

Best Beginnings Advisory Council

Early Childhood
Needs Assessment
and Strategic Plan
2013



Healthy People. Healthy Communities.

Department of Public Health & Human Services



Department of Public Health and Human Services

Early Childhood Services Bureau ♦ P.O. Box 202925 ♦ Helena, MT 59620-2925 ♦ fax: 406-444-2547

Steve Bullock, Governor

Richard H. Opper, Director

March 25, 2013

Dear Stakeholders,

The following Early Childhood Needs Assessment Report and accompanying Early Childhood Strategic Plan provides a comprehensive overview of needs related to young children and their families. The Best Beginnings Advisory Council and local community councils have been tasked with conducting a Needs Assessment and developing a strategic plan, in accord with the Early Childhood State Advisory Council federal grant. The report was written with input from a variety of stakeholders and contributors. There are many people to thank for their contributions to the planning process as well as to the final report. We would like to acknowledge the work of Montana KIDS COUNT, Bloom Consulting, Karen L. Ray Associates, Community Council Needs Assessment, individual interviews and surveys, Debora Hansen, Sarah Corbally, Denise Higgins, and Jamie Palagi.

In some areas, the Needs Assessment provides considerations outside the scope of the Best Beginnings Advisory Council, but may provide a framework for further analysis and policy decisions for other entities such as the Governor's Office, the Department of Public Health and Human Services Administration, community agencies, private contractors, and local community councils. And, while comprehensive, the Needs Assessment is not inclusive of all needs or considerations affecting young children and their families.

It is expected that this document be used to inform recommendations and strategies to improve health, mental health, family support, and early childhood services for our youngest citizens. The needs are many and the opportunities are great. Work will continue for years on the comprehensive early childhood system. The Early Childhood Needs Assessment and Strategic Plan provides a common foundation in which early childhood and policy stakeholders can work together at the state and community level in addressing the needs of children and families.

My gratitude goes to the individuals who have contributed to the Needs Assessment, and have worked tirelessly to tell the early childhood story. Special recognition is given to the members of the Best Beginnings Advisory Council for their guidance and input in the development of the Early Childhood Needs Assessment and Strategic Plan.

Sincerely,

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Best Beginnings Advisory Council Strategic Plan

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Report to:
Montana Department of Public Health and Human Services

Early Childhood Services Bureau

Early Childhood Needs Assessment

February 1, 2013



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Executive Summary

The Best Beginnings Advisory Council's (also referred to as the Council) strategic goal is to ensure Montana has a comprehensive, coordinated, early childhood system that provides a governance structure and leads to strong collaboration in order to best meet the needs of Montana's youngest citizens. The Council is pursuing work within four objectives, which support the overall strategic goal:¹

1. Children have access to high quality early childhood programs.
2. Families with young children are supported in their community.
3. Children have access to a medical home and health insurance.
4. Social, emotional, and mental health needs of young children and families are supported.

Background

The Best Beginnings Advisory Council was established in 2011 through a grant from the Administration for Children and Families (ACF). The Best Beginnings Advisory Council was formed as an enhancement to the Montana Early Childhood Advisory Council (MECAC), which was established in 1996 to advise the State on Child Care and Development Fund (CCDF) activities, the Early Childhood Comprehensive Systems grant, the US Department of Agriculture Child and Adult Care Food Program (CACFP) and the Head Start State Collaboration grant. In moving from MECAC to the Best Beginnings Advisory Council, Montana expanded the scope of the Council's work to include a broader focus on systems impacting children and families. The Best Beginnings Advisory Council is intended to improve collaboration and coordination across the spectrum of governmental and non-profit organizations providing early childhood services.

The Best Beginnings Advisory Council grant requires the State to conduct a needs assessment to outline the needs of Montana's early childhood systems. This assessment should synthesize and augment information gathered in other agencies' and local Best Beginnings councils' needs assessments. Initial recommendations from this analysis are intended for the Council to use in subsequent strategic planning work.

¹ The 2010 ACF grant application defines the Council's strategic goal and supporting objectives. Department of Public Health and Human Services (DPHHS), Early Childhood Services Bureau (ECSB) leadership, wrote the grant application.



Purpose

The objective of this needs assessment is to create a holistic view of Montana's early childhood systems focused on early childhood programs/education, family/community support, physical/medical health, and social, emotional, and mental health. This assessment looks at the systems that exist, identifies areas in these systems where needs are not being met, and offers recommendations for consideration for next steps to be used as a baseline for strategic planning. Because the scope of the needs assessment is so broad, it can be considered an environmental scan, providing a picture of the child-serving systems landscape in Montana.

Strengths of Montana's Early Childhood Systems

The purpose of this assessment is to identify outstanding needs within early childhood systems. Although there is a lot of room for improvement in these systems, there is also a lot of good work occurring, such as:

- The Children's Mental Health Bureau (CMHB) in the Montana Department of Public Health and Human Services (DPHHS) is expanding the home and community based services (HCBS) 1915c psychiatric residential treatment facilities (PRTF) waiver to be a 1915i State Plan program for youth with serious emotional disturbance (SED), which will increase the availability of mental health services for youth statewide.
- DPHHS Early Childhood Services Bureau (ECSB) is piloting a quality rating improvement system (QRIS), STARS to Quality, to enhance the quality of child care and early childhood education.
- DPHHS Human Community Services Bureau (HCSB) Offices of Public Assistance (OPAs) are beginning to undergo a business process redesign/Service First initiative to connect families to health and human services benefits more efficiently.
- DPHHS Public Health and Safety Division, Family and Community Health Bureau is implementing evidence-based home visiting programs to provide services and supports to higher risk families.
- Organizations throughout the child-serving system are working to implement evidence-based practices.
- State leadership across departments, divisions, and organizations are increasing efforts to coordinate and collaborate.

The needs identified in this analysis and associated recommendations are intended to build upon the good work already being done in Montana. It was clear through interviews and surveys that there is a strong community of committed professionals



who care deeply about early childhood issues, and want to work to continually improve the systems.

Needs Identified

The assessment analyzes needs within the four objectives identified in the Best Beginnings Advisory Council grant: 1) family/community support; 2) social, emotional, and mental health; 3) access to health insurance and a medical home; and 4) early childhood programs/education. Through the analysis, common needs emerged across these focal areas. The three most prominent were:

- The need for **increased coordination and collaboration** across and within early childhood systems.
- The need for **improved access** to help families and children receive the services and supports they need to be stable and successful.
- The need for **increased outreach and education** to help families, communities, and political leaders understand the importance of early childhood/family issues in addition to supporting access, usage, and improved outcomes.

The **need for increased coordination and collaboration** figured prominently in this assessment. There are a large number of stakeholders and systems working in Montana's early childhood landscape. Many of these systems are self-contained and do not work collaboratively with others. Collaboration and coordination is often lacking within a single system. Examples of insufficient collaboration and coordination abound throughout this analysis. For instance:

- Stakeholders from the Department of Commerce, Housing Division, Juvenile Justice, or Labor and Industry are not active members of the Best Beginnings Advisory Council.
- Families need to complete separate eligibility processes to access food, child care, and heating assistance.
- Families/children may need to complete multiple screenings and assessments to connect to mental health, medical health, and parent education services. There is no standard tool or approach used. Data is generally not shared between organizations. Families often receive conflicting advice from different providers.
- Head Start and non-Head Start child care providers generally do not share professional development/training opportunities.
- Child care providers, particularly unlicensed and unregistered providers, often do not know how to refer a child for mental health screening or services.
- Child Find activities for IDEA Parts C and B are often conducted separately from each other.
- Tribal and non-Tribal organizations do not regularly share data or communicate about early childhood system needs.



The reasons for these disconnects may be related to restrictive funding structures, a lack of trust, limited communication, or organizational inertia. The causes of poor coordination should be actively analyzed and worked on because the fragmentation of systems and services negatively impacts families and children.

Another prominent theme is **access**. Families struggle to access services and supports, including parent education, community support, mental health, health insurance, medical homes, and quality child care. Often a contributing cause to access problems is the lack of coordination across systems. Other access barriers identified throughout the report include affordability, complex policies and procedures, and limited provider supply.

An additional common thread across problems in the four focus areas is the **need for increased education** about and understanding of the issues of early childhood systems. There is a need for more education and understanding about:

- The gravity of the housing problems impacting families.
- The importance of mental health services.
- How to access services through the disjointed system of programs.
- The importance of quality child care/education.

The table below outlines the needs or problems identified across systems as well as within each of the four focus areas of this assessment – community support; social, emotional, and mental health; access to medical insurance or medical home; and early childhood programs/education.

Table 1: Needs Identified in Montana’s Early Childhood Systems

High-Level/Cross-System
<ol style="list-style-type: none">1. Limited coordination and collaboration across and within early childhood systems.2. Access challenges for families and children receive the services and supports they need to be stable and successful.3. Limited outreach and education to help families, communities, and political leaders understand the importance of early childhood/family.
Family/Community Support
<ol style="list-style-type: none">1. Housing less affordable, insufficient housing supports, increasing homelessness – Rents have been rising over the course of the recession. This coupled with wage inequality in eastern Montana and high unemployment in western Montana have made it hard for families to access affordable housing. Housing support programs, such as vouchers, are challenging to access with the demand for them far outstripping supply. As a result homelessness has increased.2. Transportation challenges and recreational access – Families living in rural or unincorporated areas outside of larger towns need to spend more of their income



on transportation to work, child care, and other activities. Many of these areas have limited access to cultural or recreational services for children and families.

3. **Rising food insecurity** – Despite high levels of participation in the Supplemental Nutrition Assistance Program (SNAP), Montana Child and Adult Care Food Program (CACFP), and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), many families are food insecure in Montana. An increasing number of families are visiting Food Banks for emergency services.
4. **Difficult to access human services** – Montana does not have a one-stop shop/no wrong door approach for health and human services benefits.² Families must navigate a confusing menagerie of programs and application processes to connect to the spectrum of benefits for which they may be eligible. Data is not widely shared between programs/agencies, creating inefficiencies for families and the State.
5. **Insufficient parent education** – There is a lot of work being done through a wide variety of organizations and programs to increase education and interventions with at risk parents. Coordination between programs is limited, causing problems and creating confusion for families. Local communities are addressing these issues through infrastructure development work under Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants, however more work remains to be done.
6. **Increasing number of children and youth in foster care** – The number of children in custody of the State grew between 2008 and 2012. This rise in incidents of abuse and neglect may be related to families not receiving the supports they need in their community, particularly in difficult economic times.

Social, Emotional, Mental Health

1. **Scope of issues not well understood** – A lack of understanding regarding social, emotional, and mental health issues means that there may not be sufficient investment on the part of policy makers, communities, and families in supporting healthy social and emotional development or preventing, identifying, and treating mental illness. Many children and adults with mental health needs are not receiving services timely to overcome mental disorders.
 2. **Challenging to access services** – There are several roadblocks to accessing social, emotional, and mental health services. Screening and assessment processes are not well coordinated across child serving systems. Prevention services are not serving the full population of children who would benefit from them. Private insurance does not always adequately cover mental health needs, and providers often do not accept private or public insurance. Child care providers often cannot meet children's special needs in the classroom, and the special needs subsidy system is not providing additional support to enough child care providers. Montana has a severe healthcare provider shortage for mental health providers, particularly for those specializing in
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² One-stop shop and no wrong door approaches provide integrated access to health and human service benefits, allowing families to apply for and maintain benefits to multiple programs through one interaction. States are implementing these approaches to eliminate program siloes and improve customer service.



the treatment of children and youth. Children with dual diagnoses often have the most trouble accessing qualified providers, meaning they sometimes have to travel far from home to receive care.

3. **Insufficient crisis and sub-crisis services** – Montana has very limited resources to support children in need of short-term crisis services. The State has few respite options and no shelter system to diffuse challenging family situations. Many children are sent to psychiatric residential treatment facilities (PRTFs) or therapeutic foster care group homes because there are no other options. Working with children outside of their community and family structures is less effective in creating long term change, and costly for the State.
4. **Limited evidence-based/outcomes-focused approaches** – Providers of mental health services often do not use effective, evidence-based, outcomes-focused practices. The service delivery system is missing key pieces of a supportive infrastructure such as provider training and retention, adequate reimbursement, strong information technology supports, and family involvement in policy, resulting in poor provider capacity and competency.³ Work being done to implement evidence-based practices is not well coordinated across the State.
5. **Medication monitoring needed** – Child and Family Services Division (CFSD) implemented a medication monitoring program for foster children to lessen problems associated with overprescribing psychotropic medications and polypharmacy. Other children and youth receiving mental health services may benefit from this service.

Connection to Medical Insurance or Medical Home

1. **Adults struggle to access insurance** – Montana has done a good job of insuring kids through the Healthy Montana Kids (HMK) outreach. However, many parents, often employed, are not able to obtain insurance, which may create financial instability for families. Families with insurance are often underinsured, and find it difficult to pay medical bills.
2. **Insufficient number of health care providers** – Montana has a shortage of primary care providers and dentists, which is particularly acute in rural areas. Many providers do not accept Medicaid or HMK because of low reimbursement rates.
3. **More children could benefit from medical homes** – Many children with special health care needs do not have access to a medical home, which may negatively impact the timeliness, coordination, and effectiveness of services they receive.

Early Childhood Programs/Education

1. **Higher quality standards needed for child care facilities** – Montana child care and education programs have inconsistent levels of quality. Licensing standards are very low and do not support quality work being done through the STARS to Quality program. Over half of Montana’s children receive care in settings unlicensed and
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³ Shannon Stagman, Janice Cooper, National Center for Children in Poverty, “Children’s Mental Health: What Every Policymaker Should Know”, April 2010.



unregulated by the State. Regulated/licensed facilities receive only minimal oversight through inspections, which may occur every three years or less often.

2. **Insufficient number of child care providers** – Families struggle to find care for infants, children with special needs, evenings, early mornings, weekends, over the summer, and for respite purposes.
 3. **Child care is expensive** – Many families find it difficult to afford child care. Financial support through Head Start, Early Head Start, and Best Beginnings child care subsidies is only available to families with very low incomes. Families earning more than 150 percent of the 2009 federal poverty level have no financial support available. Montana is one of only a few states without a publicly funded universal pre-kindergarten program to help families' access affordable, quality care options.
 4. **Best Beginnings subsidies are challenging to access and do not support stability of care** – The eligibility determination process for child care subsidies is separate from other work support programs with limited data sharing. Families must complete a 46-page application and submit a large number of verifications, which are sometimes challenging to obtain. Program policies and processes can create instability for children's care, which negatively impacts parents' abilities to maintain stable employment. Montana's 26 percent child care subsidy churn rate indicates that this is a problem.
 5. **Best Beginnings reimbursement rates are too low** – Child care providers only receive 75 percent of the 2009 market rate study figures as reimbursement for care of children receiving subsidies. This amount is too low to cover the costs associated with providing quality care.
 6. **Child Care Resource and Referral Agencies are asked to do a multitude of tasks and struggle to meet State expectations and requirements** – The federated system of child care resource and referral agencies creates inconsistency in policy interpretation and business processes for eligibility determination. This has contributed to the 11.2 percent error rate. The classroom-based training model primarily used by resource and referral agencies is not effective in ensuring evidence-based practices are implemented to fidelity. The State should support mentoring or coaching models to better train child care providers.
 7. **Child care provider training requirements are low** – Montana implemented its current requirement that child care providers receive a minimum of eight hours of annual training within the last decade. The State provides incentives for providers to participate in additional training, and the STARS to Quality initiative's higher reimbursement rates will hopefully increase the number of providers with higher levels of training. Providers, particularly in large centers with high amounts of turnover, must invest significantly in maintaining training standards across all staff members.
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Recommendations

The Best Beginnings State Advisory Council will determine next steps in addressing the issues outlined in this assessment. The recommendations included in this section are actions or approaches to consider in subsequent strategic planning. There are high-level recommendations that span the four areas of analysis in this assessment, in addition to recommendations within the four focal areas.

Table 2: Recommendations for Montana’s Early Childhood Systems and Best Beginnings State Advisory Council

High-Level/Cross-System
<ol style="list-style-type: none">1. Move Best Beginnings State Advisory Council to Governor’s office – the current structure within DPHHS is not inclusive of the full child-serving system. Missing from the council is the Department of Commerce, Housing Division, Department of Transportation, Department of Labor, and Department of Justice. Elevating the council to the Governor’s office would help get all of the relevant stakeholders to the table.2. Use data to define the work of the council – the Best Beginnings State Advisory Council should collect and use data, such as the Adverse Childhood Experiences data, to drive its work. Objective measures will allow the council to define priorities and determine the impact of services and interventions.3. Require use of evidence-based or outcomes-focused practices and pay for improved outcomes rather than services delivered. This may require increased collaboration of multi-disciplinary teams to best meet the needs of children and families. This shift may impact the way government does business at the State level.4. Coordinate work across agencies and organizations – the State should further coordinate services and their delivery to reduce duplication of efforts between agencies and organizations. Consider using electronic medical records or other information technology to support information exchange between providers.5. Increase data sharing and coordination with Tribal entities – the State needs to continue to work with Tribal entities to increase collaboration, which could support improved services and outcomes for Native American children and families. The State should meet with Tribal entities to determine how to effectively coordinate beyond extending meeting invitations.6. Coordinate with and support local Best Beginnings Councils – there is a lot of good work being done at the local level. The State needs to develop and implement a communication plan, which should include a focus on the relationship between the State and local councils. The State should work with local councils to determine how work will be sustained after the grant funding is gone.
Family/Community Support
<ol style="list-style-type: none">1. Educate local, State, and Federal officials about housing’s crucial role in supporting stable environments for children and families.2. Implement prevention and crisis services to support homeless populations and



individuals/families at risk of homelessness.

3. **Family support providers should implement a cohesive, data driven approach** to increase effectiveness of interventions, limit duplication of effort, and decrease home visiting/parent education fatigue on the part of families.
4. **Continue coordination work at local levels** to ensure organizations are aware of work being done to meet other needs in their communities. Consider analyzing and piloting no wrong door/one-stop shop approaches.
5. **Focus on Service First work in OPAs** to reduce access barriers caused by policy, process, information technology, and organizational problems.

Social, Emotional, Mental Health

1. Continue to work to **reduce stigma of mental illness and increase awareness of social, emotional, mental, and behavioral needs**, possibly through an education and outreach campaign.
2. **Train child care providers to understand and address social, emotional, mental, and behavioral health issues.** Ensure providers know how to refer children for screenings.
3. **Create and implement common screening/assessment infrastructure** for families seeking social, emotional, mental, or behavioral health services. Consider implementing no-wrong door/one-stop shop approach to help families and other referral sources, e.g. child care providers, successfully navigate the system and make referrals across systems.
4. **Increase supply of mental health providers** – work collaboratively with other stakeholder organizations to actively recruit mental health professionals, particularly in rural areas, to increase supply of providers. Analyze reimbursement rates to determine impact of an increase.
5. **Increase prevention and crisis service availability** to keep children in their communities rather than moving them to out-of-home placements.
6. **Promote integration of behavioral and primary care** to support increased service availability, allowing families to receive services in the communities.

Connection to Medical Insurance or Medical Home

1. **Coordinate policies of work support programs to align with ACA Medicaid requirements.** Try to work to coordinate beyond the OPA realm to support no-wrong-door/one-stop shop approach for easier navigation.
 2. **Recruit more providers to Montana** – the State should work collaboratively to address the provider shortage. The approach may include implementing residency programs or other educational experiences in coordination with national health education institutions to attract medical/dental/mental health providers to underserved areas.
 3. **Analyze reimbursement rate structures** and determine impact of increases. Discuss lessons learned with states with similar demographics, such as Wyoming and North Dakota.
 4. **Analyze medical home efforts** within DPHHS to determine how to increase the
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number of children using medical homes, particularly for children with special needs.

