Parent Partner in FFY 2018.	<b>Denominator:</b>	Number of CYSHCN receiving services from a Parent Partner in FFY 2019.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Number of CYSHCN receiving services from a Parent Partner in FFY 2018.								
<b>Denominator:</b>	Number of CYSHCN receiving services from a Parent Partner in FFY 2019.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	Child Health Referral Information System (CHRIS) and Montana NSCH Data								
<b>Significance:</b>	The Montana Parent Partner Program will continue to expand in FFY 2019 & FFY 2020 with new sites and more partners. 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 13.1.2 - Oral Health Pilot Project - Dissemination of Successful Processes and Lessons Learned**  
**NPM 13.1 – Percent of women who had a preventive dental visit during pregnancy**

<b>Measure Status:</b>	Inactive - Completed								
<b>Goal:</b>	To produce a report from the oral health pilot project, which will help other facilities increase their rates of dental care to pregnant clients.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>One Pilot Project Results Report</td> </tr> <tr> <td><b>Denominator:</b></td> <td>One Pilot Project Results Report</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Count</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>1</td> </tr> </table>	<b>Numerator:</b>	One Pilot Project Results Report	<b>Denominator:</b>	One Pilot Project Results Report	<b>Unit Type:</b>	Count	<b>Unit Number:</b>	1
<b>Numerator:</b>	One Pilot Project Results Report								
<b>Denominator:</b>	One Pilot Project Results Report								
<b>Unit Type:</b>	Count								
<b>Unit Number:</b>	1								
<b>Data Sources and Data Issues:</b>	Family & Community Health Bureau								
<b>Significance:</b>	The FCHB has a pilot project in FY 2017 with the Flathead CPHD and CHC, to increase dental care for pregnant clients. Data collection and patient flow process procedures are being established, and quality improvement is ongoing. A successful processes and lessons learned report will be distributed to other co-located CPHD/CHCs in the state, to help increase the overall rate of pregnant clients receiving appropriate dental care at these facilities.								

**ESM 13.1.3 - Support county public health departments who have identified increasing dental care during pregnancy as a priority need in their communities.**

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

<b>Measure Status:</b>	Active								
<b>Goal:</b>	To support county public health departments who have identified increasing dental care during pregnancy as a priority need in their communities.								
<b>Definition:</b>	<table border="1"> <tr> <td><b>Numerator:</b></td> <td>Total number of counties choosing to use MCHBG funding for oral health education activities, which have met their activity goals.</td> </tr> <tr> <td><b>Denominator:</b></td> <td>Total number of counties choosing to use MCHBG funding for oral health education activities.</td> </tr> <tr> <td><b>Unit Type:</b></td> <td>Percentage</td> </tr> <tr> <td><b>Unit Number:</b></td> <td>100</td> </tr> </table>	<b>Numerator:</b>	Total number of counties choosing to use MCHBG funding for oral health education activities, which have met their activity goals.	<b>Denominator:</b>	Total number of counties choosing to use MCHBG funding for oral health education activities.	<b>Unit Type:</b>	Percentage	<b>Unit Number:</b>	100
<b>Numerator:</b>	Total number of counties choosing to use MCHBG funding for oral health education activities, which have met their activity goals.								
<b>Denominator:</b>	Total number of counties choosing to use MCHBG funding for oral health education activities.								
<b>Unit Type:</b>	Percentage								
<b>Unit Number:</b>	100								
<b>Data Sources and Data Issues:</b>	FCHB - The number of counties choosing to use MCHBG funding in this way may change from year to year.								
<b>Significance:</b>	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.								

**Form 11  
Other State Data**

**State: Montana**

The Form 11 data are available for review via the link below.

[Form 11 Data](#)