Early Childhood Programs/Education

1. **Educate community about quality child care** – help families learn to identify quality. Educate everyone about the importance of quality early childhood education.
 2. **Increase licensing standards** to better protect health and safety of children and better coordinate with quality initiatives of ECSB.
 3. **Increase access to educational supports for families** for low-income children such as increasing the income cap for Best Beginnings subsidies, expanding Head Start/Early Head Start programs, or implementing universal pre-kindergarten.
 4. **Streamline Best Beginnings application process** and coordinate policy with other work support programs.
 5. **Implement more flexible eligibility policies** to support continuity of care for children and stability for families.
 6. **Improve relationships with providers** –
 - a. Increase reimbursement rate for CCDF subsidies.
 - b. Create method for providers to check on eligibility status of children receiving Best Beginnings scholarships.
 - c. Consider methods of better matching provider subsidy billing and payment with private paying practices.
 7. **Rethink role of resource and referral agencies** – consider removing eligibility work from their contracts and implement more effective approaches to training and resource and referral work.
 8. **Increase professional development opportunities** – continue to work toward implementing more comprehensive training. Increase cross-sector training opportunities for early childhood educators. Increase availability of intermediate and advanced training options. Rethink training model to support increased individualized training and mentoring.
 9. **Expand capacity of Best Beginnings STARS to Quality program** to serve more child care programs, expanding improved training and quality standards along with increased financial incentives.
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Methodology

This needs assessment was developed with secondary and primary source data, using the approach outlined in the table below. KIDS COUNT completed preliminary analysis, laying the groundwork for this assessment.

Table 3: Project Approach

Conduct kick off meeting	The author met with Early Childhood Services Bureau (ECSB) leadership to discuss the project scope and objectives.
Conduct key informant interviews	The author conducted key informant interviews with 47 stakeholders in DPHHS, the Office of Public Instruction (OPI), and other organizations associated with the early childhood objectives. Interviewees discussed the child serving systems, what is working well within the systems, outstanding needs, and the reason for these gaps. Insights from interviewees are included throughout the analysis. The interview protocol is included in Appendix B. Appendix C contains the list of interviewees.
Conduct survey	A survey was used to collect information on the early childhood system from the 23 local community Best Beginnings Councils coordinators and members. We received 144 responses from individuals representing organizations in each of the four early childhood focus areas. Analysis of results is included throughout the assessment, and the survey tool is included in Appendix A.
Examine administrative data	DPHHS, OPI, and other organizations provided administrative data to understand issues impacting the four early childhood focal areas. Data included information related to program caseloads, application processing, and participation rates.
Analyze local level needs assessments	Montana’s local community Best Beginnings Councils conducted local needs assessments. All of these communities used the Zero to Three Home Visiting Community Planning Tool to survey home visiting activities within the community. Counties also used the Community Collaboration Assessment Survey Tool to identify strengths and weaknesses of collaboration between local organizations. Eighteen of the 23 total were complete in advance of this statewide needs assessment.
Review secondary source data and literature	Secondary data sources included a multitude of background information from Federal and State government agencies as well as research organizations containing data on early childhood and family-related topics. A full list of these sources is included in Appendix D.
Review industry	The author reviewed and incorporated information from similar



knowledge	projects conducted in Montana and nationally to assist in the analysis of issues and trends.
Define needs in early childhood systems	The author examined the data gathered through all of the previous steps to identify where opportunities for improvement exist. These needs are defined in terms of the gap between how systems currently operate and the vision for the early childhood systems.
Develop recommendations for improvement	The author created recommendations addressing identified gaps or needs based on data gathered through research and industry knowledge. These recommendations were validated and refined with ECSB leadership.

The analysis is structured around the four objectives of the Best Beginnings State Advisory Council. The order in which they are discussed in the report represents their priority in terms of meeting human needs as defined by Maslow's Hierarchy.

1. Families with young children are supported in their community.
2. Social, emotional, and mental health needs of young children and families are supported.
3. Children have access to a medical home and health insurance.
4. Children have access to high quality early childhood programs.

This prioritization is somewhat subjective since the objectives are broad and may be argued to fit within various levels of the hierarchy. Many of the needs included in the family/community support area are related to meeting a family's basic physiological needs, such as housing and food. Because mental health is so intertwined with an individual's ability to retain employment, it can also be considered as a physiological need. Access to medical services can be argued to increase a family's safety in terms of creating increased financial stability. Family support, in terms of parent education, also falls within the belonging level. And early childhood programs generally fall within the self-esteem level because its association with achievement.



Figure 1: Maslow's Hierarchy of Needs



Issues, Assumptions, and Constraints

The following issues, assumptions and constraints formed the context for this analysis:

- **Short timeframe and limited participation** – Work completed on the final phase of this needs assessment, including all primary data collection, occurred in December 2012. This short timeframe created schedule problems limiting participation by some organizations and stakeholders. In particular, the author did not speak with representatives from the Department of Justice/Juvenile Justice, Department of Labor and Industry, or the Department of Commerce, Housing Division. Health and mental health providers participated in the survey, but the author did not speak with any providers directly for this analysis. Additionally, there was limited participation by Tribal representatives. The author interviewed a Native American early childhood educator, and other Tribal representatives responded to the survey.
- **Limited data** – In general, there was limited data available to support the needs assessment analysis. Data used in the analysis comes from disparate sources, and is generally not coordinated across issue-areas in the various early childhood systems. The lack of data made it challenging to objectively prioritize problems and recommendations.
- **Large scope with high degree of complexity** – It is an ambitious task to define the problems afflicting the statewide spectrum of child serving systems in a usable format. This analysis could be a much longer and more comprehensive, but possibly at the expense of readability and utility.



- **Focus on birth through five years old** – The majority of the analysis is focused on children birth through five years old. There is a focus on families as well, but to a lesser extent. There is minimal discussion of school age children. The author defined the focus age group narrowly to keep the report manageable and meaningful for readers.



Best Beginnings and Montana's Early Childhood Systems

The Best Beginnings Advisory Council has an expanded scope from its predecessor, the Montana Early Childhood Advisory Council (MECAC). Rather than primarily focusing on early childhood education issues, the council strives to look at children and families holistically.

The Best Beginnings Advisory Council falls under the purview of the Early Childhood Services Bureau (ECSB). ECSB provides leadership and oversight of early childhood initiatives in the State and serves as a partner in other larger early childhood systemic work such as:⁴

- Full-time kindergarten through the State Department of Education (Office of Public Instruction (OPI)).
- Public Health Home Visiting work through the Family and Community Health Bureau.
- The Systems of Care Grant through the Children's Mental Health Bureau (CMHB).

Other stakeholder collaborative councils or work groups working in Montana's early childhood systems include:⁵

- The Early Childhood Partnership for Professional Development, through OPI focused on enhancing the professional competencies of individuals who provide quality care and education for young children and families.
- Family Support Services Advisory Council focused on disability services for children 0-3 (Part C of the Individuals with Disabilities Education Act (IDEA)).
- The Early Care and Education Career Development Advisory Council, which provides guidance to the Early Childhood Project at Montana State University.

The chart on the following page includes the organizations collaborating within the Best Beginnings State Advisory Council.

⁴ DPHHS, ECSB, "Best Beginnings State Advisory Council Proposal to ACF", July 2010.

⁵ Ibid.



Figure 2: Best Beginnings Advisory Council Component Organizations



All of these organizations and initiatives work on components of Montana's early childhood systems and are connected through the Best Beginnings Advisory Council. Complimenting the work being done at the State level, are local Best Beginnings councils. There are 23 local councils statewide. The local councils are working to increase coordination across child serving systems at the grass roots level in towns, counties, and regions.



Montana’s Demographics

Montana has just fewer than one million residents. The US Census Bureau estimates that Montana’s 2011 population was 998,199. Of this population, approximately 62,000 (6.2 percent) are children age birth to five years old. Montana’s median household income for 2007 through 2011 was \$45,324, which is about \$7,500 or 14 percent lower than the US median income.⁶ In 2011, 148,183 or 15.2 percent of Montanans lived in poverty. Twenty-four percent of children from birth to five years old are included in this number,⁷ and 42 percent are considered low income, defined as twice the federal poverty limit.⁸

Table 4: Montana Poverty Rates 2007-2011 (100%FPL)⁹

	2011	2010	2009	2008	2007
All Montanans in poverty	148,183 15.2%	146,257 15.2%	142,257 15.0%	132,971 14.1%	131,433 14.1%
Montana children 0-5 in poverty	14,704 24.1%	15,720 25.7%	15,620 25.5%	13,678 22.8%	13,336 23.0%

Employment and wages are strong indicators of poverty. Montana had a 5.8 percent unemployment rate in November 2012, considerably lower than national rate of 7.7 percent.¹⁰ There is significant regional variation in the unemployment rate, with higher rates generally in the western part of the State. Big Horn, Glacier, Granite, Lincoln, and Sanders Counties all have unemployment rates of ten to 13 percent.¹¹ Montana’s Indian reservations self-reported unemployment rates are much higher than the rest of the State, ranging from 20 to 85 percent.¹²

⁶ US Census Bureau, “State and County Quick Facts, 2012”, <http://quickfacts.census.gov/qfd/states/30000.html>.

⁷ US Census Bureau, “Small Area Income and Poverty Estimates, 2011”, <http://www.census.gov/did/www/saipe/data/interactive/#>.

⁸ National Center for Children in Poverty, “Montana Family Economic Security Profile”, 2012.

⁹ US Census Bureau, “Small Area Income and Poverty Estimates, 2011”, <http://www.census.gov/did/www/saipe/data/interactive/#>.

¹⁰ Montana Department of Labor and Industry, Labor Market Information, Research and Analysis Bureau, <http://www.ourfactyourfuture.mt.gov/cgi/databrowsing/?PAGEID=4>.

¹¹ Montana Department of Labor and Industry, Labor Market Information, Research and Analysis Bureau, “November 2012 County Labor Force Statistics”, <http://www.ourfactyourfuture.org/cgi/databrowsing/?PAGEID=4&SUBID=205>.

¹² Montana Department of Commerce, Board of Housing, “White Paper, Housing in Montana, Housing Coordinating Team”, June 2012. Data from HUD Native American Housing Assistance and Self Determination Act (NAHASDA) 2012 reports.



There are a large number of families who fall into the gap between poverty and financial stability. Although the median income for Montanans was \$45,324, the average wage in 2010 was \$34,610.¹³ Families earning an average wage in the State are not considered low income, but often may struggle to get by. These families who make up the working poor are often referred to as “gap” families. Many of the working poor earn too much to qualify for health and human services programs, but too little to be able to afford to meet housing, food, healthcare, and child care needs.

Another distinction within low income families is that some are poor as a result of shorter term situations, such as the recession or temporary unemployment, and other families struggle with generational poverty, which is defined as being in poverty for two generations or longer.¹⁴ Families experiencing generational poverty may face additional barriers in accessing needed services and supports because of fewer available resources.

Report Organization

The remainder of this report is organized around the four objective areas of the council. There is a large amount of overlap between issues discussed in each of these focal areas. The placement of some issues is subjective because of this. For example, home visiting programs are used for multiple objectives, and can be thought of as a tool to promote early childhood education, family support, medical health, or mental health. This assessment includes home visiting within the family support section, but could have easily included it elsewhere.

Community outreach/education and professional development issues are included within the four focus areas, rather than as their own sections. The need to increase public awareness is a consistent theme throughout this report. Professional development concerns are closely tied with the need to implement increased evidenced-based and outcomes-focused practices across early childhood systems.

¹³ Montana Department of Labor and Industry, Labor Market Information, Research and Analysis Bureau, “Montana Quarterly Census Employment and Wages, 2010 Annual Average”, <http://www.ourfactsyourfuture.org/cgi/databrowsing/?PAGEID=4&SUBID=228>.

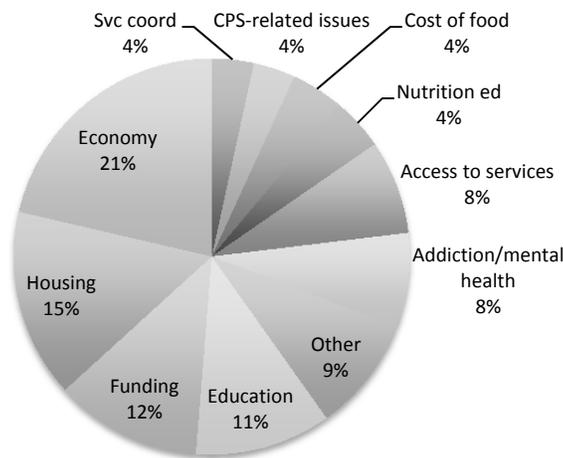
¹⁴ Ruby Payne, *A Framework for Understanding Poverty, fourth revised edition*, 2005, aha! Process, Inc.



Family/community support

Montana families struggling to meet their basic needs, such as housing, transportation, and food, are not necessarily able to focus on other issues like quality early childhood education or supporting early intervention for children’s developmental delays. Having great services available for children’s and families’ educational, developmental, and health needs will not make a difference for a family struggling to get by. The largest percentage of survey respondents, when asked about the root causes of family support needs, pointed to economic issues – lower wages, the impact of the oil boom in eastern Montana, high unemployment in the western part of the State, high rent costs, high food prices, and limited funding for services. Mental health and addiction were also commonly cited. We will address those issues in a standalone section, despite the strong interconnection between substance abuse/mental illness and a parent’s ability to retain employment and economic stability.

Figure 3: Root Causes of Family/Community Support Needs



This section looks at what supports communities provide families and children. Specifically, it analyzes housing, transportation, food, recreation, human services, child abuse and neglect prevention, and parent education needs. The previous section outlined the economic landscape undergirding these issues. Montana, like the rest of the nation, has been trying to meet increased needs with fewer resources over the course of the recession and its slow recovery.



Housing

Families struggle to afford housing in Montana. The recession lowered home purchase prices, while also reducing income. At the same time, rent costs rose. By 2010, the percentage of homeowners fell and the percentage of renter households paying more in rent than they could afford was almost 40 percent.¹⁵ The housing crisis is acute in eastern Montana because of the Bakken oil field. Rents have increased significantly, and incomes in non-oil sector jobs have not kept up with rising costs. The oil boom is squeezing Billings housing supply as families move there to access city services. Higher unemployment in the western part of the state and on reservations means families struggle to pay for housing in these regions as well.¹⁶

Homelessness

Homelessness is a growing problem in the State. The January 2011 homeless survey, which is a point in time count, identified 1,768 homeless individuals in the State.¹⁷ Montana's homelessness rate increased by 48 percent between 2009 and 2011. Within this figure, there has been a 52 percent increase in homelessness of families.¹⁸ The 2012 survey shows another four percent increase in the overall homelessness rate to 1,842 individuals. Point in time count methodologies vary, and do not necessarily provide an accurate picture of homelessness. These figures most likely underestimate the scale of the problem in Montana.

Table 5: Homelessness in Montana 2009 – 2011¹⁹

	2011	2009	Change
Overall homeless population	1,768	1,196	+47.83%
Chronically homeless	203	160	+26.88%
Homeless people in families	674	444	+51.80%
Unsheltered homeless	552	363	+52.07%
Homelessness among veterans	251	206	+21.84%

There are a number of groups who are at high risk of homelessness. Many families throughout the State live with family members, neighbors, and friends because they cannot afford their own housing. This is called the “doubled up” population. Nationally,

¹⁵ Housing affordability is defined as consuming no more than 30% of a family's income.

¹⁶ Montana Department of Commerce, Board of Housing, “White Paper, Housing in Montana, Housing Coordinating Team”, June 2012.

¹⁷ Ibid.

¹⁸ National Alliance to End Homelessness and Homelessness Research Institute, “The State of Homelessness in America”, 2012.

¹⁹ Ibid.



the rate of “doubled up” families has increased by 50 percent from 2005 to 2010.²⁰ Montana does not have data showing the scale of this issue, but empirically through interviews it appears this phenomenon is increasing in eastern and western parts of the State. Individuals released from prison, foster children aging out of care, and individuals without health insurance are also at a higher risk of homelessness.²¹

Financial Assistance with Housing

People who do not have sufficient financial resources to obtain or maintain housing often become homeless.²² The Department of Commerce, Housing Division, runs a variety of programs to help low income Montanans afford housing. However, long waiting lists is the norm for subsidized housing of all types.

In one of these programs, The US Department of Housing and Urban Development (HUD) funds Housing Choice vouchers, which provide rental assistance to very low-income families in the State.²³ The Housing Choice Voucher program currently has almost 9,000 households on the waiting list for approximately 3,600 vouchers throughout the State – requiring a wait of 24 months or more in some locations. The number of vouchers has declined in recent years as the price of rent has increased and the HUD funding has remained constant.²⁴ The table below shows number of Housing Choice vouchers available and the number of families on waitlists by region. The waitlists demonstrate an unmet need for affordable housing statewide, which appears especially acute in more populated areas.

Table 6: 2012 Housing Choice Vouchers and Waitlist²⁵

Contract Agency	Counties Covered	Vouchers Available	Families on Waitlist
Community Action Partnership of NW Montana	Flathead Lake, Lincoln, Sanders	370	1,040
District 11 HRDC	Mineral, Missoula, Ravalli	390	1,176
District 12 HRDC	Beaverhead, Deer Lodge, Granite, Madison, Powell, Silver Bow	325	398
District 14 HRDC	Blaine, Hill, Liberty	280	312
District 6 HRDC	Fergus, Golden Valley, Judith	110	56

²⁰ Ibid.

²¹ Ibid.

²² Ibid.

²³ Very low income is defined as 50% or less of the HUD median income for the county in which the family resides. HUD establishes these figures annually.

²⁴ Montana Department of Commerce, “Board of Housing, White Paper, Housing in Montana, Housing Coordinating Team”, June 2012.

²⁵ Department of Commerce, “Housing Program Descriptions”, 2012.



Contract Agency	Counties Covered	Vouchers Available	Families on Waitlist
	Basin, Musselshell, Petroleum, Wheatland		
District 7 HRDC	Big Horn, Carbon, Stillwater, Sweet Grass, Yellowstone	215	512
District 9 HRDC	Gallatin, Meagher, Park	400	1,120
Helena Housing Authority	Broadwater, Jefferson, Lewis and Clark	225	972
Opportunities Incorporated	Cascade, Choteau, Glacier, Pondera, Teton, Toole	475	1,401
Action for Eastern Montana	Carter, Custer, Daniels, Dawson, Fallon, Garfield, McCone, Phillips, Powder River, Prairie, Richland, Roosevelt, Rosebud, Sheridan, Treasure, Valley, Wibaux	330	256
Billings Housing Authority	Billings	475	1,719
Total	All	3,595	8,962

Other programs subsidizing housing costs for low income Montanans are also reducing in size. The end result is a large gap in the amount of affordable housing and housing subsidies for the population needing assistance. Affordable housing advocates have been working to increase the supply of affordable housing and housing supports, but have made limited progress at the State and local levels.

Transportation and Recreational/Cultural Opportunities

With rising housing costs, a large number of families have moved into unincorporated areas outside of city boundaries or to neighboring towns. Many other families live in rural or frontier regions of the state, with large distances between neighboring towns. These families often pay more in terms of transportation to travel to work, attend school or child care, shop, visit doctors, and participate in other activities. Outlying and rural areas generally have limited services such as public transportation, accessible parks or trails, and activities for children. In 2007, only 42 percent of Montana’s children lived in a neighborhood with sidewalks, a library, recreation center, and parks.²⁶ These issues exact a toll on families’ finances and social-emotional well-being.

²⁶ Family and Community Health Bureau, Public Health and Safety Division, DPHHS, “2010 Montana Maternal and Child Health Needs Assessment”, July 2010.



Transportation challenges also contribute to food insecurity. Thirty-one of Montana’s 56 counties are considered food deserts. More than 54,000 people live in these areas with limited access to grocery stores, making it challenging to access nutritious food.²⁷

Food Insecurity

Many Montana families are food insecure. Approximately one in seven Montanans struggle with hunger, including almost 46,000 children.²⁸ Hunger negatively impacts physical health, reduces children’s ability to learn, and is linked to childhood obesity.

There are many programs and organizations with the mission of connecting people to nutritious food. The largest of these is the Supplemental Nutrition Assistance Program (SNAP). The number of Montana households receiving SNAP benefits has increased by almost 70 percent over the course of the recession. Approximately 127,000 individuals or 59,000 households, which equates to 13 percent of Montanans, received SNAP benefits in SFY2012.²⁹

Some households eligible for SNAP benefits do not receive them. In 2009, the most recent year for which participation data is available, 76 percent of all eligible households and 79 percent of working poor households participated in Montana’s SNAP program. This is much higher than the national averages of 72 percent and 60 percent for the respective populations.

Table 7: Montana SNAP Recipients and Participation Rates^{30 31}

	2012	2011	2010	2009	2008	2007
SNAP Clients	126,547	122,410	109,330	87,241	80,114	80,324
SNAP Households	58,918	56,045	48,971	38,605	35,210	34,954
% All Eligible Participating	NA	NA	NA	76%	81%	79%
% Working Poor Participating	NA	NA	NA	79%	82%	85%

²⁷ Montana Food Bank Network, <http://mfbn.org/learn/hunger-in-montana>.

²⁸ Ibid.

²⁹ DPHHS, Fiscal Year End 2012, Statistical Report.

³⁰ DPHHS, Fiscal Year End 2012, 2011, 2010, 2009, 2008, and 2007 Statistical Reports. Figures show monthly average for each state fiscal year.

³¹ Mathematica Policy Research, Karen Cunyngnam, Laura Castner, Amang Sukasih, “Empirical Bayes Shrinkage Estimates of State SNAP Program Participation Rates in 2007-2009 for All Eligible People and the Working Poor”, February 2012.



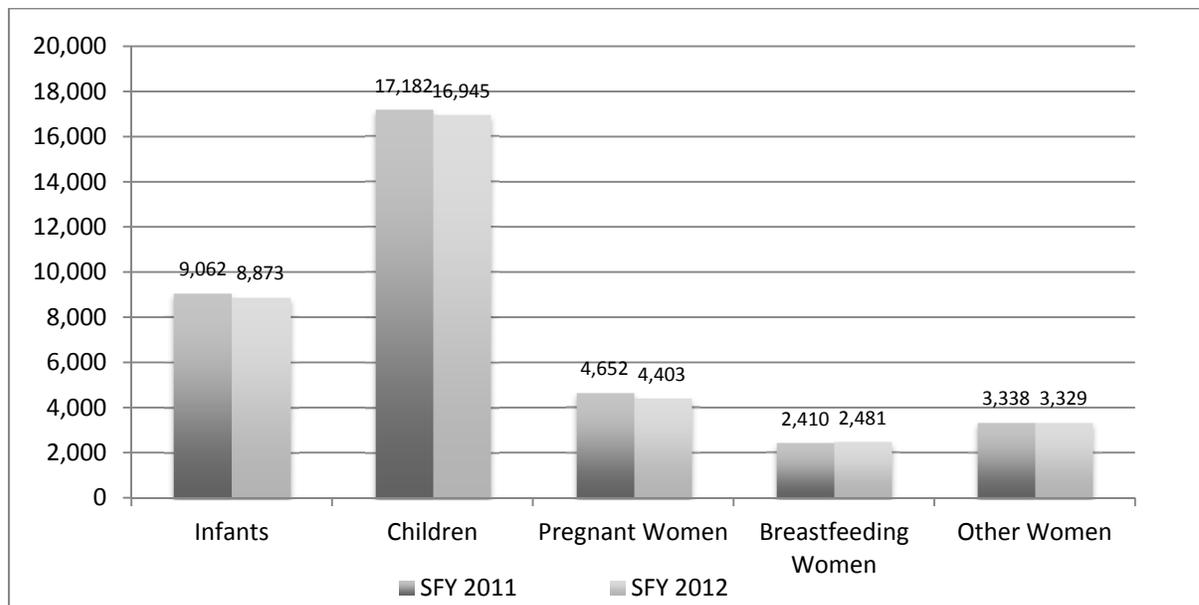
The Montana Child and Adult Care Food Program (CACFP) is another program through which many young children receive nutrition support. The reach of the program has gotten smaller over the last five years with fewer child care centers participating. However, the percentage of family/group homes enrolled in CACFP has remained steady, despite declining family/group home numbers.

Table 8: Montana Child and Adult Care Food Program³²

	2012	2011	2010	2009	2008
Montana centers enrolled in CACFP	139	145	225	209	194
% of all centers enrolled in CACFP	56%	57%	92%	86%	80%
Family/group homes enrolled in CACFP	692	730	805	813	814
% of all family/group homes enrolled in CACFP	82%	78%	85%	81%	82%

The other primary source of nutrition assistance for children age birth through five is the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Montana’s WIC program serves approximately 21,000 families.³³ Approximately 75 percent of all infants and one-third of children ages one through four statewide receive WIC benefits.³⁴

Figure 4: Montana WIC Program Participation SFYs 2011 and 2012



³² DPHHS, “Montana Early Childhood Data Report”, 2012.

³³ Montana WIC Program, WIC served 20,829 families in August 2012.

³⁴ Montana WIC Program, Carol Ballew email to Debora Hansen, October 11, 2012.

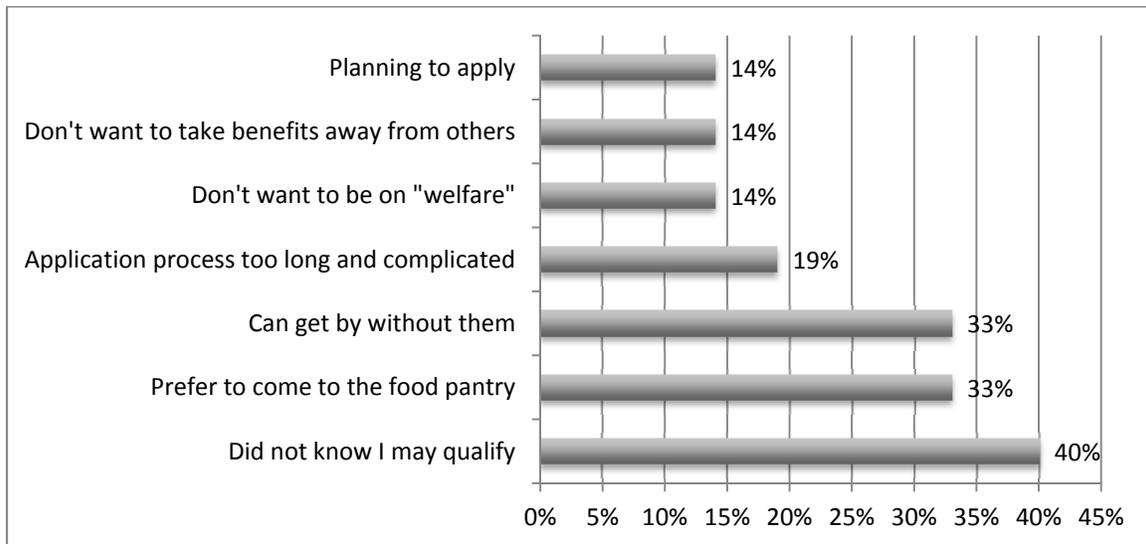


Montana is increasing collaboration across nutrition programs through the No Kid Hungry project. SNAP, WIC, and the Child and Adult Food Programs are aligning strategies through this campaign to address hunger issues in the State.

Despite the scale and reach of these nutrition programs and cross-program collaboration efforts, some Montana children and families struggle with hunger. Families are able to access emergency food through the Montana Food Bank Network. In 2011, the State’s food banks provided food to over 153,000 Montanans in 1,270,000 visits. The number of visits has increased over the last decade, with significant growth since 2008.³⁵

The Food Bank’s 2012 client survey shows that in households with children using their services, approximately 60 percent received SNAP benefits. Of those not using SNAP, approximately seven percent had submitted paperwork and were waiting for an eligibility determination. Of those who did not apply or want SNAP benefits, the largest percentage of respondents did not know that they may be eligible for assistance. Many simply did not want public assistance. Approximately 20 percent did not want to apply because the application process seemed too long and complex.

Figure 5: Reasons Food Bank Clients Did Not Apply for SNAP 2012³⁶



³⁵ Montana Food Bank Network, “Hungry in Montana: Factors Contributing to Emergency Food Needs, 2012 Client Hunger Survey”.

³⁶ Ibid.



Access to Human Services Benefits

Despite a large number of human services programs available to help low-income families, many struggle to access services. Services are provided through a disjointed web of Federal, State, regional, and local organizations, which is challenging for families to navigate, particularly when in crisis or lacking resources because of generational poverty. There is not a common front door, and agencies sometimes do not know about other available services.

Once a family locates the correct agency or service organization, there can be other barriers to access such as complex application processes, burdensome verification requirements, confusing or contradicting policy, ineffective organizational processes, unhelpful staff, and wait lists.

Work Supports through Offices of Public Assistance

DPHHS' Offices of Public Assistance (OPAs) determine eligibility for SNAP, Temporary Assistance for Needy Families (TANF), Medicaid, and Healthy Montana Kids (HMK). OPA workers have not been able to keep up the increasing workload associated with the growing number of cases. Interviewees and survey respondents discussed how OPAs do not meet many families' needs because of inefficient and ineffective business processes.

Parent Education

The need for and benefits resulting from parent education were consistent, strong themes from interviews, survey respondents, and county-level needs assessments. Parent education provides a continuum of family supports, which helps families navigate to services they need to be successful. Parent education occurs in many ways, including through interaction with early childhood educators, medical providers, or mental health providers. It can also occur through a home visiting program, group classes, or coaching sessions. Education interventions may include:

- Individualized support to help families define and work toward goals
- Modeling parenting and teaching parenting practices
- Teaching skills to support economic self-sufficiency and budgeting
- Teaching about child development and school readiness
- Providing mental health services
- Connecting families to community resources
- Providing health information and services

Home Visiting

Home visiting has been occurring in Montana for many years through public health departments, Early Head Start programs, and other service providers. The Affordable Care Act established the Maternal, Infant, and Early Childhood Home Visiting (MIECHV)



Program, which provides \$1.5 billion over five years to states to establish home visiting program models for at-risk pregnant women and children from birth to age five. The Act requires that 75 percent of the funds be used for home visiting programs using evidence-based practices.³⁷

Montana distributed the MIECHV funding to 23 local communities to build infrastructure to support comprehensive systems of early childhood services, with evidence-based home visiting programs as a central component of the systems. Six communities were awarded MIECHV service delivery funding to implement home visiting programs. Organizations are using a variety of evidence-based models, including Parents as Teachers and Nurse Family Partnership.

The Mathematica report on the effectiveness of the evidence-based models discusses how despite the fact the recommended home visiting approaches are considered evidence-based models, there is limited research evidence related to program effectiveness. There is a marked lack of research on the effectiveness of home visiting program models for Native American families, military families, and families from diverse cultural backgrounds that may not speak English as a first language.³⁸

Montana's programs generally have little data to demonstrate effectiveness. Although an analysis of Thrive's Partnership to Strengthen Families home visiting program for at risk young parents shows significant gains in a wide variety of indicators for parents and children participating in the program.³⁹

The primary gap regarding community home visiting programs cited in interviews was related to coordination. Some programs do not communicate with and receive only a small number of referrals from other related organizations in their communities. There may be limited awareness of the work being done by other groups, or possibly turf issues impeding collaboration.

Another coordination gap is related to moving families between levels (prevention and intervention) of home visiting programs. Often these programs are run by different organizations, and families commonly stop receiving services if the level of their needs changes, rather than transition to another program.

Others struggle to share assessment information between organizations conducting home visits. The duplication in efforts is trying and confusing for families, and wasteful of organizational resources. Families can receive the same assessment paired with

³⁷ Mathematica and ACF Office of Planning Research and Evaluation, "Home Visiting Evidence of Effectiveness Review", October 2011.

³⁸ Ibid.

³⁹ Geo Haynes, Gallatin County Health Department, Analysis of Life Skills Progression Outcome Panel Data, October 2012.



different advice from each organization with which they interact. Montana does not have a network of service providers that work cohesively on family support issues. Family support programs are not using a unified approach or framework.

Keeping Children Safe from Abuse and Neglect or Montana’s Foster Children

Child abuse and neglect is a result of multiple factors, many of which are related to families not being supported in their communities. Poverty, unemployment, housing insecurity, and hunger combined with addiction problems, mental health issues, or limited parenting knowledge create environments with a higher probability of child abuse and neglect occurring.

The number of children in foster care dropped between 2005 and 2008. The trend changed with the onset of the recession, and since 2008, the number of children in care statewide has increased by 13.5 percent. Children 0 to 5 years of age and Native Americans make up a disproportionate share of this growing population. In 2009, the number of children entering the system began to exceed the number exiting care. Montana’s rate of children in out-of-home care is higher than the national average (7.8 in Montana versus 5.2 nationally in 2010).⁴⁰

Table 9: Montana’s Foster Care Population Trends⁴¹

	FY05	FY06	FY07	FY08	FY09	FY10	FY11	FY12a*	Change FY05 – FY11	Change FY09 – FY12a*
In Care < 18	2,187	1,880	1,743	1,579	1,612	1,720	1,792	1,782	-18.11%	13.50%
In Care Rate per 1,000	10.1	8.9	8.4	7.2	7.3	7.8	7.9		-2.2	
Entries < 18	1,432	1,179	1,079	993	941	955	995	530	-30.50%	11.30%
Entry Rate per 1,000	6.6	5.6	5.2	4.6	4.3	4.3	4.4		-2.2	
Exits < 24	1,149	1,288	1,223	1,100	912	876	938	513	-18.40%	6.90%
# Aging Out	90	60	92	104	51	0	73	29	-18.90%	7.40%

*Data represents first six months of FY12

Children exposed to abuse and neglect and connected with the child protective services system have suffered trauma, which, without proper services, negatively impacts their outcomes.

⁴⁰ Casey Family Foundation, “Montana: 2012 State Outcomes,” July 2012.

⁴¹ Casey Family Programs, “SI Operations, Data Advocacy and Planning and Analysis”, 2012.



Social, Emotional, and Mental health

Social, emotional, mental, and behavioral health issues have a profound effect on children and their families. Children develop socially and emotionally incrementally over time, and families need to learn how to support this healthy development. Children from low-income families, who have unemployed or teenage parents, or are in the foster care system have a higher likelihood of having mental health problems.⁴² Children with mental health issues are more likely to have problems at child care and school, and be absent, suspended, or expelled.⁴³

Children's well-being is dependent on their own emotional/mental health as well as their families'. Parents with mental illness or addiction issues are less likely to maintain stable employment. This financial insecurity may lead to unstable housing, hunger issues, lack of medical insurance, and other disrupting issues.

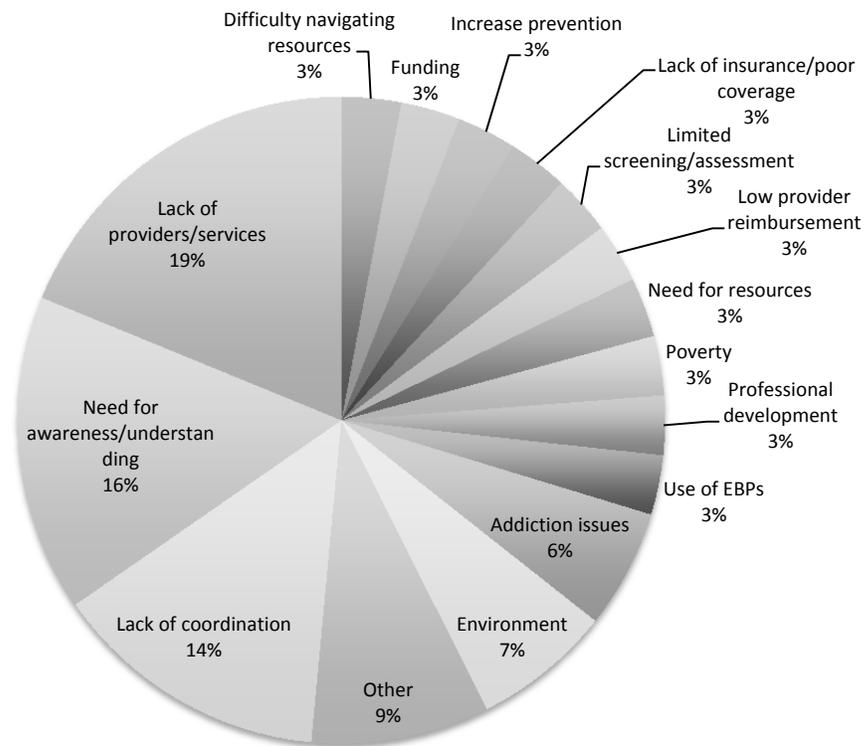
Interviewees and survey respondents commonly cited mental health and addiction problems as some of the most central issues impacting family stability and early childhood education in Montana. When asked about the root cause of mental health needs, survey respondents most often cited access issues related to not having enough providers to meet demand, inadequate insurance coverage, and insufficient screening and assessments. A limited understanding of social, emotional, and mental health issues was also commonly discussed.

⁴² Knitzer, Lefkowitz, National Center for Children in Poverty, "Helping the Most Vulnerable Infants, Toddlers, and their Families, Pathways to Early School Success", Issue Brief No. 1, 2006.

⁴³ Shannon Stagman, Janice Cooper, National Center for Children in Poverty, "Children's Mental Health: What Every Policymaker Should Know", April 2010.



Figure 6: Root Causes of Social, Emotional, Mental Health Needs



This section explores the scope of social, emotional, mental health problems in Montana, how mental health needs are identified, prevention and early intervention, access to mental health services, crisis services, the efficacy of services, and medication monitoring.

Understanding the Scope of the Need

A primary need in Montana related to social, emotional, and mental health is to better understand the scope of the issue in the State. There is an increasing awareness that this is an important and growing issue with impacts on many other aspects of family and community life, but understanding and knowledge of social, emotional, and mental health needs is not as widespread as with many other pressing social concerns. A stigma about mental illness as a moral deficiency rather than a treatable condition may contribute to this lack of understanding. This limited awareness means that parents, communities, and political leaders may not understand the importance of social-emotional development in children and, as a result, may not invest in preventing, identifying, and treating mental illness.



Mental disorders are common among children and adults. The percentage of Montana children with severe emotional disturbance (SED) is estimated to be between ten and 12 percent of youth ages nine through 17. In 2009, this equated to approximately 12,150 children.⁴⁴ Nationally, it is estimated that just over 20 percent of youth ages 13 through 18, either currently or at some point during their life, have had a seriously debilitating mental disorder.⁴⁵ If this figure is accurate, perhaps over 22,000 Montana youth may have benefited from mental health services in 2009. This figure does not include youth with less severe diagnoses who could also benefit from services and supports. Studies have found the lifetime prevalence of a mental disorder in youth ages 13 through 18 is 46.3 percent.⁴⁶

The rates of mental illness are generally lower in younger children. Montana provided mental health services to 4,035 children birth through five years old in State Fiscal Year 2010.⁴⁷ This figure most likely represents only a portion of the need for mental health services in this population. It is estimated that 2.4 percent of children birth through age three have delays or disabilities making them eligible for Individuals with Disabilities Education Act (IDEA) Part C early intervention services. IDEA Part B special education services were provided through the Office of Public Instruction to 1,696 children age three to five as of October 2011. In addition, the Comprehensive School and Community Treatment program served 180 children under the age of five in State Fiscal Year 2011.⁴⁸

The prevalence of serious mental illness for Montana adults is 5.4 percent, or 41,356 individuals in SFY 2010.⁴⁹ This is similar to the national estimate of 5.8 percent.⁵⁰ This figure does not include adults with less serious mental health conditions. Nationally, it is estimated that 26.2 percent of the adult population are diagnosable with one or more mental disorders.⁵¹ In 2006, over 121,000 Montana adults were estimated to have a mental health condition that caused them to miss a week of work or more.⁵² The

⁴⁴ DPHHS, "FY 2012-2013 Block Grant Application, Community Mental Health Plan and Report, Substance Abuse Prevention and Treatment Plan and Report", September 2011.

⁴⁵ National Institute of Mental Health, Statistics, Any Disorder Among Children, http://www.nimh.nih.gov/statistics/1anydis_child.shtml.

⁴⁶ Ibid.

⁴⁷ Data represents claims paid by Mental Health Medicaid for SFY 10, ages five and younger, from DPHHS "2012 Required Out-of-State Placement and Monitoring Report" to Montana Legislature.

⁴⁸ Children's Mental Health Bureau.

⁴⁹ DPHHS, "FY 2012-2013 Block Grant Application, Community Mental Health Plan and Report, Substance Abuse Prevention and Treatment Plan and Report", September 2011.

⁵⁰ National Institute of Mental Health, Statistics, Any Disorder Among Adults, http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml.

⁵¹ Ibid.

⁵² DMA Health Strategies, "Legislative Mental Health Study: Report to the State of Montana", November 2008.



impact on children is unclear since there is no data to indicate how many of these adults have children.

Individuals may also need mental health services because of trauma resulting from exposure to violence, abuse, or neglect. It is hard to accurately estimate the number of people impacted by these issues. The number of children in Montana's foster care system, as presented in the previous section, does not represent the total impact of abuse and neglect on children. Nationally, child protective service agencies investigate 32 percent of children exposed to Harm Standard maltreatment and 43 percent of children whose maltreatment fit the Endangerment Standard.⁵³ Local needs assessments discussed high rates of domestic violence. Nationally, it is estimated that over 20 percent of couples experience partner violence of any form, and almost 60 percent of this group have children living at home.⁵⁴

Identifying Needs of Children and Families

Some parents do not want to recognize social, emotional, mental health, and behavioral issues with their children because of the stigma or discomfort associated with mental health issues. It is often child care providers or health providers who work with parents to refer young children for screening. However, many child care providers are not adequately trained to identify needs or do not know the referral process. This is particularly true of unlicensed, unregistered child care providers, who are less likely to receive training or information from the State or its agents.

Once a child is referred for screening, additional barriers often arise. There are a large number of screening tools used in Montana. These tools do not necessarily relate to one another, and information obtained from families is not consistently shared with other agencies conducting screenings. Repetitive screenings require families to tell their story multiple times, which can re-traumatize a family. It is also an inefficient use of resources.

Fewer children in the foster care system are being assessed for mental and behavioral health needs. The number of children receiving assessments declined approximately 10 percent statewide between 2007 and 2011.⁵⁵ The Child and Family Services Division (CFSD) only assesses children and youth upon entry into the system unless an event

⁵³ Sedlak, Mettenburg, Basena, Petta, McPherson, Greene, and Li, US Department of Health and Human Services, Administration for Children and Families, "Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress", 2010.

⁵⁴ McDonal, Jouriles, Ramisetty-Milker, Caetano, Green, "Estimating the Number of American Children Living in Partner-Violent Families, *Journal of Family Psychology*", 2006, Vol. 20, No. 1.

⁵⁵ Casey Family Foundation, "Montana: 2012 State Outcomes", July 2012.



such as changing families, or having severely escalating behaviors, prompt an additional assessment. Providers do not consistently conduct and report entrance screening results.

Prevention and Early Intervention

Montana supports preventative services for children’s social, emotional, mental, and behavioral needs primarily through family support programs, where parents receive education about how to support children’s social and emotional development. The lack of prevention services for adults was consistently called out as a gap in Montana’s mental health services.

Early intervention is very effective in helping children, in the context of their families, address social, emotional, and mental health issues. Seventy-four percent of children involved with early interventions do not go into special education preschool.⁵⁶ The philosophy used by Part C agency interventionists is to work with children in their natural environments. This approach supports parents in being interventionists throughout daily activities with their children between visits. This constant coaching by parents helps children’s conditions improve quicker.

Access to Services

Access to mental health services depends on a variety of factors, including insurance coverage, participation by families and children in programs for which they are eligible, and provider availability. Limitations in Medicaid eligibility, particularly for adults, create access barriers, which can result in worsening symptoms and the need for more intensive and costly services.⁵⁷

Number of Children Accessing Care

Whether children have access to social, emotional, and mental health services largely depends on whether they have health insurance. Children insured through public medical assistance may receive better mental health care than those with private insurance because of service requirements such as wraparound facilitation. Children without health insurance generally are the largest gap. Unfortunately, we only have data about service utilization for children receiving Medicaid, HMK, or services through IDEA Parts B and C for this assessment.

⁵⁶ David Munson, Director of Early Childhood Interventions, Billings Public Schools, Interview, December 18, 2012.

⁵⁷ DMA Health Strategies, “Legislative Mental Health Study: Report to the State of Montana”, November 2008.



DPHHS' Children's Mental Health Bureau (CMHB) provides Medicaid-funded mental health services to a steadily increasing number of Montana children and youth. Approximately 50 percent of Montana's foster children and youth receive treatment for mental or behavioral health issues, making up slightly less than ten percent of the total youth population served.⁵⁸

Table 10: Youth Provided Medicaid Mental Health Services 2009-2011⁵⁹

SFY	Number Served
2009	9,049
2010	10,078
2011	10,758

In SFY 2010, Medicaid provided mental health services to 4,035 children between the ages of birth and five years, which is 40 percent of the total number of youth served in that year. The most commonly used service for these children is Therapeutic Foster and Family Care.

Table 11: Children 0-5 Served by Medicaid Mental Health Services SFY 2010⁶⁰

Age	Number Served
0	31
1	103
2	240
3	705
4	1,258
5	1,698
Total	4,035

Montana also provides services to children with autism through an autism waiver. Just over 50 children and families receive services annually through this waiver. Sixty-five children are on the waiting list for services.

Montana is providing early intervention services to children birth through age three to 1.8 percent of the total population through IDEA Part C. It is estimated that 2.4 percent of children are born with a delay or disability requiring early intervention, meaning this

⁵⁸ MMIS data for SFY 2012 shows 47.7% of foster children and youth have mental or behavioral health-related claim.

⁵⁹ Unduplicated Number of Youth Receiving Medicaid Funded Mental Health Services, from DPHHS 2011 "Required Out-of-State Placement and Monitoring Report" to Montana Legislature.

⁶⁰ Data represents claims paid by Mental Health Medicaid for SFY 10, ages five and younger, from DPHHS "2012 Required Out-of-State Placement and Monitoring Report" to Montana Legislature.



population is being underserved.⁶¹ The State is providing incentives to the IDEA Part C agencies to locate additional children through Child Find activities. These agencies are working with referral sources, primarily in the medical community, to find more children who would benefit from early intervention services.

Children and youth age three through 21 can access special education services through IDEA Part B. As of October 2011, 16,032 children received special education services in Montana through IDEA Part B. Of this population, 1,696 were age three to five. The Office of Public Instruction (OPI) received 216 referrals from Part C agencies to transition children to Part B services in SFY 2012. Of these, 172 were determined eligible. The majority of Part B recruitment happens through their Child Find processes. School districts conduct Child Finds generally four times annually. School districts have discretion over whether their Child Find events are coordinated with Part C early intervention Child Finds.⁶²

Children's mental health needs are generally going unmet at child care facilities. Most child care providers do not have the skills or staff to support children with special needs. Very few children are eligible for special needs subsidies because they must receive Best Beginnings subsidies and be determined eligible for the subsidy by child care resource and referral agency staff who often have no training or expertise regarding special needs. Only 33 children receive special needs subsidies statewide.

Number of Adults Accessing Care

It is generally harder for adults to receive mental health services through Medicaid than children. Adult diagnoses often need to be more severe to be eligible for assistance. DPHHS provided mental health services to approximately 20,100 adults in SFY 2010, which is about 50 percent of the total population estimated to have a serious mental illness.⁶³

Supply of Mental, Behavioral Health Providers

A substantial barrier to accessing mental and behavioral health services is a lack of providers. Nationally, it is estimated that 12 to 13 percent of adults with a mental health disorder receive minimally adequate treatment.⁶⁴ This small percentage is due in part to the low number of providers available (in addition to stigma and cost/insufficient insurance coverage). As stated earlier, the impact on children and families is unclear

⁶¹ David Munson Interview.

⁶² Danni McCarthy, Anne Rainey, Office of Public Instruction, Special Education Department, Interview, December 19, 2012.

⁶³ DPHHS, "FY 2012-2013 Block Grant Application, Community Mental Health Plan and Report, Substance Abuse Prevention and Treatment Plan and Report", September 2011.

⁶⁴ National Institute of Mental Health, Statistics, Any Disorder Among Adults, http://www.nimh.nih.gov/statistics/1ANYDIS_ADULT.shtml.



since there is no data to indicate how many of these adults are parents with children living at home.

Because Montana is a rural and frontier state,⁶⁵ there is a large geographic area to serve with a small population density. The state has few psychiatrists, and they tend to reside in larger towns and cities. Only a small percentage of psychiatrists specialize in children and youth. As a result, many children and families receive care from their pediatricians and family doctors for physical and mental healthcare needs because specialized care is inaccessible. Children and adults without access to specialized providers may not have their conditions accurately diagnosed or optimally treated.

Montana has 820 clinical professional counselors and 81 psychiatrists.⁶⁶ In May 2008, only 17 physicians were board certified as child adolescent psychiatrists. These providers were located in five cities, with none located in north central or eastern Montana. For specialists treating adults, the southwestern portion of the State has the highest penetration of psychiatry, while the eastern region has no resident psychiatrist. The eastern region also has the lowest rate of psychologists, social workers/professional counselors and licensed alcohol counselors per person.⁶⁷

Of this population, approximately 600 therapists bill Medicaid for mental health services.⁶⁸ According to survey respondents, providers often do not accept Medicaid or HMK because of low reimbursement rates. Many private insurance companies cover mental health as well as services to promote emotional well being,⁶⁹ however many private practice providers do not accept any form of insurance.⁷⁰ As the State moves toward requiring interventions for children in their natural environment to implement evidence-based practices, fewer providers may work with children with mental health or developmental needs. Occupational, physical, and speech therapists providing the majority of early intervention services under IDEA Part C, are struggling with how to maintain their practices when traveling to family homes, child care facilities, schools, libraries, etc. to work with children and families.

⁶⁵ Definitions for and methodology to determine rural and frontier areas can be found at: Federal Register Volume 77, Number 214 (Monday, November 5, 2012), www.gpo.gov.

⁶⁶ Family and Community Health Bureau, Public Health and Safety Division, DPHHS, "2010 Maternal Child Health Needs Assessment", July 2010.

⁶⁷ DMA Health Strategies, "Legislative Mental Health Study: Report to the State of Montana", November 2008.

⁶⁸ Dan Ladd, Children's Mental Health Bureau, email October 15, 2012.

⁶⁹ Society for Human Resource Management, "2012 Employee Benefits: The Employee Benefits Landscape in a Recovering Economy".

⁷⁰ Ron Lieber, New York Times, "Walking the Tightrope on Mental Health Coverage", December 21, 2012.



In addition to individualized therapists, Montana also has a network of mental health centers. Montana has eight licensed mental health centers providing community-based services in 55 of the State's 56 counties. This network is made up of four regional mental health centers, which provide the majority of high-end services for the public mental health system, with satellite offices. Mental health centers serve approximately 3,000 Medicaid clients. Fifteen mental health centers provide services to Medicaid children and youth.⁷¹

Children with both mental disorders and developmental disabilities often struggle to find providers able to meet their needs. The State requires different qualifications to work with populations with mental health needs versus developmental disabilities. Children receiving care through Medicaid or HMK may be sent to another town or state to receive the best possible treatment, rather than working to bring services to families. This also occurs with children needing mental health or developmental disability services in combination with substance abuse/addiction-related services. CMHB is attempting to meet this need through the addition of the co-occurring service to its State Plan program for youth with SED. Co-occurring services are designed to provide assessment/evaluation, education and treatment for co-occurring mental health and chemical dependency issues for youth through an integrated approach.

Crisis Services

Montana has historically paid a lot of money for services that remove children from their homes or community environments, which don't help families succeed in the long run. Families need to receive holistic treatment to learn how to function as a unit. This happens because Montana has a limited supply of crisis or sub-crisis/intermediate-level services available to meet the needs of children and adults close to home.

Montana has six community hospitals with inpatient psychiatric beds. Less than 20 percent of beds are used for publicly funded individuals.⁷² Children generally cannot receive services at inpatient psychiatric units. Youth in need of emergency psychiatric hospitalization are usually admitted to Shodair Hospital in Helena, Billings Deaconess Hospital, or St. Patrick's Hospital in Missoula.⁷³ Youth with less intensive needs generally have nowhere to go. There are a small number of emergency respite beds available in the State. There is no shelter system infrastructure for short-term needs to diffuse family situations.

⁷¹ DPHHS, "FY 2012-2013 Block Grant Application, Community Mental Health Plan and Report, Substance Abuse Prevention and Treatment Plan and Report", September 2011.

⁷² Ibid.

⁷³ Dan Ladd interview.



Without crisis or sub-crisis options, many children are sent to psychiatric residential treatment facilities (PRTFs) or Therapeutic Foster Group Homes (TGH). The State tries to serve youth in-state first, but if their level of care cannot be met in Montana, they are placed out-of-state. The number of children in out of state placements for PRTFs or TGHs declined between SFY 2009 and 2011.

Table 12: Children in Out-of-State Placements 2009-2011⁷⁴

Provider Type	Payment Source				Total
	Medicaid	CFSD	JJ	DOC	
2011					
PRTF	37	13	24	4	78
TGH	42	15	20	0	77
Total	79	28	44	4	155
2010					
PRTF	51	22	31	4	108
TGH	33	13	29	0	74
Total	84	35	60	4	183
2009					
PRTF	51	36	18	9	114
TGH	39	28	29	5	101
Total	90	64	47	14	215

Data from SFY 2012 shows that 124 youth were placed out of state, with 58 placed in out-of-state PRTFs and 36 in out-of-state therapeutic group homes. CMHB has been working to reduce the number of out-of-state placements by:⁷⁵

- Using wraparound facilitation services offered by the PRTF waiver, soon to be State Plan program services. Expanding waiver services statewide in 2013 should hopefully increase service/provider capacity to serve youth.
- Encouraging in-state providers to submit alternative plans before authorizing an out-of-state admission.
- Suspending out-of-state PRTF Montana Medicaid enrollment.
- Implementing a common functional assessment tool for in-state and out-of-state facilities – Child and Adolescent Needs and Strengths (CANS) – to allow CMHB to compare effectiveness of services between facilities.

Separating youth from their homes and communities means they lose connections with their families and friends, which may exacerbate their issues. This type of change,

⁷⁴ DPHHS, Report to Montana Legislature, “Required Out-of-State Placement and Monitoring Report”, July 1, 2010 through June 30, 2011 (No. 3), Submitted September, 2011.

⁷⁵ DPHHS, Report to Montana Legislature, “Required Out-of-State Placement and Monitoring Report”, July 1, 2011 through June 30, 2012 (No. 4), Submitted August, 2012.



particularly if it occurs more than once, is damaging to a youth's neurological structure.⁷⁶ Working with children in isolation from their families also lessens the chances that the child will be successful when returning to their families, which could cause the cycle of removals/placements to continue.

Effectiveness of Services

Even among children, youth, and families able to access mental health services, quality of care is often lacking. Providers of mental health services often do not use effective, evidence-based, outcomes-focused practices. The service delivery system is missing key pieces of a supportive infrastructure such as provider training and retention, adequate reimbursement, strong information technology supports, and family involvement in policy. The lack of these elements results in poor provider capacity and competency.⁷⁷

Policy makers looking to optimize outcomes are working to implement evidence-based practices. States often encounter barriers to implementing these practices in large systems, including lack of fidelity to models, provider training and preparedness, and variation in the ability to transfer practices between settings.⁷⁸

Only a small number of Montana's mental and behavioral health providers are trained in evidence-based or trauma-focused approaches. There is no consistent or widespread training available on these practices.

The State is spending a significant amount of money on supports and services without seeing improved outcomes for children and families. The State of Montana spent \$173.59 per capita on mental health expenditures in fiscal year 2010, significantly more than the national average of \$120.56.⁷⁹ Montana nationally ranks in the top quarter of states for spending on mental health services. However, the State's outcomes do not reflect this higher level of investment.

Montana's Comprehensive School and Community Treatment (CSCT) program is an example of higher spending without improved outcomes. Within CSCT, Medicaid funds school districts, Head Start programs, and one Early Head Start program to contract with mental health centers to create teams of mental health professionals to provide school-

⁷⁶ Dan Ladd interview.

⁷⁷ Shannon Stagman, Janice Cooper, National Center for Children in Poverty, "Children's Mental Health: What Every Policymaker Should Know", April 2010.

⁷⁸ Schoenwald, Chapman, Kelleher, Hoagwood, Landsverk, Stevens et. al., Administration and Policy in Mental Health and Mental Health Services Research, "A Survey of the Infrastructure for Children's Mental Health Services: Implications for the Implementation of Empirically Supported Treatments", 2008.

⁷⁹ Kaiser Family Foundation, "State Mental Health Agency, per Capita Mental Health Expenditures," FY2010, <http://www.statehealthfacts.org/comparemaptable.jsp?cat=5&ind=278>.



based therapeutic services for youth with SED. The program has been in place consistently since 2005. In that timeframe, it has grown from a \$700,000 to a \$40 million dollar budget, which is one third of total CMHB expenditures. Despite the significant investment, youth's long term outcomes are not improved as a result of program participation. Just as many youth are being placed out of state or getting involved with law enforcement. CSCT does not use an evidence-based model, although it is beginning to move in that direction.⁸⁰

Many other costly interventions for children and youth, such as PRTFs, do not use evidence-based practices. The State, however, is moving toward increased use of these models.

- CFSD is moving toward evidence-based, evidence-informed and trauma-informed practices with the recent implementation of the Safety Assessment Management System (SAMS) for initial child abuse and neglect investigations. The SAMS assessment, which includes a family functioning assessment, is based upon the safety model designed by the National Resource Center for Child Protective Services.
- CMHB is implementing high-fidelity wraparound facilitation services, which are currently being certified as evidence-based, along with the CANS assessment tool, which has an integrated trauma focus. CMHB is also planning to implement parent child interaction therapy with the State Plan program for youth with SED.
- Montana's Maternal and Child Health program within the Family and Community Health Bureau is employing evidence-based home visiting programs through the MIECHV grants.
- ECSB is implementing the pyramid model developed by Centers on the Social and Emotional Foundations for Early Learning (CSEFEL) to strengthen families in child care/educational settings.
- Medicaid is working to make the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screening trauma-informed.

The work happening across the State to move toward evidence-based practices is not well coordinated. Implementation is still in its early stages for most of these efforts. There is a desire to have the various models work together seamlessly for families and providers, but this is not yet the case.

Implementation of these practices with private providers may be challenging. Montana Medicaid uses a fee-for-service model, and does not pay for performance. The State has limited influence over private providers under the current payment model.

⁸⁰ Dan Ladd interview.



Medication Monitoring

Related to the small number of providers specializing in children's mental and behavioral health and the limited use of evidence-based practices are problems with mental health drugs being over-prescribed and polypharmacy. As mental and behavioral health needs of children and youth increase, and diagnoses become more complex, there is a growing number of children and youth prescribed mental health medications, often more than one.

Foster children are more likely to be prescribed psychotropic medications. Seventeen of the 20 most prescribed medications for children in Montana's foster system are psychotropic medications.⁸¹ Many of the children and youth taking these medications may be better served by counseling or psychotherapy, but providers do not consistently have the training to make this determination.

The State is beginning to analyze data on psychotropic medication usage for foster children. The medication management contractor is providing evidence-based prescriber education performed by clinical pharmacist staff when utilization reviews meet defined risk criteria. Other agencies within DPHHS do not have medication monitoring in place. CFSD's program could eventually expand to cover a broader population of children and youth.

⁸¹ Hermioni Lokko and Christopher Gustafson, "Effectively Monitoring Healthcare for Montana's Foster Children and Youth: An assessment of current health monitoring infrastructure for Montana's foster care population and considerations for improvement", March 2012.



Access to Health Services

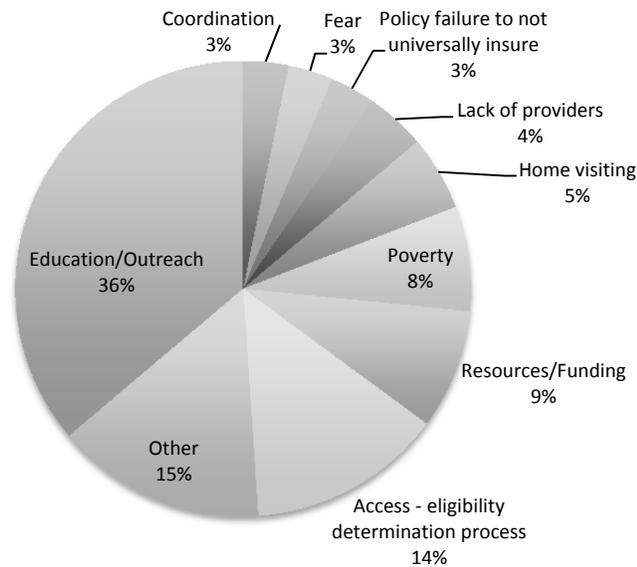
Access to health care is vital to healthy individuals, families, and communities. Access to health care impacts:⁸²

- Overall physical, social, and mental health status
- Prevention of disease and disability
- Detection and treatment of health conditions
- Quality of life
- Preventable death
- Life expectancy

People need to be able to pay for services through private insurance, public programs, or private pay and access qualified providers. Montana has done a good job of insuring its children. Outreach and education work done by HMK has increased Montana children’s participation rates in Children’s Health Insurance Plan (CHIP) and Medicaid, and decreased the uninsured rate among children and youth. The State is also working to implement medical home models.

Survey respondents thought the primary root cause of children not accessing health insurance or a medical home related to insufficient education and outreach. Also commonly cited were problems with the eligibility process for Medicaid and HMK.

Figure 7: Root Causes of Issues Related to Children Accessing Medical Insurance or Medical Home



⁸² Healthy People 2020, Access to Health Services, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=1>.



The primary gaps this section explores related to accessing health services in Montana are limited access to health insurance for many low-income parents and a lack of providers for primary care and dental services.

Access to Insurance

Not having insurance is one of the primary barriers to receiving health care. Adults' access to medical insurance is important to consider alongside children's access. Uninsured adults are more likely to be financially insecure and homeless, which negatively impacts children and families. In 2010, 18.3 percent of non-institutionalized Montanans – children and adults – were uninsured. Over 11 percent of children and youth birth to 17 years old lacked insurance. Almost 100,000, or 22 percent, of employed adults age 18-64 were uninsured. These figures are worse for unemployed adults (56 percent uninsured) and those not in the labor force (25 percent uninsured).

Table 13: Health Insurance Coverage in Montana, 2010⁸³

	Estimate	%
Civilian, non-institutionalized population	983,214	100%
With health insurance coverage	803,639	81.7%
With private health insurance	642,561	65.4%
With public coverage	290,099	29.5%
No health insurance coverage	179,575	18.3%
Civilian, non-institutionalized population, under 18	222,102	100%
No health insurance coverage	25,562	11.5%
Civilian, non-institutionalized population, 18-64	614,806	100%
Employed	447,369	
With health insurance coverage	347,777	77.7%
With private health insurance	332,205	74.3%
With public coverage	28,082	6.3%
No health insurance coverage	99,592	22.3%
Unemployed	38,028	
With health insurance coverage	16,636	43.7%
With private health insurance	12,559	33.0%
With public coverage	4,556	12.0%
No health insurance coverage	21,392	56.3%
Not in labor force	129,409	
With health insurance coverage	97,472	75.3%

⁸³ US Census Bureau, American FactFinder, 2011 American Community Survey, <http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkml>.



	Estimate	%
With private health insurance	66,119	51.1%
With public coverage	40,262	31.1%
No health insurance coverage	31,937	24.7%

Underinsurance is also an access barrier. Families often cannot afford the out-of-pocket expenses required for medical care. County needs assessments, interviews, and survey respondents discussed how many families struggle to pay medical expenses, and those able to access health services with a provider are not able to afford medication.⁸⁴

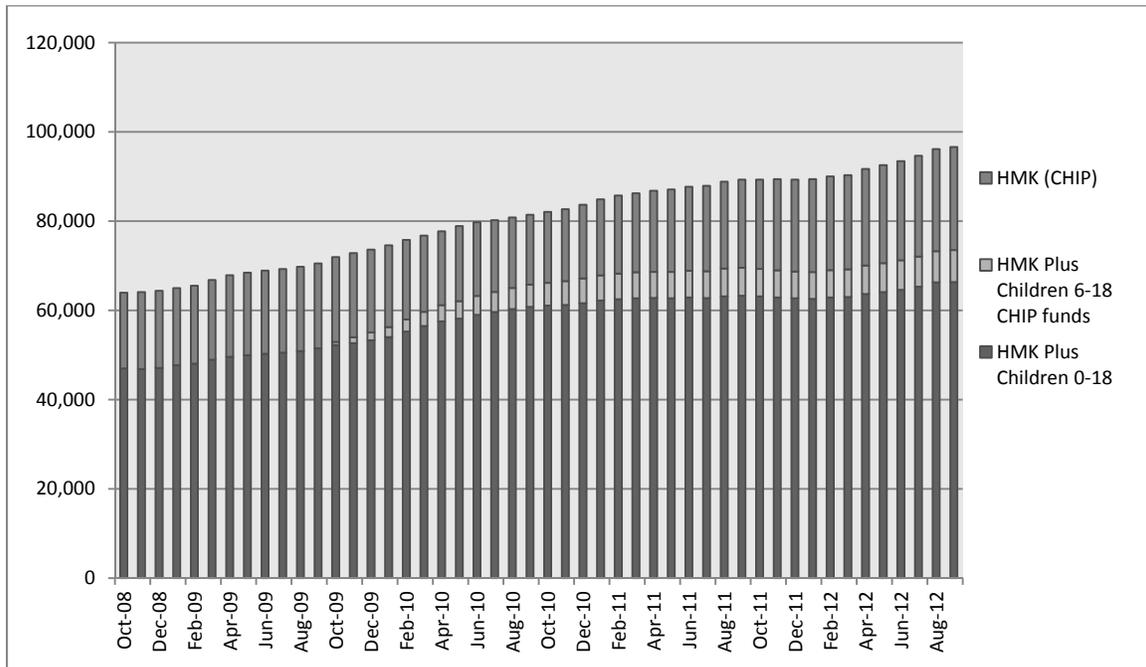
Medicaid/Healthy Montana Kids Participation

The passage of the Healthy Montana Kids Plan Act I-155 in 2008 is associated with a large increase in the number of children accessing health insurance through either HMK, funded by CHIP, or HMK Plus, which is Medicaid funded. In November 2008, approximately 64,000 children and youth were insured through CHIP or Medicaid. By September 2012, this figure increased to over 96,000. HMK covers over 23,000 of these children, CHIP funded-HMK Plus covers another 7,150, and the remaining 66,000 are insured through HMK Plus/Medicaid.

⁸⁴ The Community Action Partnership of Northwest Montana 2011 needs assessment state that 49% of 471 responses (representing 906 people) reported difficulty paying medical expenses, and 35 percent had trouble affording medication.



Figure 8: Children Insured through HMK and HMK Plus⁸⁵



In 2009, the percentage of eligible children participating in HMK and HMK Plus was just under 80 percent, which was in the bottom quarter of participation rates nationally.⁸⁶ HMK conducted an effective outreach and marketing campaign to increase participation, and now over 90 percent of eligible children and youth participate.⁸⁷

Impact of the Affordable Care Act

The Affordable Care Act could reduce access barriers by insuring more Montanans through the possible Medicaid expansion and the implementation of insurance subsidies. Additionally, simplified Medicaid eligibility requirements should improve eligibility business processes for other work support programs, such as SNAP, TANF, and possibly child care subsidies.

If Montana implements the Medicaid expansion, adults in households earning up to 138 percent of the federal poverty limit will be eligible for Medicaid. In Montana, adults who are not disabled, pregnant, or parents of young children are not eligible for medical

⁸⁵ DPHHS, Healthy Montana Kids Enrollment, December 6, 2012.

⁸⁶ Kaiser Family Foundation, "Children's Medicaid/CHIP participation rates 2009", <http://www.statehealthfacts.org/comparemactable.jsp?ind=868&cat=4#notes-1>.

⁸⁷ Mary Dalton, DPHHS, Heath Resources Division Branch Manager, Interview, December 5, 2012.



assistance. The Medicaid expansion would provide financial security for some of the lowest income families in the State.

Families earning between 138 and 400 percent of the federal poverty limit will be eligible for tax credits to subsidize the cost of insurance purchased through the Federal health care exchange. This will allow many working poor, or gap, families to afford coverage.

Implementation of the Affordable Care Act may increase participation in Montana's other work support programs, further supporting low-income, working families. Families seeking health insurance, currently unknown to the system, may be determined eligible for additional human services programs. OPAs are working to coordinate work support (SNAP, TANF, Medicaid, and HMK) policies to align around new Medicaid eligibility requirements in health care reform. These streamlining efforts should support improved access for families.

Access to Providers

There are an insufficient number of health providers in Montana to meet healthcare demand. Montana has approximately 95 health professional shortage areas for primary care, and 70 for dental care providers. This equates to over 100,000 Montanans being underserved.⁸⁸ Approximately 25 percent of Montana's provider workforce is 60 or older.⁸⁹ As providers retire, the workforce shortage will worsen.

Montanans travel long distances to access care. This is particularly true for individuals living in rural or frontier areas needing specialized care.

Table 14: Distance Traveled to See Provider⁹⁰

Distance Traveled (one way)	%
More than 5 miles	54%
More than 30 miles	13%
More than 50 miles	7%

Worsening the problem for low-income families receiving medical assistance, many providers do not accept Medicaid and HMK because of low reimbursement rates. According to interviewees, this is particularly true for dentists and therapists.

⁸⁸ US, HHS, Health Resources and Services Administration, Data Warehouse, Health Professional Shortage Area, September 2011.

⁸⁹ DPHHS, Quality Assurance Division, "Montana's Rural Health Plan", 2011.

⁹⁰ Ibid.



State and federal programs assist in recruiting providers to health professional shortage areas and provide tuition reimbursement for providers to remain in these areas. These programs are primarily for doctors, dentists, mental health professionals, and nurses.

Access to a Medical Home

Medical homes are clinical practices that organize and coordinate care based on child and family needs and priorities. Effective medical homes provide accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.⁹¹ Access to a medical home is generally considered more important for children than adults, particularly for children with special health care needs. Adults with chronic conditions also benefit from a medical home.

Approximately 14 percent of children in Montana have special health care needs.⁹² A majority of these children live in households with incomes under 200 percent of the federal poverty limit.⁹³ Approximately ten percent of these children do not have a usual source of care when sick, and 39 percent do not have a medical home.⁹⁴

There are various medical home projects/efforts currently underway in Montana:

- Montana's Health Care Benefits Division has successfully implemented a State health clinic in Helena using a prevention-focused medical home model. The response has been overwhelmingly positive, and the model is being extended to two other locations in the next year. However, this is a closed system for State employees and their families. Children must be two years old to receive care at these clinics.
- Montana's Commissioner of Securities and Insurance (CSI) is proposing legislation to implement a different patient-centered medical home model in the 2013 session. Under this approach, CSI is planning to transition the existing primary care system into a medical home model by providing incentives. This project is still in its nascent stages.
- The Family and Community Health Bureau focuses on children with special health care needs, and has been working to increase the number of children connected to a medical home. These efforts may have the greatest impact on connecting children with special needs to a medical home in the short to medium term.

⁹¹ Massachusetts General Hospital Center for Child and Adolescent Health Policy, "Medical Home for Children and Youth with Special Health Care Needs: A Review of the Evidence", June 2009.

⁹² 2009/10 National Survey of Children with Special Health Care Needs, <http://www.childhealthdata.org/browse/snapshots/cshcn-profiles?rpt=9&geo=28>.

⁹³ Ibid.

⁹⁴ DPHHS, "Children with Special Health Care Needs: Needs Summary", February 2012.

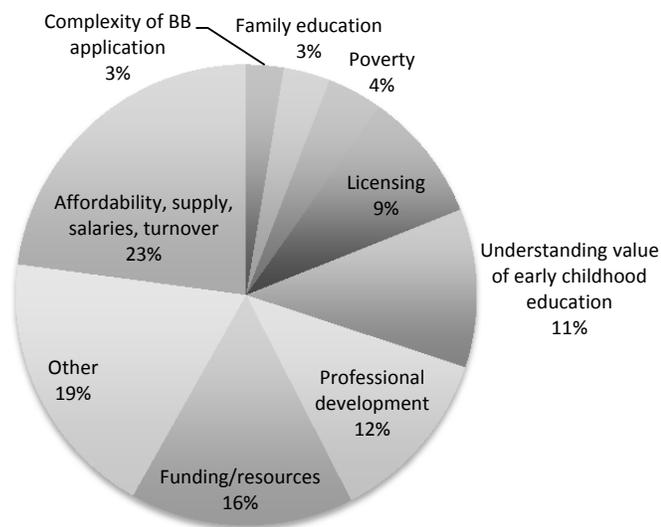


Early Childhood Programs/Education

Early childhood programs are often central in creating stability for children and families. Quality child care supports healthy development and school readiness in children, and also impacts parents' ability to work, which in turn affects family stability in terms of meeting basic needs such as affording housing and food.⁹⁵

Survey respondents thought the cause of many of the unmet needs in early childhood education were monetary. Quality child care is expensive for families. Child care facilities are only able to pay small salaries to staff, resulting in high turnover rates. Increased quality standards and related professional development needs were commonly discussed, as was the need for the community and families to understand the value of high quality early childhood education.

Figure 9: Root Cause of Issues Related to Early Childhood Programs/Education



This section outlines issues around quality, licensing, affordability, access and professional development.

Quality in Montana's Child Care/Early Childhood Education

Providing high quality early childhood development and educational opportunities supports better outcomes for children over their lifetimes. Particularly for low-income children, studies show that those in quality programs have a decreased need for other

⁹⁵ Adams, Rohacek, Urban Institute, "Child Care Instability", 2008.



services such as special education and grade repetition, and have improved life outcomes including higher academic achievement, increased graduation rates, and more consistent employment.⁹⁶

Montana struggles to support high quality care consistently throughout the State. Child Care Aware ranked Montana 38th nationally out of 52 for registered family child care homes and 32nd for child care centers. Problems cited in the national study include a low ratio of licensors to child care providers, allowing facilities to be licensed prior to inspection, weak inspection requirements, weak provider background check requirements, and low provider training requirements. Only 12 percent of Montana's child care centers are nationally accredited,⁹⁷ and over 55 percent of providers are unlicensed and unregistered.^{98 99 100}

A common sentiment from interviewees and survey respondents is that quality child care is not valued in Montana. Families, communities, and political leaders need to be educated about what quality looks like and why it matters.

STARS to Quality

States are recognizing the difference quality can make in a child's development and school readiness. Twenty-eight states operate Quality Rating Improvement Systems (QRIS), seven are piloting a QRIS, and another 14 are developing a program.¹⁰¹

Montana has been field testing (statewide) the second iteration of its QRIS program, called STARS to Quality, and plans to continue the field test for another two years to gather more data and further refine the program. Providers are generally pleased with the definition of quality being used. The biggest complaint expressed about the program is the cost and burden associated with the training requirements. This is particularly true for larger centers and other providers who experience more staff turnover.

Participating providers feel that children's outcomes are improving because of the training they received through the STARS program. In particular, providers cited the impact of the CSEFEL training focused on promoting social emotional development and

⁹⁶ The White House, Early Childhood Education, <http://www.whitehouse.gov/issues/education/early-childhood>.

⁹⁷ Child Care Aware, "2012 Child Care in the State of Montana".

⁹⁸ Ibid.

⁹⁹ DPHHS, "2012 Early Childhood Montana Data Report, Draft".

¹⁰⁰ In the 2012 Child Care in the State of Montana report, Child Care Aware estimates that Montana has 21,247 slots available in child care centers, group child care homes, and family child care homes.

¹⁰¹ Child Care Aware, "Child Care Subsidy Policy: Access to What?", 2012.



school readiness of young children birth to age 5. Providers feel better equipped to work with children exhibiting challenging behaviors.

Child Care Licensing

Interviews and surveys consistently cited weaknesses of Montana's child care licensing requirements, which may negatively impact the welfare and safety of children and the quality of care. The highest priority concerns within child care licensing are:

- Weak laws allowing for a large number of child care providers to be unlicensed or unregistered in Montana.
- Insufficient inspection requirements for licensed and registered child care providers.
- Low standards for licensing or registering a child care provider and lack of coordination with ECSB quality initiatives.
- Weak background check requirements.

Unlicensed/unregistered child care providers

A significant percentage of Montana's children receive care in unlicensed, unregistered child care settings. Child Care Aware estimated that 46,473 children under the age of six potentially need care because either both parents or single parents of children are in the work force.¹⁰² The total capacity of licensed child care centers, registered group child care homes, and registered family child care homes throughout Montana for 2012 is 19,938.^{103 104} The remaining 26,535 children, who comprise 57 percent of the total population needing child care, receive care in settings receiving no oversight from the State of Montana. This unlicensed/unregistered group of providers includes preschools, many Montessori schools, drop in child care facilities, and relative caretakers. A subset of unlicensed and unregistered providers has not had background check requirements or basic health and safety training.

Inspection requirements

Montana regulations require limited inspections of child care providers. The State exceeds its requirement to visit 20 percent of providers annually. In SFY 2012, licensing inspected 31 percent of child care providers. Montana does not need to meet the Child Care Aware recommended ratio of one inspector for every 50 child care facilities to support current inspection requirements. There is a sentiment among providers and other stakeholders in the early childhood system that the current standards are insufficient.

¹⁰² Child Care Aware, "2012 Child Care in the State of Montana".

¹⁰³ DPHHS, "2012 Early Childhood Montana Data Report, Draft".

¹⁰⁴ In the 2012 Child Care in the State of Montana report, Child Care Aware estimates that Montana has 21,247 slots available in child care centers, group child care homes, and family child care homes.



An additional inspection requirement cited by the 2012 Child Care Aware analysis of child care in Montana as problematic is the fact that home care facilities can be licensed before inspection. Child care licensing inspects facilities within 120 days of opening. There is a lack of certainty that health and safety standards are being met for up to the first four months of operations.

Licensing standards and quality coordination

Child care licensing is very clear that licensing does not represent quality. Rather, it is the minimum data set or the floor/foundation upon which quality is built.¹⁰⁵ Licensing is responsible for ensuring health and safety standards are met, and ECSB works with providers to improve quality. All providers participating in Montana's QRIS, STARS to Quality, must be licensed as a first step in the process. Interviewees generally felt the minimum threshold represented by licensing was not high enough, and felt the floor should be raised. Child care licensing may need to partner further with ECSB to support the broader implementation of quality improvements under STARS to Quality.

Background checks

Child care licensing does not conduct comprehensive background checks on providers. Licensing conducts name-based background checks within Montana on providers unless they moved to the State within the last five years. In these cases, licensing conducts fingerprint-based federal criminal background checks. QAD would like to use fingerprint-based federal criminal background checks for all providers, but has not been able to do so because of budgetary constraints. Licensing is hesitant to pass this cost on to providers.

Adequate Provider Supply

A consistent theme from county needs assessments, interviewees, and survey respondents is that there is not an adequate supply of child care providers in Montana to meet demand. Providers often choose to not provide care in these shortage areas because of financial reasons. The shortage is acute for:

- **Infant care** – Restrictions on the ratio of infants to providers offset the financial benefits of increased rates charged for their care.
- **Off-hour care (evenings, weekends, early mornings, holidays)** – Fewer parents need off-hour care, reducing the number of children for which providers would care.

¹⁰⁵ Becky Fleming-Siebenaler, QAD, Child Care Licensing, Chief of Licensure Bureau, Interview, December 13, 2012.



- **Care for children with special needs and behavioral problems** – Many providers are not trained or staffed adequately to work with children with special needs or behavioral problems.
- **Child care over the summer** – Demand for child care rises when school is not in session. Montana’s limited supply of providers cannot adequately meet this demand.
- **Respite care** – There is a statewide shortage of respite providers, particularly for children with special needs.

Because many families struggle to simply find someone with capacity to care for their children, families often do not select a provider based on quality of care considerations.

Child Care Affordability

Child care is expensive. Families struggle to pay for quality care. The following table shows the average price of child care in Montana.

Table 15: Average Annual Child Care Fees¹⁰⁶

Child Care Center	Montana	United States
Infant	\$8,307	\$4,591 - \$20,178
4-year old child	\$7,285	\$3,911 - \$15,437
School-age child (before/after school)	\$6,679	\$1,954 - \$10,962
Family Child Care Home	Montana	United States
Infant	\$6,907	\$4,020 - \$12,329
4-year old child	\$6,445	\$3,840 - \$9,620
School-age child (before/after school)	\$6,314	\$1,788 - \$9,506

This is a significant expense for families. Based on the median family income for Montanans, infant care in a center costs approximately 12 percent of a married couple’s income and over 40 percent of a single mother’s income.¹⁰⁷

Montana has Head Start and Early Head Start available to support low-income residents in accessing child care. There are 13 Head Start programs, seven Early Head Start programs, seven Tribal Head Start programs, and three Tribal Early Head Start programs serving 5,198 children and youth in Montana (4,330 in Head Start programs and 868 in Early Head Start Programs).¹⁰⁸

¹⁰⁶ Child Care Aware, “2012 Child Care in the State of Montana report”.

¹⁰⁷ Ibid.

¹⁰⁸ ACF, Office of Head Start, “Head Start Program Information Report”, 2012.



There are many more children eligible for Head Start and Early Head Start than there is funding to serve. Head Start and Early Head Start provide services to approximately 35 percent of children birth to age five at or below 100 percent of the federal poverty level. Many communities do not have a program, and others have not grown to meet demographic shifts. Head Start and Early Head Start programs determine which children to serve based off prioritization factors, such as homelessness, rather than first in, first out of the waiting list. This means that many low-income families remain on the waiting list without receiving services despite being income eligible. The following table outlines the number of children on the wait list in each of the Head Start/Early Head Start offices statewide for which data was available.¹⁰⁹

Table 16: Head Start/Early Head Start Capacity and Wait List¹¹⁰

Program	Location	Wait List
Northwest Montana Head Start	Kalispell, Canyon, Columbia Falls, Eureka	138
AWARE Head Start	Butte	45
AWARE Early Head Start	Dillon	2
Ravalli Head Start	Hamilton	21
Ravalli Early Head Start	Missoula and Hamilton	72
Billings Head Start	Billings(North Park), Laurel, Joliet, Red Lodge, Lockwood, Hardin	110 ¹¹¹
Missoula Head Start	Missoula	108
Action for Eastern Montana	Glendive, Glasgow, Miles City	15
Young Families Early Head Start	Billings	28
Kootenai Valley Head Start	Libby	27
Northern Montana CDC Head Start	Havre	31
Northern Montana CDC Early Head Start	Havre	31
Northern Cheyenne	Lame Deer, Lodge Pole	0
Total		628

Montana also has Best Beginnings scholarships, through which families making 150 percent of the federal poverty limit or less (based on 2009 levels) receive CCDF child care subsidies. The US Department of Health and Human Services estimates that

¹⁰⁹ Only 13 of the Head Start and Early Head Start offices provided wait list information, meaning more than 50 percent of the offices are not represented in the chart.

¹¹⁰ Montana Head Start Collaboration Office.

¹¹¹ North Park only processes up to 100 applications to the waitlist. There are over 150 applications in a drawer that have never been processed



approximately 17 percent of children eligible for economic assistance to offset child care costs actually receive it.¹¹² In September 2012, approximately 3,000 families received child care subsidies, 2,100 under the non-TANF Best Beginnings scholarship.¹¹³ When combined with Head Start/Early Head Start data, the gap in affordable care for Montana families is significant, with over 60 percent of low-income families (<200 percent of the federal poverty limit) not accessing child care supports. The table below represents the total number of individuals and families receiving child care subsidies throughout State Fiscal Year 2012.

Table 17: Child Care by Category State Fiscal Year 2012¹¹⁴

	Working Caretaker Relative	Child Protective Services	TANF Block Grant	CCDF Block Grant	Tribal IV-E	Total
Children	139	923	2,724	7,722	34	10,352
Families	88	923	1,561	4,455	34	6,522

The families that do not qualify for Head Start, Early Head Start, or Best Beginnings because they earn too much money often struggle to afford care for their children. Montana is one of very few states that does not offer a universal pre-kindergarten program. Many providers are wary of the impact of a publicly funded pre-kindergarten program, which may reduce the demand for their services. Detractors worry that school systems are not capable of implementing pre-kindergarten correctly using an early childhood framework. Others see a state-funded pre-kindergarten program as an opportunity to implement higher quality standards universally throughout the early childhood education system and compensate providers adequately through the public school system. States with pre-kindergarten programs have almost all implemented comprehensive Early Learning Standards, and research has shown that children attending pre-kindergarten programs enter school more ready to learn than their peers.¹¹⁵ A publicly funded pre-kindergarten program could help fill in the gap for families ineligible or on a waiting list for other educational supports or subsidies, and remove a significant source of financial stress for the working poor.

¹¹² Child Care Aware, “Child Care Subsidy Policy: Access to What?”, 2012.

¹¹³ Statistical Report, Montana DPHHS, State Fiscal Year 2013, September.

¹¹⁴ Statistical Report, Montana DPHHS, State Fiscal Year 2012.

¹¹⁵ The Center for Public Education, <http://www.centerforpubliceducation.org/Main-Menu/Pre-kindergarten/Pre-Kindergarten>.



Best Beginnings Scholarships

Montana's child care subsidy program, Best Beginnings Scholarships, supports child care costs for working families and those participating in approved activities. The most pressing needs within the Best Beginnings program are related to access. Within the broad category of access, specifically there are concerns about:

- Insufficient coordination with other work support programs
- Burdensome application process
- Onerous verification requirements
- Promoting quality through stability of early childhood education experiences

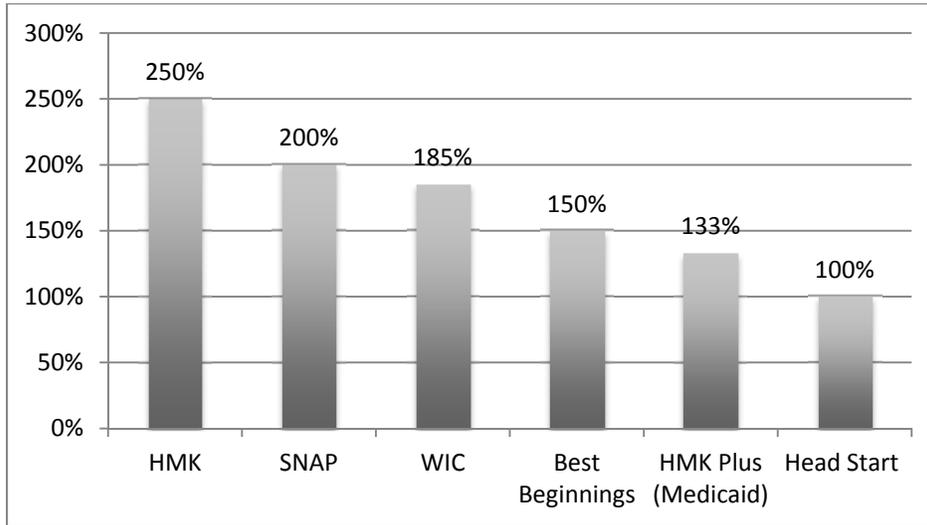
This section also discusses provider relationships with the State through the Best Beginnings program.

Work Support Coordination

Families earning 150 percent of the 2009 federal poverty limit or less are eligible for child care scholarships. Many states' child care subsidy programs have higher income limits. Montana has not increased income limits on the program because of budgetary constraints. Best Beginnings generally has a lower income eligibility than other work support programs in Montana. All TANF families participating in Family Investment Activities/Employability Plan are eligible for child care subsidies. However, families receiving HMK, SNAP, and WIC benefits earning more than 150 percent of the 2009 federal poverty limit are not eligible for Best Beginnings. Lack of access to child care subsidies for these families may create barriers for parents to work, or create incentives to find less expensive care alternatives, such as unlicensed, unregulated care in a private home.



Figure 10: Early Childhood Work and Educational Support Programs Income Eligibility Comparison¹¹⁶



Application Process

Because the income eligibility limit for Best Beginnings is lower than other work support programs, such as HMK, Medicaid, and SNAP, it is likely that many families receiving child care subsidies also participate in these other programs. The current application process is separate from work support eligibility, processed through the OPAs. This means that families must provide information to the OPAs as well as their local resource and referral agency to apply for multiple benefits. There is some information exchange when parents indicate they already receive SNAP on their child care application, but parents must still complete a 46-page application for Best Beginnings. Parents and providers consistently cited the complexity of the application as a barrier to access.

OPAs are implementing a new eligibility system, and are about to undergo major business process changes, Service First. Once these changes are stabilized, it may make sense to consider integrating or further coordinating Best Beginnings eligibility with work support program eligibility. ECSB is already moving in this direction with the upcoming online Best Beginnings application, which will share data with SNAP, TANF, and medical assistance eligibility. Increased coordination could present an opportunity to streamline the application process and align eligibility, verification, recertification, and change reporting requirements as much as possible with other work support programs.

¹¹⁶ Best Beginnings eligibility is based on 2009 FPL. SNAP eligibility is 130% FPL for families who have had a household member disqualified, therefore not making the family expanded categorically eligible.



Verifications

Montana requires families to provide verification of income, citizenship, residency, work/activity schedules, child care service plan, and child support cooperation to access subsidies. Work or training schedules are used to document the number of hours for which parents need child care. Providers and resource and referral agencies discussed the challenges parents face in getting work verification. The State places a burden on employers with this requirement. Geographic distances between employees and managers create logistical barriers to moving the paperwork around easily. Some employers may be hesitant to commit to a work schedule for an employee working irregular hours.

Policy allows eligibility to be determined without work verification by using two months of consecutive wages and a verbal statement of schedule. However, this exception does not seem to be consistently implemented by resource and referral agencies. Interviewees discussed denying applicants unable to acquire work verification.

Montana has a relatively low percentage (approximately 16 percent) of applications pended for more information. Montana's denial rate is also low at 12 percent. This may indicate that these requirements are not presenting major barriers to entry. However, tying child care subsidies closely to work/activity hours creates obstacles to supporting stable, continuous care for children receiving subsidies. The federal government requires very little documentation verification for families to receive child care subsidies. Montana has discretion over these requirements. Lessening them would make the application process less error prone for the State and less onerous for applicants and their employers.

Promoting Stability and Continuity of Care through Subsidies

Historically, concerns about access to subsidies and supporting work and self-sufficiency through child care vouchers were seen as separate from conversations about quality in early childhood education. That is no longer the case. It is clear that supporting work and economic stability for a family supports child development, and that supporting stable subsidies and systems that support providers is supporting quality.¹¹⁷ While in the past, there was a tendency to focus on enforcement and strict calibration between time in care and time parents are in an approved activity, there has been a growing understanding nationally that this approach doesn't support the overarching goals of child development, work support, and program integrity. This new perspective on the need to balance these goals reflects a national movement.

Under the CCDF block grant, states have flexibility to design child care subsidy policies

¹¹⁷ Adams, Rohacek, Urban Institute, "Child Care Voucher Programs, Provider Experiences", 2008.



and systems that support the long-term, sustainable success of children and families. The ACF Office of Child Care encourages states to implement policies that promote continuity of care for children and stability for families. Montana could consider:¹¹⁸

- **Implementing year-long eligibility periods** – to decrease the work required by families and the State in maintaining eligibility and decrease churn from families losing benefits at redetermination.
- **Allowing for changes in a family’s circumstances** – through allowing for temporary income increases without impacting eligibility or implementing tiered eligibility using a higher income eligibility threshold for families once they receive subsidies to encourage income advancement.
- **Not tying hours of care to work/activity schedule** – allowing a child to attend a five-day program with a curriculum despite irregular parent work or activity schedules.

Approximately 26 percent of Montana’s child care subsidy cases were closed and reopened between October 2011 and September 2012. Policy changes would allow many of these families churning off and on subsidies to remain connected. This increased stability benefits children and families.

Provider Relationships under Best Beginnings

Provider interviewees, overall, seemed satisfied with their interactions with the State through the Best Beginnings program. The primary complaint was the low reimbursement rate. Montana reimburses providers at 75 percent of the 2009 rates established by the market rate survey. Providers generally receive less money for children receiving Best Beginnings scholarships than for private pay clients, and the amount received is too low to fully support quality services. Providers are able to charge the difference to parents through a copayment. Providers differ in their approach to this – many are reluctant to do so because it creates an access barrier for families.

Another area of concern for providers is communication with the State. Resource and referral agencies often do not inform providers when families lose eligibility. The State does not have a provider interactive voice response system or online system with a provider portal for providers to look up information on client eligibility. This creates situations where providers continue to provide care after the subsidy ends, and cannot collect the lost revenue from the state or families. Some providers also struggle with communication as families apply for benefits. Presumptive eligibility is not consistently offered as an option to families waiting for eligibility decisions, which puts providers and families into challenging situations where they have to determine whether and how to support child care needs while waiting. This may mean parents cannot work while

¹¹⁸ CCDF-ACF-IM-2011-01.



waiting for a decision, or a provider provides care that may not be reimbursed depending on the whether the family is found eligible.

The provider survey conducted in Gallatin County also included some complaints around payment timing. The State reimburses for child care under Best Beginnings retrospectively, after care is provided, rather than up front as is done with private paying clients.

Resource and Referral Agencies

ECSB contracts with child care resource and referral agencies throughout the state to determine eligibility for Best Beginnings scholarships, evaluate special needs referrals, and provide training for child care providers. Child care referral services are centralized within one resource and referral agency. Each agency works independently from the others even though they belong to a common network. This infrequent interaction creates the opportunity for inconsistent interpretations and implementations of child care subsidy policy. ECSB has no oversight of hiring or training of staff within the resource and referral agencies. Despite this, the State is accountable to the federal government for the work done by these agencies.

These agencies are asked to wear a lot of different hats that require different skill sets. Some of these agencies are doing so with very limited staffing. As a result, eligibility determinations made by these agencies are not meeting accuracy standards. Currently, Montana has an 11.2 percent error rate in child care subsidy eligibility determination. ECSB is in the process of creating online training for staff at these agencies to increase consistency in eligibility processes.

Resource and referral agencies provide training, but limited follow up or implementation work occurs. The State cannot say that it is using evidence-based practices, such as the CSEFEL pyramid model, without follow up coaching/mentoring to ensure practices are being implemented to fidelity. The State may want to change the model of child care provider training to support the shift toward evidence-based practices and improved outcomes generally.

Montana received 3,915 referral requests in 2012.^{119 120} Providers and other resource and referral agencies have indicated the centralized resource and referral work may need improvement. Information provided to parents does not include current availability, and requires parents to do an extensive amount of legwork locally. Parents receive very little information to help them identify a quality child care setting for their

¹¹⁹ Child Care Aware, "2012 Child Care in the State of Montana".

¹²⁰ The draft 2012 Early Childhood Montana Data Report shows 5,366 referrals made in FFY 2012. This estimate is based on data from the Child Care Resource and Referral quarterly reports.



children. A centralized approach makes sense to retain in terms of efficiency and consistency, however the current approach may need improvement to better support families in finding quality child care options.

Child Care Provider/Early Childhood Educator Professional Development

Montana implemented an annual training requirement for child care providers in 2004/2005. Now all child care providers are required to complete a minimum of eight hours of training annually. Providers are able to do more training than the minimum, and those participating in the STARS to Quality program are required to meet higher standards.

The state promotes increased training through incentives, including professional development incentive awards for people who take a 25-50 hour block of training in a year, professional development for higher education, which is money toward tuition, and incentives for participating in the training registry. Despite this support, providers often cite the cost of training as a barrier because of additional expenses including staff salaries, travel, food, and hotel costs.

Montana is moving in the direction of having more comprehensive, curriculum-based professional development opportunities available for child care providers. Montana's training system hasn't kept up with providers' needs. In particular, early childhood providers are lacking:

- Cross sector training in mental/behavioral health, family support, and physical health
- Intermediate and advanced level training opportunities
- Individualized mentoring or coaching of providers

Providers primarily receive their training through their local resource and referral agencies. Other organizations provide trainings, but these are not often accessible by child care providers. For example, Head Start/Early Head Start has standalone training, and it is rare for these providers to take trainings through their local resource and referral agency or vice versa.¹²¹

¹²¹ Montana KIDS COUNT, "Montana 2011 Head Start Needs Assessment, Update".



Recommendations

The broad scope of this needs assessment lends itself to a long list of identified needs or problems throughout Montana’s child serving systems. The Best Beginnings State Advisory Council will determine next steps in addressing these issues. The recommendations included in this section are actions or approaches to consider in strategic planning. There are high-level recommendations that span the four areas of analysis in this assessment, in addition to recommendations within the four focus areas of community support, social, emotional, and mental health, connection to medical insurance or medical home, and early childhood programs/education.

As the council considers next steps, it may be helpful to further categorize recommendations into categories denoting the type of work required to implement the recommendation. The four categories used are: 1) policy; 2) process/operations; 3) administrative structure; and 4) information technology. Some recommendations span multiple categories, making placement decisions somewhat subjective. The vast majority of the recommendations fall within policy and process recommendation categories. No recommendations are classified primarily as information technology recommendations, although many would require information technology to support process and policy changes.

Table 18: Recommendations for Montana’s Early Childhood Systems and Best Beginnings State Advisory Council

High-Level/Cross-System

Policy:

1. **Require use of evidence-based or outcomes-focused practices** and pay for improved outcomes rather than services delivered. This may require increased collaboration of multi-disciplinary teams to best meet the needs of children and families. This shift may impact the way government does business at the State level.

Process/Operations:

2. **Use data to define the work of the council** – the Best Beginnings State Advisory Council should collect and use data, such as the Adverse Childhood Experiences data, to drive its work. Objective measures will allow the council to define priorities and determine the impact of services and interventions.

Administrative Structure:

3. **Move Best Beginnings State Advisory Council to Governor’s office** – the current structure within DPHHS is not inclusive of the full child-serving system. Missing from the council is the Department of Commerce, Housing Division, Department of Transportation, Department of Labor, and Department of Justice. Elevating the
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council to the Governor's office would help get all of the relevant stakeholders to the table.

4. **Coordinate work across agencies and organizations** – the State should further coordinate services and their delivery to reduce duplication of efforts between agencies and organizations. Consider using electronic medical records or other information technology to support information exchange between providers.
5. **Increase data sharing and coordination with Tribal entities** – the State needs to continue to work with Tribal entities to increase collaboration, which could support improved services and outcomes for Native American children and families. The State should meet with Tribal entities to determine how to effectively coordinate beyond extending meeting invitations.
6. **Coordinate with and support local Best Beginnings Councils** – there is a lot of good work being done at the local level. The State needs to develop and implement a communication plan, which should include a focus on the relationship between the State and local councils. The State should work with local councils to determine how work will be sustained after the grant funding is gone.

Family/Community Support

Policy:

1. **Implement prevention and crisis services to support homeless populations** and individuals/families at risk of homelessness.

Process/Organizational:

2. **Educate local, State, and Federal officials about housing's crucial role** in supporting stable environments for children and families.
3. **Family support providers should implement a cohesive, data driven approach** to increase effectiveness of interventions, limit duplication of effort, and decrease home visiting/parent education fatigue on the part of families.
4. **Continue coordination work at local levels** to ensure organizations are aware of work being done to meet other needs in their communities. Consider analyzing and piloting no wrong door/one-stop shop approaches.
5. **Focus on Service First work in OPAs** to reduce access barriers caused by policy, process, information technology, and organizational problems.

Social, Emotional, Mental Health

Policy:

1. **Increase prevention and crisis service availability** to keep children in their communities rather than placing them in out-of-home placements.
 2. **Promote integration of behavioral and primary care** to support increased service availability, allowing families to receive services in the communities.
 3. **Create and implement common screening/assessment infrastructure** for families seeking social, emotional, mental, or behavioral health services. Consider implementing no wrong door/one-stop shop approach to help families and other referral sources, e.g. child care providers, successfully navigate the system and make
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referrals across systems.

4. **Increase supply of mental health providers** – work collaboratively with other stakeholder organizations to actively recruit mental health professionals, particularly in rural areas, to increase supply of providers. Analyze reimbursement rates to determine impact of an increase.

Process/Organizational:

5. Continue to work to **reduce stigma of mental illness and increase awareness of social, emotional, mental, and behavioral needs**, possibly through an education and outreach campaign.
6. **Train child care providers to understand and address social, emotional, mental, and behavioral health issues.** Ensure providers know how to refer children for screenings.

Connection to Medical Insurance or Medical Home

Policy:

1. **Coordinate policies of work support programs to align with Affordable Care Act Medicaid requirements.** Try to work to coordinate beyond the OPA realm to support a no wrong door/one-stop shop approach and easier navigation.
2. **Recruit more providers to Montana** – the State should work collaboratively to address the provider shortage. The approach may include implementing residency programs or other educational experiences in coordination with national health education institutions to attract medical/dental/mental health providers to underserved areas.
3. **Analyze reimbursement rate structures** and determine impact of increases. Discuss lessons learned with states with similar demographics, such as Wyoming and North Dakota.
4. **Analyze medical home efforts** within DPHHS to determine how to increase the number of children using medical homes, particularly for children with special needs.

Process/Organizational:

5. **Continue work to redesign business practices in OPAs** to support streamlined access to services for families and increased efficiency for eligibility workers.

Early Childhood Programs/Education

Policy:

1. **Increase licensing standards** to better protect health and safety of children and better coordinate with quality initiatives of ECSB.
 2. **Increase access to educational supports for families** for low-income children such as increasing the income cap for Best Beginnings subsidies, expanding Head Start/Early Head Start programs, or implementing universal pre-kindergarten.
 3. **Streamline Best Beginnings application process** and coordinate policy with other work support programs.
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4. **Implement more flexible eligibility policies** to support continuity of care for children and stability for families.
 5. **Improve relationships with providers** –
 - a. Increase reimbursement rate for CCDF subsidies.
 - b. Create method for providers to check on eligibility status of children receiving Best Beginnings scholarships.
 - c. Consider methods of better matching provider subsidy billing and payment with private paying practices.
 6. **Rethink role of resource and referral agencies** – consider removing eligibility work from their contracts and implement more effective approaches to training and resource and referral work.

Process/Organizational:

7. **Educate community about quality child care** – help families learn to identify quality. Educate everyone about the importance of quality early childhood education.
 8. **Increase professional development opportunities** – continue to work toward implementing more comprehensive training opportunities. Increase cross-sector training opportunities for early childhood educators. Increase availability of intermediate and advanced training opportunities. Rethink training model to support increased individualized training and mentoring.
 9. **Expand capacity of Best Beginnings STARS to Quality program** to serve more child care programs, expanding improved training and quality standards along with increased financial incentives.
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Appendix A – Data Sources

The table below contains secondary data sources used in this assessment.

Table 19: Data Sources

Data Source	Organization/Author
2012 Employee Benefits: The Employee Benefits Landscape in a Recovering Economy.	Society for Human Resource Management
2010 Montana Maternal and Child Health Needs Assessment, July 2010.	DPHHS, Family and Community Health Bureau, Public Health and Safety Division
2011 – 2012 Head Start Program Information Report, Summary Report – State Level, Montana, September 13, 2012	Administration for Children and Families, Office of Head Start
2012 Child Care in the State of Montana, June 2012	Child Care Aware of America and Montana
2012 State of Small Family Child Care Group Homes in Montana	National Association of Child Care Resource and Referral Agencies
A Framework for Understanding Poverty, fourth revised edition, 2005, aha! Process, Inc.	Ruby Payne
A Survey of the Infrastructure for Children’s Mental Health Services: Implications for the Implementation of Empirically Supported Treatments, 2008	Schoenwald, Chapman, Kelleher, Hoagwood, Landsverk, Stevens et. al., Administration and Policy in Mental Health and Mental Health Services Research
Analysis of Life Skills Progression Outcome Panel Data, October 2012	Geo Haynes, Gallatin County Health Department
Child Care Centers in Montana, 2012	National Association of Child Care Resource and Referral Agencies
Child Care Instability: Definitions, Context, and Policy Implications, October 2010	The Urban Institute, Gina Adams, Monica Rohacek, with assistance from Anna Danzinger
Child Care Subsidy Policy: Access to What?, White Paper, September 2012	Child Care Aware of America
Child Care Voucher Programs: Provider Experiences in Five Counties, 2008	The Urban Institute, Gina Adams, Monica Rohacek, Kathleen Snyder
Children with Special Health Care Needs in Montana: Needs Summary, February 2012	DPHHS, Public Health and Safety, Maternal and Child Health and Children’s Special Health Services
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Appendix B – Acronyms

Below is a table of the acronyms used in this report.

Table 20: Acronyms

Acronym	Definition
ACA	Affordable Care Act
ACF	Administration for Children and Families
CACFP	Child and Adult Care Food Program
CANS	Child and Adolescent Needs and Strengths
CCDF	Child Care and Development Fund
CFSD	Child and Family Services Division
CMHB	Children’s Mental Health Bureau
CSCT	Comprehensive School and Community Treatment
CSEFEL	Centers on the Social and Emotional Foundations for Early Learning
CSI	Commissioner of Securities and Insurance
ECSB	Early Childhood Services Bureau
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
HCBS	Home and Community Based Services
HMK	Healthy Montana Kids
IDEA	Individuals with Disabilities Education Act
MECAC	Montana Early Childhood Advisory Council
MIECHV	Maternal, Infant, and Early Childhood Home Visiting
OPA	Office of Public Assistance
OPI	Office of Public Instruction
PRTF	Psychiatric Residential Treatment Facility
QRIS	Quality Rating Improvement System
SAMS	Safety Assessment Management System
SNAP	Supplemental Nutrition Assistance Program
TANF	Temporary Assistance for Needy Families





Report to:
Montana Department of Public Health and Human Services

Early Childhood Services Bureau

Best Beginnings Advisory Council Strategic Plan
March 22, 2013



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Introduction

The Best Beginnings Advisory Council (also referred to as the Council) was established in 2011 to ensure Montana has a comprehensive, coordinated, early childhood system that provides a governance structure and leads to strong collaboration in order to best meet the needs of Montana's youngest citizens. The Council was formed as an enhancement to the Montana Early Childhood Advisory Council (MECAC), expanding the scope from primarily early childhood education to a broader focus on systems impacting children and families.

The Best Beginnings Advisory Council grant from the Administration for Children and Families (ACF) required the State to conduct a needs assessment. This was complete in December 2012. The recommendations from this assessment were used as the starting place for the strategic planning process. The needs assessment executive summary, along with recommendations, is included in Appendix A.

The Council met on January 9 and 10, 2013 for a facilitated strategic planning session. This strategic plan resulting from the January meeting outlines strategic directions or objectives and associated milestones to support the Council's vision and goals.

The Best Beginnings Advisory Council is comprised of six committees:

1. Strategic Communication, Outreach, and Public Awareness
2. Professional Development
3. Family Support
4. Social, Emotional, and Mental Health
5. Health
6. High Quality Early Care and Education

The committees are the vehicles through which the Council's work will be accomplished. The Council committees created work plans for defined accomplishments, which will guide their work in the upcoming year.

The Best Beginnings Advisory Council Coordinator is the overall coordinator for this strategic plan. The committee chairs are responsible for coordinating the work plans within their committees' purview. This strategic plan is a living document, and should be revisited and updated at least quarterly by Council committees and the overall Council to reflect accomplishments, lessons learned, delays, and other changes.

The Best Beginnings Advisory Council committees will work with local councils as they seek to accomplish the work outlined in this strategic plan. Seven local councils were established alongside the State Council under the ACF grant. Sixteen additional local



councils were created under the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) grants. Local councils are completing community needs assessments and strategic plans, which are tied to State-level efforts.



Vision and Objectives

The Best Beginnings Advisory Council’s vision is to ***ensure Montana has a comprehensive, coordinated, early childhood system that provides a governance structure and leads to strong collaboration in order to best meet the needs of Montana’s youngest citizens.*** The Council is pursuing work within four objectives, which support the overall vision:¹²²

5. Families with young children are supported in their community.
6. Social, emotional, and mental health needs of young children and families are supported.
7. Children have access to a medical home and health insurance.
8. Children have access to high quality early childhood programs.

If the Council and partnering stakeholders are successful in implementing these objectives, the following would be in place in three to five years as a result of their actions:

<p>Families with young children are supported in their community</p> <ul style="list-style-type: none"> • There is decreased food insecurity • Housing is viewed as a basic need and housing services are available to ensure all families have affordable housing • Family support services are offered through a no-wrong door approach 	<p>Social, emotional, and mental health needs of young children and families are supported</p> <ul style="list-style-type: none"> • There is less need for mental health providers • The stigma associated with mental health needs is reduced • Evidence-based practices are widely used and possibly required • Screening and assessment tools are consistently used in a well-coordinated fashion • The pyramid model is being used • EPSDT is a required tool • Programs, including those within Children's Mental Health, incorporate a focus on early childhood (0-5)
<p>Children have access to a medical home and health insurance</p> <ul style="list-style-type: none"> • There is a larger number of early childhood health specialists in the State • More children with special health care needs are connected to medical homes • More low income children and their families are connected to health insurance 	<p>Children have access to high quality early childhood programs</p> <ul style="list-style-type: none"> • High quality is defined and broadly understood • Private and public sector early child care systems are connected • Early childhood systems are better coordinated with Office of Public Instruction, with some shared budget for collective initiatives • Pre-service education requirements for early childhood educators are enhanced

¹²² The 2010 ACF grant application defines the Council’s vision and supporting objectives. Department of Public Health and Human Services (DPHHS), Early Childhood Services Bureau (ECSB) leadership, wrote the grant application.



Challenges

The Council must address the following obstacles in order to accomplish the vision and supporting objectives.

Inflexible Systems with Narrow Views and Uncoordinated Policies Create Barriers	
<ul style="list-style-type: none"> • Uncoordinated and rigid policies provide insufficient support to families in obtaining self-sufficiency • Policies are overly complex and could be simplified to support more efficient and effective service delivery • Policies can be uncoordinated across and within early childhood systems 	<ul style="list-style-type: none"> • There is inadequate focus on efficient, effective and relevant spending of current funding • Program policy and funding structures create silos • There is insufficient focus on prevention • Child care licensing regulations could be strengthened and better enforced
Disconnect Exists Between Early Childhood Systems	
<ul style="list-style-type: none"> • Shared vision for interagency collaboration is missing • Minimal partnerships exist between health and early childhood education • Collaboration and commitment to collaborative work between agencies and programs could be increased • Political polarization exacerbates coordination problems • The education system is siloed 	<ul style="list-style-type: none"> • Public and private stakeholders do not necessarily understand each other's roles, and have limited venues in which to engage • Additional buy-in is needed from other stakeholders for early childhood work, including the Office of Public Instruction, Governor's office, Housing Division and stakeholders, and provider groups
A Clear Message to Educate Cohesively and Develop Awareness Is Missing	
<ul style="list-style-type: none"> • There is insufficient education about hunger, creating a limited realization that hunger is malnutrition • A stigma exists for those using health and human services programs because of inadequate understanding of recipients by the community • Additional community mental health education is needed • There is limited understanding of preventative family support needs, meaning proactive, preventative approaches are not prioritized over reactive ones • There is a need for increased family engagement 	<ul style="list-style-type: none"> • There is limited cultural competency • A common vision is needed for early childhood systems across the State • Clear messages are not being developed or delivered • Key and non-key stakeholders need to be identified and educated • Buy in needs to be created with a broader group of stakeholders • Political and public commitment to early childhood education is lacking, possibly because of limited awareness of the critical importance of a child's early years • Early childhood education is not broadly perceived as a highly skilled profession because of low standards in Montana
The Best Beginnings Advisory Council Has Experienced Program Planning Challenges	
<ul style="list-style-type: none"> • The Council has a compressed timeframe within the grant 	<ul style="list-style-type: none"> • The Council has struggled to identify concrete steps to move forward



<ul style="list-style-type: none"> • It is challenging to secure and share resources, (money and time) • The Council needs to demonstrate and communicate Council progress 	<ul style="list-style-type: none"> • There is limited funding available for service delivery
Data Could be Better Managed and Used	
<ul style="list-style-type: none"> • Existing data elements have not been identified consistently or coordinated • Community asset maps are needed – available services are not identified 	<ul style="list-style-type: none"> • There is limited coordinated, consistent, accurate, comparable, shared data across early childhood systems, inhibiting ability to analyze issues
Cross-Sector Professional Development Is Limited	
<ul style="list-style-type: none"> • There is a lot of turnover in early childhood systems, inhibiting professional development efforts 	<ul style="list-style-type: none"> • Additional resources and time for community education are needed • Low requirements result in limited pre-service professional development



Objectives and Milestones

The Council defined innovative, substantial actions to deal with the underlying contradictions and move the group toward the vision and objectives. Strategic work is needed in multiple settings, including:

1. The Governor’s office
2. Department of Public Health and Human Services administration
3. The private sector and Montana communities
4. The Best Beginnings Advisory Council
5. The Best Beginnings Advisory Council’s committees

The following sections provide additional detail on the work required from each stakeholder to implement the Best Beginnings Advisory Council’s strategic plan. The numbers associated with the stakeholders above are continued in the subsequent sections using an outline approach as shown below:

- 1 Stakeholder
 - 1.1 Objective
 - 1.1.1 Milestone

Governor’s Office

The Best Beginnings Advisory Council offers the following recommendations to the Governor’s Office as suggested approaches to providing leadership across Montana’s child-serving systems. The Council feels this leadership is particularly important for issues that span across or beyond State government departments and agencies. Many of the recommendations included for the Governor’s office emerged from the 2012 Best Beginnings needs assessment, and are beyond the scope of the Council’s responsibilities or control. The table below outlines recommended objectives and associated milestones for the Governor’s Office, which would support the work of the Best Beginnings Advisory Council.

Table 21: Governor’s Office Objectives and Milestones

1 Governor’s Office	
Objectives	Milestones
1.1 Increase collaboration between stakeholders in early childhood system	1.1.1 Additional stakeholders invited to Best Beginnings Advisory Council 1.1.2 Approach to increased coordination with Tribal entities jointly defined with Tribes 1.1.3 Best Beginnings Advisory Council move to Governor’s Office analyzed 1.1.4 Increased collaboration opportunities between Office of Public Instruction and Early Childhood Services Bureau and early childhood systems



1 Governor's Office	
Objectives	Milestones
	analyzed
1.2 Increase access to affordable housing	1.2.1 Local, State, and Federal officials educated about housing's crucial role in supporting stable environments for children and families 1.2.2 Prevention and crisis services defined and/or implemented to support homeless populations and individuals/families at risk of homelessness
1.3 Increase access to health services and providers	1.3.1 Plan created to recruit more primary and mental health providers to Montana
1.4 Implement policies and processes supporting higher quality standards and increased access to high quality early childhood education	1.4.1 Additional providers participating in Best Beginnings STARS to Quality program 1.4.2 Reimbursement rate for Child Care Development Fund subsidies increased 1.4.3 Recommendations to increase access to educational supports (i.e. increasing the income cap for Best Beginnings subsidies, expanding Head Start/Early Head Start programs, or implementing pre-kindergarten) considered
1.5 Use data to drive work of Best Beginnings Advisory Council and child serving systems	1.5.1 Data sharing across departments facilitated with integrated statewide IT systems
1.6 Educate and engage the public through effective communication and outreach	1.6.1 Broad-based campaign defined to address key messages included in Best Beginnings needs assessment and draw attention to early childhood as key to the lifelong success of a child

Department of Public Health and Human Services Administration

The Best Beginnings Advisory Council provides the following recommendations to the administration of the Department of Public Health and Human Services (DPHHS) to support implementation of the Council's strategic plan. As with the Governor's Office, many of these objectives and milestones stem from the needs assessment, and are beyond the scope of the Council's responsibilities or control. Some of this work is the sole responsibility of DPHHS, and other objectives are shared responsibilities between DPHHS administration and the Council or the Governor's Office. The table below defines the objectives and associated milestones for the DPHHS administration.

Table 22: DPHHS Administration Objectives and Milestones

2 DPHHS Administration	
Objectives	Milestones
2.1 Use data to drive work of Best	2.1.1 Data indicators and collection approach defined



2 DPHHS Administration	
Objectives	Milestones
Beginnings Advisory Council and child serving systems	(e.g. ACE data) 2.1.2 Cohesive, data-driven approach jointly defined with family support providers
2.2 Increase use of evidence-based and outcome-focused practices	2.2.1 National best practice research conducted on approaches to increasing evidence-based and outcome-focused practices 2.2.2 Service areas and approach to implement increased evidence-based and outcomes-focus practices defined
2.3 Increase collaboration and coordination between stakeholders in early childhood systems	2.3.1 Areas where duplication exists across agencies and organizations identified and recommendations for consolidation/ coordination created 2.3.2 Research conducted and communication initiated regarding electronic medical record efforts in Montana and nationally 2.3.3 Approach to increased coordination with Tribal entities jointly defined with Tribes 2.3.4 Community resource directories created 2.3.5 Plan created to align and coordinate information technology systems 2.3.6 Options to combine/coordinate existing councils and advisory groups into one evaluated (i.e. advisory councils for Part C, Best Beginnings Advisory Council and Children with Special Health Care Needs)
2.4 Develop strategies to sustain Best Beginnings work happening at State and local levels	2.4.1 Plan created to sustain local and State councils 2.4.2 Communication plan between local and State councils created
2.5 Educate and engage the public through effective communication and outreach	2.5.1 Education and outreach campaign defined to reduce stigma of mental illness and increase awareness of social, emotional, mental, and behavioral needs 2.5.2 Education and outreach efforts defined to inform public about quality early childcare
2.6 Support professional development across child-serving systems	2.6.1 Provider (i.e. child care, health, mental health) professional development approach defined to understand and address social, emotional, mental, and behavioral health issues
2.7 Identify and adopt a universal model for early childhood social, emotional, and mental health	2.7.1 Common screening and assessment infrastructure defined



2 DPHHS Administration	
Objectives	Milestones
2.8 Increase access to health services and providers	2.8.1 Current recruitment efforts for primary care and mental health providers supported 2.8.2 Increased prevention and crisis services defined and implementation plans created 2.8.3 Medicaid reimbursement rate structures analyzed 2.8.4 Medical home efforts analyzed 2.8.5 Immunization efforts supported
2.9 Align policies and processes to decrease access barriers to health and human services	2.9.1 Service First project at Offices of Public Assistance implemented 2.9.2 Policies of work support programs coordinated to align with ACA Medicaid requirements 2.9.3 Meetings held to discuss implementation of no wrong door/one-stop shop approaches to service delivery at local level
2.10 Implement policies and processes supporting high quality standards and increased access to high quality early childhood education	2.10.1 Recommendations to increase licensing standards considered and implementation plan created 2.10.2 Recommendations to increase access to educational supports (i.e. increasing the income cap for Best Beginnings subsidies, expanding Head Start/Early Head Start programs, or implementing pre-kindergarten) created 2.10.3 Best Beginnings application streamlined and policies aligned with work support programs 2.10.4 Recommendations considered to make Best Beginnings eligibility policies more flexible 2.10.5 Recommendations considered to provide improved access to providers to verify eligibility status of children receiving Best Beginnings scholarships 2.10.6 Methods to match provider subsidy billing and payment with private paying practices analyzed 2.10.7 Role of resource and referral agencies analyzed 2.10.8 Additional providers participating in Best Beginnings STARS to Quality program
2.11 Collaborate and align with other agencies and officials to increase access to affordable housing	2.11.1 Support and coordination role provided to educate local, State, and Federal officials about housing's crucial role in supporting stable environments for children and families 2.11.2 Support and coordination role provided to define and/or implement prevention and crisis services to support homeless populations and individuals/families at risk of homelessness



Local Councils and Communities

A subset of the objectives or strategic directions defined by the Council fall within the purview of the local councils and communities, including private sector providers. Local efforts are needed to plan and implement at the ground level. All of the defined objectives are shared with other stakeholders in this strategic plan, including the Governor’s office, DPHHS administration, the Council, and its committees. The table below outlines the overall objectives and associated milestones for local councils and communities.

Table 23: Local Councils and Communities Objectives and Milestones

3 Local Councils, Private Sector, and Montana Communities	
Objectives	Milestones
3.1 Develop strategies to sustain Best Beginnings work happening at State and local levels	3.1.1 Plan created to sustain local councils 3.1.2 Communication plan between local and State councils created
3.2 Increase access to affordable housing	3.2.1 Local, State, and Federal officials educated about housing’s crucial role in supporting stable environments for children and families 3.2.2 Prevention and crisis services defined and/or implemented to support homeless populations and individuals/families at risk of homelessness
3.3 Increase collaboration and coordination between stakeholders in early childhood system	3.3.1 Community resource directories created
3.4 Align policies and processes to decrease access barriers to health and human services	3.4.1 Meetings held to discuss implementation of no wrong door/one-stop shop approaches to service delivery at local level
3.5 Educate and engage the public through effective communication and outreach	3.5.1 Education and outreach campaigns supported at the local level
3.6 Support professional development across child-serving systems	3.6.1 Provider (i.e. child care, health, and mental health) training developed to understand and address social, emotional, mental, and behavioral health issues at local level 3.6.2 Cross-system professional development opportunity identified and tracked
3.7 Assist processes supporting high quality standards and increased access to high quality early childhood education	3.7.1 Role of resource and referral agencies analyzed 3.7.2 Collaborative work between resource and referral agencies and local councils defined



Best Beginnings Advisory Council

A portion of the work for which the Council is responsible must occur at the Council level, rather than in individual committees. These objectives or strategic directions span across multiple committees and broadly impact the child serving systems. The Council shares responsibility for many of the defined objectives with other stakeholders, including Council committees, DPHHS Administration, and local councils/stakeholders. The table below defines the overall objectives and associated milestones for the Best Beginnings Advisory Council.

Table 24: Best Beginnings Advisory Council Objectives and Milestones

4 Best Beginnings Advisory Council	
Objectives	Milestones
4.1 Use data to drive work of Best Beginnings Advisory Council and child serving systems	4.1.1 Data indicators and collection approach defined (e.g. ACE)
4.2 Develop strategies to sustain Best Beginnings work happening at State and local levels	4.2.1 Plan created to sustain State and local councils 4.2.2 Communication plan between local and State councils created
4.3 Continue to assess and respond to evolving needs in early childhood systems	4.3.1 Periodic comprehensive needs assessment plan created 4.3.2 Montana-specific cultural and linguistic competency framework for understanding and responsiveness across early childhood system created

Strategic Communication, Outreach, and Public Awareness Committee

The Strategic Communication, Outreach, and Public Awareness (SCOPA) committee's charge is to develop recommendations for a strategic communication and outreach plan related to early childhood services in Montana. The SCOPA committee must work closely with other Council committees and DPHHS administration. The table below outlines the objective and associated milestones for the SCOPA committee.

Table 25: Strategic Communication, Outreach, and Public Awareness Committee Objective and Milestones

5 Strategic Communication, Outreach, and Public Awareness Committee	
Objectives	Milestones
5.1 Provide recommendations to educate and engage the public	5.1.1 Communication plan drafted 5.1.1.1 Recommendations created for education and



5 Strategic Communication, Outreach, and Public Awareness Committee	
Objectives	Milestones
through effective communication and outreach	outreach campaign to reduce stigma of mental illness and increase awareness of social, emotional, mental, and behavioral needs 5.1.1.2 Recommendations created for education and outreach efforts to inform public about early care and education
5.2 Improve referral processes to promote increased access to health care	5.2.1 Communication established between healthcare providers and early childhood educators

Professional Development

The Professional Development committee’s charge is to promote and support cross-sector early childhood professional development and workforce preparation for those professionals working with young children and families. The Professional Development committee must work closely with other Council committees and DPHHS administration. The table below defines the objectives and associated milestones for the Professional Development committee.

Table 26: Professional Development Committee Objectives and Milestones

6 Professional Development Committee	
Objectives	Milestones
6.1 Support professional development and workforce preparation across child-serving systems	6.1.1 Strengthening Families training including pyramid framework adopted 6.1.2 Cross-sector professional development opportunities identified and tracked
6.2 Support child care professional development opportunities aligned with STARS to Quality initiative	6.2.1 Early childhood center directors’ credential program and process developed, inclusive of Aim 4 Excellence cohort model 6.2.2 Montana Early Learning Guidelines (ELGs) for ages 0-5 evaluated, revised, and cross-walked with kindergarten standards and the MT Early Care and Education Knowledge Base (KBase) and embedded in Early Childhood Higher Education (ECHEC) student learner outcomes. 6.2.3 Coaching Framework is established 6.2.4 Connection between STARS to Quality training requirements and early childhood higher education programs and degrees analyzed 6.2.5 Two trainers trained in PAS/BAS in each quadrant 6.2.6 Entry level training required for new providers



6 Professional Development Committee	
Objectives	Milestones
	6.2.7 Minimum training hours for licensing increased 6.2.8 Compensation parity for early childhood education professionals analyzed 6.2.9 Mentoring as strategy for early childhood education program improvement analyzed

Family Support

The Family Support committee’s charge is to support and enhance services to families around the state; to support a network of services around the state by ensuring referrals are provided and systems are connected; and to provide information to and awareness around parent education and family support services. The Family Support committee must work closely with other Council committees and DPHHS administration. The table below defines the objectives and associated milestones for the Family Support committee.

Table 27: Family Support Committee Objectives and Milestones

7 Family Support Committee	
Objectives	Milestones
7.1 Support improved access to and increased retention of family support services	7.1.1 Gaps, duplications, and models statewide related to home visitation models, programs, and services identified 7.1.2 Community resource needs identified 7.1.3 Best practices researched of innovative approaches to support children and families as they transition between programs and services, and into public school
7.2 Increase and improve coordination of parent education opportunities	7.2.1 Family forum results reported to Best Beginnings Advisory Council 7.2.2 Statewide family support network created 7.2.3 Collaborative parent education held in local, neutral environments 7.2.4 Action plan created for parent training and education using the CSEFEL Parent Modules in partnership with other statewide services for families



Social, Emotional, Mental Health Committee

The Social, Emotional, and Mental Health committee’s charge is to work with multiple agencies, systems, and communities, provide leadership in Identifying opportunities to use the Pyramid model to promote the social emotional well-being of young children using, prevent challenging behaviors and provide intense, individual, interventions when needed. The Social, Emotional, and Mental Health committee must work closely with other Council committees and DPHHS administration. The table below defines the objectives and associated milestones for the Social, Emotional, and Mental Health committee.

Table 28: Social, Emotional, and Mental Health Committee Objectives and Milestones

8 Social, Emotional, and Mental Health Committee	
Objectives	Milestones
8.1 Identify and recommend a universal model for early childhood social, emotional, and mental health	8.1.1 Consensus on universal model obtained within Best Beginnings Advisory Council and related stakeholders 8.1.2 Pyramid Model coached to fidelity in 1 to 2 Best Beginning Communities using early childhood coaches as defined by the Montana Early Childhood Coaching Framework. 8.1.3 Recommendations provided to communities on sustaining coaching 8.1.4 Training/coaching model evaluated
8.2 Increase use of evidence-based and outcome-focused practices	8.2.1 National best practices on mental health models and training researched and identified 8.2.2 National best practices on infant/toddler mental health researched and identified 8.2.3 Common screening and assessment infrastructure recommendations provided to DPHHS
8.3 Address mental health service gaps and access problems	8.3.1 Early childhood mental health service providers identified in pilot communities and approaches defined to connect young children and families to services
8.4 Support professional development across child-serving systems	8.4.1 Provider (i.e. child care, health, and mental health) training developed to understand and address social, emotional, mental, and behavioral health issues



Health Committee

The Health committee’s charge is to work with multiple agencies, systems, and communities to: 1) strengthen collaborative relationships among local public health authorities and early care and education services; 2) increase Montana’s rankings related to immunization utilization, especially in relation to the early childhood population; 3) develop innovative approaches to accessing dental care services for low income and rural populations; and 4) develop Montana Physical Activity and Nutrition Guidelines for Early Childhood. The Health committee must work closely with other Council committees and DPHHS administration. The table below defines the objectives and associated milestones for the Health committee.

Table 29: Health Committee Objectives and Milestones

9 Health Committee	
Objectives	Milestones
9.1 Increase access to health services and providers	9.1.1 Best Beginnings Advisory Council educated about current provider recruitment efforts 9.1.2 BBAC next steps defined to address provider shortage in support role to DPHHS defined 9.1.3 Medical home efforts analyzed
9.2 Improve referral processes to promote increased access to health care	9.2.1 Communication established between healthcare providers and early childhood educators
9.3 Analyze policy approaches to improving access to health care	9.3.1 Affordable Care Act impacts on early childhood programs identified
9.4 Improve early childhood nutrition	9.4.1 Montana Physical Activity and Nutrition Guidelines developed

High Quality Early Care and Education Committee

The High Quality Early Care and Education’s committee’s charge is to assure access and affordability of high quality child care in a variety of settings including child care centers, family and group child care, and informal care settings. High quality care is family friendly and/or driven as applicable, and fair to providers. The committee is charged with assuring that the basic health and safety needs of children are addressed in child care settings and that all children shall benefit from quality experiences in which young children are supported as they develop. The High Quality Early Care and Education committee must work closely with other Council committees and DPHHS administration. The table below outlines the objectives and associated milestones for the High Quality Early Care and Education committee.



Table 30: High Quality Early Care and Education Committee Objectives and Milestones

10 High Quality Early Care and Education Committee	
Objectives	Milestones
10.1 Implement policies and processes supporting high quality standards and increased access to high quality early childhood education	10.1.1 Recommendations to streamline Best Beginnings application and eligibility processes provided to DPHHS 10.1.2 Recommendations to make Best Beginnings scholarships more flexible provided to DPHHS 10.1.3 Collaborative work conducted with QAD/Licensing to increase health and licensing standards 10.1.4 STARS program continued and growth potential analyzed 10.1.5 Role of resource and referral agencies analyzed
10.2 Increase collaboration with other early childhood systems to improve outcomes for children and families	10.2.1 Shared Service Delivery Plan proposal complete
10.3 Educate and engage public through effective communication and outreach	10.3.1 Child care provider representation in Best Beginnings Advisory Council increased 10.3.2 Education and outreach efforts defined to inform public about quality early childcare
10.4 Support child care professional development opportunities aligned with STARS to Quality initiative	10.4.1 Recommendations to increase professional development opportunities provided to Professional Development committee
10.5 Continue to assess and respond to evolving needs in early childhood systems	10.5.1 Child care capacity by age-group, geographic location, special needs, and non-traditional hours formally assessed through comprehensive periodic needs assessment



Implementation Steps

The Council and its committees defined activities or implementation steps required to achieve the accomplishments or milestones. The Council and its committees use these work plans to guide their work. Because they are actively managed and often modified, these work plans are maintained separate from this strategic plan.

Bloom 

Report to:
Montana Department of Public Health and Human Services

Early Childhood Services Bureau

Appendix
February 1, 2013



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Best Beginnings Advisory Council Original Grant Goals and Objectives

May 2011

Governance, Collaboration, and Coordination

Objective 1: Conduct a comprehensive scan of existing state level needs assessments.

Status: Complete

Objective 2: Provide opportunity for local entities to establish formal community advisory councils, tied to the state council.

Status: Complete

Objective 3: Assist local councils in assessing needs in local communities and developing community strategic early childhood plans.

Status: In process/ongoing

Objective 4: Develop a periodic comprehensive needs assessment plan over three years with public input identifying strengths and gaps in services.

Status: Complete

Objective 5: Develop a formal strategic plan for early childhood aligned with other State project/grant strategic and/or state plans and in response to needs assessment results.

Status: Complete

Objective 6: Create a Montana specific cultural and linguistic competency framework for understanding and responsiveness across the early Childhood system.

Status: In planning

Strategic Communication, Outreach, and Public Awareness Committee

Objective 1: Develop a strategic communication and outreach plan related to early childhood services in Montana.

Status: In process/ongoing

High Quality Early Childhood Education Committee

Objective 1: Continue Best Beginnings STARS to Quality Field Test and determine best practices, effective methodology, approach, and needs to provide opportunity for all providers to participate in the STARS to Quality Program, including centers, family and group providers, Head Start, Early Head Start, Public Preschool, and possibly informal care providers.

Status: In process/ongoing

Objective 2: Utilizing information from the Best Beginnings STARS to Quality evaluation findings and various needs assessments, identify other professional development needs to include in the comprehensive strategic plan.

Status: In process/ongoing

Objective 3: Continue to assure that low income families have access to high quality early childhood programming by maintaining a sliding fee scale with the current federal poverty index.

Status: In planning

Objective 4: Develop innovative models to address underrepresented populations and or families that are over income for assistance but still face difficulty in affording child care.

Status: In planning

Objective 5: Strengthen informal care provider networks, policies, and professional development opportunities.

Status: In process/ongoing

Objective 6: Formally assess child care capacity by age group, geographic location, special needs, and non-traditional hours through the comprehensive periodic needs assessment.

Status: In planning

Objective 7: Identify gaps and barriers to family friendly policies and implement family friendly policy changes when appropriate in early childhood programs.

Status: In process/ongoing

Objective 8: Conduct a SWOT (strengths, weaknesses, opportunities, and threats) analysis and assessment of gaps and duplication of services related to the Special Needs Subsidy program and address innovative approaches to maintain effective service delivery.

Status: In planning

Professional Development Committee

Objective 1: Evaluate, revise, and align the Montana Early Learning Guidelines for ages 3-5 with Kindergarten standards and Early Childhood Higher Education student learner outcomes.

Status: In process/ongoing

Objective 2: Develop a career ladder for the after school/school age workforce that aligns with the current Montana Early Care and Education Career Ladder.

Status: In process/ongoing

Objective 3: Develop a Center Director's Credential program and process.

Status: In process/ongoing

Objective 4: Enhance the Trainer Directory and establish firm trainer and coach qualifications which may include credentialing and identification of professional development needs for trainers/coaches.

Status: In process/ongoing

Objective 5: Continue to focus on workforce preparation with identification of common and specific coursework and comprehensive training in specialty areas for early childhood. Expand professional development opportunities to serve the needs of all practitioners in Montana, including distance learning.

Status: In process/ongoing

Objective 6: Continue to enhance Montana's coaching model and repertoire through increased awareness, training, and support.

Status: In process/ongoing

Family Support Committee

Objective 1: Identify gaps, duplications and models statewide related to home visitation models, programs, and services.

Status: In process/ongoing

Objective 2: Expand and align program expectations and approaches related to implementation of CSEFEL Teaching Pyramid Model cross system including mental health services, early care and education services, family support services, and public education. Develop an action plan for parent training and education using the CSEFEL Parent Modules in partnership with other state wide services for families.

Status: In planning

Objective 3: As part of the comprehensive early childhood needs assessment scan and needs assessment tool, identify family support models statewide that address family support, parent education and leadership.

Status: In process/ongoing

Objective 4: Develop innovative approaches utilizing best practices to support children and families as they transition between programs and services, and into public school.

Status: In planning

Health Committee

Objective 1: Strengthen collaborative relationships among local public health authorities and early care and education services.

Status: In process/ongoing

Objective 2: Increase Montana's rankings related to immunization utilization, especially in relation to the early childhood population.

Status: In planning

Objective 3: Develop innovative approaches to accessing dental care services for low income and rural populations.

Status: In process/ongoing

Objective 4: Develop Montana Physical Activity and Nutrition Guidelines for early childhood.

Status: In process/ongoing

Social/ Emotional/ Mental Health Committee

Objective 5: Strengthen and expand the CSEFEL Pyramid Model for practitioners and parents, cross system.

Status: In process/ongoing

Objective 6: Continue to build a repertoire of coaching professionals related to CSEFEL and social emotional support.

Status: In process/ongoing

Objective 7: As part of the strategic comprehensive scan of services, identify early childhood mental health services providers statewide and build bridges related to supporting young children with behavioral needs and their families.

Status: In planning

Objective 8: Develop a strong partnership between DPHHS and OPI MBI in expanding the CSEFEL Pyramid Model and assuring fidelity of the CSEFEL approach for early childhood professional working with children 0-5.

Status: In process/ongoing

Best Beginnings State Advisory Council

As of March 25, 2013

Ex-Officio Members

Child and Adult Care Food Program	Mary Musil
Child Care Licensing	Becky Fleming Siebenaler
Child Protective Services	Sarah Corbally
Department of Labor and Industry	
Developmental Services Division	Rebecca de Camara
Developmental Services Division; Part C	
Early Childhood Project	Libby Hancock
Early Childhood Services Bureau	Patty Butler
Family and Community Health Bureau	Denise Higgins
Family and Community Health Bureau; Home Visiting	Dianna Frick
Head Start Collaboration	Caitlin Jensen
Montana State Library	Sara Groves
Office of Public Instruction	
Office of Public Instruction; Early Grades Specialist	Terri Barclay
Public Assistance	Stephanie Wilkins

Volunteer Positions

Business	Kriste Jensen
Child and Adult Care Food Program Sponsors	Michelle Parks
Child Care Center	Collette Box
Child Care Family Home	
Child Care Group Home	David B. Cook
Child Care Resource and Referral Network	Eileen Donohoue
Early Childhood Higher Education	Dr. Cindy O'Dell
Early Childhood Project; Special Projects	Christy Hill Larson
Family Support	Deborah Neuman
Head Start Association	Debbie Richert
Military Child Care	Susan Ritter
Montana Child Care Association	Connie Sturgis
Montana Association for the Education of Young Children	Sharon DiBrito
Organized Labor – Union	
Parent	Holley Woosley Vennes
Philanthropy	Carol Townsend
Pregnant and Parenting Teens	Kelly Hart
Statewide Health Consultant Coordinator	Shelly Meyer
Eastern Montana-3 Community Council Coordinator	Brenda Stockert
Flathead County Community Council Coordinator	Erin Riggs
Gallatin County Community Council Coordinator	Amy Cory
Lewis and Clark County Community Council Coordinator	Katy Bugni
Missoula County Community Council Coordinator	Steve Schmidt
Ravalli County Community Council Coordinator	Kayla Gieseke
Silver Bow County Community Council Coordinator	Lynette Petritz
Blackfeet Tribal Community	
Confederated Salish and Kootenai Tribal Community	Jeanne Christopher
Crow Tribal Community	
Fort Belknap Tribal Community	
Fort Peck Tribal Community	Viola Wood
Northern Cheyenne Tribal Community	Lucinda Burns
Chippewa Cree Tribal Community	Josette Bill

BBAC Staff

Best Beginnings Advisory Council Coordinator	Debora Hansen
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